



**TENNCARE PROVIDER BILLING MANUAL FOR
INSTITUTIONAL MEDICARE CROSSOVER
CLAIMS**

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1 Introduction

1.1 Purpose

The Division of TennCare has developed a provider billing manual for hospitals, Intermediate Care Facilities (ICF), Skilled Nursing Facilities (SNF), Home Health Agencies, and Institutional Medicare/Medicaid Crossover paper claims. This manual contains all of the guidelines for submitting TennCare paper claims. Integrity, accuracy, completeness, and clarity are important details emphasized throughout this manual, as claims will be not suitable for processing if all required/situational information is not provided or legible.

This manual contains the following sections:

- Integrity of Claims
- Provider Registration
- Claim Submission
- Processing Claims
- Adjustment/Void Request
- Refunds
- Appeals

1.2 Contact Information

For information regarding member service eligibility, claim status, provider registration, mailing addresses, timely filing guidelines, and other information, providers may contact TennCare Provider Services at (800) 852-2683.

2 Integrity of Claims

A provider fraud task force was created to more effectively combat health care fraud in the State of Tennessee. To find out more about this task force, please visit the Attorney General's website: <http://www.tn.gov/attorneygeneral>

Under the Tennessee False Claims Act (TFCA), those who knowingly submit, or cause another person or entity to submit, false claims for payment of government funds are liable for three times the government's damages plus civil penalties of \$5,500 to \$25,000 per false claim. TennCare's policy related to fraud and the False Claims Act, PI 08-001.

See more at: <https://www.tn.gov/tenncare/fraud-and-abuse.html>

3 Provider Registration

TennCare recognizes the National Provider Identifier (NPI) as the only identifier to be submitted on claims in accordance with the Health Insurance Portability and Accountability Act (HIPAA) standards for claim transactions for healthcare services. Exclusions apply to the atypical provider, whereas they can only submit claim transactions with their Medicaid Identifier.

3.1 How is the NPI Obtained

Visit the National Plan & Provider Enumeration System (NPPES) website: <https://nppes.cms.hhs.gov>

OR

By phone at (800) 465-3203

3.2 How is a Medicaid ID Obtained

Individual providers can submit key information to obtain a Medicaid ID for a new provider, whereas existing providers can enter key information which will allow us to receive updates electronically. No matter if you are a new provider to TennCare/Medicaid or an existing TennCare/Medicaid provider; you will need to register your information.

TennCare is now using web-based technology to simplify and improve the provider registration/re-verification process. Individual providers only need to register once to be added to the TennCare Council for Affordable Quality Healthcare (CAQH) roster. Once registered, all other updates should be maintained in CAQH. Single and multi-specialty groups will register and update their data and members from this web portal. All other provider entities will register electronically by clicking the [All Other Provider Registration](#) link below.

Once your registration is approved, you will receive a TennCare/Medicaid ID number. A valid TennCare/Medicaid ID number is required for participation in TennCare, Tennessee's Medicaid program. A valid TennCare/Medicaid ID number is required to:

1. Get prescriptions covered by the TennCare Pharmacy Benefit for TennCare members.
2. Submit Medicare/Medicaid "crossover" claims to TennCare for consideration of Medicare copays and deductibles for our members with Medicare as a primary carrier.
3. Contract with any TennCare Managed Care Organization (MCO) in order to provide medically necessary services to TennCare members.
4. Receive payments from TennCare's Electronic Health Record (EHR) Incentive Program.

Please select the appropriate link below to access provider registration information appropriate for your provider type.

[Individual \(Provider Person\) Provider Registration Information](#)

Examples of an individual provider:

- John Doe, M.D., a solo practitioner
- Jane Doe, M. D. a practitioner participating as a member of a group.

[All Other Provider Registration Information](#)

Examples of a group provider:

- Any town Dental Practice (a group of General Dentists – Single Specialty)
- Happy Valley Medical Clinic (a group of Family Practitioners, Internists, and Pediatricians – Multi Specialty)
- ABC Medical Equipment (supplier of Durable Medical Equipment)
- Any city Hospital (Acute Care Hospital)
- Summertime County School District

Step by step instructions to electronic registration can be found by clicking

<https://www.tn.gov/content/dam/tn/tenncare/documents/GroupRegistrationInstructions.pdf> link.

Per Federal Regulations, as defined in 42CFR 455.410(b), all providers reported on Medicaid/TennCare claims, whether the provider is a billing or secondary provider, must be registered as a TennCare provider. Please be advised that paper claims are rejected when the NPI is not registered with TennCare and will be returned to the billing provider as unprocessed.

Providers who are registered with TennCare, but are not eligible for the entire claim dates of service, will be denied payment for the claim that was submitted.

See more at: <https://www.tn.gov/tenncare/providers/provider-registration.html>



Did you know?

Any time that a provider updates their facility information via the Provider Database Management System (PDMS) portal, the new updated information needs to be reflected immediately on all claim submissions or resubmissions once verified.

4 Claim Submission

For Institutional paper claims, the only acceptable claim forms are the official red drop-out ink form printed in Flint OCR Red, (J6983 or exact match) ink. Compliance with this standard is required to facilitate the use of image processing technology such as Optical Character Recognition (OCR), facsimile transmission, and image storing. It involves scanning a paper document to create a digital image of the text and then using software to store knowledge about that digital image. With OCR, it is very important suppliers follow proper paper claim submission guidelines. The Division of TennCare returns claims that are not submitted on an original form.

All claim forms and Explanation of Benefits/Explanations of Medicare Benefits (EOB/EOMB) are required to be completed in a legible dark black ink; use 10 or 12 point font (COURIER NEW or TIMES NEW ROMAN) in ALL CAPS. Do not handwrite, circle, underline, or highlight any information on the claim or EOB/EOMB. All claim forms must have a complete EOB/EOMB attached and a Third Party Liability (TPL) EOMB, when applicable.

4.1 Submissions of Taxonomy

When submitting a claim with a NPI number that is assigned to more than one service facility location, it is advised to submit these claims with the appropriate taxonomy number. Not doing so will result in delaying your claim to a final adjudication status. To alleviate this issue, TennCare has implemented that providers need to submit their taxonomy number in Form Locator (FL) 81CC of the Uniform Billing (UB) 04 claim form with "B3" as the qualifier along with its appropriate taxonomy number. Listed below are examples of taxonomy numbers:

- LEVEL I/ICF: 313M00000X
- LEVEL II/SNF: 314000000X
- ICF/MR: 315P00000X
- ICF/MR REHAB: 320900000X
- HCBS: 251E00000X

The reported taxonomy number must match to the NPI where the service was rendered or billed, when submitting claims to TennCare for adjudication.

Claim forms submitted without the required information will not be processed and will be Returned to Provider (RTP) for the necessary corrections.

UB-04 forms submitted on paper must be mailed to its appropriate P.O. Box listed below:

Box 470 – UB-04 Claim Forms

Box 480 – UB-04 Claim Forms (Long Term Support and Services [LTSS])

Providers may refer to Appendix B, “UB-04 Claim Form” for form completion instructions and an example of the UB-04 claim form, along with an example of the RTP sheet.



Did you know?

- Sending claims to any address not listed above does not guarantee timely processing. They may be delayed, or even get lost in the USPS postal mail run.
- Certified mail does not guarantee that your claim will reach an adjudicated status. Claims are reviewed by receipt date order and submission guidelines.
- Certified/Registered mail is signed for by a DXC Technology (DXC) representative. When signed, a confirmation is sent back to the provider. DXC keeps a confirmation tracking log by date of receipt to verify that each package has been received.
- Claims are not viewed by the human eye during the data validation process. To optimize the accuracy of claims, it is viewed by the OCR system. This ensures that all data transmits systematically vs human intervention of the data. During this process, it also validates provider/recipient information, eligibility, covered services, and so on, for claim adjudication in accordance with State and Federal requirements.

4.2 Tips for Submitting Paper Claims

The guidelines below must be followed to prevent claims from being returned. Listed are basic tips on submitting paper claims so that they can be processed in a timely manner:

- Use only Flint OCR red drop-out (J6983 or exact match) forms that are approved UB-04 forms. Approved forms will be notated with the statement “UB-04 CMS-1450 APPROVED OMB NO. 0938-0997” which is located at the bottom left hand side of the form. The National Uniform Billing Committee (NUBC) Template No. will be located at the bottom center with its version number (i.e. LIC3810506).
- Photocopied (colored/black and white) claims and/or EOB’s/EOMB’s will be returned to the provider unprocessed.
- Use a legible dark ink; 10 or 12 point font in all CAPITAL/UPPERCASE letters in either COURIER NEW or TIMES NEW ROMAN font.
- Claims and all associated EOB’s/EOMB’s must be legible.
- Do not handwrite, circle, underline, or highlight any information on the claim or EOB/EOMB.
- Do a print test and review claims prior to submission to ensure claim fields are displayed with proper alignment. Data should not fall outside the designated fields.
- Smudges, mark-through, stamps and pre-printed data in the body of the claim renders the legibility of claims and are considered extraneous information on the claim.
- When submitting paper claims, the use of paper clips are the preferred method of securing documentation, as staples impacts the manual handling/review process.
- Do not use tape or glue to fix a claim form or attachments.

- Do not use correction fluid/tape.
- Do not submit negative charges on the claim or EOB/EOMB.
- All providers must be registered with TennCare in order to obtain payment. A valid NPI is required and must be indicated in the appropriate form locator on all claims submitted to TennCare. For Atypical providers, a valid Medicaid ID is required.
- The last payer should always be read TennCare/Medicaid, spanning across form locator's 50-65.
- When billing Third Party Liability (TPL) claims, the payer line entry is to be made on line "B", spanning across form locator's 50-65, whereas the TennCare/Medicaid payer line will have an entry on payer line "C".
- When submitting a claim with a NPI number that is assigned to more than one service facility, complete FL 81CC with the "B3" qualifier and taxonomy number.
- Required fields cannot be left blank.
- Do not abbreviate fields, as they should be completed to its entirety. Improvising by typing the word "SAME" in a field (for example, service facility provider is the same as the rendering provider), will result in the claim being not suitable for processing.
- All claims must include a legible copy of the Medicare EOB/EOMB and TPL EOB, when applicable.
- All comparable information on the claim form must match the EOB/EOMB. Including one of the following NPI's: Billing, Attending, Operating, or Other.
- The EOB/EOMB needs to match the claim.
- The following fields are required to be visible on the EOB/EOMB:
 - Paid Date
 - "From" and "To" Service Dates
 - Billed Amount
 - Procedure Codes
 - Modifiers
 - Allowed Amount
 - Deductible Amount
 - Coinsurance/Copay Amount
 - Medicare Paid Amount
- When submitting HMO claims ensure a cover letter is submitted for each claim stating, "Special Handle, Medicare Advantage Plan". This will ensure that your claim is adjudicated correctly.



Did you know?

- The TennCare standard font is specific for a reason. The letter "I" (i) makes all the difference in the determination from the mistake of "1". Notice how the "I" in Arial font and the "I" in Times New Roman look. The "I" in Arial can easily be mistaken for a "1" when read by the OCR scanner whereas the "I" in Times New Roman has the dashes on the top and bottom to distinguish it from "1".

- The requirement for claims to be submitted in ALL CAPS/UPPERCASE is similar to the reason above; whereas a lower case "L" (l) can be misinterpreted for an uppercase (i) "I".

Below are helpful links:

https://networkhealthmedicare.com/files/pdf/Provider_Manual/CMS-UB04_Fact_Sheet.pdf

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c25.pdf>

http://www.lamedicaid.com/provweb1/billing_information/ub04instructions.htm

4.3 Returned to Provider Claims

Claims that fail to meet submission guidelines are returned to the provider. DXC Technology receives paper claim submissions twice daily during the mail postal runs to ensure claims are received in a timely manner. Reviewing criteria beforehand determines if a claim can be processed efficiently within the data validation process without any hindrance. Trained specialists review claims, according to State and Federal regulations, to ensure that submissions adhere to new day claim guidelines for TennCare processing. Any claim that fails the basic rules and regulations will be returned back to the provider with an RTP sheet explaining any pertinent data that may not adhere to the guidelines.

To ensure complete traceability, the claim is scanned with a Document Control Number (DCN) to refer back when a provider has questions about their claims.

4.4 Claim Requirement Guidelines

The Division of TennCare has tailored submission guidelines, which is entirely unique to the TennCare program, referenced in Appendix B, "UB-04 Claim Form". Any claim that fails to meet these guidelines are not suitable for processing and will either be returned to the provider or denied in the claims adjudication process.

Manuals and mandates have been filed and verified through the Division of TennCare in which our contracted support (DXC Technology) are required to uphold. Doing so, streamlines the process in which "clean claims" can be paid in a timely manner. A "clean claim" is defined as a claim that meets the guidelines and fully adjudicates to a paid or denied status in the TennCare Management Information System (TCMIS) within 30 business days.

An "unclean claim" can take a longer time to process due to system editing failure in the TCMIS. These claims with this criteria stop in the adjudication process and are placed in a "suspended" status. Meaning that they have to be manually researched and reviewed in order to determine if a claim can continue through the adjudication process to reach a paid or denied status, for example, a provider's NPI on the submitted claim being processed matches the NPI on file, but has a different taxonomy.

5 Processing Claims

The Administrative Simplification Compliance Act (ASCA) requires that as of October 16, 2003, all initial Medicare claims be submitted electronically, except in limited situations. Medicare is prohibited from payment of claims submitted on a paper claim form that do not meet the limited exception criteria.

CMS has provided a listing of exceptions to electronic claim submission on its Administrative Simplification Compliance Act Self-Assessment External Website Web page

<https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/ASCASelfAssessment.html>.

Some of these reasons include:

- Small Institutional facility claims
- Claims from providers that submit fewer than 10 claims per month on average during a calendar year
- Claims for payment under a Medicare demonstration project that specifies paper submission

Claims for TennCare recipients who have a Dual Special Needs Plan (D-SNP) as a replacement for their traditional Medicare, are now submitted electronically by the recipients' respective DSNP plan. The initial claim CANNOT be submitted on paper. Adjustments can be submitted electronically or on paper.

The Division of TennCare is required to process claims per the Committee on Operating Rules for Information Exchange (CORE) regulations. Per NUBC standards all paper claims are to be aligned and processed per the electronic 837I transaction. Providers may notice more claims being returned due to the CORE and National Uniform Billing Committee NUBC standard.

Claims go through a determination process once received in the mail. After meeting the basic requirements needed to process a claim, the claim is then scanned to create a digital image of the text. It then uses software to store the data fields of the claim in a repository for future references. During the scanning process, it then receives an Internal Control Number (ICN) in order to track the claim in the adjudication process.

The ICN is used for the following:

- To document the source of submission (electronic, web, or paper), identified by the first two digits of the ICN.
 - Electronic claims are identified by "20", "28", or "30". These claims are not eligible for reprocess as they were submitted via Secure File Transfer Protocol (SFTP).
 - Paper claims are identified by "10", "11", "90", or "92". These claims are eligible for reprocess as long as there is an error/issue associated with the claim due to the fault of TennCare/DXC Technology during the data validation process.
- Tracks the claim from system entry to adjudication finalization.

The ICN is populated on the Tennessee Medicaid Remittance Advice (both 835 and Provider PDMS portal [PDF version]) and is the source of reference for claim status inquiries.

5.1 Crossover Claims

TennCare receives Medicare crossover claims directly from Medicare's Coordination of Benefits Agreements (COBA), if the provider has elected for this service.

What is the process?

For recipients who have dual eligibility (Medicare and Medicaid), providers will bill claims to Medicare. Medicare will automatically send the claim data to TennCare for processing and payment of the deductible/coinsurance or co-pay amounts (also known as the Medicare Patient Responsibility). TennCare will deny the claim if a claim is crossed over with no patient responsibility.

Providers are urged to review their Medicare remittances to determine whether their claims have been crossed over to TennCare for processing. Claims that are indicated on the Tennessee Medical Assistance Programs remittance advice as a crossover (for example, the first two digits of the ICN read 20 or 30) should not be submitted to TennCare as a paper claim.

5.2 Third Party Liability Claims

What is Third Party Liability?

In most cases, when a recipient has TennCare they may also have other (usually private) insurance. The other insurance is sometimes called “third party liability” or “TPL.” It simply means that a third party—someone besides the recipient (or their family member or conservator) may have primary responsibility for paying for covered services.

When a recipient applies for TennCare, they must report any TPL they have. If a recipient gets other insurance after they are enrolled in TennCare, they are required to notify TennCare of the other insurance.

If a recipient has other insurance (or TPL), TennCare can only process for services** that are not covered by the other insurance, or that the other insurance doesn’t pay “in full.” This may or may not include services where the recipient’s other insurance says they must pay or has a co-pay or deductible due.

** While the provider may bill a service, all services are not covered by TennCare.

5.2.1 How TPL Works for Most TennCare Services

For most TennCare services (like hospital and doctor visits), if a recipient has TPL, the provider who rendered the service must bill the other insurance company first before TennCare can process a claim for that service. If the other insurance doesn’t pay the full amount due, the provider can send a claim to TennCare. The provider must include, with its claim to TennCare, the EOB from the other insurance, showing if the service was covered, and if so, the amount the other insurance paid for the service.

TennCare will then process a claim for the balance due for that service, however if the process finds that the recipient has TPL information in the TCMIS system, the claim will process to a denied status indicating that a TPL is on file. The TPL denial will post to the providers remittance advice, including the information for the third party insurance.

For example, Third Party Carrier Liability Data

Insured Policy No: ABC9999	Name of Insured: Doe, John
Carrier Name: XYZ Health	Group Policy Number: EFG99999
Carrier Address: 123 Durry Lane Nashville, TN 99999	Group Employer Name: XYZ Health

The amount TennCare pays will be no more than TennCare would have paid if the recipient didn’t have TPL. But, the provider must accept that amount as payment in full, even if the TennCare payment is zero. Providers cannot bill a TennCare recipient for any balance due.

5.2.2 TennCare’s TPL Contractor

TennCare has a contractor who helps collect TPL from other insurance companies for services provided to TennCare members. The contractor’s name is Health Management Services (HMS). Any payment received from the work HMS does is used to help offset the cost of Medicaid services TennCare has paid for.

5.3 Claim Adjudication

Paper claims are reviewed to ensure they contain all the information needed to systematically process. Claims missing required information are returned to the provider with a letter explaining the reason(s) for return. Providers may refer to Appendix B, "UB-04 Claim Form" for an example of the *Return to Provider* letter.

Upon completing the review, the system assigns each claim a status: paid, denied, or suspended.

Adjudicated "clean claims" (paid or denied) are processed through the weekly financial cycle, at which time a Remittance Advice (RA) 835 is produced and payments are processed, if applicable. Claims that adjudicate before 5:00 PM, CST, on Tuesday, will be included on the Friday RA/835 of the same week.

Claims approved for payment are issued by check or by Electronic Funds Transfer (EFT) transaction, according to the State of Tennessee Department of Treasury Guidelines.

TennCare's pricing methodology is applied to all claims that meet payment adjudication criteria. Claim payments are reduced when a TPL and/or patient liability amount (applicable for LTSS only) is present on claims.

5.3.1 Pricing/Payment Methodology

Institutional crossover claims are billed using HIPAA 837I transactions. Institutional crossover claims are for recipients with dual eligibility, Medicare, and Medicaid.

Institutional crossover claims are billed to the Division of TennCare by Medicare and are processed as Fee-for-Service (FFS) claims in interChange. Payment for these services is to the individual/billing service providers.

TennCare receives the following types of Institutional crossover claims:

- Inpatient Hospital
- Outpatient Hospital
- SNF

TennCare's fiscal year is from July 1st through June 30th.

5.3.1.1 Pricing Information – Inpatient Hospital

TennCare has only one level of care (hospital) for Institutional inpatient crossover claims. There are five methods to price Institutional inpatient crossover claims:

- Inpatient mental health payment method
- 80% of Medicare allowed
- Hospital Part B payment method
- Per diem up to 20 days payment method
- Per diem over 20 days payment method

The following is an example of TennCare using the 60% pricing logic when the recipient used more than 20 covered days per fiscal year:

- Medicaid Allowed Total 1 = (Per Diem) * (60%) * (Covered Days over 20)
- Medicaid Allowed Total 2 = (Per Diem) * (Covered Days not over 20)
- Medicaid Allowed = (Medicaid Allowed Total 1) + (Medicaid Allowed Total 2)
- If Medicare Paid amount is greater than Medicaid Allowed pay zero, if not continue

- Allowed = (Medicaid Allowed) – (Medicare Paid)
- Payment = Lesser of (Allowed) or (Coinsurance) or (Deductible) + (Blood Deductible) - (TPL amount)

The following is an example for a claim where the recipient used more than 20 covered days during the fiscal year:

Table 5.3.1-1: Claim used more than 20 Covered Days

Per Diem	Per Diem 60%	Days @ 60%	Med. Allow Total 1	Med. Allow Total 2	Med. Allow	Med. Paid	Med. Allow	Coins.	Pay
620.18	372.108	60	22326.48	0	22326.48	15053.72	7272.76	2030.00	2030.00

5.3.1.2 Pricing Information – Outpatient

TennCare has three methods to price Institutional outpatient crossover claims:

- Provider Percentage and Coinsurance Times 4 and 5 Payment Method
- Outpatient Mental Health Payment Method
- Deductible plus Coinsurance Payment Method

The following is an example of Provider Percentage and Coinsurance Times 4 and 5 Payment Method:

The system uses this payment method for crossover outpatient claims for which the providers are hospitals primary type, secondary type, outpatient, or out of state. These providers are identified in interChange as Provider type 01, specialty 012 – Hospital Rehabilitation; Provider type 01, specialty 017 – Acute Care- Rural; and Provider type 01, specialty 010 – Acute Care.

The Medicaid payment amount is calculated as follows:

- Coinsurance4 = (Coinsurance amount) * 4
- Coinsurance5 = (Coinsurance amount) * 5
- Medicaid Coinsurance = (Provider Reimbursement %) * (Coinsurance5)
- Medicaid Allowed = (Medicaid Coinsurance) – (Coinsurance4) if Medicaid allowed less than zero (0), pay Medicaid allowed to zero (0)
- Payment = (Medicaid allowed) + (Deductible amount) – (TPL amount)

If there is no provider percentage on file, calculate provider percentage at zero.

Example:

Table 5.3.1.2: Calculate Provider Percentage at Zero

Coins * 4	Coins * 5	Prov. % *Coins 5	Medicaid Coins – Coins 4	Medicaid Allow + Deductible	Payment
38.50	38.50	0.00	0.00	0.00	\$64.47
X 4	X 5	X 192.50	- 154.00	+ \$64.47	
\$154.00	\$192.05	\$0.00	\$154.00	\$64.47	

5.3.1.3 Pricing Information – SNF (Claim Type A)

TennCare has one method to price Institutional SNF crossover claims which is the “Per Diem Payment Method”.

The Medicaid payment amount is calculated as follows:

- $\text{Coinsurance Days} = (\text{Coinsurance amount}) / (\text{Coinsurance Rate})$
- $\text{Medicaid Allowed} = (\text{Coinsurance Days}) * (\text{Medicaid Per Diem Rate})$
- $\text{Daily Patient Liability} = (\text{Monthly Liability Rate}) / (\text{Number of days on the month out of the From Date of Service})$
- $\text{Patient Liability} = (\text{Daily Liability}) * (\text{Coinsurance Days})$
- $\text{Allowed} = (\text{Medicaid Allowed}) - (\text{Medicare Paid amount}) - (\text{TPL}) - (\text{Patient Liability})$
- $\text{Reduced Coinsurance Amount} = (\text{Coinsurance Amount}) - \text{Patient Liability}$
- $\text{Payment} = \text{Lesser of (Allowed) or (Reduced Coinsurance) Amount}$

The system applies rounding on each calculation.

5.4 Suspended Claims

The definition of a suspended claim is an “unclean claim” that has failed validation during the claim adjudication process. These claims are delayed in adjudicating to a paid or denied status based on systems validation versus claim information. Claims have to be manually researched and reviewed in receipt date order to determine if a claim will be adjudicated to a paid or denied status. For example, a claim is submitted with the spouse’s Social Security Number (SSN) and the linked account is not in the insured’s name, this results in a patient’s SSN mismatch.

Note: Claims can suspend multiple times during verification before final adjudication of paid or denied.



Did you know?

- If an electronic claim is processed by Medicare, Medicare will automatically crossover an electronic claim to TennCare on your behalf if you have signed up for this service. If you would like to sign up for this service visit www.tn.gov/tenncare.
- When an electronic claim is submitted and also a paper claim is mailed, the electronic version will always reach a paid or denied status first. The paper claim will take longer to process and will be denied as a duplicate because of the electronic version that is on file. DO NOT submit a paper claim to the Division of TennCare if an electronic version has been submitted.

5.5 Reprocessing Claims

Per TennCare, “A reprocess should occur when there is an error/issue on our (TennCare/DXC) side (e.g., keying error, a void of a paper claim that should have been an adjustment, a system issue that has a work request tied to it, etc.). A billing error/issue on the provider side does not constitute as a reprocess. The provider will need to resubmit a new red dropout claim with all updated and pertinent information so that the claim can adjudicate correctly.”

Common Reprocess Requests:

- Keying/Scanning error
- Alignment issue (invalid claim forms)

- Invalid information (light print skews data)

5.6 Timely Filing Limits

Medicare crossover claims are usually sent to TennCare by the Medicare Coordination of Benefits Contractor and Dual Special Needs Plans. However, there are occasions when providers may submit Medicare crossover claims directly to TennCare utilizing the appropriate paper claim form.

If the Medicare claim did not automatically cross over to TennCare, and the claim is outside of the one year timely filing limit, the provider has six months from the date he/she was notified by Medicare of payment or denial of his/her claim to submit his/her request for crossover payment directly to TennCare.

TennCare may consider exceptions to the submission deadline only in the following circumstances:

- Recipient eligibility is determined retroactively. Claims must be submitted within two years from the date in which the recipient's eligibility is added to the TennCare system.
- A Medicare claim that does not automatically crossover to TennCare. Once the claim is processed by Medicare, the provider has six months from the Medicare paid date to submit the claim to TennCare.
- Denied claims must be resubmitted within six months from the date the claim was originally denied and if the claim does not adjudicate at this time, a follow up must be done every six months thereafter until claim has adjudicated. This will ensure that claims will adjudicate within the timely filing guidelines.
- Claims submitted due to third party coverage must be submitted within 60 days of the TPL payment and if the claim does not adjudicate at this time, a follow up must be done every six months thereafter until claim has adjudicated. This will ensure that claims will adjudicate within the timely filing guidelines.

5.6.1 Top 10 Paper Claim Rejection Reasons

- Light print on claim form
- Invalid font
- Alignment issue with claim
- EOB/EOMB not attached
- Type of bill/revenue code not in four-digit format
- Billing and/or secondary NPI not on file
- Diagnosis/Procedure code not on file
- Medicare paid date (occurrence code 53) missing on claim
- Occurrence/Value code and/or amount missing
- Invalid recipient unique identifier

5.6.2 Top 10 Suspended Reasons

- Submitted billing NPI's taxonomy does not match to TennCare's system.
- Submitted billing NPI's Tax ID does not match to record on file in TennCare's system
- Recipient name and recipient number does not match 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 duplicate of another claim (for example, same or different provider).
- Recipient has third party insurance.
- Submitted billing NPI on the claim is 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.
- Medicare coinsurance amount greater than amount paid by Medicare.
- Timely filing limit exceeded.

5.6.3 Top 10 Denial Reasons

- Recipients eligible in the Specified Low Income Medicare Beneficiaries (SLMB) program
- Recipient not eligible for dates of service - no financial benefits
- Medicare allowed amount invalid or missing, resubmit claim and original Medicare EOMB
- Rendering provider not eligible on all dates of service
- Exact duplicate - detail
- Rendering provider not eligible to render services on dates of service
- Attending NPI not submitted/valid/on file
- Zip code does not match the billing provider
- Recipient date of death is prior to date of service
- Procedure/Formulary age restriction
- Patient has two coverage types

6 Adjustment/Void Request

Adjustment/Void claims are submitted when it is necessary to change information on a previously processed claim. The change must impact the processing of the original bill or additional bills in order for the adjustment to be performed. The claim being adjusted must be in a finalized paid status.

If a claim in a paid status has been reviewed by TennCare and has one or more line items denied, adjustments can be made to the paid line items.

Note: Adjustments cannot be made to any part of a denied line item on a partially paid claim.

The *Adjustment/Void Request* form allows the Division of TennCare to correct or annul payments. All requests must be submitted on the most current version. Adjustments or voids submitted on any other version will be returned to the provider, for the claims will be unsuitable for processing.

Providers have two years, from the date the claim was originally paid, to submit an adjustment for processing.

Reasons for the submission of an *Adjustment/Void Request* form may include, but are not limited to the following:

- Overpayments/Refunds
- Underpayments
- Payments for an incorrect procedure code(s)
- Incorrect number of units

The *Adjustment/Void Request* form can be located on the TennCare website

<http://www.tn.gov/assets/entities/tenncare/attachments/avform.pdf>.

6.1 Adjustment/Void Request Form Submission Guidelines

The *Adjustment/Void Request* form is required for each claim ICN to be adjusted or voided.

Claims requiring a change to the provider number (NPI or billing number) must be voided and a new UB-04 1450 claim form submitted with the correct provider information. The *Adjustment/Void Request* forms missing information will be returned to the provider unprocessed.

All completed *Adjustment/Void Request* forms must be sent to the following address:

State of Tennessee

Division of TennCare

P.O. Box 1700

Nashville, TN 37202-1700

Providers may refer to Figure B.3, "Adjustment/Void Request Form" for a sample of the *Adjustment/Void Request* form and completion instructions.

7 Refunds

Refunds are voluntary payments made to TennCare by providers due to overpayments. When submitting a refund:

- Complete an *Adjustment/Void Request* form to include checking the box labeled "Overpayment – Refund Check Attached".
- Submit pertinent supporting documentation, including, but not limited to:
 - Medicare EOMB
 - TPL EOMB
- Include a check made payable to the State of Tennessee.

Refunds must be sent to the following address:

State of Tennessee, Division of TennCare
 Attention: Division of Budget/Finance
 310 Great Circle Road
 Nashville, TN37243-1700

Refund amounts for claims paid by an active Managed Care Organization/Managed Care Contractor (MCO/MCC) will be returned. Refunds for these claims should be sent to the respective TennCare MCO/MCC that made the original payment.

Refund amounts for claims paid by an inactive MCO/MCC will be processed by TennCare.

8 Appeals

Providers who have filed claims with TennCare directly and who believe they have not been paid correctly have certain appeal rights, in accordance with TennCare Rule 1200-13-18.

Claims may be appealable if they were filed in accordance with TennCare rules and policies and they meet certain basic criteria. Criteria's include, but are not limited to, the following:

- The claim was a "clean claim".
- The claim contained no errors such as incorrect dates, codes, and so on.
- The claim was filed timely. See Policy PAY 13-001 for timely filing policies.
- The claim was for a covered service.
- The claim was for a service delivered to an eligible recipient.
- The claim was processed in accordance with Federal and TennCare rules and policies.
- The claim was processed correctly by the TennCare vendor, which includes accurately scanning, keying, and manual adjudication of suspended claims/audits.

There are certain types of claims for which no appeal will be provided. These include, but are not limited to, claims that do not meet one or more of the criteria stated above. As a general rule of thumb, a claim that was denied because it does not meet the above criteria is not appealable.

After reviewing a claim, one of three decisions will be made:

- The claim should have been paid as requested.
- The claim is not appealable, and no reimbursement will be made.
- The claim is appealable, and changes in reimbursement may be made, depending upon the outcome of the appeal.

Procedures for appeals are as follows:

1. Provider appeals will be mailed to the attention of the Claims Unit Manager, at the following address:
 Division of TennCare
 310 Great Circle Rd.
 Nashville, TN 37243
2. The Claims Unit will review and research the claim to determine which of the above three decisions is appropriate. They will check for keying errors or general processing errors that may have occurred in the TennCare system, in addition to validating that a clean claim was submitted appropriately by the provider within the timely filing guidelines and that the required follow-up was performed in accordance with the rules/regulations/policies.
3. If the decision is that the claim should have been paid as requested, the Claims Unit will take appropriate action to pay the claim. The Claims Unit will use the Resolvable Appeal template to respond to the provider.
4. If the decision is that the claim is not resolvable, as defined above, the Claims Unit will consult with the Office of General Counsel on the matter of correspondence to the provider—appropriate citations, specific verbiage, and so on and will utilize either the Denied Claim Response to Provider – No Appeal Rights or the Denied Claim

Response to Provider – Appeal Rights template notice to respond to the provider. The correspondence will be sent to the provider via certified mail.

5. If the claim appears to be appealable, as defined above, the Claims Unit will notify the provider of the opportunity to appeal. This notification letter will contain the information the provider is to include in a request for an appeal, the deadline for communicating the request for an appeal to the Claims Unit, and the address for the Claims Unit. When a request for an appeal is received, the documents and the envelope in which they were received from the provider will be dated, then scanned and saved for Claims Unit files. The originals will be hand-delivered to the Office of General Counsel's State Litigation Unit. An appeal request received from a provider is time-sensitive and must be delivered to the Office of General Counsel on the date of receipt.
6. At that point, the Office of General Counsel will take over handling the appeal. Claims Unit staff will be available to assist as needed.

Appendix A: Glossary

Table A: Glossary

Term	Definition
835	Remittance Advice
837I	Electronic Institutional Claim – HIPAA Compliance of Claim Processing through the Electronic Billing of Third Party Insurance Claims
ASC	Accredited Standards Committee
ASCA	Administrative Simplification Compliance Act
CAQH	Council for Affordable Quality Healthcare
CMS	Center for Medicare and Medicaid Services
COBA	Coordination of Benefits Agreement
CORE	Committee on Operating Rules for Information Exchange
CPT	Current Procedural Terminology
Crossover Claim	A claim for services rendered to a patient eligible for benefits under both Medicare and Medicaid Programs
CST	Central Standard Time
DCN	Document Control Number
D-SNP	Dual Special Needs Plan
DX	ICD version
DXC	DXC Technology
ECI	External Cause of Injury
EFT	Electronic Funds Transfer
EHR	Electronic Health Record
EOB	Explanation of Benefits
EOMB	Explanation of Medicare Benefits
ESRD	End Stage Renal Disease
FFS	Fee-for-Service
FL	Form Locator
HCBS	Home and Community Based Services
HCPCS	Healthcare Common Procedural Coding System
HIPAA	Health Insurance Portability and Accountability Act
HIPPS	Health Insurance Prospective Payment
HMS	Health Management Service
ICD-10-CM	International Classification of Diseases, Tenth Revision, Clinical Modification
ICD-9-CM	International Classification of Diseases, Ninth Revision, Clinical Modification
ICF	Intermediate Care Facilities
ICN	Internal Control Number
IDE	Investigational Device Exemption
LTSS	Long Term Service and Support
MCC	Managed Care Contractor
MCO	Managed Care Organization
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NUBC	National Uniform Billing Committee
OCR	Optical Character Recognition
OMB	
PDF	Portable Document Format
PDMS	Provider Database Management System
POA	Present on Admittance

Term	Definition
PPS	Prospective Payment System
RA	Remittance Advice
RTP	Returned To Provider
SFTP	Secure File Transfer Protocol
SLMB	Specified Low Income Medicare Beneficiaries
SNF	Skilled Nursing Facility
SSN	Social Security Number
TCMIS	TennCare Management Information System
TFCA	Tennessee False Claims Act
TOB	Type of Bill
TPL	Third Party Liability
UB	Uniform Billing
UB-04/UB-04 1450	Uniform Billing 04 - The common claim form used by institutions to bill for services.
UMO	Utilization Management Organization
USPS	United States Postal Service

Appendix B: UB-04 Claim Form

B.1 UB-04 Claim Form Completion Instructions

The instructions below describe information that should be entered in each of the form locator numbers on the *UB-04 Claim Form*. Form locator numbers not referenced are not needed to adjudicate the claim.

The following instructions are tailored for submitting claims to TennCare, refer to Section 4.4, Claim Requirement Guidelines". For additional claim submission instructions, refer to the *National UB-04 Uniform Billing Manual* prepared by the National Uniform Billing Committee. The *National UB-04 Uniform Billing Manual* contains important coding information not available in these instructions. Providers may purchase the *National UB-04 Uniform Billing Manual* by accessing the NUBC website at <http://www.nubc.org/>.

Form Locator 1 – Billing Provider Name, Address and Telephone Number (required)

Enter the billing provider name, address, city, state, zip code, and telephone number.

Note: The address must be a street address. Report post office boxes and lockboxes in FL2.

Form Locator 2 – Billing Provider's Designated Pay-to Address (situational)

Enter the name, street address, city, state, and zip code where the provider submitting the claims intends payment to be sent.

Note: Report only if it is different from the billing provider in FL1. The taxonomy code is reported for the billing provider only.

Form Locator 3a – Patient Control Number (required)

Enter the patient's unique alphanumeric control number assigned by the provider to the patient.

Note: The maximum number of characters to be supported in this field is 20.

Form Locator 3b – Medical/Health Record Number (situational)

Enter the number assigned to the patient's medical or health record by the provider.

Note: This field is situational, but required when the provider needs to identify the actual medical record of the patient for future inquiries. Payers may also require this field depending on claim processing requirements. Providers may enter up to 24 characters of the patient's medical or health record. This number will appear on the RA and/or the 835 transaction.

Form Locator 4 – Type of Bill (required)

Enter the four-digit code indicating a specific type of bill.

Refer to the *NUBC UB-04 Data Specifications Manual* for the valid type of bill code specific to the claim for which is being submitted.

Type of Bill Codes

- 011X Hospital Inpatient (Part A)
- 012X Hospital Inpatient (Part B)
- 013X Hospital Outpatient
- 014X Hospital Other (Part B)
- 018X Hospital Swing Bed
- 021X SNF Inpatient
- 022X SNF Inpatient (Part B)
- 023X SNF Outpatient
- 028X SNF Swing Bed
- 032X Home Health
- 033X Home Health
- 034X Home Health (Part B Only)
- 041X Religious Nonmedical Health Care Institutions
- 071X Clinical Rural Health
- 072X Clinic End Stage Renal Disease (ESRD)
- 073X Clinic – Freestanding/ Federally Qualified Health Centers
- 074X Clinic OPT
- 075X Clinic CORF
- 076X Community Mental Health Centers
- 077X Federally Qualified Health Centers
- 081X Nonhospital based hospice
- 082X Hospital based hospice
- 083X Hospital Outpatient (Accredited Standards Committee [ASC])
- 085X Critical Access Hospital

Form Locator 5 – Federal Tax Number (required)

Enter the hospital-specific Federal tax identification number on the lower line in the following format: XX-XXXXXXX.

Note: The upper line is used to identify the provider's affiliated subsidiaries (for example, hospital psychiatric pavilion), using a Federal tax sub-identification number.

Form Locator 6 – Statement Covers Period (from and through) (required)

Enter the beginning and ending service dates of the period included on the bill using a six-digit date format (MMDDYY). For services rendered on a single day, both the “From” and “Through” dates must be the same.

Form Locator 8 – Patient Name/Identifier (required)

Report the patient ID in FL8a if it is different from the subscriber/insured’s ID (FL 60). Enter the patient’s last name, first name, and middle initial in FL8b.

Use commas to separate the last name, first name, and middle initial. A hyphen can be used for hyphenated names. Do not use periods within the name.

Note: The patient name on the claim form must match the name as it is on the Medicare health insurance card or Medicare notice (for example, do not use “Tom” if the card uses “Thomas”).

Form Locator 9 – Patient Address (required)

Enter the patient’s complete mailing address (field’s 9a-9e), including street (9a), city (9b), state (9c), and zip code (9d).

Form Locator 10 – Birth Date (required)

Enter the patient’s date of birth using an eight-digit date format (MMDDCCYY). If the full birth date is unknown, report zeros for all eight digits.

Form Locator 11 – Sex (required)

Enter an “M” (male), “F” (female), or “U” (Unknown)

Form Locator 12 – Admission/Start of Care Date (situational)

Enter the date that the patient was admitted using a six-digit format (MMDDYY).

Note: Required on all inpatient claims, 012X, 022X, 032X, 034X, 081X, and 082X.

Form Locator 13 – Admission Hour (situational)

Hours are entered in military time using two numeric character. For example, “00” 12:00 (midnight) – 12:59a.m., “12” 12:00 (noon)-12:59p.m.

Note: Required on inpatient claims except for SNF inpatient, TOB 021X.

Form Locator 14 – Priority (Type) of Admission/Visit (required)

Required for inpatient hospital services if the Type of Bill (TOB) code in FL4 is 011X, 012X, 018X, 021X, 022X, or 041X. This fields contains single numeric codes defined below:

1. Emergency
2. Urgent
3. Elective
4. Newborn
5. Trauma Center
6. Information not Available

Form Locator 15 – Point of Origin for Admission or Visit/SRC (required)

Enter the appropriate admission or visit referral source code.

Note: This field is required on all TOBs except 014X.

Form Locator 16 – Discharge Hour/DHC (situational)

Required on all final inpatient claims except for SNF inpatient, TOB 021X. This includes claims with a frequency code of 1, 4, or 7 when the replacement is for a prior final claim. Enter the appropriate two-digit discharge code referring to the hour during which the patient was discharged. Hours are indicated in military time.

Note: If this is an interim bill (patient status of “30”), leave the form locator blank.

Form Locator 17 – Patient Discharge Status/STAT (required)

Enter the appropriate two-digit code indicating the patient’s discharge status

Form Locator 18-28 – Condition Codes (situational)

Enter the appropriate two-digit condition code or codes if applicable to the patient’s condition. Report in alphanumeric sequence.

Note: If additional reporting is required, enter A1 and the condition code in FL 81.

Form Locator 29 – Accident State (situational)

Required when the claim is related to an auto accident and the accident occurred in a country or location that has a state, province, or sub-country code.

Form Locator 31-34 – Occurrence Codes and Dates (required/situational)

Enter the event code and associated date defining a significant event or events related to the billing period. Event codes are two digits and dates should be six digits (MMDDYY).

- For all crossover claims, occurrence code 53 is required when billing TennCare along with the Medicare paid date (MMDDYY).

Note: TennCare is working towards changing system logic to remove Occurrence Code 53. However the date has yet to be determined and therefore it will still be required until further notice.

- For all Skilled Nursing Facility/Long Term Care/Home and Community Based Services (SNF/LTC/HCBS) claims, occurrence code 51, 52, and/or 54 is required when billing TennCare along with the Medicaid paid date (MMDDYY).
- 24-TPL denial date (list the TPL as a payer if no payment is made) attach TPL RA.
- 25-TPL termination date (list the TPL as a payer if no payment is made) attach TPL term letter/notice.

Note: Report occurrence codes in the following order: FLs 31a, 32a, 33a, 34a, 31b, 32b, 33b, and 34b. If additional codes need to be reported and there are no occurrence span codes to report, then the additional codes may be reported in 35a, 36a, 35b, and 36b with the date in the “From” field.

Form Locator 35-36 – Occurrence Span Codes and Dates (situational)

Enter the appropriate two-digit occurrence span code and related from/through date using a six-digit format (MMDDYY) that identifies an event that’s related to the payment of the claim. These codes identify occurrences that happened over a span of time.

Form Locator 38 – Responsible Party Name and Address (situational)

Enter the name, address, city, state, and zip code of the party responsible for the bill. Even though the national billing guideline state that this field is not required by Medicare, the information, when provided, must be accurate.

Form Locator 39-41 – Value Codes and Amounts (required/situational)

Enter the appropriate two-digit value code and value amount if there is a value code and value amount appropriate for this claim.

Value Codes and Amounts:

- Enter Value Code A1 for Deductible (07 is not valid) along with the dollar amount to the right of the value code.
- Enter Value Code 06 for Blood Deductible along with the dollar amount to the right of the value code.
- Enter Value Code 08 for Lifetime Reserve Days along with the dollar amount to the right of the value code.
- Enter Value Code 09 or A2 for Part B Co-insurance along with the dollar amount to the right of the value code.
- Enter Value Code A7 for Part B Co-pay along with the dollar amount to the right of the value code.
- Enter Value Code 80 for Covered Days and the number of days, as a whole number, to the right of the value code (for example, 1 days = 1 or 10 days 10, not 1.00 or 10.00).
- Enter Value Code 81 for Non-Covered Days and the number of days, as a whole number, to the right of the value code (for example, 1 days = 1 or 10 days 10, not 1.00 or 10.00).
- Enter Value Code 82 for Co-insurance Days and the number of days, as a whole number, to the right of the value code (for example, 1 days = 1 or 10 days 10, not 1.00 or 10.00).
- Enter Value Code 83 for Lifetime Reserve Days and the number of days, as a whole number, to the right of the value code (for example, 1 days = 1 or 10 days 10, not 1.00 or 10.00).

Note: Complete all “a” fields before using any “b” fields, all “b” fields before using “c”, and all “c” fields before using “d”.

Form Locator 42 – Revenue Code (required)

Enter the applicable Revenue Code for the services rendered in the format of 4 digits (OXXX). Required for all claim types that require procedure or drug information to be reported for claim adjudication.

Note: The 23rd line is reserved for an incremental page count, total number of pages, date of creation, summary totals of covered, and non-covered charges. On multiple page bills, the incremental and total page count should appear on each page with only the final page containing all data elements.

Form Locator 43 – Revenue Description/IDE Number/Medicaid Drug Rebate (required)

Enter the applicable Revenue Code description for the services rendered.

Form Locator 44 – Healthcare Common Procedural Coding System (HCPCS) /Accommodation Rates/HIPPS Rate Codes (situational)

Enter the applicable HCPCS (CPT)/HIPPS rate code for the service line item if the claim was for ancillary outpatient services and accommodation rates. Also report HCPCS modifiers when a modifier clarifies or improves the reporting accuracy.

Note: Data elements are required for all outpatient claims when an appropriate HIPPS or HCPCS code exists for the service line item. For inpatient claims, report the accommodation rates corresponding with the revenue code in sequential order. Must include whole dollars, the decimal and cents, such as \$999.99.

Form Locator 45 – Service/Assessment Date (situational)

Enter the applicable six-digit format (MMDDYY) for the service line item if the claim was for outpatient services, Skilled Nursing Facility/Prospective Payment System (SNF/PPS) assessment date, or needed to report the creation date for line 23.

Medicare claims require that every revenue code have an associated line-item date of service or dates of service range for bill types 012X, 013X, 014X, 022X, 023X, 032X, 033X, 034X, 071X, 072X, 073X, 074X, 075X, 076X, 077X, 081X, 082X, 083X, and 085X.

Note: Report the creation date on line 23 on every page of a multiple page bill.

Form Locator 46 – Service Units (required)

Enter the number of units provided for the service line item. Report where appropriate and defined by revenue code requirements. When a decimal point is used, no more than three digits are allowed to the right of the decimal. Leading zeroes should not be reported.

Form Locator 47 – Total Charges (required)

Enter the total charges for each service provided. Enter the total charges using Revenue Code 0001. Total charges included both covered and non-covered services.

Note: For all SNF Part A Inpatient claims (TOB code 021X [FL4]) and swing-bed claims (TOB 018X), this field should contain zero total charges when RC 0022 is reported in FL 42. For accommodation RCs 010X-021X, the total charges must equal the rate (reported in FL 44) times the units reported in FL 46.

Form Locator 48 – Non-covered Charges (situational)

Enter any non-covered charges as it pertains to related Revenue Code.

Note: The total dollars in this column must sum to the amount reported in this field applicable to the total revenue code line 0001.

Form Locator 50 – Payer Name (required)

Enter the health plan that the provider might expect some payment from for the claim.

Enter all health insurance payer identifications:

- A = Primary
- B = Secondary
- C = Tertiary

Note: All additional entries across line A, B, or C, (FLs 52-55) must provide information needed by the payer reported in this field.

Secondary Payer Line/Third Party Liability Claims

If TPL makes payment (after Medicare):

Whenever there is an open TPL involved, you should list the payer name, along with policy number, paid amount, and recipient information in 50B-60B, even if \$0.00 payment was made.

If TPL denies/terminates:

In form locator 31-36, you should use an Occurrence Code (listed below) and list the TPL information in 50B-65B (even if \$0.00 payment is made):

24-TPL denial date (list the TPL as a payer, if no payment is made) attach TPL RA

25-TPL termination date (list the TPL as a payer, if no payment is made) attach TPL term letter/notice

Even if no TPL payment is made, the name of the TPL must still be entered in Form Locator 50B-60B. Last payer should always be Medicaid, spanning across FL's 50-65.

Please ensure that you attach both the Medicare RA (if applicable) and the complete TPL RA's with the UB-04 and a separate note that reads: O/R TPL—TPL RA ATTACHED

If you have a claim that has a TPL, you will need to mail it to:

Division of TennCare
ATTENTION: CLAIMS PROCESSING
P.O. Box 480
Nashville, TN 37202

Form Locator 51 – Payer ID/Health Plan ID (required)

Enter the number used by the primary (51a and 51b) health plan to identify itself. Enter a tertiary (51c) health plan, if applicable.

Note: Report the HIPAA national plan identifier when it is mandated for use. Until that point, report the legacy or proprietary number as defined in trading partner agreements.

Form Locator 52 – Release of Information Certification Indicator (required)

Enter "Y" or "I" to indicate if the provider has, on file, a signed statement from the patient or patient's legal representative allowing the provider to release information to the carrier. This indicator applies to the payers listed in FL50 on lines A and B, line C when applicable.

Form Locator 53 – Assignment of Benefits Certification Indicator (situational)

Enter a "Y", "N", or "W" to indicate if the provider has a signed statement on file from the patient or patient's legal representative assigned payment to the provider for the primary (53a) and secondary (53b). Enter the tertiary (53c) payer when applicable.

Form Locator 54 – Prior Payments – Payers (required)

Enter the amount of payment the provider has received (to date) by the health plan toward payment of the claim.

Note: This information is required when a prior payment has been received on the claim. Report 0.00 if the indicated payer did not pay on the claim, including those instances where the payment was applied to the deductible or coinsurance.

Form Locator 55 – Estimated Amount Due – Payer (situational)

Enter the amount estimated by the provider to be due from the indicated payer in FL50 on lines A and B, line C when applicable.

Form Locator 56 – National Provider Identifier – Billing Provider (required)

Enter the billing provider's unique ten-digit NPI number.

Form Locator 57 – Other (Billing) Provider Identifier (required)

Enter the unique identification number assigned by the health plan to the provider submitting the claim.

Note: FL 57 is required when the NPI is not used in FL 56 and an identification number other than the NPI is necessary for the receiver to identify the provider. The number should not be hyphenated, nor should there be any special characters or spaces between the characters.

Form Locator 58 – Insured's Name (required)

Enter the name of the patient or insured individual whose name the insurance is issued as qualified by the payer organization listed in FL 50 on lines A and B, line C when applicable.

Use commas to separate the last name and first name. A hyphen can be used for hyphenated names. Do not use periods within the name.

Form Locator 59 – Patient's Relationship to Insured (required)

Enter the appropriate two-digit code to describe the patient's relationship to the insured listed in FL 50 on lines A and B, line C when applicable.

Form Locator 60 – Insured's Unique ID (required)

Enter the insured's identification number assigned by the payer organization listed in FL 50 on lines A, B, and C.

Note: Enter the Medicaid identification number of the insured shown on the Medicaid identification card. Medicaid also requires the primary payer information on line A when Medicaid is secondary.

Form Locator 61 – Insured Group Name (situational)

If group name is available, enter insured's employer group name.

Form Locator 62 – Insurance Group Number (situational)

If insured's identification card shows a group number, enter insured's employer group number (62a). If applicable, enter other insured's employer group numbers when other payers are known to be involved (62b and 62c).

Form Locator 63 – Authorization Code/Referral Number (situational)

Enter the pre-authorization for treatment code assigned by the primary payer (63a). If applicable, enter the pre-authorization for treatment code assigned by the secondary and tertiary payer (63b and 63c).

Note: The authorization code is required when an authorization code has been assigned by the payer or Utilization Management Organization (UMO) and must be reported on the claims. The referral number is required when an authorization code has been assigned by the payer or UMO and a referral is involved.

Form Locator 64 – Document Control Number (situational)

Enter if this is a void or replacement bill to a previously adjudicated claim.

Form Locator 65 – Employer Name of the Insured (situational)

Enter when the employer of the insured is known to potentially be involved in paying claims.

Form Locator 66 – Diagnosis and Procedure Code Qualifier – ICD version {DX} (required)

Enter the required value of “0” (10th revision) or “9” (9th revision) to identify which version of the International Classification of Diseases (ICD) that is being reported for all subsequent diagnosis and procedure codes in FLs 67-74.

Note: ICD “9” will no longer be used for Dates of Service after October 1, 2015.

Form Locator 67 – Principal Diagnosis Code (required)

Enter the principal diagnosis code for the patient’s condition. The reporting of a decimal point between the third and fourth digits is unnecessary as it is implied.

Form Locator 67A – 67Q – Other Diagnosis Codes (situational)

Enter additional diagnosis codes if more than one diagnosis code applies to the claim. The reporting of a decimal point between the third and fourth digits is unnecessary as it is implied.

Note: Report the additional diagnosis codes in order of priority based on the information provided by the medical record department.

Present on Admission (POA) Indicator

Applies to diagnosis codes for inpatient claims to general acute-care hospitals or other facilities, as required by law of regulation for public health reporting. It is the eighth digit attached to the corresponding diagnosis codes in FLs 67, 67a-q, and 72a-c.

- Y = Yes, present at the time of inpatient admission.
- N = No, not present at the time of inpatient admission.
- U = No information in the record, documentation is insufficient to determine if condition is present on admission.
- W = Clinically undetermined, provider is unable to clinically determine whether condition was present on admission or not.

Form Locator 69 – Admitting Diagnosis (required)

Enter the diagnosis code for the patient’s condition upon all inpatient claims, 012X and 022X; except for 028X, 065X, 066X, and 086X

Form Locator 70a-70c – Patient Reason Diagnosis (situational)

Enter the appropriate reason for visit code only for bill types 013X, 078X, and 085X when the priority (type) of visit (FL14) is 1, 2, or 5 and one of the following revenue codes is present: 045X, 0516, 0526, or 0762 (observation room).

Form Locator 71 – Prospective Payment System (PPS) (situational)

Inpatient only. Enter the three-digit DRG based on software for inpatient claims when required under contract grouper with a payer.

Form Locator 72a – 72c – External Cause of Injury (ECI Code) (situational)

Enter the cause of injury code or codes when injury, poisoning, or adverse effect is the cause for seeking medical care.

Form Locator 74 – Principal Procedure Code and Date (situational)

Enter the principle procedure code and date using a six-digit format (MMDDYY) if the patient has undergone additional inpatient procedures.

Note: Required on inpatient claims.

Form Locator 74a-74e –Other Procedure Codes and Dates (situational)

Enter the other procedure codes and dates using a six-digit format (MMDDYY) if the patient has undergone additional inpatient procedure.

Note: Required on inpatient claims.

Form Locator 76 – Attending Provider Name and Identifiers (required)

Enter the attending provider's NPI number, last name, and first name. Enter secondary identifier qualifiers and numbers as needed.

Form Locator 77 – Operating Physician Name and Identifiers (situational)

Enter the operating provider's NPI number, identification qualifier, identification number, last and first name. Enter secondary identifier qualifiers and numbers as needed.

Note: Required when a surgical procedure code is listed on the claim (FL 74).

Form Locator 78 and 79 – Other Provider Names and Identifiers (situational)

Enter any other provider's NPI number, identification qualifier, identification number, last and first name. Enter secondary identifier qualifiers and numbers as needed.

Note: Required if another provider is involved with service submitted for payment.

Provider Type Qualifier Codes/Definition/Situational Usage Notes:

- DN – Referring Provider. The provider who sends the patient to another provider for services. Required on an outpatient claim when the referring provider is different than the attending physician. If not required, do not send.
- ZZ – Other Operating Physician. An individual performing a secondary surgical procedure or assisting the operating physician. Required when another operating physician is involved. If not required, do not send.
- 82 – Rendering Provider. The health care professional who delivers or completes a particular medical service or non-surgical procedure. Report when State or Federal regulatory requirements call for a combined claim, such as a claim that includes both facility and professional fee components (for example, a Medicaid clinic bill or Critical Access Hospital claim). If not required, do not send.

G2 – Provider Commercial Number (Secondary Identifier Qualifiers):

Form Locator 81CCa – d – Code-Code Field (required)

Enter "B3" qualifier along with the taxonomy for the billing provider.

Note – This field is also used to report overflow or additional codes related to field locators or to report externally maintained codes approved by the NUBC for inclusion in the institutional data set. Refer to the *Uniform Billing Editor* manual for further instructions.

B.2 UB-04 Return to Provider Letter

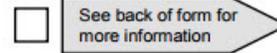
OCR Reject
Manual Review Reject



STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF TENNCARE
P.O. Box 1700
NASHVILLE, TENNESSEE 37202-1700

Date: _____

Clerk Initials: _____



ATTENTION PROVIDERS:

Effective 1/1/17, please be advised that **TennCare has enforced national billing standards to allow clean paper claims to adjudicate.** Providers may notice more claims being returned due to claim processing regulations. Provider corrections and resubmission of a Returned to Provider (RTP) claim will apply a new receipt date to the claim. Consequently, providers will need to submit a new claim if this occurs. Please visit www.nubc.org for additional guidelines. Listed below are common reason codes of why claims are RTP'd for correction:

TennCare no longer accepts paper claims that are either entirely handwritten or have been corrected with handwritten data. Please refer to back of this letter for proper claims submission guidelines.

The only acceptable claim forms are the official red drop-out ink form printed in Flint OCR Red, J6983, (or exact match) ink. Use UPPERCASE, 10 or 12 point font, Courier New or Times New Roman in a legible dark black ink. This font ensures that characters have a clear definition for the Optical Character Recognition (OCR) system. (e.g. The letter 'l' (i) makes all the difference in the determination from the mistake of '1'. Notice how the 'l' in Arial font and the 'l' in Times New Roman looks.) Compliance with these standards are required to facilitate the use of image processing technology (e.g. facsimile transmission & image storing). When submitting paper claims, the use of paper clips are the preferred method of securing documentation, as staples impacts the manual handling/review process. For more information please visit www.cms.gov

REQUIRED FIELD(S)

- () Invalid Font (Lowercase, Illegible Ink [Broken/Light Characters, Bold/Bleeding/Smudged Characters])
- () Provider Billing Information Missing/Invalid (FL1) ***P.O. Boxes are NOT accepted***
- () Patient Control Number Missing (FL3a)
- () Type of Bill Missing/Invalid (FL4) ***4 Digits Required***
- () Federal Tax Number Missing/Invalid (FL5)
- () Statement Covers Period [From/Through] Missing/Invalid (FL6)
- () Patient Name [Last name, First name] Missing (FL8b)
- () Patient Address Missing (FL9a-e)
- () Date of Birth [MM/DD/CCYY] (FL10), Sex (FL11) Missing/Invalid
- () Admission Type (FL14), Admission Source (FL15), Patient Discharge Status (FL17) Missing /Invalid
- () X-Over Medicare Paid Date and/or Occurrence Code 53 Missing/Invalid (FL31 - FL34)
- () SNF Medicaid Paid Date and/or Occurrence Code 51, 52 or 54 Missing/Invalid for TOB 021X, 066X, 089X (FL31 - FL34)
- () Copay/Co-Insurance and/or Deductible Value Code/Amount Missing/Invalid (FL39 – FL41)
- () Revenue Code Missing/Invalid (FL42) ***4 Digits Required***
- () HPCS/Rates/HIPPS Code, Modifier Missing/Invalid (FL44)
- () Service Date (FL45), Service Units (FL46), Total Charges (FL47) Missing/Invalid
- () Service Date (FL45) must be within Statement Covers Period Dates (FL6)
- () Creation Date Missing/Invalid (FL45, Line 23)
- () Detail line missing (FL42 – FL47)
- () Sum of detail lines do not equal total charge on last page of claim (FL47, Line 23)
- () Payer Name Missing/Invalid (FL50)
- () Health Plan Identification Number Missing/Invalid (FL51)
- () Patient Release of Information Missing/Invalid (FL52)
- () Prior Payment Missing/Invalid (FL54) ***Negative amounts cannot be processed***
- () Billing NPI Number Missing/Invalid (FL56)
- () Other Provider Number Missing (FL57) ***Applies to Atypical Providers***
- () Other Provider Number Invalid (FL57)
- () Insured's Name [Last, First] Missing (FL58)
- () Insured's Unique ID Number Missing/Invalid (FL60) ***Must be 11 Digit RID or 9 Digit SSN for TennCare***
- () Insured's Name (FL 58) on claim form does not match Insured's Unique ID Number (FL60) on file
- () Primary payer line Missing/Invalid (FL50 – FL65)
- () TennCare payer line Missing/Invalid (FL50 – FL65)
- () TennCare is not on the last payer line (FL50 – FL65)
- () Invalid entries on a payer line (FL50 – FL65)
- () DX Qualifier/ICD Indicator Missing/Invalid (FL66)
- () Primary Diagnosis Code Missing/Invalid (FL67)
- () Secondary Diagnosis Code Invalid (FL67A – Q)
- () Attending NPI (FL76), Operating NPI (FL77), Other NPI Missing/Invalid (FL78 or 79)
- () Qualifier and/or Taxonomy Missing/Invalid (FL81CC)
- () Invalid claim form

ALIGNMENT/PRINT INK

() Form's and EOMB's must be aligned and in a dark ink print per UB-04 Data Element printing specifications. For more information please visit www.nubc.org

OTHER: _____

UB04-1450

YOUR ASSISTANCE IN THIS MATTER IS GREATLY APPRECIATED

Revised 01/19/18

NCR Key: 1 2 3 4 5 6 7 8 9 10

The form is a UB-04 Return to Provider Letter, used for institutional Medicare crossover claims. It contains numerous fields for patient information, insurance details, and claim data. Key fields include:

- 1 PATIENT NAME:** Marked with 'R'.
- 2 PATIENT ADDRESS:** Marked with 'R'.
- 3 PATIENT BIRTHDATE:** Marked with 'R'.
- 4 TYPE OF BILL:** Marked with 'R'.
- 5 PATIENT SEX:** Marked with 'R'.
- 6 STATE:** Marked with 'R'.
- 7 STATE:** Marked with 'NR'.
- 8 STATE:** Marked with 'R'.
- 9 PATIENT ADDRESS:** Marked with 'R'.
- 10 BIRTHDATE:** Marked with 'R'.
- 11 SEX:** Marked with 'R'.
- 12 DATE:** Marked with 'S'.
- 13 HR:** Marked with 'S'.
- 14 TYPE:** Marked with 'R'.
- 15 SSC:** Marked with 'R'.
- 16 DHR:** Marked with 'S'.
- 17 STAT:** Marked with 'R'.
- 18-21:** Marked with 'S'.
- 22-23:** Marked with 'S'.
- 24-25:** Marked with 'S'.
- 26-27:** Marked with 'S'.
- 28-29:** Marked with 'S'.
- 30:** Marked with 'NR'.
- 31-37:** Marked with 'R'.
- 38-43:** Marked with 'S'.
- 44-46:** Marked with 'R'.
- 47-48:** Marked with 'R'.
- 49:** Marked with 'NR'.
- 50-53:** Marked with 'R'.
- 54-56:** Marked with 'R'.
- 57-58:** Marked with 'R'.
- 59-61:** Marked with 'S'.
- 62-63:** Marked with 'S'.
- 64-65:** Marked with 'S'.
- 66-67:** Marked with 'S'.
- 68-69:** Marked with 'S'.
- 70-73:** Marked with 'S'.
- 74-76:** Marked with 'S'.
- 77-79:** Marked with 'S'.
- 80-81:** Marked with 'S'.
- 82-83:** Marked with 'S'.
- 84-85:** Marked with 'S'.
- 86-87:** Marked with 'S'.
- 88-89:** Marked with 'S'.
- 90-91:** Marked with 'S'.
- 92-93:** Marked with 'S'.
- 94-95:** Marked with 'S'.
- 96-97:** Marked with 'S'.
- 98-99:** Marked with 'S'.

Manually Review/Non-Compliant claims:

1. Extraneous data (i.e. Stamps, Typed/Handwritten notations)
2. Type of Bill or Revenue Codes not in 4-digit format
3. White out or correction tape
4. Highlighting, Smudges or Discolorations
5. Handwritten corrections
6. Post-it notes attached
7. Submission of negative charges
8. Photocopies of the UB04 claim form or EOMB
9. EOMB not attached
10. Alignment issue with claim, data not within fields

Key: R – Required
S – Situational
NR – Not Required

FOR CLAIM(S) INQUIRIES/STATUS, PLEASE CONTACT PROVIDER SERVICES AT: 1-800-852-2683

Figure B.2: UB-04 Return to Provider Letter

B.3 Adjustment/Void Request Form Completion Instructions

INSTRUCTIONS FOR COMPLETING FORM

PLEASE NOTE: *A SEPARATE ADJUSTMENT/VOID REQUEST FORM MUST BE COMPLETED AND SUBMITTED FOR EACH CLAIM LINE YOU WOULD LIKE TO ADJUST OR VOID.*

1. **Provider Information**
 - a) **Provider name:** Enter name of provider.
 - b) **Street Address:** Enter the street address of the facility.
 - c) **City, State, Zip:** Enter the City and Zip Code of the facility.
 - d) **Provider Number:** Enter your 7-digit provider number.
2. **Check the 'Refund Due' box.**
3. **Give the reason for the Refund Request:** Give the specific reason for your request for a refund.
4. **TPL Information:** If Refund Request is due to third party payment, complete items (a) through (i) or attach a copy of the check received from the insurance company.
5. **Refer to your Remittance Advice for the following data. Enter all data requested.**
 - a) **Claim Number:** Enter the 13-digit claim number found on the R/A.
 - b) **Patient Name:** Enter the patient's last name, first name, and middle initial.
 - c) **Recipient ID Number:** Enter the 11-digit recipient identification number exactly as it is found on the R/A.
 - d) **Remittance Advice Date:** Enter the date of the Remittance Advice found at the top right corner of the R/A.
 - e) **Date of Service:** Enter the Date of Service.
 - f) **Billed Amount:** Enter the amount actually billed.
 - g) **Monthly Patient Liability:** Enter the complete liability shown on the 2362 and the effective date (ICF/SNF use only).
6. **Signature:** Signature of the requestor and the date the request was prepared.

I hereby certify that the claim for services listed on the reverse of this form is true and correct; that the amount is due; that the amount received (as determined by the Single State Agency within limits defined by State and Federal laws) will be accepted as full payment for all services rendered the patient as set forth hereon; that no unlisted payment is due or has been received; and that no third party payments will be accepted in excess of the determined usual and customary charges for services rendered or directed by the physician/practitioner; that the physician/practitioner is licensed to practice under the laws of the State of Tennessee or other state in which services were rendered; that pertinent medical information will be made available to authorized representatives of the State Agency subject to appropriate legal, ethical and professional limitations; and that this claim for payment under Medicaid-Title XIX Program is for services rendered to a properly identified eligible recipient. I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the States Title XIX plan and to furnish information regarding any payments claimed for providing as the State Agency may request for three years from date of service. The State Agency operates under the provisions of Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973. Under the provisions of these Acts any provider of services receiving Federal funds must comply with the intent of these Acts, and this means there shall be no discrimination because of race, color, national origin or handicap. These Acts also provide for strict compliance and complaint procedures. I understand that payment and satisfaction of this claim will be Federal and State funds and that any false claims, statements, or documents, or concealment of a material fact may be prosecuted under applicable Federal and State laws.

MEDICAID-TITLE XIX
AV ADJUSTMENT/
 VOID REQUEST



BUREAU OF TENNCARE
 P. O. BOX 1700
 NASHVILLE, TN 37202-1700

STATE OF TENNESSEE
 DEPARTMENT OF FINANCE
 AND ADMINISTRATION

I. Provider Information

- a) _____
Name
- b) _____
Street Address
- c) _____ TN _____
City State Zip
- d) Provider No. _____

IF YOU CHECK THIS BOX (b) PLEASE SEND THE REFUND CHECK
 AND THIS COMPLETED FORM TO:
 State of Tennessee
 Bureau of TennCare, Floor 4 East
 Attention: Fiscal Budget
 310 Great Circle Road
 Nashville, TN 37243-1700

ALL OTHER COMPLETED ADJUSTMENT/VOID
 REQUESTS SHOULD BE SENT TO:
 State of Tennessee
 Bureau of TennCare
 P.O. Box 1700
 Nashville, TN 37202-1700

- II. a. Underpayment b. Overpayment – Refund Check c. Overpayment – Please deduct from future claims payment

III. Give Reason for Request:

IV. TPL information – If AV request is due to third party payment, complete the following, or attach a copy of check received:

- a) Insurance Co. _____ b) Policy # _____
- c) Name of Insured _____ d) Claim # _____
- e) Amount Paid by Third Party _____ f) SSN# _____
- g) DOB _____ h) Policy Termination Date _____
- i) Policy Effective Date _____

V. PLEASE ENTER THE FOLLOWING DATA FROM YOUR REMITTANCE ADVISE

- a) Claim# _____ b) Recipient ID# _____
- c) Patient Name _____
Last First MI
- d) Remittance Advice Date _____ e) Date of Service _____
- f) Billed Amount _____ g) Paid Amount _____

FOR LTSS PROVIDER USE ONLY

Monthly Patient Liability Amount _____	Effective Date _____
--	----------------------

VI. I request that reprocessing of the claim be made with the information given above. I hereby certify that the above claim for services is true and correct. I further understand and agree that the conditions on the reverse side of this claim and conditions in the appropriate Provider Manual apply to this claim.

Signature _____ Date _____

Note: Please attach a corrected claim copy.

Figure B.3: Adjustment/Void Request Form