CROSSOVER CLAIMS REQUIREMENTS

Frequently Asked Questions

Q: How do I make an adjustment to a PAID crossover claim that is older than one (1) year from the date of service, but a third-party liability (TPL) payment was made AFTER TennCare/Medicaid has paid?

A: If you need to make an *adjustment* to a PAID crossover claim (*that is **older** than one (1) year from the date of service*), you have **sixty (60) days from the TPL notice to the provider** to complete the A/V form found on the TennCare website: https://www.tn.gov/content/dam/tn/tenncare/documents/avform.pdf. The form and required attachments (a new UB04/CMS 1500 claim form, the Medicare EOMB and the TPL EOB) should be mailed to the address listed on the form. **TPL claims that are over one (1) year old, are subject to timely filing guidelines pursuant to TennCare Rules 1200-13-13-.08(12) and 1200-13-14-.08(12) https://publications.tnsosfiles.com/rules/1200/1200-13/1200-13.htm.*

Q: I have a PAID crossover claim where the dates of service are two (2) years old. Although it is well past the one (1) year timely filing requirement, can I adjust TennCare/Medicaid's original payment?

A: Yes. In order to make the adjustment, you would need to complete the A/V form found on the TennCare website: https://www.tn.gov/content/dam/tn/tenncare/documents/avform.pdf. The form and required attachments (a new UB04/CMS 1500 claim form, the Medicare EOMB, and the TPL EOB, if applicable) should be mailed to the address listed on the form. ** TennCare will not reimburse providers on claims that are older than two (2) years from the dates of service, as there is no Federal Financial Participation (FFP) for such claims as outlined in TennCare Rules 1200-13-13-.08(12) and 1200-13-14-.08(12) https://publications.tnsosfiles.com/rules/1200/1200-13/1200-13.htm.*

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 noncovered.
- *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 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 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 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 Tennessee Community Services Agency Call Center at 1-800-852-2683 (Option #2) to inquire about a claim status will not qualify as evidence for resubmission.

Q: What documentation is needed to request a claim be reprocessed due to 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/Tennessee Community Services Agency Tennessee Community Services Agency 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 screenshots from the provider's office or facility are **not acceptable**.

These requests can be sent via *secured* email or by USPS if the claim paid/denied in error due to a TennCare keying error or a TennCare system issue. *Billing errors do not justify a "reprocess". Those claims will need to be corrected and MAILED to the appropriate P.O. BOX, outlined in the provider billing manuals, for adjudication consideration.*

Crossover.Reprocess.Request@tn.gov

**It is the sender's responsibility to transmit any PHI/PII securely. If you are not able to send your request via secured email, please mail in your request to the address provided below.*

Division of TennCare
Attn: Crossover
Claims Manager
310 Great Circle
Road Nashville, TN
37243

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 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 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 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's 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 to adjudicate a claim that involves a TPL policy.

Q: Why are my crossover 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 my paper 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 Tennessee Community Services Agency Call Center at 1-800-852-2683 (Option #2) to check claim status 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 an burden to providers unless the electronic claim has been adjudicated incorrectly or needs to be adjusted by the provider because 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 (except for 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 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 Tennessee Community Services Agency Call Center at 1-800-852-2683 (Option #2)** 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 Tennessee Community Services Agency Call Center representative 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 Tennessee Community Services Agency Call Center at 1-800-852-2683 (Option #2), 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 Tennessee Community Services Agency Call Center representative at 1-800-852-2683 (Option #2) 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 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 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
8.1	03/08/2023	Sonya Smith	Changed the name of TennCare Call Center to Tennessee Community Services Agency Call Center throughout document