What are the State's Tenncare requirements regarding Out Of Network Referrals, especially for emergent care & follow up?

http://www.tn.gov/tenncare/forms/MCOStatewideContract.pdf

A.2.13.11 Emergency Services Obtained from Non-Contract Providers
2.13.11.1 Payments to non-contract providers for emergency services may, at the CONTRACTOR's option, be limited to the treatment of emergency medical conditions, including post-stabilization care services, as described in Section A.1. Payment amounts shall be consistent with the pricing policies developed by the CONTRACTOR and in accordance with TENNCARE requirements, including TennCare rules and regulations for emergency services provided by non-contract providers.

2.13.11.2 Payment by the CONTRACTOR for properly documented claims for emergency services rendered by a non-contract provider shall be made within thirty (30) calendar days of receipt of a clean claim by the CONTRACTOR.

2.13.11.3 The CONTRACTOR shall review and approve or disapprove claims for emergency services based on the definition of emergency services specified in Section A.1 of this Contract. If the CONTRACTOR determines that a claim requesting payment of emergency services does not meet the definition as specified in Section A.1 and subsequently denies the claim, the CONTRACTOR shall notify the provider of the denial. This notification shall include information to the provider regarding the CONTRACTOR's process and time frames for reconsideration. In the event a provider disagrees with the CONTRACTOR's decision to disapprove a claim for emergency services, the provider may pursue the independent review process for disputed claims as provided by TCA 56-32-126, including but not limited to reconsideration by the CONTRACTOR.

A.2.13.12 Medically Necessary Services Obtained from Non-Contract Provider when MCO Assignment is Unknown
2.13.12.1 The CONTRACTOR shall pay for medically necessary covered services provided to an enrollee by a non-contract provider when TENNCARE has enrolled the enrollee in the CONTRACTOR's MCO, but the enrollee could not have known which MCO they were enrolled in at the time of the service. Examples of when this may occur include, but are not limited to, (i) when an enrollee receives services during a retroactive eligibility period (see Section A.2.4.5) and the enrollee did not select an MCO and is assigned to an MCO by TENNCARE, or (ii) the enrollee was assigned to an MCO other than the one that he/she requested (see Section A.2.4.4.5). In these cases, the effective date of enrollment may occur prior to the CONTRACTOR or the enrollee being notified of the enrollee becoming a member of the CONTRACTOR's MCO.

2.13.12.2 When this situation arises, the CONTRACTOR shall not deny payment for medically necessary covered services provided during this period of eligibility for lack of prior authorization or lack of referral; likewise, the CONTRACTOR shall not deny a claim on the basis of the provider's failure to file a claim within a specified time period after the date of service when the provider could not have reasonably known which MCO the enrollee was in during the timely filing period. However, in such cases the CONTRACTOR may impose timely filing requirements beginning on the date of notification of the individual's enrollment.

2.13.12.3 The CONTRACTOR shall only pay for covered long-term care services for which the member was eligible (see Section A.2.6), as determined by the State and shown in the outbound 834 enrollment file furnished by TENNCARE to the CONTRACTOR.

A.2.13.13 Medically Necessary Services Obtained from Contract Provider without Prior Authorization when MCO Assignment is Unknown

2.13.13.1 The CONTRACTOR shall pay for medically necessary covered services provided to an enrollee by a contract provider without prior authorization or referral when TENNCARE has enrolled the enrollee in the CONTRACTOR's MCO, but the enrollee could not have known which MCO they were enrolled in at the time of the service.

2.13.13.2 When this situation arises, the CONTRACTOR shall not deny payment for medically necessary covered services for lack of prior authorization or lack of referral; likewise, a CONTRACTOR shall not deny a claim on the basis of the provider's failure to file a claim within a specified time period after the date of service when the provider could not have reasonably known which MCO the enrollee was in during the timely filing period. However, in such cases the CONTRACTOR may impose timely filing requirements beginning on the date of notification of the individual's enrollment.

2.13.13.3 The CONTRACTOR shall only pay for covered long-term care services for which the member was eligible (see Section A.2.6), as determined by the State and shown in the outbound 834 enrollment file furnished by TENNCARE to the CONTRACTOR.

A.2.13.14 Medically Necessary Services Obtained from Non-Contract Provider Referred by Contract Provider

The CONTRACTOR shall pay for any medically necessary covered services provided to a member by a non-contract provider at the request of a contract provider. The CONTRACTOR's payment shall not be less than eighty percent (80%) of the rate that would have been paid by the CONTRACTOR if the member had received the services from a contract provider. The CONTRACTOR shall only pay for covered long-term care services for which the member was eligible (see Section A.2.6) and that were authorized by the CONTRACTOR in accordance with the requirements of this Contract.

A.2.13.15 Medically Necessary Services Obtained from Non-Contract Provider Not Authorized by the CONTRACTOR

2.13.15.1 With the exception of circumstances described in Section A.2.13.14 when an enrollee has utilized medically necessary non-emergency covered services from a non-contract provider, and the CONTRACTOR has not authorized such use in advance, the CONTRACTOR shall not be required to pay for the service(s) received unless payment is required pursuant to a directive from TENNCARE or an Administrative Law Judge.

2.13.15.2 The CONTRACTOR shall not make payment to non-contract providers for covered services that are not medically necessary or for long-term care services for which the member was not eligible (see Section A.2.6).

A.2.13.16 Covered Services Ordered by Medicare Providers for Dual Eligibles

2.13.16.1 Generally, when a TennCare enrollee is dually eligible for Medicare and TennCare and requires services that are covered under this Contract but are not covered by Medicare, and the services are ordered by a Medicare provider who is a non-contract provider, the CONTRACTOR shall pay for the ordered, medically necessary service if it is provided by a contract provider. However, if all of the following criteria are met, the CONTRACTOR may require that the ordering physician be a contract provider:

2.13.16.1.1 The ordered service requires prior authorization; and

2.13.16.1.2 Dually eligible enrollees have been clearly informed of the contract provider requirement and instructed in how to obtain assistance identifying and making an appointment with a contract provider; and

2.13.16.1.3 The CONTRACTOR assists the enrollee in obtaining a timely appointment with a contract provider upon request of the enrollee or upon receipt of an order from a non-contract provider.

2.13.16.2 Reimbursement shall be at the same rate that would have been paid had the service been ordered by a contract provider.

2.13.16.3 The CONTRACTOR shall not pay for non-covered services, services that are not medically necessary, or services ordered and obtained from non-contract providers.

Can you give us some background on how the Tenncare rolls are updated and how that information is transferred to the MCO's / Carriers?

A.2.4.5 Effective Date of Enrollment

2.4.5.1 Initial Enrollment of Current TennCare Enrollees

The effective date of initial enrollment in an MCO for TennCare enrollees who are enrolled in accordance with Section A.2.4.4.2 shall be the date provided on the outbound 834 enrollment file from TENNCARE. In general, the effective date of enrollment for these enrollees will be the start date of operations.

2.4.5.2 Ongoing Enrollment

In general, a member's effective date of enrollment in the CONTRACTOR's MCO will be the member's effective date of eligibility for TennCare. For SSI enrollees the effective date of eligibility/enrollment is determined by the Social Security Administration in approving SSI coverage for the individual. The effective date of eligibility for other TennCare enrollees is the date of application or the date of the qualifying event (e.g., the date the spend down obligation is met for medically needy enrollees). The effective date on the outbound 834 enrollment file provided by TENNCARE to the CONTRACTOR shall govern regardless of the other provisions of this Section A.2.4.5.2.

2.4.5.3 In the event the effective date of eligibility provided by TENNCARE to the CONTRACTOR for either the initial enrollment of current TennCare enrollees or ongoing enrollment precedes the start date of operations, the CONTRACTOR shall treat the enrollee as a member of the CONTRACTOR's MCO effective on the start date of operations. Although the enrollee is not a member of the CONTRACTOR's MCO prior to the start date of operations, the CONTRACTOR shall be responsible for the payment of claims incurred by the enrollee during the period of eligibility prior to the start date of operations as specified in Section B.1.

2.4.5.4 Enrollment Prior to Notification

2.4.5.4.1 Because individuals can be retroactively eligible for TennCare, and the effective date of initial enrollment in an MCO is the effective date of eligibility or start date of operations, whichever is sooner, the effective date of enrollment may occur prior to the CONTRACTOR being notified of the person's enrollment. Therefore, enrollment of individuals in the CONTRACTOR's MCO may occur without prior notice to the CONTRACTOR or enrollee.

2.4.5.4.2 The CONTRACTOR shall not be liable for the cost of any covered services prior to the effective date of enrollment/eligibility but shall be responsible for the costs of covered services obtained on or after 12:01 a.m. on the effective date of enrollment/eligibility.

2.4.5.4.3 TENNCARE shall make payments to the CONTRACTOR from the effective date of an enrollee's date of enrollment/eligibility. If the effective date of enrollment/eligibility precedes the start date of operations, payment shall be made in accordance with Section C.3.

2.4.5.4.4 Except for applicable TennCare cost sharing and patient liability, the CONTRACTOR shall ensure that members are held harmless for the cost of covered services provided as of the effective date of enrollment with the CONTRACTOR.

A.2.4.6 Eligibility and Enrollment Data

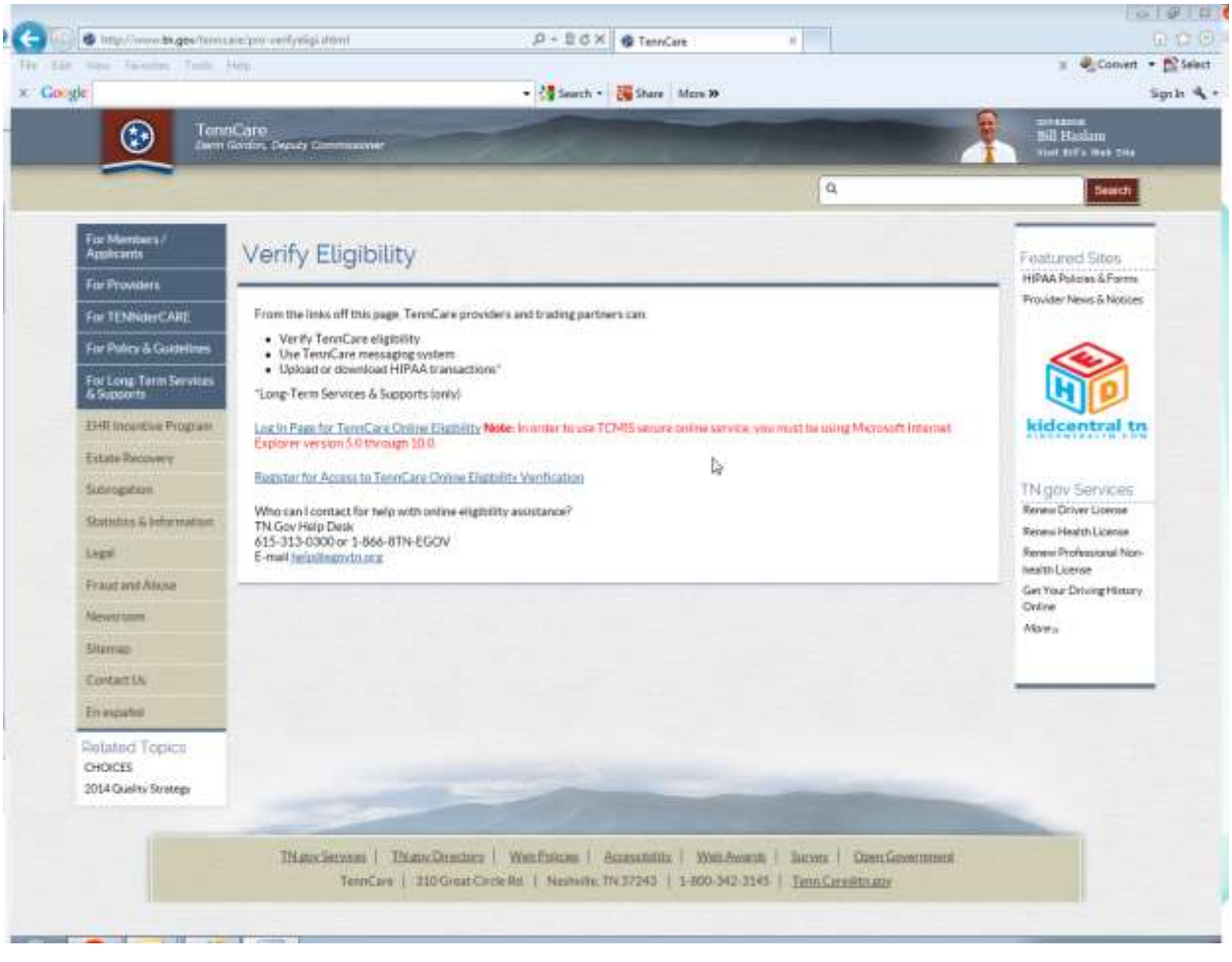
2.4.6.1 The CONTRACTOR shall receive, process, and update outbound 834 enrollment files from TENNCARE. Enrollment data shall be updated or uploaded systematically to the CONTRACTOR's eligibility/enrollment database(s) within twenty-four (24) hours of receipt from TENNCARE. Any outbound 834 transactions which fail to update/load systematically must be manually updated within twenty-four (24) hours of receipt. The CONTRACTOR shall report to TENNCARE, in a form and format to be provided by TENNCARE, outbound 834 transactions that are not processed within these time frames and include information regarding when the transactions were completed. Any transactions that are not updated/loaded within twenty-four (24) hours of receipt from TENNCARE and/or persistent issues with high volumes of transitions that require manual upload may require the CONTRACTOR to initiate a Corrective Action Plan for resolution of the issues preventing compliance. If the CONTRACTOR has reason to believe they may not meet this requirement based on unusual circumstances, the CONTRACTOR must notify TENNCARE and TENNCARE may make an exception without requiring a Corrective Action Plan.

2.4.6.2 The CONTRACTOR shall provide an electronic eligibility file (inbound 834) to TENNCARE as specified and in conformance to data exchange format and method standards outlined in Section A.2.23.5.

When a patient is retro-eligible and does not tell us what recourse do we have? What is the time limit to file an appeal in that case?

2.12.9.28 Provide for prompt submission of information needed to make payment. Specify that **a provider shall have one hundred twenty (120) calendar days from the date of rendering a covered service to file a claim** with the CONTRACTOR **except** in situations regarding coordination of benefits or subrogation in which case the provider is pursuing payment from a third party **or** if an enrollee is enrolled in the MCO with a **retroactive eligibility date**. In situations of third party benefits, the maximum time frames for filing a claim shall begin on the date that the third party documented resolution of the claim**. In situations of enrollment in the CONTRACTOR's MCO with a retroactive eligibility date, the time frames for filing a claim shall begin on the date that the CONTRACTOR receives notification from TENNCARE of the enrollee's eligibility/enrollment**;

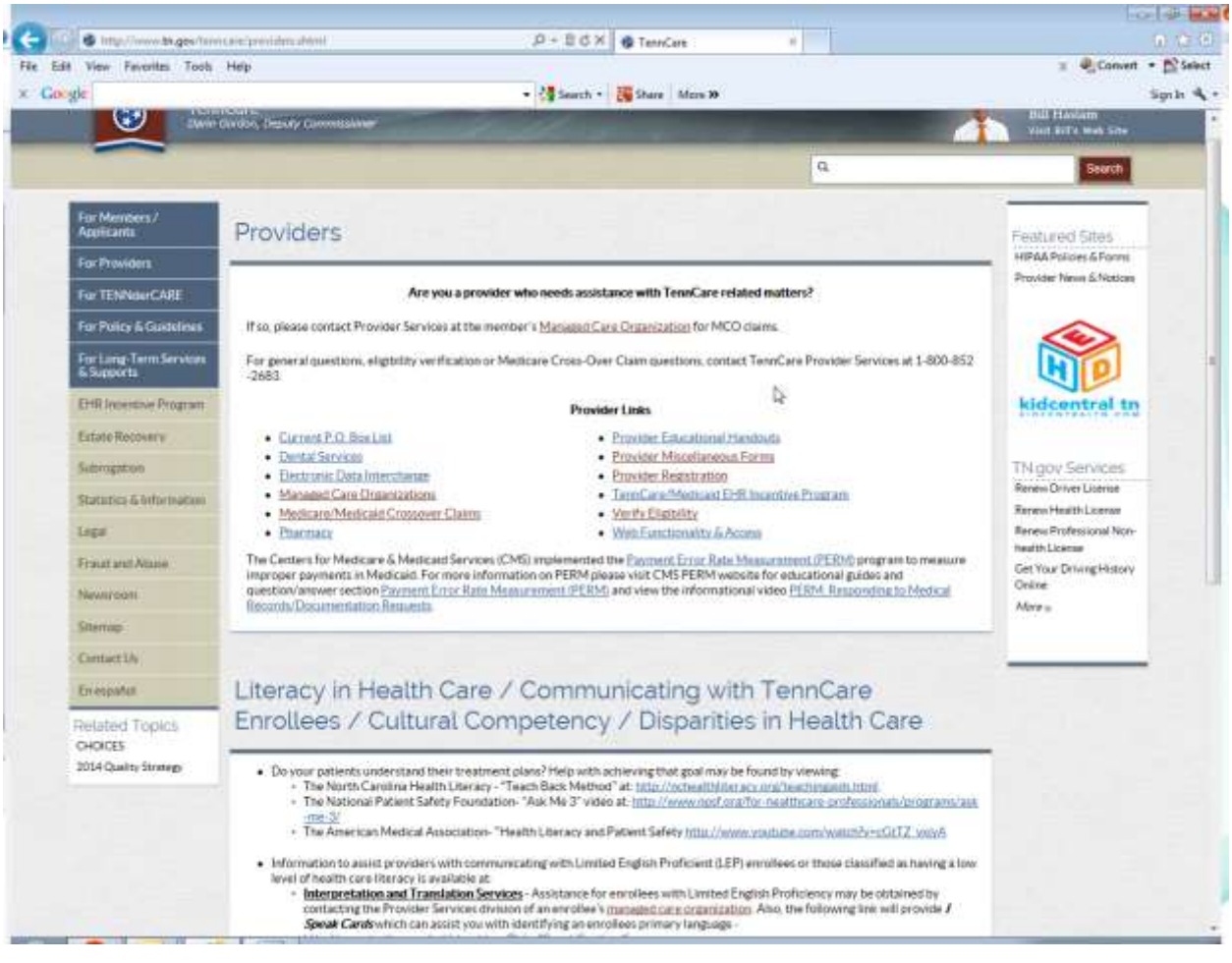
http://www.tn.gov/tenncare/pro-verifyeligi.shtml



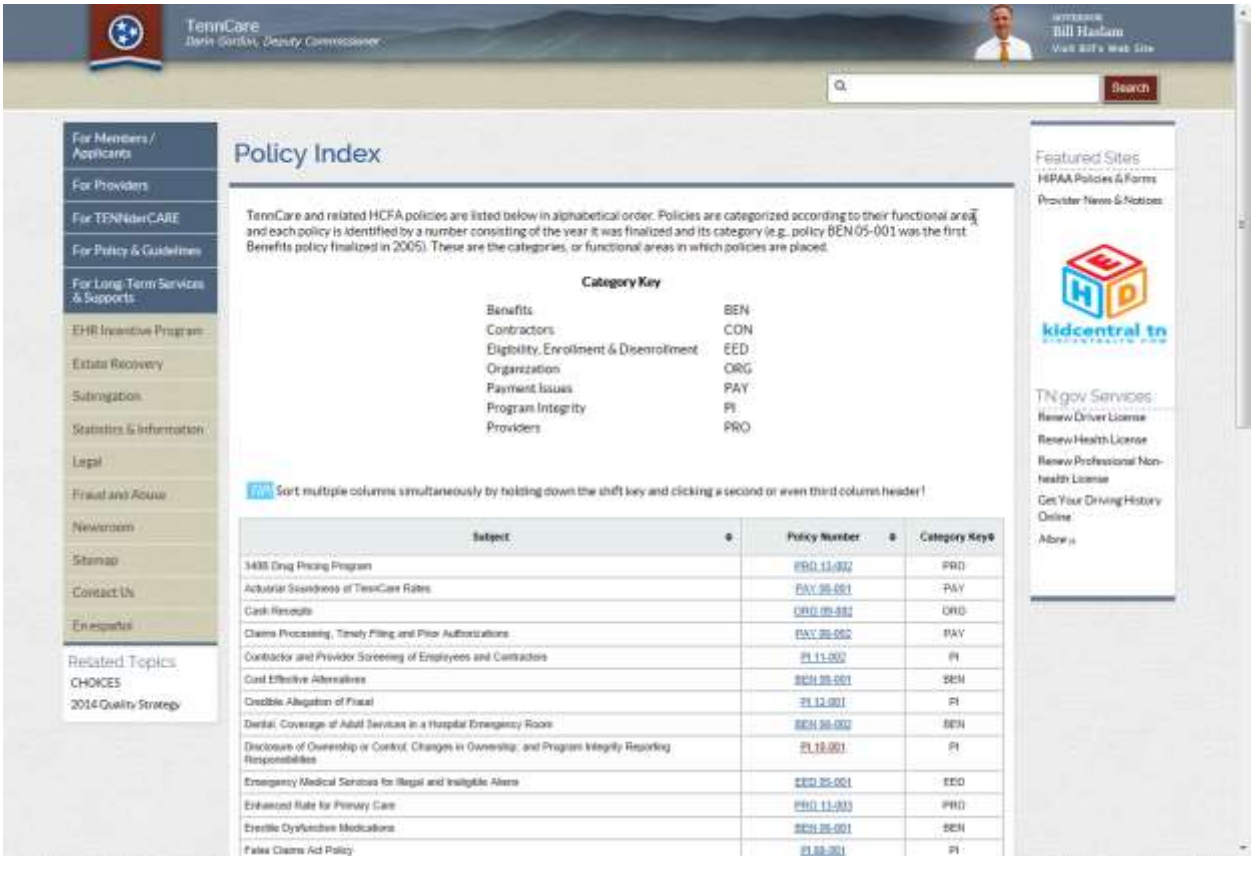
Is that anything that providers can do pro-actively to lessen some of the issues that we're having with getting authorizations, disclosures being on file, etc?

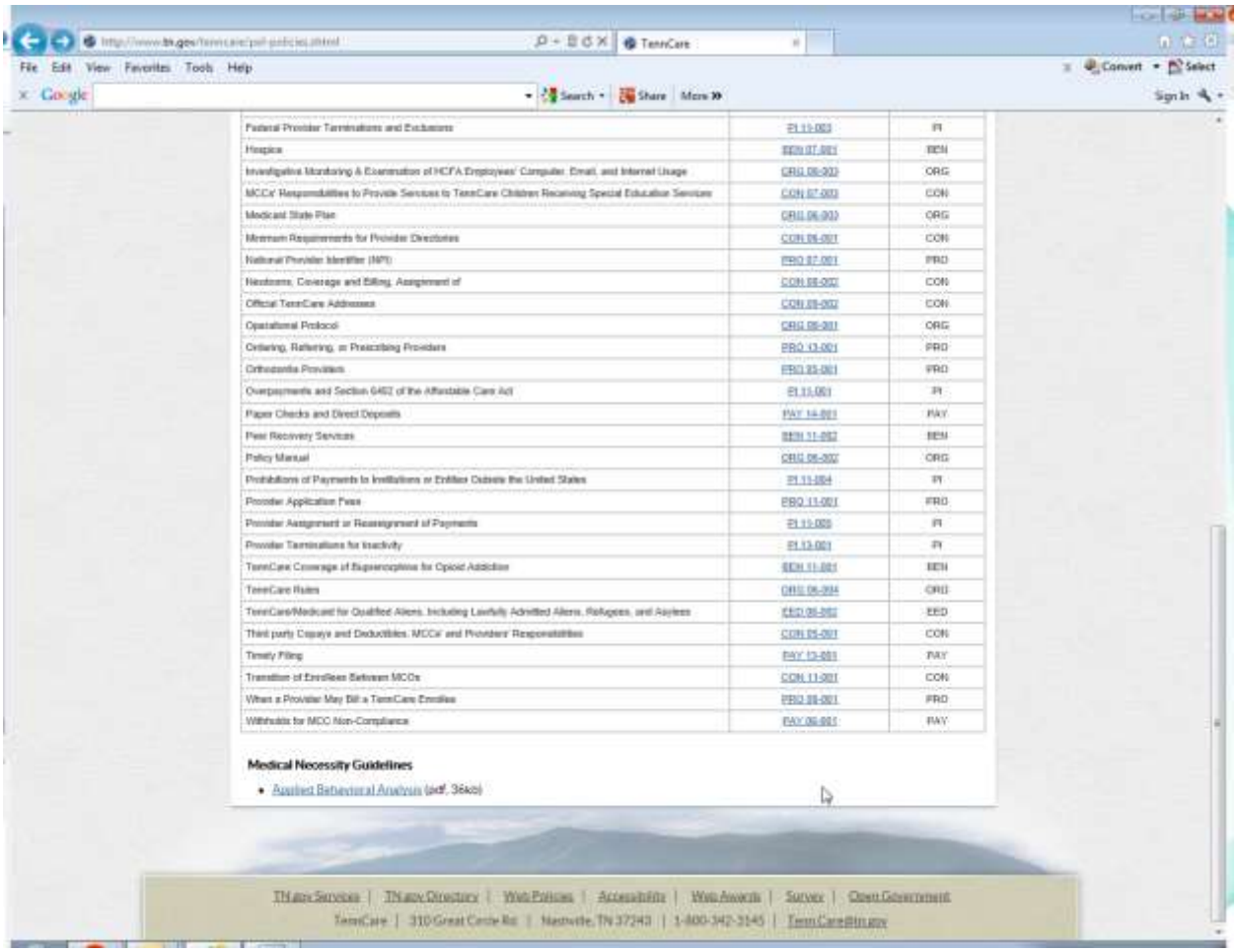
Timothy Stalnaker, TennCare Bureau: Timothy.Stalnaker@tn.gov

http://www.tn.gov/tenncare/providers.shtml



http://www.tn.gov/tenncare/policy.shtml




TennCare
File Edit View Favorites Tools Help
Google
Search
Share
More
Convert
Select
Sign In
Federal Provider Terminations and Exclusions PI 11-003 PI
Hospice BEN 07-001 BEN
Investigative Monitoring & Examination of HCFA Employees' Computer, Email, and Internet Usage ORG 06-003 ORG
MCCs' Responsibilities to Provide Services to TennCare Children Receiving Special Education Services CON 07-003 CON
Medicaid State Plan ORG 06-001 ORG
Minimum Requirements for Provider Directories CON 09-001 CON
National Provider Identifier (NPI) PRO 07-001 PRO
Newborns, Coverage and Billing, Assignment of CON 08-002 CON
Official TennCare Addresses CON 09-002 CON
Operational Protocol ORG 06-001 ORG
Ordering, Referring, or Prescribing Providers PRO 13-001 PRO
Orthoxemia Providers PRO 05-001 PRO
Overpayments and Section 6402 of the Affordable Care Act PI 11-001 PI
Paper Checks and Direct Deposits PAY 14-001 PAY
Peer Recovery Services BEN 11-002 BEN
Policy Manual ORG 06-002 ORG
Prohibitions of Payments to Institutions or Entities Outside the United States PI 11-004 PI
Provider Application Fees PRO 11-001 PRO
Provider Assignment or Reassignment of Payments PI 11-002 PI
Provider Terminations for Inactivity PI 13-001 PI
TennCare Coverage of Buprenorphine for Opioid Addiction BEN 11-001 BEN
TennCare Rules ORG 06-004 ORG
TennCare/Medicaid for Qualified Aliens, Including Lawfully Admitted Aliens, Refugees, and Asylees ELIG 06-002 ELIG
Third party Copays and Deductibles: MCCs' and Providers' Responsibilities CON 05-001 CON
Timely Filing PAY 13-001 PAY
Transition of Enrollees Between MCOs CON 11-001 CON
When a Provider May Bill a TennCare Enrollee PRO 08-001 PRO
Withholds for MCC Non-Compliance PAY 06-001 PAY
Medical Necessity Guidelines
Applied Behavioral Analysis (pdf, 36kb)
TN.gov Services | TN.gov Directory | Web Policies | Accessibility | Web Awards | Survey | Open Government
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