RULES
OF
DEPARTMENT OF COMMERCE AND INSURANCE
DIVISION OF INSURANCE AND DIVISION OF TENNCARE

CHAPTER 0780-1-73
UNIFORM CLAIMS PROCESS FOR TENNCARE
PARTICIPATING MANAGED CARE ORGANIZATIONS

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0780-1-73-.01 AUTHORITY. These rules are promulgated pursuant to the authority granted by Tenn. Pub. Acts ch. 209, § 1, T.C.A. § 56-32-218(a).

Authority: *T.C.A. §56-32-218(a) and Public Acts of 2001, Chapter 209, § 1.* ***Administrative History:*** *Original rule filed April 4, 2002; effective June 18, 2002.*

0780-1-73-.02 PURPOSE AND SCOPE.

(1) Purpose. These rules designate a uniform TennCare claims process, which contains standardized instructions for completing the form and creates standardized responses to questions and other information required on the form, for providers and managed care organizations participating in the TennCare program to use in the submission of claims by providers seeking payment.

(2) Scope. These rules apply to the TennCare bureau, TennCare program and TennCare Partners program health claims and encounter data reporting.

(a) Except as otherwise specifically provided, the requirements of these rules apply to TennCare health maintenance organizations (HMOs), TennCare Partners program behavioral health organizations (BHOs), TennCare program providers, and TennCare Partners program providers that contract directly with the State and have claims processing responsibility, including, but not limited to, TennCare program and TennCare Partners program prepaid limited health service organizations (PLHSOs).

(b) These rules do not prohibit an issuer from requesting additional information required to determine eligibility of the claim under the terms and conditions of the TennCare program or the TennCare Partners program.

(c) These rules do not prohibit an HMO, BHO, or provider from using capitation payment methodology, daily rate methodology or other similar arrangements for compensating providers.

(d) These rules do not exempt a provider or HMO or BHO from data reporting requirements under state or federal law or regulation.

Authority: *T.C.A. §56-32-218(a) and Public Acts of 2001, Chapter 209, § 1.* ***Administrative History:*** *Original rule filed April 4, 2002; effective June 18, 2002.*

0780-1-73-.03 DEFINITIONS. As used in these rules, unless the context requires otherwise:

(1) Uniform Claim Forms

(a) "UB-92, HCFA-1450 or CMS-1450" means the health insurance claim form maintained by HCFA/CMS for use by institutional care providers. Currently this form is known as the UB-92.

(b) "HCFA-1500 or CMS-1500 (12-90)" means the health insurance claim form maintained by HCFA/CMS for use by health care providers.

(c) "American Dental Association, 1999 Version 2000" means the uniform dental claim form approved by the American Dental Association (ADA) for use by dentists, as amended or updated by the American Dental Association.

(d) "NCPDP" means the National Council for Prescription Drug Program's claim form or its electronic counterpart.

(2) Uniform Claim Codes

(a) "ASA Codes" means the codes contained in the ASA Relative Value Guide developed and maintained by the American Society of Anesthesiologists to describe anesthesia services and related modifiers.

(b) "CDT-3 Codes" means the current dental terminology prescribed by the American Dental Association, including the terminology updates and revision issued in the future by the American Dental Association.

(c) "CPT-4 Codes" ("Level I Codes") means the Physicians' Current Procedural Terminology, Fourth Edition, published by the American Medical Association.

(d) "ICD-9-CM Codes" means the diagnosis and procedure codes in the International Classification of Diseases, Ninth Revision, clinical modifications published by the U.S. Department of Health and Human Services.

(e) "NDC" means the National Drug Codes of the Food and Drug Administration.

(f) "UB-92 Codes" means the code structure and instructions established for use by the National Uniform Billing Committee.

(g) "HCPCS Codes" ("Level II Codes") means the Health Care Financing Administration's Common Procedure Coding System. This means national codes developed by HCFA/CMS to supplement CPT codes. They include physical services not included in CPT as well as non-physician services such as ambulance, physical therapy and durable medical equipment. The acronym "HCPCS" stands for the HCFA/CMS Common Procedure Coding System.

(3) "Managed Care Organization" means TennCare program HMO or TennCare Partners program BHO that pays for, or reimburses for, the costs of health care expenses.

(4) "Provider" means any person, partnership, association, corporation or other facility or institution that renders or causes to be rendered health care or professional services to TennCare program enrollees or TennCare Partners program enrollees, and officers, employees or agents of any of the above acting in the course and scope of their employment.

(Rule 0780-1-73-.03, continued)

(5) "HCFA or CMS" means the Centers for Medicare & Medicaid Services, formerly known as the Health Care Financing Administration of the U.S. Department of Health and Human Services.

Authority: *T.C.A. §§56-32-218(a), 71-5-191, and Public Acts of 2001, Chapter 209, § 1.* ***Administrative History:*** *Original rule filed April 4, 2002; effective June 18, 2002. Amendment filed October 24, 2002; effective January 7, 2003.*

0780-1-73-.04 UNIFORM FORMS REQUIRED.

(1) Uniform Forms Required. TennCare program HMOs and TennCare Partners program BHOs shall accept and may require the applicable uniform claim forms completed with the uniform claim codes.

(2) Submission of Uniform Forms:

(a) For the purposes of submitting the HCFA-1500/CMS-1500 form, providers should complete the form in accordance with the instructions appended hereto as Appendix A to these rules.

(b) For the purposes of submitting the HCFA-1450/CMS-1450 (UB-92) form, providers should complete the form in accordance with the Medicare instructions.

(c) For the purposes of submitting the "American Dental Association, 1999 Version 2000" uniform dental claim form approved by the American Dental Association for use by dentists, as amended or updated by the American Dental Association, providers should complete the form in accordance with ADA instructions.

(d) For the purposes of submitting the NCPDP prescription drug claim form or its electronic counterpart, providers should complete the form in accordance with NCPDP instructions.

(e) CPT Code Usage. For the purposes of these rules, providers are authorized to use the expiring or updated CPT codes on claims submitted during the period January 1 through March 31 of each year. From April 1 through December 31 of each year, however, providers must use the updated/current CPT codes.

(f) CDT Code Usage. For the purposes of these rules, dentist providers shall utilize the most current CDT codes as required by the federal Health Insurance Portability and Accountability Act of 1996, Pub.L. 104-191, Aug. 21, 1996, 110 Stat. 1936 (HIPAA) rules and regulations for commercial dental benefit programs.

(g) ICD-9 Code Usage. For the purposes of these rules, providers are authorized to use the expiring or updated ICD-9 codes on claims submitted during the period October 1 through subsequent March 31 of each year. From April 1 through December 31 of each year however, providers must use the updated/current ICD-9 codes.

(h) HCPCS Code Usage. For the purposes of these rules, providers are authorized to use the expiring or updated HCPCS codes on claims submitted during the period January 1 through March 31 of each year. From April 1 though December 31 of each year, however, providers must use the updated/current HCPCS codes.

Authority: *T.C.A. §§56-32-218(a), 71-5-191, and Public Acts of 2001, Chapter 209, § 1.* ***Administrative History:*** *Original rule filed April 4, 2002; effective June 18, 2002. Amendment filed October 24, 2002; effective January 7, 2003.*

0780-1-73-.05 SEVERABILITY AND PREEMPTION.

If any provision of these rules or the application to any person or circumstance is for any reason held to be invalid, the remainder of the rules and the application of the provisions to other persons or circumstances shall not be affected. If any provision of these rules or the application to any person or circumstance conflict with the requirements of the federal Health Insurance Portability and Accountability Act (HIPAA), the requirements of HIPAA shall control.

Authority: *T.C.A. §56-32-218(a) and Public Acts of 2001, Chapter 209, § 1.* ***Administrative History:*** *Original rule filed April 4, 2002; effective June 18, 2002.*

0780-1-73-.06 APPENDIX A.

Appendix A – Instructions for Completion of HCFA-1500/CMS-1500 Claim Forms

Item	HCFA-1500/CMS-1500 Form	HCFA/CMS (Complete Guide to Part B Billing and Compliance – Dated January 2001)
Block 1	Type of Plan	Place an X in the box to indicate the type of insurance.
Block 1a	Insured's ID Number	Provide the TennCare enrollee patient identification number for the HMO/BHO being billed from the enrollment materials provided the enrollee, i.e., ID card, etc.
Block 2	Member's Name	List the patient's last name first, followed by the first name and middle initial (if any). Enter the name exactly as shown on the TennCare health insurance card or other official TennCare notice.
Block 3	Member's Date of Birth	Enter the patient's date of birth and sex. Enter the patient's birth date in numerical format, using two (2) digits for the month, two (2) for the day and four (4) for the year, for a total of eight (8) digits. Check the box that indicates the sex of the patient.
Block 4	Insured's Name	Enter the name of the insured person only if that person's insurance either through the patient's or spouse's employment or any other source is primary to TennCare. If TennCare is the primary insurance, leave this item blank. Enter the insured's name in order of last name, first name and middle initial (if any). If the patient indicated in Item 2 and the insured are the same, enter the word "same".
Block 5	Member's Address and Telephone Number	Enter the patient's complete mailing address and telephone number. Provide the patient's complete and current mailing address, including the number and street on the first line, the city and state on the second line, and a valid zip code and the telephone number (with area code) on the third line. If the patient lives in a nursing home or other extended-care facility, provide the facility's address.
Block 6	Member's Relationship to Insured	Enter the item indicating the patient's relationship to the primary insured individual. The choices are "self", "spouse", "child" and "other". Complete this item only if Item 4 is completed. Otherwise, leave this item blank.
Block 7	Insured's Address	Enter the address (including street, city, state and zip code) and telephone

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		number of the insured individual indicated in Items 4 and 11. Complete this item only if Items 4 and 11 are completed. If the address and telephone number are the same as the patient's, as indicated in Item 5, enter the word "same". If the insured's address is "in care of" someone else, enter the "c/o" reference in the first three positions on the first line of the insured's address.
Block 8	Member Status	Place an X in the appropriate boxes pertaining to marital status and employment status. The choices for the patient's marital status are "single", married" and "other". The choices for employment status are "employed", "full-time student" and "part-time student". Check all applicable boxes.
Block 9	Other Insured's Name	Enter the name of the insured individual who is enrolled in any other policy if the name is different from that shown in Item 2. Enter the word "same" if the name is the same for Item 2. If no other policy benefits are assigned, leave this item blank. The name of the insured individual is entered in the order of the last name, first name and middle initial. (For additional information see instructions.)
Block 9a	Other Insured's Policy Number	Enter the policy or group number of the other insurance coverage for the enrollee. If the patient does not have other insurance coverage, leave this item blank.
Block 9b	Other Insured's Date of Birth	Enter the eight (8)-digit date of birth and the sex of the person you have identified in Block 9. If the patient does not have other coverage, leave this item blank.
Block 9c	Employer Name or School Name	Enter the employer name or school name of the person listed in Block 9.
Block 9d	Insurance Plan Name or Program Name	Enter the name of the other insured's health insurance organization plan name or program name for the person shown in Block 9.
Block 10a-10c	Employment – Related Condition	Indicate whether the patient's condition is related to his or her employment and is applicable to one (1) or more of the services described in Item 24. If the patient's condition is related to employment, put an X in the "yes" box and indicate whether it is related to the patient's "current" or "previous" employment by circling the appropriate term. If the injury or illness is related to an automobile accident, place an X in the "yes" box. Enter the date of the accident in Item 14 in eight (8)-digit format. If the patient's condition is related to an "other accident", place an X in the "yes" box. Enter the date of the accident in Item 14. File the claim with the other insurer as the primary payer (Item 11). Once a response (either a payment or denial notice) is received from the primary insurer, file the secondary claim with TennCare MCO/BHO.
Block 10d	(Reserved for local use)	This item is not used for the TennCare program. Leave blank.
Block 11	Insured's Policy, Group or FECA Number	Enter the policy, group or FECA identification number of any insurer that is primary to TennCare. By completing this item, the physician or supplier acknowledges having made a good-faith effort to determine whether TennCare is the secondary payor. Do not leave this item blank. If there is no insurance primary to TennCare, enter the word "none" and proceed to

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		Item 12. If there is insurance primary to TennCare, enter the insured's policy or group number and complete Item 11a. TennCare is always the payor of last resort. The TennCare group number will never belong here.
Block 11a	Insured's Date of Birth	Enter the date of birth and sex of the insured (if the insured is not the patient) in the eight (8)-digit format. Place an X in the appropriate box to indicate the insured's sex.
Block 11b	Employer Name or School Name	Enter the employer name, if applicable. If there has been a recent change in the insured's insurance status enter the date of the change preceded by a brief description of the change.
Block 11c	Insurance Plan Name or Program Name	Enter the complete name of the insurance plan or program that is primary to TennCare.
Block 11 d	Is there another insurance plan?	Indicate whether there is another health benefit plan primary to TennCare.
Block 12	Patient's or Authorized Person's Signature (Information Release / Government Assignment)	This item contains the signature of the patient or the patient's representative and the date in the eight (8)-digit format. The signature authorizes the release of medical information necessary to process the claim and the payment of benefits to the physician or supplier if the physician/supplier accepts assignment. In lieu of a signature on the claim, enter "SOF" in this item if there is a "signature on file" agreement with the provider. (For additional information see instructions.) Signature on file will also be accepted here.
Block 13	Insured's or Authorized Person's Signature (Payment Authorization)	For non-government programs, an assignment of benefits separate from the information release (Block 12) is required if benefits are to be sent to the provider. The patient must sign in this block if payment to the provider is desired, or the patient/insured's signature on a separate document must be maintained in the patient's file (enter "ON FILE"), or some provider agreements (PPO's, HMO's, etc.) specifically address how payments are to be handled, in which case leave the block blank. However, it is still advisable to obtain an assignment of benefits from the patient or patient's representative if payment is to go to your office. Do not make any notation in this space if payment is to go to the patient. Signature on file will also be accepted here.
Block 14	Date of Current Illness, Injury, or Pregnancy	Enter the date of the current illness (first symptom), injury (accident) or pregnancy (last menstrual period, or LMP) in the eight (8)-digit format. This information is necessary to determine the effective date of TennCare secondary payer coverage. If an accident date is provided, complete Item 10b or 10c. For chiropractic services, enter the date of the initiation of the course of treatment and the eight (8)-digit x-ray date in Item 19. This item is not required for TennCare billing unless the services were rendered as the result of an accident or injury that may be covered by another insurer.
Block 15	If Patient has had Same or Similar Illness	Enter (if applicable) the date that the patient first had the same or a similar illness. When billing TennCare, leave this item blank since it is not required.
Block 16	Dates Patient Unable to	This item identifies the dates that the patient was employed but unable to

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	Work in Current Occupation	work in his or her current occupation and may indicate employment-related insurance coverage. The eight (8)-digit format must be used in this item. Completion of this field is important for worker's compensation cases. An entry in this field may indicate employment-related insurance coverage.
Block 17 and 17A	Name of Referring Physician or Other Source and ID Number of Referring Physician	This field contains the complete name of the physician who requests or orders a service or item. A referring physician is a physician who requests a service or item for the patient for which payment may be made under the TennCare program. An ordering physician is a physician who orders a nonphysician service or item for the patient, such as diagnostic laboratory test, clinical laboratory test, durable medical equipment or pharmaceutical services. This item contains the NPI (UPIN) of the referring or ordering physician listed in Item 17. The NPI (UPIN) is assigned to the physician by CMS/HCFA.
Block 18	Hospitalization Dates	Enter the applicable month, day and year of the hospital admission and discharge using an eight (8)-digit date format. This item is to be completed when medical services are rendered as a result of, or subsequent to, a related hospitalization. If services were rendered in a facility other than the patient's home or a physician's office, provide the name and address of that facility in Item 32.
Block 19	(Reserved for local use)	This block is not required by TennCare program HMOs/BHOs. Leave blank.
Block 20	Outside Lab	Indicate whether any diagnostic tests subject to purchase price limitations were performed outside the physician's office, and enter the charges for those purchased services. Place an X in the "yes" box when a provider other than the provider billing for the service performed the diagnostic test. When "yes" is checked, Item 32 must be completed with the name and address of the clinical laboratory or other supplier that performed the service. If billing for multiple purchased diagnostic test, each test must be submitted on a separate claim form. Enter the purchase price of the tests in the charges column. Show dollars and cents, omitting the dollar sign. Place an X in the "no" box when diagnostic tests are performed in the physician's office or supervised by the physician (e.g., no purchased tests are included on the claim).
Block 21	Diagnosis or Nature of Illness or Injury	Enter the ICD-9-CM codes for the diagnoses, conditions, problems or other reasons for the encounter or visit. All physician specialties must use an ICD-9-CM code number and code up to the highest level of specificity. Report at least one diagnosis code on the claim. You may report up to four (4) codes in order of priority (primary, secondary conditions, etc.) to accurately describe the reason for the encounter. List first the code for the diagnosis, condition, problem, etc., shown in the medical record to be chiefly responsible for the service provided, then list codes that describe coexisting conditions.
Block 22	Medicaid (TennCare) Resubmission	This item contains the acronym "CC" denoting that it is a "corrected claim". When billing Medicare, leave this item blank.
Block 23	Prior Authorization Number	Enter the authorization number(s) assigned by the HMO/BHO for appropriate procedures.

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Block 24a	Dates of Service	This item indicates the beginning and ending dates of service for the entire period reflected by the procedure code, using the eight (8)-digit format, excluding all punctuation. Do not use slashes between dates. If the date or month is a single digit, precede it with a zero (0). Make sure the dates shown are no earlier than the date of the current illness shown in Item 14. If the same service is furnished on different dates, each date should be listed on the claim. For services performed on a single day, the "from" and "to" dates are the same. (For additional information see instructions).
Block 24b	Place of Service	This item indicates the site of service where services were rendered or an item was utilized. Enter the appropriate two (2)-digit numeric code pertaining to the place of service. If services were provided in the emergency department, use code 23. If services were provided in an urgent care center, use code 22. If services were rendered in a hospital, clinic, laboratory or other facility, show the name and the address of the facility in Item 32.
Block 24c	Type of Service	Enter the Medicare codes describing the type of service rendered.
Block 24d	Procedures, Services, or Supplies	Enter the CPT code applicable to the services, procedures or supplies rendered. Include CPT modifiers when necessary. The codes and modifiers selected must be supported by medical documentation in the patient's record. Link each CPT code with the appropriate ICD-9-CM code listed in Items 21 and 24e. In the absence of an applicable CPT code, enter the HCPCS code applicable to the services, procedure or supplies rendered. The codes and modifiers selected must be supported by medical documentation in the patient's record. Link each HCPCS code with the appropriate ICD-9-CM code listed in Items 21and 24e. Enter the specific procedure code without a descriptive narrative. If no specific procedure codes are available that fully describe the procedure performed, and an "unlisted" or "not otherwise classified" procedure code must be used, include the narrative description in Item 19.
Block 24e	Diagnosis Code	Indicate reference numbers linking the ICD-9-CM codes listed in Item 21 to the dates of service and CPT codes listed in Items 24a and 24d. The information is used to document that the patient's diagnosis warranted the physician's services. Enter only one (1) reference number per line item. When multiple services are performed, enter the primary reference number for each service. In a situation where two (2) or more diagnoses are required for a procedure code, you must reference only one (1) of the diagnoses in Item 21.
Block 24f	Charges	Enter the amount charged by the physician for each of the services or procedures listed on the claim. If multiple occurrences of the same procedure are being billed on the same line, indicate the inclusive dates of service in Item 24a. List the separate charge for each service in this item and the number of units or days in Item 24g. Do not bill a flat fee for multiple dates of service on one line.
Block 24g	Days or Units	This item shows the number of days or units of procedures, services or supplies listed in Item 24d. This field is most commonly used to report

		multiple visits, units of supplies, minutes of anesthesia and oxygen volume. The number "1" must be entered if only one service is performed. For some services (e.g., hospital visits, test, treatments, doses of an injectable drug, etc.), indicate the actual quantity provided. When the number of days is reported, it is compared with the inclusive dates of service listed in Item 24a. Days usually are reported when the patient has been hospitalized. When billing radiology services, do not provide the number of x-ray views in this column. Use the appropriate procedure code to report the number of views. However, when the same radiology procedure is performed more than once on the same day, the number of times should be shown in this item. Anesthesia claims must be reported in minutes.
Block 24h	EPSDT	Enter "Y" for "yes" and "N" for "no" to indicate that early and periodic screening, diagnosis and treatment (EPSDT) services were provided. EPSDT applies only to children who are under 21 and receive medical benefits through public assistance.
Block 24i	EMG	This item indicates that the service was rendered in a hospital emergency department. When this item is checked, show place-of-service code 23 (hospital emergency department) in Item 24b.
Block 24j and 24k	24j Coordination of Benefits (COB) and 24k (Reserved for local use)	This block is not required by TennCare program HMOs/BHOs. Leave blank.
Block 25	Federal Tax ID or SSN	Enter the federal tax identification number of the physician or supplier. The number may be the Social Security number (SSN) or the federal tax ID number/employee identification number (EIN). Designate whether number listed is SSN or EIN by placing an "X" in the appropriate box.
Block 26	Patient's Account Number	The patient's account number assigned by the physician's or supplier's accounting system should be entered in Item 26. The patient's account number is used by the provider for retrieving individual patient accounts and case records and for posting payment.
Block 27	Accept Assignment	If the physician or supplier agrees to accept the charge allowed by TennCare as the full payment for the service, place an X in the "yes" box. This establishes this claim as an assigned claim. A TennCare participating physician must always check the "yes" box.
Block 28	Total Charge	Enter the dollars and cents, omitting the dollar sign. Also, verify that this amount equals the total of the charges listed in Item 24f. To bill a Medicare secondary payer (MSP) claim, bill the full amount of the charges in this item. Do not report the difference between what the primary payer paid and the total charges or the allowed amounts. Attach a copy of the primary payer's explanation of benefits (EOB) that contains the payment information.
Block 29	Amount Paid	This item must be completed when billing TennCare as the secondary payer. Enter the amount paid by the patient-for covered services only-using dollars and cents, omitting the dollar sign.
Block 30	Balance Due	Enter difference between Block 28 and Block 29.

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Block 31	Signature of Physician or Supplier	Enter the signature of the physician or supplier, or a representative, and the date the claim form was signed in eight (8)-digit format. The provider or his or her authorized representative must sign the provider's name, or an approved facsimile stamp may be used. Type the provider's full name below the signature or stamp. Do not enter the name of an association or corporation in this field. (Computer generated/printed provider's name of "Signature on file" will also be accepted here.)
Block 32	Name and Address of Facility Where Services Were Rendered	Enter the name and address of the facility where the services were furnished if they were furnished in a hospital, clinic, laboratory, or any facility other than the patient's home or physician's office. A complete address includes the zip code, which allows carriers to determine the correct pricing locality for purposes of claims payment. When the name and the address of the facility where services were furnished is the same as the name and address shown in Item 33, enter the word "same". For additional information see instructions.
Block 33	Physician's, Supervising Physician's and Supplier's Billing Name, Address	Enter the name and billing address of the individual providing the claimed services. Enter the individual provider number and/or the group provider, if appropriate, number assigned by the HMO/BHO to whom the services are being billed.

Authority: *T.C.A. §§56-32-218(a), 71-5-191, and Public Acts of 2001, Chapter 209, § 1.* ***Administrative History:*** *Original rule filed April 4, 2002; effective June 18, 2002. Amendment filed October 24, 2002; effective January 7, 2003.*