TennCare Policy Manual

Policy No:	PAY 06-002 (Rev. 4)	
Subject:	Claims Processing Relating to Timely Filing & Prior Authorizations	
Approval:	Kent Gaither	**Date:** 7/31/19

POLICY AND PURPOSE:

The purpose of this policy is to furnish guidance to providers regarding what to do when they are considering delivering a service or have already delivered a service to a TennCare applicant or enrollee and the individual's TennCare managed care organization (MCO) is unknown.

DISCUSSION:

In most cases providers who are asked to treat a TennCare enrollee can quickly find out the TennCare MCO to which that person is assigned. They can ask to see the enrollee's identification card, or they can look up enrollment information using one of a number of commercial sources of information. Providers can also check enrollment information available on MCOs' websites or TennCare Online Services, a TennCare web service that offers primarily eligibility information.[1] Once providers know the individual's MCO, they can contact the MCO for coverage and billing information.

There are, however, a few cases where an enrollee's MCO will not be known. An enrollee who has applied for TennCare will not have an MCO until he has been determined eligible. This is true even though once he has been determined eligible, his eligibility is retroactive, usually to the date of application, and the MCO to which he is assigned will be responsible for care he received from his date of application. (In these cases, MCOs receive retroactive capitation payments for up to one year, depending on the length of time between an individual's application date and the date his application is approved.) Other applicants might have requested assignment to particular MCOs, as an example, but for one reason or another did not receive their first choice of MCOs when they became eligible, meaning that their MCOs were unknown, even if just for a brief time.

When the identity of an individual's MCO is unknown, two issues are of special concern: (1) the timely filing deadline, which is the length of time that a provider has to file a claim with the MCO, assuming he is not filing a claim with a third party payer, and (2) any prior authorization requirements that the MCO may have for specific services. In addressing these issues, there are significant dates to consider. These dates are listed below and defined in terms of how they relate to a hypothetical applicant ("Mary Bright") and to Mary after she is determined eligible for TennCare.

[1] The URL for TennCare Online Services is https://tcmisweb.tenncare.tn.gov/tcmis/tennessee/Security/logon.asp.

Key Date	Definition	Comments
Date of application	The date that Mary applies for TennCare. If Mary is applying for SSI, the date of her SSI application is also considered the date of her application for TennCare, since if Mary is determined eligible for SSI she is automatically enrolled in TennCare.	TennCare cannot cover any services that Mary receives prior to her date of application.
Date of approval	The date that Mary's application for TennCare is approved.	The date of approval is NOT the effective date of TennCare eligibility. See the definition of "effective date of TennCare eligibility" below.
Date of service	The date that a service is delivered to Mary.	
Effective date of TennCare eligibility, assuming the application is approved	The date of application or, if applicable, the date of the qualifying event (such as meeting a "spend-down" obligation), whichever is *later*.	*In Tennessee, unlike most other states, the effective date of TennCare eligibility cannot be earlier than the date of application.*
Effective date of MCO enrollment	The date provided on the 834 enrollment file sent to the MCO by TennCare.	In general, the effective date of MCO enrollment and the effective date of TennCare eligibility are the same.
"120-day timely filing clock"	The period during which a provider who is not filing a claim with a third party payer must file a claim with a TennCare enrollee's MCO in order for it to be considered "timely."	

POLICY ON TIMELY FILING WHEN THE MCO IS NOT KNOWN:

Ordinarily, the first day of the "120-day timely filing clock" is the date of service. However, if the individual receiving the service has applied for but not acquired TennCare eligibility as of the date of service, there is no MCO with which to file a claim. In these circumstances, the 120-day timely filing clock begins on the effective date of MCO enrollment.

EXAMPLE: Mary Bright filed a TennCare application on January 2, 2014. On January 15, 2014, Mary fell and broke her leg. She sought treatment from Dr. Jones on the same day. She told Dr. Jones that her TennCare eligibility was pending. On January 21, 2014, Mary was determined eligible for TennCare and enrolled in ABC MCO, effective January 2, 2014.

- Date of application: January 2, 2014
- Date of service: January 15, 2014

- Date of approval: January 21, 2014
- Date of TennCare eligibility and MCO enrollment: January 2, 2014
- Start date for the "120-day timely filing clock" (assuming Mary has no third party coverage which Dr. Jones can bill): January 21, 2014

Assuming that Mary has no third party liability, Dr. Jones has 120 days from January 21, 2014 (the date of Mary's approval for TennCare), to file his claim with Mary's MCO. If Mary had already been eligible when Dr. Jones treated her on January 15, Dr. Jones would have had 120 days from January 15, 2014 (the date of service), to file his claim with ABC MCO.

POLICY ON PRIOR APPROVAL WHEN THE MCO IS NOT KNOWN:

In the example of Mary Bright described above, her broken leg was an emergency, so no prior approval could have been required for her to receive treatment from Dr. Jones, assuming she was eligible for TennCare. What if, instead of an emergency service, Mary had used a service on January 15, 2014, that ABC MCO covers only with prior approval?

On January 15, 2014, the day Dr. Jones treated Mary, he had no way of knowing whether Mary would be determined eligible for TennCare or which MCO she would be assigned to. In this circumstance, it would not be reasonable to require that he obtain prior approval before delivering a covered service. The MCO would not have grounds to deny his claim on the basis that he did not seek prior approval.

Regardless of when they are delivered, however, services must be medically necessary in order to be covered by TennCare. In the situation described above, ABC MCO could have examined the service Dr. Jones delivered to Mary and determined, after the fact, that it was not medically necessary. In that case, it would be appropriate for ABC MCO to deny the claim, even though Mary was not yet enrolled in TennCare on the date of service.

OFFICES OF PRIMARY RESPONSIBILITY:

Managed Care Operations

REFERENCES:

TennCare Medicaid Rules
1200-13-13-.02(5)(b), 1200-13-13-.03(1)(a), and 1200-13-13-.08(12)
https://publications.tnsosfiles.com/rules/1200/1200-13/1200-13.htm

TennCare Standard Rules
1200-13-14-.03(1)(a) and 1200-13-14-.08(12)
https://publications.tnsosfiles.com/rules/1200/1200-13/1200-13.htm

MCO Statewide Contract
https://www.tn.gov/content/dam/tn/tenncare/documents/MCOStatewideContract.pdf

Original: 05/10/06: DAS
Reviewed /No changes: 10/2006: DAS
Revision 1: 12/10/07: DAS
Revision 2: 11/10/08: DAS
Reviewed / No changes: 11/2009: DAS
Reviewed / No changes: 01/14/11: MC
Hyperlinks Updated: 05/04/11: SLM
Reviewed / No changes: 01/25/12: AB
Reviewed: List of TennCare offices updated: 01/09/13: CH
Revision 3: 04/09/14: AB
Hyperlinks Updated: 06/22/15: AY
Revision 4: 08/05/19: RH