THE STATE OF TENNESSEE

BUREAU OF TENNCARE

Long Term Care - User Manual

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Long Term Care User Manual

310 Great Circle Road
Nashville, Tennessee 37243

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Overview

The Long Term Care (LTC) program within the State of Tennessee includes, in addition to the Home & Community Base Services (HCBS) and any other related Waiver programs, Level I, (formerly ICF/Intermediate Care Facilities), ICFs-MR/Intermediate Care Facilities for the Mentally Retarded; Level II, (formerly SNF/Skilled Nursing Facilities) and Medicare/Medicaid Cross-Over institutional claims.

The responsibility of this division is to assist all of the Medicaid and, in many instances, Medicare participating providers in the submission of claims, the resolution of same and the education of the correct completion of claims submitted to the State of Tennessee for processing and payment.

The system that is currently being used to process these claims is HIPAA (Health Insurance Portability and Accountability Act of 1996) compliant. In the future, the State of Tennessee will have the capability to accept and respond electronically to any and all submission of claims, adjustments, Pre-Admission Evaluations/PAEs, and any other Long Term Care related business. This Long Term Care provider training manual is to assist you, the provider doing business with the State, with the necessary means for submitting claims, checking claims' status, Remittance Advices/RAs amounts, PAEs (not yet available), Transfer Forms (not yet available), etc. Guidance will be ensured regarding the submission and status of PAEs and all other documents associated with this process.

Reimbursement Channels

The TCMIS system will offer three bill payment options. Below is a brief description of each option:

Internet - this option allows the users to submit Level 1 and Level 2 claims via an on-line form

Paper - traditional process of submitting claims via a paper form (crossover claims)

Trade Files - this feature allows the user to exchange files with TennCare via the web through an upload and download interface (837I)

Benefits of an Internet Channel

The Internet provides an easy, quick and more importantly, a secure method of filing LTC claims to the Bureau of TennCare. The Internet also provides the user with instant feedback on required and optional fields within the on-line forms. Contained within Appendix A and B are a step-by-step instructions on submitting a LTC claim via the Web.

Paper Claims

The traditional method of processing paper claims will continue as normal **with one exception.** Turnaround Documents (TADs) will no longer be available for provider use. Level I, formerly ICF/Intermediate Care Facilities, will submit all paper claims using the UB04 form. HCBS Providers can refer to Appendix B for additional instructions on submission of paper claims. If you have any questions regarding the submission of paper claims, please feel free to contact the following:

LTC Division of the Bureau of TennCare
615-507-6944 or
877-224-0219

Getting Started – Internet

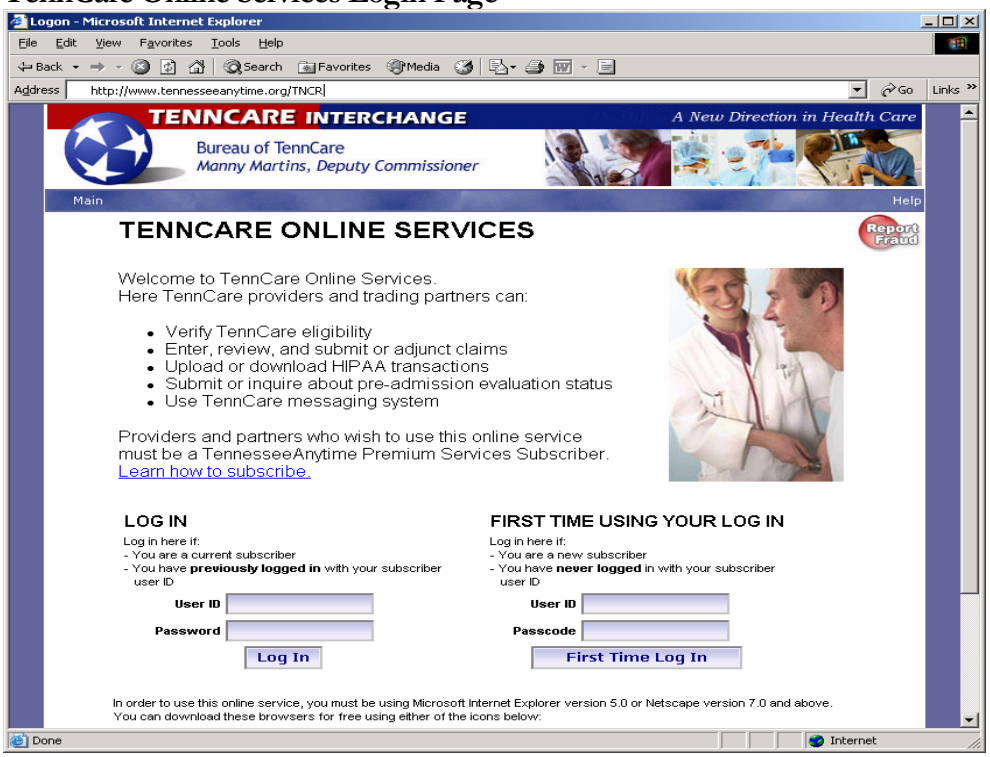
Before you can access the system, you must obtain a user ID and temporary password from TennCare's systems administrator. If you do not already have a **Tenneesee.Gov** Provider ID and password, the Internet address below will provide instructions on how to obtain and submit an application:

http://www.tennesseeanytime.org/tncr

Once you have received your user ID and temporary password you can use the above Internet address to gain access to the system or contact Tennessee Anytime at 615-313-0300.

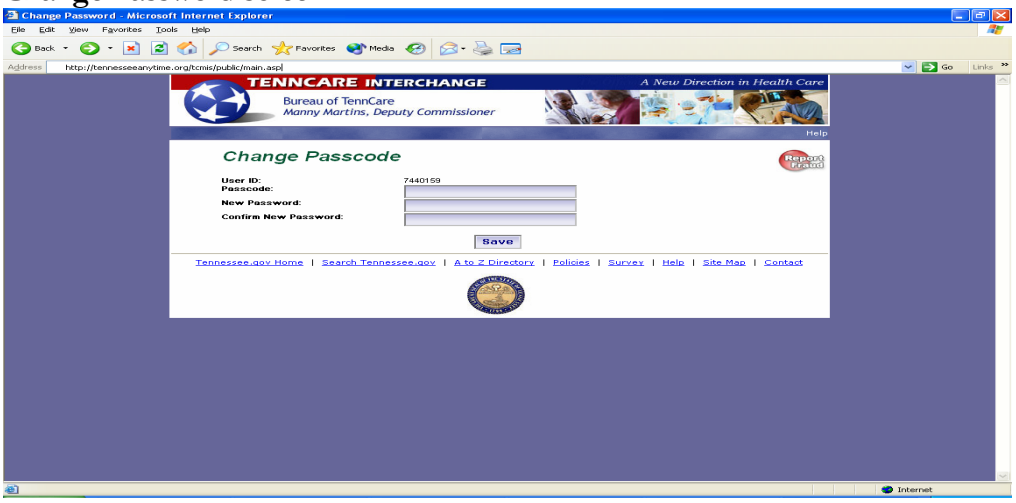
Please note: If you require your password to be reset, please contact Tennessee Anytime.

TennCare Online Services Login Page



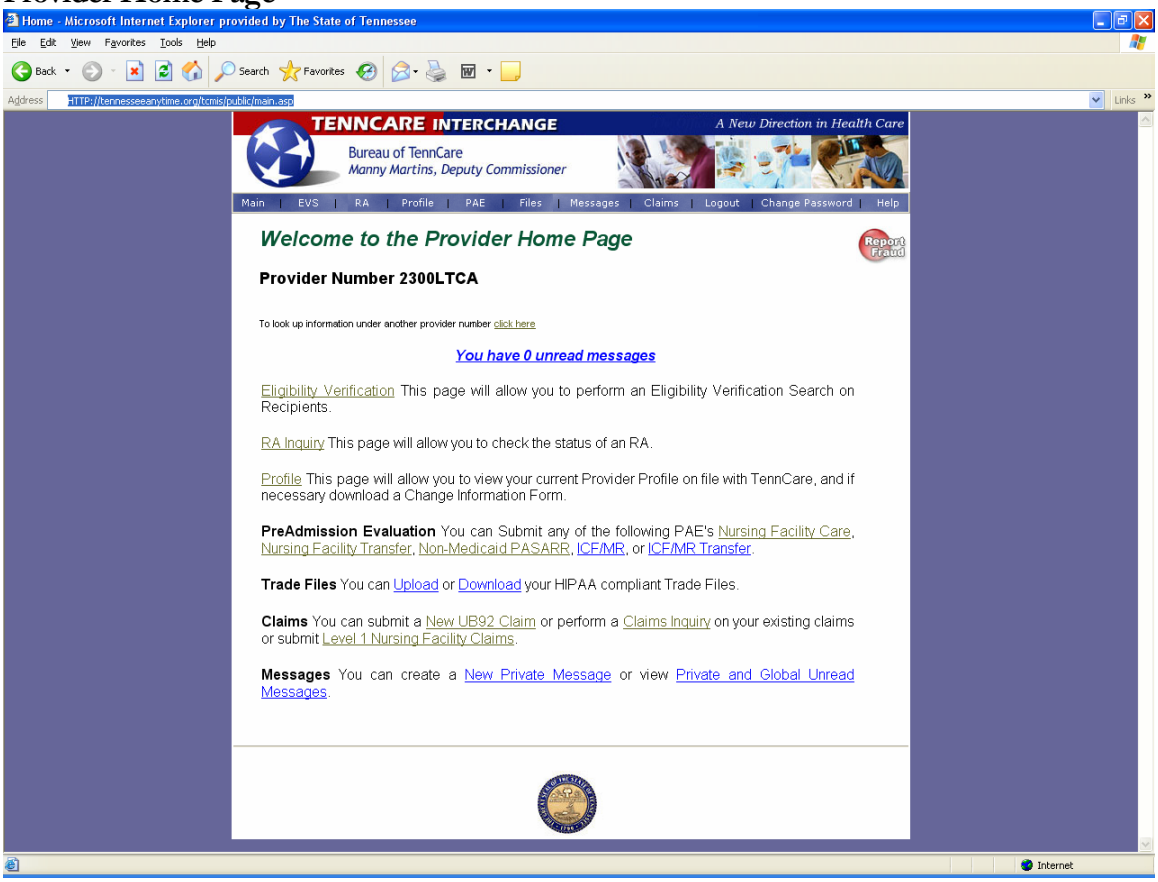
1) If you're a first time user, you will type your user name and password in the "First Time Users" section and click **First Time Login**

Change Password screen



1) Type your assigned password in the "Password" field
2) In the new password field, key in the new password. The password must be between 6-8 characters, at least two characters must be numeric. The confirmed password has to match the new password.

Provider Home Page



The Home Page allows the user to access a number of functions and features relating to claims reimbursement. To file or check the status of a claim, please see the following appendixes:

Appendix A – Institutions

Appendix B – HCBS

Appendix C - contains instructions on how to submit or view the status of a **Pre-Admission Evaluation**

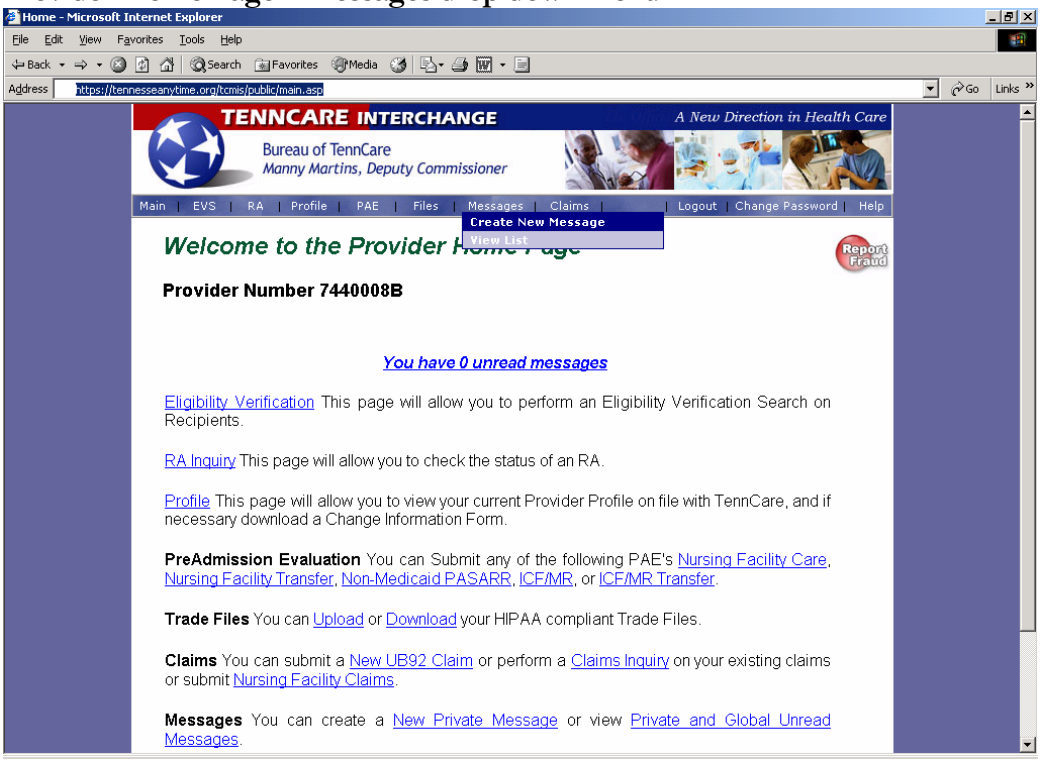
Other Features & Functionality

Messaging

The purpose of the messages feature is to inform providers of any changes in federal and state regulations and changes in state policies and procedures. This section would include messages that may appear in bulletins, on Remittance Advice (RA) messages and provider letters.

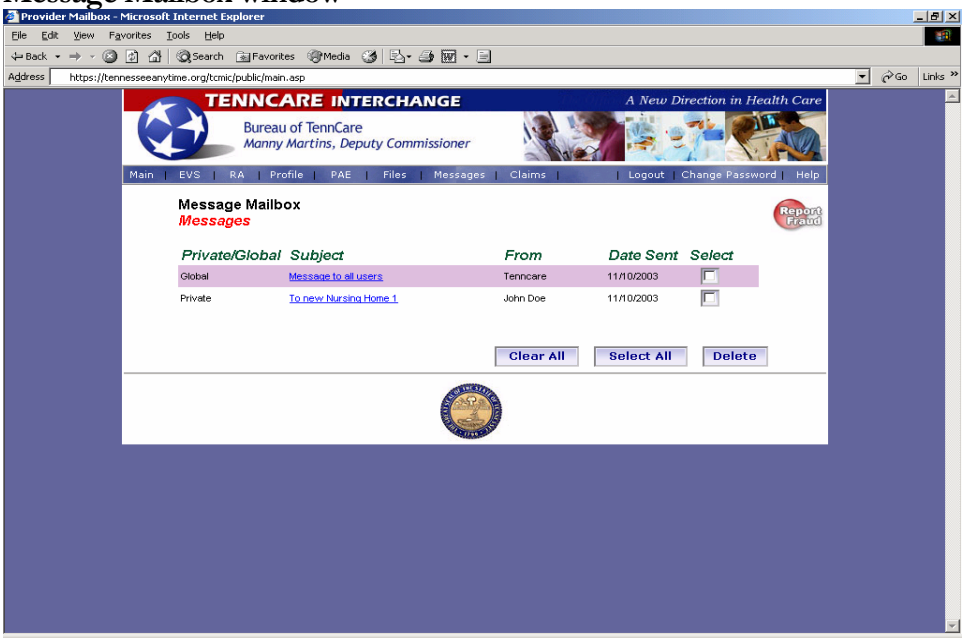
To access the message feature, click on **"Messages"** from the top menu or select the options listed within the **Message** section at the bottom of the Provider Home Page.

Provider Home Page – Messages drop down menu

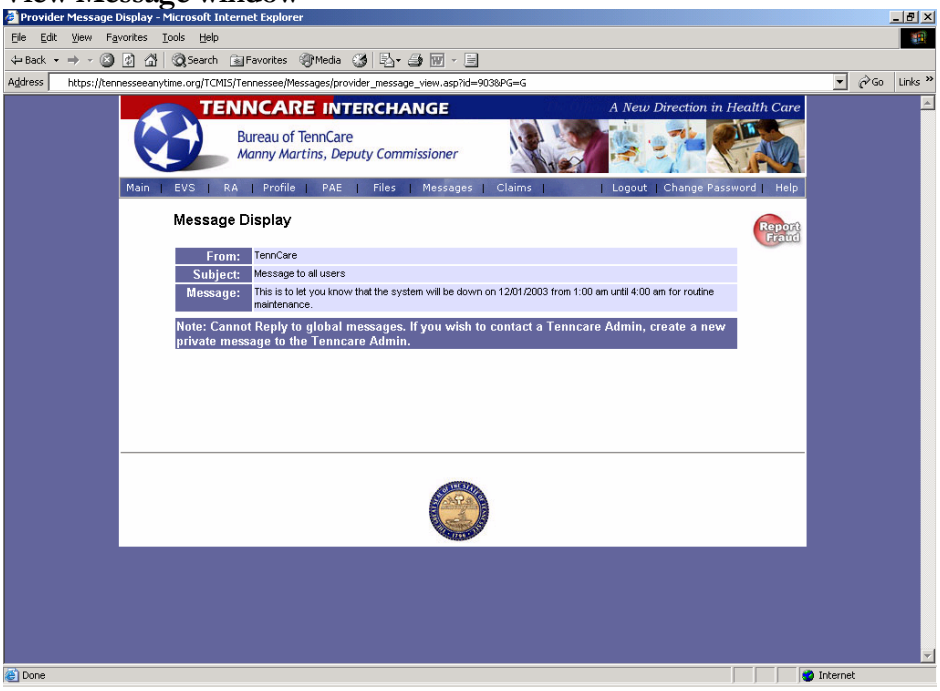


1) To access your messages, click "View List" (see next page)
2) Select your message from the "View List" option (see next page)

Message Mailbox window



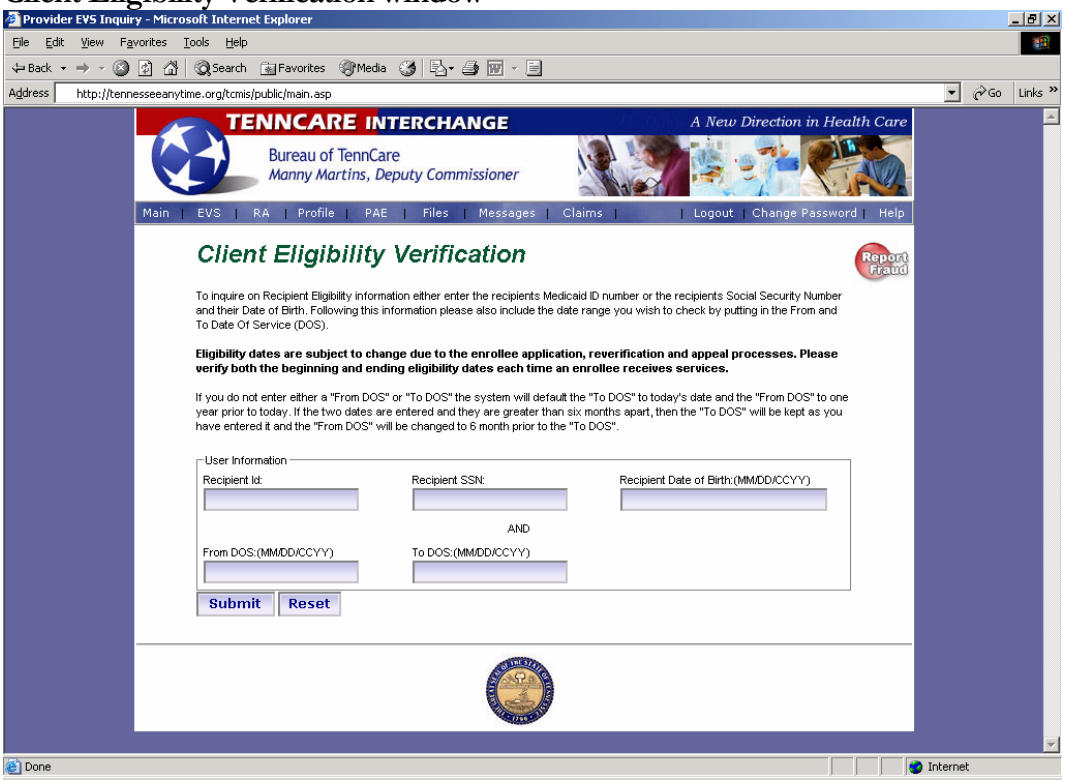
View Message window



Eligibility Verification

This feature allows the user to verify eligibility for benefit programs. Recipient eligibility may be determined from searching client ID or a combination of Social Security Number (SSN) and birth date. From and to dates of service are required for the search. Third Party Liability, managed care, and lock-in information are also displayed.

Client Eligibility Verification window



Profile

This window allows providers to view their profile information. The provider may request changes to this information by printing a form and sending it to TennCare by fax or mail. Below is the information displayed in this window

- ✓ License#
- ✓ License Expiration date
- ✓ Tax ID
- ✓ CLIA #
- ✓ Medicare #
- ✓ Program Eligibility Type
- ✓ Program Eligibility Effective and End Dates
- ✓ Home, Service, Mail and Pay Contact information

Electronic PreAdmission Evaluation (Currently Unavailable)

The PreAdmission Evaluation (PAE) is the assessment tool used to document an individual's medical condition and eligibility for Medicaid reimbursed care in a nursing facility, ICF/MR Institution and Home and Community Base Services (HCBS) waiver. For instructions on how to complete the PAE application, please refer to Appendix C.

RA Inquiry

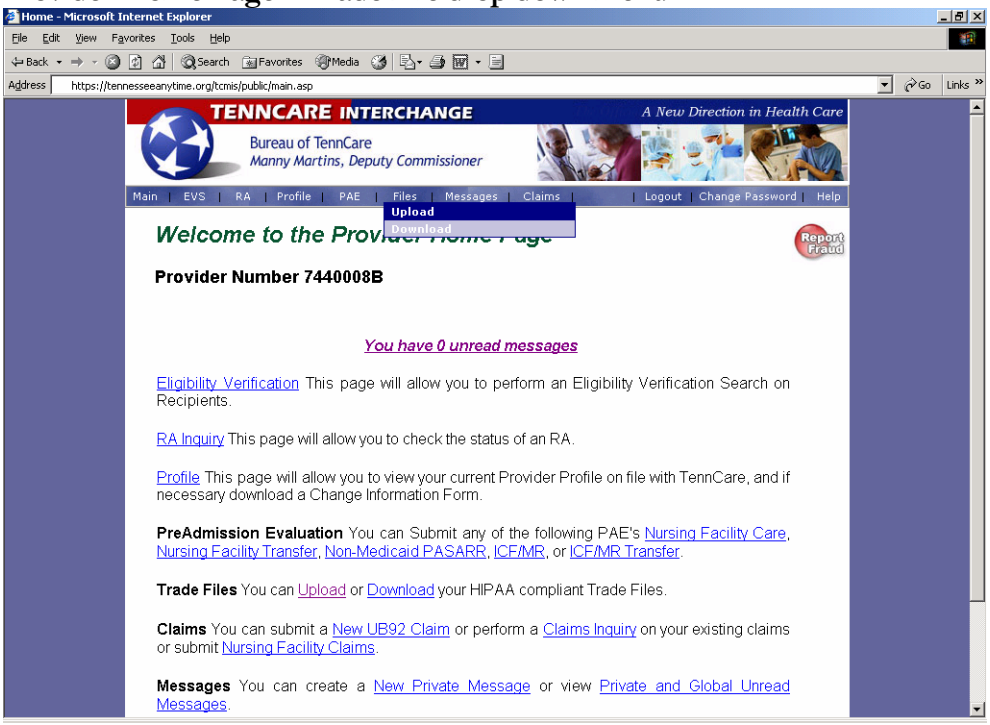
The RA Inquiry window searches for remittance advice (RA) and warrant (check) information for a given provider number. The user can search by any combination of the following:

- ✓ RA number
- ✓ Check number
- ✓ RA from date
- ✓ RA to date
- ✓ Pay to address

Trade Files

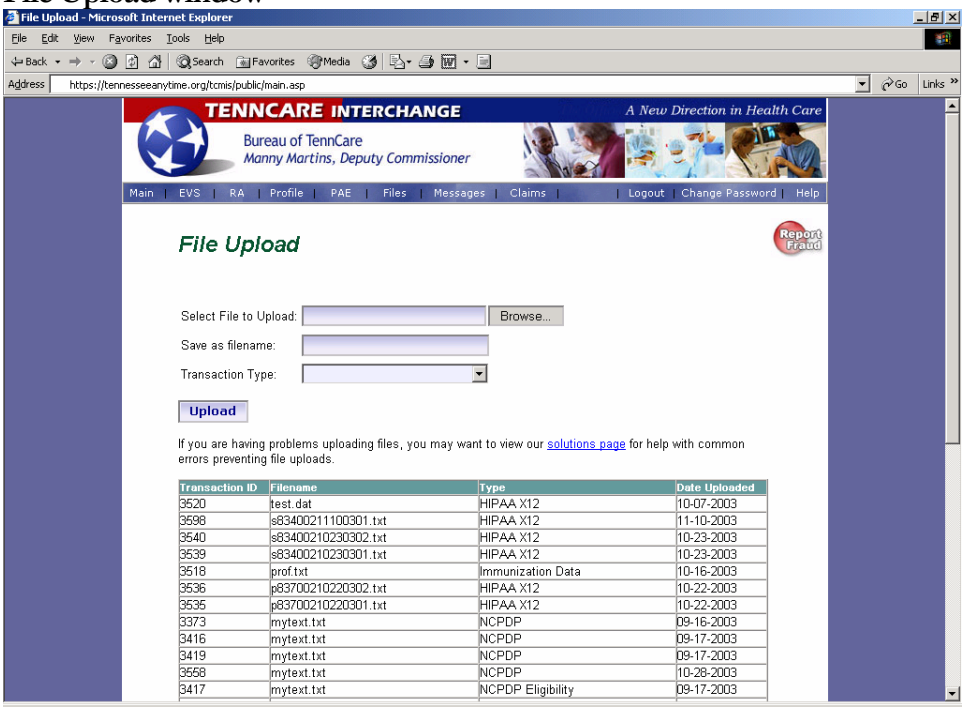
The purpose of the Trade Files feature is to exchange HIPAA compliant files (837I Transaction) between Providers and the Bureau of TennCare. To access the trade file feature, click on **"Files"** from the top menu or select the options listed within the **Trade Files** section at the bottom of the Provider Home Page. **Please note**: There are certain requirements to utilize this function. Please contact the TennCare Bureau's, Information Systems Unit for more information.

Provider Home Page – Trade File drop down menu



1) To upload a file, click "Upload" (see next page)
2) To download, click "Download" (see next page)

File Upload window



File Download window

Glossary & Common Terms

ACCENT

The term ACCENT refers to the Automated Client Certification Eligibility Network for Tennessee. This Department of Human Services (DHS) information system determines TennCare Standard eligibility for Title XIX individuals and families and forwards this predetermined eligibility to the Bureau of TennCare.

Adjudicated Claim

The term adjudicated claim refers to a claim, which has reached final disposition such that it has either been paid or denied.

Adjustment / Void

The term adjustment refers to a debit and credit or void transaction that corrects a previously paid claim or capitation payment. The correction may affect claim data, enrollment data, and/or amount of payment.

Benefits

The term benefits refers to a schedule of covered health care services that an eligible participant in TennCare may receive.

Billed Amount

The term billed amount refers to the dollar figure submitted as charges by a provider for medical services rendered.

Bureau

The term Bureau used in this document refers to the Bureau of TennCare.

Capitation

The term capitation refers to the monthly payments made for TennCare clients to Managed Care Contractors.

Claim

The term claim refers to a payment request from a provider for health care services provided to a recipient.

Claims History File

A claim history file is a computer file containing all types of claims and all subsequent adjustments, which have been adjudicated by the TCMIS.

Clean Claim

The term clean claim refers to a claim, which is not from a provider under investigation for possible fraud and noncompliance, and does not require additional information from the provider of the service or from a third party.

Cross over Claim

The term cross over claim refers to a claim for services rendered to a client eligible for benefits under both Medicaid and Medicare programs. Medicare benefits must be processed prior to Medicaid payment consideration.

DOH

The term DOH refers to the Tennessee Department of Health. This agency is a health care service provider, regulatory body, advocate and outreach entity. In 17 Tennessee counties, the local DOH departments serve as the TennCare client's primary care physician. This agency is also responsible for reporting health care statistics, tracking and trending health care, reporting, surveillance, and control of communicable diseases, and performing focused studies on various health related issues.

Duplicate Claim

The term duplicate claim refers to a claim (service) that is either totally or partially an exact or near duplicate of a claim (service) previously billed or in process.

EDS

The term EDS refers to Electronic Data Systems. EDS is the current Facilities Manager for the TennCare program.

Eligibility File

The term eligibility file refers to a computer file, which contains pertinent data for each eligible or previously eligible TennCare enrollee or other Medicaid recipient.

Enrollment

The term enrollment refers to the process of adding members to the TennCare Program once members choose or are assigned to a Managed Care Organization.

EOB

The term EOB refers to Explanation of Benefits, which is a four-digit code assigned by the system or suspend resolution staff to further explain processing parameters applied to the claim. The three-digit code correlates to an English description and other parameters on the error text file. This definition does not apply to explanations of benefits received from Medicare intermediaries and carriers or other third party resources.

HCBS

This term refers to Home and Community Based Services, which is a CMS waiver program for the elderly and disabled population.

HCPCS

The term HCPCS refers to the CMS Common Procedure Coding System.

HIPAA

The term HIPAA refers to the Health Insurance Portability and Accountability Act of 1996 requirements passed by the federal government.

HIPP

The term HIPP refers to the Health Insurance Purchasing Program. In the future TennCare proposes to assist low income working Tennesseans who have access to employer sponsored health insurance by assisting in the purchase of health insurance coverage through group health insurance programs. Eligibility for this program will be determined based on family composition and family income levels.

LTC

This term refers to long-term care, which includes nursing care in Tennessee, Intermediate Care Facilities for the Mentally Retarded (ICF/MR), State Developmental Centers, and Home and Community Based Services (HCBS).

MCO

The term MCO refers to a Managed Care Organization

Medicaid

See Title XIX.

Medically Needy Only

The term medically needy only refers to those recipients who meet Medicaid eligibility criteria but whose income and resources are above the limits prescribed for the categorically needy and are within the limits set under the Tennessee Medicaid plan.

Medicare

See Title XVIII.

Medicare Crossover

Same as a crossover claim.

On-Line Claim Summary

This is the web application used by Level 1 (ICF) providers to submit claims. This term replaces the document formerly known as a TAD (Turn Around Document).

PACE

This term refers to the Program of All-inclusive Care for the Elderly, an elderly and disabled HCBS waiver program. Currently, only one (1) county in Tennessee is operating this waiver.

PAE

This term refers to Preadmission Evaluation, an application for individuals seeking Medicaid reimbursement of nursing home care, Home and Community Based Services (HCBS) in a waiver program, and PACE services. PAEs are applications made by or for individuals seeking Medicaid reimbursement for nursing home care, Home and Community Based Services (HCBS) in a waiver program, and PACE (Program of All-inclusive Care for the Elderly) services. PAEs are also required for level of care change requests for nursing facilities, transfers from one institutional facility to another, and transfers between institutional and waiver programs.

PC

The term PC refers to personal computer.

PCP

The term PCP refers to Primary Care Provider.

ProLaw

The term ProLaw refers to the software system used to track all documentation and information related to a particular medical or reimbursement appeal and its status.

Returned Claim

The term returned claim refers to a claim which contains errors such as missing data, incorrect entries on the claim form, or conflicting information and that is returned to the provider without being adjudicated.

Revenue Code

The term revenue code refers to a three-digit code used identify and bill for services on a UB04 claim form.

SSA

The term SSA refers to Social Security Administration..

SSI

The term SSI refers to Supplemental Security Income

SSN

The term SSN refers to Social Security Number.

TAD

This term refers to a Turnaround Document. Long term care Level I nursing facilities as well as HCBS and PACE (TennCare portion of capitation payments) provider services are currently billed to TennCare via this method. This term is now known as On-Line Claim Summary.

TCMIS

The term TCMIS is used to refer to the current TennCare Management Information System.

TDCI

The term TDCI refers to the Tennessee Department of Commerce and Insurance.

URL

Uniform Resource Locator (Internet Address/World Wide Address)

Program Integrity – Fraud and Abuse

- Deficit Reduction Act of 2005

Effective 1/1/07 – All health care providers that receive or make annual Medicaid payments of $5 million or more per year, are required to educate employees, contractors or agents about certain fraud and abuse laws.

- Federal False Claims Act
    - Submitting or causing to be submitted a false claim to the United States Government for payment or approval;
    - Making, using or causing to be made or used, a false record or statement to get a false claim paid or approved by the Government;
    - Conspiring to get a false claim allowed or paid by the Government; or
    - Making, using or causing to be made or used, a false record to conceal, avoid or decrease an obligation to pay money or transmit property to the Government.

- Whistleblower Protection
    - Prohibits retaliation against public employees who report official wrongdoing, along with possible rewards for the Whistleblower.

- Tennessee Medicaid False Claims Act (TMFCA)
    - State law designed to apply solely to false claims under the Medicaid program.
    - Liability and Damages – Actions that violate TMFCA
        - Submitting a false claim for payment
        - Making or using a false record to get a false claim paid
        - Conspiring to make a false claim or get one paid, or
        - Making or using a false record to avoid payments owed.
        - Benefiting from a mistakenly submitted false claim that is not disclosed soon after he or she discovers the error.

Both Federal and State False Claims Acts may impose a civil penalty per claim, plus three times the amount of damages to the state may be imposed for violations.

Please call, fax, e-mail or mail to:
Vicki Guye, Chief Audit Executive
TennCare Internal Audit
615-507-6407
Fax: 615-253-5441
Vicki.Guye@tn.gov
310 Great Cirlce Road
Nashville, TN 37243
OR
Call or Fax:
The Office of Inspector General
TennCare Fraud and Abuse Hot-Line
1-800-433-3982
Fax: 615-256-3852
YOU ARE NOT REQUIRED TO PROVIDE YOUR NAME