CLAIMS UNIT PROTOCOL

TOPIC: Processing Appeals for Medicaid Crossover Claims	**DATE: 10/1/2014**

Overview

Providers who have filed claims with TennCare directly and who believe they have not been paid correctly have certain appeal rights, in accordance with TennCare Rule 1200-13-18.

Claims may be appealable if they were filed in accordance with TennCare rules and policies and they meet certain basic criteria. These criteria include, but are not limited to, the following:

- The claim was a "clean claim," meaning a claim for which no further written information or substantiation was required in order to make a payment.
- The claim contained no errors such as incorrect dates, codes, etc.
- The claim was filed timely. See Policy PAY 13-001 at http://www.tn.gov/tenncare/forms/pay13001.pdf for timely filing policies.
- The claim was for a covered service.
- The claim was for a service delivered to an eligible recipient.
- The claim was processed correctly by the TennCare Vendor, which includes accurately scanning, keying, and manual adjudication of suspended claims/audits.
- The claim was processed in accordance with federal and TennCare rules and policies.

There are certain types of claims for which no appeal will be provided. These include, but are not limited to, claims that do not meet one or more of the criteria stated above. As a general rule of thumb, a claim that was denied because it does not meet the above criteria is not appealable.

After reviewing a claim, one of three decisions will be made:

- The claim should have been paid as requested.
- The claim is not appealable, and no reimbursement will be made.
- The claim is appealable, and changes in reimbursement may be made, depending upon the outcome of the appeal.

Procedures

1. Provider appeals will be mailed to the attention of the Claims Unit Manager, at the following address:
   Bureau of TennCare
   310 Great Circle Rd.
   Nashville, TN 37243

2. The Claims Unit will review and research the claim to determine which of the above three decisions is appropriate. They will check for keying errors or general processing errors that may have occurred in the TennCare system, in addition to validating that a clean claim was submitted

appropriately by the provider within the timely filing guidelines and that the required follow-up was performed in accordance with the rules/regs/policies.

3. If the decision is that the claim should have been paid as requested, the Claims Unit will take appropriate action to pay the claim. The Claims Unit will use the **Resolvable Appeal** template to respond to the provider.

4. If the decision is that the claim is not resolvable, as defined above, the Claims Unit will consult with the Office of General Counsel on the matter of correspondence to the provider—appropriate citations, specific verbiage, etc. and will utilize either the **Denied Claim Response to Provider – No Appeal Rights** **OR** the **Denied Claim Response to Provider – Appeal Rights** template notice to respond to the provider. The correspondence will be sent to the provider via certified mail.

5. If the claim appears to be appealable, as defined above, the Claims Unit will notify the provider of the opportunity to appeal. This notification letter will contain the information the provider is to include in a request for an appeal, the deadline for communicating the request for an appeal to the Claims Unit, and the address for the Claims Unit. When a request for an appeal is received, the documents and the envelope in which they were received from the provider will be dated, then scanned and saved for Claims Unit files. The originals will be hand-delivered to Office of General Counsel's State Litigation Unit. **An appeal request received from a provider is time-sensitive and must be delivered to the Office of General Counsel on the date of receipt.**

6. At that point, the Office of General Counsel will take over handling the appeal. Claims Unit staff will be available to assist as needed.