



THE STATE OF TENNESSEE

Appendix A – Institutional Nursing Facility

BUREAU OF TENNCARE

Long Term Care - User Manual

BUREAU OF TENNCARE

Long Term Care User Manual – Appendix A

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Overview

This document is specifically designed for 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.

This document will provide guidance and education to the providers on the correct submission of claims. Included will be procedures and processes on how to submit Level 1 Care Claims via an online web portal. There will also be a review of Level II billing, via the web using the UB04 format.

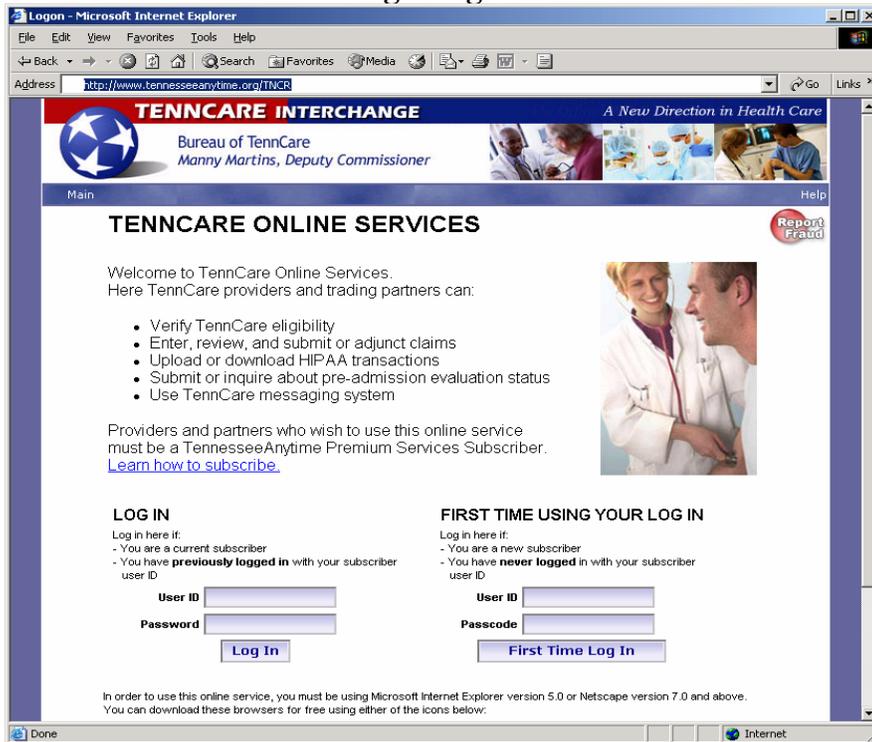
Getting Started – Internet

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 **Tennessee.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>

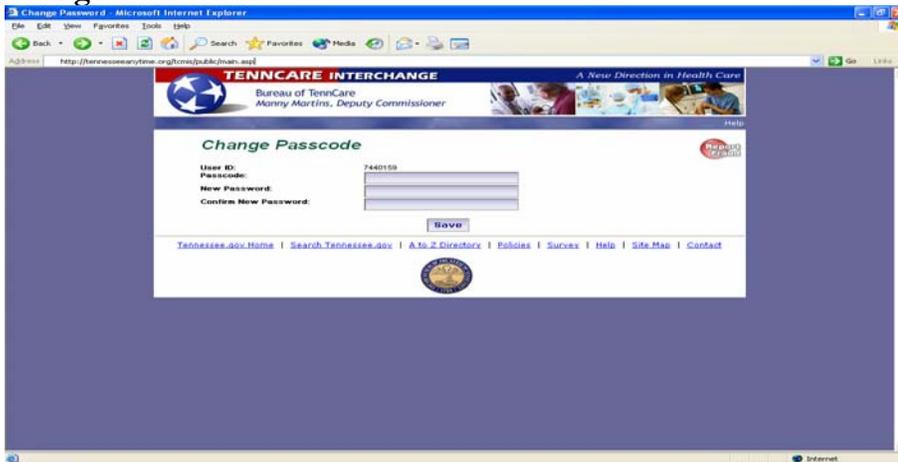
Once you have received your user ID and temporary password you can use the above Internet address to gain access to the system.

TennCare Online Services Login Page



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

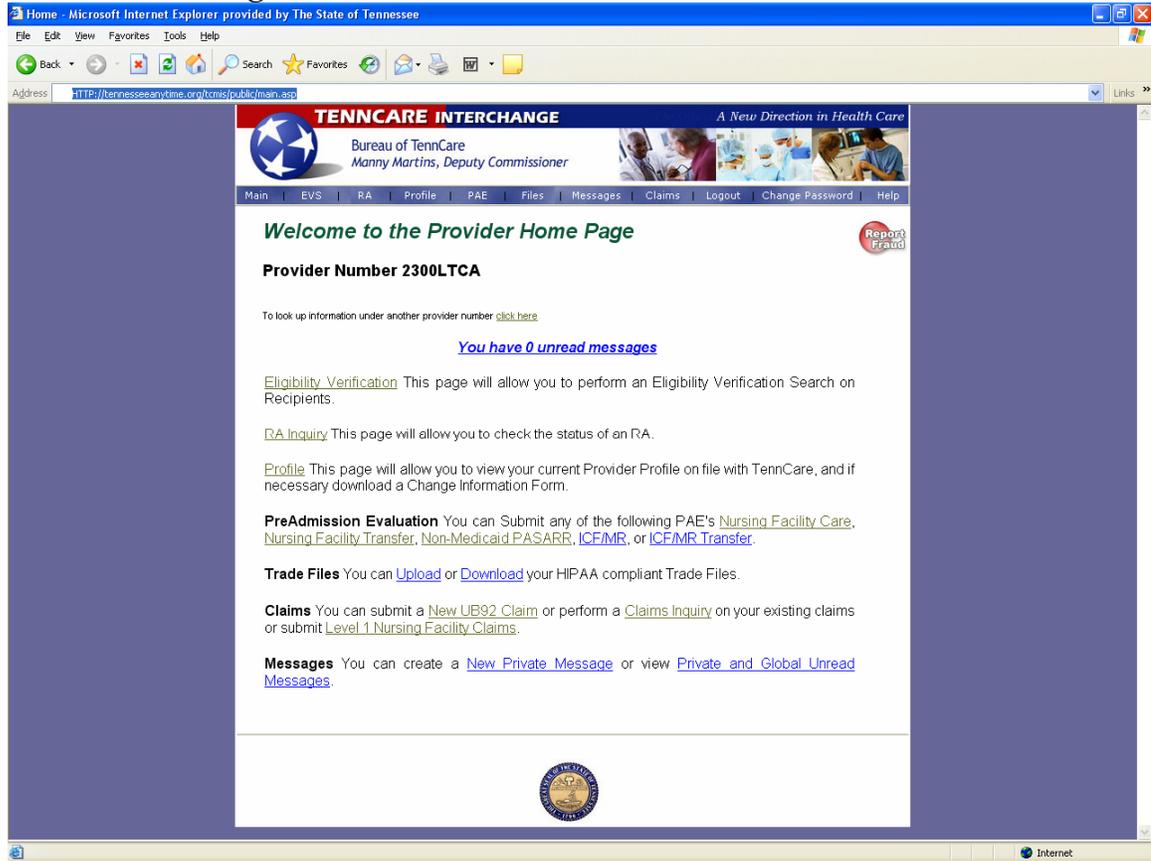
Change Passcode screen



- 1) Type your assigned passcode in the "Passcode" 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.

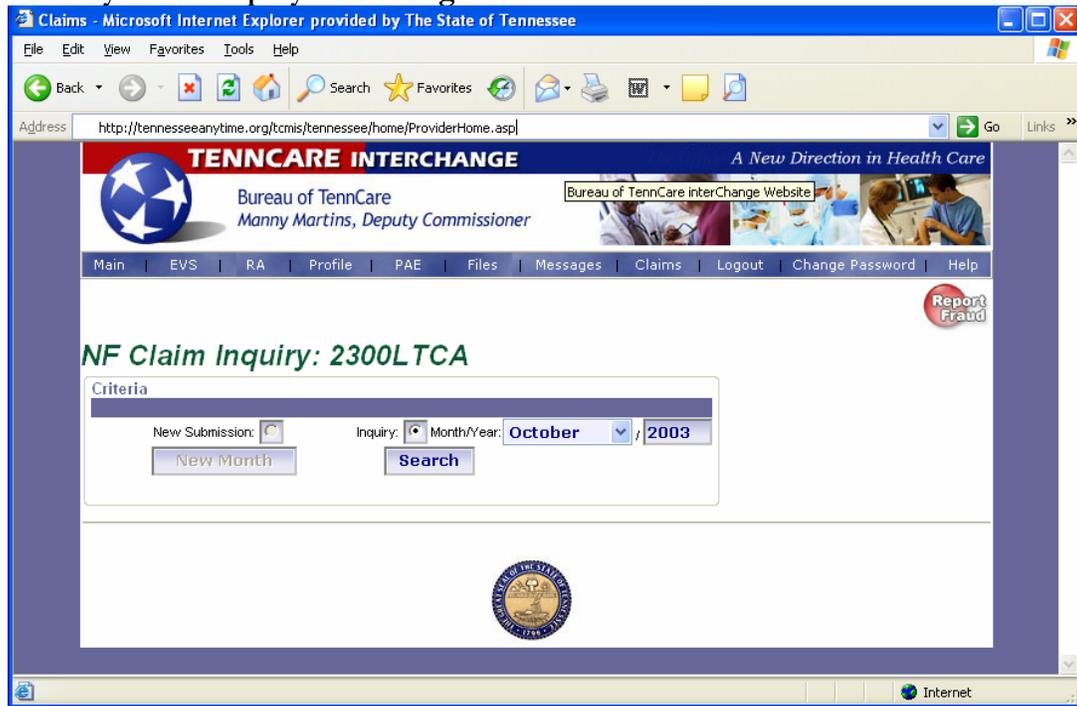
Instructions for Completing Level 1 – ICF Claims

Provider Home Page



- 1) Log on using the Log-On ID (usually the provider ID) and password.
- 2) Click on the “Level 1 Nursing Facility Claim” link listed at the bottom of the **Provider Home Page**.

Monthly Claim Inquiry Search Page



- 1) Click on “New Month” for new submission of claims. As a default the new month will display the current billing summary. See the Online Claim Summary window below.
- 2) To view any previous month’s activity, click “Inquiry” and select the month and year
- 3) Click on “Search”

Online Claims Summary (top section)

This window displays the current online claims summary for your facility prior to submission of claims. The majority of your edits will be performed in this window. A UB04 claim form is associated with each summary line. Below is a list of data elements to include brief descriptions that can be modified for each individual claim:

- **Edit** – Provides access to all data elements associated with the UB04
- **Recipient Last, First Name** - Recipient’s last name = two alpha characters and recipient’s first name = three alpha characters
- **MC ID#** - Recipient 11 digit Medicaid ID number
- **Hospital From Date** – Date resident admitted to the hospital
- **Diagnosis Code** – Primary diagnosis code for recipient
- **Physician Visit** – Federally mandated physician visit for Level I and Level II NF residents
 - a) **Physician Recertification Date** – Federally mandated physician recertification date for Level I, ICF-MR residents
- **Admit Date** – Date of admission into the nursing facility
- **Patient Status** – Resident status at the time of claim submission
- **Admission Code** - Source of admission
- **Type of Bill** - Three digit number, 663, for Level 1 participating nursing facilities

- **From Date of Service** – The begin date of the date of service being billed
- **Level** – Level of care code associated with this claim
- **Total Days** – Total days being billed
- **Facility Days** – Number of days the LTC resident was in-house
- **Hospital Leave Days** – Number of days the LTC resident was hospitalized
- **Therapeutic Leave Days** – Number of days resident was on home leave
- **Non-Covered Days** – Number of days nursing facility is not being paid
- **Claims Status** – Status of the claim being Paid, Denied or Suspended

Online Claims Summary Edit

Online Claims Summary (top) section

TENNCARE INTERCHANGE
Bureau of TennCare
Manny Martins, Deputy Commissioner

Address: <http://tennesseeanystate.org/tcmis/tennessee/home/ProviderHome.asp>

NF Claim Inquiry: 100001A

Criteria

New Submission: Inquiry: Month/Year: **November** / **2003**

	Recipient Last, First Name	MC ID #	Hospital From Date	Diag.	Phys. Visit	Admit Date	P Stat	ADM	Type of Bill	From DOS	Level	Total Days	Facility Days	HSP LV	THER LV	Non COV	C Stat
edit	r- fir	01008368749		4381	10/01/2003	10/14/1996	30	3	663	11/01/2003	A	30	30	0	0	0	
edit	r- fir	01008369199		29040	10/01/2003	10/04/2003	30	3	663	11/01/2003	A	30	30	0	0	0	
edit	r- fir	01008369855		2900	10/01/2003	05/22/2003	30	3	663	11/01/2003	A	30	30	0	0	0	
edit	r- fir	01008368717		290	10/01/2003	03/08/1997	30	3	663	11/01/2003	A	30	30	0	0	0	
edit	r- fir	01008369308		2959	10/01/2003	07/27/2003	30	3	663	11/01/2003	A	30	30	0	0	0	
edit	r- fir	01008369526		2948	10/01/2003	06/05/2003	30	3	663	11/01/2003	A	30	30	0	0	0	
edit	r- fir	01008368580		2902	10/01/2003	01/09/1995	30	3	663	11/01/2003	A	30	30	0	0	0	
edit	r- fir	01008368446		4019	10/01/2003	01/27/1996	30	3	663	11/01/2003	A	30	30	0	0	0	
edit	r- fir	01008369070		340	10/01/2003	01/07/1996	30	3	663	11/01/2003	A	30	30	0	0	0	
edit	r- fir	01008369207		290	10/01/2003	10/26/1995	30	3	663	11/01/2003	A	30	30	0	0	0	
edit	r- fir	01008369284		2989	10/01/2003	03/13/2003	30	3	663	11/01/2003	A	30	30	0	0	0	

Within this window, a user can select data elements to modify a claim.

- 1) Review the summary of claims to be submitted and check for discrepancies
- 2) Click on a particular data element to modify the information within the claim

Examples:

- 1) **Billing for Hospital Leave Days**
 - a) Modify the number of hospital leave days located in the “HSP LV” column
 - b) Modify the facility days located in the “Facility Days” column
 - c) Add your admit date in the “Hospital From Date” column
- 2) **Modifying the Physician Visit Date**
 - a) Click the “Physician Visit” field
 - b) Modify the date displayed

UB04 Claim Edits

There are data elements that cannot be modified through the online summary screen. To access the UB04, click the “Edit” link on the far left column of the online summary page. The pre-populated UB04 will open a new window and take a few seconds to load recipient data.

UB04 Claims Submission window (top section)

The window above displays a pre-populated UB04. The data elements displayed can be modified for submission. An example, billing for the date of death is a common change often seen to an existing claim. To modify the **date of death**, the user must change the following fields:

Top Section:

Thru Date	Patient Status
Covered Days	Discharge Time

Bottom Section:

Item 1:	To DOS	Units		
Item 2: Click “Add”	From DOS	To DOS	Revenue Code=224	Units=1

Note: ICFs-MR that bills multiple levels of care during a month will do so by that level of care.

UB04 Claims Submission window (middle section)

Institutional Claim Submission - Microsoft Internet Explorer

Referring Phys:
 Facility Number:
 Other Physician:
 Insurance Denied?:

Admit Source: **HMO Referral**
 Admission Type: **3 Elective**
 Admission Date: **10/14/1996**
 Admission Hour:
 Discharge Time: **0**

Billing Codes
 Add Diagnosis Code*

 Add Procedure Code Date
 Add Condition Code
 Add Value Code Amount
 Add Occurrence/Span Code From Thru

 Add Payer Code Prior Payment Estimated Due

Charges
 Total Charges: **3733.95**

Item	Rev. Code	Procedure	Units	Charges	Status	Allowed Amount
1	120	Y1802	30	3733.95		0.00

Add
Remove

UB04 Claims Submission window (bottom section)

Institutional Claim Submission - Microsoft Internet Explorer

Item	Rev. Code	Procedure	Units	Charges	Status	Allowed Amount
1	120	Y1802	30	3733.95		0.00

Add
Remove

Detail Information
 Item: From DOS*: To DOS:
 Revenue Code: HCPCS / Rates: Modifiers:
 Units*: Units of Measurement:
 Charges: Co-Pay: TPL Amount:
 Status: Allowed Amount:
 Units Allowed: Paid Amount:

Close

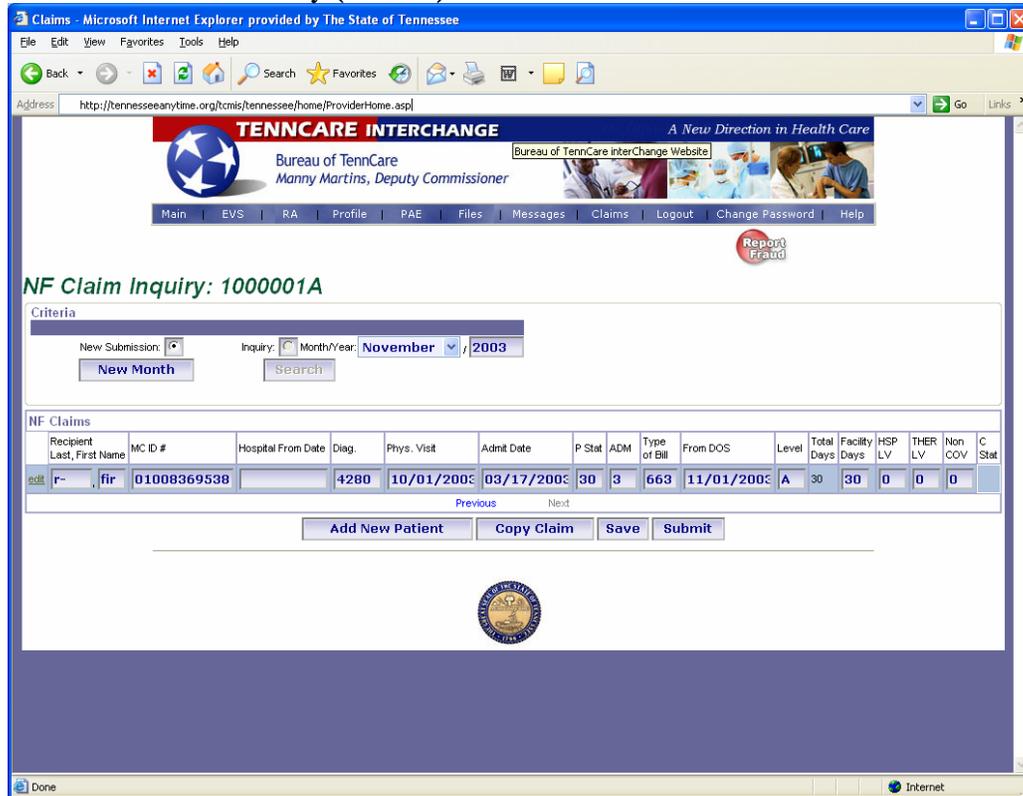
Claim Status Information
 Not Submitted yet.



Upon completion of the UB04 edit, click the “Close” button, which will take you back to the **Online Claims Summary window**.

Submit a Level 1 Online Claims Summary

Online Claims Summary (bottom) section



Once you have completed all of your modification, click “Submit” listed at the bottom of the page.

PLEASE NOTE: DO NOT SUBMIT A NEW UB04 WITH THE SAME MONTH OF SERVICE UNTIL AFTER YOUR ON-LINE CLAIMS SUMMARY (TAD) HAS BEEN SUBMITTED.

A small window will indicate that your claims are being processed.



After you click “OK”, your **Provider Home Page** will be displayed. To check the status on your claims, click on the “Level 1 Nursing Facility Claims” link or the “Claims Inquiry” link. Both functions are listed in separate sections of this document.

PLEASE NOTE: To ensure your claims have been submitted, **ALWAYS** re-enter the “Level 1 Nursing Facility Claims”. After submission, the “Edit/Delete” selections will show as “View”.

Online Claims Status – Level 1

To check the status of your level 1 claims, select “Level 1 Nursing Facility Claims” from the **Provider Home Page**.

Online Claims Summary (top)

TENNCARE INTERCHANGE
 Bureau of TennCare
 Manny Martins, Director
 Bureau of TennCare InterChange Website

NF Claim Inquiry: 1000020B

Criteria
 New Submission: Inquiry: Month/Year: **October**, **2003**

	Recipient Last, First Name	MC ID #	Hospital From Date	Diag.	Phys. Visit	Admit Date	P Stat	ADM	Type of Bill	From DOS	Level	Total Days	Facility Days	HSP LV	THER LV	Non COV	C Stat
view	r- fir	01008368493		25061	10/01/2000	07/27/1990	30	3	663	10/01/2000	B	31	31	0	0	0	P
view	r- fir	01008368959		436	10/01/2000	05/07/1990	30	3	663	10/01/2000	B	31	31	0	0	0	P
view	r- fir	01008369277		3314	10/01/2000	01/12/2001	30	3	663	10/01/2000	B	31	31	0	0	0	P
view	r- fir	01008368761		8244	10/01/2000	12/18/2000	30	3	663	10/01/2000	B	31	31	0	0	0	P
view	r- fir	01008368967		82013	10/01/2000	09/14/1990	30	3	663	10/01/2000	B	31	31	0	0	0	P
view	r- fir	01008369181		29411	10/01/2000	03/16/1990	30	3	663	10/01/2000	B	31	31	0	0	0	P
view	r- fir	01008369630		25000	10/01/2000	11/09/2000	30	3	663	10/01/2000	B	31	31	0	0	0	P
view	r- fir	01008368342		4280	10/01/2000	02/22/2001	30	3	663	10/01/2000	B	31	31	0	0	0	P
view	r- fir	01008369211		25002	10/01/2000	10/27/2000	30	3	663	10/01/2000	B	31	31	0	0	0	P
view	r- fir	01008369638		3310	10/01/2000	10/31/2000	30	3	663	10/01/2000	B	31	31	0	0	0	P

The window above displays an online summary page that has been submitted to TennCare. On far right column (C Stat) displays the status of each claim. Below is list of characters found in the C Stat column:

- P = Paid
- D = Denied
- S = Suspended

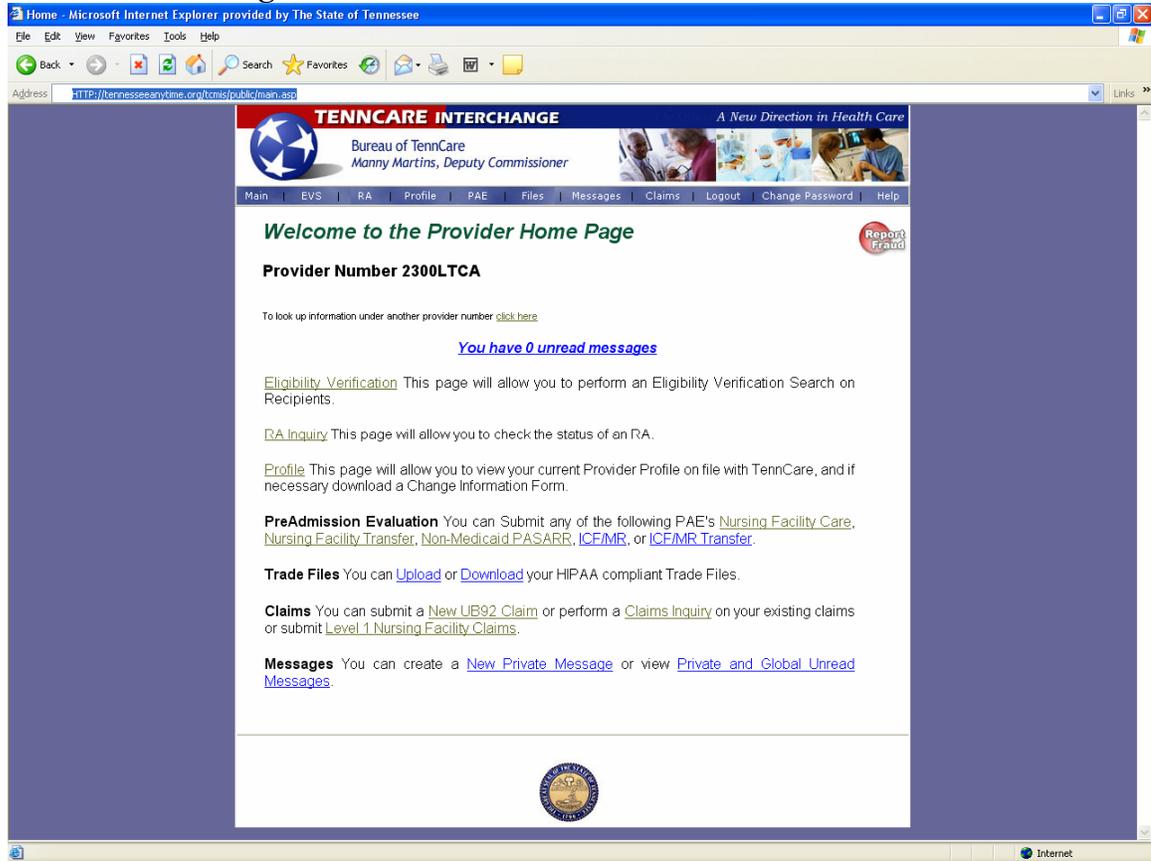
Click “View” on the far left column to display the UB04 claim, which provides details of the claim status. For additional information on how to adjust a paid claim, please refer to the section, [Adjusting/Voiding a Previously Paid Claim](#). To correct a denied status, please refer to sections, [Online Claims Summary Edit](#) and [UB04 Claim Edits](#). For information regarding a suspended claim, see the [Initial Claim Status](#) section.

Instructions for Completing a New Level 1 Claim

This section outlines the process of creating a new UB04 claim for a new recipient.

Creating a New Level 1 Claim

Provider Home Page



To create a new claim, click the “New UB04 Claim” link located at the bottom of the **Provider Home Page** or click on “Claims” listed in the menu bar.

UB04 Claim Submission (top section)

The UB04 claim form consist of three sections (top, middle and bottom)

The following fields will need to be completed under the billing information section located at the upper left side on the claim form:

- 1) Provider number is populated based on sign-in (required)
- 2) Enter recipient ID#, and press tab key. Upon pressing the tab key the recipient's first and last name will populate. (required)
- 3) Enter the patient account # (optional)
- 4) Attending physician ID (required). The number can be the practitioner's state ID # or Medicaid ID number.
- 5) Referring physician ID (optional)

The following fields will need to be completed under the service information section located on the upper right side of the claim form:

- 6) Claim type (required) - from the drop down box select Long Term Care claim
- 7) Type of bill, 663 is used for all Level 1 claims
- 8) Enter the from and thru date (required) - this is the statement covered period
- 9) Covered Days is a (required) field

- 10) Patient Status (required) – select the status from the drop down box
- 11) Admit Source (required) - select the status from the drop down box
- 12) Admission Type (required) - select the status from the drop down box
- 13) Admission date (required) - cannot be later than “from date”
- 14) Discharge Time – must be entered in military hours, if attempting to be paid for date of death

UB04 Claim Submission (middle section)

The screenshot shows a web browser window with the URL <https://tennesseeanytme.org/tcmis/public/mail.asp>. The page title is "UB04 Claim Submission (middle section)". The form is divided into several sections:

- Billing Codes:**
 - Diagnosis Code*:** A dropdown menu with "Principle" selected.
 - Procedure Code:** A text input field with "1" entered.
 - Date:** Two text input fields for date.
 - Condition Code:** A dropdown menu with "1" selected.
 - Value Code:** A dropdown menu with "1" selected.
 - Amount:** A text input field with "0.00" entered.
 - Occurrence/Span Code:** A dropdown menu with "1" selected.
 - From:** A text input field.
 - Thru:** A text input field.
 - Payer Code:** A dropdown menu with "1" selected.
 - Prior Payment:** A text input field with "0.00" entered.
 - Estimated Due:** A text input field with "0.00" entered.
- Charges:** A box containing "Total Charges" and "0.00".
- Table:**

Item	Rev. Code	Procedure	Units	Charges	Status	Allowed Amount
1	0		0	0.00		0.00

The following fields will need to be completed under the billing code section located on the middle left side of the claim form:

- 1) Enter diagnosis code in the shaded box (required)
- 2) Occurrence/Span Code – Occurrence Code 54 and the physician visit date is required on all Level I Medicaid billing.

Occurrence Code 51 and the physician recertification visit date is required on all Level I, ICF-MR Medicaid billing

Occurrence Code 24 is required when there is TPL/Third Party Liability, also known as other insurance, and the insurance denied. Complete the field with the code and the date the insurance carrier denied.

Occurrence Code 25 is required when there is TPL/Third Party Liability, also known as other insurance, and the insurance policy has been cancelled. Complete the field with the code and the date the insurance carrier terminated the policy.

You may use the drop-down arrows for the Occurrence Codes.

- 3) Payer Code – Click on ‘Add’ to choose the appropriate payer. Enter ‘Prior Payment’.

- 4) If additional 'Line Items' are needed, you may proceed to that area and click on 'Add'. After clicking on 'Add', you will return to the 'Detail Information' area of the claim and proceed to populate the relevant fields.

UB04 Claim Submission (bottom section)

The screenshot shows a web browser window with the following elements:

- Browser Title:** Institutional Claim Submission - Microsoft Internet Explorer provided by The State of Tennessee
- Address Bar:** http://tennesseeanyttime.org/tcmis/tennessee/home/ProviderHome.asp
- Form Fields:**
 - Add Payer Code: [x] 1
 - Prior Payment: 0.00
 - Estimated Due: 0.00
- Table:**

Item	Rev. Code	Procedure	Units	Charges	Status	Allowed Amount
1	0		0	0.00		0.00
- Buttons:** Add, Remove, Submit
- Detail Information Section:**
 - Item: 1
 - Revenue Code: 0
 - Units*: 0
 - Charges: 0.00
 - Status: []
 - Units Allowed: []
 - From DOS*: []
 - To DOS: []
 - HCPCS / Rates: []
 - Units of Measurement: []
 - Co-Pay: 0.00
 - Allowed Amount: 0.00
 - TPL Amount: 0.00
 - Modifiers: 1
- Claim Status Information:** Not Submitted yet.

The following fields will need to be completed under the Detail Information Section:

- 1) Enter the from and thru dates of service (DOS) (required)
- 2) Enter revenue code (required)
- 3) Enter HCPCS/Rates (as required for HCBS Claims)
- 4) Enter the unit(s) (required)
- 5) To enter the unit of measure, click on the drop down box and select “Day” or “Unit” (optional)
- 6) Enter co-pay and/or TPL amount, if applicable
- 7) Once all of the required fields are entered, click on “Submit”

Please refer to the Initial Claim Status section of this document to view the status and reason codes of the adjudicated claim.

Instructions for Completing Level 2 – SNF Claims

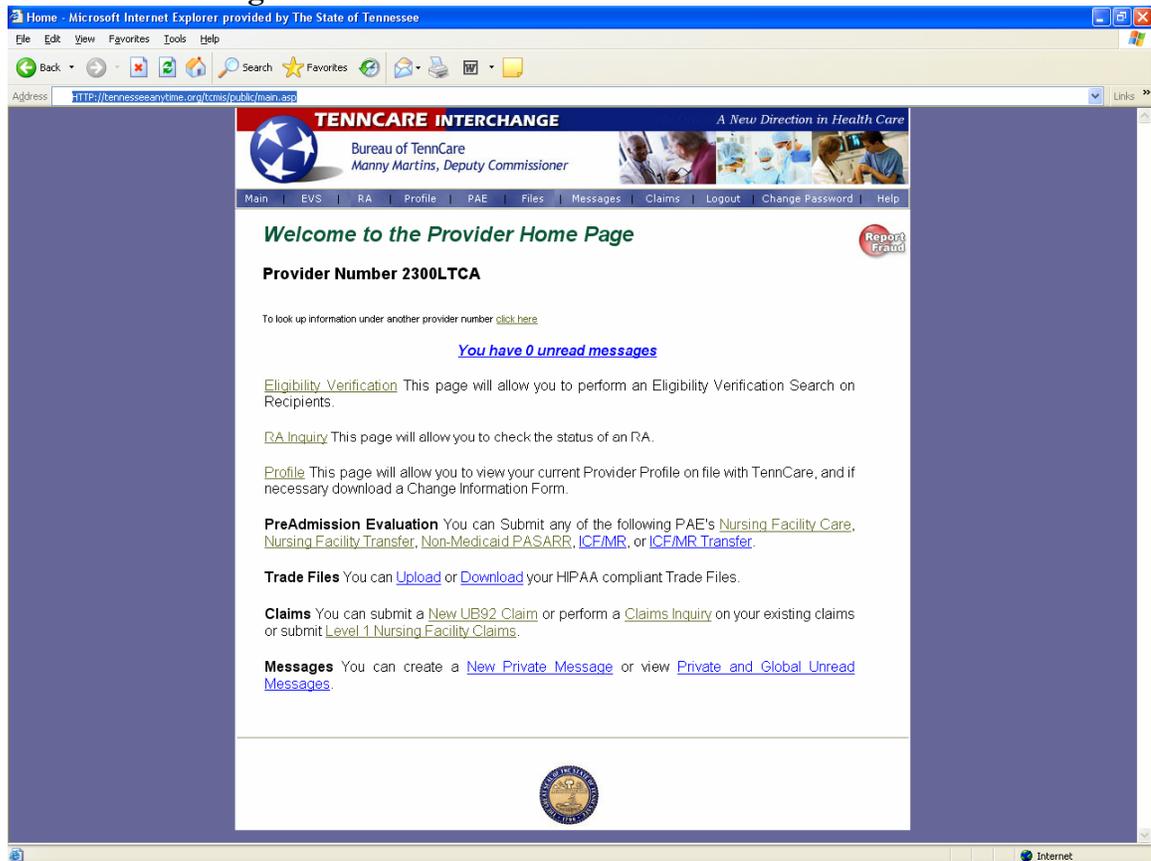
To submit a Level 2 claim, a user can select one of two options:

- 1) Copying/modifying a previously paid claim from an existing recipient
- 2) Creating a new claim

Creating a Claim on an Existing Recipient

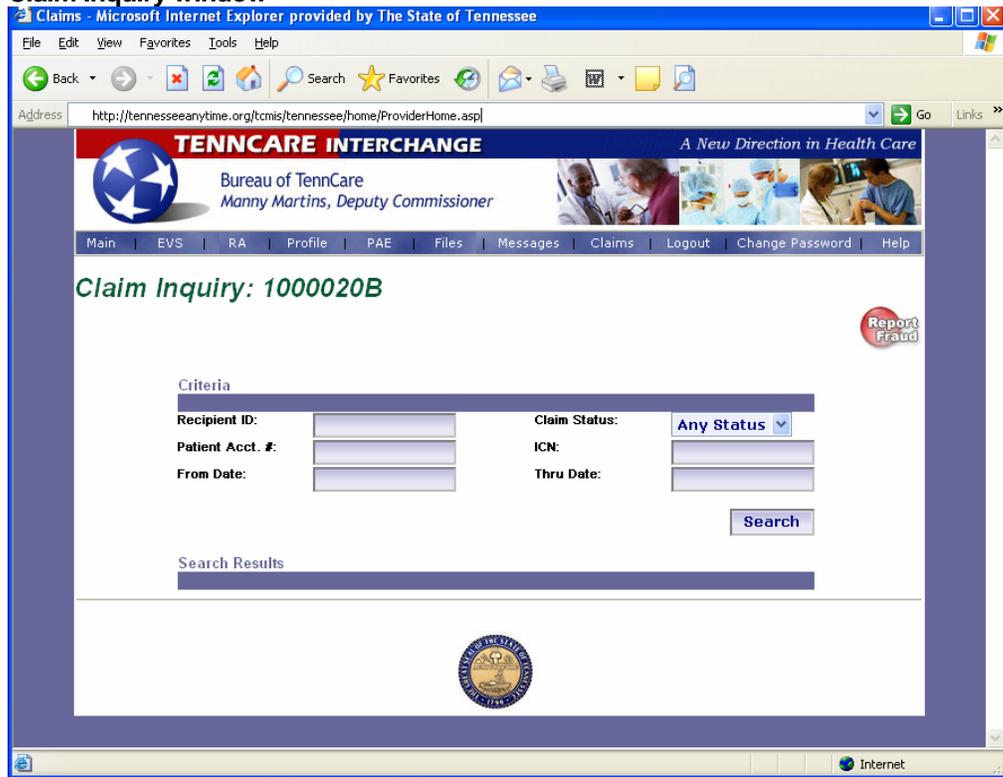
This section outlines the process to copy a previously paid claim (from a previous month) and create a claim for the current month. Below is an example of this process:

Provider Home Page



- 1) Click “Claim Inquiry”, listed at the bottom of the **Provider Home Page**

Claim Inquiry window



A user can perform a claim inquiry by selecting any of the options listed below. Utilize as many options as possible to refine your search.

- 1) Enter recipient ID #
- 2) Claim status from drop down box
- 3) Patient Account Number
- 4) Enter ICN, if available
- 5) Enter from and thru date
- 6) Click on the “Search” button

Claims Inquiry Result Window

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 Bureau of TennCare
 Manny Martins, Deputy Commissioner

Main | EVS | RA | Profile | PAE | Files | Messages | Claims | Logout | Change Password | Help

Claim Inquiry: 100020B

Criteria

Recipient ID: Claim Status: **Any Status**
 Patient Acct. #: ICN:
 From Date: Thru Date:

Search Results

ICN	Client ID	Patient Acct. #	From Date	Thru Date	Date Paid	Billed Amount	Paid Amount	Status
4003336001889	01008368493		20031001	20031031	20031101	3733.95	3150.22	Paid
4003336001890	01008368959		20031001	20031031	20031101	3733.95	2379.65	Paid
4003336001891	01008369277		20031001	20031031	20031101	3733.95	2922.95	Paid
4003336001892	01008368761		20031001	20031031	20031101	3733.95	3244.95	Paid
4003336001893	01008368967		20031001	20031031	20031101	3733.95	2500.60	Paid

- 1) Click on the "ICN" field listed above. This will display a previously adjudicated UB04 claim.

UB04 Claim Window (bottom section)

Detail Information

Item	1	From DOS*	10/01/2003	To DOS	10/31/2003
Revenue Code	120	HCPCS / Rates		Modifiers	
Units*	31.00	Units of Measurement			
Charges	3733.95	Co-Pay	0.00	TPL Amount	0.00
Status	P	Allowed Amount	3733.95		
Units Allowed	0.00				

Claim Status Information

Claim Status	Paid
Claim ICN	4003336001889
Paid Date	20031101
Allowed Amount	3733.95

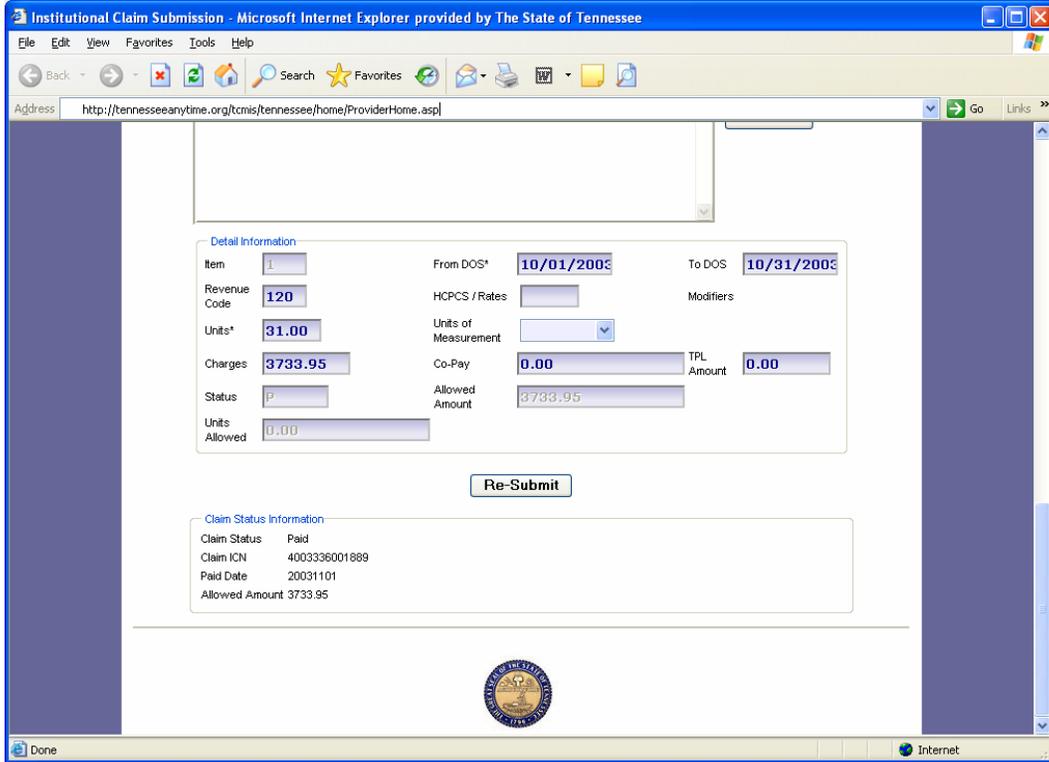
Buttons: **Adjust** **Void** **Copy Claim**

Verify the information displayed on the entire UB04 form is correct

- 1) Click “Copy Claim” listed at the bottom section of the page

The new claim window will load the previous month's information. Make any modifications (i.e. DOS, Days, Units, Type of Bill, etc.) necessary throughout the claim.

Copied – UB04 Claim Window (bottom section)

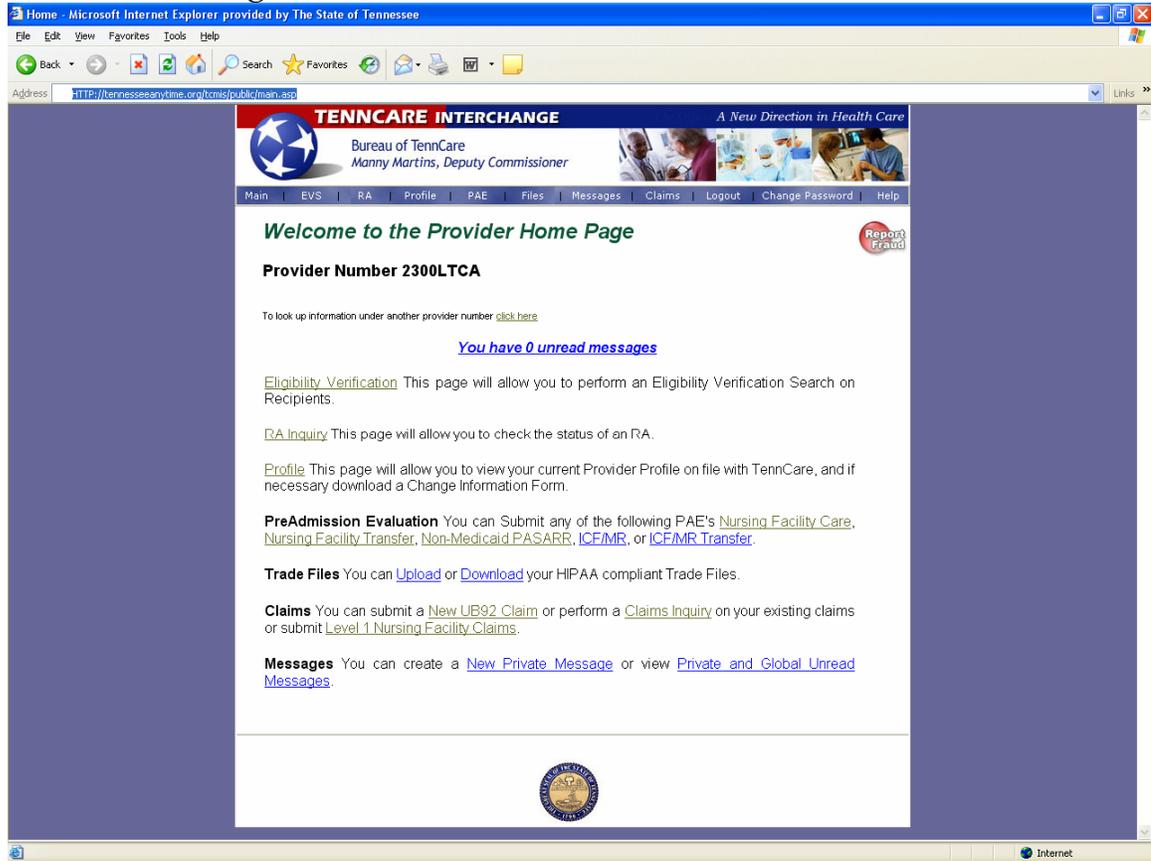


1) Click “Re-Submit”

To verify the status of the claim, please refer to the Initial Claim Status section of this document.

Creating a New Level 2 Claim

Provider Home Page



To create a new claim, click on “New UB04 Claim” link located at the bottom of the **Provider Home Page** or click on “Claims” listed in the menu bar.

UB04 Claim Submission (top section)

The UB04 claim form consists of three sections (top, middle and bottom)

The following fields will need to be completed under the billing information section located at the upper left side on the claim form:

- 1) Provider number (or NPI Number) is populated based on sign-in (required)
- 2) Enter recipient ID#, and press tab key. Upon pressing the tab key the recipient's first and last name will populate. (required)
- 3) Enter the patient account # (optional)
- 4) Attending physician ID (required). The number will be the practitioner's NPI number.
- 5) Referring physician ID (optional)

The following fields will need to be completed under the service information section located on the upper right side of the claim form:

- 6) Claim type (required) - from the drop down box select Long Term Care claim
- 7) Type of bill, a three digit code indicates the specific type of bill (required)
 - 211----Admit through discharge claim
 - 212----Initial Claim
 - 213----Continuing Claim
 - 214----Final Claim
 - 217----Replacement of a prior claim (Adjustment)

218----Void or cancellation of a prior claim

Note: Type of Bill – for Medicare/Medicaid Part A Room and Board Cross-Over claims the same bill types will be used as reflected above for the Level II Care/SNF billing.

However, for Medicare/Medicaid Part B Institutional Inpatient Cross-Over Claims, the type of bill will be the same as in the past:

221 – Admit through Discharge Claim

222 – Initial Claim

223 – Continuing Claim

224 – Final Claim

And, for the Medicare/Medicaid Part B Institutional Outpatient Cross-Over Claims, the type of bill will be the same as in the past. Remember the middle digit for this ‘type of bill’ is a ‘3’.

- 8) Enter the from and thru date (required) - this is the statement covered period
- 9) Covered Days is a (required) field, except for Medicare/Medicaid crossover claims.
- 10) Patient Status (required) – select the status from the drop down box
- 11) Admit Source (required) - select the status from the drop down box
- 12) Admission Type (required) - select the status from the drop down box
- 13) Admission date (required) - cannot be later than “from date”
- 14) Discharge Time – must be populated if attempting to be paid for date of death

PLEASE NOTE: MEDICARE CROSSOVER CLAIMS CANNOT BE BILLED USING THIS WEB APPLICATION.

UB04 Claim Submission (middle section)

The following fields will need to be completed under the Billing Code section located on the middle left side of the claim form:

- 1) Enter diagnosis code in the shaded box (required)
- 2) Condition Code – Condition Code 39 may be required if billing private room charge.
- 3) Value Code – This field is used to report Medicare Co-Insurance and/or the Deductible and the amounts associated with them. You may use the drop-down boxes to populate these fields.
- 4) Occurrence/Span Code – Occurrence Code 54 and the physician visit date is required on all Level II, SNF/Straight Skilled Medicaid billing.

Occurrence Code 24 is required when there is TPL/Third Party Liability, also known as other insurance, and the insurance denied. Complete the field with the code and the date the insurance carrier denied.

Occurrence Code 25 is required when there is TPL/Third Party Liability, also known as other insurance, and the insurance policy has been cancelled. Complete the field with the code and the date the insurance carrier terminated the policy.

You may use the drop-down arrows for the Occurrence Codes.

- 5) Payer Code – Click on ‘Add’ to choose the appropriate payer. Enter ‘Prior Payment’. ‘Estimated Amount’ field is optional.

- 6) If additional 'Line Items' are needed, you may proceed to that area and click on 'Add'. After clicking on 'Add', you will return to the 'Detail Information' area of the claim and proceed to populate the relevant fields.

UB04 Claim Submission (bottom section)

The following fields will need to be completed under the detail information section:

- 1) Enter the from and thru dates of service (DOS) (required)
- 2) Enter revenue code/s (required)
- 3) Enter HCPCS/Rates (as required for HCBS claims)
- 4) Enter the unit(s) (required)
- 5) To enter the unit of measure, click on the drop down box select “Day” or “Unit” (optional)
- 6) Enter charges (required)
- 7) Enter co-pay and/or TPL amount, if applicable
- 8) Once all of the required fields are entered, click on “Submit”

Please refer to the Initial Claim Status section of this document to view the status and reason codes of the adjudicated claim.

Initial Claims Status

Once the claim has been submitted, the Claim Status Information section will list the current status of the claim as being paid, denied or suspended. The assigned ICN number will also appear.

UB04 Claim Submission Form (bottom section) paid

The screenshot shows a web browser window titled "Institutional Claim Submission - Microsoft Internet Explorer provided by The State of Tennessee". The address bar shows "https://tennesseearmytime.org/tcms/public/main.asp". The main content area is divided into two sections:

Detail Information

Item	1	From DOS*	10/01/2003	To DOS	10/31/2003
Revenue Code	0	HCPCS / Rates	S9123	Modifiers	1
Units*	2	Units of Measurement	LIN - Unit		
Charges	\$67.40	Co-Pay	0.00	TPL Amount	0.00
Status		Allowed Amount	0.00		
Units Allowed		Paid Amount			

Below the form is a "Submit" button.

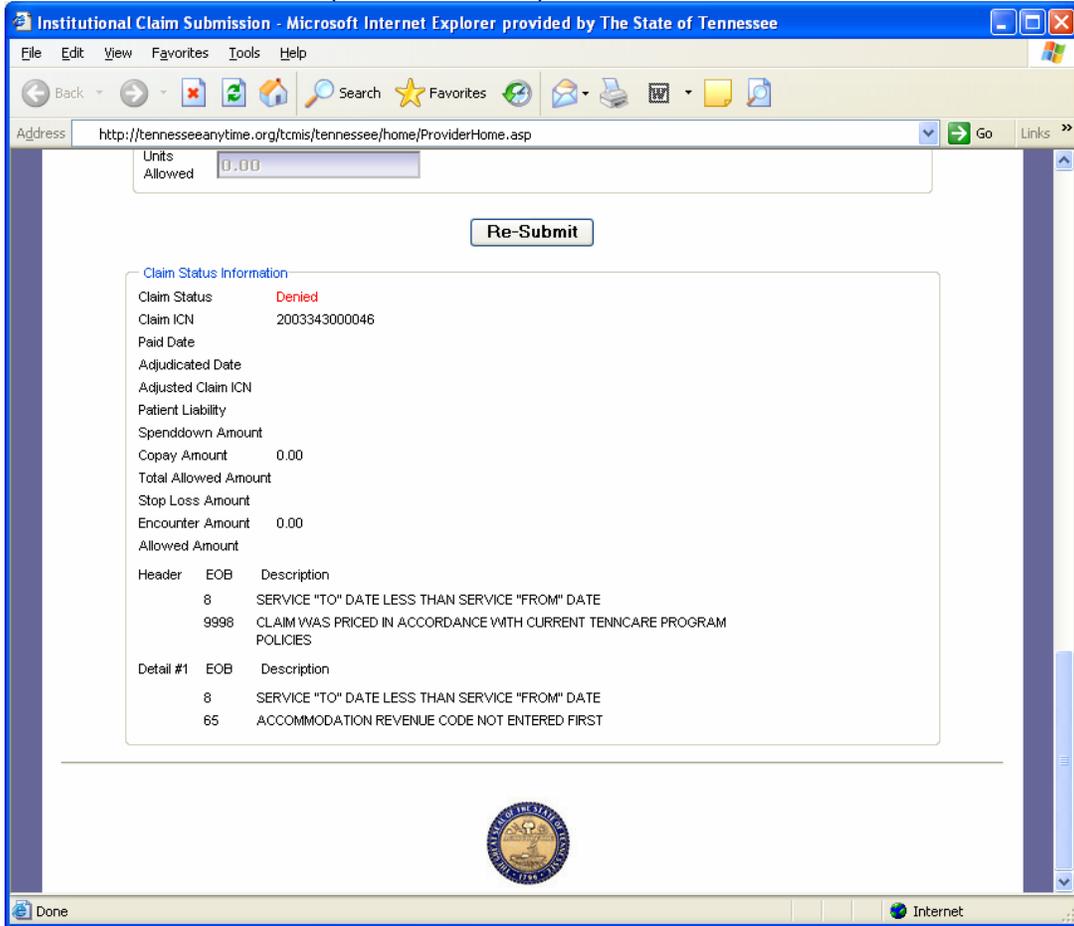
Claim Status Information

Claim Status	Paid
Claim ICN	2503310000008
Paid Date	
Adjudicated Date	
Adjusted Claim ICN	
Patient Liability	
Spenddown Amount	0.00
Copay Amount	0.00
Total Allowed Amount	
Stop Loss Amount	
Encounter Amount	0.00
Allowed Amount	

At the bottom of the form are buttons for "RequestIsland", "ResponseIsland", "DefaultIsland", and "Display Log".

The window above indicates a **paid** status

UB04 Claim Submitted (bottom section) denied



The window above indicates a **denied** status

Note: When a claim is denied, the reason(s) for the denial should be reviewed, corrected and then the claim submitted. If further assistance is needed to resolve a denied claim, please contact the Long Term Care Claims Unit at 877-224-0219 or 615-507-6944. Below is the fax number for the Long Term Care Claims and HCBS Claims Unit.

Fax 615-253-3179

UB04 Claim Submitted (bottom section) suspended

Detail Information

Item	<input type="text" value="1"/>	From DOS*	<input type="text" value="11/01/2005"/>	To DOS	<input type="text" value="11/30/2005"/>
Revenue Code	<input type="text" value="120"/>	HCPCS / Rates	<input type="text"/>	Modifiers	<input type="text"/>
Units*	<input type="text" value="30.00"/>	Units of Measurement	<input type="text"/>		
Charges	<input type="text" value="3516.95"/>	Co-Pay	<input type="text"/>	TPL Amount	<input type="text" value="0.00"/>
Status	<input type="text" value="P"/>	Allowed Amount	<input type="text" value="0.00"/>		
Units Allowed	<input type="text"/>				

Claim Status Information

Claim Status: Suspended
 Claim ICN: 2003343000038
 Paid Date: 0
 Allowed Amount: 0.00

Header	EOB	Description
	9998	CLAIM WAS PRICED IN ACCORDANCE WITH CURRENT TENNCARE PROGRAM POLICIES
	0331	NO PAE AVAILABLE FOR RECIPIENT ADMISSION

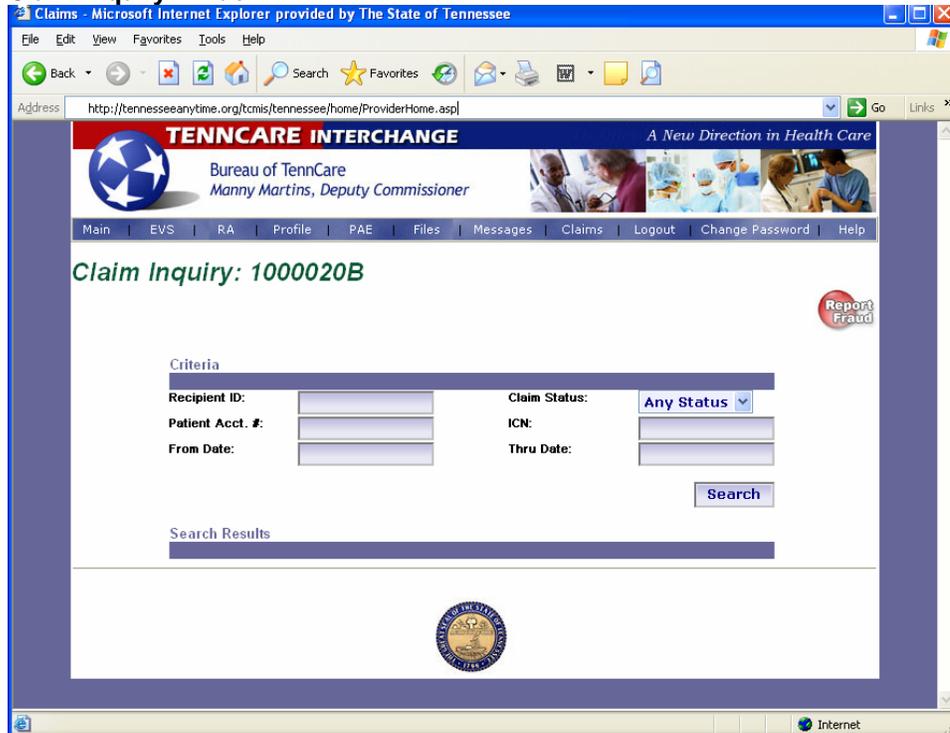
The window above indicates a **suspended** status

Note: If further assistance is needed to resolve a suspended claim, please contact the Long Term Care Claims Unit at 877-224-0219 or 615-507-6944.

Claim Inquiry

This feature allows the user to search on previously submitted claims within the system. From the bottom of **Provider Home Page**, you may click the “Claim Inquiry” link from the top menu, which will display the following window.

Claim Inquiry window



A user can perform a claim inquiry by selecting any of the options listed below. Utilize as many options as possible to refine your search.

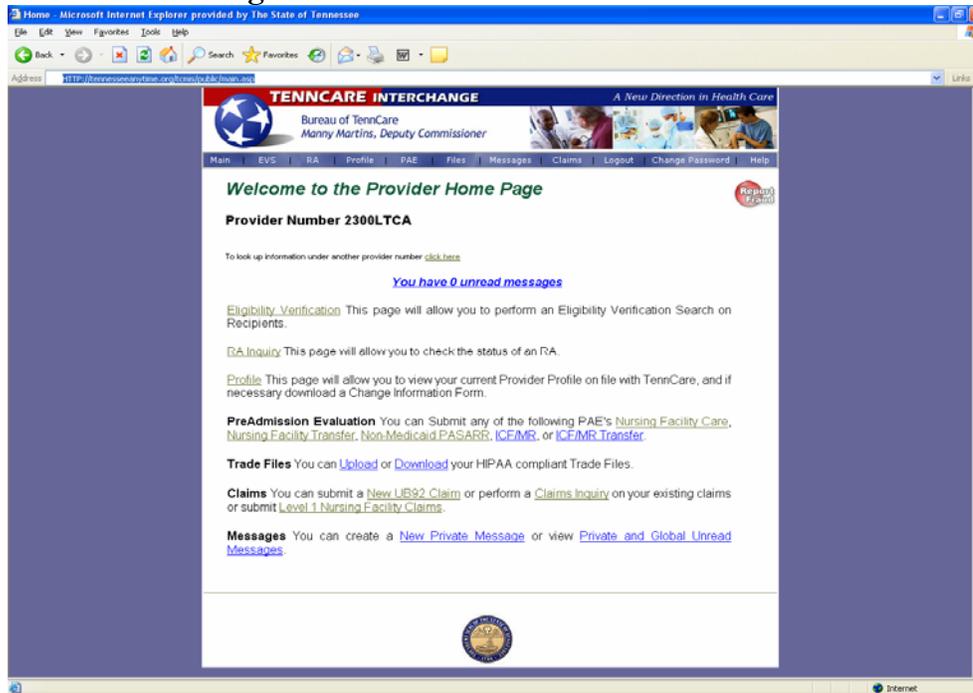
- 1) Enter recipient ID #
- 2) Claim status from drop down box
- 3) Patient Account Number
- 4) Enter ICN, if available
- 5) Enter from and thru date
- 6) Click on the “Search” button

Note: You may also click on the “Claims” link from the top menu to obtain the same result.

Adjusting/Voiding a Previously Paid Claim

It may be determined that a claim was billed and paid in error. Therefore, an Adjustment or Void may be needed. Outlined below is the process to Adjust/Void a previously paid claim.

Provider Home Page



- 1) Click "Claims Inquiry"

Claims Inquiry Window

Claims - Microsoft Internet Explorer provided by The State of Tennessee

File Edit View Favorites Tools Help

Back Forward Stop Home Search Favorites Print Mail

Address http://tennesseeanytme.org/tcmis/tennessee/home/ProviderHome.aspx

TENNCARE INTERCHANGE A New Direction in Health Care

Bureau of TennCare
Manny Martins, Deputy Commissioner

Main | EVS | RA | Profile | PAE | Files | Messages | Claims | Logout | Change Password | Help

Claim Inquiry: 100020B

Report Fraud

Criteria

Recipient ID: Claim Status:

Patient Acct. #: ICN:

From Date: Thru Date:

Search

Search Results

Internet

A user can perform a claim inquiry by selecting any of the options listed below. Utilize as many options as possible to refine your search.

- 1) Enter recipient ID #
- 2) Claim status from drop down box
- 3) Patient Account Number
- 4) Enter ICN, if available
- 5) Enter from and thru date
- 6) Click on the search button

Claims Inquiry Result Window

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 Bureau of TennCare
 Manny Martins, Deputy Commissioner

Main | EVS | RA | Profile | PAE | Files | Messages | Claims | Logout | Change Password | Help

Claim Inquiry: 1000012A

Report Fraud

Criteria

Recipient ID: Claim Status: **Any Status**
 Patient Acct. #: ICN:
 From Date: Thru Date:

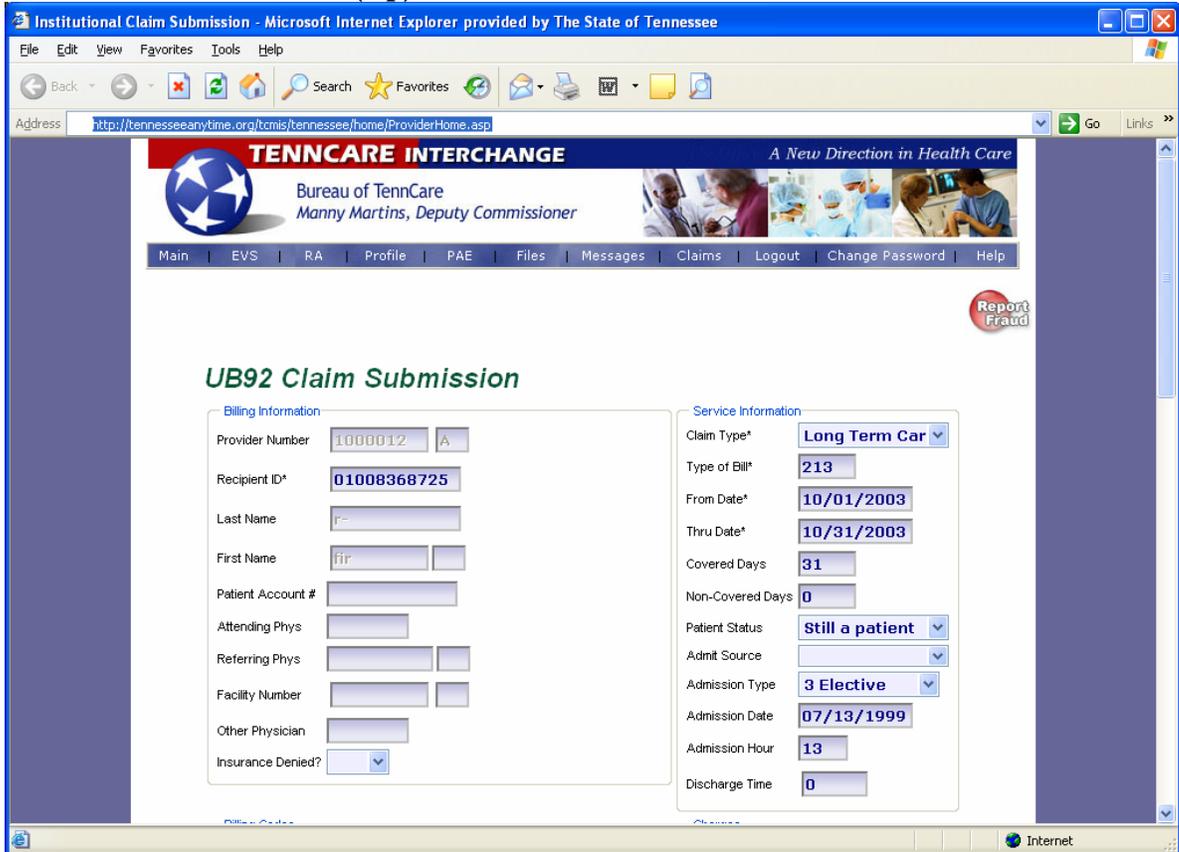
Search Results

ICN	Client ID	Patient Acct. #	From Date	Thru Date	Date Paid	Billed Amount	Paid Amount	Status
4003336001566	01008368725		20031001	20031031	20031101	5014.87	4908.23	Paid
4003336001568	01008369706		20031001	20031031	20031101	4640.36	4908.23	Paid
4003336002196	01008368499		20031001	20031031	20031101	5144.85	3957.93	Paid
4003336001874	01008368911		20031001	20031031	20031101	7884.93	4497.35	Paid
4003336001876	01008369321		20031001	20031031	20031101	4674.04	4908.23	Paid
4003336001878	01008369553		20031001	20031031	20031101	5673.47	4908.23	Paid

- 1) Click on the ICN link of the claim that requires an adjustment or void. Please note: If adjusting a previously adjusted claim, the adjustment must be made to the previous adjustment.

Below is an example of adjusting for a claim for a **Date of Service**.

UB04 Paid Claim Window (top)

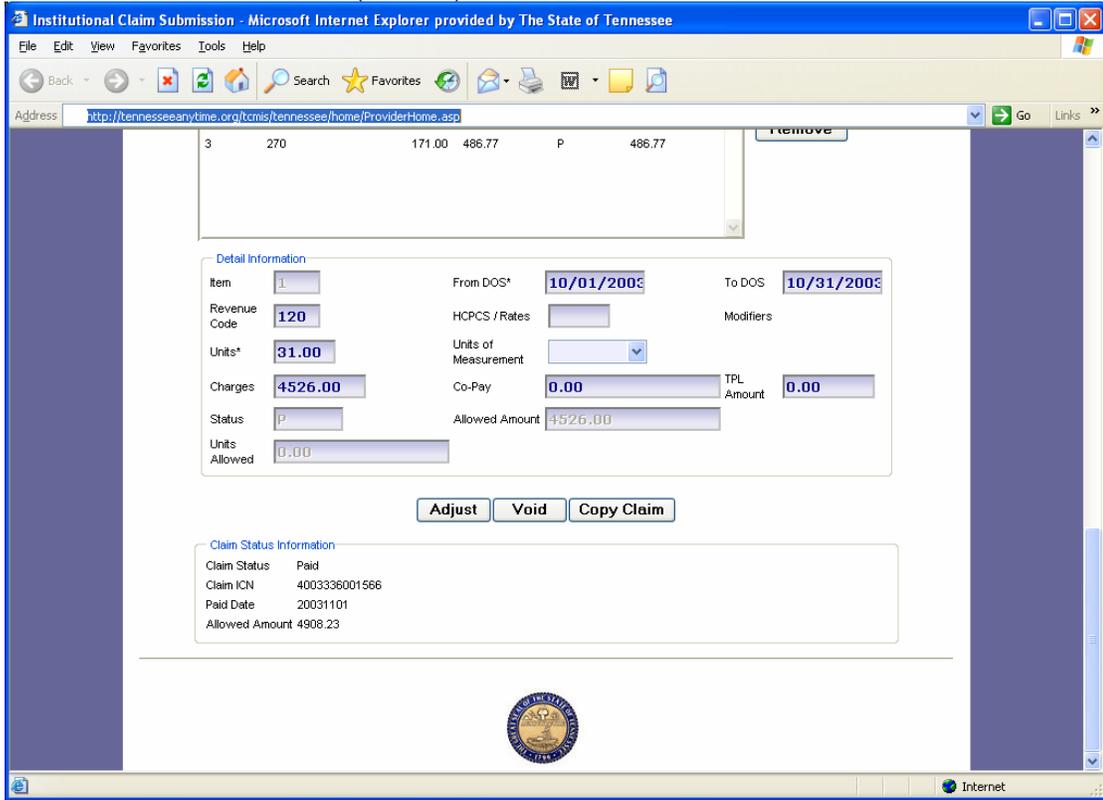


- 1) Change the "From Date" (if applicable)
- 2) Change the "Thru Date" (if applicable)
- 3) Change the "Covered Days"
- 4) Change "Patient Status"

Note: Level 2 claims may require a change in the "Type of Bill"

Note: Medicare/Medicaid claims must be voided and a new paper claim submitted

UB04 Paid Claim Window (bottom)



- 1) Verify that the DOS (from/to) match the information in the upper and lower section of the claim
- 2) Change “Units”
- 3) Click the “Adjust” button

To verify the status of a claim, please refer to the Initial Claim Status section of this document.

Instructions for Completing Paper Claims for Level 1 & Level 2

Upon implementation of the online bill system, TADs (Turnaround Documents) will be eliminated. If you elect to submit your Level 1 care billing, via paper, you must use a UB04 claim form. The fields indicated below are used for Level 1 & 2 paper claims submission.

BILLING ON THE UB-04. The following identifies the required fields.

UB04 REFERENCE Table

NUMBER	LOCATOR	REMARKS
1 REQUIRED	Provider Name, Address, and Telephone Number	Provider name must appear the same as on the enrollment form
2 SITUATIONAL	Provider Pay to Address	Use only if the pay to address is different from the location address
3a OPTIONAL	Patient Control Number	Will be carried in the system and reported on the Remittance Advice. The number may be the medical record account number
3b OPTIONAL	Medical Record Number	This is the Medical Record number of the patient
4 REQUIRED	Type of Bill	A 3-digit code indicates the specific type of bill For Part A crossovers: 211—Admit through discharge 212—Initial or First time Billing 213—Intermediate ongoing/continuing 214—Intermediate final billing (discharge or death) For Part B inpatient crossovers, replace the middle number to a “2” For Part B outpatient crossovers, replace the middle number to a “3” 663—Intermediate Care Billing
5 REQUIRED	Federal Tax ID #	This is the Federal Tax ID number of the billing provider
6 REQUIRED	Statement covers Period	This billing period must include only that period for which the patient is an eligible recipient. Cannot be earlier than the Admission Date in Form Locator 12
7	Blank	New field - Blank
8a REQUIRED (IF APPLICABLE)	Patient ID Number	This field is used if the subscriber/recipient ID is different as reported in Form Locator 60
8b REQUIRED	Patient Name	Report name by using last, first and middle initial
9a-e REQUIRED	Patient Street Address	Use to report the patient’s address, P O Box, City, State and zip code
10 REQUIRED	Patient Birth date	Required format = MM/DD/CCYY

TENNCARE MANAGEMENT INFORMATION SYSTEM

11 REQUIRED	Patient Sex	Field should be reported as either "F" or "M"
12 REQUIRED	Admission Date	Cannot be later than 'From' date of Form Locator 6 Format = MM/DD/YY
13 OPTIONAL	Admission Hour	Used to report the time a patient entered a facility or institution
14 REQUIRED	Admission Type	This code indicates the priority of the admission 1 – Emergency 2 – Urgent 3 – Elective 4 – Newborn 5- Trauma Center 6-8 – Reserved for National Assignment 9 – Information Not Available
15 REQUIRED	Admission Source	This field is used to report the source of a referral 1 – Physician Referral 2 – Clinic Referral 3 – Managed Care Plan Referral 4 – Transfer from a Hospital (or different facility) 5 – Transfer from a SNF 6 – Transfer from Another Health Care Facility 7 – Emergency Room 8 – Court/Law Enforcement 9 – Information Not Available A – Transfer from a Critical Access Hospital B – Transfer from Another Home Health Agency C – Readmission to Same Home Health Agency D – Transfer from Hospital Inpatient in the Same Facility Resulting in a Separate Claim to the Payer E – Z – Reserved from National Assignment
16 *OPTIONAL	Discharge Hour	This field reports the time a person discharges *It is only required when billing for date of death, using 224 revenue code for late discharge
17 REQUIRED	Patient Status	Valid Code 30—Still a Patient or Expected to Return 20—Expired (deceased) 07----Left against medical advice 06----Discharged/Transferred to home under care of organized home health service organization in anticipation of covered skills care 05—Discharged to another type of Institution (PACE, hospice, etc) 04—Discharge/Transfer to Level I 03—Discharge/Transfer to Level II 02----Transferred to the hospital 01----Discharged
18 - 28 *REQUIRED	Condition Codes	This field describes conditions or events that apply to this billing period *Required for cross over billing only
29 NOT USED	Accident State	Data entered will be ignored
30 NOT USED	Untitled	Data entered will be ignored
31-36 REQUIRED (FL 35 & 36 Represent Occurrence Span Codes and Dates)	Occurrence Codes and Date	Codes must be accompanied by dates *51—Physician Last Certification/Re-certification Date *54—Physician Visit Date *The above mentioned codes are no longer valid per UB04 Manual TennCare has addressed this issue with CMS and at this time are waiting for a set of alternate codes
37 NOT USED	Untitled	Data entered will be ignored
38	Responsible Party Name and Address	Used for claims that involve payers of higher priority than Medicare

TENNCARE MANAGEMENT INFORMATION SYSTEM

OPTIONAL		
39 - 41 REQUIRED	Value Codes and Amounts Required	Field is used to report codes related to dollar or unit amounts 80 – Covered Days 81 – Non-Covered Days 82 – Co-Insurance Days A1 – Medicare Part A Deductible A2 – Medicare Part A Co-Insurance B1 – Medicare Part B Deductible B2 – Medicare Part B Co-Insurance
42 rows 1-22 REQUIRED	Revenue Code	Relevant Revenue Codes are used in this field including 001—Indicating Total Charges, must be placed at the bottom of the column
43 NOT REQUIRED	Revenue Code Description	This field is used to describe the service if a provider chooses to do so (example: Room and Board)
44 REQUIRED	HCPCS/Rate/HIPPS Code	This field is used to enter the HCPCS codes of services provided For inpatient use, the accommodation rate can be reported here
45 REQUIRED	Service Dates	Used to report the date(s) of service(s) that each reported revenue code or HCPCS was provided
46 REQUIRED	Service Units	Enter the number of units provided for the statement covered period for each reported Revenue or HCPCS
47 REQUIRED	Total Charges	Enter the total charges for each Revenue or HCPCS code
48 REQUIRED	Non-Covered Charges	This field is used to report the total of non-covered charges pertaining to relevant revenue codes
49 NOT USED	Untitled	Data entered will be ignored
Line 23 REQUIRED	Page ___ of ___ Creation Date	If billing requires the use of multiple UB04 forms, information for all items on line 23 must be reported on all pages (Creation date is the date the form was filled out)
50 (A, B & C) REQUIRED	Payer Identification	If Medicaid is the primary payer, Medicaid will be entered on the form Additional payers will be listed in the order in which they paid A – Primary B – Secondary C – Tertiary
51 A – REQUIRED B – SITUATIONAL C – SITUATIONAL	Health Plan ID	This field is used to report the national health plan identifier when one is established; otherwise report the “number” Medicare has assigned
52 (A, B & C) REQUIRED	Release of Information	Valid codes for these fields are “Y” – provider has on file a signed statement permitting it to release data to other organizations in order to adjudicate the claim (Most common used code) “I” – Indicates Informed Consent to release medical information for conditions or diagnoses regulated by federal statues Required when the provider has not collected a signature and state or federal laws do not supersede the HIPAA privacy rule by requiring a signature be collected (Least common used code)
53 NOT USED	Assignment of Benefits Certification Indicator	Data entered will be ignored
54 (A, B & C) SITUATIONAL	Prior Payments	Required only if another payer source is involved If no prior payments, leave blank
55 (A, B & C) OPTIONAL	Estimated Amount Due From Patient	This field is usually not applicable to Medicaid patients However, if a non-covered Medicaid service is billed, this field may be used to report the amount of the non-covered Medicaid service
56 REQUIRED	National Provider ID (NPI)	Required effective 5/23/2007 to be reported on all billing (electronic, paper, etc)
57 SITUATIONAL	Other Provider ID (primary, secondary and/or tertiary)	Use this field to report other provider identifiers as assigned by a health plan (legacy provider ID's)

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58 (A, B & C) REQUIRED	Insured's Name	The name must be the same as it appears on the ID card (Last name, First name)
59 (A, B & C) REQUIRED	Patient's Relationship to Insured	Code used to identify patient to insured 01 – Spouse 18 – Self 19 – Child 20 – Employee 21 – Unknown 39 – Organ Donor 53 – Life Partner G8 – Other Relationship
60 (A, B & C) REQUIRED	MID Number or SSN	Enter the unique identification number exactly as shown on the Medicaid ID card
61 (A, B & C) SITUATIONAL	Insurance Group Name	This field is for patients who have a Third Party payer, to report the name of the group
62 (A, B & C) SITUATIONAL	Insurance Group Number	This field is for patients who have a Third Party payer, to report the group number
63 SITUATIONAL	Treatment Authorization Code	This field is used to report a prior authorization or referral number assigned by a payer
64 SITUATIONAL	Document Control Number (DCN)	The control number assigned to the original bill by the health plan or the health plan's fiscal agent as part of their internal control
65 SITUATIONAL	Employer Name	This field is used to report the employer
66 & 67 (67 A-Q) REQUIRED	Principal Diagnosis Code Other Diagnosis Codes	Enter the valid ICD-9-CM code
68 NOT USED	Not Used	Data entered will be ignored
69 REQUIRED	Admitting Diagnosis	Enter the diagnosis to identify the reason for admission
70 (A-C) SITUATIONAL	Patient's Reason for Visit	Required for all un-scheduled outpatient visits for outpatient bills
71 NOT USED	Prospective Payment System Code	Data entered will be ignored
72 NOT USED	External Cause of Injury Codes	Data entered will be ignored
73 NOT USED	Not Used	Data entered will be ignored
74 (74 A-E) SITUATIONAL	Principal Procedure Code and Date 74 A-E – Other Procedure Codes and Dates	Required on inpatient claims when procedures must be reported Not used on outpatient claims Required on inpatient claims when additional procedures must be reported Not used on outpatient claims
75 NOT USED	Not Used	Data entered will be ignored
76 SITUATIONAL	Attending Provider Name and Identifiers (including NPI)	Required when claim/encounter contains any services other than nonscheduled transportation services The attending provider is the individual who has overall responsibility for the patient's medical care and treatment reported on this claim/encounter Secondary Identifier Qualifiers: 0B – State License Number

		1G – Provider UPIN Number G2 – Provider Commercial Number
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Other Features & Functionality

Please refer to Long Term Care – User Manual for information about additional features and functionality.

Revenue Codes

All revenue codes can be found in the UB04 manual, which is produced by CMS. Below is the URL to the CMS organization: <http://www.cms.gov/>

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 Circle 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

Comments Questions and Answers

