



TENNCARE POLICY MANUAL

Policy No:	PRO 08-001 (Rev. 9)	
Subject:	When a Provider May Bill a TennCare Enrollee	
Approval:	<i>Debie Baird</i>	Date: 10/30/14

PURPOSE:

The purpose of this policy is to clarify the circumstances under which providers may bill TennCare enrollees. This policy applies to TennCare providers, as that term is defined below. The Bureau of TennCare has no authority over the practices of non-TennCare providers, as that term is defined below.

APPLICABILITY:

The Bureau of TennCare groups health care providers as follows:

- 1. TennCare providers.** Providers who are registered with TennCare and who accept some form of TennCare reimbursement for their services. Examples of TennCare providers include the following:

- Providers enrolled with a TennCare Managed Care contractor (a Managed Care Organization, the Pharmacy Benefits Manager, the Dental Benefits Manager)
- Providers who are not enrolled with a TennCare MCC but who furnish services under single-case agreements with TennCare MCCs
- Providers who deliver emergency services to TennCare enrollees
- Providers of Medicare crossover services
- Providers of services in one of TennCare's Home and Community Based Services waivers

TennCare providers in the managed care portion of TennCare may be either network or out-of-network providers.

- a. Network providers.** TennCare providers who are enrolled with an individual enrollee's MCC.
- b. Out-of-network providers.** TennCare providers who are not enrolled with an individual enrollee's MCC. For an enrollee who is a member of

AMERIGROUP, as an example, a provider who is enrolled with BlueCare but not AMERIGROUP would be an out-of-network provider for that enrollee.

- 2. Non-TennCare providers.** Providers who are not registered with TennCare and who accept no TennCare reimbursement for any service. A provider who is registered with TennCare but who has decided to accept no TennCare reimbursement for any service must formally terminate his registration with TennCare in order to be considered a non-TennCare provider. It should be noted that a non-TennCare provider who bills TennCare or a TennCare MCC cannot be considered a “non-TennCare provider,” for purposes of that claim. By billing TennCare or a TennCare MCC, the provider indicates he is willing to accept TennCare reimbursement as payment in full. Once a non-TennCare provider has billed either TennCare or a TennCare MCC, he cannot then bill the enrollee if his claim is denied or if the payment he receives, after any applicable copays, is less than his charges.

CIRCUMSTANCES WHEN A TENNCARE PROVIDER MAY BILL A TENNCARE ENROLLEE:

TennCare’s payment, when combined with any applicable TennCare copays, is considered “payment in full.” By agreeing to participate in TennCare, a provider agrees to accept TennCare’s payment as payment in full. See Rules 1200-13-13-.08(1) and 1200-13-14-.08(1).

The circumstances in which TennCare providers may bill TennCare enrollees are limited to the following:

- 1. Applicable copays.** Certain services have copays for some enrollees. The list of copays and the groups of TennCare enrollees to whom they apply is provided in the table below. However, it should be noted that providers cannot refuse services because of an enrollee’s failure to make a copay.¹

TennCare Copays

Benefit	Applicability
Brand name prescription drugs within a 5-prescription per month limit	<ul style="list-style-type: none">• \$3.00 for Medicaid adults aged 21 and older who are not institutionalized or participants in CHOICES or a Home and Community Based Services (HCBS) waiver program• \$3.00 for enrollees in the SSD program• \$3.00 for enrollees in CHOICES Group 3 (including Interim CHOICES Group 3)
Generic prescription within a 5-prescription per month limit	<ul style="list-style-type: none">• 1.50 for enrollees in the above-named groups

¹ TennCare Rules 1200-13-13-.08(11) and 1200-13-14-.08(11).

Benefit	Applicability
Brand name prescription drugs (no limit)	<ul style="list-style-type: none"> • \$3.00 for TennCare Standard children with incomes at or above 100% of poverty
Generic prescription (no limit)	<ul style="list-style-type: none"> • \$1.50 for enrollees in the above-named groups
Hospital emergency room services in the absence of an emergency (waived if admitted)	<ul style="list-style-type: none"> • \$10.00 for TennCare Standard children with incomes between 100% and 199% of poverty • \$50.00 for TennCare Standard children with incomes at or above 200% of poverty
Primary care provider and Community Mental Health Agency services other than preventive care	<ul style="list-style-type: none"> • \$5.00 for TennCare Standard children with incomes between 100% and 199% of poverty • \$15.00 for TennCare Standard children with incomes at or above 200% of poverty
Physician specialists (including psychiatrists) and dentists	<ul style="list-style-type: none"> • \$5.00 for TennCare Standard children with incomes between 100% and 199% of poverty • \$20.00 for TennCare Standard children with incomes at or above 200% of poverty
Inpatient hospital admissions (copay waived if enrollee is readmitted within 48 hours for the same episode)	<ul style="list-style-type: none"> • \$5.00 for TennCare Standard children with incomes between 100% and 199% of poverty • \$100.00 for TennCare Standard children with incomes at or above 200% of poverty

2. **Non-covered services.** When the service the provider is furnishing is not covered by TennCare, and the provider has informed the enrollee that the service is non-covered before providing the service, the provider may bill the enrollee. A service may be non-covered for one of three reasons:
- a. **It is excluded from TennCare coverage.** Specific “exclusions” are listed in Rules 1200-13-13-.10 and 1200-13-14-.10.
 - b. **It would be covered by TennCare, but it exceeds a benefit limit.** As an example, a 6th prescription in a month would be a non-covered service for an enrollee who is subject to a 5-prescription per month benefit limit on prescription drugs. Where possible, pharmacists are encouraged to count the most expensive prescriptions within the 5-prescription limit and bill the enrollee for the least expensive prescriptions.
 - c. **It would be covered by TennCare with prior authorization, but TennCare or one of its MCCs has denied a request for prior authorization because the service is not medically necessary.** When a provider has documentation that TennCare or one of its MCCs has denied a request for prior authorization because the service is not medically necessary, the provider may bill the enrollee or the enrollee’s family if he has informed them prior

to delivering the service that it will not be covered by TennCare and they have agreed to pay.

SPECIAL CIRCUMSTANCES:

- 1. When the enrollee has other insurance that requires copays.** If an enrollee has other insurance that requires copays, TennCare providers may bill the enrollee only for the copay permitted by TennCare for services that are covered by TennCare.

Example: Johnny Brown is enrolled in TennCare Medicaid. He has insurance that allows him to visit his pediatrician for a copay of \$10 per visit. Johnny's TennCare exempts him from copay for TennCare covered services. Therefore, he is entitled to get the service without paying the \$10 copay. The provider should still bill the third party carrier, since that carrier is "first payer." The third party payer will presumably deduct the \$10 copay from the provider's payment, even though the provider did not collect the copay. The MCC would then pay only if the MCC allowable is greater than the amount paid by the third party.

- 2. When a covered service is delivered in a hospital Emergency Department (ED).** Enrollees who present to EDs are assessed to determine whether they need urgent or emergent care. If urgent or emergent care is not needed, the enrollee may be referred to another type of provider, such as his primary care provider (PCP) or an outpatient clinic for treatment.

If the enrollee elects to be treated in the ED despite the absence of an urgent or emergency condition and the ED elects to treat the enrollee in such a circumstance, the enrollee may be charged a copay only if he is a TennCare Standard child with a family income above poverty. (See chart entitled "TennCare Copays" above.) He cannot be charged for the service as a "non-covered service," since the service would be covered in an alternate setting. In addition, TennCare's Compliance Plan approved by CMS on April 12, 2012, requires the following:

- Before imposing a copay for non-emergency services provided in the emergency department, a hospital will be required to assist the patient in gaining access to an alternative non-emergency services provider (a physician's office, a health care clinic, community health center, hospital outpatient department, or similar provider). This requirement could be met if, before providing non-emergency care subject to copayment, emergency department staff recommend that the patient or the patient's caretaker call the 24/7 nurse staffed call center for the patient's MCO to obtain help in locating an available provider in the community, and offer to assist with placing a call to the call center.

- 3. Financial responsibility statements.** In order for a provider to document that he properly informed an enrollee that a service is "non-covered," he may choose to use a financial responsibility statement.

Financial responsibility statements must be written at no higher than a 6th grade level, as measured by the Fogg index, the Flesch Index, the Flesch-Kincaid Index, or other recognized readability instrument. The statement must be signed by the enrollee. There must be two copies—one retained by the provider and one given to the enrollee.

There are two situations in which financial responsibility statements are not appropriate.

- When the provider is asking the enrollee to be responsible for payment if the provider's claim to the MCC is denied.
- When the provider participates in TennCare but not the enrollee's MCC (i.e., he is an "out-of-network provider" for that enrollee, as that term is defined in the "Applicability" section of this policy), and the service the enrollee is seeking is available to him through his MCC.

4. Definition of "enrollee." "Enrollee" is defined in TennCare Rules 1200-13-13-.01 and 1200-13-14-.01. For the purposes of this policy, the term "enrollee" shall include the patient's "responsible parties" (parents, spouses, children, guardians) as defined in T.C.A. § 71-5-103(12). Attempts to bill the patient's parents, as an example, are treated the same as attempts to bill the patient himself.

5. Provider-preventable conditions. Provider-preventable conditions, including health care-acquired conditions, are defined at 42 C.F.R. § 447.26(b). TennCare providers may not bill enrollees for services provided to treat a condition that TennCare has determined to be a health care acquired condition or a provider-preventable condition. These include:

- Hospital-Acquired Conditions as identified by Medicare, other than Deep Vein Thrombosis (DVT) Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients; and
- Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

6. When the enrollee requests a "HIPAA exemption." In January 2013, HHS issued a final rule containing new privacy protections for enrollees, to be effective on September 23, 2013. One of these protections was this: When individuals pay by cash, they can instruct their provider not to share information about their treatment with their health plan. Medicare recognizes this provision; Medicare beneficiaries who pay out of pocket for a service may request a restriction on the disclosure of Protected Health Information (PHI) to Medicare. Providers have asked whether this provision applies to TennCare. The answer is no. As stated elsewhere in this policy, TennCare providers do not have the discretion to accept out of pocket payments for services unless the service is not covered by TennCare and the provider clearly informs the

enrollee of that fact prior to delivering the service. See TennCare Rules 1200-13-13-.08(5)(a) and 1200-13-14-.08(5)(a).

FREQUENTLY ASKED QUESTIONS (FAQs) FROM PROVIDERS:

Listed below are questions that are sometimes asked by providers, together with TennCare's responses. These responses are applicable to providers who participate in TennCare in any way. (See the section at the beginning of this policy entitled "Applicability.")

- 1. "I didn't know John Smith had TennCare when he came to my office. May I bill him since he didn't tell me?"**

No. It is the provider's responsibility to determine whether or not a patient is a TennCare enrollee. Providers can verify a TennCare enrollee's eligibility by logging onto TennCare Online Services or calling the individual's MCC.² See TennCare Rules 1200-13-13-.08(6)(f) and 1200-13-14-.08(6)(f).

- 2. "Jane Doe knows that I am a provider in a TennCare MCO but I am not a provider in her MCO. She is willing to pay out-of-pocket for me to treat her. May I bill her if she signs a financial responsibility statement saying that she understands that I am not in her MCO and she has agreed to pay me?"**

No. While the situation presented in the question may seem reasonable on its face, the fact is that enrollees who have signed such statements sometimes send their bills from the provider to TennCare to pay as "reimbursement appeals." Enrollees may or may not have understood what they were signing. See TennCare Rules 1200-13-13-.08(5) and 1200-13-14-.08(5).

- 3. "In my office, we bill patients who don't show up for their appointments. Is that a problem if the patient is on TennCare?"**

Yes. TennCare providers are prohibited from billing enrollees or MCCs for missed appointments. See TennCare Rules 1200-13-13-.08(6)(h) and 1200-13-14-.08(6)(h).

- 4. "My patient Bob Woods has TennCare but also has other insurance. I have tried to bill Bob's insurance company, but they won't pay because Bob won't sign something they sent him attesting to the fact that I treated him. May I bill Bob?"**

Yes. When a TennCare enrollee has third party coverage but refuses to comply with the requirements of the third party carrier, the particular item or service that he received is

² Information about how to access TennCare Online Services can be found at the following address:
<https://tn.gov/tenncare/topic/verify-eligibility>.

considered “non-covered” by TennCare. The provider may bill for non-covered services. See TennCare Rules 1200-13-13-.10(1)(n) and 1200-13-14-.10(1)(n).

5. **“I am not registered with TennCare for any purpose and I accept no TennCare payments. Do I have to abide by TennCare rules regarding billing TennCare patients?”**

TennCare has no authority over the actions taken by providers who are not registered with TennCare for any purpose, who do not file claims with TennCare, and who accept no TennCare payments.

6. **“I am providing eyeglasses to Tonya Green. Tonya would like to have some special frames with a designer logo. May I “balance bill” Tonya’s parents the difference between what TennCare would pay for the eyeglasses and what the special frames cost?”**

No. TennCare payment is payment in full. See Rules 1200-13-13-.08(1) and 1200-13-14-.08(1).

7. **“Jimmy Smart’s mother has asked me to fill out a medical form that Jimmy needs to be able to go to camp. I charge my private pay patients \$10 for filling out medical forms like this. Jimmy has TennCare. May I charge Mrs. Smart?”**

No. TennCare recognizes the American Medical Association 2014 Current Procedural Terminology Manual in such situations. Activities such as “communicating further with other professionals and the patient through written reports and telephone contact” is included in calculating total work in an encounter for any Evaluation and Management (E&M) visit. In other words, the E&M payment includes reimbursement for post-encounter written reports. This is part of the provider’s payment, and the provider should not charge either the MCO or the patient separately for this service.

OFFICES OF PRIMARY RESPONSIBILITY:

Managed Care Operations
Office of Member Services
Office of Provider Services

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Revision 4: 01/12/12: AB

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