REPROCESSING GUIDELINES FOR CROSSOVER CLAIMS

1. After the claim adjudicates and the remittance advice (RA) is received, if the provider finds that the claim paid amount is incorrect or the denial reason was due to a TennCare keying error or TennCare system issue, a provider can submit a request for reprocessing by mail or secured email to:

   Claims Unit Manager
   Division of TennCare
   310 Great Circle Road, Nashville, TN 37243, **or**
   Crossover.Reprocess.Request@tn.gov

Please Note: Provider billing errors do **not** qualify for a reprocess. Also, a delay in the provider's registration/recertification process due to invalid and/or incomplete information required from the registering provider/group/facility, is **not** a TennCare system issue and does not qualify for the reprocessing of claims.

The reprocessing request must be in writing and contain the reasons the Provider believes the payment amount or reason for denial was incorrect. The request must be filed within **35 days from the RA** date and must include any documentation the provider deems relevant to this request.

2. The Claims Unit will review and research the claim to determine whether the decision was appropriate. They will check for keying errors or general processing errors that may have occurred in the TennCare system, validate that a clean claim was submitted and filed by the provider within the timely filing guidelines and that the required follow-up was performed in accordance with the applicable Federal regulations, TennCare rules, and policies.
   a. Claims may only be reprocessed 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:
      i. The claim was a "clean claim," meaning a claim for which no further written information or substantiation was required to make a payment.
      ii. The claim contained no biller submission errors such as incorrect dates, codes, etc.
      iii. The claim was filed in accordance with TennCare requirements detailed within the Institutional and Professional Provider Billing manuals located on the TennCare website.
      iv. The claim was filed and received within the TennCare timely filing guidelines. See Policy for timely filing policies, PAY 13-001 at https://www.tn.gov/content/dam/tn/tenncare/documents2/pay13001.pdf.
      v. The claim was for a service delivered to a dual eligible member.

vi. TennCare received the claim from Medicare, Dual Special Needs Plans or providers and it was processed incorrectly by the TennCare Vendor for errors related to scanning, keying, and manual adjudication of suspended claims/audits.
vii. The claim was for a covered service.
viii. The claim was processed in accordance with federal and TennCare rules and policies.

b. If the claim meets the criteria for reprocessing, as outlined above, the claim should be reprocessed as requested and changes in reimbursement may be made. The Claims Unit will then utilize the Reprocess Approval template notice to respond to the Provider.

3. If the claim does not meet the criteria for reprocessing, as outline above, the claim cannot be reprocessed as requested, and no reimbursement will be made. The Claims Unit will then utilize the Reprocess Denial template notice as relevant to the specific reason for denial, to respond to the Provider.

4. TennCare will make its decision within 60 days from the receipt of the reprocess request. Notification of the reprocess decision will be mailed to the Provider via certified mail or via secured email if the request was sent to the Claims Unit via email.