Division of TennCare
IS Policy Manual

Revised— 05/29/2018

Policy No: BTC-Pol-Enc-200608-002	
Subject: Provider Identification Usage on Submitted Transactions	
Approval: Encounter Policy Workgroup	**Date:** 03/28/2011

PURPOSE OF THE POLICY STATEMENT: To clarify TennCare's position regarding the placement of provider identification numbers on all claim transactions except coordination of benefits contractor (COBC) sourced claims. This policy will provide clarification on the use of the provider fields on all encounter claims reported to TennCare. This policy became effective with the implementation of 5010/D.0 changes by TennCare.

POLICY:
In the interest of receiving more consistent data TennCare has clarified the X12 and NCPDP specifications for reporting provider information. All providers on all claims shall be reported in a manner that is compliant with the guidelines provided in this document. TennCare requires complete provider information on the provider file for all required provider types.

General Requirements:

1. Provider:
    a. A provider is either a person or organizational entity who has either provided or participated in some aspect of the service(s) described in a claim transaction.
    b. Providers must be identified as either health care or atypical providers.
    c. Atypical providers are service providers that do not meet the definition of health care provider and should not obtain a National Provider Identifier (NPI). Any provider who obtains an NPI is required to use the NPI number in all situations for all services per federal guidelines. For example, if an atypical provider such as meals-on-wheels or a non-licensed behavioral health professional obtains an NPI they must use it on all transactions for all services.

d. Provider name information must be appropriate for the provider loop being reported and must agree with the provider ID being reported. For example, it is not appropriate to use the Rendering Provider's name in conjunction with the Billing Provider's NPI if the rendering and billing providers are not the same.
e. It is not appropriate to report a given provider ID (NPI or Medicaid ID) more than once on a given claim except for on the 837I where the operating or other operating physician may be the same as the attending provider, or the 837P where the Supervising Provider may be the same as the Rendering Provider.

2. Standard Lengths for Provider Identifiers:
    a. NPI - 10 numbers assigned by NPPES. This is the primary identifier for all health care providers.
    b. TennCare Medicaid ID - 7 alphanumeric assigned by TennCare Provider Enrollment. This is the primary identifier for all atypical providers.
    c. Tax ID (SSN or EIN) - 9 numbers assigned by the government. The EIN or SSN should only be reported in the appropriate Billing Provider field.

3. Provider Identification for Claim Reporting:
    a. TennCare requires all health care providers to be identified via their NPI on all claim formats.
    b. TennCare requires all atypical providers to be identified via their TennCare Medicaid ID number unless they have obtained an NPI which they must use.
    c. Post-adjudicated claims shall contain provider information from the original provider submitted claim.

Provider Definitions:

1. Billing Provider: - 837P, 837I, 837D, NCPDP
    a. The Billing Provider is the provider or provider organization to which payment is intended to be made. Payment is included in the provider's 1099 reporting.
    b. The Billing Provider must be a health care or atypical service provider. Billing services and healthcare clearinghouses are not Billing Providers.
    c. In cases where the Billing and Rendering Provider are the same, the Rendering (Performing) Provider information should not be reported.
    d. The TIN (EIN or SSN) used for IRS Form 1099 purposes, must be reported in the 2010AA Billing Provider REF segment for X12 transactions and in the appropriate corresponding field on all other claim formats.
    e. When the Billing Provider is an organization health care provider, the NPI of the organization health care provider must be reported.
    f. When the Billing Provider is an organization that has enumerated its subparts, the NPI reported must represent the most detailed level of enumeration.

g. When the Billing Provider is an atypical provider, the Billing Provider shall be the legal entity used for tax reporting.
h. The Billing Provider may be an individual only when the health care provider performing services is an independent, unincorporated entity.
i. The Billing Provider Address must be a street address.
j. Billing Provider information must be present on the MCC provider file.
k. Taxonomy is required for Billing Provider reporting except on the NCPDP formats.

2. Pay-To Address: - 837P, 837I, 837D
    a. This information is required if the Pay-To address is different than the Billing Provider address. Post Office Box or Lock Box addresses are only to be sent in the Pay-To Address loop, if necessary.
    b. The Billing Provider is the Pay-To Provider.

3. Rendering Provider: - 837P, 837D
    a. Required when the Rendering Provider information is different from the Billing Provider.
    b. The Rendering Provider is the person or company (laboratory or other facility) who rendered the service.
    c. It is not permissible to report an organization health care provider's NPI as the Rendering Provider if the Rendering Provider is a subpart or employee of the Billing Provider.
    d. Rendering Provider information must be present on the MCC provider file.
    e. Taxonomy is required for Rendering Provider Reporting.

4. Rendering Provider: - 837I
    a. Required on institutional claims when the Rendering Provider is different than the Attending Provider or when state or federal regulatory requirements call for a "combined claim such as Medicaid clinic bills or Critical Access Hospital claims".
    b. The Rendering Provider is the individual who delivers or completes a particular service or non-surgical procedure.
    c. Rendering Provider information must be present on the MCC provider file.

5. Service Location or Service Facility Location – 837P, 837I, 837D
    a. The Service Facility Location must be reported if the address where service(s) were rendered is different than the address of the Billing Provider.
    b. It is not permissible to report an organization health care provider's NPI as the Service Location if the Service Location is a subpart of the Billing Provider.
    c. The purpose of this loop is to identify specifically where the service was rendered. If the Service Facility Location is in an area where there are no street addresses,

enter a description of where the service was rendered. See 837 TR3 (Implementation Guide) 2310C N3 for examples.

d. Do not report this loop for ambulance services which use Ambulance pick-up and drop-off location fields – 837P only.

6. Referring Provider: - 837P, 837I, 837D
    a. The Referring Provider is the provider who sends the patient to another provider for services and is required when the claim involves a referral. The referring provider is required when the rendering of a service is contingent upon or the direct result of a referral.
    b. The Referring Provider is required on an outpatient claim when the Referring Provider is different than the Attending Provider – 837I only.
    c. The Referring Provider information must be present on the MCC provider file.

7. Supervising Provider: - 837P, 837D
    a. The Supervising Provider is required when the Rendering Provider is supervised by a physician.
    b. The Supervising Provider is required when the Rendering Provider is an atypical provider under the general or direct supervision of a physician or non-physician practitioner.
    c. For Behavioral Health Services, services rendered under a plan of care, or a person centered support plan, a minimum of direct supervision is required during service initiation, which may be followed by general supervision for the remainder of the service at the discretion of the supervisory practitioner.
        i. Direct supervision means the supervising provider must be immediately available to furnish assistance and direction throughout the performance of the procedure.
        ii. General supervision means the service is performed under the supervisory practitioner's overall direction and control but his or her presence is not required during the performance procedure.

    d. The Supervising Provider information must be present on the MCC provider file.

8. Assistant Surgeon: - 837D
    a. Required when an Assistant Surgeon is involved on the claim.
    b. The Assistant Surgeon information must be present on the MCC provider file.

9. Attending Provider: - 837I
    a. The Attending Provider is the individual who has overall responsibility for the patient's medical care and treatment reported in a given claim.
    b. Required when an institutional claim contains any services other than non-scheduled transportations services.

c. Attending Provider information must be present on MCC provider file.
d. Taxonomy is required for Attending Provider reporting.
e. For atypical providers, submit the billing provider in the attending provider field.

10. Operating Physician: - 837I
    a. Required when a surgical procedure code is listed on the claim.
    b. The Operating Physician is the individual with primary responsibility for performing the surgical procedure(s).

11. Other Operating Physician: - 837I
    a. Required when a second Operating Physician is involved on the claim.
    b. The Other Operating Physician is the individual performing a secondary surgical procedure or assisting the Operating Physician and may only be present on a claim that contains an Operating Physician.

12. Prescribing Provider: - NCPDP
    a. The NPI of the provider who prescribed the pharmaceutical.
    b. The Prescribing Provider is required on all prescription drug claims.

Exceptions:

None

REFERENCE DOCUMENTS:

1. TennCare HIPAA Companion Guides
2. ASC 837 TR3
3. 42 CFR §410.27 Therapeutic outpatient hospital or CAH services and supplies incident to a physician's or non-physician practitioner's service: Conditions
4. Publication 100-2 Medicare Benefit Policy-*https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R169BP.pdf*
5. Hospital Outpatient Prospective Payment System- *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html*

OFFICES OF PRIMARY RESPONSIBILITY:

1. TennCare IS Division—to ensure that encounter claims are submitted to TennCare in the approved format.
2. Information Systems Management Contractor – to process encounter claims through the TCMIS system.
3. Managed Care Operations - to enforce transaction requirements.
4. MCCs and DSNPs – to follow transaction requirements.