Bureau of TennCare
Policy Manual

Policy No: PAY 06-002	
Subject: Claims Processing Relating to Timely Filing & Prior Authorizations	
Approval: J.D. Hickey DG	Date: 5/10/2006

POLICY AND PURPOSE:

The purpose of this policy is to set forth the parameters for MCC processing of provider claims where there has been a delay in notification of which MCO the enrollee has been assigned. This policy supersedes TSOP #017.

DISCUSSION:

The Bureau of TennCare has been contacted by providers whose claims are being denied due to timely filing limitations when an individual first becomes eligible for TennCare. Although an MCC may receive a request from an applicant to obtain medical services and who has yet to be approved and assigned to an MCC, MCCs are not required to make actual payment for services received by the individual until notified by the Bureau of TennCare of the individual's eligibility and MCC assignment.

There are many reasons why an individual may not be assigned to the MCC he/she requested. Beyond that, there could be a delay in the provider's ability to know which MCC to bill for services, reasons including length of time for application processing [ex: error corrections and/or obtaining missing or incomplete information], and notification by the individual of MCC assignment. During this time, if the applicant/enrollee uses providers outside of the assigned MCC's network, the MCC may review rendered services for medical necessity and make a decision regarding payment on that basis. MCCs cannot deny a claim solely on the basis of being outside the MCC's timely filing requirement when the provider could not have reasonably known which MCC the enrollee was enrolled in during the timely filing period.

Likewise, a denial may not be made due to a lack of prior authorization for services rendered. The MCC may use medical necessity as the basis for a decision regarding payment, but not the

failure to obtain prior authorization when the provider could not have reasonably known which MCC the applicant/enrollee was in when services were rendered.

PROCEDURES:

TennCare/MCC contracts specify that a provider shall have at least, but no more than, 120 days from the date of service to file a claim, except in situations regarding coordination of benefits or subrogation in which case the provider is pursuing payment from a third party, or if the enrollee is enrolled in the plan with a retroactive eligibility date. In situations of third party benefits, the maximum time frames for filing a claim shall begin on the date the third party documented resolution of the claim.

In situations of enrollment in the plan with a retroactive eligibility date, the minimum and maximum time frames for filing a claim shall begin on the date that the MCC receives notification from TennCare of the enrollee's eligibility. Claims for services rendered during the time of application processing and notification to the enrollee and the MCC may be reviewed for medical necessity and adjudicated accordingly. Denials of claims for use of out-of-network providers or lack of prior authorization are not permissible.

OFFICES OF PRIMARY RESPONSIBILITY:

TennCare Office of Networks

REFERENCES:

TennCare Rules 1200-13-12-.03(1); 1200-13-13-.02(3)
TennCare Medicaid Rules 1200-13-13-.03(1)
TennCare Standard Rules 1200-13-14-.03(1)
TennCare/MCO CRA Sections 2-3.j; 2-6.a.4; 2-6.b.1; 2-9.g.6; & 2-18.jj
TennCare/BHO Contract Sections 2.3; 3.4.1.3.7; & 3.13.2

DAS