

**RULES
OF
TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE**

**CHAPTER 1200-13-17
TENNCARE CROSSOVER PAYMENTS FOR MEDICARE DEDUCTIBLES AND
COINSURANCE**

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1200-13-17-.01 DEFINITIONS.

- (1) COST EFFECTIVE ALTERNATIVE SERVICE is defined at Rule 1200-13-13-.01.
- (2) DUAL ELIGIBLE shall mean a person who is a Medicare beneficiary and who is entitled to some form of assistance from TennCare Medicaid.
- (3) FULL BENEFIT DUAL ELIGIBLE (FBDE) shall mean a Medicare beneficiary who also qualifies for TennCare benefits, except that Waiver Duals are not considered FBDEs.
- (4) MANAGED CARE CONTRACTOR (MCC) is defined at Rule 1200-13-13-.01.
- (5) MEDICARE ALLOWED AMOUNT shall mean the amount that Medicare considers reasonable for a Medicare-covered service, as defined on the claim for that service.
- (6) MEDICARE BENEFITS shall mean the health care services available to Medicare beneficiaries through the Medicare program where payment for the services is either completely the obligation of the Medicare program or in part the obligation of the Medicare program, with the remaining payment (cost sharing) obligations belonging to the beneficiary, some other third party, or TennCare.
- (7) MEDICARE COINSURANCE is defined as "Coinsurance" at Rule 1240-3-1-.02(1).
- (8) MEDICARE COST-SHARING shall mean TennCare's obligation for payment of certain Medicare beneficiaries' Medicare deductibles and coinsurance.
- (9) MEDICARE CROSSOVER CLAIM shall mean a claim that has been submitted to the Bureau of TennCare for Medicare cost sharing payments after the claim has been adjudicated by Medicare and paid by Medicare and Medicare has determined the enrollee's liability. Claims denied by Medicare or not submitted to Medicare are not considered Medicare crossover claims.
- (10) MEDICARE DEDUCTIBLE is defined as "Deductible" at Rule 1240-3-1-.02(1).
- (11) MEDICARE PAID AMOUNT is defined as the amount Medicare actually paid on a claim, which is generally a percentage of the Medicare allowed amount. The Medicare paid amount on a Medicare Part C claim is the amount that the Part C plan paid.
- (12) MEDICARE PART A is defined at Rule 1240-3-1-.02(1).

(Rule 1200-13-17-.01, continued)

- (13) MEDICARE PART B is defined at Rule 1240-3-1-.02(1).
- (14) MEDICARE PART C refers to the Medicare Advantage program authorized under Part C of Title XVIII of the Social Security Act, through which beneficiaries may choose to enroll in private managed care plans that contract with the Centers for Medicare and Medicaid Services (CMS). These plans may be HMO plans, PPO plans, or private fee-for-service plans. They offer combined coverage of Part A, Part B, and, in most cases, Part D benefits. Some Medicare Advantage plans offer additional benefits not otherwise covered by Medicare.
- (15) MEDICARE PREMIUMS shall mean the Medicare Part A and/or Medicare Part B premiums for which TennCare is responsible, depending on the enrollee's eligibility group. TennCare does not pay for Medicare Part C premiums, Medicare Part D premiums, or any other Medicare premiums.
- (16) PROFESSIONAL SERVICES shall mean the professional/technical component of Medicare services. These services are typically provided by non-institutional providers or suppliers such as physicians, outpatient clinics, and Durable Medical Equipment vendors. They are generally covered under Medicare Part B and billed on a CMS-1500 claim form. Services that are not billed on a CMS-1500 claim form or an ASC X12N 837P claim transaction are not considered part of this definition.
- (17) QMB shall mean Qualified Medicare Beneficiary, as defined at Rule 1240-3-2-.02(2).
- (18) SSI shall mean the federal Supplemental Security Income program that provides monthly income to low-income aged, blind, and disabled individuals. An "active" SSI recipient is one who is receiving monthly SSI checks.
- (19) TENNCARE ALLOWABLE shall mean the lower of the TennCare maximum fee or 80% of the Medicare allowed amount on the claim.
- (20) TENNCARE COVERED SERVICE shall mean any service that is listed as "covered" in Rules 1200-13-13-.04 and 1200-13-14-.04 and that is not listed specifically as an exclusion in Rules 1200-13-13-.10 and 1200-13-14-.10.
- (21) TENNCARE MAXIMUM FEE shall mean the maximum amount considered by TennCare for reimbursement of a particular Medicare-covered service. The TennCare maximum fee is 80% of the Cigna Medicare fee schedule amount for participating providers that was in effect on January 1, 2008.
- (22) TENNCARE PAYMENT AMOUNT shall mean the net amount paid by TennCare on a Medicare crossover claim. The TennCare payment amount will be the TennCare allowable, less the amount Medicare paid on the claim, less any third party liability. The TennCare payment amount shall not exceed the enrollee's liability on the claim.
- (23) WAIVER DUAL shall mean a person who was enrolled in TennCare as of December 31, 2001, as an Uninsured or Uninsurable and who also had Medicare. This category was closed for adults 19 and older on April 29, 2005. Waiver Duals are not considered Full Benefit Dual Eligibles.

Authority: T.C.A. 4-5-202, 71-5-105, and 71-5-109. **Administrative History:** Public necessity rule filed July 1, 2008; effective through December 13, 2008. New rule filed September 24, 2008; effective December 8, 2008.

1200-13-17-.02 ELIGIBILITY FOR CROSSOVER PAYMENTS.

- (1) The following dual eligibles are eligible for TennCare to make Medicare crossover payments on all Medicare covered services, regardless of whether or not these services are also covered by TennCare:
 - (a) QMBs;
 - (b) Non-QMB FBDEs who are under age 21; and
 - (c) Non-QMB FBDEs who are active SSI beneficiaries.
- (2) Non-QMB FBDEs who are age 21 and older and who are not active SSI beneficiaries are eligible for TennCare to make Medicare crossover payments on all Medicare covered services that are also TennCare covered services. They are not eligible for TennCare to make Medicare crossover payments when the service on which the payment is requested is not a TennCare covered service.

Authority: T.C.A. 4-5-202, 71-5-105, and 71-5-109. **Administrative History:** Public necessity rule filed July 1, 2008; effective through December 13, 2008. New rule filed September 24, 2008; effective December 8, 2008.

1200-13-17-.03 THIRD PARTY RESOURCES.

When a TennCare enrollee is covered by other third party payers, in addition to Medicare, TennCare is the payer of last resort. Whether or not Medicare is the primary payer, providers must bill all other third party payers prior to submitting a crossover claim to the Bureau of TennCare.

Authority: T.C.A. 4-5-202, 71-5-105, and 71-5-109. **Administrative History:** Public necessity rule filed July 1, 2008; effective through December 13, 2008. New rule filed September 24, 2008; effective December 8, 2008.

1200-13-17-.04 MEDICARE CROSSOVER PAYMENT METHODOLOGY.

Notwithstanding anything in these rules to the contrary, TennCare's payment methodology for crossover claims submitted on behalf of FBDEs for professional services delivered under either Medicare Part B or Medicare Part C is as follows:

- (1) On crossover claims for professional services and procedures with dates of service on or after July 1, 2008, TennCare will pay the TennCare allowable, as defined in these rules, less the Medicare paid amount, less any third party liability.
- (2) In no circumstance will the TennCare payment exceed the enrollee's liability on the Medicare crossover claim.
- (3) Medicare crossover payments are normally made by the Bureau of TennCare separately from the Managed Care Contractors. However, if an MCC should choose to authorize a non-covered TennCare service as a cost-effective alternative service for a non-QMB FBDE who is age 21 or older and not an SSI recipient, the MCC will be responsible for the Medicare crossover payment on that service. The calculation of this payment should be included by the MCC in its analysis of whether or not the non-covered TennCare service is a cost-effective alternative service.

(Rule 1200-13-17-.04, continued)

Authority: T.C.A. 4-5-202, 71-5-105, and 71-5-109. **Administrative History:** Public necessity rule filed July 1, 2008; effective through December 13, 2008. New rule filed September 24, 2008; effective December 8, 2008.

1200-13-17-.05 PROVIDER ENROLLMENT AND PARTICIPATION REQUIREMENTS.

- (1) Medicare providers who are licensed professionals and who wish to bill for services provided to Medicare beneficiaries must enroll with the TennCare program and obtain TennCare Medicaid identification numbers.
- (2) Participation in the TennCare/Medicare crossover program is limited to providers who maintain current Tennessee medical licenses and/or current licenses in the states in which they practice.
- (3) Providers must be licensed and accredited according to the specific laws and regulations that apply to their service type.
- (4) Health care providers who are required under Tennessee law to render services under the supervision of other health care providers will not be assigned TennCare identification numbers. These providers' claims must be submitted by the licensed or certified health care providers who supervise them.

Authority: T.C.A. 4-5-202, 71-5-105, and 71-5-109. **Administrative History:** Public necessity rule filed July 1, 2008; effective through December 13, 2008. New rule filed September 24, 2008; effective December 8, 2008.