

**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) ENHANCED PAYMENT RATE shall mean the payment rate referred to in 42 U.S.C. § 1396a(a)(13)(C). Enhanced payment rates are made only to primary care providers and to providers of vaccine administration services, as defined in these rules. These rates are applicable only for dates of service between January 1, 2013, and December 31, 2014.
- (4) FULL BENEFIT DUAL ELIGIBLE (FBDE) shall mean a Medicare beneficiary who also qualifies for TennCare benefits, except that Waiver Duals are not considered FBDEs.
- (5) MANAGED CARE CONTRACTOR (MCC) is defined at Rule 1200-13-13-.01.
- (6) MEDICARE ALLOWED AMOUNT shall mean the amount that Medicare considers reasonable for a Medicare-covered service, as defined on the claim for that service.
- (7) 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.
- (8) MEDICARE COINSURANCE is defined as "Coinsurance" at Rule 1240-03-01-.02(1).
- (9) MEDICARE COST-SHARING shall mean TennCare's obligation for payment of certain Medicare beneficiaries' Medicare deductibles and coinsurance.
- (10) 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.
- (11) MEDICARE DEDUCTIBLE is defined as "Deductible" at Rule 1240-03-01-.02(1).

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

- (12) 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.
- (13) MEDICARE PART A is defined at Rule 1240-03-01-.02(1).
- (14) MEDICARE PART B is defined at Rule 1240-03-01-.02(1).
- (15) 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.
- (16) 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.
- (17) PHARMACY PROVIDERS shall mean providers enrolled with the Medicare program and with Medicaid to provide Medicare Part B pharmacy services.
- (18) PHARMACY SERVICES shall mean outpatient prescription drugs provided through Medicare Part B.
- (19) PRIMARY CARE PROVIDERS shall mean, for purposes of the enhanced payment rate, as defined in these rules, primary care providers practicing in family medicine, general internal medicine, pediatric medicine, and related subspecialists who meet requirements as described in 42 C.F.R. § 447.400(a). In accordance with policies set forth by the Bureau of TennCare, these providers must adequately demonstrate to an MCO or the Bureau of TennCare that they meet the minimum board certification requirements and/or that 60 percent of the services they provide represent the eligible codes identified in these rules as primary care or vaccine administration services.
- (20) PRIMARY CARE SERVICES are services for which enhanced payment rates, as defined in these rules, will be paid for dates of service between January 1, 2013, and December 31, 2014. The procedure codes for these services, as published in the American Medical Association's Current Procedural Terminology (2013 edition), are Evaluation and Management Codes 99201 through 99499, or their successor codes.
- (21) 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.
- (22) QMB shall mean Qualified Medicare Beneficiary, as defined at Rule 1240-03-02-.02(2).

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

- (23) 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.
- (24) TENNCARE ALLOWABLE shall mean the lower of the TennCare maximum fee or 85% of the Medicare allowed amount on the claim.
- (25) 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.
- (26) TENNCARE MAXIMUM FEE shall mean the maximum amount considered by TennCare for reimbursement of a particular Medicare-covered service. The TennCare maximum fee is 85% of the Cigna Medicare fee schedule amount for participating providers that was in effect on January 1, 2008. For Medicare-covered services that were introduced after January 1, 2008, and that therefore had no Medicare fee schedule amount in effect on that date, the TennCare maximum fee is 85% of the Medicare fee schedule amount for the participating providers that was in effect on the date the service was introduced.
- (27) 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.
- (28) TENNCARE PHARMACY ALLOWABLE shall mean, for Medicare Part B pharmacy services provided to FBDEs by pharmacy providers, as defined in these rules, 100% of the Medicare allowed amount on the claim.
- (29) TENNCARE PRIMARY CARE ALLOWABLE shall mean 100% of the designated Medicare Cost-Sharing amounts for primary care services provided by primary care providers as defined in these rules during Calendar Years (CY) 2013 and 2014.
- (30) TENNCARE VACCINATION ADMINISTRATION ALLOWABLE shall mean 100% of the designated Medicare Cost-Sharing amounts for vaccine administration services provided by primary care providers as defined in these rules during Calendar Years (CY) 2013 and 2014.
- (31) VACCINE ADMINISTRATION SERVICES are services for which enhanced payment rates, as defined in these rules, will be paid for dates of service between January 1, 2013, and December 31, 2014. The procedure codes for these services, as published in the American Medical Association’s Current Procedural Terminology (2013 edition), are Vaccine Administration Codes 90460, 90461, 90471, 90472, 90473, and 90474 or their successor codes.
- (32) 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, 4-5-208, 4-5-209, 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. Public necessity rules filed July 1, 2009; effective through December 13, 2009. Amendments filed September 11, 2009; effective

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

*December 10, 2009. Emergency rule filed June 21, 2013; effective through December 18, 2013. Amendment filed August 15, 2013; effective November 13, 2013.*

#### **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.**

- (1) On crossover claims for professional services and procedures with dates of service on or after July 1, 2008, TennCare will pay the lesser of (a) billed charges or (b) the TennCare allowable, as defined in these rules, less the Medicare paid amount, less any third party liability.
- (2) On crossover claims for Medicare Part B pharmacy services provided by pharmacy providers, as defined in these rules, to non-FBDEs with dates of service on or after July 1, 2009, TennCare will pay the lesser of (a) billed charges or (b) the TennCare allowable, as defined in these rules, less the Medicare paid amount, less any third party liability.
- (3) On crossover claims for Medicare Part B pharmacy services provided by pharmacy providers, as defined in these rules, to FBDEs with dates of service on or after July 1, 2009, TennCare will pay the lesser of (a) billed charges or (b) the TennCare pharmacy allowable, as defined in these rules, less the Medicare paid amount, less any third party liability.

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

- (4) On crossover claims for primary care services, as defined in these rules, TennCare will pay an enhanced payment rate for dates of service between January 1, 2013, and December 31, 2014. The enhanced payment rate will be the lesser of (a) billed charges or (b) the TennCare primary care allowable, as defined in these rules, less the Medicare paid amount, less any third party liability.
- (5) On crossover claims for vaccine administration services, as defined in these rules, TennCare will pay an enhanced payment rate for services between January 1, 2013, and December 31, 2014. The enhanced payment rate will be the lesser of (a) billed charges or (b) the TennCare vaccination administration allowable, as defined in these rules, less the Medicare paid amount, less any third party liability.
- (6) In no circumstance will the TennCare payment exceed the enrollee's liability on the Medicare crossover claim.
- (7) Medicare crossover payments are normally made by the Bureau of TennCare separately from the Managed Care Contractors. Rules 1200-13-13-.08(12)(b) and 1200-13-14-.08(12)(b) set forth the guidelines for timely filing Medicare crossover claims. 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.

**Authority:** T.C.A. §§ 4-5-202, 4-5-208, 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. Public necessity rule filed July 1, 2009; effective through December 13, 2009. Amendment filed September 11, 2009; effective December 10, 2009. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendment filed May 27, 2010; effective August 25, 2010. Emergency rule filed June 21, 2013; effective through December 18, 2013. Amendment filed August 15, 2013; effective November 13, 2013.

#### **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.