

Rulemaking Hearing Rules
of
Tennessee Department of Finance and Administration

Bureau of TennCare

Chapter 1200-13-13
TennCare Medicaid

Amendment

Paragraph (5) of rule 1200-13-13-.08 Providers is deleted in its entirety and replaced with a new paragraph (5) which shall read as follows:

- (5) Providers may seek payment from a TennCare enrollee only under the following circumstances:
- (a) If the services are not covered by the TennCare program and, prior to providing the services, the provider informed the enrollee that the services were not covered; or
 - (b) If the services are not covered because they are in excess of an enrollee's benefit limit and one of the following circumstances applies:
 - 1. The provider determines effective on the date of service that the enrollee has reached his/her benefit limit for the particular service being requested and, prior to providing the service, informs the enrollee that the service is not covered and the service will not be paid for by TennCare. The source of the provider's information must be a database listed on the TennCare website as approved by TennCare on the date of the provider's inquiry.
 - 2. The provider has information in his/her own records to support the fact that the enrollee has reached his/her benefit limit for the particular service being requested and, prior to providing the service, informs the enrollee that the service is not covered and will not be paid for by TennCare. This information may include:
 - (i) A previous written denial of a claim on the basis that the service was in excess of the enrollee's benefit limit for a service within the same benefit category as the service being requested, if the time period applicable to that benefit limit is still in effect;
 - (ii) That the provider had previously examined the database referenced in part 1. above and determined that the enrollee had reached his/her benefit limit for the particular service being requested, if the time period applicable to that benefit limit is still in effect; or
 - (iii) That the provider had personally provided services to the enrollee in excess of his/her benefit limit within the same benefit category as the service being requested, if the time period applicable to that benefit limit is still in effect.
 - 3. The provider submits a claim for service to the appropriate managed care contractor (MCC) and receives a written denial of that claim on the basis that the service exceeds the enrollee's benefit limit. Thereafter, within the remainder of the period

applicable to that benefit limit, the provider may continue to bill the enrollee for services within that same exhausted benefit category without having to submit, for repeated MCC denial, claims for those subsequent services.

4. The provider had previously taken the steps in parts 1., 2., or 3. above and determined that the enrollee had reached his/her benefit limit for the particular service being requested, if the time period applicable to that benefit limit is still in effect, and informs the enrollee, prior to providing the service, that the service is not covered and will not be paid for by TennCare.

Statutory Authority: T.C.A 4-5-202, 71-5-105, 71-5-109, Executive Order No. 23.

The rulemaking hearing rules set out herein were properly filed in the Department of State on the 27th day of October, 2005 and will become effective on the 10th day of January, 2006.