

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

**CHAPTER 1200-13-18
TENNCARE ADMINISTRATIVE ACTIONS AND PROVIDER APPEALS**

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1200-13-18-.01 SCOPE AND AUTHORITY.

- (1) An approved provider of TennCare services may appeal the following administrative actions:
 - (a) An administrative action for recovery against a person other than an enrollee, recipient or applicant brought by the Bureau of TennCare upon written request of the Attorney General pursuant to the Tennessee Medicaid False Claims Act;
 - (b) An action proposed or taken by the Bureau of TennCare or its audit contractor to recover, recoup or withhold payment from a provider, as a result of any audit performed by or on behalf of the Centers for Medicare and Medicaid Services or the Bureau pursuant to state or federal law;
 - (c) A Bureau of TennCare determination to suspend payments to a provider due to a credible allegation of fraud for which an investigation is pending;
 - (d) A denial of eligibility for or a determination of the amount of an incentive payment pursuant to the federal Medicaid Electronic Health Record Incentive Program (EHR-IP); or,
 - (e) Termination of an approved provider's Tennessee Medicaid Provider Number by the Bureau, except when federal law mandates exclusion of the provider.
- (2) A provider of services may not appeal the following administrative actions:
 - (a) An MCC's refusal to contract with the provider;
 - (b) A decision by the Bureau to decline coverage of prescriptions not written by a provider with prescribing authority; or,
 - (c) Termination or exclusion from the Program as required by federal law.
- (3) In order to exercise the right to a hearing, a provider must submit his appeal and request for a hearing in writing to the Bureau. The notice of the Bureau action shall contain specific instructions concerning the right to appeal and the address for filing an appeal.
- (4) Any request for an appeal must be received at the address contained in the notice of action no later than 35 days following the date of the notice.

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- (5) Provider appeals shall be conducted as contested case hearings by the Tennessee Department of State, Administrative Procedures Division, pursuant to the Tennessee Uniform Administrative Procedures Act (APA).
- (6) The Uniform Rules of Procedure for Hearing Contested Cases Before State Administrative Agencies, Chapter 1360-04-01, promulgated under the APA, are adopted by the Bureau and incorporated by reference herein. The Uniform Rules shall govern the conduct of a provider appeal except where a specific contrary provision is adopted by the Bureau in this Chapter.
- (7) For purposes of issuing an initial order, a contested case hearing shall be conducted by an administrative judge hearing the case alone.

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109. **Administrative History:** Emergency rule filed February 18, 2011; effective through August 17, 2011. Original rule filed May 18, 2011; effective August 16, 2011.

1200-13-18-.02 DEFINITIONS.

- (1) Administrative Judge. An employee or official of the Office of the Secretary of State who is licensed to practice law and authorized by law to conduct contested case proceedings.
- (2) Administrative Procedures Act (APA). The Tennessee Uniform Administrative Procedures Act, as amended, codified at T.C.A. §§ 4-5-301, et seq.
- (3) Approved Provider. A provider of health care services who has registered with and been approved by the Bureau and has been issued a Tennessee Medicaid Provider Number.
- (4) Audit. The systematic process of objectively obtaining and evaluating evidence regarding assertions about economic actions and events to ascertain the degree of correspondence between those assertions and established criteria and communicating the results to interested parties. Audits are conducted in accordance with AICPA (American Institute of Certified Public Accountants) auditing or attestation engagement standards. For purposes of this chapter, audits are conducted of health care provider records, financial information, and statistical data according to principles of cost reimbursement to determine the reasonableness and allowance of costs reimbursable under the Program.
- (5) Bureau of TennCare (Bureau). The division of the Tennessee Department of Finance and Administration, the single state Medicaid agency, that administers the TennCare Program. For purposes of this Chapter, the Bureau shall represent the State of Tennessee.
- (6) Civil Penalty. A monetary penalty assessed by the Bureau against a provider in an amount of not less than \$1,000 nor more than \$5,000 for each violation of the Tennessee Medicaid False Claims Act. T.C.A. § 71-5-183(h)(3).
- (7) Claim. Any request or demand for money, property, or services made to any employee, officer, or agent of the state, or to any contractor, grantee, or other recipient, whether under contract or not, if any portion of the money, property, or services requested or demanded was issued from, or was provided by, the State.
- (8) Commissioner. The chief administrative officer of the Tennessee Department where the Bureau is administratively located.
- (9) Commissioner's Designee. A person authorized by the Commissioner to review appeals of initial orders and to enter final orders pursuant to T.C.A. § 4-5-315, or to review petitions for stay or reconsideration of final orders.

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- (10) **Contested Case.** An administrative proceeding in which the legal rights, duties or privileges of a party are required by any statute or constitutional provision to be determined by an agency after an opportunity for a hearing.
- (11) **Credible Allegation of Fraud.** Information which has been verified by the Bureau through judicious case-by-case review and found to contain indicia of reliability. This information may be from any source, including but not limited to hotline complaints, claims data mining, patterns identified through provider audits, civil false claims cases, or law enforcement investigations.
- (12) **Department.** The Tennessee Department of Finance and Administration.
- (13) **Electronic Health Record Incentive Program (EHR-IP).** The provisions of the American Recovery and Reinvestment Act of 2009 (ARRA) that provide for incentive payments to eligible professionals (EPs) and eligible hospitals (EHs), including acute care, children's and critical access hospitals (CAHs) participating in Medicare and Medicaid programs that adopt, implement or update a certified system and successfully demonstrate meaningful use of certified electronic health record (EHR) technology as required by federal regulations.
- (14) **Enrollee.** An individual eligible for and enrolled in the TennCare program.
- (15) **Error Rate.** The percentage of claims in a sample population that was not billed properly and is actionable. Error rates can be applied to entire populations if the sample was the result of statically valid random sampling. The use of the term "error" does not indicate the intent of the person or entity submitting the claim.
- (16) **Findings of Fact.** The factual findings issued by the Administrative Judge or Commissioner's Designee following an administrative hearing. The factual findings are enumerated in the initial and/or final order. An order must include a concise and explicit statement of the underlying facts of record to support the findings.
- (17) **Final Agency Decision.** A Final Order.
- (18) **Final Order.** An initial order becomes a final order without further notice if not timely appealed, or if the initial order is appealed pursuant to T.C.A. § 4-5-315, the Commissioner or Commissioner's Designee may render a final order. A statement of the procedures and time limits for seeking reconsideration or judicial review shall be included with the issuance of a final order.
- (19) **Good Cause Not to Suspend Payment.** The Bureau may determine not to suspend payment or not to continue suspension of payment to a provider being investigated due to a credible allegation of fraud if:
 - (a) Law enforcement officials have specifically requested that a payment suspension not be imposed because such a payment suspension may compromise or jeopardize an investigation;
 - (b) Other available remedies implemented by the State more effectively or quickly protect Program funds;
 - (c) The Bureau determines, based upon the submission of written evidence by the provider that is the subject of the payment suspension, that the suspension should be removed;
 - (d) Enrollee access to items or services would be jeopardized by a payment suspension because the provider is the sole community physician, the sole source of essential

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- specialized services in a community, or serves a large number of enrollees within a HRSA-designated medically underserved area;
- (e) Law enforcement declines to certify that a matter continues to be under investigation; or
 - (f) The Bureau determines that payment suspension is not in the best interests of the Program.
- (20) Good Cause to Suspend Payment Only in Part. The Bureau may determine to suspend payments in part, or to convert a payment suspension previously imposed in whole to one only in part, to a provider being investigated due to a credible allegation of fraud if:
- (a) Enrollee access to items or services would be jeopardized by a payment suspension in whole or part because the provider is the sole community physician, the sole source of essential specialized services in a community, or serves a large number of recipients within a HRSA-designated medically underserved area;
 - (b) The Bureau determines, based upon the submission of written evidence by the provider that is the subject of a whole payment suspension, that such suspension should be imposed only in part;
 - (c) The credible allegation focuses solely and definitively on only a specific type of claim or arises from only a specific business unit of a provider, and the Bureau determines and documents in writing that a payment suspension in part would effectively ensure that potentially fraudulent claims were not continuing to be paid;
 - (d) Law enforcement declines to certify that a matter continues to be under investigation; or
 - (e) The Bureau determines that payment suspension only in part is in the best interests of the Program.
- (21) Hearing. A contested case proceeding.
- (22) Indicia of Reliability. Factors which the Bureau will examine in determining whether a credible allegation of fraud exists, requiring the suspension of payments to a provider, including but not limited to:
- (a) Firsthand knowledge;
 - (b) Corroborating witness;
 - (c) Witness conflict (disgruntled employee);
 - (d) Prior bad acts;
 - (e) Pattern of bad acts;
 - (f) Documentary proof;
 - (g) Admission by provider;
 - (h) Expert opinion; or
 - (i) Indictment by a court of competent jurisdiction.

(Rule 1200-13-18-.02, continued)

- (23) Initial Order. The decision issued by the administrative judge following a hearing. The initial order shall contain the decision, findings of fact, conclusions of law, the policy reasons for the decision and the remedy prescribed. It shall include a statement of the procedure for filing an appeal of the initial order as well as a statement of any circumstances under which the initial order may, without further notice, become a final order. A statement of the procedures and time limits for seeking reconsideration or other administrative relief and the time limits for seeking judicial review shall be included.
- (24) Notice of Action. The document or letter sent by the Bureau to a provider detailing the action the Bureau intends to take against the provider. The notice shall include a statement of the reasons and authority for the action as well as a statement of the provider's right to appeal the action, if applicable.
- (25) Notice of Hearing. The pleading filed with the Administrative Procedures Division by the Bureau upon receipt of an appeal. It shall contain a statement of the time, place, nature of the hearing, and the right to be represented by counsel; a statement of the legal authority and jurisdiction under which the hearing is to be held, referring to the particular statutes and rules involved; and, a short and plain statement of the matters asserted, in compliance with the APA.
- (26) Program. See TennCare.
- (27) Provider with Prescribing Authority. A health care professional authorized by law or regulation to order prescription medications for her patients and who:
- (a) Participates in the provider network of the MCC in which the beneficiary is enrolled; or
 - (b) Has received a referral of the beneficiary, approved by the MCC, authorizing her to treat the beneficiary; or,
 - (c) In the case of a TennCare beneficiary who is also enrolled in Medicare, is authorized to treat Medicare patients.
- (28) RAT-STATS. A widely accepted statistical software tool designed to assist the user in conducting statistically valid random sampling and evaluating audit results.
- (29) Standard of Proof. A preponderance of the evidence.
- (30) Statistically Valid Random Sampling. A method for determining error rates in healthcare billings using extrapolation. Typically used for large numbers of suspect claims or patients, a random sample of claims from a chosen population is selected using RAT-STATS or a similar program. That sample is then analyzed for errors. If the sample is the result of statistically valid random sampling, the error rate in the sample can be extrapolated to the entire population of claims.
- (31) TennCare. The program administered by the Single State Agency as designated by the State and CMS pursuant to Title XIX of the Social Security Act and the Section 1115 Research and Demonstration Waiver granted to the State of Tennessee.
- (32) Tennessee Medicaid Provider Number. The identifying number issued by the Bureau to an approved provider for the purpose of receiving payment in exchange for rendering services to TennCare enrollees.
- (33) Tennessee Medicaid False Claims Act (Act). T.C.A. §§ 71-5-181, *et seq.*

(Rule 1200-13-18-.02, continued)

- (34) Termination. The deactivation of a provider's Tennessee Medicaid Provider Number and the cessation of the provider's TennCare billing privileges.

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109. **Administrative History:** Emergency rule filed February 18, 2011; effective through August 17, 2011. Original rule filed May 18, 2011; effective August 16, 2011.

1200-13-18-.03 ADMINISTRATIVE ACTION FOR RECOVERY UNDER THE TENNESSEE MEDICAID FALSE CLAIMS ACT.

- (1) The Attorney General, following an investigation of an approved provider's claims, may determine that certain provider actions are appropriate for administrative action by the Bureau, pursuant to the Act. The Attorney General may refer any such matters to the Bureau Director, or his designee, along with the investigative file and a recommendation for action.
- (2) The Attorney General shall not refer matters originally brought under T.C.A. § 71-5-183(b) or if any person has the right to participate in or recover from the proceeding pursuant to T.C.A. § 71-5-183(c)(5).
- (3) Upon receipt of a written request from the Attorney General, the Bureau may commence a contested case proceeding on behalf of the State for recovery under the Act against any person other than an enrollee, recipient or applicant.
- (4) The Bureau may initiate the recovery process by notice of action to the provider setting out:
 - (a) The assessment of damages, civil penalties and related costs;
 - (b) The name and contact information of an individual within the Bureau with knowledge of the claim(s) and the assessment who is authorized to discuss the matter with the provider; and
 - (c) A statement of the right of the provider to appeal the assessment and the manner in which an appeal must be filed.
- (5) Any appeal of a notice of action shall be conducted according to rule .01 of this chapter.
- (6) The Bureau may recover actual damages in an amount no greater than ten thousand dollars (\$10,000). The amount of actual damages may be based upon a statistically valid random sample utilizing a software tool such as RAT-STATS.
- (7) In addition to and not limited by the amount of actual damages, the Bureau may recover:
 - (a) Civil penalties of not less than one thousand dollars (\$1,000) nor more than five thousand dollars (\$5,000) for each claim found to be in violation of the Act;
 - (b) Costs of the administrative action; and
 - (c) Treble the amount of actual damages.
- (8) Any action for recovery shall not be brought:
 - (a) More than six (6) years following the date on which the violation of the Act is committed; or
 - (b) More than three (3) years after the date when facts material to the right of action are known or reasonably should have been known by the state official charged with

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responsibility to act in the circumstances, but in no event not more than ten (10) years after the date the violation was committed, whichever occurs last.

- (9) A subpoena issued by an administrative judge pursuant to the APA requiring the attendance of a witness at a hearing may be served by certified mail at any place in the United States.
- (10) For purposes of rendering a final order pursuant to the APA, the Bureau is designated as the agency to review initial orders and issue final agency decisions. Orders issued by the Bureau shall have the effect of a final order pursuant to the APA.
- (11) Judgment. A final order issued by the Bureau under this rule may be enforced as a final judgment, as follows:
 - (a) A notarized copy of the final order must be filed in the office of the Clerk of the Chancery Court of Davidson County;
 - (b) Upon filing with the Clerk, a final order shall be considered as a judgment by consent of the parties on the same terms and conditions as those recited in the order;
 - (c) The judgment shall be promptly entered by the Court;
 - (d) The judgment shall become final on the date of entry; and
 - (e) A final judgment shall have the same effect, is subject to the same procedures and may be enforced or satisfied in the same manner as any other judgment of a court of record of the State of Tennessee.

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109. **Administrative History:** Emergency rule filed February 18, 2011; effective through August 17, 2011. Original rule filed May 18, 2011; effective August 16, 2011.

1200-13-18-.04 RECOUPMENT OR WITHHOLD.

- (1) The Bureau is required by state and federal law to protect the integrity of the Medicaid program. This is accomplished in part by causing audits of provider claims to be conducted. Audit findings are reported to the Bureau for the purpose of recovering incorrect payments, by recoupment or withhold.
- (2) The Bureau shall notify a provider of its intent to recoup or withhold based upon audit findings by issuing a notice of action. Each notice of action sent to a provider shall contain the proposed recovery action and the following information:
 - (a) The name and contact information of an individual knowledgeable about the audit findings and who is authorized to discuss the proposed recovery action with the provider;
 - (b) The manner by which the provider may submit additional information to support his disagreement with the proposed recovery action;
 - (c) A statement that the provider has the right to appeal the proposed recovery action and the manner in which an appeal must be filed.
- (3) Any appeal of a notice of action shall be conducted according to rule .01 of this chapter.
- (4) The audit and the audit findings are not subject to appeal. (See NHC v. Snodgrass, 555 S.W.2d 403 (Tenn. 1977)).

(Rule 1200-13-18-.04, continued)

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109. **Administrative History:** Emergency rule filed February 18, 2011; effective through August 17, 2011. Original rule filed May 18, 2011; effective August 16, 2011.

1200-13-18-.05 SUSPENSION OF PAYMENT.

- (1) Pursuant to 42 C.F.R. § 447.90, the Bureau is prohibited by federal law from receiving federal financial participation (FFP) for payment to a provider of medical items or services with respect to which there is a pending investigation of a credible allegation of fraud, absent good cause not to suspend payment or good cause to suspend payment only in part.
- (2) The Bureau must provide written notice to the provider of a suspension of payments:
 - (a) Five (5) days after suspending payments unless a law enforcement agency has submitted a written request to delay the notice; or
 - (b) Thirty (30) days after suspending payments when a delay was properly requested by law enforcement, except the delay may be renewed twice in writing not to exceed ninety (90) days.
- (3) Written notice of suspension of payment must contain:
 - (a) A statement that payments are suspended according to this rule and federal regulation;
 - (b) The general allegations as to the nature of the suspension action, but need not disclose any specific information concerning an ongoing investigation;
 - (c) A statement that the suspension is temporary and the circumstances under which it will be terminated;
 - (d) If applicable, state the type(s) of TennCare/Medicaid claims to which suspension is effective;
 - (e) A statement that the provider has the right to submit written evidence for consideration by the Bureau; and
 - (f) A statement that the provider has the right to appeal the suspension and the manner in which an appeal must be filed.
- (4) Any appeal of a notice of suspension of payment shall be conducted according to rule .01 of this chapter.
- (5) Any suspension of payment shall be temporary and shall not continue after:
 - (a) The Bureau or prosecuting authority determines there is insufficient evidence of fraud by the provider; or
 - (b) Legal proceedings related to the provider's alleged fraud are completed.
- (6) The Bureau must document in writing the termination of a suspension of payment. Such document must include any applicable appeal rights available to the provider.

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109. **Administrative History:** Emergency rule filed February 18, 2011; effective through August 17, 2011. Original rule filed May 18, 2011; effective August 16, 2011.

1200-13-18-.06 ELECTRONIC HEALTH RECORD INCENTIVE PROGRAM (EHR-IP).

- (1) An approved provider of TennCare services, upon receipt of a notice of action, may appeal the following issues related to the EHR-IP:
 - (a) Denial of an incentive payment;
 - (b) Incentive payment amount;
 - (c) Determination of eligibility for an incentive payment, including but not limited to measurement of patient volume;
 - (d) Determination of efforts to adopt, implement or upgrade to certified EHR technology during the first year of the EHR-IP or meaningful use of certified EHR technology in subsequent years;
 - (e) Whether the provider is hospital-based;
 - (f) Whether the provider is practicing predominantly in an FQHC or RHC;
 - (g) Whether a hospital qualifies as an acute care or children's hospital; or,
 - (h) Whether the provider is already participating in the Medicare incentive program or in the Medicaid incentive program of another state and therefore is ineligible for duplicate TennCare incentive program payments.
- (2) Each notice of action sent to a provider of a determination of any matter listed in paragraph (1) shall contain the following:
 - (a) The contact information to reach an individual knowledgeable about the EHR-IP who is authorized to discuss the determination with which the provider disagrees;
 - (b) The manner by which the provider may submit additional information to support his disagreement with the determination; and
 - (c) A statement that the provider has the right to appeal the determination with which he disagrees and the manner in which an appeal must be filed.
- (3) Any appeal of a notice of action shall be conducted according to rule .01 of this chapter.

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109. **Administrative History:** Emergency rule filed February 18, 2011; effective through August 17, 2011. Original rule filed May 18, 2011; effective August 16, 2011.

1200-13-18-.07 TERMINATION OR EXCLUSION OF A PROVIDER FROM PROGRAM PARTICIPATION.

- (1) A provider may be terminated or excluded from participation in the TennCare program.
- (2) Federal Mandatory Exclusion. The Bureau is required by federal law to exclude a provider from participation in the TennCare program upon notice from HHS or CMS under the following circumstances:
 - (a) Conviction of program-related crimes;

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- (b) Conviction relating to patient abuse;
 - (c) Felony conviction relating to health care fraud; or
 - (d) Felony conviction relating to controlled substance.
- (3) Federal Permissive Exclusion. Pursuant to federal law, the Bureau may exclude a provider from participation in the TennCare program under the following circumstances:
- (a) Conviction related to fraud;
 - (b) Conviction related to obstruction of an investigation or audit;
 - (c) Misdemeanor conviction related to controlled substance;
 - (d) License revocation or suspension;
 - (e) Exclusion or suspension under federal or state health care program;
 - (f) Claims for excessive charges or unnecessary services and failure of certain organizations to furnish medically necessary services;
 - (g) Fraud, kickbacks, and other prohibited activities;
 - (h) Entities controlled by a sanctioned individual;
 - (i) Failure to disclose required information;
 - (j) Failure to supply requested information on subcontractors and suppliers;
 - (k) Failure to supply payment information;
 - (l) Failure to grant immediate access;
 - (m) Failure to take corrective action;
 - (n) Default on health education loan or scholarship obligations;
 - (o) Individuals controlling a sanctioned entity; or
 - (p) Making false statements or misrepresentation of material facts.
- (4) When a provider exclusion is mandatory, the notice of action shall state that the provider has no right to appeal the termination from program participation.
- (5) When a provider exclusion is permissive, the notice of action shall include a statement that the provider has the right to appeal the termination from program participation and the manner in which an appeal must be filed.

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109. **Administrative History:** Emergency rule filed February 18, 2011; effective through August 17, 2011. Original rule filed May 18, 2011; effective August 16, 2011.

1200-13-18-.08 PROVIDER SANCTIONS.

- (1) Pursuant to the authority granted by T.C.A. § 71-5-118 to the Commissioner to impose sanctions against providers, the Commissioner, through the Bureau, may take the following actions against a provider upon a finding that such actions will further the purpose of the Tennessee Medical Assistance Act:
 - (a) Subject providers to stringent review and audit procedures which may include clinical evaluation of claim services and a prepayment requirement for documentation and for justification of each claim;
 - (b) Refuse to issue or terminate a Tennessee Medicaid Provider Number if any person who has an ownership or controlling interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the U.S. Title XX Services Program;
 - (c) Refuse to issue or terminate a Tennessee Medicaid Provider Number if a determination is made that the provider did not fully and accurately make any disclosure of any person who has ownership or controlling interest in the provider, or is an agent or managing employee of the provider and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the U.S. Title XX Services Program since the inception of these programs;
 - (d) Refuse to issue or terminate a Tennessee Medicaid Provider Number if the appropriate State Board of Licensing or Certification fails to license or certify the provider at any time for any reason or suspends or revokes a license or certification;
 - (e) Refuse to issue or terminate a Tennessee Medicaid Provider Number upon notification by the U.S. Office of Inspector General Department of Health and Human Services that the provider is not eligible under Medicare or Medicaid for federal financial participation;
 - (f) Suspend or withhold payments to a provider in cases of fraud, willful misrepresentation, or flagrant noncompliance; or,
 - (g) Recover from a provider any payments made by a recipient and/or his family for a covered service when evidence of recipient billing by the provider is determined by the Bureau and repayment by the provider to the recipient and/or his family is not made within 30 days of receiving notification from the Bureau to make repayment. If a provider knowingly bills a recipient and/or family for a TennCare covered service, in total or in part, except as otherwise permitted by State rules, the Bureau may terminate the provider from participation in the program.
- (2) In addition to the grounds for sanctions set out in T.C.A. § 71-5-118, activities or practices which justify sanctions against a provider and may include recoupment of monies incorrectly paid shall include but not be limited to:
 - (a) Noncompliance with contractual terms;
 - (b) Billing for a service in a quantity which is greater than the amount provided;
 - (c) Billing for a service which is not provided or not documented;

- (d) Knowingly providing incomplete, inaccurate, or erroneous information to TennCare or its agent(s);
- (e) Continued provision of poor record keeping or inappropriate or inadequate medical care;
- (f) Medical assistance of a quality below recognized standards;
- (g) Suspension from the Medicare or Medicaid program(s) by the authorized U.S. enforcement agency;
- (h) Partial or total loss (voluntary or otherwise) of a provider's federal Drug Enforcement Agency (DEA) dispensing or prescribing certification;
- (i) Restriction to or loss of practice by a state licensing board action;
- (j) Acceptance of a pretrial diversion, in state or federal court, from a Medicaid or Medicare fraud charge or evidence from such charge;
- (k) Violation of the responsible state licensing board license or certification rules;
- (l) Conviction of any felony, any offense under state or federal drug laws, or any offense involving moral turpitude;
- (m) Dispensing, prescribing, or otherwise distributing any controlled substance or any other drug not in the course of professional practice, or not in good faith to relieve pain and suffering, or not to cure an ailment, physical or mental infirmity or disease;
- (n) Dispensing, prescribing, or otherwise distributing to any person a controlled substance or other drug if such person is addicted to the habit of using controlled substances without making a bona fide effort to cure the habit of such patient;
- (o) Dispensing, prescribing or otherwise distributing any controlled substance or other drug to any person in violation of any law of the state or of the United States of America;
- (p) Engaging in the provision of medical or dental service when mentally or physically unable to safely do so;
- (q) Billing TennCare an amount that is greater than the provider's usual and customary charge to the general public for that service;
- (r) Falsifying or causing to be falsified dates of service, dates of certification or recertification or back dating any record which results in or could result in an inappropriate cost to TennCare;
- (s) Fragmentation or submitting claims separately on the component parts of a procedure instead of claiming a single procedure code which includes the entire procedure or all component parts, when such approach results in TennCare paying a greater amount for the components than it would for the entire procedure; or,
- (t) Submitting claims for a separate procedure which is commonly carried out as a component part of a larger procedure, unless it is performed alone for a medically justified specific purpose.

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109. **Administrative History:** Original rule filed May 18, 2011; effective August 16, 2011.