

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

**CHAPTER 1200-13-21
COVERKIDS**

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1200-13-21-.01 SCOPE AND AUTHORITY.

- (1) The CoverKids program was created by the CoverKids Act of 2006, T.C.A. §§ 71-3-1101, et seq., and placed under the authority of the Tennessee Department of Finance and Administration (“Department”).
- (2) The Department is authorized to establish, administer and monitor the program, including contracting for the provision of services and adopting rules for governing the program.
- (3) The Commissioner of the Tennessee Department of Finance and Administration placed the CoverKids Program into the Division of Health Care Finance & Administration under the oversight of the Deputy Commissioner/Director of TennCare on March 31, 2011, for the purposes of coordination of resources and to achieve greater effectiveness and efficiencies. The Division was renamed the Division of TennCare effective August 7, 2017.
- (4) The purpose of the CoverKids program is to provide health care coverage for uninsured children who are not eligible for TennCare coverage.
- (5) The CoverKids program is a federal program, the “State Child Health Plan Under Title XXI of the Social Security Act State Children’s Health Insurance Program” and is distinct and separate from the Title XIX TennCare program.

Authority: T.C.A. §§ 4-5-202, 71-3-1103 through 1108, 71-3-1110, and the Tennessee Title XXI Children’s Health Insurance Program State Plan. **Administrative History:** Original rules filed November 28, 2018; effective February 26, 2018.

1200-13-21-.02 DEFINITIONS.

- (1) Covered services. Benefits listed in this Chapter and authorized by the Plan Administrator or Dental Benefits Manager.
- (2) CoverKids. The program created by T.C.A. §§ 71-3-1101, et seq., its authorized employees and agents, as the context of this Chapter requires.
- (3) CoverKids network. A group of health care providers that have entered into contracts with the Plan Administrator or Dental Benefits Manager to furnish covered services to CoverKids enrollees. These contracts may take the form of general contracts or single case agreements.
- (4) CoverKids provider. An appropriately licensed institution, facility, agency, person, corporation, partnership or association, that delivers health care services and that participates in the Plan Administrator’s or Dental Benefits Manager’s network.

(Rule 1200-13-21-.02, continued)

- (5) Days. Calendar days, not business days.
- (6) Dental Benefits Manager (DBM). The entity responsible for the administrative services associated with providing covered dental services, preventive, routine and orthodontic, to CoverKids enrollees.
- (7) Emergency services. Includes emergency medical, emergency mental health and substance abuse emergency treatment services, furnished by a provider qualified to furnish the services, needed to evaluate, treat, or stabilize an emergency medical condition manifested by the sudden and unexpected onset of acute symptoms of sufficient severity, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:
 - (a) Placing the person's (or with respect to a pregnant woman, her unborn child's) health in serious jeopardy;
 - (b) Serious impairment to bodily functions; or
 - (c) Serious dysfunction of any bodily organ or part.
- (8) Medically necessary. A medical item or service which meets all the following criteria:
 - (a) Recommended by a licensed physician who is treating the enrollee or other licensed healthcare provider practicing within his scope of licensure who is treating the enrollee;
 - (b) Required in order to diagnose or treat an enrollee's medical condition;
 - (c) Safe and effective;
 - (d) The least costly alternative course of diagnosis or treatment that is adequate for the medical condition of the enrollee; and
 - (e) Not experimental or investigational.
- (9) Non-CoverKids provider. A health care provider of non-emergency services that does not participate in the Plan Administrator's or Dental Benefits Manager's network.
- (10) Parent. A natural or adoptive father or mother of a minor child; or, a guardian as defined by T.C.A. § 34-1-101, subject to court orders entered or recognized by the courts of the state of Tennessee.
- (11) Plan Administrator or PA. The entity or entities responsible for the administrative services associated with providing health care, pharmaceutical or other related services to CoverKids enrollees. This may be a private contractor, government agency, or Departmental entity.

Authority: T.C.A. §§ 4-5-202, 71-3-1106, 71-3-1110, and the Tennessee Title XXI Children's Health Insurance Program State Plan. **Administrative History:** Original rules filed November 28, 2018; effective February 26, 2018.

1200-13-21-.03 ELIGIBILITY. Financial and Technical Eligibility Requirements. See Chapter 1200-13-20.

Authority: T.C.A. §§ 4-5-202, 71-3-1106, 71-3-1110, and the Tennessee Title XXI Children's Health Insurance Program State Plan. **Administrative History:** Original rules filed November 28, 2018; effective February 26, 2018.

1200-13-21-.04 BENEFITS.

- (1) The following benefits are covered by the CoverKids program for children under age 19 as medically necessary, subject to the limitations stated:
 - (a) Ambulance services, air and ground.
 - (b) Care coordination services.
 - (c) Case management services.
 - (d) Chiropractic care. Maintenance visits not covered when no additional progress is apparent or expected to occur.
 - (e) Clinic services and other ambulatory health care services.
 - (f) Dental benefits:
 1. Dental services. Limited to a \$1,000 annual benefit maximum per enrollee.
 2. Orthodontic services. Limited to a \$1,250 lifetime benefit maximum per enrollee. Covered only after a 12-month waiting period.
 - (g) Disposable medical supplies.
 - (h) Durable medical equipment and other medically-related or remedial devices:
 1. Limited to the most basic equipment that will provide the needed care.
 2. Hearing aids are limited to one per ear per calendar year up to age 5, and limited to one per ear every two years thereafter.
 - (i) Emergency care.
 - (j) Home health services. Prior approval required. Limited to 125 visits per enrollee per calendar year.
 - (k) Hospice care.
 - (l) Inpatient hospital services, including rehabilitation hospital services.
 - (m) Inpatient mental health and substance abuse services.
 - (n) Laboratory and radiological services.
 - (o) Outpatient mental health and substance abuse services.
 - (p) Outpatient services.
 - (q) Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders. Limited to 52 visits per calendar year per type of therapy.
 - (r) Physician services.
 - (s) Prenatal care and prepregnancy family services and supplies.

(Rule 1200-13-21-.04, continued)

- (t) Prescription drugs.
- (u) Routine health assessments and immunizations.
- (v) Skilled Nursing Facility services. Limited to 100 days per calendar year following an approved hospitalization.
- (w) Surgical services.
- (x) Vision benefits:
 - 1. Annual vision exam including refractive exam and glaucoma screening.
 - 2. Prescription eyeglass lenses. Limited to one pair per calendar year. \$85 maximum benefit per pair.
 - 3. Eyeglass frames. Coverage for replacement frames limited to once every two calendar years. \$100 maximum benefit per pair.
 - 4. Prescription contact lenses in lieu of eyeglasses. Limited to one pair per calendar year. \$150 maximum benefit per pair.
- (2) Mothers of eligible unborn children who are over age 19 receive all benefits listed in Paragraph (1), subject to the same limitations and as medically necessary, except chiropractic services, routine dental services, and vision services are not covered for these enrollees.
- (3) All services covered by CoverKids must be medically necessary.
- (4) The following services and items are excluded from coverage by the CoverKids program:
 - (a) Comfort or convenience items not related to an enrollee's illness.
 - (b) Dietary guidance services.
 - (c) Homemaker or housekeeping services.
 - (d) Maintenance visits when no additional progress is apparent or expected to occur.
 - (e) Meals.
 - (f) Medical social services.
 - (g) Non-treatment services.
 - (h) Private duty nursing services.
 - (i) Routine transportation.

Authority: T.C.A. §§ 4-5-202, 71-3-1106, 71-3-1110, and the Tennessee Title XXI Children's Health Insurance Program State Plan. **Administrative History:** Original rules filed November 28, 2018; effective February 26, 2018.

1200-13-21-.05 COST SHARING.

- (1) There are no premiums or deductibles required for participation in CoverKids.
- (2) Copays.
 - (a) The following services are exempt from copays:
 1. Ambulance services.
 2. Emergency services.
 3. Lab and X-ray services.
 4. Maternity services. There are no copays for prenatal visits or for hospital admissions for the birth of a child.
 5. Routine health assessments and immunizations given under American Academy of Pediatrics guidelines.
 - (b) The following copays are required, based on the enrollee's household income:

| Service | Copay When Household Income is Less than 200% FPL | Copay When Household Income is Between 200% FPL and 250% FPL |
|--|---|---|
| MEDICAL BENEFITS | | |
| Chiropractic care | \$5 per visit | \$15 per visit |
| Emergency room | \$10 copay per use for non-emergency | \$50 copay per use for non-emergency |
| Hospital admissions and other inpatient services | \$5 per admission (waived if readmitted within 48 hours for same episode) | \$100 per admission (waived if readmitted within 48 hours for same episode) |
| Inpatient mental health and substance abuse treatment | \$5 per admission (waived if readmitted within 48 hours for same episode) | \$100 per admission (waived if readmitted within 48 hours for same episode) |
| Outpatient mental health and substance abuse treatment | \$5 per session | \$15 per session |
| Physical, speech, and occupational therapy | \$5 per visit | \$15 per visit |
| Physician office visit | \$5 per visit (primary care); \$5 per visit (specialist) | \$15 per visit (primary care); \$20 per visit (specialist) |
| Prescription drugs | \$1 generic; \$3 preferred brand; \$5 non-preferred brand | \$5 generic; \$20 preferred brand; \$40 non-preferred brand |
| Vision services | \$5 for lenses; \$5 for frames (when lenses and frames are ordered at the same time, only one copay is charged) | \$15 for lenses; \$15 for frames (when lenses and frames are ordered at the same time, only one copay is charged) |
| DENTAL BENEFITS | | |
| Dental services | \$5 per visit No copay for routine preventive oral exam, X-rays, and fluoride application | \$15 per visit No copay for routine preventive oral exam, X-rays, and fluoride application |

(Rule 1200-13-21-.05, continued)

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| Orthodontic services | \$5 per visit | \$15 per visit |
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- (3) An enrollee's annual cost sharing obligations shall not exceed 5 percent of his household's annual income.
- (4) Eligible children who do not pay a required copay remain enrolled in the program. An individual provider may at his discretion refuse service for non-payment of a copay unless a medical emergency exists. The state does not participate in collection action or impose any benefit limitations if enrollees do not pay their copays.

Authority: T.C.A. §§ 4-5-202, 71-3-1106, 71-3-1110, and the Tennessee Title XXI Children's Health Insurance Program State Plan. **Administrative History:** Original rules filed November 28, 2018; effective February 26, 2018.

1200-13-21-.06 DISENROLLMENT.

- (1) Grounds for Disenrollment from CoverKids. Children enrolled in CoverKids at or below 250% of the FPL are financially eligible for 12 months, except in the following situations which will result in disenrollment from CoverKids coverage prior to the end of the 12 month period:
 - (a) An enrollee, through an authorized family member, requests disenrollment.
 - (b) Admission of a CoverKids enrollee into a correctional facility or an institution for mental disease.
 - (c) A CoverKids enrollee moves from the state.
 - (d) Death of a CoverKids enrollee.
 - (e) A CoverKids enrollee is enrolled in TennCare.
 - (f) A CoverKids enrollee meets a TennCare Medicaid spend-down.
 - (g) A CoverKids enrollee turns age 19.
 - (h) A woman 19 or older who was enrolled because of pregnancy is no longer eligible after the last day of the month in which the sixtieth postpartum day occurs.
 - (i) A CoverKids enrollee is discovered not to have been eligible for CoverKids at the time of enrollment. This includes, but is not limited to, enrollees whose enrollment was obtained by fraud or misrepresentation by an enrollee, parent, guardian, or representative.
- (2) Procedures. Disenrollment shall be conducted as set out in Chapter 1200-13-19.

Authority: T.C.A. §§ 4-5-202, 71-3-1106, 71-3-1110, and the Tennessee Title XXI Children's Health Insurance Program State Plan. **Administrative History:** Original rules filed November 28, 2018; effective February 26, 2018.

1200-13-21-.07 REVIEW OF COVERKIDS DECISIONS.

- (1) Eligibility and Enrollment Matters. Administrative review of matters related to eligibility and enrollment shall be conducted as set out in Chapter 1200-13-19.
- (2) Health Services Matters. A parent or authorized representative of a CoverKids enrollee may request review of a CoverKids action to delay, deny, reduce, suspend, or terminate health

(Rule 1200-13-21-.07, continued)

services, or a failure to approve, furnish, or provide payment for health services in a timely manner, according to the following provisions:

- (a) **Notice.** Any decision denying or delaying a requested health service, reducing, suspending or terminating an existing health service, or failure to approve, furnish or provide payment for health services in a timely manner shall be in writing and must contain the reason for the determination, an explanation of review rights and procedures, the standard and expedited time frames for review, the manner of requesting a review, and the circumstances under which existing health services may continue pending review unless there is question that the existing health services are harmful.
- (b) **Plan Administrator (PA) or Dental Benefits Manager (DBM) Review.** A parent or authorized representative may commence the review process by submitting a written request to the PA or DBM within 30 days of issuance of written notice of the action or, if no notice is provided, from the time the enrollee becomes aware of the action, not to exceed six (6) months from when the action occurred. The PA or DBM will review this request and issue a written decision within 30 days of receipt of this request. Expedited reviews (within 72 hours) will be available for situations in which a benefit determination or a preauthorization denial has been made prior to services being received and the attending medical professional determines the medical situation to be life threatening or would seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain or regain maximum function. This determination should be made in legible writing with an original signature.
- (c) **State Informal Review.** After the PA's or DBM's internal review is completed, the parent or authorized representative of an enrollee who disagrees with the decision may request further review by telephone or by submitting a letter or form to the Division of TennCare, CoverKids Appeals, which must be received within 8 days of the PA's or DBM's decision. The Appeals Coordinator will review the matter and gather supplemental information from the family, physician, and/or insurer as needed. The Appeals Coordinator will request review by the state's independent medical consultant and a written decision will be issued within 20 days of receipt of the request for further review.
- (d) **State Review Committee.** If the informal review does not grant the relief requested by the parent or authorized representative, the request will be scheduled for review by the CoverKids Review Committee. The Committee will be composed of five members, including Division of TennCare staff and at least one independent licensed medical professional. The members of the Committee will not have been directly involved in the matter under review. The parent or authorized representative will be given the opportunity to review the file, be represented by a representative of the parent's or authorized representative's choice, and provide supplemental information. The Committee may allow the parent or authorized representative to appear in person if it finds that scheduling the appearance will not cause delay in the review process. The Review Committee is not required to provide an in-person hearing or a contested case under the Uniform Administrative Procedures Act. The parent or authorized representative will receive written notification of the final decision stating the reasons for the decision. The decision of the CoverKids Review Committee is the final administrative recourse available to the member.
- (e) **Time for Reviews.** Review of all non-expedited health or dental services appeals will be completed within 90 days of receipt of the initial request for review by the PA or DBM. Reviews by both the Appeals Coordinator and the Committee may be expedited (completed within 72 hours at each of the PA or DBM and State levels) for situations in which a benefit determination or a preauthorization denial has been made prior

(Rule 1200-13-21-.07, continued)

to services being received and the attending medical professional determines the medical situation to be life threatening or would seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain or regain maximum function. This determination should be made in legible writing with an original signature.

- (3) Scope of Review. CoverKids will not provide a review process for a change in enrollment, eligibility, or coverage under the health benefits package required by a change in the State plan or Federal and State law requiring an automatic change that affects all or a group of applicants or enrollees without regard to their individual circumstances.

Authority: T.C.A. §§ 4-5-202, 71-3-1106, 71-3-1110, and the Tennessee Title XXI Children's Health Insurance Program State Plan. **Administrative History:** Original rules filed November 28, 2018; effective February 26, 2018.

1200-13-21-.08 PROVIDERS.

- (1) Payment in full.
 - (a) All CoverKids providers, as defined in this rule, must accept as payment in full for provision of covered services to a CoverKids enrollee, the amount paid by the PA or DBM, plus any copayment required by the CoverKids program to be paid by the individual.
 - (b) Any non-CoverKids providers who furnish CoverKids covered services by authorization from the PA or DBM must accept as payment in full for provision of covered services to CoverKids enrollees the amounts paid by the PA or DBM plus any copayment required by the CoverKids program to be paid by the individual.
 - (c) CoverKids will not pay for non-emergency services furnished by non-CoverKids providers unless these services are authorized by the PA or DBM. Any non-CoverKids provider who furnishes CoverKids Program covered non-emergency services to a CoverKids enrollee without authorization from the PA or DBM does so at his own risk. He may not bill the patient for such services except as provided in Paragraph (3).
- (2) Non-CoverKids Providers.
 - (a) When the PA or DBM authorizes a service to be rendered by a non-CoverKids provider, payment to the provider shall be no less than 80% of the lowest rate paid by the PA or DBM to equivalent participating CoverKids network providers for the same service, consistent with the methodology contained in Rule 1200-13-13-.08(2)(a).
 - (b) Covered medically necessary outpatient emergency services, when provided to CoverKids enrollees by non-CoverKids network hospitals, shall be reimbursed at 74% of the 2006 Medicare rates for the services, consistent with the methodology contained in Rule 1200-13-13-.08(2)(b). Emergency care to enrollees shall not require preauthorization.
 - (c) Covered medically necessary inpatient hospital admissions required as the result of emergency outpatient services, when provided to CoverKids enrollees by non-CoverKids network hospitals, shall be reimbursed at 57% of the 2008 Medicare DRG rates (excluding Medical Education and Disproportionate Share components) determined according to 42 CFR § 412 for the services, consistent with the methodology contained in Rule 1200-13-13-.08(2)(c). Such an inpatient stay will continue until no longer medically necessary or until the patient can be safely transported to a network hospital, whichever comes first.

(Rule 1200-13-21-.08, continued)

- (3) Providers may seek payment from a CoverKids enrollee only under the following circumstances. These circumstances include situations where the enrollee may choose to seek a specific covered service from a non-CoverKids provider.
 - (a) If the services are not covered by the CoverKids program and, prior to providing the services, the provider informed the enrollee that the services were not covered.
 - (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 has information in her own records to support the fact that the enrollee has reached his 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 CoverKids. 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 the benefit limit is still in effect;
 - (ii) That the provider had personally provided services to the enrollee in excess of his benefit limit within the same benefit category as the service being requested, if the time period applicable to that benefit period is still in effect; or
 - (iii) The enrollee's PA or DBM has provided confirmation to the provider that the enrollee has reached his benefit limit for the applicable service.
 2. The provider submits a claim for service to the PA or DBM and receives a written denial of that claim on the basis that the service exceeds the enrollee's benefit limit. After informing the enrollee and within the remainder of the period applicable to that benefit limit, the provider may bill the enrollee for services within that same exhausted benefit category without having to submit claims for those subsequent services for repeated PA or DBM denial. If the provider informed the enrollee prior to providing the service for which the claim was denied that the service would exceed the enrollee's benefit limit and would not be paid for by CoverKids, the provider may bill the enrollee for that service.
 3. The provider had previously taken the steps in parts 1. or 2. above and determined that the enrollee had reached his benefit limit for the particular service being requested, if the time period applicable to the 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 CoverKids.
 - (c) If the services are covered only with prior authorization and prior authorization has been requested but denied, or is requested and a specified lesser level of care is approved, and the provider has given prior notice to the enrollee that the services are not covered, the enrollee may elect to receive those services for which prior authorization has been denied or which exceed the authorized level of care and be billed by the provider for such services.
- (4) Providers may not seek payment from a CoverKids enrollee under the following conditions:
 - (a) The provider knew or should have known about the patient's CoverKids enrollment prior to providing services.

(Rule 1200-13-21-.08, continued)

- (b) The claim submitted to the PA or DBM for payment was denied due to provider billing error or a CoverKids claim processing error.
 - (c) The provider accepted CoverKids assignment on a claim and it is determined that another payer paid an amount equal to or greater than the CoverKids allowable amount.
 - (d) The provider failed to comply with CoverKids policies and procedures or provided a service which lacks medical necessity or justification.
 - (e) The provider failed to submit or resubmit claims for payment within the time periods required by the PA or DBM or CoverKids.
 - (f) The provider failed to inform the enrollee prior to providing a service not covered by CoverKids that the service was not covered and the enrollee may be responsible for the cost of the service. Services which are non-covered by virtue of exceeding limitations are exempt from this requirement if the provider has complied with paragraph (3) above.
 - (g) The enrollee failed to keep a scheduled appointment(s).
- (5) Pharmacy providers may not waive pharmacy copayments for CoverKids enrollees as a means of attracting business to their establishments. This does not prohibit a pharmacy from exercising professional judgment in cases where an enrollee may have a temporary or acute need for a prescribed drug, but is unable, at that moment, to pay the required copayment.

Authority: T.C.A. §§ 4-5-202, 71-3-1106, 71-3-1110, and the Tennessee Title XXI Children's Health Insurance Program State Plan. **Administrative History:** Original rules filed November 28, 2018; effective February 26, 2018.