

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

**CHAPTER 1200-13-1  
GENERAL RULES**

**TABLE OF CONTENTS**

1200-13-1-.01	Definitions	1200-13-1-.18	Criteria for Medicaid Reimbursement for Home Health
1200-13-1-.02	Eligibility	1200-13-1-.19	Medicaid Assurance of Transportation
1200-13-1-.03	Amount, Duration, and Scope of Assistance	1200-13-1-.20	Communication Aid Device
1200-13-1-.04	Third Party Resources	1200-13-1-.21	Provider Noncompliance or Fraud of Medicaid Program
1200-13-1-.05	Providers	1200-13-1-.22	Medicaid Coverage of Services for Certified Nurse-Midwives
1200-13-1-.06	Provider Reimbursement	1200-13-1-.23	Nursing Home Preadmission Screenings for Mental Illness and Mental Retardation
1200-13-1-.07	Medicaid Exclusions	1200-13-1-.24	Criteria for Medicaid Reimbursement for Community Mental Health Clinics
1200-13-1-.08	Admissions to Long-Term Care Facilities	1200-13-1-.25	Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled
1200-13-1-.09	Third Party Signature	1200-13-1-.26	Home and Community Based Services Waiver for the Elderly and Disabled in Davidson, Hamilton, and Knox Counties
1200-13-1-.10	Criteria for Medicaid Reimbursement of Care in Nursing Facilities	1200-13-1-.27	Home and Community Based Services Waiver for the Elderly and Disabled in Shelby County
1200-13-1-.11	Recipient Abuse and Overutilization of Medicaid Program		
1200-13-1-.12 through 1200-13-1-.14	Repealed		
1200-13-1-.15	Criteria for Medicaid Reimbursement of Care in an Intermediate Care Facility for the Mentally Retarded (ICF/MR).		
1200-13-1-.16	Medicaid Dental Program		
1200-13-1-.17	Statewide Home and Community Based Services Waiver for the Elderly and Disabled		

**1200-13-1-.01 DEFINITIONS.**

- (1) Nursing Facility shall mean that as defined in 42 USCA 1395X(j) as of the effective date of these rules.
- (2) Intermediate Care Facility shall mean that as defined in 42 USCA 1396 (d) as of the effective dates of these rules.
- (3) Physician means a doctor of medicine or osteopathy who has received a degree from an accredited medical school and licensed to practice their profession in this state.
- (4) Provider means any person, institution, agency, or business concern providing medical care services or goods authorized under these rules, holding, where applicable, a current valid license to provide such services or to dispense such goods.
- (5) Categorically needy shall mean those individuals determined to be categorically needy by the Tennessee Department of Human Services pursuant to Rule 1240-3-2-.02, *Official Compilation of the Rules and Regulations of the State of Tennessee*.
- (6) Medically needy shall mean those individuals determined to be medically needy by the Tennessee Department of Human Services pursuant to Rule 1240-3-2-.03, *Official Compilation of the Rules and Regulations of the State of Tennessee*.
- (7) Durable medical equipment shall mean equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury, and is appropriate for use in the home.
- (8) Medical supplies shall mean expendable items that are primarily and customarily used to serve a medical purpose and generally are not useful to a person in the absence of illness or injury.

(Rule 1200-13-1-.01, continued)

- (9) Emergency medical condition means a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to potentially 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.
- (10) Prosthetic devices covered under the Home Health or Medical Vendor Program are devices which replace all or part of a missing portion of the body.
- (11) Orthotic appliances are rigid and semi-rigid devices which are used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body. Elastic stockings and similar devices do not come within the scope of this definition.
- (12) The recipient's place of residence is wherever he/she makes his/her home. Institutions that meet the definition of a hospital, a nursing facility or an intermediate care/mental retardation facility, are not considered the recipient's place of residence for coverage of home medical equipment or medical supplies under the Medicaid program.
- (13) Applicant shall mean any person who seeks admission to a Long-term Care Facility and is not limited to those persons who have completed an official application or have complied with the Long-term Care Facility's preadmission requirements. The term shall include all persons who have affirmatively expressed an intent to be considered for current or future admission to the Long-term Care Facility or requested that their name be entered on any "wait list". Persons who only make casual inquiry concerning the Long-term Care Facility or its admission practices, who request information on these subjects, or who do not express any intention that they wish to be actively considered for admission shall not be considered applicants. All persons, whether applicants or non-applicants, who contact a Long-term Care Facility to casually inquire about the facility's services or admissions policies shall be informed by the facility of that person's right to apply for admission and be considered for admission on a nondiscriminatory basis and in conformance with Rule 1200-13-1-.08.
- (14) Medicaid eligible shall mean a person who has been determined by the Tennessee Department of Human Services or the Social Security Administration to be financially eligible to have Medicaid make reimbursement for covered services.
- (15) Medically Entitled shall mean a person who has a Pre-Admission Evaluation (PAE) that has been certified by a physician and that has been approved by the Department.
- (16) Involuntary transfer or discharge shall Mean any transfer or discharge that is opposed by the resident or a representative of the resident. For purposes of compliance with the requirements of Rule 1200-13-1-.05(18), a discharge or transfer is involuntary when the Long-term Care Facility initiates the action to transfer or discharge.
- (17) Notice, when used in regulations pertaining to Long-term Care Facilities, shall mean notification that must be provided by the facility to "residents" or "applicants," and shall also include notification to the person identified in a PAE application as the resident's or applicant's designated representative and any other individual who is authorized by law to act on the resident's or applicant's behalf or who is in fact acting on the resident's or applicant's behalf in dealing with the Long-term Care Facility.

(Rule 1200-13-1-.01, continued)

- (18) Adjudicated claim shall mean a request for payment submitted by a provider, as described in rule 1200-13-1-.05, that has reached final disposition such that it has either been paid or denied.
- (19) Provider's usual and customary charge for a covered service means the uniform amount which the individual provider charges to the general public for a specific medical procedure or service.
- (20) Reserved
- (21) Presumptive eligibility shall mean temporary eligibility granted to a pregnant woman whose family income is at or below a specified percentage of the federal poverty level in order for the woman to receive ambulatory prenatal care services.
- (22) Qualified Medicare Beneficiary (QMB) shall mean any individual who meets the income and resource standards set forth in the Medicare Catastrophic Coverage Act of 1988 and is designated as a Qualified Medicare Beneficiary.

**Authority:** T.C.A. 4-5-202, 71-5-105, 71-5-109, Executive Order No. 11.. **Administrative History:** Original rule filed September 10, 1975; effective October 10, 1975. Repealed and refiled July 13, 1977; effective August 12, 1977. Repealed and refiled November 17, 1977; effective December 19, 1977. Amendment filed August 31, 1981; effective October 15, 1981. Amendment filed June 27, 1984; effective July 27, 1984. Amendment filed February 9, 1987; effective April 9, 1987. Amendment filed May 30, 1989; effective July 14, 1989. Amendment filed November 28, 1990; effective January 12, 1991. Amendment filed February 22, 1991; effective April 9, 1991. Amendment filed September 16, 1991; effective October 31, 1991. Amendment filed September 19, 1991; effective November 3, 1991. Amendment filed January 10, 1992; effective February 24, 1992. Amendment filed May 1, 1992; effective June 15, 1992. Amendment filed October 20, 1999; effective January 3, 2000. Amendment filed June 29, 2000; effective September 12, 2000.

#### **1200-13-1-.02 ELIGIBILITY.**

- (1) The Department of Health and Environment accepts the eligibility dates for Medicaid recipients as determined by the Department of Human Services and the Department of Health, Education and Welfare-Social Security.

In effectuating the provisions of Chapter 177, Public Acts of 1979, the Department of Health and Environment shall be guided by the following federal requirements defining eligibility for benefits.

When eligibility is determined for the adult categories in Medicaid, the Department of Human Services will follow the regulations as set out in the Social Security Act, Sections 1614 (f)(1) and 1614 (f)(2) which provide:

- (a) (f)(1) For purposes of determining eligibility for and the amount of benefits for any individual who is married and whose spouse is living with him in the same household but is not an eligible spouse, such individual's income and resources shall be deemed to include any income and resources of such spouse, whether or not available to such individual, except to the extent determined by the Secretary to be inequitable under the circumstances. (42 USCA 1382c(f)(1).)
  - (b) (2) For purposes of determining eligibility for and the amount of benefits for any individual who is a child under age 21, such individual's income and resources shall be deemed to include any income and resources of a parent of such individual who is living in the same household as such individual, whether or not available to such individual, except to the extent determined by the Secretary to be inequitable under the circumstances.
- (2) Eligible individuals may be entitled to medical assistance during the three months preceding the month of application. Coverage is provided for any full month provided the individual met all the eligibility conditions at any time during the month.

(Rule 1200-13-1-.02, continued)

- (3) Eligibility data furnished Fiscal Agent on eligible individuals by providers will include both the Medicare identification number (SSA claim number), where appropriate, and the Medicaid identification number (recipient number), for each individual.
- (4) In the aid for dependent children category the present income of parents to the children will be considered in determination of eligibility in the same manner as is used in determining eligibility for cash assistance. Only those individuals who are cash recipients of the Aid to Families With Dependent Children Program or the Supplementary Security Income Program will be eligible for the Department to purchase Part B premiums for those benefits available under Part B of Title XVIII of the Social Security Act.
- (5) In institutional cases the income of legally responsible relatives will be considered in the amount actually contributed to an applicant for Medicaid.
- (6) In cases of disability, the effective date for Medicaid coverage shall be established retroactive to the date of eligibility as established by the Department of Human Services, provided that all conditions of eligibility were met, as determined from the application for assistance. If the initial application was denied but the decision subsequently reversed, the effective date for Medicaid coverage shall be established retroactive to the date of eligibility as established by the Department of Human Services, provided that all conditions of eligibility were met, as determined from the application for assistance.
- (7) The Department of Health and Environment in conjunction with the Department of Human Services will develop a program to increase collections from absent parents for medical care and services provided their legal children.
- (8) When funds from any of the above sources are identified, the Department of Health and Environment will make demand on the party for payment. If payment is not made to the Department, the Department will furnish the Attorney General all the facts and information available and request the Attorney General to take appropriate action.

**Authority:** T.C.A. §§14-23-105, 14-23-109, and 4-5-202. **Administrative History:** Original rule filed November 17, 1977; effective December 19, 1977. Amendment filed December 31, 1979; effective February 14, 1980. Amendment filed May 26, 1983; effective June 27, 1983. Amendment filed September 16, 1987; effective October 31, 1987. Amendment filed November 10, 1988; effective December 25, 1988. Public necessity rule filed January 30, 2006; effective through July 14, 2006. Public necessity rule filed January 30, 2006, expired on July 14, 2006. On July 15, 2006, rule reverted to status in effect on January 29, 2006.

#### **1200-13-1-.03 AMOUNT, DURATION, AND SCOPE OF ASSISTANCE.**

- (1) Medically necessary medical assistance available to eligible categorically needy and medically needy individuals for which participating providers will be reimbursed after compliance with Medicaid policies and procedures as defined in current rules, regulations, provider manuals, and bulletins and submission of a properly completed claim shall be in the following amount, duration, and scope:
  - (a) Inpatient hospital services other than those provided in an institution for mental disease and those associated with approved organ transplants shall be covered as medically necessary. The first twenty (20) days per fiscal year will be reimbursed at 100 percent of the operating component plus 100 percent of the capital, direct and indirect education, return on equity (for proprietary providers only), and Medicaid Disproportionate Share Adjustment (MDSA) components. For days in excess of twenty (20), reimbursement will be made at 60 percent of the operating component plus 100 percent of the capital, direct and indirect education, return on equity (for proprietary providers only), and MDSA components. Transplants involving heart, liver and bone marrow shall be limited to the number of inpatient days as specified in rule 1200-13-1-.06(18)(f)2. and will be reimbursed at 100 percent of the operating component plus 100 percent of the capital, direct and indirect education, return on equity (for proprietary providers

(Rule 1200-13-1-.03, continued)

only), and MDSA components. Admissions and stays involving organ transplants that span fiscal years will be reimbursed as if the entire stay had occurred during the first fiscal year. Any hospital days paid by insurance or other third party benefits will be considered to be days paid by the Medicaid program. Friday and Saturday admissions will be limited to emergencies or surgery the same or next day.

- (b) Out-Patient hospital services will be limited to thirty visits per fiscal year.
- (c) Laboratory and x-ray services, other than inpatient hospital, will be covered but limited to services provided on thirty occasions per fiscal year. An occasion is interpreted to mean laboratory and/or x-ray services performed during a recipient visit, i.e., to a radiologist; or to procedures, i.e., laboratory tests performed for recipient on a given day by an independent laboratory.
- (d) Skilled Nursing Facility services (other than services in an institution for tuberculosis mental diseases) will be covered.
- (e) Early periodic screening and diagnosis of individuals under 21 years of age and treatment of conditions found will be covered for eligible recipients. Those individuals receiving EPSDT services shall be allowed up to twenty days of inpatient hospital services and twenty physician inpatient hospital visits per fiscal year.
- (f) Family planning services and supplies for individuals of child bearing age will be covered as required by agreement between Medicaid and Family Planning Services.
- (g) Physicians services will be limited to the following visits per fiscal year:
  - 1. Twenty-four (24) office visits. Visits made pursuant to subparagraphs (hh) and (ll) of rule 1200-13-1-.03(l) will count toward this limit.
  - 2. Inpatient hospital visits will be limited to twenty (20) except that when transplant procedures occur, the total limit will increase as described in Rule 1200-13-1-.06(18)(f)2.
  - 3. Inpatient psychiatric hospital visits will be limited to the corresponding number of approved inpatient days.
- (h) Routine vision care services shall be covered for recipients under age 21 and limited to the following benefits:
  - 1. One (1) eye examination for the treatment and/or diagnosis of refractive error per fiscal year.
  - 2. One (1) pair of eyeglasses (frames and lenses) per fiscal year. Contact lenses, in lieu of eyeglasses, will be reimbursed only with justification that they are medically necessary.
  - 3. One (1) pair of replacement eyeglasses or contact lenses (subject to the conditions in 2. above) per fiscal year. The previously provided eyeglasses or contact lenses:
    - (i) must have been lost; or
    - (ii) must have been broken or damaged beyond repair; or
    - (iii) are no longer usable due to a change in the recipient's vision so that a new prescription is required.

(Rule 1200-13-1-.03, continued)

4. Services in excess of the limits described above may be reimbursed when prior authorization for medical necessity is obtained from Medicaid.
- (i) Home health services will be covered with a limit of 60 visits per recipient per fiscal year when the following conditions, described in rule 1200-13-1-.18, are met:
    1. The recipient has been determined homebound after physical examination by a physician;
    2. The home health services are medically necessary, ordered and certified/recertified by a physician having personal knowledge of the recipient; and
    3. The services are provided pursuant to a plan of care developed by the physician pursuant to 1200-13-1-.05(12) and 1200-13-1-.18 of these rules.
    4. The services are not provided to a recipient who resides in a Nursing Facility, or an Intermediate Care Facility for the Mentally Retarded, except for physical therapy services in a Nursing Facility which provides Level I care and which does not otherwise provide physical therapy services.
  - (j) Community Health Clinics; Rural Health Clinics; Ambulatory Surgical Treatment Centers; and Neighborhood Health Organizations services will be covered.
  - (k) Dental services will be covered with limitations as set out in rule 1200-13-1-.16.
  - (l) One complete hearing evaluation per fiscal year will be covered for eligible individuals under 21 years of age when performed in a State approved speech and hearing center. This complete hearing evaluation may be conducted as a result of an EPSDT referral or on a self identification basis. The prescribing, changing and fitting of hearing aids are covered for individuals under the age of 21 when performed in a State approved speech and hearing center. Hearing aids are furnished within the following limitations per fiscal year: (a) one complete hearing aid examination; (b) one hearing aid or aids and molds for each year as recommended as a result of the hearing aid evaluation; and (c) replacement of lost, stolen or broken aids will be made only by prior approval. Audiology testing services will be covered for all eligibles when performed by or under the supervision of a physician and rendered as a necessary part of treatment services.
  - (m) Prescribed drugs will be covered as listed in the Tennessee Department of Health and Environment Title XIX Drug Formulary. Each recipient will be limited to a maximum of 7 prescriptions and/or refills per month.
  - (n) Dentures will be covered but limited to individuals under 21 years of age requiring dentures.
  - (o) Prosthetic and orthotic devices will be covered on the written request of the attending physician and proper documentation of medical necessity. Prior approval is required for any prosthetic device or orthotic appliance for which the billed amount is \$150.00 or more. Orthotic shoes or other supportive devices for the feet are not covered unless the shoe is attached permanently to a leg brace.
  - (p) Inpatient hospital services for individuals age 65 and older in institutions of tuberculosis will be covered.
  - (q) Skilled Nursing Facility services for individuals age 65 or older in institutions for tuberculosis will be covered.

(Rule 1200-13-1-.03, continued)

- (r) Intermediate Care Facility services for individuals age 65 or older in institutions for tuberculosis will be covered for those who require institutional health services below the level of care rendered in skilled nursing facilities.
- (s) Inpatient hospital services for individuals age 65 or older in institutions for mental diseases will be covered.
- (t) Skilled Nursing Facility services for individuals age 65 or older in institutions for mental diseases will be covered, after initial authorization is granted by the Department based on the daily need of skilled patient prepared by the attending physician in terms of the plan of treatment and patient evaluation.
- (u) Intermediate Care Facility services for individuals age 65 or older in institutions for mental diseases will be covered for those who require institutional health services below the level of care rendered in skilled nursing facilities.
- (v) Intermediate Care Facility services other than services in an institution for tuberculosis or mental diseases will be covered.
- (w) Acute inpatient psychiatric services shall be provided as follows:
  - 1. According to the following definitions when used in Rule 1200-13-1-.03(l)(w) inclusive, unless otherwise indicated as follows:
    - (i) Psychiatric Emergency - Sudden onset of a psychiatric condition manifesting itself by acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in serious dysfunction of any bodily organ/part or death of the individual or harm to another person by the individual.
    - (ii) Acute Psychiatric Inpatient Care-Hospital based treatment provided under the direction of a physician for a psychiatric condition which has a relatively sudden onset and a short, severe course. The psychiatric condition should be of such a nature as to pose a significant and immediate danger to self, others, or the public safety or one which has resulted in marked psychosocial dysfunction or grave mental disability of the patient. The therapeutic intervention should be aggressive and aimed towards expeditiously moving the patient to a less restricted environment.
    - (iii) Elective Admission-Any admission which is non-emergency or does not involve transfer from one hospital to another.
    - (iv) Non-Elective Admission-Admission which involves an emergency or involves transfer from one hospital to another.
    - (v) Pre-Approval Certification Review-The review and approval process which assures that ambulatory care resources available in the community do not meet the needs of the recipient; that proper treatment of the recipient's psychiatric condition requires services on an acute inpatient basis under the direction of a physician; and that upon admission acute psychiatric services can reasonably be expected to improve the recipient's condition or prevent further regression so that such services will no longer be needed.
    - (vi) Concurrent Review-A review to determine if there is a need for continued acute inpatient treatment in the psychiatric facility, to be performed at no greater than 30

(Rule 1200-13-1-.03, continued)

day intervals. The criteria used for concurrent reviews will be the same as those used for pre-approval reviews.

- (vii) Independent Team Review-An individualized in-hospital case review performed by a three member professional team at 120 day intervals after admission to determine if there is a need for continued acute inpatient treatment in the psychiatric facility.
  - (viii) Telephone Review-A pre-approval certification review or concurrent review in which a recipient's case is reviewed over the telephone.
  - (ix) Face to Face Review-A pre-approval certification review or concurrent review in which a recipient, his treating clinicians or both are seen personally by a clinical professional designated by the contractor at a location convenient to the recipient. A patient will not be required to leave the facility for a concurrent review. Reviews will first be conducted by telephone. A face to face review will be requested only when the telephone review provides insufficient clinical information upon which to make a decision.
  - (x) Criteria-The criteria for acute psychiatric care are based on multiaxial diagnosis contained in the Diagnostic and Statistical Manual of Mental Disorders (Third Edition - Revised) published by the American Psychiatric Association. The diagnostic ratings plus clinical information must confirm that the patient's condition is not amenable to outpatient treatment and requires admission to an acute inpatient psychiatric facility.
  - (xi) Working day - Monday through Friday, 9:00 a.m. to 5:00 p.m., excluding State holiday.
  - (ix) Patient-A child or adolescent under age 21 with a currently valid Medicaid I.D. card.
  - (xiii) Guardian-The patient's parent, patient's legal guardian, guardian ad litem
2. Under the direction of a physician;
  3. By a psychiatric facility or a distinct unit of an acute care hospital accredited as a "psychiatric facility" by the Joint Commission on Accreditation of Health Care Organizations;
  4. Before the individual reaches age 21, but if the individual was receiving the services immediately before reaching age 21 and continues to require the services, then the services may continue until he/she no longer needs the services or unto the individual reaches age 22; whichever occurs first;
  5. According to the requirements of the Code of Federal Regulations at Title 42, Part 441, Subpart D (42 CFR 441.150 through .156, effective October 1, 1981); and
  6. The recipient shall meet the following criteria as indicated in (i), (ii), (iii) and (iv) in order to be certified for admission and continued stay:
    - (i) Have a psychiatric condition/disorder which is classified as a DSM III-R (Diagnostic and Statistical Manual, Third edition, revised, 1987) Axis I diagnosis; and



(Rule 1200-13-1-.03, continued)

- (ii) Is experiencing a level of psychosocial stressors which warrants a rating on DSM III-R Axis IV of 4 (severe) or greater and has a current level of adaptive functioning which warrants a rating on DSM III-R Axis V of 50 (serious symptoms) or less; and
- (iii) Is currently experiencing problems in one of the four following categories, designated (I), (II), (III) and (IV)
  - (I) Self Care Deficit: Basic impairment of needs for nutrition, sleep, hygiene, rest, stimulation due to a DSM-II-R diagnosis (not mental retardation or developmental delay) and
    - I. Self-care deficit severe and long-standing enough to prohibit participation in any alternative in the community, including refusal to comply with treatment (i.e. refuse medications); or
    - II. Self-care deficit that places the child in a life-threatening physiological imbalance without skilled intervention and supervision (examples: dehydration, starvation states, exhaustion due to extreme hyperactivity); or
    - III. Sleep deprivation or significant weight loss.
  - (II) Impaired Safety, Threat to Self or Others: Verbalizations or gestures of intent to harm self or others, caused by mental disorder and
    - I. Threats accompanied by one of the following:
      - A. Depressed mood, or
      - B. Recent loss, or
      - C. Recent suicide attempt or gesture, or
      - D. Concomitant substance abuse; or
    - II. Verbalizations escalating in intensity; or verbalization of intent accompanied by gesture or plan; or
    - III. Disruption of safety of self, family, peer or community group.
  - (III) Impaired Thought Processes: Inability to perceive and validate reality to extent that child cannot negotiate basic environment, nor participate in family/school life, (Examples: paranoia, hallucinations, delusions) and
    - I. Impaired reality testing sufficient to prohibit participation in any community educational alternative; or
    - II. Not responsive to outpatient trial of medication, supportive care; or
    - III. Requires inpatient diagnostic evaluation to determine treatment needs.
  - (IV) Severely Dysfunctional Patterns: Family/environmental/behavioral processes which place the child at risk and

(Rule 1200-13-1-.03, continued)

- I. Documentation by mental health professional of family environment that is causing escalation of the child's symptoms or places the child at risk; or
  - II. Family situation not responsive to outpatient or community resources and interventions; or
  - III. Escalation of instability or disruption; or
  - IV. Situation does not improve with provision of economic/social resources; or
  - V. Situation does not warrant foster home placement (as determined by DHS) and child's behavior or lack of family cooperation renders participation in any alternative outpatient educational setting impossible; or
  - VI. Severe behavior prohibits any participation in any alternative educational or treatment setting in community, including day treatment, crisis stabilization and residential programs such as therapeutic boarding homes, ranches, camps that deal with conduct problems.
- (iv) In addition to providing the above information along with supporting documentation, the facility must provide a description of the plan for treatment and discharge.
7. According to the following procedures:
- (i) Pre-approval certifications review for approval of admissions to psychiatric facilities will be conducted by the Department or the Department's contractor as follows:  
  
Requests for
    - (I) Pre-approval certifications shall be requested by the admitting/attending physician or the acute inpatient psychiatric facility.
    - (II) Except for emergency admissions (discussed below at (III)), pre-approval certification of all admissions to acute inpatient psychiatric facilities shall be requested before the; Patient is admitted to the hospital.
    - (III) Pre-approval certification for emergency admissions shall be requested within fourteen (14) calendar days of the admission.
    - (IV) Pre-approval certification of individuals who apply for medical assistance while in the facility shall be requested within ten (10) working days of the date that written notification is received by the facility from the Department of Human Services before Medicaid authorizes payment and shall cover any authorized period prior to the application period for which claims are made. Upon receipt of notification from the Department of Human Services, the facility shall date stamp such notification.

(Rule 1200-13-1-.03, continued)

- (ii) At least once every thirty (30) days after the initial certification, the physician shall recertify the individual's need for continued acute inpatient service in a psychiatric facility. This recertification must be verified by the Department.
  - (iii) The acute inpatient psychiatric services must include active treatment implemented through an individual plan of care which:
    - (I) is developed and designed by a team of professionals (specified at 42 CFR 441.156, effective October 1, 1981) in consultation with the individual and his or her family or others in whose care the individual will be released after discharge. Not later than fourteen (14) days after admission, the plan shall be developed for each individual to improve his or her condition to the extent that acute inpatient care is no longer necessary and to achieve the individual's discharge from inpatient status at the earliest possible time.
    - (II) is based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the individual's situation. The plan shall include diagnoses, symptoms, complaints and complications. The plan shall indicate the need for admission and for acute inpatient psychiatric care.
    - (III) states treatment objectives and prescribes an integrated program of therapies, activities and experiences designed to meet the objectives.
    - (IV) includes all orders for medications, treatments, restorative and rehabilitative services, activities, therapies, social , diet and special procedures recommended for the health and safety of the Individual.
    - (V) sets forth a plan for continuing care including, at the appropriate time, a partial discharge plan and/or a post-discharge plan for the coordination of inpatient services with related community services to ensure continuity of care with the individuals family, school and community upon discharge.
    - (VI) is professionally supervised and shall be implemented not later than fourteen (14) days after admission.
    - (VII) is reviewed every thirty (30) days to determine that the services being provided are required on an inpatient basis and to recommend changes indicated by the individual's overall adjustment as an inpatient. The written report of each evaluation and plan of care must be entered in the individual's medical record.
8. For a duration not longer than the period during which the individual's psychiatric condition continues to require acute inpatient treatment, as provided by the federal regulations, cited above. The psychiatric facility shall monitor and evaluate this need through the processes of certification and periodic review of the plan of care. In addition, the Department will review and evaluate this need, at intervals not less frequent than every one hundred and twenty (120) days, through independent teams, as follows:
- (i) On, or before, the date of the fourth certification of the individual's need for continued acute inpatient service in a psychiatric facility, but not later than the 120th day after admission, an independent team, appointed by the Department, will evaluate the individual's need for continued acute inpatient treatment.

(Rule 1200-13-1-.03, continued)

- (ii) For so long as the individual continues to require acute inpatient treatment, independent team review and evaluation will be repeated on, or before, every fourth certification period (not later than the 120th day, the 240th day and, if the individual is still an inpatient, the 360th day et seq.). After an evaluation, an independent review team may recommend that the individual's need be reevaluated at the next certification period.
- (iii) An independent review team will consist of three (3) members, one of whom must be a psychiatric social worker. The other two (2) members will be appointed from the professional fields of clinical psychology, psychiatry with an emphasis on child and adolescent behavior, medicine with an orientation to child and adolescent psychiatry, psychiatric nursing and/or special education. After an evaluation, a team may recommend that the next evaluation of the individual include a team member with certain expertise appropriate to the case. Team members must be knowledgeable of acute inpatient psychiatric treatment.
- (iv) No member of an independent review team may be an officer or employee of state government, although a member may contract with Medicaid as a provider of medical assistance or may perform the evaluations established by this rule. No member of a team shall be an employee of, contractor with, consultant to, hold staff privileges in, or have a financial interest in the psychiatric facility in which the individual to be evaluated is being treated or any other facility with related management or ownership. No member may have knowledge of an individual to be evaluated, except that acquired through a previous evaluation.
- (v) Each member of an independent review team shall maintain the confidentiality of the information reviewed and acquired during the evaluation. Such information may be shared only with the Department for the limited purpose of administering the acute inpatient psychiatric program and with those facility personnel who are both involved in the individual's treatment and similarly bound to maintain the confidences.
- (vi) An independent team review will be conducted at the facility in which an individual to be evaluated is being treated. The independent team will review the individual's initial written treatment plan (plan of care); specific goals and projected/completed treatment milestones; progress notes and documentation of progress made against treatment plan; medications; family/significant other involvement in the treatment progress; level of function; discharge plans; therapeutic notes and psychological test results and physician's recertification of the need for continued stay. As appropriate, the team may discuss the individual with personnel involved in the treatment, and interview the individual.
- (vii) Upon concluding an independent review, the team will make a written report to the Department with one of the following recommendations:
  - (I) continuation of acute inpatient treatment in the psychiatric facility.
  - (II) the individual's psychiatric condition no longer requires acute inpatient services under the direction of a physician. Accompanying any such recommendation, the team will indicate of the information reviewed or acquired during the independent review and the reasons that the team reached this conclusion.
  - (III) the individual's need for continued acute inpatient treatment could not reasonably be determined due to specified reasons or conditions.

(Rule 1200-13-1-.03, continued)

In addition to one of these alternatives, the team may also recommend reevaluation of the individual's continued need at the next thirty (30) day certification period, inclusion of a team member with specified expertise in the next evaluation, consideration of an amendment to the plan of care, more complete or specialized evaluation of the individual and his or her need for treatment, and/or review of the facility's treatment program for compliance with federal requirements.

9. Upon completion of any review, the parties to be notified in writing of the decision will include the attending physician, the facility, the patient's guardian and the patient.
10. Subsequent to the completion of any review if the admission or the continued stay is denied, the written notice will include an explanation of the denial, the reasons for the denial the specific regulations supporting the denial, and an explanation of the individuals right to request a fair hearing.
11. Failure to Request Pre-approval Certification
  - (i) For an elective admission if a pre-approval certification is not requested prior to admission, the recipient shall not be billed for any costs covered by Medicaid that are associated with the hospitalization and that would have been covered by Medicaid upon the prior approval of a pre-approved certification.
  - (ii) If pre-approval certification is not requested within fourteen (14) working days after admission for an emergency admission, the recipient shall not be billed for any cost covered by Medicaid that are associated with the hospitalization and that would have been covered by Medicaid upon approval of a pre-approval certification.
  - (iii) In situations where individuals apply for medical assistance while in the facility, if a pre-approval certification is not requested within ten (10), working days of the date that notification is received by the facility that an individual is financially eligible for medical assistance, the recipient shall not be billed for any costs covered by Medicaid that are associated with the hospitalization and that would have been covered by Medicaid upon approval of a pre-approval certification.
  - (iv) If a facility admits a Medicaid recipient without an approved pre-approval certification for that recipient the guardian of the recipient and/or the recipient shall be informed that Medicaid reimbursement will not be paid until and unless the certification is approved. Any facility that admits a recipient without an approved pre-approval certification for that recipient does so at its own financial risk.
12. Appeal of Denied Pre-Approval Certification or Continued Stay Requests
  - (i) Immediately following verbal denial of a request for pre-approval certification or continued stay, the recipient and a provider will be notified in writing of the decision.
  - (ii) An appeal may be initiated by the recipient or the recipient's legal guardian.
  - (iii) The notification will set forth the specific rights to appeal the decision, the procedures to effect the appeal, and the time periods for exercising the rights set out in the notice.

(Rule 1200-13-1-.03, continued)

- (iv) The recipient and the recipient's guardian will be notified of the right to:
  - (I) An informal reconsideration conducted by the Department or the Department's contractor using appropriate psychiatric consultation.
    - I. A request for informal reconsideration shall be made in writing within ten (10) working days after receiving notification of a denied pre-approval certification or continued stay request. An informal reconsideration will be held within three (3) working days after receipt of the written request for such.
    - II. If the reconsideration is unfavorable the recipient will be notified in writing of the right to a fair hearing to review this decision through a formal contested case proceeding before the Department of Health and Environment, pursuant to T.C.A. §71-5-113. Any such petition for appeal shall be submitted to the Department in writing within fifteen (15) calendar days after the date of receipt by the recipient of the notification of the unfavorable reconsideration decision. or of the initial decision if informal reconsideration is not demanded.
  - (II) In any contested case proceeding the opinions of the certifying physician and the treating physician of the patient concerning the necessity of acute inpatient psychiatric care for the patient shall not automatically be of controlling weight but such opinions are to be properly weighed against all other evidence before the Commissioner.

13. Continuation of Services

- (i) If after receiving notice of the denial of continued stay, the recipient requests a hearing before the date of discharge, Medicaid may not terminate or reduce services until a final order is issued after the hearing.
  - (ii) If the decision is sustained by the hearing, Medicaid may institute recovery procedures against the facility to recoup the cost of any services furnished the recipient, to the extent they were furnished solely by reason of this section.
- (x) Transportation will be covered under the following conditions.
- 1. Emergency ambulance transportation shall be provided for recipients in case of injury or acute medical condition where the same is liable to cause death or severe injury or illness as determined by the attending physician, paramedic, emergency medical technician, or registered nurse.
    - (i) Coverage shall be limited to one-way transportation to the nearest appropriate facility. For purposes of this rule, appropriate facility shall mean an institution that is generally equipped and staffed to provide the needed hospital care for the illness or injury involved. The fact that a more distant institution may be better equipped to care for the patient shall not warrant a finding that a closer institution does not have "appropriate facilities". An institution shall not be considered an appropriate facility if there is no bed available.
    - (ii) Coverage of air ambulance transportation shall be limited to situations where transportation by land ambulance was contraindicated because the point of pickup was inaccessible by land vehicle or the time/distance to reach a hospital with appropriate facilities was prohibitive because of the patient's medical condition.

(Rule 1200-13-1-.03, continued)

2. Non-emergency ambulance transportation shall be provided when the recipient's condition is such that use of any other method of transportation is contraindicated. In every instance of transportation a physician, paramedic, emergency medical technician, registered nurse, or licensed practical nurse must prepare written documentation that the patient's condition warrants such services. This documentation must be attached to the ambulance provider's request for payment.
- (y) Care and services covered in a Christian Science Sanatoria will be provided but limited to ten days per fiscal year.
- (z) Emergency Hospital Services:
1. Emergency hospital services will be covered but such emergency care is included in the number of days allowed pursuant to subparagraph (a) of this paragraph. Hospitals which do not have an agreement to participate in the medical assistance program may receive payment for inpatient hospital services or outpatient services furnished by it, or by other under arrangements with it, if:
    - (i) the services are emergency services; and
    - (ii) the patient is eligible for Medicaid at the time services are rendered; and
    - (iii) the services are covered services under the Medicaid Program; and
    - (iv) the hospital meets the definition of a hospital as defined in T.C.A. 53-130(a), (but it need not meet the utilization review plan and the health and safety conditions prescribed by the Secretary of Health, and Human Services); and
    - (v) the hospital agrees on an individual case basis not to charge the patient or other person for items or services covered by the Medicaid Program; and to return any money incorrectly collected.
  2. An emergency no longer exists when it becomes safe from a medical standpoint determined by the attending physician to move the patient to a participating institution, or to discharge him, whichever comes first.
- (aa) Medicaid will pay for sterilization under the following conditions only:
1. The individual must be over 21 years of age, legally and mentally competent to give voluntary consent to the sterilization operation;
  2. The individual must sign a Medicaid approved consent form after a complete examination of the form and its meaning.
  3. At least 30 days, but not more than 180 days, have passed between the date of informed consent and the date of the sterilization, except in the case of premature delivery or emergency abdominal surgery. An individual may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least 72 hours have passed since he or she gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.

(Rule 1200-13-1-.03, continued)

- (bb) Services by a Certified Registered Nurse Anesthetist are covered when she/he has completed an advanced course in anesthesia, and holds a current certification from the American Association of Nurse Anesthetists as a nurse anesthetist as required in T.C.A. §71-5-107(22).
- (cc) When Medicaid enters into an agreement with a Health Maintenance Organization or any organization providing pre-paid health services, the full range of benefits offered by these organizations may be given the recipients, but limited to recipients who reside in the geographic area served by the contracting organization and who elect to obtain services from it.
- (dd) Physician office visits over and above the number allowed in subsection (g) above that are for the purpose of providing second or third surgical opinions as provided at Rule 1200-13-1-.06(19) and (20), and laboratory and x-ray services over and above the amount allowed in subsection (c) above that are necessary for the provision of such opinions, shall be covered, subject to the limitations in Rule 1200-13-1-.06(20).
- (ee) The following items of durable medical equipment shall be covered, subject to any conditions and requirements set forth herein and elsewhere in these rules:
  - 1. Hospital beds, with mattresses
    - (i) Standard
    - (ii) Semi-electric
    - (iii) Hi-Low
    - (iv) Pediatric, hospital crib
    - (v) Crib, child, standard
    - (vi) Crib, youth
  - 2. Replacement parts
    - (i) Mattress, innerspring
    - (ii) Mattress, regular
    - (iii) Side rail, full length
    - (iv) Side rail, 3/4 length
    - (v) Side rail, 1/2 length
  - 3. Bed pans and urinals
    - (i) Standard bed pan, metal or plastic
    - (ii) Male urinal, jug, type, any material
    - (iii) Female urinal, jug type, any material
  - 4. Canes
    - (i) Adjustable or fixed quad or 3 prong, all materials
    - (ii) Standard, all materials
  - 5. Crutches, pair, adjustable or fixed with tips and handgrips
    - (i) Aluminum
    - (ii) Wood
    - (iii) Forearm
    - (iv) Gaither-aid-crutches



(Rule 1200-13-1-.03, continued)

## 6. Walkers

- (i) Adjustable, or fixed, rigid (pickup) height
- (ii) Wheels, with seat/crutch attached
- (iii) Walk-n-roll
- (iv) Folding (pickup), adjustable or fixed height
- (v) Junior training walker
- (vi) Toddlers, guardian walker, on wheels
- (vii) Wheels for guardian walker
- (viii) Pediatric walker, on wheels, platform crutch on right or left side
- (ix) Platform crutch attachment, forearm crutch
- (x) Wheels for pediatric walker

## 7. Wheelchairs

- (i) Standard
- (ii) Standard, detachable arms, swing-away, detachable footrest
- (iii) Standard, detachable arms, detachable elevating leg rests, swingaway
- (iv) Lightweight, with fixed, full length arms, elevating leg rests, detachable
- (v) Lightweight, with detachable desk, full length arm style, swinging detachable footrests
- (vi) Amputee, fixed full length arms, swing-away, detachable, elevating leg rests
- (vii) Amputee, fixed full length arms, elevating leg rests, heavy duty
- (viii) Amputee, detachable arms (desk or full length) elevating leg rests, swing-away
- (ix) Amputee, fixed arms (desk or full length) without foot rests or leg rests
- (x) Full reclining, fixed full length arms; swing-away detachable elevating leg rests
- (xi) Full reclining, removable arms, elevating leg rests
- (xii) Adult, full reclining, swinging, detachable leg rest, adjustable, desk length
- (xiii) Semi-reclining, fixed full length arms, swingaway, detachable elevating leg rests
- (xiv) Adult, outdoor frame, 8" caster, detachable, desk length, arm style, semi-reclining backstyle, swinging detachable, foot rests, cam release
- (xv) Semi-reclining, detachable arms, elevating leg rests
- (xvi) High back reclining
- (xvii) Adult size, 8" caster, 18" outdoor frame, lightweight, detachable desk or full length arm, swing-away detachable elevating leg rests
- (xviii) Adult, outdoor frame, 8" caster, adjustable, detachable, desk length armstyle, sectional back, swinging detachable foot rests, (cam release)
- (xix) Adult, 8" caster, outdoor frame detachable, desk length armstyle, swinging, detachable elevating, leg rests, cam release
- (xx) Narrow adult, 8" caster, outdoor frame, adjustable, detachable, full length arm style, semireclining back style, swinging, detachable, elevating leg rests, cam release
- (xxi) Narrow adult, 8" caster, outdoor frame, adjustable, detachable full length arm style, standard back, swinging detachable footrest, cam release
- (xxii) Narrow adult outdoor frame, 8" caster, detachable desk length arm style, swinging detachable foot rests, cam release
- (xxiii) Tall, adult
- (xxiv) Hemi with detachable arms, swingaway, detachable, elevating leg rests
- (xxv) Heavy duty, extra wide, 22 (in) detachable arms, swing-away foot rests, detachable, elevating leg rests
- (xxvi) Tiny tot, 5" caster, high seat, detachable full length arm style, semi-reclining back, tiny tot footrests
- (xxvii) Tiny tot 12", outdoor frame, 5" caster, highseat, detachable desk length arm, tiny tot footrests

(Rule 1200-13-1-.03, continued)

- (xxviii) Child model, detachable desk arm
- (xxvix) Pediatric growing chair
- (xxx) Child size chair
- (xxxix) Growing chair, 8" caster, standard lightweight, fixed non-detachable arm style, swinging detachable foot rests, cam release
- (xxxii) Growing chair, outdoor frame, 8" caster, detachable full length arm style, swinging detachable, footrests, cam release
- (xxxiii) Chair with one wheel drive
- (xxxiv) Rigid frame, sports type
- (xxxv) Folding chair, sports type, includes anti-tipping device
- (xxxvi) Swede chair, ortho-kinetic
- (xxxvii) Wheelchair transporter
- (xxxviii) Wheelchair, micromax, ortho-kinetic
- (xxxix) Gunnell positioning chair
- (xl) Gunnell wheelchair insert
- (xli) Motorized wheelchair, detachable arms desk or full length, swing-away detachable footrests
- (xlii) Motorized wheelchair, detachable arms, desk or full length swing-away leg rests
- (xliii) Powered wheelchair, adult
- (xliv) Powered wheelchair, junior
- (xlv) Powered wheelchair, youth
- (xlvi) Wheelchair recliner, powered
- (xlvii) Hi-Quad chair, with short throw chin control/sip/puff, etc.)
- (xlviii) Specially sized or constructed, brand name required
- (xlvix) Travel chair
- (l) Travel chair, ortho-kinetic chair #6302

## 8. Wheelchair Accessories

- (i) Abduction Pad
- (ii) Abduction System Swing-Away
- (iii) Anti-Tipping Device
- (iv) Arm Pad for W/C
- (v) Arm Support, Mobile for reclining wheelchair with arm trough
- (vi) Back, Custom Made
- (vii) Back, Support Panel
- (viii) Battery for Wheelchair 12 Volt (one set per recipient in a twelve (12) month period)
- (ix) Battery charger 12 volt
- (x) Battery charger, 24 volt
- (xi) Belt, Perineal
- (xii) Belt, seat w/velcro closure
- (xiii) Calf support for swede, ortho-kinetic wheelchair
- (xiv) Chest belt w/pad
- (xv) Chest Panel, Custom
- (xvi) Clothing Guard
- (xvii) Cushion, for wheelchair back
- (xviii) Cushion, Jay
- (xix) Cushion, Quadra
- (xx) Cushion, Seat Temper Foam, 4" w/vinyl and double knit cover
- (xxi) Elbow Block
- (xxii) Foot Plate
- (xxiii) Foot Platform
- (xxiv) Footboard Reinforcement Plate Set
- (xxv) Footrest, Individual, Adjustable

(Rule 1200-13-1-.03, continued)

- (xxvi) Foot Restraint
- (xxvii) Grade Aid, PR
- (xxviii) H. Strap
- (xxix) Handrims for protection, W/C (pr.)
- (xxx) Head Rest, Hook on, extension
- (xxxi) Heel Loop
- (xxxii) Heel Rest
- (xxxiii) Hip Bolster
- (xxxiv) Knee Strap
- (xxxv) Lateral Support
- (xxxvi) Leg Rest
- (xxxvii) Pad, Scoliosis
- (xxxviii) Pad, W/C Tri-Pad
- (xxxix) Reacher, for W/C
- (xl) Seat, Custom Made
- (xli) Seat, Solid
- (xlii) Shoulder retractor adjustable
- (xlili) Spoke Repair Kit, Heavy Duty Wheel - 10 spokes and nipples pkg.
- (xliv) Spoke Protector
- (xlv) Support, Wedgehead w/headband
- (xlvi) Tire, Pneumatic
- (xlvii) Toe Loop
- (xlviii) Tray, ABS
- (xlix) Tray, Adjusto
- (l) Tray, Arm Restraining
- (li) Tray, Arm Restraining with storable tray
- (lii) Tray, Clear
- (liii) Tray, Customized
- (liv) Webb Strap
- (lv) Wheel Lock, Handle Extension
- (lvi) Wheel Lock, Toggle Extension

MISCELLANEOUS DME

- (lvii) Apnea Monitor Respirators/Bradycardia/Tachycardia for persons one year of age or above
  - (lviii) Apnea Monitor Respirators/Bradycardia/Tachycardia for children under one year of age
  - (lix) Bathaid, Modular Medical
  - (lx) Battery for Voice Box (CR15V, set of 2)
  - (lxi) Commode Chair, Custom adaptation for standard
  - (lxii) Commode Chair, stationary with Fixed Arms
  - (lxiii) Commode Chair, Tiny Tot
  - (lxiv) Floor sitter (C4)
9. Seating systems
- (i) Basic unit for McLaren, all hardware, U frame, seat w/pad and back
  - (ii) Basic unit for wheelchair, all hardware and straps, U frame, seat w/pad and back
  - (iii) McLaren Buggy
  - (iv) U8A/N-260-760 without upholstery or footrest
  - (v) DESEMO Seating System Adult
  - (vi) DESEMO Seating System Child
  - (vii) Foam-in-Place Back (Pindot-Contour U System, Quick Foam)
  - (viii) Foam-in-Place Seat (Pindot Quick Foam Contour System)

(Rule 1200-13-1-.03, continued)

- (ix) Foam and Plywood Complex Seat (Pindot, Endo Flex System (Seat and Back Included) Plano System (Includes Seat and Back))
  - (x) Foam and Plywood Seat, MPI Like
  - (xi) Foam and Plywood Flat Side
  - (xii) Foam and Plywood Complex Back, Pindot, Endo Flex System (Seat & Back Included) Plano System (Includes seat & Back)
  - (xiii) Foam and Plywood Back, MPI Like
  - (xiv) Foam and Plywood Flat Back
  - (xv) Foam and Plywood Seat and Back on Adjustable Frame
  - (xvi) Foam and Plywood Seat or Back with one MPI component (either seat or back) on adjustable frame
  - (xvii) Orthotic Custom Contoured Bead Back
  - (xviii) Orthotic Custom Bead Seat
  - (xix) Orthotic Shell
  - (xx) Presto Main Streamer Chair
10. Mulholland Seating Systems
- (i) Positioning chair
  - (ii) Insert System
  - (iii) Junior System
  - (iv) Toddler System
  - (v) Youth System
  - (vi) Halo System
  - (vii) Power Attachment
11. Seating System Accessories and Parts
- (i) Back
  - (ii) Back Pad
  - (iii) Bandoliers
  - (iv) Footrests
  - (v) Foot Straps
  - (vi) OB Headrest & Fixture
  - (vii) Seat with Pad
  - (viii) Seat Pad, All Sizes
  - (ix) Tray for Wheelchair
  - (x) Tray overlay, clear
  - (xi) M.E.D. Headrest and Fixture
  - (xii) M.E.D. Neck Collar and Fixture
  - (xiii) M.E.D. 2 step and Fixtures
  - (xiv) O.B. Headrest #1
  - (xv) O.B. Headrest #2
  - (xvi) O.B. Headrest, 2 step fixture
  - (xvii) O.B. Neckrest and Fixture #1
  - (xviii) O.B. Neckrest and Fixture #2
  - (xix) O.B. Neckrest
  - (xx) O.B. Neckrest, Small
  - (xxi) O.B. 2 step
  - (xxii) O.B. Trunk Support Pads, Pr
  - (xxiii) O.B. Wheelchair Mounting Kit
  - (xxiv) Footrest for Main Streamer Chair

(Rule 1200-13-1-.03, continued)

## 12. Decubitis Care Equipment

- (i) Alternating pressure mattress with pump
- (ii) Foam Leveling Gel Pad
- (iii) Mattress, floatation, dry
- (iv) Gel Pressure Pad or Cushion
- (v) Dry Pressure Pad for Mattress

## 13. Respiratory Equipment

- (i) Oxygen Concentrator (Inc. cannula or mask, and tubing)
- (ii) Oxygen, System, Gaseous Stationary, Setup (Includes contents, oxygen cylinder, regulator with flow gauge, humidifier/nebulizer, cannula, or mask and tubing.)
- (iii) Oxygen System, Gaseous Portable (Inc. contents portable container, cart or carrying case, regulator with flow gauge, humidifier, cannula or mask and tubing)
- (iv) Oxygen System, Liquid stationary (includes reservoir, contents, contents indicator, flow meter, humidifier, cannula or mask, tubing and nebulizer).
- (v) Oxygen System, Liquid Portable (Includes contents, container, cart or carrying case, cannula or masks tubing and contents indicator.)
- (vi) Oxygen Tent, Complete
- (vii) Percussor, Electric or Pneumatic Home Model
- (viii) Nasal Airway Pressure System (CPAP-BiPAP)
- (ix) Resuscitator Bag, Adult
- (x) Resuscitator Bag, Pediatric
- (xi) Volume Ventilator, Portable, (Includes battery, battery charger and battery cables)
- (xii) Ventilator battery
- (xiii) Ventilator Circuits, each
- (xiv) Ventilator Cart
- (xv) Ventilator Cleaning Kit
- (xvi) Ventilator Tray for W/C
- (xvii) Suction Machine, Home Model, Portable
- (xviii) Suction Machine Base
- (xix) Trach tubes, cuffless, each
- (xx) Air Compressor Large, Portable
- (xxi) Cascade Heated Humidifier w/extra Jar and Lid
- (xxii) Cool Mist Croupette Tent
- (xxiii) Medical Air Compressor for Oxygen Tent
- (xiv) Nebulizer with Compressor, (i.e., Maxi Mist)
- (xxv) Nebulizer Disposable, For Use with i.e. (Pulmoaide, Maxi Mist)
- (xxvi) Nebulizer Heater (for trach patient only)
- (xxvii) Nebulizer, Durable Glass or Autoclavable, plastic bottle type for use with Regulator or Flow meter
- (xxviii) Nebulizer, Ultrasonic Self Contained
- (xxix) Oxygen Accumulator
- (xxx) Oxygen-Aerosol Mist Tent
- (xxxi) IPPB Units, Manual Valves, External Power Source, Built in Nebulization

## 14. Communication Aid Devices

- (i) Electronic
- (ii) Manual

(Rule 1200-13-1-.03, continued)

- (iii) Modification, Manual and Electronic
15. Blood Glucose Monitors/Accessories
    - (i) Blood glucose monitor
    - (ii) Lancet Holder
  16. Dry Heat Application
    - (i) Heat Lamp with Stand, Bulb or Infrared element
    - (ii) Heating Pad, electric
  17. Enteral/Parenteral Equipment
    - (i) Enteral Pump
    - (ii) Parenteral
    - (iii) IV Stands, Attach to Bed/wheelchair
    - (iv) Floor Base
  18. Miscellaneous DME
    - (i) Floor sitter (C5)
    - (ii) Headgear accessories
    - (iii) Headgear customization
    - (iv) Headgear helmet
    - (v) Lift for Patient, bathtub mount
    - (vi) Lift for Patient, hydraulic
    - (vii) Noninvasive Osteogenic stimulation system
    - (viii) Osto-Aide (for seat belt users)
    - (ix) Pacemaker Monitor self contained
    - (x) Phototherapy System (covered for a maximum of 4 days)
    - (xi) Pogan Buggy, Youth
    - (xii) Ambulatory, Infusion, Pump with Administrative Equipment, Worn by Patient
    - (xiii) Pump, for insulin infusion
    - (xiv) Pump, Lymphedema, (nonsegmental therapy type)
    - (xv) Segmental Pump
    - (xvi) Leg Appliance for Pump
    - (xvii) Rifton Knee Pads
    - (xviii) Rifton Scooter E60
    - (xix) Rifton Side Lying Board E90
    - (xx) Rifton Toddler Chair E77
    - (xxi) Trunk Support Pads Rigid Mount, Pr.
    - (xxii) Whirlpool Portable (over-the-tub type)
    - (xxiii) Rifton Trunk Support
    - (xxiv) Shower Chair, with back
    - (xxv) Sitz Bath
    - (xxvi) Dynasplint Elbow Extension
    - (xxvii) Dynasplint Cuffing Kit
    - (xxviii) Dynasplint Pediatric Elbow Extension
    - (xix) Dynasplint Universal, Knee extension, adult
    - (xxx) Dynasplint Elbow Flexion
    - (xxxi) Dynasplint Universal Knee Extension, pediatric
    - (xxxii) Dynasplint, Universal, wrist extension
    - (xxxiii) Dynasplint LPS Ankle Dorsi Flexion
    - (xxxiv) Dynasplint LPS Universal Knee Flexion

(Rule 1200-13-1-.03, continued)

- (xxxv) Dynasplint Elbow Extension
  - (xxxvi) Dynasplint Pediatric Elbow Extension
  - (xxxiii) Dynasplint Elbow Flexion
  - (xxix) Dynasplint Universal Knee Extension, Pediatric
  - (xl) Dynasplint Universal Wrist Extension
  - (xli) Dynasplint LPS Ankle Dorsi Flexion
  - (xlii) Dynasplint Knee Flexion
19. Other items of durable medical equipment including prosthetic devices and orthotic appliances not listed above may be covered if prior approval is obtained, where a recipient's medical condition requires the use of the equipment, no other type of equipment will adequately meet the recipient's medical needs, there is no less expensive means of adequately meeting the recipient's medical needs, and the recipient's medical condition will seriously deteriorate without the equipment. Prior approval of such equipment shall include a determination whether it should be rented or purchased, based on the recipient's anticipated period of need for the equipment its total cost, and whether potential frequency of repair would make rental more practical, whatever the intended period of use.
20. Repair, maintenance, and replacement of equipment and expendable parts thereof shall be covered as specified in rule 1200-13-1-.05(10)(h)2
- (ff) Except as provided in rule 1200-13-1-.07, medically necessary medical supplies not included s part of institutional services shall be covered only when provided by or through a home health agency or by or through a medical vendor supplier. Medical supplies require a written prescription by the recipient's attending physician. The following medical supplies will be covered subject to any conditions and requirements set forth herein and elsewhere in these rules.
1. Anti-embolism support items
    - (i) Sleeve, Arm
    - (ii) Sleeve, Arm/Shoulder Flap
    - (iii) Stockings, Knee Length
    - (iv) Sleeve, Arm
    - (v) Stockings, Thigh Length
    - (vi) Tights, Waist Height
  2. Bandages, dressings - gauze - tape
    - (i) Bandage, Elastic
    - (ii) Bandage, Kling, Nonsterile
    - (iii) Bandages, Kling, Sterile
    - (iv) Dressings, Nonsterile
    - (v) Dressings, Primary Surgical Kit (Sterile Dressings, pads, etc.)
    - (vi) Gauze, Iodoform

(Rule 1200-13-1-.03, continued)

- (vii) Gauze, Vaseline
  - (viii) Sterile-Strip Skin Closures
  - (ix) Tape, All Types, All Sizes
  - (x) Tape, Paper
  - (xi) Tape, Transpore
3. Decubitus ulcer products
- (i) Dressings, Hydro-colloid
  - (ii) Granules, Absorptive 4 gram pkg.
  - (iii) Pad, Sheepskin/Lambswool, Any Size
4. Diabetes products
- (i) Blood Glucose Test or Reagent Strips for Home Blood Glucose Monitor.
  - (ii) Dextrochek Control Solution
  - (iii) Lancets
  - (iv) Perm-Calibration Chips
  - (v) Syringes, Insulin
5. Incontinence products
- (i) Catheter, Male External, With or Without Adhesive, With or Without Anti-Reflux Device.
  - (ii) Catheter, Indwelling, Foley Type, Three Way, for Continuous Irrigation
  - (iii) Catheter, French
  - (iv) Catheter, Indwelling, Foley Type, Two-Way Latex With Coating (Teflon, Silicone, Silicone Elastomer, or Hydrophillic, Etc.)
  - (v) Catheter, Indwelling-Foley Type, All Silicone
  - (vi) Insertion Tray With Drainage Bag but Without Catheter.
  - (vii) Urinary Drainage Bag, Bedside Drainage Bag, Day or Night, With or Without Anti-Reflux Device, With or Without Tube
  - (viii) Urinary Leg Bag, Vinyl, With or Without Tube.
- Incontinence Undergarments
- (ix) Disposable Incontinent, Briefs, Small



(Rule 1200-13-1-.03, continued)

- (x) Disposable Incontinent, Briefs, Medium
  - (xi) Disposable Incontinent, Briefs, Large
  - (xii) Incontinent Pants
  - (xiii) Liners, Pants
6. Irrigation equipment and supplies
- (i) Frame
  - (ii) Irrigation, Adapter
  - (iii) Irrigation Bag, with Stoma Cone
  - (iv) Irrigation Supply; Sleeve
  - (v) Irrigation Trays (Disposable)
  - (vi) Irrigation Tray
  - (vii) Ostomy Irrigation Set
  - (viii) Stoma Cone Replacement Unit
  - (ix) Tubing
7. IV supplies
- (i) Catheters, Vascular Implantable, Vascular Access Portal/Catheter (Venous, Arterial, or Peritoneal)
  - (ii) Gauze pads
  - (iii) Heparin lock (for syringes)
  - (iv) Tubing
  - (v) I.V. Solutions, 500 cc
  - (vi) Sponges, Softwick
8. Ostomy/colostomy products
- (i) Adhesive Disc
  - (ii) Belt, Ostomy
  - (iii) Gasket
  - (iv) Stoma Caps with Filter

(Rule 1200-13-1-.03, continued)

9. Adhesive and removers
  - (i) Adhesive Remover
  - (ii) Adhesive Karaya, Stoma Powder
  - (iii) Adhesive for Ostomy or Catheter Liquid (Spray, Brush, Etc.) Cement Powder or Paste, any Composition (ec. Silicone, Latex) Per Oz.
10. Pouches
  - (i) Colostomy, Mini Pouch
  - (ii) Colostomy Pouch, Disposable with Seal
  - (iii) Colostomy Pouch Drainable Without Barrier Attached (one piece)
  - (iv) Ileostomy Pouch
  - (v) Loop-Ostomy Pouch
  - (vi) Pouch, urinary with barrier (one piece)
  - (vii) Urostomy Pouch
11. Skin barrier blankets
  - (i) Barrier Skin Wafers
  - (ii) Skin, Barrier with Flange (Solid, Flexible or Accordion) Any Size
  - (iii) Plate Shield/ace
12. Skin barrier liquids, pastes, powder and rings.
  - (i) Body Ring/Frame
  - (ii) Karaya Ring/Washers
  - (iii) Ostomy Skin Barrier; Liquid, (Spray Brush, Etc.) Powder or Paste;
  - (iv) Oval Ring (Large or Double Stoma)
  - (v) Skin Barrier; Solid or Equivalent;
  - (vi) Ostomy Skin Barrier Extended Wear
13. Skin care and skin gel products
  - (i) Cleaner, Skin
  - (ii) Gel, Skin

(Rule 1200-13-1-.03, continued)

14. Ventilator supplies
  - (i) Artificial Nose
  - (ii) Cannula, Nasal
  - (iii) Catheter, Trachael Suction, Any Type.
  - (iv) Catheter Tray, Suction Sterile w/gloves, water and catheter
  - (v) Neublizer, Flexible Hose
  - (vi) Softwick, Trach Sponges
  - (vii) Inch Tray (Disp) for Cleaning
  - (viii) Tracheostomy Tubes
  - (ix) Tubing, corrugated
  - (x) Tracheotomy Mask or Collar
  
15. Miscellaneous
  - (i) Benzoin, Liquid
  - (ii) Benzoin, Tincture
  - (iii) Dakin's Solution
  - (iv) Dialdehyde
  - (v) Donuts, Plastic
  - (vi) Dressing, Bard Absorption Sterile jar
  - (vii) Enema, Fleets
  - (viii) Eye Pads
  - (ix) Finger Splint
  - (x) Gloves-Sterile or nonsterile
  - (xi) Infusion Pump, Supply Kit - Medication cassettes, tubing, etc.
  - (xii) Leg Belt, Velcro
  - (xiii) Needles, Sterile
  - (xiv) Reston, Foam Pads
  - (xv) Restraints, Any Type (Body, Chest, Wrist, or Ankle)

(Rule 1200-13-1-.03, continued)

- (xvi) Saline Irrigation Solution, Nonsterile
  - (xvii) Saline Irrigation Solution, Sterile
  - (xviii) Scalp Vein Set
  - (xix) Sitz Bath, Disposable
  - (xx) Solution, Betadine or Phisohex
  - (xxi) Sodium Chloride INJ
  - (xxii) Sodium Chloride (0.9%)
  - (xxiii) Solutions, Alcohol or Peroxide
  - (xxiv) Splint, Wrist
  - (xxv) Suture removal tray
  - (xxvi) Syringes
  - (xxvii) Syringes, Asepto
  - (xxviii) Syringes, Piston/Bult
  - (xxix) Telfa Pads
  - (xxx) Telfa Strips
  - (xxxi) Tens units - Electrodes Carbon (1 set per yr)
  - (xxxii) Tens units - Leadwires (1 pr. per yr.)
  - (xxxiv) Ten units - patches (100 per a 30 day period)
  - (xxxv) Uni-Boots
  - (xxxvi) Water, Saline Sterile
  - (xxxvii) Water, Sterile
16. Enteral-parenteral kits
- (i) Parenteral Administration Kit (Bags, Clips, etc.) monthly
  - (ii) Parenteral Nutrition Supply Kit for 1 Month, Premix
  - (iii) Supply Kit - Gravity Fed (1 per month)
  - (iv) Supply Kit - Pump Fed (Monthly) (1 per month)
  - (v) Supply Kit - Syringe Fed (Monthly) (1 per month)

(Rule 1200-13-1-.03, continued)

17. Enteral formulae
    - (i) Category I - Semi-synthetic Per 100 Calories
    - (ii) Category I - Blenderized Per 100 Calories
    - (iii) Category II Per 100 Calories
    - (iv) Category III Per 100 Calories
    - (v) Category IV Per 100 Calories
    - (vi) Category V Per 100 Calories
    - (vii) Category VI Per 100 Calories
  18. TPN solution
    - (i) Permixon
  19. Tubes and tubing
    - (i) Gastrostomy/Jejunostomy Tube (1 per month)
    - (ii) Mic Gastrostomy Tube
    - (iii) NG Tube with Stylet (3 Per Month)
    - (iv) NG Tube Without Stylet (3 Per Month)
    - (v) Stomach Tube - Levine Type (15 per month)
  20. Special formulae and supplements
    - (i) Ltyrosine, Supplement
    - (ii) Vita-Carne-LCarnitine
    - (iii) Betaine
    - (iv) Biotin
    - (v) Pediasure
- (gg) Medically necessary circumcision will be covered only on an outpatient basis unless admission as an inpatient is justified by the attending physician as required by rule 1200-13-1-.06 (18) (d) of this chapter Routine newborn circumcision is not covered under any circumstances.
- (hh) Podiatry services will be covered. Services are to be provided within the podiatrist's license to practice. Office visits will be limited to two (2) per recipient per fiscal year. These visits will count toward the limit on office visits as specified in rule 1200-13-1-.03(l)(g)l.
- (ii) Reserved

(Rule 1200-13-1-.03, continued)

- (jj) The service of a physician assistant will be covered when ordered and billed by a physician.
- (kk) Certified nurse-midwife services (to the extent provided in rule 1200-13-1-.22) will be covered.
- (ll) Optometry services will be covered. Services are to be provided within the optometrist's license to practice. Optometry services for recipient's over age 21 do not include services for the purposes of prescribing or providing eyeglasses or contact lenses. Office visits will be limited to four (4) per recipient per fiscal year and will count toward the limit on office visits as specified in rule 1200-13-1-.03(l)(g)l.
- (mm) Hospice services will be covered in accordance with the following sequence of election periods:
  1. An initial 90-day period.
  2. A subsequent 90-day period.
  3. A subsequent 30-day period.

Hospice benefits paid by Medicare or other insurance will be considered to be benefits paid by the Medicaid program.

- (nn) Private duty nursing services will be covered as follows:
  1. Services shall be limited to children under age 21 who have a medical condition that requires nursing care (e.g., ventilator care, total parenteral nutrition care, etc.) provided by a licensed nurse. The nursing care must be expected to improve the child's medical condition, to prevent the child's health status from deteriorating, or to delay the progression of a disease. There must be sufficient documentation, as determined by the Department, to establish and justify the medical necessity of the services. The need for nursing care must be in excess of that which can be provided on an intermittent basis through covered home health services; and
  2. The child must meet the medical criteria established by Tennessee Medicaid for care in a nursing facility; and
  3. The child must have a medical disability or impairment that confines the child to the home and necessitates the provision of nursing care services in the home; and
  4. The child must have a responsible adult caretaker (e.g., parent, grandparent or guardian) with whom the child resides and who is available and able to meet the child's needs when private duty nursing services are not being provided; and
  5. Private duty nursing care must be ordered and supervised by the child's attending physician. Any changes in the number of hours of nursing care must be ordered by the child's attending physician and be approved by Medicaid; and
  6. There must be no other more cost effective course of treatment, as determined by the Department, that is available or medically appropriate for the person; and
  7. Services shall be provided only by licensed home health agencies enrolled in the Tennessee Medicaid program; and
  8. Services must be provided in a private resident that serves as the child's home. Private duty nursing services provided to a child who is in an institutional setting (e.g. hospital,

(Rule 1200-13-1-.03, continued)

nursing facility, Intermediate Care Facility for the Mentally Retarded) are not covered; and

9. Written prior authorization for private duty nursing services must be obtained from the Department. The home health agency requesting prior authorization must submit a properly completed Prior Authorization Request for Private Duty Nursing form containing the following information:
  - (i) Diagnoses;
  - (ii) History and physical;
  - (iii) Medications;
  - (iv) Description of required nursing services;
  - (v) Estimated amount, frequency and duration of nursing services; and
  - (vi) Certification by the attending physician.

The child's attending physician must recertify the child's need for private duty nursing services at intervals of no greater than 62 days; and

10. A letter from the child's attending physician containing the following information must be submitted with the request for prior authorization:
  - (i) Primary diagnosis or diagnoses for which private duty nursing is required;
  - (ii) History of the child's illness; and
  - (iii) Estimated amount, frequency and duration of nursing services (e.g., 8 hours per day, 5 days a week for 62 days).
11. Information regarding the availability of any third party resources for coverage of nursing services must be submitted with the request for prior authorization; and
12. Information regarding the availability of nursing facilities or other community resources to meet the child's nursing care needs must be submitted with the request for prior authorization. There must be documentation that a minimum of three local nursing facilities have been contacted regarding placement of the child and the results of such placement requests.
13. Each prior authorization request will be reviewed by the Department and written notice of the decision will be issued. If the request is approved, the notification will specify the period of time, the number of hours per day and the days per week that were approved. If the request is not approved, the notification will specify the reason for denial.
14. When a child's medical condition changes and necessitates a change in the amount, frequency or duration of the required nursing services, the provider agency must submit a properly completed Prior Authorization Request for Private Duty Nursing form along with the following information provided in a letter from the child's attending physician:
  - (i) Primary diagnosis or diagnoses for which private duty nursing is required;

(Rule 1200-13-1-.03, continued)

- (ii) An explanation of the change in the child's medical condition which necessitates the change in the amount, frequency or duration of nursing care; and
  - (iii) An estimate of the required amount, frequency and duration of private duty nursing services (e.g., 8 hours per day, 5 days a week for 62 days).
- 15. If a transfer of care from one enrolled provider to another occurs, the new provider agency must promptly notify the Department in writing of the transfer, specify the reasons for the transfer and submit a properly completed Prior Authorization Request for Private Duty Nursing form. The new provider agency must coordinate the transfer of services with the child's attending physician and must obtain the physician's orders to provide the required nursing services.
- (oo) Speech pathology evaluations are limited to (2) per recipient per fiscal year and covered only when:
  - 1. Ordered by a physician,
  - 2. Performed by a physician or certified speech pathologist and
  - 3. Billed by a home health agency, community health clinic, rural health clinic or physician enrolled in the Medicaid program.
- (pp) Services provided by qualified Community Mental Retardation Clinics shall be limited to those to be provided by each clinic.
- (2) Medical assistance, to the extent established in the Rules, will be furnished to Medicaid eligible individuals who are residents of the State of Tennessee, but are absent therefrom, if any of the following conditions are met.
  - (a) Where an emergency arises from accident or illness;
  - (b) Where the health of the individual would be endangered if he/she were required to return to the State of Tennessee;
  - (c) When it is general practice for residents of a particular locality to use medical resources outside the State of Tennessee;
  - (d) When non-emergency medical care and services, or needed supplementary resources are not available within Tennessee as determined by the Medicaid Medical Director. Prior approval of the Medicaid Medical Director is required; or
  - (e) When the medical care and services are provided to a child in custody, of the State of Tennessee or for whom Tennessee makes adoption assistance or foster care maintenance payments under Title IV-E of the Act.
- (3) Nobody may be compelled to undergo any medical services, diagnosis, or treatment or, to accept any other health service under Tennessee Medicaid if the individual objects, or, in the case of a child, if a parent or guardian objects, on religious grounds. However, if a physical examination is necessary to establish eligibility based on disability or blindness, the individual cannot be found eligible unless he undergoes the examination.
- (4) The fiscal year begins on July 1 ends on June 30 of the following year. Unused benefits are not transferrable and may not be carried forward to the succeeding years.



(Rule 1200-13-1-.03, continued)

- (5) Medicaid will pay for abortion only when:
- (a) A physician has found and certified in writing to the Medicaid agency, that on the basis of his professional judgment the life of the mother would be endangered if the fetus were carried to term. The certification must contain the name and address of the patient.
  - (b) The certification and documentation must be submitted to the Medicaid agency prior to payment for an abortion.
  - (c) The certification must be accomplished by proper completion of a Certification of Medical Necessity for Abortion - Mother's Life, form TDH-604, signed by the physician in his/her own original handwriting. Instructions for proper completion of form TDH-604 are found in the applicable Medicaid provider manuals.
- (6) Patients receiving inpatient hospital services or Skilled Nursing Facility care must be moved promptly to the appropriate level of care once the Utilization Review Committee, PSRO, Tennessee Department of Health and Environment, and/or attending physician decides that further care in the facility is not required or necessary. After the decision has been made that the patient no longer requires care in the facility, but additional time is needed to relocate the patient at the appropriate level of care, i.e., to find a vacant Intermediate Care Facility bed or someone to stay at home with the patient. Medicaid will continue to reimburse the facility for the period of additional stay up to a maximum of three days.
- (7) Reserved.
- (8) Payment of Premiums For Cost Effective Health Insurance Policies.
- (a) Coverage for Medicaid recipients  
Medicaid shall pay health insurance premiums (policyholder portion only if it is an employment related policy) for Medicaid recipients with policies determined to be cost effective to the Medicaid program. These payments shall be made directly to the employer or health insurer providing the coverage.
  - (b) Cost effectiveness based on average expenditure projection.  
Cost effectiveness of a health insurance policy to Medicaid shall be determined by comparing the annualized premium, deductible, and copayments, and the cost of analysis and processing established by the Department of Human Services and the Department of Health - Bureau of Medicaid against the average Medicaid expenditure for a recipient(s) in the recipient's eligibility classification. The premium shall be paid even if the policy covers other non-Medicaid person(s). Federal financial participation shall be available for the premium.
  - (c) Cost effectiveness based on actual expenditures  
Cost effectiveness or health insurance may be based upon actual expenditure documentation (Explanation of Benefits) from the insurer which, based upon a recipient's existing condition, are likely to continue and that exceed the annualized cost of the policy as described in (b).
  - (d) Continuation coverage of Medicaid recipients  
If a current Medicaid recipient, covered by an employer's policy:
    - 1. dies;

(Rule 1200-13-1-.03, continued)

2. is terminated by the employer for reasons other than gross misconduct or loses work hours sufficient to lose health insurance coverage;
3. is divorced or legally separated from the employee's spouse;
4. becomes eligible for Medicare; or
5. is a dependent child and to be a dependent child under the generally applicable requirements of the plan;

and, the employer is under COBRA 1985 and other laws relative to it, Medicaid will pay premiums for continuation coverage of cost effective health policies for the time frame permitted under federal law.

(e) Policies with coverage limitations

Health insurance policies which may not be cost effective based upon the limited nature of their coverage are accident, indemnity, Medicare Supplemental and surgical policies. For Medicaid purposes these policies shall not be considered cost effective and therefore will not be evaluated. Dread disease and cancer policies may be cost effective if documentation is provided by the recipient of recent insurance payments made which can be expected to be ongoing and when applied against the cost of the policy as described in (b).

(f) Notification requirements for recipient

The recipient shall notify the Department of Human Services in the event of any change of status which might affect the cost effectiveness of the health insurance, immediately.

(g) Notification requirements for employee/insurance company/plan administrator

The employer or insurance company receiving payment for premiums from Medicaid shall immediately notify Medicaid in the event of a policyholder status change, as in (d), and any applicable policy continuation premium information.

(h) Notification requirements under Public Chapter 420.

1. The following notice shall be distributed in accordance with the notification requirements under Chapter 420.

“You may be entitled to have the State of Tennessee pay the premium for your ongoing health insurance if.

- (i) You are eligible for Medicaid coverage, and
- (ii) You have the availability of health insurance either through your employment or through COBRA regulations governing the continuation of health insurance during periods of unemployment or a reduction in work hours.

For more information, contact your local Department of Human Services.”

(Rule 1200-13-1-.03, continued)

2. These notices shall be prominently displayed and available at all offices of the Tennessee Department of Employment Security and Human Services. Each Department shall be responsible for printing and distribution of these notices in accordance with this part.
- (9) Medical assistance for persons whose entitlement for assistance is limited to Qualified Medicare Beneficiary (QMB) only status shall be limited to the payment of Medicare Part A and B buy-in premiums and Medicare Part A and B deductible/coinsurance. For persons dually eligible for assistance under QMB status and categorically needy or medically needy eligibility, medical assistance shall include payment of Medicare Part A and B buy-in premiums, Medicare Part A and B deductibles/coinsurance and other medically necessary medical assistance as described elsewhere in this chapter.
- (10) Women who are granted presumptive eligibility shall be entitled to receive medical assistance as described in these rules when such assistance is provided pursuant to the following conditions:
  - (a) Services must be provided on an ambulatory basis;
  - (b) Services must be related to the pregnancy; and
  - (c) Services must not be provided for the purposes of terminating the pregnancy or preventing future pregnancy.
- (11) For services provided prior to January 1, 1994, the rules as set out at 1200-13-1-.03(1)-(10) shall apply. Effective January 1, 1994, medical services previously covered under the Tennessee Medicaid program with the exceptions of nursing facility services, intermediate care facility services for the mentally retarded (ICF-MR), Home and Community Based Waiver Services, and payment of Medicare Beneficiaries (QMBs) and Special Low-Income Medicare Beneficiaries (SLIMBs) will be provided through the TennCare program. The rules of TennCare are set out at rule chapter 1200-13-12.

**Authority:** T.C.A. §§4-5-202, 4-5-205, 71-5-105, 71-5-109, Executive Order No. 23, and Public Chapter 358 of the Acts of 1993. **Administrative History:** Original rule filed November 17, 1977; effective December 19, 1977. Amendment filed January 31, 1979; effective March 16, 1979. Amendment filed August 31, 1981; effective October 15, 1981. Amendment filed November 4, 1981; effective December 21, 1981. Amendment filed September 27, 1982; effective October 27, 1982. Amendment filed February 11, 1983; effective March 14, 1983. Amendment filed May 27, 1983; effective June 27, 1983. Amendment filed June 23, 1983; effective July 25, 1983. Amendment filed February 14, 1984; effective March 15, 1984. Amendment filed March 12, 1984; effective April 11, 1984. Amendment filed June 27, 1984; effective July 27, 1984. Amendment filed June 25, 1984; effective September 11, 1984. Amendment filed September 10, 1985; effective October 10, 1985. Amendment filed November 4, 1985; effective December 4, 1985. Amendment filed November 4, 1985; effective February 12, 1986. Amendment filed April 29, 1986; effective May 29, 1986. Original rule filed July 30, 1987; effective September 13, 1987. Amendment filed September 30, 1987; effective November 14, 1987. Amendment filed January 22, 1988; effective March 7, 1988. Amendment filed September 30, 1988; effective November 14, 1988. Amendment filed October 27, 1988; effective December 11, 1988. Amendment filed November 10, 1988; effective December 25, 1988. Amendment filed December 15, 1988; effective January 29, 1989. Amendment filed May 30, 1989; effective July 14, 1989. Amendment filed July 22, 1989; effective August 4, 1989. Amendment filed August 31, 1989; effective October 15, 1989. Amendment filed November 27, 1989; effective January 11, 1990. Amendment filed January 29, 1990; effective March 15, 1990. Amendment filed March 1, 1990; effective April 15, 1990. Amendment filed November 5, 1990; effective December 20, 1990. Amendment filed January 17, 1991; effective March 3, 1991. Amendment filed January 31, 1991; effective March 17, 1991. Amendment filed February 12, 1991; effective March 29, 1991. Amendment filed February 21, 1991; effective April 7, 1991. Amendment filed February 27, 1991; effective April 13, 1991. Amendment filed June 12, 1991; effective July 27, 1991. Amendment filed September 11, 1991; effective October 26, 1991. Amendment filed September 17, 1991; effective November 1, 1991. Amendment filed October 25, 1991; effective December 9, 1991. Amendment filed November 27, 1991; effective January 11, 1992. Amendment filed March 9, 1992; effective April 23, 1992. Amendment filed March 10, 1992; effective April 24, 1992. Amendment filed March 17, 1992; effective May 1, 1992. Amendment filed April 14, 1992; effective May

(Rule 1200-13-1-.03, continued)

*29, 1992. Amendment filed April 30, 1992; effective June 14, 1992. Amendment filed May 1, 1992; effective June 15, 1992. Amendment filed December 4, 1992; effective January 19, 1993. Amendment filed November 17, 1993; effective January 31, 1994. Amendment filed December 7, 1993; effective February 20, 1994. Amendment filed March 18, 1994; effective June 1, 1994. Public necessity rule filed July 1, 2005; effective through December 13, 2005. Public necessity rule filed September 26, 2005; effective through March 10, 2006. Amendment filed December 20, 2005; effective March 5, 2006.*

#### **1200-13-1-.04 THIRD PARTY RESOURCES.**

(1) Definitions

- (a) Third party resources shall mean any individual, entity or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished to a Tennessee Medicaid recipient.

Recipient resources acquired through medical malpractice or victim compensation actions or from indemnity insurance, which compensates for loss of work or loss of limb, shall not be considered a third party resource. An indemnity insurance policy which compensates for specific medical services such as inpatient hospital confinement, is a third party resource.

- (b) Third party payment shall mean compensation provided to a Medical provider or to Medicaid by any third party resource which eliminates or reduces Medicaid's indebtedness for medical assistance furnished to a Tennessee Medicaid recipient.
- (c) Direct billing shall mean the process used by Medicaid to collect/recover payments for covered services from any third party resource available to a Medicaid recipient.
- (d) Recipient assignment of rights shall mean that a recipient or responsible party shall assign rights to Medicaid for medical support or other third party payments. The recipient and/or responsible party shall cooperate with Medicaid and providers in obtaining Medical support or payments.
- (e) Third party documentation shall mean:
1. an insurance company's explanation of benefits (EOB) related to the specific claim, or
  2. a statement on the provider's letterhead indicating contact with the insurance company and the reason for denial. The statement must be signed and dated by an authorized employee of the provider and include the insurance company name, policy and group number, the date of contact, the date of service, the recipient name and Medicaid identification number.

- (2) Claims for Medicaid covered services provided to Medicaid eligibles shall not be made against Medicaid until Medicare and other probable third party resources to the recipient have been collected, unless prohibited by federal law except where third party resources are provided by other state agencies under contract with this Department which designated the agency as payor after Medicaid.

- (a) Medicaid may be bill following formal notification from the third party resources that the services provided are not covered or payable or when third party payment has been received. AD claims submitted shall indicate the third party payment amount received, if third party resources are found to be nonexistent, copies of letter(s) or other supporting documentation shall be attached to the claim.
1. If third party payment is less than the Medicaid allowable, Medicaid will pay the difference between the third party payment and the Medicaid allowable. No further claim shall be allowed against the recipient and/or the recipient's responsible party(s) for Medicaid services, or

(Rule 1200-13-1-.04, continued)

2. If third party payment is equal to or exceeds the Medicaid allowable no further claim shall be allowed against Medicaid or the Medicaid recipient and/or that recipient's responsible party(s) for Medicaid covered services.
- (3) Providers receiving third party payments following Medicaid payment shall notify and refund Medicaid within 60 days of receipt of the third party payment. The refund to Medicaid shall be the lesser of the third party or Medicaid payment. The provider shall submit a check to Medicaid, or may request Medicaid to setoff the refund amount from the provider's current claim. A Medicaid - Title XIX Adjustment Void Request from identifying the recipient's name and Medicaid number, date(s) of service, remittance advice I number and the name and address of the third party resource, shall be submitted with a check or request for setoff to assure the proper credit is provided and recipient accounts.
- (4) Providers having received third party payments which should have been reported and refundable in whole or in part to Medicaid as specified in parts (2) and (3), which were held more than 60 days and not refunded, and/or which are found in an audit/review shall be subject to any resulting federal monetary assessment against the State Medicaid program.
- (5) Medicaid shall perform audits of provider records to identify third party resources unreported and/or unrefunded to Medicaid as specified in part (3). Provider(s) to be audited shall be selected based upon the potential of the provider and/or provider category (hospitals, physicians, etc.) to receive third party resources.
- (6) Direct Billing
  - (a) Medicaid shall utilize direct billing when it is determined that a previously paid service(s) may have been covered by a third party. Additionally, notwithstanding Section (2), direct billing for some services may be more cost effective than requiring the provider to collect prior to billing Medicaid. These services shall be, but are not limited to, pharmacy claims.
  - (b) Medicaid shall identify to the third party resource, the recipient name and address, the third party group and/or policy number (if appropriate), the name of the responsible party/policyholder, the name of the provider of service, the description of the service that was provided, the date(s) of the service, the amount billed Medicaid by the provider of service, and the amount paid by Medicaid to the provider of service.
  - (c) The third party resources shall submit payment to Medicaid and/or notify Medicaid in writing of no-coverage data such as the date the policy started and lapsed, services that are non-covered, and the identity of any other party having been paid by the third party resource for any of the identified service(s).
  - (d) Medicaid shall notify the Tennessee Department of Human Services in the event an absent parent, court ordered to provided for medical expenses, cannot be located and/or refuses to make full restitution to Medicaid.
- (7) Reserved.
- (8) Provider Billing Requirements
  - (a) Providers shall bill Medicaid for all covered services rendered under the plan and report third party collections.
  - (b) Unless otherwise allocated on the payor's explanation of benefits (EOB), third party payment reported to Medicaid shall be prorated equally over the institutional days or professional services billed.

(Rule 1200-13-1-.04, continued)

- (c) Medicaid will not make payment if the provider is aware of a third party resource prior to rendering service and is denied payment from the third party resource because of provider non-compliance with policy/contract provisions.
- (9) Paid claims, for which a third party resource is later identified, may be voided by Medicaid if the date of service is within one year of the resource identification. The third party resource will be identified to the provider on the remittance advice which identifies the voided claim.
- (10) Provider Discrimination

A provider who furnished services and is participating under the plan may not refuse to furnish services to a recipient because of a third party potential liability for payment for the service.

(11) Assignment of Benefits

- (a) A recipient assigns rights to Medicaid when the recipient uses a Medicaid card to receive medical assistance.
- (b) Any document released by a provider to a Medicaid recipient concerning the provision of a covered service shall have "Benefits Assigned" printed boldly on the statement. If a provider refunds third party payments to a recipient the provider is subject to recovery from Medicaid up to the Medicaid paid amount. If a third party pays the recipient directly Medicaid shall recover from the recipient.
- (c) A provider shall immediately notify Medicaid of a request for medical records from a Medicaid recipient and/or agent or attorney. If proper authorization is received from the recipient the records may be released with the statement "Benefits Assigned." The notification to Medicaid must include:
  - 1. name and Medicaid number of the recipient,
  - 2. dates of service in question.
  - 3. provider name and provider number,
  - 4. attorney name, address and telephone number, and/or
  - 5. insurance company name, address and telephone number.

(12) Recipient Shall Cooperate with Provider

If the provider documents at least two attempts to obtain recipient cooperation in meeting third party resource policy/plan requirements they may contact the Medicaid TPL Unit for assistance. The provider may bill Medicaid after 180 days with copies of the documentation attached to the claim. Medicaid shall pay the provider and attempt recovery from the recipient and/or third party resource.

(13) Absent Parents

- (a) An absent parent obligated by court order to provide continuing health insurance, medical support or a combination of insurance and support shall:
  - 1. be billed by Medicaid for reimbursement of costs incurred for his/her child, and
  - 2. reimburse Medicaid promptly or provide adequate health insurance coverage information to Medicaid.

Medicaid may bill the insurance carrier directly and request provider assistance in the recovery. Medicaid will enter into a written cooperative agreement for the enforcement of rights to, and collection of, such third party benefits as provided in 42 CFR Section 433.151, as amended.

(Rule 1200-13-1-.04, continued)

- (b) An absent parent obligated by court order to pay for paternity expenses only shall be billed for costs incurred for the delivery of his/her child. Failure by the absent parent to reimburse Medicaid will initiate the recovery process in Section (13)(a).

(14) Subrogation Notice

Medicaid shall notify any third party or attorney of the state's claim of subrogation, when either is suspected of representing a Medicaid recipient who has received benefits. If an unauthorized settlement is distributed to the recipient and/or a responsible party after the receipt of the subrogation notice, the person responsible for the distribution shall be financially liable to the State for Medicaid's payments.

(15) Third Party Documentation/Explanation of Benefits

- (a) A provider shall maintain third party documentation/explanation of benefits until audited but no longer than three (3) years from date of service, unless other record requirements apply.
- (b) A provider shall attach explicit documentation of a third party resource denial to the Medicaid claim, except in the case of UB-82 and tape billing. This documentation must provide sufficient information for Medicaid to justify payment. The information will also be used by Medicaid to update its third party resource files as appropriate.
- (c) If a third party resource denial is based on services in excess of an annual limitation, the documentation shall only be valid on claims for the applicable year. Documentation shall be appropriate to the claim submitted or the claim will be denied.

(16) Third party is established and available on the date of service.

If provider learns of a third party resource after billing Medicaid the provider shall immediately bill the third party. If third party payment is received the provider shall adjust the previous Medicaid payment using the Medicaid Adjustment/Void Request Form. The insurance company name and policy number should be entered on the form. If no third party payment is received the explanation of benefits should be kept on file by the provider.

(17) Third party is not established or available on the date of service (example: automobile accident - party possibly at fault with liability coverage which may pay recipient medical claims.)

- (a) A provider may elect to bill the anticipated liable third party for a covered Medicaid service, or
- (b) If the provider elects to bill Medicaid, Medicaid will recover from the third party.
- (c) The provider may not include charges for covered services billed to Medicaid in an independent claim to the potentially liable third party.
- (d) The provider may void a claim previously paid by Medicaid at any time in an attempt to recover a larger payment from a potentially liable third party.
- (e) Medicaid may not be billed for a covered service under the plan following the expiration of Medicaid's timely filing limits.

(18) A provider may keep the total third party payment even if it exceeds the Medicaid allowable amount.

(19) Medical assistance benefits shall be coordinated with third party resources and reimbursement shall not be made for services which would have been reimbursable by the third party except for failure to adhere to the third party's requirements.

(Rule 1200-13-1-.04, continued)

**Authority:** T.C.A. §§14-23-105, 14-23-109 and 4-5-202. **Administrative History:** Original rule filed November 17, 1977; effective December 19, 1977. Amendment filed January 31, 1979; effective March 16, 1979. Amendments filed May 29, 1987; effective July 13, 1987. Amendment filed June 22, 1989; effective August 4, 1989. Amendment filed August 31, 1989; effective October 15, 1989.

#### **1200-13-1-.05 PROVIDERS.**

- (1) Providers may be eligible for reimbursement for Medicaid services on the date of their application, providing they are subsequently determined eligible and enrolled as a Medicaid provider.
  - (a) Participation in the Medicaid program will be limited to providers who:
    1. Accept, as payment in full, the amounts paid by Medicaid or paid in lieu of Medicaid by a third party (Medicare, insurance, etc.);
    2. Maintain Tennessee, or the State in which they practice, medical licenses and/or certifications as required by their practice;
    3. Are not under a federal Drug Enforcement Agency (DEA) restriction of their prescribing and/or dispensing certification for scheduled drugs (relative to physicians, osteopaths, dentists and pharmacists);
    4. Agree to maintain and provide access to Medicaid and/or its agency all Medicaid recipient medical records for five (5) years from the date of service or upon written authorization from Medicaid following an audit, whichever is shorter,
    5. Provide medical assistance at or above recognized standards of practice; and
    6. Comply with all contractual terms and Medicaid policies as outlined in federal and state rules and regulations and Medicaid provider manuals and bulletins.
    7. Failure to comply with any of the above provisions 1. through 6. may subject a provider to actions described in rule 1200-13-1-.21.
  - (b) Provider Solicitations and Referrals
    1. A provider shall not solicit Medicaid recipients by any method offering as enticements other goods and services (free or otherwise) for the opportunity of providing the recipient with Medicaid covered services that are not medically necessary and/or overutilize the Medicaid program.
    2. A provider may request a waiver from this restriction in writing to Medicaid. Medicaid shall determine the value of a waiver request based upon the medical necessity and need for the solicitation. The provider may implement the solicitation only upon receipt of a written waiver approval from Medicaid. This waiver is not transferable and may be canceled by Medicaid upon written notice.
    3. Medicaid payments for services related to a non-waivered solicitation enticement shall be considered by Medicaid as a non-covered service and recouped. The provider may not bill the recipient for non-covered services recouped under this authority.
    4. A provider shall not offer or receive remuneration in any form related to the volume of referrals made or received from or to another provider.



(Rule 1200-13-1-.05, continued)

- (c) Providers may seek payment from a Medicaid recipient under the following conditions:
1. the services provided are not covered by Medicaid and the provider informed the recipient the service was not covered prior to providing the service.
  2. the services provided are Medicaid-covered services but exceed the number or limitation on services.
  3. after reasonable inquiry, the provider was not clearly informed of Medicaid eligibility by the recipient, or the recipient's responsible party, prior to providing non-emergency services.
  4. the provider clearly informed the recipient or the recipient's responsible party prior to providing non-emergency services that the provider did not accept Medicaid assignment and the recipient negotiated a private agreement with the provider to be responsible for the costs of the service.
- (d) Providers may not seek payment from a Medicaid recipient under the following conditions:
1. the provider was aware of Medicaid eligibility or pending eligibility prior to providing services and did not clearly inform the recipient that they did not accept Medicaid assignment.
  2. the claim(s) submitted to Medicaid for payment were denied due to provider billing error or a Medicaid claim processing error.
  3. the provider accepted Medicaid assignment on a claim and it is determined that another payor paid an amount equal to or greater than the Medicaid allowable amount.
  4. the provider failed to comply with Medicaid policies and procedures or provided a service which lacks medical necessity or justification. These policies and procedures include, but are not limited to, prior authorization, second surgical opinions, sterilization consent form, inpatient hospital admission review, psychiatric hospital admission review.
  5. the provider failed to submit or resubmit claims for payment within the time periods required pursuant to rule 1200-13-1-.06(2).
  6. the provider failed to ascertain the existence of Medicaid eligibility or pending eligibility prior to providing non-emergency services.
  7. the provider failed to inform the recipient prior to providing a service not covered by Medicaid that the service was not covered and the recipient may be responsible for the cost of the service. Services which are non-covered by virtue of exceeding limitations are exempt from this requirement and shall be governed by rule 1200-13-1-.05(1)(c)2.
  8. the recipient failed to keep a scheduled appointment(s).
- (e) Providers may seek payment from a person whose Medicaid eligibility is pending at the time services are provided if the provider informs the person they will not accept Medicaid assignment whether or not eligibility is established retroactively.
- (f) Providers may seek payment from a person whose Medicaid eligibility is pending at the time services are provided, however, all monies collected must be refunded when a claim is

(Rule 1200-13-1-.05, continued)

submitted to Medicaid if the provider agreed to accept Medicaid assignment once retroactive Medicaid eligibility was established.

- (2) Providers of inpatient hospital services, outpatient hospital services, skilled nursing facility services, independent laboratory and x-ray services, hospice services, and home health agencies must be approved for Title XVIII-Medicare in order to be certified as providers under the Medicaid Program; in the case of hospitals, the hospital must meet state licensure requirements and be approved by Medicare as an acute care hospital as of the date of enrollment in Tennessee Medicaid. Children's hospitals and State mental hospitals may participate in Medicaid without having been Medicare approved; however, they must be approved by the Joint Commission for Accreditation of Health Care Organizations as a condition of participation.
  - (a) Medical records in inpatient acute care hospitals shall include:
    1. Physician's admission note and orders upon admission.
    2. Complete history and physical (H&P) within 24 hours of admission. Generally accepted components are chief complaint, present illness, past medical history, review of systems, social history and habits, and physical examination findings.
    3. Emergency room report, if appropriate.
    4. Physician orders, as appropriate. Must be legible and signed and dated by the physician.
    5. Physician progress notes sufficient to denote changes or progress - at least daily. Deficiencies shall be subject to per diem recoupment and physical visit recoupment.
    6. Nurses notes, during each shift, sufficient to describe/document patients condition, course, treatment, response to treatments, with evaluation of complaints and nursing evaluations and responses.
    7. Medication records, during each shift, noting all medications given, time, form, dose/strength, and IV fluids if not kept separately.
    8. Lab/x-ray/EKG and other procedure reports, if ordered and done.
    9. Vital sign reports, each shift, as ordered and/or per nursing protocol for the hospital to include, temperature, pulse, respirations and blood pressure.
    10. Intake/output and weights, as appropriate to diagnosis.
    11. Dietary reports, as appropriate.
    12. P.T., R.T., O.T., and speech therapy reports, as appropriate, to include evaluations, recommendations, treatments and responses.
    13. Consultation reports, as appropriate.
    14. Social service notes, as appropriate.
    15. Short stay summary, if stay is 48 hours or less - within 24 hours of discharge in lieu of H&P discharge summary.
    16. Discharge summary, within two (2) weeks of discharge.

(Rule 1200-13-1-.05, continued)

- (b) Medical records in psychiatric hospitals, and psychiatric and alcohol and drugs units of acute care hospitals, shall include:
    - 1. Physician's admission note and orders upon admission.
    - 2. Complete history and physical (H&P), within 24 hours of admission. Generally accepted components are noted in Rule 1200-13-1-.05(2)(a)2. above.
    - 3. Treatment plan signed by a physician within five (5) days of admission.
    - 4. Physician orders, as appropriate. Must be legible and signed and dated by the physician.
    - 5. Physician's progress notes sufficient to denote changes or progress shall be written daily for alcohol and drug (A & D) detoxification and at least every other day for A & D treatment and every third day for other psychiatric diagnoses. Deficiencies shall be subject to per diem recoupment and physician visit payment recoupment.
    - 6. Other discipline progress notes, shift and/or daily as appropriate.
    - 7. Medical or other consultation reports, as appropriate.
    - 8. Nurses notes, during each shift, sufficient to describe/document patients condition, course, treatments, response to treatments, with evaluation of complaints and nursing conditions and responses.
    - 9. Medication records. during each shift, noting all medications given, time, form, dose/strength, and IV fluids if not kept separately.
    - 10. Discharge summary, within two (2) weeks of discharge.
  - (c) Medical records of all providers shall include at a minimum the following:
    - 1. Documentation sufficient to justify the medical necessity of tests or other services ordered for, or provided to, Medicaid recipients. Documentation shall be considered to be invalid if it is illegible, and services based on illegible documentation shall be subject to recoupment.
    - 2. Documentation of all medications administered to. or prescribed for. Medicaid recipients and the diagnoses for which the medications were administered or prescribed.
    - 3. Documentation of orders for laboratory, radiologic, EKG, hearing, vision, and other tests and the results of such tests.
  - (d) Services are to be justified by the medical records. Services insufficiently justified shall be determined as not medically necessary and subject to recoupment by Medicaid.
- (3) Medicaid will pay the Medicare part A deductible and Medicare part B deductible and co-insurance for Medicare/Medicaid recipients according to the following restrictions:
- (a) The payment of the deductible(s) and coinsurance will be made only to providers who accept assignment of the recipient's Medicare, and;
  - (b) The deductible(s) and co-insurance shall be paid only as they are incurred for health care services covered under the Tennessee Medical Assistance Plan, and;

(Rule 1200-13-1-.05, continued)

- (c) the total amount paid by a combination of Medicare for the covered health care services, patient liability, if any, and Medicaid as deductible and co-insurance shall not exceed the limit of the Medicaid fee schedule for the covered services in question or, where there is no Medicaid fee schedule for the covered service, reasonable billed charges, and;
  - (d) The payment, if any, made by Medicaid pursuant to this paragraph shall be the maximum amount collectible by the provider from the Medicaid program or the Medicaid recipient or that recipient's responsible parties (i.e. family, members, guardians, etc.). Consequently, the provider shall not attempt to bill a Medicaid recipient for the deductible or co-insurance.
- (4) Skilled Nursing Facilities will be reimbursed subject to the following conditions:
- (a) The facilities must enter into a provider agreement with the Department.
  - (b) Nursing Facilities (Medicare SNFs and TennCare facilities providing Level II Care services) must be certified by Medicare, showing they have met the Federal certifications standards. Any of these nursing facilities participating in the State of Tennessee's TennCare program shall be terminated as a TennCare provider if the Inspector General terminates Medicare participation.
  - (c) If the patient has available resources to apply toward payment, the payment made by the State is the current maximum payment per day, charges or per diem cost, whichever is less, minus the patient's available resources.
  - (d) No payments for covered services from relatives or others are allowed except to reduce Medicaid payments.
  - (e) If the Skilled Nursing Facility (upon submission of a cost settlement report and an audit of its cost), has collected on a per diem basis during the period covered by the cost report and audit, more than cost reimbursement allowed, the skilled nursing facility shall be required to reimburse the State (through the Medicaid Division), for that portion of the reimbursement collected in excess of the actual recorded and audited cost.
  - (f) If the Skilled Nursing Facility (upon submission of a cost settlement report and audit of its cost) has collected on a per diem basis and reimbursement is less than its actual and reported per diem cost, retroactive settlement shall be made by the State. The skilled nursing facility shall have the right, and shall be responsible for adjusting its "interim reimbursable per diem cost rate" at any time during its fiscal period, so that its verified cost rate approximates as nearly as possible the actual current operation cost of the facility.
  - (g) Regardless of the reimbursement rate established for a Skilled Nursing Facility, no Skilled Nursing Facility may charge Medicaid patients an amount greater than the amount per day charged to private paying patients for equivalent accommodations and services.
- (5) Intermediate Care Facilities will be reimbursed under the following conditions:
- (a) The Intermediate Care Facility, must enter into a provider agreement with the Department.
  - (b) The Intermediate Care Facility, must be certified by the Department, showing they have met the standards set out in 45 CFR 249.12 or in the case of Intermediate Care Facilities for the mentally retarded, 45 CFR 249.13.
  - (c) Nursing Facilities (providing Level I Care services) and Intermediate Care Facilities for Mentally Retarded participating in the State of Tennessee's TennCare program shall be terminated as a TennCare provider if certification is canceled by the Commissioner.

(Rule 1200-13-1-.05, continued)

- (d) If the resident has resources to apply toward payment, the payment made by the state will be his current maximum payment per day, charges or per diem cost (whichever is less), minus the available patient resources.
  - (e) No payments from relatives or others are allowed except to reduce payments by the state.
  - (f) Payments for residents, requiring Intermediate Care Facility Services, and institutions for the mentally retarded, will not exceed per diem costs or charges, whichever is less.
  - (g) If an Intermediate Care Facility (upon submission of a cost report and audit of its cost), has collected on a per diem basis during the period covered by the cost report and audit, more than cost reimbursement allowed for the ICF patient, the facility shall be required to reimburse the state (through the Medicaid Division and/or the ICFs Third Party), for that portion of the reimbursement collected in excess of the cost reimbursement allowed.
  - (h) Regardless of the reimbursement rate established for an Intermediate Care Facility, no Intermediate Care Facility may charge Medicaid patients an amount greater than the amount per day charge to private paying patients for equivalent accommodations and services.
  - (i) Effective July 1, 1990, personal laundry services in a nursing facility or an intermediate care facility for the mentally retarded shall be considered a covered service and included in the per diem rate. Medicaid patients may not be charged for personal laundry services.
- (6) Except in those cases in which it is determined that payments are denied because of the failure of Medicaid to act in a timely manner, Medicaid will not reimburse providers for services for which there is not federal financial participation.
- (7) Rules concerning provider abuse or fraud of the Medicaid program shall be found in rule 1200-13-1-.21.
- (8) (a) Nursing facilities are responsible for assuring that physician visits are made according to the schedule set out at 42 CFR 483.40.

To meet the requirement for a physician visit, the physician must, at the time of the visit,

1. See the patient; and
2. Review the patient's total program of care, including treatments; and
3. Verify that the patient continues to need the designated level of nursing facility care and document it in the progress notes or orders; and
4. Write, sign, and date progress notes; and
5. Sign all orders.

At the option of the physician, required visits after the initial visit may alternate between visits by a physician and visits by a physician assistant or nurse practitioner working under the physician's delegation.

A physician visit will be considered to be timely if it occurs not later than 10 days after the date of the required visit. Failure of the visit to be made timely will result in non-payment of claims, or a recoupment of all amounts paid by the Department during the time that the physician visit has lapsed.

(Rule 1200-13-1-.05, continued)

- (b) Nursing facilities are responsible for assuring that the physician verify at the time of each physician's visit the Medicaid recipient's continued need for nursing facility level of care and whether or not he/she is being served at the appropriate level of care.
  - 1. Failure to obtain the verification at the time of the scheduled physician visit may result in a recoupment of all amounts paid by the Department during the time that the verification/physician visit has lapsed.
  - 2. If such a recoupment is made, the participating facility shall not:
    - (i) Attempt to recoup from the resident; or
    - (ii) Discharge the resident based on the recoupment.
  - 3. In cases where the physician refused to make the required verification because the physician believes that the level of care is no longer appropriate, a new resident assessment must be completed by the nursing facility.
- (9) No Medicaid reimbursed resident of an Intermediate Care Facility or Skilled Nursing Facility shall, on the ground of race, color, or national origin be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination by any such Facility.
  - (a) An Intermediate Care Facility or Skilled Nursing Facility may not directly or through contractual or other arrangements, on ground of race, color, or national origin:
    - 1. Deny a Medicaid reimbursed resident any service or benefit provided under the program.
    - 2. Provide any service or benefit to a Medicaid reimbursed resident which is different, or is provided in a different manner, from that provided to others under the program.
    - 3. Subject a Medicaid reimbursed recipient to segregation or separate treatment in any matter related to the receipt of any service or benefit under the program.
    - 4. Restrict a Medicaid reimbursed resident in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any service or benefit under the program.
    - 5. Treat a Medicaid reimbursed resident differently from others in determining whether he satisfies any admission, enrollment, quota, eligibility, membership or other requirement or condition which the resident must meet in order to be provided any service or benefit provided under the program;
  - (b) An Intermediate Care Facility or Skilled Nursing Facility, in determining the types of services, or benefits which will be provided under any such program, or the Medicaid reimbursed resident to whom, or the situations in which, such services or benefits will be provided under the program, or the Medicaid reimbursed resident to be afforded an opportunity to participate in the program, may not, directly or through contractual or other arrangements, utilize criteria or methods of administration which have the effect of subjecting those residents to discrimination because of their race, color, or national origin, or have the effect of defeating or substantially impairing accomplishments of the objective of the program with respect to those residents of a particular race, color, or national origin.
  - (c) As used in this rule, the services or benefits by an Intermediate Care Facility or Skilled Nursing Facility shall be deemed to include any service, or benefit provided in or through a facility participating in this program.

(Rule 1200-13-1-.05, continued)

- (d) The enumeration of specific forms of prohibited discrimination in this rule does not limit the generality of the prohibition in this rule.
  - (e) When an Intermediate Care Facility or Skilled Nursing Facility has previously discriminated against persons on the ground of race, color, or national origin, the facility must take affirmative action to overcome the effects of prior discrimination.
  - (f) Even in the absence of such prior discrimination, a facility may take affirmative action to overcome the effects of conditions which resulted in limiting participation by persons of a particular race, color, or national origin.
  - (g) All Long-term Care Facilities shall establish written policies and procedures addressing admission, transfer and discharge, consistent with Medicaid General Rule, Chapter 1200-13-1. These policies and procedures shall be available for inspection by the Department.
- (10) Reimbursement for covered durable medical equipment, including repairs, maintenance, and replacement of equipment and expendable parts thereof, shall be made only to a home health agency or a supplier of durable medical equipment which has an approved participation agreement or contract with the Department of Health and Environment, Medicaid program. Such reimbursement shall be made only as provided in this section and subject to the conditions and requirements set forth herein and elsewhere in this chapter.
- (a) Every item of durable medical equipment shall be ordered in writing by a physician. The physician's order shall indicate, with as great specificity as possible, the type of equipment required and the recipient's anticipated period of need of the equipment in months.
  - (b) Where prior approval is required for any equipment, the home health agency or durable medical equipment supplier shall obtain such approval or assure that it is properly obtained.
  - (c) All durable medical equipment placed on or after July 27, 1984, shall be newly manufactured equipment and shall be placed and reimbursed either as rental or rent-to-purchase equipment as described and limited in this section; however, equipment originally placed as rental equipment may be converted to a rent-to-purchase basis as provided in subsection (g) 2. below.
  - (d) Equipment already placed in a recipient's home on a rental basis prior to July 27, 1984, shall continue to be rented upon the same terms, subject to the recipient's need, until July 27, 1984. Rental of such equipment from and after July 27, 1984, shall be subject to the certification and recertification requirements set forth in subsection (g) 1. below. If any such equipment other than that listed at rule 1200-13-1-.03(gg)13., 14(i), 14(vi) through (viii), 14(xv), 15(ix), or 15(xi) through (xiii) is still in use on October 27, 1984, it shall be converted to a rent-to-purchase basis; all rental payments made for such equipment for the period of July 27, 1984 through October 27, 1984, shall be applied to the total reimbursement purchase amount; and the remainder due shall be billed as provided in subsection (f) below; however, such equipment shall bear the same warranty as newly manufactured equipment of the same type. If a provider does not offer such a warranty, reimbursement shall be denied on the equipment. Newly manufactured equipment may be placed in place of the old equipment and billed as provided in subsection (f) below.
  - (e) The provider of every item of equipment placed on or after July 27, 1994, shall assure the provision of effective training in the proper and safe operation of the equipment, to the recipient, or if the recipient is unable to perform such tasks, to an appropriate person who will be available to assist the recipient in performing such tasks.

(Rule 1200-13-1-.05, continued)

(f) Purchase of Equipment:

All equipment, except that listed at Rule 1200-13-1-.03 (1)(gg)13., 14(i), 14(vi) through (viii), 14(xv), 15(ix), and 15(xi) through (xiii), for which the anticipated period of need as specified in the physician's order is six months or longer, and all equipment listed at Rule 1200-13-1-.03(1)(gg)3., 12(i), 15(i), 15(ii), and 15(x), whatever its anticipated period of need shall be reimbursed by Medicaid as follows:

1. The provider of the equipment shall bill Medicaid for the total charge in one bill after the equipment is delivered and put into operation in the recipient's place of residence.
2. After the provider is reimbursed by Medicaid for the equipment, the equipment shall become the property of the recipient. Such property shall not be considered a resource for purposes of eligibility determination.

(g) Rental Equipment:

1. All equipment, except that listed at Rule 1200-13-1-.03(1)(gg)3., 12(i), 15(i), 15(ii), and 15(x), for which the anticipated period of need as specified in the physician's order is less than six months, and all equipment listed at Rule 1200-13-1-.03(1)(gg)13., 14(i), 14(vi) through (viii), 14(xv), 15(ix), and 15(xi) through (xiii), whatever its anticipated period of need shall be placed as rental equipment and reimbursed only for periods of recipient eligibility for which there is a valid physician's certification. The original physician's order shall suffice as the original certification and shall be valid for such purpose for up to six (6) consecutive months. Thereafter, every six (6) months for as long as the equipment is rented; the provider of the equipment shall assure that a physician provides written medical justification that the recipient's medical condition requires continued use of the equipment.
2. If an item of equipment other than that listed at Rule 1200-13-1-.03(1)(gg)13., 14(i), 14(vi) through (viii), 14(xv), 15(ix), and 15(xi) through (xiii) is originally placed as rental equipment, but the recipient is subsequently determined to need the equipment for six months or longer based upon the physician's certification, the equipment shall be reimbursed as provided in subsection (f) above; however, if any rental payments have already been made, for periods commencing on or after July 27, 1984, they shall be applied to the total reimbursement purchase amount, and the remainder due shall be billed as provided in subsection (f) above.

(h) Repair, Maintenance, and Replacement of Equipment and Parts.

1. Providers of rented durable medical equipment shall assure that all such equipment is adequately maintained and kept in good working order. No reimbursement shall be made in addition to the regular rental payments for such maintenance, repair or replacement of parts.
2. Providers shall be reimbursed for reasonable and necessary repair and maintenance costs and costs of replacement of expendable parts, including but not limited to hoses, fuses or batteries, for all purchased equipment (repair of rental equipment is the responsibility of the rental provider) other than that listed at rule 1200-13-1-.03(1)(ee)3., if proper prior approval is obtained; however, prior approval shall not be required for reimbursement for the replacement of expendable parts the billed amount for which is less than \$75.00. Prior approval shall not be granted, nor shall reimbursement be made for repairs or maintenance covered by a manufacturer's warranty, the result of the recipient's abuse or



(Rule 1200-13-1-.05, continued)

for any repair the reimbursable amount for which exceeds 75% in cumulative of the allowable replacement cost of the equipment.

3. Prior approval shall be required for reimbursement for replacement for any item of purchased durable medical equipment, and for reimbursement for the purchase of any item of equipment for a recipient when an item of the same type has previously been purchased by the Department for the same recipient from any provider, except where the provider of the new item had no knowledge of, and could not reasonably have obtained knowledge of, the previous purchase.
  - (i) Prior Approval.
    1. All items and services listed at subsections (i) through (iii) below shall require prior approval by the Medicaid medical director, or a designated representative, in order for the items or services to be reimbursed by Medicaid:
      - (i) All durable medical equipment listed at rule 1200-13-1-.03(1)(ee)1.(ii), 1.(iii), 6.(iii), 7.(ii) through (ix), 7.(xi) through (xiii), 9.(i) through (iii), 11.(iii), 13.(i) and (ii), 14.(i), 14.(iii), 14.(vi) through (ix), 14.(xi) and (xii), 14.(xv), 15.(vii) through (xiii), and 16.; providers seeking to obtain prior approval for the items listed at rule 1200-13-1-.03(1)(ee)14.(iii), 14.(vi) through 14.(viii), and 14.(xv), shall provide PO2 or O2 level readings in their requests for approval.
      - (ii) Any covered repair and maintenance of durable medical equipment, and replacement of expendable parts thereof for which the billed amount is \$25.00 or more, approval to be subject to the conditions set forth in rule 1200-13-1-.05(1)(h)2., in addition to the standards set forth at subsection 2. below.
      - (iii) Replacement of any item of durable medical equipment, and purchase of any item for a recipient when an item of the same type has previously been purchased by the Department for the same recipient from any provider, except where the provider of the new item had no knowledge of, and could not reasonably have obtained knowledge of, the previous purchase.
    2. The basis for granting or denying prior approval shall be whether the item or service is medically necessary, whether a less expensive alternative would adequately meet the recipient's medical needs, whether the proposed item or service conforms to commonly accepted standards in the medical community, whether any further conditions set forth in these rules have been adequately met, and whether requests include sufficient factual data as determined by the Bureau of Medicaid to enable a fair and objective decision.
    3. Failure to obtain prior approval for an item or service shall not invalidate a claim for reimbursement, where it can be shown that an emergency situation existed.

However, in such cases, the provider or a representative shall telephone Medicaid for approval on the next working day after provision of the service and submit a written request documenting the above conditions, prior to payment of that claim.

4. When a request for prior approval is denied, the recipient for whom the services were requested shall be promptly notified in writing of the denial, of the factual basis for the denial, and of the right requested, and procedures for requesting, a hearing pursuant to TCA. §14-23-113, where he may contest the denial.
5. Providers/suppliers must not request prior approval to purchase, rent or repair home medical equipment or purchase medical supplies for recipients whose place of residence

(Rule 1200-13-1-.05, continued)

does not meet the definition of recipient's place of residence found in rule 1200-1 3-1-.01(15).

- (11) Ambulance service will be provided on an emergency and non-emergency basis.
- (a) Emergency Ambulance service will be reimbursed for a one-way trip to the nearest hospital that can handle the medical emergency. Emergency ambulance transportation shall be provided for recipients in the case of injury or acute medical condition where the same is liable to cause death or severe injury or illness as determined by the attending physician, paramedic, emergency medical technician, or registered nurse.
  - (b) Non-Emergency Ambulance services will be reimbursed when the recipient's condition is such that use of any other method of transportation is contraindicated. For reimbursement, a physician, paramedic, emergency medical technician, registered nurse, or licensed practical nurse must present written documentation that the patient's condition warrants such services. This documentation must be attached to the ambulance provider's request for payment.
- (12) Home health agency providers must limit acceptance of Medicaid recipients for home health care to cases where there is reasonable expectation that the recipient's health needs can be adequately met by the agency in the recipient's place of residence. Services for which the home health agency seeks Medicaid reimbursement must be furnished by the home health agency or by another health organization or individual pursuant to a written agreement between the home health agency and the contracting health organization or individual. All such agreements for the provision of services must stipulate that receipt of payment by the home health agency for the service, whether in its own right or as an agent, relieves the recipient of liability to pay for such services. Home health agencies shall not provide home health services pursuant to a plan of care established, certified or recertified by a physician who has a significant ownership interest, as defined in rule 1200-1 3-1-.21 (1)(i) in the agency.

Home health agencies shall limit acceptance of Medicaid recipients for home health care to cases where the recipient's place of residence is less than seventy-five (75) miles distance according to the official state map from the home health agency's parent or branch office site that is certified for participation in Medicare and Medicaid. Home health agency providers are responsible for obtaining certifications and recertifications of the recipient's homebound status and medical necessity for home health services from the attending physician. Services rendered to recipients on days for which the recipient was not properly certified/recertified or homebound pursuant 1200-13-1-.18 are not reimbursable by Medicaid nor may they be billed to the recipient and/or responsible party.

- (a) Attending physician certification/recertification and approval of the plan of care for home health services.
  - 1. Plans of care and certifications/recertifications need not be documented on a specific form; however, they must be presented in a format that Medicaid representatives can determine, where necessary, that the plan of care and certification/recertification requirements are met. The plan of care and certification/recertification must:
    - (i) Be legible;
    - (ii) Contain the statement "I am the attending physician for this patient and in my professional judgment this patient is homebound according to Medicaid rule 1200-13-1-.18 and the services are medically necessary. Further, I understand that if I knowingly authorize home health services for persons who are not homebound according to Medicaid homebound criteria, and the services are not medically necessary, I may be in violation of Medicaid rule 1200-13-1-.21 and subject to the sanctions described therein."

(Rule 1200-13-1-.05, continued)

- (iii) Be signed and simultaneously dated by the attending physician.
- 2. An attending physician is one who has knowledge of the patient which is based on his personal examination of the patient and/or his personal review of the patient's institutional medical record or a physician's office record.
- 3. Plan of Care
  - (i) Items and services provided through a home health agency must be furnished under an established plan of care that is signed and simultaneously dated by the recipient's attending physician.
  - (ii) The written plan of care must be submitted to the home health agency which has accepted the patient as a client. The home health agency may establish a written plan of care based on the physician's verbal orders. These verbal orders must be recorded by a registered nurse, or qualified therapist employed by the home health agency and forwarded to the attending physician for him to sign and simultaneously date within ten (10) working days. The date of the attending physician's verbal orders should be listed on the plan of care by the home health agency and shall serve as the certification date.
  - (iii) The plan of care must be reviewed by the attending physician once every sixty (60) days.
- 4. Certification/Recertification
  - (i) Certification
    - (I) In order for a home health provider to be reimbursed by Medicaid for home health services rendered to a recipient the attending physician must certify that:
      - I. The individual is in need of the services at the time the plan of care is established;
      - II. The home health services are required because the individual is confined to his home;
      - III. The individual needs skilled nursing care, physical therapy, occupational therapy, or the services of a home health aide, on an intermittent basis;
      - IV. A written plan for furnishing such services to the individual has been established, and
      - V. The services are furnished while the individual is under the care of a physician.
    - (II) Method and Disposition of Certifications
      - I. The attending physician certification must be presented in a format that Medicaid representatives can determine, where necessary, that the certification and requirements are met. The certification by the attending physician will be retained by the home health agency. The

(Rule 1200-13-1-.05, continued)

agency also must indicate on the billing form that the certification has been made by the attending physician.

(ii) Recertification

- (I) When services are continued, the attending physician must certify at intervals not exceeding sixty-two (62) days that there is a continuing need for services and should estimate how long services will be needed. The recertification should be obtained at the time the plan of care is reviewed (at least once every sixty-two days). Recertifications must be signed and simultaneously dated by the attending physician who reviews the plan of care.
- (13) Hospitals participating as providers in the Medicaid program shall not seek payment or contribution of all or any part of the inpatient hospital deductible under Part A of the Medicare program incurred by any recipient of Tennessee Medicaid assistance during the period beginning July 1, 1982, through and including December 31, 1984, including but not limited to, direct collections from said Medicaid recipients, and efforts to collect from said Medicaid recipients through collection agencies or litigation, whether or not they are current Medicaid recipients.
- (14) All providers receiving payments pursuant to TCA, §71-5-101, et seq., are subject to Audit. Statistical sampling techniques may be employed to determine and/or assess overpayments in a provider's Medicaid claim population.
- (15) Facilities requesting voluntary termination of provider agreements shall comply with the following:
- (a) Facilities which choose to voluntarily terminate their provider agreements may do so by notifying the Department in writing of such intent. The effective date of the termination will be determined by the Department consistent with the terms of the TennCare Provider Agreement then in force between the Department and the facility.
- (b) The facility will not be entitled to payment for any additional or newly admitted TennCare eligible residents from the date of the facility's notice of withdrawal from the TennCare program. The facility may, however, at its election, continue to receive TennCare payment for those individuals who resided in the facility, on the date of such notice, so long as they continue to reside in and receive services from the facility and provided that such individuals are TennCare-eligible during the period for which reimbursement is sought. The facility's right to continue to receive TennCare payments for such individuals following the date of its notice of intent to withdraw from the TennCare program is contingent upon:
1. the facility's compliance with all requirements for TennCare participation; and
  2. its agreement to continue to serve, and accept TennCare payment for, on a non-discriminatory basis, all individuals residing in the facility on the date of notification of withdrawal, who are or become TennCare eligible.
- (c) The notification must provide the following information:
1. The reason(s) for voluntary termination;
  2. The names and TennCare identification number of all TennCare-eligible residents;
  3. Name of the resident and name of the contact person for the resident (if any) for residents with an application for TennCare eligibility pending;

(Rule 1200-13-1-.05, continued)

4. A copy of the letter the facility will send to each resident informing them of the voluntary termination, and a copy of the letter to be sent to all TennCare-eligible residents regarding this action;
  5. A copy of the letter sent to all applicants on the wait list informing them of the facility's voluntary termination; and
  6. Whether or not the facility intends to continue to provide services to non-TennCare residents who were residents of the facility on the date withdrawal was approved, in the event they convert to TennCare eligibility; and a copy of the notice to residents explaining that decision; and,
  7. Other information determined by the Department as necessary to process the request for termination.
- (d) The termination of the provider's involvement in TennCare must be done in such a manner as to minimize the harm to current residents.
1. Residents who are currently TennCare-eligible shall be informed, in a notice to be provided by the facility and approved by the Department, the facility has elected to withdraw from the TennCare program. If the facility has elected under subsection (b) of the section to continue to receive TennCare payments for residents of the facility as of the date of notice of withdrawal from the TennCare program, the notice shall inform the resident of the right to remain in the facility as a TennCare patient as long as they wish to do so and remain otherwise eligible under the rules of the TennCare Program. The notice shall also inform the resident that, if they wish to transfer to another facility, under the supervision of the Department, the Long Term Care Facility where they now reside will assist in locating a new placement and providing orientation and preparation for the transfer, in accordance with 42 U.S.C. §1396r(c)(2)(C) and implementing regulations and guidelines, if any.
  2. All other residents of the facility shall receive a separate notice informing them of the facility's intention to withdraw from the TennCare program. The notice will be provided by the Facility after having been first reviewed and approved by the Department. The notice shall inform such residents that, should they become eligible for TennCare coverage, they will be able to convert to TennCare from their current source of payment and remain in the facility only during a period that ends with the termination of the facility's provider agreement, a date to be determined in accordance with the terms of the provider agreement. They will not be eligible for TennCare coverage of their care in the facility thereafter. Transfer of these residents shall be considered an involuntary transfer and shall comply with Department regulations governing involuntary transfer or discharges.

The same notice will caution these residents that, if they require care as TennCare patient after the facility's provider agreement is terminated, they will have to transfer to another facility. The notice will also inform the residents that, when their present facility is no longer participating in the TennCare program, certain legal rights and protections that apply to all residents (regardless of source of payment) in TennCare facilities will no longer be available to those who remain in the Long-Term Care Facility. Readers of the notice will be informed that, if they wish to transfer, or to have their names placed on wait lists at other facilities, the facility that is withdrawing from the program will assist them by providing preparation and orientation under the supervision of the Department, as required by 42 U.S.C. § 1396r(c)(2)(C) and implementing regulations and guidelines, if any.

(Rule 1200-13-1-.05, continued)

3. Applicants whose names are on the facility's wait list will be notified by the facility on a form that has been reviewed and approved by the Department, that the facility intends to withdraw from the TennCare program. They will be cautioned that they will not be able to obtain TennCare coverage for any care that they receive in the facility. The notice shall also inform them that certain legal rights and protections that apply to all residents (regardless of source of payment) in TennCare participating facilities will not be available in the Long Term Care Facility to which they have applied, once that facility has withdrawn from the TennCare program.

Applicants will be informed in the notice that, if they wish to make application at other facilities, the withdrawing facility, under the supervision of the Department, shall assist them in seeking placement elsewhere.

- (e) Following submission of a notice of withdrawal from the TennCare program a facility cannot opt to receive continued TennCare payments for any resident unless it agrees to accept continual TennCare payment for all individuals who are residents on the date of the notice of withdrawal, and who are or become TennCare-eligible provided, however, that TennCare will pay the facility for all covered services actually provided to TennCare-eligible residents following notice of the facility's withdrawal and pending the resident's transfer or discharge. In instances where facilities elect to continue to receive such TennCare payments, their provider agreements will remain in effect until the last TennCare-eligible individual, who resided in the facility as of the date of notification of withdrawal, has been discharged or transferred from the facility in accordance with TennCare and state licensure requirements .
  - (f) Facilities which terminate their provider agreement shall not be permitted to participate in TennCare for a period of at least two years from the date the provider agreement is terminated .
  - (g) Unless the facility notifies the department within thirty (30) days after giving a notice of termination, the facility may not stop the termination procedure consistent with this order without written approval from the Department.
- (16) Long-term Care Facilities may be involuntarily decertified by the Department because of their failure to comply with the provisions of Medicaid General Rule, Chapter 1200-13-1. Facility that are involuntary decertified shall not be permitted to participate in the Medicaid program for a minimum of five (5) years from the date of the decertification.
  - (17) Long-term Care Facilities participating in the Medicaid Program shall not as a condition of admission to or continued stay at the facility request or require:
    - (a) Transfer or discharge of a Medicaid-eligible resident because Medicaid has been or becomes the resident's source of payment for long-term care.
    - (b) Payment of an amount from a Medicaid-eligible resident in excess of the amount of patient liability determined by the Tennessee Department of Human Services.
    - (c) Payment in excess of the amount of patient liability determined by the Tennessee Department of Human Services from any resident who is financially eligible for medical assistance but who has not submitted a PAE for consideration or whose appeal rights for a denied PAE have not been exhausted.
    - (d) Any person to forego his or her right to Title XIX Medical Assistance benefits for any period of time.

(Rule 1200-13-1-.05, continued)

- (e) A third party (i.e. responsible party) signature, except as required of a court appointed legal guardian or conservator, or require payment of any kind by a third party on behalf of a Medicaid Eligible individual.
- (18) Long-term Care Facilities participating in the Medicaid Program must comply with the following guidelines regarding transfers, discharges and/or readmissions.
- (a) Transfer and Discharge Rights - A Long-term Care Facility must permit each resident to remain in the facility and must not transfer or discharge the resident from the facility unless;
    1. The transfer or discharge is necessary to meet the resident's welfare which cannot be met in the facility;
    2. The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
    3. The safety of individuals in the facility is endangered;
    4. The health of individuals in the facility would otherwise be endangered;
    5. The resident has failed, after reasonable and appropriate notice, to pay (or to have paid under Title XIX or Title XVIII on the resident's behalf) for a stay at the facility; or
    6. The facility ceases to operate.

In each of the cases described above, no patient shall be discharged or transferred without a written order from the attending physician or through other legal processes and timely notification of next of kin and/or sponsor or authorized representative, if any. Each Long-term Care Facility shall establish a policy for handling patients who wish to leave the facility against medical advice. The basis for the transfer or discharge must be documented in the resident's clinical record. In the cases described in the clauses (a) 1. and (a)2., the documentation must be made by the resident's physician, and in the case described in clause (a)4. the documentation must be made by a physician. For purposes of clause (a)5., in the case of a resident who becomes eligible for assistance under Title XIX after admission to the facility, only charges which may be imposed under Title XIX shall be considered to be allowable.

When a patient is transferred, a summary of treatment given at the facility, condition of patient at time of transfer and date and place to which transferred shall be entered in the record. If transfer is due to an emergency; this information will be recorded within forty-eight (48) hours; otherwise, it will precede the transfer of the patient.

When a patient is transferred, a copy of the clinical summary should, with consent of the patient, be sent to the Long-term Care Facility that will continue the care of the patient.

Where an involuntary transfer is proposed, in addition to any other relevant factors, the following factors shall be taken into account:

- (i) The traumatic effect on the patient.
- (ii) The proximity of the proposed Long-term Care Facility to the present facility and to the family and friends of the patient.
- (iii) The availability of necessary medical and social services at the proposed Long-term Care Facility.

(Rule 1200-13-1-.05, continued)

- (iv) Compliance by the proposed Long-term Care Facility with all applicable Federal and State regulations.
- (b) Pre-Transfer and Pre-Discharge Notice - Before effecting a transfer or discharge of a resident, a Long-term Care Facility must:
1. Notify- the resident (and, if known, a family member of the resident or legal representative) of the transfer or discharge and the reasons therefore.
  2. Record the reasons in the resident's clinical record (including any documentation required pursuant to (a) above) and include in the notice the items described in (d) below.
  3. Notify the Department and the long-term care Ombudsman.
  4. Not transfer or discharge a resident until the above agencies have designated their intention to intervene and until any appeal process is complete, should the resident request a fair hearing.
- (c) Timing of Notice - The notice under (b) must be made at least thirty (30) days in advance of the resident's transfer or discharge except:
1. In a case described in (a)3. or (a)4. above.
  2. In a case described in (a)2. where the resident's health improves sufficiently to allow a more immediate transfer or discharge.
  3. In a case described in (a)1. where a more immediate transfer or discharge is necessitated by the resident's urgent medical needs.
  4. In a case where a resident has not resided in the facility for thirty (30) days.
- In the case of such exceptions, notice must be given as many days before the date of transfer or discharge as is practicable.
- (d) Items included in notice - Each pre-transfer and pre-discharge notice under (b) must include:
1. For transfers or discharges effected on or after October 1, 1990, notice of the resident's right to appeal the transfer or discharge.
  2. The name, mailing address, and telephone number of the long-term care ombudsman.
  3. In the case of residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy system for developmentally disabled individuals.
  4. In the case of mentally ill residents, the mailing address and telephone number of the agency responsible for the protection and advocacy system for mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.
- (e) Orientation - A Long-term Care Facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.



(Rule 1200-13-1-.05, continued)

- (f) Notice of Bed-Hold Policy and Readmission - Before a resident of a Long-term Care Facility is transferred for hospitalization or therapeutic leave, a Long-term Care Facility must provide written information to the resident and a family member or legal representative concerning:
    - 1. The provisions of the State plan under this Title XIX regarding the period (if any) during which the resident will be permitted under the State plan to return and resume residence in the facility, and
    - 2. The policies of the facility consistent with (g) below, regarding such a period.
  - (g) Notice Upon Transfer - At the time of transfer of a resident to a hospital or for therapeutic leave, a Long-term Care Facility must provide written notice to the resident and a family member or legal representative of the duration of any period under the State plan allowed for the resumption of residence in the facility.
- (19) Effective October 1, 1990, Medicaid recipients served in Nursing Facilities (NF) enrolled in the Medicaid program will be categorized, according to their needs, as either Level 1 NF residents or Level 2 NF residents. Level I NF residents meet the criteria formerly required for participation at the Intermediate Care Facility level of care. while Level 2 NF residents meet the criteria formerly required for participation at the Skilled Nursing Facility level of care. Medicaid will provide Level 2 NF reimbursement only for beds that are certified for both Medicaid and Medicare for the provision of nursing facility care.
- (20) (a) No change of ownership or controlling interest of an existing Medicaid provider, including but not limited to: hospitals, nursing home facilities, home health agencies, and pharmacies, can occur until monies as may be owed to Medicaid are provided for. The purchaser shall notify Medicaid of the purchase at the time of ownership change and is financially liable for the outstanding liabilities to Medicaid for one (1) year from the date of purchase or for one (1) year following Medicaid's receipt of the provider's Medicare final notice of program reimbursement, whichever is later. The purchaser shall be entitled to utilize any means available to it by law to secure and recoup these funds from the selling entity. In addition, purchasers of nursing facilities are responsible for obtaining an accurate accounting and transfer of funds held in trust for Medicaid residents at the time of the change of ownership or controlling interest.
- (b) If the division of Medicaid has not reimbursed a business for Medicaid services provided under the Medicaid program at the time the business is sold, when such an amount is determined the division of Medicaid shall be required to reimburse the person owning the business provided such sale included the sale of such assets.
- (21) Long-term Care Facilities shall require that all solid, oral dosage forms of medications intended for consumption by Tennessee Medicaid/TennCare patients, residing in such facilities, be provided in unit dose packaging.
- (a) Unit dose packaging is an individual package designed to hold a separate and distinct solid, oral dosage form drug product intended for administration as a single dose. Unit dose packaging bears at least the name of the drug, strength, expiration date, control number, and the name of the manufacturer as required by Tennessee pharmacy law.
  - (b) A unit dose distribution system shall provide no more than a seven day supply of medication(s) to each patient and shall have the ability to bill only for medications after they have been consumed.
- (22) The Tennessee Bureau of Medicaid and the Tennessee Department of Mental Health and Mental Retardation are jointly responsible for certifying community mental health providers for participation in the Medicaid Program's Clinic Services option. After a potential community mental health provider

(Rule 1200-13-1-.05, continued)

has met certification criteria the Department of Mental Health and Mental Retardation listed below, the Bureau of Medicaid shall certify that provider for enrollment, under the Clinic Services option, in the Medicaid Program if all provider enrollment criteria as set out in rule 1200-13-1-.05(1)(a) are met.

The Department of Mental Health and Mental Retardation shall certify an agency or organization as a community mental health provider under the Clinic Services option for availability of Medicaid reimbursement for community mental health services if the agency/organization:

- (a) Provides an array of services which, at a minimum, include the covered services listed in rule 1200-13-1-.24 (with the exception of therapeutic nursery and case management. which are optional) and the following services which may or may not be covered by Medicaid:
    - 1. Outpatient services including but not limited to prescreening, follow-up/liaison, and treatment;
    - 2. Emergency services;
    - 3. Day treatment services;
    - 4. Transitional/residential services; and
    - 5. Consultation and education services.
  - (b) Makes the above listed services available to all members of the priority population in the catchment area assigned to the community mental health center by the Department of Mental Health and Mental Retardation;
  - (c) Complies with applicable licensure rules of the Tennessee Department of Mental Health and Mental Retardation;
  - (d) Has appropriate licensure from the Department of Mental Health and Mental Retardation;
  - (e) Adheres to the Department of Mental Health and Mental Retardation's fiscal reporting requirements; and
  - (f) Is under contract with the Department of Mental Health and Mental Retardation to provide community mental health services.
- (23) For providers enrolled in the Tennessee Medicaid program prior to January 1, 1994, the rule as set out at 1200-13-1-.05(1) - (20) shall apply. Effective January 1, 1994, the rules of TennCare as set out at rule chapter 1200-13-12 shall apply except for providers of nursing facility services, providers of intermediate care facility services for the mentally retarded (ICF-MR), providers of Home and Community Based Waiver Services, providers of Medicare Services for Qualified Medicare Beneficiaries (QMBs) and providers of Medicare services for Special Low-Income Medicare Beneficiaries (SLIMBs). Nursing facilities, intermediate care facilities for the mentally retarded (ICF-MR), providers of Home and Community Based Waiver Services, providers of Medicare services for Qualified Medicare Beneficiaries and providers of Medicare Services for Special Low-Income Medicare Beneficiaries (SLIMBs) will continue to be governed by the Tennessee Medicaid rules in effect prior to January 1, 1994, and as may be amended.

**Authority:** T.C.A. §§4-5-202, 71-5-105, 71-5-109, and Executive Order No. 11 and 23. **Administrative History:** Original rule filed November 17, 1977; effective December 19, 1977. Amendment filed January 31, 1979; effective March 16, 1979. Amendment filed April 8, 1981; effective May 26, 1981. Amendment filed August 31, 1981; effective October 15, 1981. Amendment filed November 4, 1981; effective December 21, 1981. Amendment filed January 29, 1982; effective March 15, 1982. Amendment filed May 14, 1982; effective July 1, 1982. Amendment filed May 26, 1983; effective June 27, 1983. Amendment filed June 23, 1983; effective July 25, 1983. Amendment

(Rule 1200-13-1-.05, continued)

*filed June 27, 1984; effective July 27, 1984. Amendment filed November 30, 1984; effective December 30, 1984. Amendment filed September 18, 1985; effective October 18, 1985. Amendment filed February 12, 1986; effective March 14, 1986. Amendment filed February 23, 1987; effective April 9, 1987. Amendment filed March 25, 1987; effective May 9, 1987. Amendment filed July 30, 1987; effective September 13, 1987. Amendment filed September 30, 1987; effective November 14, 1987. Amendment filed October 22, 1987; effective December 6, 1987. Amendment filed October 12, 1987; effective January 27, 1988. Amendment filed August 17, 1988; effective October 1, 1988. Amendment filed July 26, 1989; effective September 10, 1989. Amendment filed February 23, 1990; effective April 9, 1990. Amendment filed May 10, 1990; effective June 24, 1990. Amendment filed June 8, 1990; effective July 23, 1990. Amendment filed August 17, 1990; effective October 1, 1990. Amendment filed September 28, 1990; effective November 12, 1990. Amendment filed November 5, 1990; effective December 20, 1990. Amendment filed November 27, 1990; effective January 11, 1991. Amendment filed January 9, 1991; effective February 23, 1991. Amendment filed February 12, 1991; effective March 29, 1991. Amendment filed February 21, 1991; effective April 7, 1991. Amendment filed February 1991; effective April 9, 1991. Amendment filed February 27, 1991; effective April 13, 1991. Amendment filed April 1, 1991; effective May 16, 1991. Amendment filed June 12, 1991; elective July 27, 1991. Amendment filed November 22, 1991; effective January 6, 1992. Amendment filed April 29, 1992; effective June 13, 1992. Amendment filed May 1, 1992; effective June 15, 1992. Amendment filed October 8, 1992; effective November 22, 1992. Amendment filed October 26, 1992; effective December 10, 1992. Amendment filed November 17, 1993; effective January 31, 1994. Amendment filed March 11, 1994; effective May 25, 1994. Amendment filed March 18, 1994; effective June 1, 1994. Amendment filed May 2, 1994; effective July 16, 1994. Amendment filed November 10, 1994; effective January 24, 1995. Amendment filed March 3, 1995; effective June 15, 1995. Amendment filed June 29, 2000; effective September 12, 2000. Amendment filed August 21, 2001; effective November 4, 2001.*

#### **1200-13-1-.06 PROVIDER REIMBURSEMENT.**

- (1) An Emergency Medial Technician's or physician's certification of emergency is required for reimbursement of emergency ambulance service.
- (2) (a) All claims must be filed within one (1) year of the date of service in the following circumstances:
  1. Recipient eligibility was determined retroactively to the extent that filing within one (1) year was not possible. In such situations, claims must be filed within one year after final determination of eligibility.
  2. The claim was filed with Medicare on a timely basis and if the claim was not automatically crossed over from the Medicare carrier to the Medicaid fiscal agent, was followed up with a Medicaid claim within six (6) months of notification from Medicare, of payment or denial.
- (b) Should an original claim be denied, any resubmission or follow-up of the initial claim must be received within six (6) months from the original date. Medicaid will not process submissions received after the six (6) month time limit. The one exception is those claims returned due to available third party coverage. These claims must be submitted within sixty (60) days of notice from the third party provider.
- (c) Should a correction document involving a pended claim be sent to the provider, the claim will be denied if the correction document is not completed by the provider and returned to the Fiscal Agent within 90 days from the date on the document.
- (d) If claim is not filed within the above time frames no reimbursement may be made.
- (e) Claims will be paid on a first claim approved - first claim paid basis.

(Rule 1200-13-1-.06, continued)

- (f) Medicaid will not reimburse providers for services for which there is no Federal financial participation.
  - (g) If medically necessary, Medicaid services are provided to a person whose disability application is pending beyond the time limits as set out in applicable state or federal regulations or in appeal. Once eligibility is established, the provider may request Medicaid reimbursement within one year after the final determination of eligibility and refund the amount paid by the recipient. Medicaid reimbursement shall be in accordance with the rules of the Tennessee Department of Health and Environment, Bureau of Medicaid.
  - (h) If medically necessary, Medicaid covered services are provided to a person whose disability application is pending beyond the time limits as set out in applicable state or federal regulations or in appeal. Once eligibility is established, if the provider refuses to request Medicaid reimbursement, the recipient may seek Medicaid reimbursement directly by submitting documentation sufficient to determine the type of service, date of service, the amount paid for the service, and necessity for the service. Claims must be filed within one year after the final determination of eligibility. Medicaid reimbursement to the recipient shall not exceed the amount that would be paid to the provider, pursuant to subparagraph (g) above.
  - (i)-(k) Reserved.
  - (l) When a provider was originally paid within a retrospective payment system that is subject to regular adjustments and the provider disputes the proposed adjustment action, the provider must file with the Department not later than thirty (30) days after receipt of the notice informing the provider of the proposed adjustment action, a request for hearing. The provider's right to a hearing shall be deemed waived if a hearing is not requested within thirty (30) days after receipt of the notice.
- (3) Level II Nursing Facilities
- (a) A Level II Nursing Facility will be reimbursed on the lowest of the following:
    1. Allowable costs,
    2. Allowable charges,
    3. An amount representing the reimbursable cost of the 65th percentile of all such facilities or beds, whichever is lower, participating in the Level II Medicaid nursing facility program. In determining the 65th percentile for purposes of this subsection, each provider's most recently filed and reviewed cost report shall be inflated from the mid-point of the provider's cost reporting period to the mid-point of the state's payment period. The trending factor shall be computed for facilities that have submitted cost reports covering at least six months of program operations. For facilities that have submitted cost reports covering at least three full years of program participation, the trending factor shall be the average cost increase over the three-year period, limited to the 75th percentile trending factor of facilities participating for at least three years. Negative averages shall be considered zero. For facilities that have not completed three full years in the program, the one-year trending factor shall be the 50th percentile trending factor of facilities participating in the program for at least three years. For facilities that have failed to file timely cost reports, the trending factor shall be zero.
    4. A prospective amount representing the reimbursable cost of the 65th percentile of facilities or beds, whichever is lower, participating in the nursing facility Level II Program. In determining the 65th percentile ceiling for purposes of this sub-section, operating costs from each provider's most recently filed and reviewed cost report will be

(Rule 1200-13-1-.06, continued)

inflated from the midpoint of the provider's cost reporting period to the mid-point of the state's payment period. The inflation factor shall be as described in 3. above. Capital-related costs are not subject to indexing. Operating and capital-related costs are as specified on Worksheet B of the Medicare skilled nursing facility cost report form. Budgeted cost reports receive no inflation allowance; or

5. For State Fiscal Year 1997-98, the budgeted amount for level I and level II care of \$672,040,000. For State Fiscal Year 1998-99, the budgeted amount for level I and level II care of \$705,642,000. For State Fiscal Year 1999-2000 and subsequent years, a proportional share of expenditures not to exceed the amount budgeted by the State for nursing facility reimbursement. Expenditures will be monitored throughout each year to determine if rate adjustments are necessary to assure that each level of care is within the budgeted amount.

To assure the proper application of limit 5. above, the Comptroller's Office shall be authorized to adjust per-diem rates up or down as necessary during the year.

The cost report closing date for determination of the Level II 65th percentile shall be the first working day of the month preceding the month in which the recomputed 65th percentile is effective. All clean cost reports received by the Comptroller's Office on or before the closing date shall be included in the determination of the 65th percentile. A clean cost report is one upon which rates may be set without additional communication from the provider. Home office cost reports must be filed before any individual nursing home cost reports included in a chain can be processed.

The annual nursing facility tax will be passed through as an allowable cost, but will be excluded for purposes of computing the inflation allowance and cost-containment incentive. The nursing home tax will not be subject to the 65th percentile limits but is subject to the limit specified in rule 1200-13-1-.06(3)(a)5.

Once a per-diem rate is determined from a clean cost report, the rate will not be changed until the next ceiling redetermination except for audit adjustments, correction of errors, or termination of a budgeted rate, or as necessary to comply with rule 1200-13-1-.06(3)(a)5.

If the patient has no available resources to apply toward payment, the payment made by the state is the lower of per-diem cost, charges, or the 65th percentile of beds or facilities, whichever is lower, participating in the Medicaid Program. Cost is determined on a facility by facility basis.

- (b) Medicare Part B charges are non-allowable in calculating Medicaid Level II nursing facility reimbursement.
- (c) Effective on the approved effective date of the State Plan Amendment approved by the Health Care Financing Administration, Department of Health and Human Services, qualifying Medicaid Level II nursing facilities shall be eligible to receive a Medicaid nursing facility Level II disproportionate share payment (M2DSA).
  1. To be eligible to receive a (M2DSA) payment, a facility must be:
    - (i) County owned;
    - (ii) Medicaid Level I and Level II covered days, from the facility's most recently filed Medicaid Level I cost report, must be equal to or greater than 75% of total facility patient days;

(Rule 1200-13-1-.06, continued)

- (iii) The facility must have more than 200 beds; and
    - (iv) The facility must be the largest provider of Medicaid days in its county.
  2. For all facilities participating in the Medicaid Program, the Department of Finance and Administration shall determine a maximum upper payment limit in accordance with 42 CFR 447.272(a) in effect October 1, 1998.
  3. The Department of Finance and Administration shall negotiate a supplemental payment with eligible nursing facilities as described in Part 1. above. The negotiated payment cannot exceed the upper payment limit described in Part 2. above.
  4. Using the most recently filed cost report for each facility described in Part 1. above, the Department of Finance and Administration shall determine each facility's (M2DSA) percentage by dividing the facility's Medicaid Level II days by the total number of Medicaid Level II patient days for all facilities described in Part 1. above.
  5. Each eligible facility's (M2DSA) shall be determined by multiplying its (M2DSA) percentage by the negotiated supplemental payment described in Part 3.
- (4) Level I Nursing Facilities
  - (a) A Level I Nursing Facility will be reimbursed on the lowest of the following:
    1. Allowable cost,
    2. Allowable charges,
    3. An amount representing the 65th percentile of all such facilities or beds, whichever is lower, participating in the Level I Medicaid nursing facility program. In determining the 65th percentile for purposes of this sub-section, each provider's most recently filed and reviewed cost report shall be inflated from the mid-point of the provider's cost reporting period to the mid-point of the state's payment period. The trending factor shall be computed for facilities that have submitted cost reports covering at least six months of program operations. For facilities that have submitted cost reports covering at least three full years of program participation, the trending factor shall be the average cost increase over the three-year period, limited to the 75th percentile trending factor of facilities participating for at least three years. Negative averages shall be considered zero. For facilities that have not completed three full years in the program, the one-year trending factor shall be the 50th percentile trending factor of facilities participating in the program for at least three years. For facilities that have failed to file timely cost reports, the trending factor shall be zero,
    4. An amount representing the reimbursable cost of the 65th percentile of facilities or beds, whichever is lower, participating in the nursing facility Level I Program. In determining the 65th percentile ceiling for purposes of this sub-section, operating costs from each provider's most recently filed and reviewed cost report will be inflated from the mid-point of the provider's cost reporting period to the mid-point of the state's payment period. The inflation factor shall be as described in 3. above. Capital-related costs are not subject to indexing. Capital-related costs are property, depreciation, and amortization expenses included in Section F.18 and F.19 of the Nursing Facility Cost Report Form. All other costs, including home office costs and management fees, are operating costs. No inflation factor will be allowed for providers not filing timely cost reports. For providers in the program less than three years, the inflation factor shall be the 50th

(Rule 1200-13-1-.06, continued)

percentile of allowable inflation factors for providers participating in the program for at least three years. Budgeted cost reports receive no inflation allowance; or

5. For State Fiscal Year 1997-98, the budgeted amount for level I and level II care of \$672,040,000. For State Fiscal Year 1998-99, the budgeted amount for level I and level II care of \$705,642,000. For State Fiscal Year 1999-2000 and subsequent years, a proportional share of expenditures not to exceed the amount budgeted by the State for nursing facility reimbursement. Expenditures will be monitored throughout each year to determine if rate adjustments are necessary to assure that each level of care is within the budgeted amount.

To assure the proper application of limit 5. above, the Comptroller's Office shall be authorized to adjust per-diem rates up or down as necessary during the year.

The annual nursing facility tax will be passed through as an allowable cost, but will be excluded for purposes of computing the inflation allowance and cost-containment incentive. The nursing home tax will not be subject to the 65th percentile limits but is subject to the limit specified in rule 1200-13-1-.06(4)(a)5.

If the patient has no available resources to apply toward payment, the payment made by the state is the lower of per-diem cost, charges, or the 65th percentile of all such facilities or beds participating in the Medicaid Program, whichever is less. Cost is determined on a facility by facility basis.

The cost report closing date for determination of the Level I 65<sup>th</sup> percentile shall be the first working day of the month preceding the month in which the recomputed 65<sup>th</sup> percentile is effective. All clean cost reports received by the Comptroller's Office on or before the closing date shall be included in the determination of the 65<sup>th</sup> percentile ceiling. A clean cost report is one upon which rates may be set without additional communication from the provider. Home office cost reports must be filed before any individual nursing home cost reports included in a chain can be processed.

- (b) A Level 1 nursing facility (NF) shall be reimbursed in accordance with this paragraph for the recipient's bed in that facility during the recipient's temporary absence from that facility in accordance with the following:
  1. Effective October 1, 2005, reimbursement will be made for up to a total of 10 days per state fiscal year while the resident is hospitalized or absent from the facility on therapeutic leave. The following conditions must be met in order for a bed hold reimbursement to be made under this provision:
    - (i) The resident intends to return to the NF.
    - (ii) For hospital leave days:
      - (I) Each period of hospitalization is physician ordered and so documented in the patient's medical record in the NF; and
      - (II) The hospital provides a discharge plan for the resident.
    - (iii) Therapeutic leave days, when the resident is absent from the facility on a therapeutic home visit or other therapeutic absence, are provided pursuant to a physician's order.

(Rule 1200-13-1-.06, continued)

- (iv) At least 85% of all other beds in the NF are occupied at the time of the hospital admission or therapeutic absence.
  - (c) Costs for supplies and other items billed to Medicare Part B on behalf of all patients must be included as a reduction to reimbursable expenses in Section G of the nursing facility cost report.
  - (d) Once a per-diem rate is determined from a clean cost report, the rate will not be changed until the next ceiling redetermination except for audit adjustments, correction of errors, or termination of a budgeted rate, or as necessary to comply with rule 1200-13-1-.06(4)(a)5.
  - (e) Effective on the approved effective date of the State Plan Amendment approved by the Health Care Financing Administration, Department of Health and Human Services, qualifying Medicaid Level I nursing facilities shall be eligible to receive a Medicaid nursing facility Level I disproportionate share payment (MIDSA).
    - 1. To be eligible to receive a (MIDSA) payment, a facility must be:
      - (i) County owned;
      - (ii) Medicaid Level I and Level II covered days, from the facility's most recently filed Medicaid Level I cost report, must be equal to or greater than 75% of total facility patient days;
      - (iii) The facility must have more than 200 beds; and
      - (iv) The facility must be the largest provider of Medicaid days in its county.
    - 2. For all facilities participating in the Medicaid Program, the Department of Finance and Administration shall determine a maximum upper payment limit in accordance with 42 CFR 447.272(a) in effect October 1, 1998.
    - 3. The Department of Finance and Administration shall negotiate a supplemental payment with eligible nursing facilities as described in Part 1. above. The negotiated payment cannot exceed the upper payment limit described in Part 2. above.
    - 4. Using the most recently filed cost report for each facility described in Part 1. above, the Department of Finance and Administration shall determine each facility's (MIDSA) percentage by dividing the facility's Medicaid Level I days by the total number of Medicaid Level I patient days for all facilities described in Part 1. above.
    - 5. Each eligible facility's (MIDSA) shall be determined by multiplying its (MIDSA) percentage by the negotiated supplemental payment described in Part 3.
- (5) Outpatient service other than ambulance service shall be paid in accordance with Medicare principles of cost reimbursement as set out in the Medicare provider reimbursement manual in effect on October 1, 1982, except that the lower of cost or charges determination will be made separately and without consideration of inpatient cost or charges. Ambulance service shall be paid in accordance with 1200-13-1-.06(15).
- (6) Independent Laboratory and X-Ray.
- (a) Independent Laboratory - Reimbursement is the lesser of billed charges or 60% of the Medicare Statewide Area Prevailing Rate for all procedures restricted by the Consolidated Omnibus Budget Reconciliation Act of 1985. Procedures not restricted by the Consolidated Omnibus Budget Reconciliation Act of 1985 are reimbursed the lesser of billed charges, 85% of the



(Rule 1200-13-1-.06, continued)

Statewide Area Prevailing 75th Percentile amount. All laboratory procedure will be reimbursed at the lesser of the rate in effect June 30, 1988 or the cap rate established by the Consolidated Omnibus Budget Reconciliation Act of 1985.

- (b) X-Ray
1. Reimbursement is not to exceed the lesser of:
    - (i) 100% of billed charges, or
    - (ii) 85% of the usual and customary charges at the 50th percentile, or
    - (iii) 85% of the statewide area prevailing charges at the 75th percentile, or
    - (iv) 100% of a statewide x-ray fee schedule, established where usual and customary charges and area prevailing charges do not exist.
  2. Payment for any of the above will not exceed the amount that would have been paid on June 30, 1988.
- (7) Early Periodic Screening, Diagnosis and Treatment. payment to EPSD & T screening providers will be made as provided for in this paragraph.

(a)	Age of Recipient	Screening	Developmental Assessment	Physician Exam and Diagnosis
	0-2 years	12.00	11.00	5.00
	3-11 years	14.00	11.00	5.00
	12-20 years	18.00	11.00	5.00

- (b) Reimbursement for laboratory services and treatment services resulting from the EPSD & T screening will be made in accordance with reimbursements, established in this rule for the providers who furnish such services.
- (c) Reimbursement for immunizations will be the average wholesale price of the vaccine, as established in the most recent edition of the *Red Book-Drug Topic*, as published by the Medical Economics Company, plus a \$2.00 administration fee.
- (8) Medicaid will reimburse qualified providers for the following family planning services:
- (a) Complete Physical - The patient receives, but is not limited to, the following list of required medical services: pap smear, pelvic exam, breast exam, heart/lung, thyroid, abdomen, extremities, urinalysis, blood pressure check, hematocrit/hemoglobin, and gonorrhea culture. During the complete physical the health care practitioner will advise the patient on types of suitable contraceptive methods available, and the patient is free to choose the contraceptive method to be used if not medically contraindicated. Reimbursement for a complete physical will be made pursuant to the terms of the participation agreement
  - (b) I.U.D./Diaphragm Visit - An I.U.D. insertion or diaphragm fitting done at a time other than the complete physical exam. Reimbursement for an I.U.D./Diaphragm visit will be made pursuant to the terms of the participation agreement
  - (c) Medical Visit - Patient receives one or more medical services which requires being placed on the table (breast exam, pelvic exam, pap smear, heart/lung evaluation, wet smear, biopsy, gonorrhea culture, other physical exam which includes diaphragm check, and/or I.U.D. string

(Rule 1200-13-1-.06, continued)

- check and any contraceptive and/or therapeutic supplies associated with the visit). Reimbursement for a medical visit will be made pursuant to the terms of the participation agreement.
- (d) Supply Visit - Patient receives a contraceptive supply accompanied by appropriate tests, but does not receive an examination and patient is not placed upon the examination table. Reimbursement for a supply visit will be made pursuant to the terms of the participation agreement.
  - (e) Pregnancy Test Visit - Patient receives a pregnancy test only and does not receive any other services. Reimbursement for a pregnancy test will be made pursuant to the terms of the participation agreement.
  - (f) Other Visit - Patient receives services in the clinic, and the services do not fall in one of the above categories. An "Other Visit" includes: counseling, hematocrit/hemoglobin check, blood pressure check, and/or urinalysis. Reimbursement for other visits will be made pursuant to the terms of the participation agreement.
- (9) Physician services payment is not to exceed the lesser of the billed amounts, 85 % of the usual and customary charges accumulated by each individual physician, or 85 % of the 75th percentile of the range of weighted customary charges by physicians in the State (Physicians profile) for the 1984 calendar year. Physician service reimbursement shall not exceed the amount in effect June 30, 1988. Effective December 1, 1990, physician services provided to children under age 21 in excess of the 24 office visit limit, the 20 hospital visit limit or hospital visit limits for approved organ transplants will be reimbursed at 60% of what would otherwise be reimbursed. No reduction in reimbursement for physician office or hospital visits will be made when provided to a pregnant recipient or when the visit is provided to a recipient under age 21 as a result of an EPSD&T screening.
- (10) Home Health Care Services - Payment is based on the lesser of:
- (a) Billed charges, or
  - (b) Reasonable cost according to Medicare principles of reimbursement and limits, or
  - (c) The median statewide cost per visit for each home health care service as determined each July 1. Each provider's most recent cost report on file as of April 1 of each year will be included in the determination of the median. Costs per visit will be trended from the midpoint of the providers cost reporting period to the midpoint of the state's fiscal year using the forecasted percent increase in the home health agency market basket as published in the federal register.
  - (d) After a period of five years following the implementation of the TennCare Program on January 1, 1994, amended or corrected home health agency cost reports with claims for reimbursement for services prior to January 1, 1994 shall not be accepted.
- (11) (a) Purchased durable medical equipment, prosthetic devices, orthotic appliances and medical supplies, except medical supplies for continuous ambulatory peritoneal dialysis (CAPD) and continuous cycling peritoneal dialysis (CCPD), provided by a Home Health Agency or Medical Vendor will be reimbursed at the lesser of:
- 1. Billed charges, or
  - 2. 100% of the 75th percentile of Medicare prevailing charges in effect as of June 30, 1988, or

(Rule 1200-13-1-.06, continued)

3. Where there are no Medicare prevailing charges, an amount in effect June 30, 1988, that was derived by obtaining suggested retail prices from at least three manufacturers and setting an amount equal to the median of these prices. At such time as Medicare prices become available, the Medicare price will be used.
4. The lowest bid price for the equipment, device, appliance or supply resulting from advertisements requesting bids from qualified vendors to furnish these items.
5. For specific items determined by the Department to be essential to the health of the recipient, and the absence of the item could reasonably be expected to result in a significant deterioration in the recipient's health status, the price limitation described in part 2. may be waived if the Department determines the price limitation significantly and adversely affects accessibility of the item.

All payments are deemed payment in full and are excluded from cost settlement.

- (b) In the case of rental equipment, Medicaid reimburses a monthly rental payment which is ten (10) percent of the Medicaid allowable purchase fee, except that the following rental only items are reimbursed at the lesser of billed charges, the Medicare prevailing monthly rental charge in effect June 30, 1988 or where there are no Medicare prevailing monthly charges, an amount in effect June 30, 1988, that was derived by obtaining usual and customary rental fees for such equipment from at least three equipment rental suppliers and setting an amount equal to the median of these fees. At such time as Medicare rates become available, the Medicare rates will be used.

1. Oxygen concentrator
2. Oxygen system (gas setup)
3. Oxygen system (gas portable)
4. Oxygen system (liquid stationary)
5. Oxygen system (liquid portable)
6. Ventilator portable (home-use)

- (c) Necessary repairs, maintenance and replacement of expendable parts of purchased equipment shall be reimbursed at 80% of billed charges.
- (d) Reimbursement for continuous ambulatory peritoneal dialysis (CAPD) will be at the lessor of billed charges, or \$1,600 per month (120 treatments per month). However, the supplier may bill Medicaid for one month's supplies in reserve in case of emergency. This payment is made to only one supplier, one time, per recipient.

All payments are deemed payment in full and are excluded from cost settlement.

- (e) Reimbursement for continuous cycling peritoneal dialysis (CCPD) will be at the lessor of: billed charges, or \$2,086 per month (30 treatments per month). However, the supplier may bill Medicaid for one month's supplies in reserve in case of emergency. This payment is made to only one supplier, one time, per recipient.

All payments are deemed payment in full and are excluded from cost settlement.

(Rule 1200-13-1-.06, continued)

- (12) Dental service payment is not to exceed the lesser of the billed amount, 85% of the usual and customary charges accumulated by each individual dentist, or 85 % of the 75th percentile of the range of weighted customary charges by dentists in the State (Dental profile) for the 1984 calendar year. Dental service reimbursement shall not exceed the amount in effect June 30, 1988.
- (13) Prescribed Drugs
- (a) Payment for legend drugs authorized under the program will be the lesser of:
1. Ninety-two percent (92%) of the Average Wholesale Price, as defined in the Tennessee Department of Health and Environment Title XIX Drug Formulary, plus the dispensing fee except for DEA Schedule II drugs which shall be one hundred percent (100%) of the Average Wholesale Price, plus the dispensing fee; or
  2. Maximum allowable cost (MAC), as published in the Tennessee Department of Health and Environment Title XIX Drug Formulary, plus the dispensing fee; or
  3. Providers' usual customary charges.
- (b) When covered drugs are repackaged into acceptable unit dose packages, the cost of repackaging not to exceed a maximum of \$.03 (3 cents) per billing unit, will be allowed in addition to the amounts described in (13)(a).
- (c) Payment for any covered non-legend drug or product, authorized under the program, shall be the lesser of:
1. The provider's usual and customary retail charge to a non-Medicaid patient; or
  2. Maximum allowable cost (MAC), as published in the Tennessee Department of Health and Environment Title XIX Drug Formulary.
- (d) When prescribed legend drugs or non-legend drugs listed on the *Tennessee Department of Health and Environment Title XIX Drug Formulary* are furnished recipients as a part of skilled nursing services or intermediate care facility services, reimbursement will be made to the facility with no dispensing fee.
- (e) The dispensing fee is established at \$3.91 for each prescription, except for approved unit dose vendors dispensing unit dose products who shall receive a fee of \$6.00.
- (f) All pharmacy vendors, unless the vendor has qualified and been approved by the Department as a unit dose vendor, shall bill the Medicaid program for all drugs utilized on a maintenance basis in thirty (30) days quantities or the nearest stock packet size (if so dispensed) as the pharmacist desires. Dispensing and billing for all other categories or drugs shall either be in the maximum base supply as indicated in the *Tennessee Medicaid Title XIX Pharmacy Manual* or the quantity prescribed by the physician, whichever is less. All drugs dispensed on a maintenance type basis on or after July 1, 1981, by approved unit dose vendors will be reimbursed as set out in subparagraph (13)(a) and (b), except that the dispensing fee will be that as established in subparagraph (13)(e). The approved unit dose vendor shall be allowed to bill the Medicaid Program for dispensing maintenance type drugs only once a month.
- (14) Eyeglasses-payment not to exceed the usual and customary charges or the following:
- (a) Qualified providers will be reimbursed forty dollars for the examination and refraction of a patient.

(Rule 1200-13-1-.06, continued)

- (b) Qualified providers will be reimbursed twenty-two dollars for a pair of single vision (glass or plastic) lenses.
  - (c) Qualified providers will be reimbursed twenty-four dollars and eighty cents for a pair of bifocal or multifocal vision (glass or plastic) lenses.
  - (d) Qualified providers will be reimbursed the actual acquisition cost for special lenses, which have been prior approved by Medicaid.
  - (e) Qualified providers will be reimbursed their usual and customary charge not to exceed eighteen dollars for a pair of standard frames that are appropriate for and acceptable to the patient, and currently manufactured and listed in a standard industry publication such as *FRAMES PRICE BOOK/NEW PRODUCTS*.
  - (f) In addition to the above, the provider will receive a dispensing fee of twenty-one dollars for dispensing a pair of eyeglasses.
- (15) Ambulance Services - payment will be made for the type service provided.
- (a) Emergency land ambulance - payment shall be lesser of:
    - 1. Billed charges for the services,
    - 2. 100% of the 75th percentile of the Medicare prevailing charges for the services, or
    - 3. A maximum of \$65 for the basic life support base rate, \$100 for the advanced life support base rate, \$1.10 per loaded mile outside the county and \$10 for oxygen.
  - (b) Non-Emergency land ambulance payment shall be the lesser of:
    - 1. Billed charges for the services,
    - 2. 100% of the 75th percentile of the Medicare prevailing charges for the services, or
    - 3. A maximum of \$65 one-way or \$130 round-trip for the non-emergency base rate, \$1.10 per loaded mile outside the county and \$10 for oxygen.
  - (c) Emergency air ambulance - payment shall be the lesser of:
    - 1. Billed charges for the services,
    - 2. 100% of the 75th percentile of the Medicare prevailing charges for the services, or
    - 3. A maximum of \$100 for the base rate, \$3.00 per loaded mile and \$15 for oxygen.
  - (d) The maximum payment per ambulance transport shall not exceed \$573.00.
  - (e) When emergency air ambulance services are provided and it is determined that emergency land ambulance services would have sufficed, payment shall be the lesser of the land ambulance rate or the air ambulance rate for the transport.
- (16) Community Mental Health Center reimbursement shall be based on a differential rate established for the category of service provided. The rate will be set prospectively in July of each year and will be based on the lower of costs or charges for the previous fiscal year, determined according to Medicare principles. On an annual basis, the rate will be trended forward using the Consumer Price Index for

(Rule 1200-13-1-.06, continued)

outpatient services averaged over the most recent three year period. Annual reimbursement amounts will not be subject to cost settlement.

(17) Clinics

(a) Community health clinics and neighborhood health organizations

1. Medicaid will reimburse providers, except community health clinics designated as a nominal provider, the lesser of:
  - (i) Reasonable allowable cost according to Medicare principles of reimbursement; or
  - (ii) Charges
2. Community health clinics designated as nominal providers, and federally qualified health centers will be reimbursed at reasonable allowable cost.

(b) Ambulatory Surgical Centers

1. Payment is for facility services and shall be the lesser of billed charges or 100% of a prospectively determined rate per covered procedure which is based upon Medicare principles as specified in the October 1, 1986, edition of 42 CFR 416.120(c). The national average index for each procedure is determined and covered procedures are classified into four groups by that value. Rates for each group are established by the following method and adjusted for inflation:
  - (i) Adjusting actual charges to remove the effects of area wage differences;
  - (ii) Calculating the average charge for each procedure in the group;
  - (iii) Calculating the relationship of costs and charges for ambulatory surgical centers; and
  - (iv) Selecting a rate for the group that would result in ambulatory surgical centers being paid the average approximate cost for the procedures in each group.

Reimbursement will be restricted to the rates in effect as of July 1, 1988.

- (c) Rural Health Clinics - Prospective payment system is based on an all inclusive rate for each beneficiary visit for covered services. Payment will be in accordance with the provisions as set out in the October 1, 1986 edition of 42 CFR 447.371(c) (1)-(3). Reimbursement will be restricted to the rates in effect as of June 30, 1988.

(d) Community Mental Retardation Clinics

Payment for covered services shall be a prospective fee equal to the lesser of billed charges or a maximum amount established by Medicaid for the type of services provided.

(18) Inpatient Hospital Services

- (a) For each hospital, the State agency will apply the Title XVIII standards and principles, as described in 20 CFR 405.402-455, as of the effective date of these rules, the inpatient routine services costs for medical assistance recipients will be determined subsequent to the application of the Title XVIII methods of appointment, and the calculation will exclude the applicable Title XVIII inpatient routing service costs (including any nursing salary cost differential).

(Rule 1200-13-1-.06, continued)

- (b) With respect to cost reporting periods beginning after December 31, 1973, payments to hospitals for inpatient services shall be based on the lesser of the reasonable cost of services or the customary charges to the general public for such services, or, the case of public hospitals rendering services free or at a nominal charge, on the basis of fair compensation for such services, in accordance with the provisions of 20 CFR 405.455, as of the effective date of these rules.
- (c) With respect to hospital's fiscal years beginning on or after October 1, 1983, payments to hospitals for inpatient services shall be based on a prospective method of reimbursement as described in the Rules of the Comptroller of the Treasury, Chapter 0380-1-8 entitled Medicaid Hospitalization Program.
- (d) Medicaid will not provide reimbursement for inpatient hospital surgical procedures unless pre-admission approval has been obtained, except as specified in rule 1200-13-1-.06(18)(e).
- (e) Medicaid will not provide reimbursement for inpatient hospital services unless pre-admission approval has been obtained, except as specifically excluded in this rule.
  - 1. Requests for approval shall be made in the following manner:
    - (i) Requests shall be made by telephone.
    - (ii) Approval for hospitalization of the recipient is sought by the licensed physician or oral and maxillofacial surgeon in charge of the recipient's care or a hospital representative on behalf of the licensed physician or oral and maxillofacial surgeon. If approval is sought by a hospital representative on behalf of the licensed physician or oral and maxillofacial surgeon, it is the responsibility of the hospital representative to ascertain the completeness and accuracy of the information from the physician or oral and maxillofacial surgeon.
    - (iii) Except for emergency or urgent admissions (discussed below at (iv)) and transfer between hospitals (discussed below at (v)), all inpatient hospital services must be approved by Medicaid before the patient is admitted to the hospital.
    - (iv) Approval for emergency or urgent admissions shall be obtained from Medicaid within two (2) working days of admission. Emergency admissions are those resulting from sudden onset of a medical condition manifesting itself by acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in serious dysfunction of any bodily organ/part or death of the individual. Urgent admissions are those resulting from sudden and unexpected onset of a medical condition requiring treatment immediately after onset or within 72 hours.
    - (v) Approval for transfers from one acute care hospital to another or from a psychiatric hospital to an acute care hospital shall be obtained from Medicaid within two (2) working days of admission.
    - (vi) Approval for corneal or renal transplants must be obtained from Medicaid before the patient is admitted to the hospital.
  - 2. The condition of the recipient as shown in the request for hospitalization meets the criteria set forth in the *Interqual ISD-A Review System - Intensity of Service, Severity of Illness and Discharge and Appropriateness Screens*, November, 1984 edition.

(Rule 1200-13-1-.06, continued)

3. Pre-Admission Approval shall not be required for the situations described below:
  - (i) Diagnosis of pregnancy with active labor indicating delivery can be expected within 24 hours of admission or if premature labor intervention is required to stop active labor.
  - (ii) Hospitals that are located out-of-state and outside the medical marketing area. These hospitals are still subject to Medicaid out-of-state coverage requirements as set forth in rule 1200-13-1-.03(2). Medical market is defined as the counties of surrounding states that border Tennessee and that routinely and customarily provide medical services to Tennessee residents.
  - (iii) Admissions to inpatient psychiatric facilities or distinct units of hospitals which are accredited as psychiatric facilities by the Joint Commission on Accreditation of Health Care Institutions. However, approval must still be obtained for admissions to acute care hospitals for psychiatric diagnoses.
  - (iv) Heart, liver or bone marrow transplants that have prior approval from the Medicaid Medical Director.
  - (v) Recipients enrolled in Medicaid Health Maintenance Organizations.
4. Pre-Admission approval shall be valid for admissions occurring within 30 days from the date approval is given.
5. All reimbursements are made within the limitations of the Medicaid Program. If approval for inpatient hospitalization is denied, Medicaid reimbursement is available only if covered services are provided in an outpatient setting.
6. Approval of the admission does not constitute approval of the length of confinement nor guarantee payment of hospital charges. All other applicable Medicaid requirements must be met for payment to be made.
7. Failure to Request Pre-Admission Approval.
  - (i) If approval prior to admission is not obtained for elective admissions, the recipient must not be billed for any cost associated with the hospitalization that could have been covered by Medicaid if approval had been obtained.
  - (ii) If approval is not obtained from Medicaid within two (2) working days of admission for emergency admissions or within two (2) working days of transfer from one acute care hospital to another or from a psychiatric hospital to an acute care hospital, the recipient must not be billed for any cost associated with the hospitalization that could have been covered by Medicaid if approval had been obtained.
8. Medicaid Denial of Request for Pre-Admission Approval.
  - (i) The party seeking approval must explain to the recipient that Medicaid has denied the request for admission and that the recipient has a right to appeal the denial and/or the right to negotiate a private agreement with the hospital to be responsible for any costs associated with the non-covered hospitalization.



(Rule 1200-13-1-.06, continued)

- (ii) If, after the request for approval is denied, the recipient is admitted to the hospital for an elective admission, the recipient may be billed for any cost associated with the hospitalization.
  - (iii) If the request for approval involving a suspected emergency or a transfer from one facility to another is denied, the recipient may not be billed for any cost associated with the hospitalization that could have been covered by Medicaid if approval had been obtained through the date of denial. However, any cost associated with the hospitalization after the date of verbal denial may be billed to the recipient.
9. Appeal of Denied Pre-Admission Requests.
- (i) Immediately following verbal denial of the request for pre-admission authorization, the recipient and provider will be notified in writing of the decision.
  - (ii) The notification will contain specific rights to appeal the decision, the procedures to effect the appeal, and the time periods for exercising the rights set out in the notice. Additionally, the recipient and provider will be notified of the right to:
    - first, an informal reconsideration conducted by two physicians who have had no previous involvement with the case and at least one of whom is board certified or board eligible in the type of care that is proposed. The case shall be reconsidered within three (3) working days after receipt of the written request for reconsideration and written notice of the decision shall be sent to the recipient and the provider. If the reconsideration denies the request for pre-admission approval, the recipient must be notified in writing of the right to appeal this decision through a formal contested case hearing before the Department of Health, pursuant to T.C.A. §71-5-113.
10. Acute inpatient psychiatric and/or alcohol and drug detoxification and treatment services in acute care hospitals shall be provided under the following conditions:
- (i) Under the direction of a physician, according to the following definitions when used in rule 1200-13-1-.06(18)(e)10. inclusive, unless otherwise indicated:
    - (I) Acute Psychiatric Inpatient Care - Hospital based treatment provided under the direction of a physician, who has competence in diagnosis and treatment of mental illness, for a psychiatric condition which has a relatively sudden onset and a short, severe course. The psychiatric condition should be of such a nature as to pose a significant and immediate danger to self, others, or the public safety or one which has resulted in marked psychosocial dysfunction or grave mental disability of the patient. The therapeutic intervention should be aggressive and aimed towards expeditiously moving the patient to a less restricted environment.
    - (II) Alcohol or Substance Abuse Detoxification - The provision of medically necessary services to stabilize the medical condition of an individual who experiences a serious episode of intoxication due to alcohol or substance abuse.
    - (III) Alcohol or Substance Abuse Treatment - The provision of medically necessary services subsequent to detoxification in order to restore or to improve the functioning of an individual who has become physically or psychologically dependent upon, or addicted to, alcohol or drugs or other substances of abuse.

(Rule 1200-13-1-.06, continued)

- (IV) Concurrent Review - A review to determine the medical necessity of continued acute inpatient treatment in an acute care hospital, to be performed at no greater than 10 day intervals.
- (V) Crisis Stabilization - The provision of medically psychiatric services to control and ameliorate a critical situation in which the absence of immediate care would reasonably be expected to endanger the life of the individual, to result in severe bodily dysfunction, or to endanger others.
- (VI) Elective Admission - Any admission which is non-emergency or does not involve transfer from one hospital to another.
- (VII) Emergency - Sudden onset of a medical/psychiatric condition manifesting itself by acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in serious dysfunction of any bodily organ/part or death of the individual or harm to another person by the individual.
- (VIII) Reviews - a pre-approval certification review or concurrent review which is conducted when the telephone review provides insufficient clinical information upon which to make a decision. Reviews are conducted in one of the following ways:
  - I. Face to Face - a pre-admission meeting with the recipient and the Department or its contractor.
  - II. Chart - a pre-admission review of medical documentation to assess the medical necessity of an inpatient admission to be covered by Medicaid; or a post-admission, concurrent stay, or post-discharge review at the facility whereby the Department or its contractor reviews the patient's chart and meets with a hospital designee or any other such person deemed necessary by the reviewer; or a review of the patient's chart, which has been submitted at the Department's or its contractor's request in order to assess medical necessity for an inpatient stay.
- (IX) Guardian - The patient's parent, legal guardian, or guardian ad item.
- (X) Non-Elective Admission - Admission which involves an emergency, or involves transfer from one hospital to another.
- (XI) Pre-Approval Certification Review - The review and approval process which assures that ambulatory care resources available in the community do not meet the needs of the recipient; that proper treatment of the recipient's psychiatric and/or alcohol and drug condition requires services on an acute inpatient basis under the direction of a physician; and that upon admission acute psychiatric and/or alcohol and drug services can reasonably be expected to improve the recipient's condition or prevent further regression so that such services will no longer be needed.
- (XII) Telephone Review - A pre-approval certification review or concurrent review in which a recipient's case is reviewed over the telephone.

(Rule 1200-13-1-.06, continued)

(XIII) Working Day - Monday through Friday, 8:00 a.m. to 5:00 p.m. Central Time, excluding State holidays.

(ii) For Psychiatric Care:

(I) Participating acute care hospitals must have begun the process of obtaining accreditation from the Joint Commission on Accreditation of Healthcare Organizations or from the American Osteopathic Association and must have obtained this accreditation by November 1, 1992, or have begun that process and based on all available evidence will be certified prior to June 30, 1993;

(II) Concurrent reviews will be performed at intervals of no greater than 10 days;

(III) Physician progress notes on the patient must be made at intervals of no greater than 3 days, beginning with the first day of treatment.

(IV) The acute inpatient psychiatric services in acute care hospitals must include active treatment implemented through an individual plan of care which is based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the individuals situation. The plan shall include diagnoses symptoms, complaints and complications. The plan shall indicate the need for admission and for acute inpatient psychiatric care.

(iii) For Alcohol and Drug Services:

(I) Participating acute care hospitals must have begun the process of obtaining accreditation from the Joint Commission on Accreditation of Healthcare Organizations or from the American Osteopathic Association and must have obtained this accreditation by November 1, 1992, or have begun that process and based on all available evidence will be certified prior to June 30, 1993;

(II) Detoxification

I. Admission approvals should average 2-3 days with occasional need for up to 10 days when it is medically necessary. The medical necessity of all stays must be documented by a physician. In cases that require additional days for detoxification, there must be documentation by a physician which substantiates that a longer period of acute care is medically necessary. Medicaid will make reimbursement for alcohol and drug detoxification for a maximum of 10 days.

II. Physician progress notes on the patient must be made daily.

(III) Treatment

I. Concurrent reviews will be performed by the Department or the Department's contractor at intervals of no greater than 10 days.

(Rule 1200-13-1-.06, continued)

- II. Physician progress notes on the patient must be made at intervals of no greater than 2 days, beginning with the first day of the treatment period.
- III. Admissions for alcohol and drug treatment services for recipients over age 21 will generally be limited to 3 per recipient per lifetime. Individuals who meet established medical necessity criteria may be approved for admission for alcohol and drug treatment in excess of the 3 per recipient per lifetime limit.
- IV. The Department may waive the three (3) per lifetime limit for alcohol/drug treatment if the following criteria are met:

- A. It must reasonably be expected that the patient's condition will significantly improve with an intensive alcohol/drug treatment program; and
- B. The patient does not have an active physical or mental illness that impairs the ability of the patient to actively participate in, comprehend, or benefit from an intensive alcohol/drug treatment program; and
- C. The patient has medical complications (eg., severe hepatic encephalopathy, esophageal varicies with multiple episodes of severe bleeding, endocarditis) that are eminently disabling or life-threatening, and it would be reasonably expected that continued substance abuse would result in repeated hospitalizations for treatment of the medical complications; or

The patient has relapsed after a period of abstinence of one year; or

The patient has relapsed despite active and compliant participation in aftercare/outpatient treatment on a weekly basis for a period of six months.

The determination regarding whether the period of abstinence is sufficient to meet the requirement of this rule shall be based on an independent assessment of the patient by the Department or the department's contractor with confirmation by the patient's physician, clergyman, support/recovery group (e.g., Alcoholics Anonymous, Narcotics Anonymous), or a family member or other person having appropriate knowledge of the patient.

- (iv) In order for a patient to be certified for admission or continued stay for crisis stabilization, alcohol and drug detoxification, alcohol and drug treatment services, or elective psychiatric inpatient hospitalization, the patient must meet the following criteria:

- (I) For Psychiatric Crisis Stabilization

- I. Admission criteria

- A. The patient must have a DSM-III-R diagnosis with acute symptoms; and

(Rule 1200-13-1-.06, continued)

- B. The patient's psychiatric condition is of such intensity that the absence of immediate medical/psychiatric care would reasonably be expected to endanger the life of the patient, to result in severe bodily dysfunction, or to endanger others; and
  - C. The patient's psychiatric condition must require 24-hour medical/psychiatric and nursing services and must be of an intensity such that needed service can be appropriately provided only at an acute level of hospital care; and
  - D. There must be a plan of treatment which is specific to the acute psychiatric symptoms for which inpatient hospitalization is required.
- II. Continued stay criteria - The patient's psychiatric condition must continue to require 24-hour medical/psychiatric and nursing services and must be of an intensity such that needed services can be appropriately provided only at an acute level of hospital care.
- (II) For Detoxification Services for Alcohol or Other Substance Abuse.
- I. Admission criteria
    - A. The patient must, in the absence of immediate medical care provided in an acute care hospital, be at medical risk for life-threatening consequences due to acute intoxication with alcohol or a substance of abuse, or the patient must have a history of current use of alcohol or a substance of abuse at a level and with a frequency to have developed tolerance and to be at medical risk of life-threatening consequences associated with a specific withdrawal syndrome if the substance is terminated without medical supervision; and
    - B. The patient's medical condition must require 24-hour medical and nursing services and must be of an intensity such that needed services can be appropriately provided only at an acute level of hospital care.
  - II. Continued stay criteria - The patient must continue to be at medical risk for life-threatening consequences due to acute intoxication with alcohol or a substance of abuse or due to withdrawal from alcohol or a substance of abuse.
- (III) For Other Psychiatric Inpatient Hospitalization
- I. Admission criteria
    - A. The patient must have a DSM-III-R Axis I diagnosis and a DSM-III-R Axis V rating of 50 or less; and
    - B. The patient's psychiatric condition must require 24-hour medical/psychiatric and nursing services and must be of an intensity such that needed services can be appropriately provided only at an acute level of hospital care; and

(Rule 1200-13-1-.06, continued)

- C. Inpatient services in an acute care hospital must reasonably be expected to significantly improve the patient's psychiatric condition within a short period of time so that 24-hour inpatient medical/psychiatric and nursing services will no longer be needed; and
  - D. There must be a plan of treatment, discharge, and follow-up care which is specific to the psychiatric symptoms for which inpatient hospitalization is required and which is consistent with general standards of practice.
- II. Continued stay criteria - The patient's psychiatric condition must continue to require 24-hour medical/psychiatric and nursing services and must be of an intensity such that needed services can be appropriately provided only at an acute level of hospital care.
- (IV) For Treatment Services for Alcohol or Other Substances Abuse
- I. Admission criteria
    - A. The patient must have a diagnosis of dependency on alcohol or other substances of abuse, based on DSM-III-R criteria, with ongoing current usage at a level which endangers the health or safety of the patient; and
    - B. The patient must demonstrate potential for significant improvement from a relatively intense, coordinated, multidisciplinary inpatient treatment program; and
    - C. The patient must not have a physical impairment or medical barrier that would preclude active participation in the treatment program; and
    - D. The patient must not have a mental impairment or disability that would preclude cooperation in, and comprehension of, the treatment program; and
    - E. The patient's medical condition must require 24-hour medical and nursing services and must be of an intensity such that needed services can be appropriately provided only at an acute level of hospital care.
  - II. Continued stay criteria
    - A. The patient's medical condition must continue to require 24-hour medical and nursing services and must be of an intensity such that needed services can be appropriately provided only at an acute level of hospital care; and
    - B. The patient must demonstrate significant progress toward treatment goals as outlined in the treatment plan; and
    - C. The patient must demonstrate potential for further significant improvement from the inpatient treatment program.

(Rule 1200-13-1-.06, continued)

- (v) Pre-approval certification review for approval of admissions to acute care hospitals for psychiatric and/or alcohol and drug treatment will be conducted by the Department's contractor as follows:
  - (I) Pre-approval certifications shall be requested by the attending physician or the hospital.

Except for emergency admissions, pre-approval certification of all admissions to acute care hospitals for psychiatric and/or alcohol and drug treatment shall be requested before the patient is admitted to the hospital.
  - (II) Pre-approval certification for emergency admissions shall be requested within two (2) working days of the admission.
  - (III) Pre-approval certification of individuals who become Medicaid eligible after they have been admitted to or discharged from a facility shall be requested within two (2) working days of the date that the facility is aware of the individual's eligibility.
- (vi) Continued Stays - Concurrent reviews are to be performed at no greater than 10 days intervals and shall be requested by the attending physician or the hospital not more than 72 hours (3 working days) not less than 48 hours (2 working days) prior to the expiration of the current certified period of stay.
- (vii) Face to Face Reviews for Admissions and Continued Stays - Reviews will first be conducted by telephone. A face to face review will be requested only when the telephone review provides insufficient clinical information upon which to make a decision.
- (viii) Failure to Request Pre-approval Certification
  - (I) For an elective admission if a pre-approval certification is not requested prior to admission, the recipient shall not be billed for any costs covered by Medicaid that are associated with the hospitalization and that would have been covered by Medicaid upon the prior approval of a pre-approval certification.
  - (II) If pre-approval certification is not requested for an emergency admission within two (2) working days of the admission, the recipient shall not be billed for any cost covered by Medicaid that is associated with the hospitalization and that would have been covered by Medicaid upon approval of a pre-approval certification.
  - (III) In situations where an individual becomes Medicaid eligible after being admitted to the facility, if a pre-approval certification is not requested within two (2) working days of the date that the facility is aware that the individual is Medicaid eligible, the recipient shall not be billed for any costs covered by Medicaid that are associated with the hospitalization and that would have been covered by Medicaid upon approval of a pre-approval certification.
  - (IV) If a hospital admits a Medicaid recipient without an approved pre-approval certification for that recipient, the guardian of the recipient and/or the recipient shall be informed that Medicaid reimbursement will not be paid

(Rule 1200-13-1-.06, continued)

until and unless the certification is approved. Any hospital that admits a recipient without an approved pre-approval certification for that recipient does so at its own financial risk.

- (ix) Failure to Request a Concurrent Review for a Continued Stay - If the attending physician or the hospital fails to request the required authorization for a continued stay, the recipient shall not be billed for any costs covered by Medicaid that are associated with the hospitalization and that would have been covered by Medicaid upon the prior approval of a continued stay request.
- (x) Appeal of Denied Pre-Approval or Continued Stay

The recipient and the recipient's guardian will be notified of the right to an informal reconsideration and/or a contested case proceeding as follows:

- (I) An informal reconsideration conducted by the Department or the Department's contractor using appropriate psychiatric and/or alcohol and drug consultation. A request for informal reconsideration shall be made in writing within ten (10) days after moving notification of a denied pre-approval certification or continued stay request. An informal reconsideration will be held within three (3) working days after receipt of all necessary medical information.
  - (II) If the reconsideration is unfavorable the recipient will be notified in writing of the right to a hearing to review this decision through a formal contested case proceeding before the Department of Health, pursuant to *T.C.A. §71-5-113*. Any such petition for appeal shall be submitted to the Department in writing within fifteen (15) calendar days after the date of receipt by the recipient of the notification of the unfavorable reconsideration decision, or of the initial decision if informal reconsideration is not demanded.
  - (III) In any contested case proceeding the opinions of the certifying physician of the patient concerning the necessity of acute inpatient psychiatric and/or alcohol and drug care for the patient shall not automatically be of controlling weight but such opinions are to be properly weighed against all other evidence.
- (xi) Continuation of Services
    - (I) If after the receiving notice of the denial of continued stay, the recipient requests a hearing within fifteen (15) days of the notice and before the date of discharge, Medicaid may not terminate or reduce services until a decision is rendered after the hearing.
    - (II) If the decision is sustained by the hearing, Medicaid may institute recovery procedures against the facility to recoup the cost of any services furnished the recipient, to the extent they were furnished solely by reason of this section.
- (f) Medicaid shall provide reimbursement for any medically necessary organ transplant procedure which is not considered experimental by the National Institutes of Health and the Tennessee Department of Health. Experimental for the purposes of this rule shall mean those transplants and/or procedures which are not considered reasonable and necessary and which have not been approved by the Health Care Financing Administration and as published in the Federal Register.



(Rule 1200-13-1-.06, continued)

1. Medicaid coverage shall be limited to the following transplant procedures:
  - (i) Renal transplants
  - (ii) Heart transplants
  - (iii) Liver transplants
  - (iv) Corneal transplants
  - (v) Bone Marrow transplants

Exceptions to the above list of transplants may be made for other nonexperimental transplants if it is found to be medically necessary and cost effective as determined by Medicaid. The allowable inpatient days will be the average length of stay for that transplant.

2. Medicaid coverage for heart, liver and bone marrow transplants, shall be limited to the number of inpatient hospital days listed below for each procedure. Inpatient hospital days associated with these approved organ transplants will be reimbursed at 100 percent of the operating component plus 100 percent of the capital, direct and indirect education, return on equity (for proprietor), providers only), and Medicaid Disproportionate Share Adjustment components. Admissions and stay that span fiscal years will be reimbursed as if the entire stay had occurred during the first fiscal year. In accordance with federal regulations at 42 CFR 413.157, effective October 1, 1989, Tennessee Medicaid will no longer cover return on equity.

<u>Transplant Procedures</u>	<u>Number of Days Per Transplant</u>
(i) Heart transplants	43 days
(ii) Liver transplants	67 days
(iii) Bone marrow, transplants	40 days

3. All transplants except for corneal and renal require prior approval from the Medicaid Medical Director. Hospitalization pre-admission approval is required for corneal and renal transplants. Friday and Saturday admissions will be limited to emergencies or surgery the same or next day.
4. Reimbursement shall be provided for organ transplants only to the extent that the services provided do not exceed the reimbursement and service limitations as outlined in chapter 1200-13 of the Medicaid Rules.
  - (i) Section 1862 of the Social Security Act requires Medicare recipients to have transplant procedures performed in Medicare certified transplant centers. In accordance with this policy, Medicare/Medicaid recipients will be required to adhere to these requirements. Transplants may be approved at centers other than those approved by Medicare for recipients with Medicaid only. Reimbursement shall be limited to the Medicare applied inpatient deductible methods in accordance with current pricing methodologies as outlined in rule 1200-13-1-.07(2).
  - (ii) Transplant procedures performed in hospitals that are located out-of-state and outside the medical marketing area shall be subject to the Medicaid out-of-state reimbursement requirements as set forth in rule 1200-13-1-.03(2) and 1200-13-5-.07(2).
- (g) Medicaid will not provide reimbursement for a leave of absence from an acute care or psychiatric hospital. A leave of absence for the purposes of this rule shall mean the approved

(Rule 1200-13-1-.06, continued)

absence from an acute care or psychiatric hospital that has been granted to a patient by the staff in accordance with the rules and regulations of that facility.

- (h) Donor organ procurement is not a covered service.
  - (i) The first twenty (20) days of an inpatient stay per fiscal year will be reimbursed at 100 percent of the operating component plus 100 percent of the capital, direct and indirect education, and Medicaid Disproportionate Share Adjustment (MDSA). For days in excess of twenty (20), reimbursement will be made at 60 percent of the operating, component plus 100 percent of the capital, direct and indirect education, and MDSA components. Tennessee Medicaid will no longer cover return on equity.
  - (j) Any hospital days paid by insurance or other third party benefits will be considered to be days paid by the Medicaid Program.
- (19) Health Maintenance Organizations or any other type of pre-paid health delivery organization with which the State has entered into a contract will be reimbursed based on a per capita rate of payment of services provided. The per capita rate will be defined through the competitive bid process for all health maintenance organizations or any other type of pre-paid health delivery organization desiring to participate in the Medicaid Program. All contracts entered into must be cost effective and further approved by the Health Care Financing Administration.
- (20) (a) Except as provided in subsection (d) below, a provider shall not be reimbursed for any of the surgical procedures listed at subsection (b) below, or for hospital or ambulatory surgical treatment center services provided for the same, unless:
- 1. The provider has assured that the patient on whom the procedure is performed has, prior to the surgery but not earlier than one year preceding the surgery, obtained a second surgical opinion as set forth herein on the recommended procedure; and
  - 2. The provider, including both the provider performing the procedure and the hospital or ambulatory surgical treatment center where it is performed, submits documentation of the provision of such opinion, in a form furnished by the Department.
- (b) The procedures for which second surgical opinions shall be required, except as provided in subsection (d) below, are:
- 1. Cholecystectomy
  - 2. Inguinal hernia repair
  - 3. Hysterectomy
  - 4. Dilatation and curettage
  - 5. Tonsillectomy with adenoidectomy
- (c) The original recommendation for the performance of any of the procedures listed in subsection (b) above may be by any, physician; however, a second or third surgical opinion as required or permitted in this section and section (20) below shall be provided by a physician who is enrolled as a surgeon in the Medicaid program. Nothing in this section shall prohibit a provider of such a second or third opinion from performing the surgery if the patient chooses to have him do so; nor does anything in this section prohibit the performing of the surgery when a second or third opinion does not confirm the recommendation for surgery, if the patient elects to have the surgery; however, reimbursement shall in all cases be subject to the conditions set forth in this section.

(Rule 1200-13-1-.06, continued)

- (d) Second surgical opinions shall not be required in any of the following circumstances:
1. The severity of the patient's condition is such that the surgery must be performed within one month of the original recommendation in order to protect the health and safety of the patient; however, in such event in order to receive reimbursement, the provider performing the surgery and the hospital or ambulatory surgical treatment center where it is performed shall indicate such condition in any claims for reimbursement, assure that such condition is documented in the patient's medical records, and made such records and documentation available to Medicaid upon request.
  2. The patient must travel more than forty miles or one hour from his home in order to obtain a second surgical opinion as set forth herein, and does not wish to travel to obtain such opinion; however, in such event, in order to receive reimbursement, the provider performing the surgery and the hospital or ambulatory surgical treatment center where it is performed shall indicate such circumstance in any claims for reimbursement.
  3. Any of the procedures listed at subsection (b) above are performed incidental to a more major procedure, and such is clearly indicated on any claims for reimbursement.
  4. The patient is also a recipient of benefits under Title XVIII of the Social Security Act (Medicare), or is a participant in a case management or health insuring organization demonstration project as set forth in rules 1200-13-1-.12 and 1200-13-1-.14.
- (e) A provider shall not bill a patient who was a Medicaid recipient at the time of surgery for any of the procedures listed at subsection (b) above, or for hospital or ambulatory treatment center services provided for the same, when the requirements of this section have not been met, unless the recipient knowingly refused to get a second opinion as required herein, with full understanding of the consequences of such refusal, and knowingly assumed the obligation to pay directly for the services.
- (21) (a) A provider of a second surgical opinion required pursuant to section (20) above shall be reimbursed as provided in subsection (c) below, if he satisfies the following conditions:
1. He is enrolled as a surgeon in the Medicaid program; and
  2. He has provided any necessary notifications required pursuant to subsection (d) below and so indicates on his claim for reimbursement.
- (b) A provider of a third surgical opinion regarding any of the procedures listed at subsection (20)(b) above shall be reimbursed as provided in subsection (c) below, if he satisfies the following conditions:
1. He is enrolled as a surgeon in the Medicaid program;
  2. The second opinion was required pursuant to section (20) above;
  3. The second opinion did not confirm the original recommendation for surgery; and
  4. He has provided any necessary notifications required pursuant to subsection (d) below and so indicates in his claim for reimbursement.
- (c) Reimbursement to a provider of either a second or third surgical opinion as described in subsection (a) and (b) above shall be limited to:

(Rule 1200-13-1-.06, continued)

1. The lesser of billed charges or \$30.00, which shall include and cover all office visits necessary to the provision of the opinion; and
  2. Reimbursement at the same levels provided for at section (9) above for the in-office provision of any laboratory or x-ray services that are necessary to the provisions of the opinion; however, the fact that such services were necessary for such an opinion shall be indicated on the claim for reimbursement.
- (d) Providers of second and third surgical opinions as described at subsections (a) and (b) above who require the use of independent laboratory and x-ray services for the provision of their opinions shall, in the order for such services, notify the provider of such laboratory and x-ray services in writing that the services are required for the provision of a second or third surgical opinion.
- (e) Providers of independent laboratory and x-ray services that are required for the provision of a second or third surgical opinion as provided herein shall indicate in their claims for reimbursement such fact, and shall be reimbursed as provided in section (6) above for such services.
- (22) Reimbursement to certified nurse-midwives for covered services will be the lesser of:
- (a) Billed amount; or
  - (b) 90% of the maximum amount paid to physicians statewide for similar maternity and newborn services.
- (23) Except for an emergency as deemed in rule 1200-13-1-.01(12), delivery of the newborn infant will not be reimbursed unless provided in a hospital as defined in T. C.A. §68-11-201(11) or in an Ambulatory Surgical Center classified to provide maternity services as defined in rule 1200-8-10-.02.
- (24) Reimbursement will be made for services provided by Certified Registered Nurse Anesthetists qualifying under Rule 1200-13-1-.03(1)(bb) under the following conditions:
- (a) Services provided with medical direction will be reimbursed the lesser of billed charges or forty-four percent (44%) of what would have been paid to a physician for similar services when:
    1. Billed by an independently enrolled Certified Registered Nurse Anesthetist; or
    2. Billed separately by a hospital that has not elected to retain Certified Registered Nurse Anesthetist costs in its rate; or
    3. Billed by a physician on behalf of a Certified Registered Nurse Anesthetist.
  - (b) Services provided without medical direction will be reimbursed the lesser of billed charges or eighty percent (80%) of what would have been paid to a physician for similar services when:
    1. Billed by an independently enrolled Certified Registered Nurse Anesthetist; or
    2. Billed separately by a hospital that has not elected to retain Certified Registered Nurse Anesthetist costs in its rate; or
    3. Billed by a physician on behalf of a Certified Registered Nurse Anesthetist.

(Rule 1200-13-1-.06, continued)

- (c) The Certified Registered Nurse Anesthetist that performed the service must be identified on claims submitted for payment except when the claim is submitted by an individual Certified Registered Nurse Anesthetist for services they personally performed.
- (25) Reimbursement to physician anesthesiologists for medical direction of Certified Registered Nurse Anesthetists will be the lesser of:
  - (a) Billed charges; or
  - (b) When medically directing two (2) concurrent procedures, fifty-six percent (56%) of what would have been paid to the physician for providing the complete service; or
  - (c) When medically directing three (3) concurrent procedures, fifty-one (51%) of what would have been paid to the physician for providing the complete service; or
  - (d) When medically directing four (4) concurrent procedures, forty-six (46%) of what would have been paid to the physician for providing the complete service.
- (26) Reimbursement for hospice services shall be the lesser of billed charges or 100% of a prospectively determined rate per covered day which is based upon the methodology used in setting Medicare rates, adjusted to disregard cost offsets attributable to Medicare coinsurance amounts. Rates shall be determined for each of four levels of care and adjusted for inflation as described in Rule 1200-13-10.
- (27) Disbursement of funds for adjudicated claims shall be made to providers on a weekly basis except when such disbursement would be less than \$5. If disbursement to the provider would be less than \$5, the adjudicated claims will be accrued until the value of accrued claims exceeds \$5 at which time disbursement shall be made. In the event the value of accrued claims does not exceed \$5 within three (3) months of the initiation of accrual, disbursement of funds shall not be made but the claims shall be considered as paid.
- (28) Private Duty Nursing Services.
  - (a) Reimbursement will be limited to licensed home health agencies enrolled in the Tennessee Medicaid program.
  - (b) Reimbursement will be billed charges not to exceed \$15.50 per hour.
  - (c) Reimbursement will not be made for home health aide visits, personal care services, or skilled nursing visits during the same time period when private duty nursing services are being provided to a child. A member of the child's immediate family (spouses, parent, grandparent, sibling or corresponding step or in-law relationship) may not be employed by the provider agency to provide Medicaid-reimbursed private duty nursing services to the child.
- (29) Medicaid payments, or the amounts paid in lieu of Medicaid by a third party (Medicare, insurance, etc.), shall be payment in full for the service provided. No additional payment will be allowed for component parts of a procedure when a single procedure was or could have been appropriately billed to include all component parts.
- (30) For services provided prior to January 1, 1994, the reimbursement rules as set out at 1200-13-1-.06(l) - (29) shall apply. Effective January 1, 1994, the rules of TennCare as set out at rule chapter 1200-13-12 shall apply except to providers of nursing facility services, providers of intermediate care facility services for the mentally retarded (ICF-MR), providers of Home and Community based Waiver Services, and payment of Medicare premiums, deductibles and copayments for Qualified Medicare Beneficiaries (QMBS) and Special Low-Income Medicare Beneficiaries (SLIMBs) which will

(Rule 1200-13-1-.06, continued)

continue to be reimbursed in accordance with Medicaid rules in effect prior to January 1, 1994, and as may be amended.

(31) Intermediate Care Facilities for the Mentally Retarded

- (a) Private for-profit and private not-for-profit Intermediate Care Facilities for the Mentally Retarded (ICF/MR) shall be reimbursed at the lower of Medicaid cost or charges. An annual inflation factor will be applied to operating costs. The trending factor shall be computed for facilities that have submitted cost reports covering at least six months of program operations. For facilities that have submitted cost reports covering at least three full years of program participation, the trending factor shall be the average cost increase over the three-year period, limited to the 75th percentile trending factor of facilities participating for at least three years. Negative averages shall be considered zero. For facilities that have not completed three full years in the program, the one-year trending factor shall be the 50th percentile trending factor of facilities participating in the program for at least three years. For facilities that have failed to file timely cost reports, the trending factor shall be zero. Capital-related costs are not subject to indexing. Capital-related costs are property, depreciation, and amortization expenses included in Section F.18 and F.19 of the Nursing Facility Cost Report Form. All other costs, including home office costs and management fees, are operating costs. Once a per-diem rate is determined from a clean cost report, the rate will not be changed until the next rate determination except for audit adjustments, correction of errors, or termination of a budgeted rate.
- (b) Effective July 1, 1995, public Intermediate Care Facilities for the Mentally Retarded (ICF/MR) that are owned by government shall be reimbursed at 100% of allowable Medicaid costs with no cost-containment incentive. Reimbursement shall be based on Medicare principles of retrospective cost reimbursement with year-end cost report settlements. Interim per-diem rates for the fiscal year beginning July 1, 1995 and ending June 30, 1996 shall be established from budgeted cost and patient day information submitted by the government ICF/MR facilities. Thereafter, interim rates shall be based on the providers' cost reports. There will be a tentative year-end cost settlement within 30 days of submission of the cost reports and a final settlement within 12 months of submission of the cost reports.
- (c) An ICF/MR will be reimbursed in accordance with this paragraph for the recipient's bed in that facility during the recipient's temporary absence from that facility in accordance with the following:
1. For days not to exceed 15 days per occasion while the recipient is hospitalized and the following conditions are met:
    - (i) The resident intends to return to the ICF/MR.
    - (ii) The hospital provides a discharge plan for the resident.
    - (iii) At least 85% of all other beds in the ICF/MR certified at the recipient's designated level of care (i.e., intensive training, high personal care or medical), when computed separately, are occupied at the time of hospital admission.
    - (iv) Each period of hospitalization must be physician ordered and so documented in the patient's medical record in the ICF/MR.
  2. For days not to exceed 60 days per state fiscal year and limited to 14 days per occasion while the recipient, pursuant to a physician's order, is absent from the facility on a therapeutic home visit or other therapeutic absence.

(Rule 1200-13-1-.06, continued)

- (d) Costs for supplies and other items billed to Medicare Part B on behalf of all patients must be included as a reduction to reimbursable expenses in Section G of the nursing facility cost report.

**Authority:** T.C.A. 4-5-202, 12-4-301, 71-5-105, 71-5-109, and Executive Order No. 23. **Administrative History:** Original rule filed November 17, 1977; effective December 19, 1977. Amendment filed January 31, 1979; effective March 16, 1979. Amendment filed August 31, 1981; effective October 15, 1981. Amendment filed September 16, 1981; effective November 2, 1981. Amendment filed November 6, 1981; effective December 21, 1981. Amendment filed August 18, 1982; effective September 17, 1982. Amendment filed September 2, 1982; effective October 4, 1982. Amendment filed September 27, 1982; effective October 27, 1982. Amendment filed November 12, 1982; effective December 13, 1982. Amendment filed June 23, 1983; effective July 25, 1983. Amendment filed August 31, 1983; effective September 30, 1983. Amendment filed March 12, 1984; effective April 11, 1984. Amendment filed June 27, 1984; effective July 27, 1984. Amendments filed March 27, 1985; effective April 26, 1985. Amendment filed June 4, 1985; effective July 4, 1985. Amendment filed September 18, 1985; effective October 18, 1985. Amendment filed April 29, 1986; effective May 29, 1986. Amendment filed June 30, 1986; effective July 30, 1986. Amendment filed July 17, 1986; effective August 31, 1986. Amendment filed September 2, 1986; effective October 17, 1986. Amendment filed July 30, 1987; effective September 13, 1987. Amendment filed September 30, 1987; effective November 14, 1987. Amendment filed February 19, 1988; effective April 4, 1988. Amendment filed June 2, 1988; effective July 17, 1988. Amendment filed September 6, 1988; effective October 21, 1988. Amendment filed November 10, 1988; effective December 25, 1988. Amendment filed March 22, 1989; effective May 8, 1989. Amendment filed June 22, 1989; effective August 4, 1989. Amendment filed June 29, 1989; effective August 14, 1989. Amendment filed July 26, 1989; effective September 10, 1989. Amendment filed August 31, 1989; effective October 15, 1989. Amendment filed October 11, 1989; effective November 25, 1989. Amendment filed November 30, 1989; effective January 14, 1990. Amendment filed December 8, 1989; effective January 22, 1990. Amendments filed January 29, 1990; effective March 15, 1990. Amendment filed July 5, 1990; effective August 19, 1990. Amendment filed August 17, 1990; effective October 1, 1990. Amendment filed November 27, 1990; effective January 11, 1991. Amendment filed December 14, 1990; effective January 28, 1991. Amendment filed January 16, 1991; effective March 2, 1991. Amendment filed February 19, 1991; effective April 5, 1991. Amendment filed February 26, 1991; effective April 12, 1991. Amendment filed May 7, 1991; effective June 21, 1991. Amendment filed June 12, 1991; effective July 27, 1991. Amendment filed June 14, 1991; effective July 29, 1991. Amendment filed September 16, 1991; effective October 31, 1991. Amendment filed September 17, 1991; effective November 1, 1991. Amendment filed September 30, 1991; effective November 14, 1991. Amendment filed October 14, 1991; effective November 28, 1991. Amendment filed October 21, 1991; effective December 5, 1991. Amendment filed October 23, 1991; effective December 7, 1991. Amendment filed March 10, 1992; effective April 24, 1992. Amendment filed March 26, 1992; effective May 10, 1992. Amendment filed April 29, 1992; effective June 13, 1992. Amendment filed September 29, 1992; effective November 13, 1992. Amendment filed October 20, 1992; effective December 4, 1992. Amendment filed December 7, 1993; effective February 20, 1994. Amendment filed March 18, 1994; effective June 1, 1994. Amendment filed May 25, 1994; effective August 9, 1994. Amendment filed November 10, 1994; effective January 24, 1995. Amendment filed August 1, 1995; effective October 14, 1995. Amendment filed October 20, 1995; effective January 3, 1996. Amendment filed July 15, 1996; effective September 28, 1996. Amendment filed April 20, 1998; effective July 4, 1998. Amendment filed October 14, 1998; effective December 28, 1998. Amendment filed January 3, 2000; effective March 18, 2000. Amendment filed June 22, 2000; effective September 5, 2000. Amendment filed January 9, 2002; effective March 25, 2002. Amendment filed July 24, 2003; effective October 7, 2003. Public necessity rule filed July 1, 2005; effective through December 13, 2005. Public necessity rule filed September 26, 2005; effective through March 10, 2006. Amendments filed December 20, 2005; effective March 5, 2006. Amendment filed January 16, 2006; effective April 1, 2006.

#### **1200-13-1-.07 MEDICAID EXCLUSIONS.**

- (1) Medicaid will not provide or pay for:
- (a) Provision of medical assistance which is not medically necessary or justified;
  - (b) Audiological therapy prescribing, fitting or changing hearing aids except when performed in a state approved speech and hearing facility through the EPSDT program for individuals under 21 years of age;

(Rule 1200-13-1-.07, continued)

- (c) Ballistocardiograph (BCG);
- (d) Outpatient drugs not listed as covered in the Tennessee Medicaid Drug Formulary, except when medically necessary in emergency life-threatening situations and ordered by the attending physician or emergency medical technician (EMT). Medicaid coverage is not available in any setting for drugs considered less than effective by the FDA. Medicaid reimbursement is not available for an injectable drug administered in the office by a provider (e.g., physician) unless the injectable drug is listed in the Tennessee Medicaid injectable Drug Formulary. Medicaid will not provide or pay for injections where oral medications can be sufficiently prescribed and are within the accepted medical practice in the locale.
- (e) Chiropractor's services;
- (f) Services performed for cosmetic purposes except as required for the prompt repair of accidental injury or for improvement of the functioning of a malformed body member;
- (g) Consultations by telephone;
- (h) Routine dental care such as, extracting, fillings, and prophylaxis, except through the EPSDT program for individuals under 21 years of age;
- (i) Durable medical equipment or medical supplies provided by or through a home health agency or medical vendor for use by a recipient who resides in an institution (e.g., hospital, Nursing Facility, Intermediate Care Facility for the Mentally Retarded).
- (j) Eyeglasses and/or contact lenses and eye examinations for the purpose of prescribing, fitting, or changing eyeglasses and/or contact lenses, and procedures performed to determine the refractive state of the eye(s) are not covered for recipients 21 years of age and over.
- (k) Excision of carotid body tumor as treatment for asthma;
- (l) Hospitalization for tests that can be performed satisfactorily in a physician's office, appropriate clinics or hospital outpatient department.
- (m) Icterus Index;
- (n) Immunizations that are regularly provided by local public health departments;
- (o) Injections where oral medications can be sufficiently prescribed and are within the accepted medical practice in the locale;
- (p) Ligation of internal mammary arteries, unilateral or bilateral;
- (q) Medical services for individuals committed to penal institutions, local, State or Federal;
- (r) The following medical supplies as described at Rule 1200-13-1-.03(l)(hh):
  - 1. transfer boards;
  - 2. deodorizers;
  - 3. disinfectant sprays;
  - 4. supports other than jobs supports;
  - 5. oxygen, except when provided upon the order of a physician and administered under the direction of a physician.



(Rule 1200-13-1-.07, continued)

- (s) Medical services for injuries or conditions resulting from war or provided by Veteran's Administration physicians;
- (t) Medical services performed outside the United States;
- (u) Routine newborn circumcision;
- (v) Private Duty Nursing services (licensed R.N., L.P.N., aides and sitters) except as set out in rule 1200-13-1-.03(l)(nn);
- (w) Organ transplants, except for renal, heart, liver, corneal, and bone marrow transplants. All transplants except renal and corneal require prior approval from the Medicaid Medical Director.
- (x) Protein Bound Iodine (PBI)
- (y) Psychological evaluations and testing are covered only when provided in approved Community Mental Health Centers as defined in rule 1200-13-4 or when ordered and billed by a physician and performed by a licensed psychologist. A qualified physician is one who:
  - 1. is licensed to practice medicine and surgery in the State of Tennessee;
  - 2. participates in the Tennessee Medicaid program in specialty areas of general practice, family practice or pediatrics;
  - 3. has personally examined the patient and determined the need for psychological services prior to performing or causing the services to be performed;
  - 4. intends to utilize the results of such evaluations and testing as an integral part of overall medical management of the patient.
- (z) Psychiatric evaluations and treatment are covered only when performed in or by approved Community Mental Health Centers as defined in rule 1200-13-4 or by a qualified psychiatrist or when ordered and billed by a psychiatrist and performed by a psychologist, nurse practitioner, nurse clinician, a person holding a Master of Social Work degree certified to perform psychiatric evaluation or treatment. A qualified psychiatrist is one who:
  - 1. is licensed to practice medicine and surgery in the State of Tennessee;
  - 2. participates in the Tennessee Medicaid program in the specialty area of psychiatry;
  - 3. has personally examined the patient and determined the need for psychological services prior to performing or causing the services to be performed;
  - 4. intends to utilize the results of such evaluations or treatments as an integral part of overall medical management of the patient.
- (aa) Recertification of patients in intermediate and skilled nursing facilities;
- (bb) Vision therapy;
- (cc) Routine physical examinations, except through the EPSDT program for individuals under 21 years of age;
- (dd) Services that are not within the Amount, Duration, and Scope of Assistance as described in the Tennessee Medicaid Rules and presents no definable obligation on the part of Medicaid to pay for services rendered;

(Rule 1200-13-1-.07, continued)

- (ee) Services provided by immediate relatives, i.e. mothers, fathers, sisters, brothers, in-laws, etc. or members of the recipient's household that have not been authorized by prior approval;
- (ff) Speech therapy,
- (gg) Services for the treatment of obesity, including by-pass surgery or weight loss program or any service when obesity is the only diagnosis.
- (hh) Services when mental retardation is the only diagnosis except:
  - 1. when rendered in an ICF/MR or community mental retardation clinics,
  - 2. to establish an initial diagnosis of mental retardation,
  - 3. to re-establish or confirm a diagnosis of mental retardation at intervals of no less than two (2) years (24 months).
- (ii) Services of an independently practicing registered physical therapist or psychologist except when ordered and billed by a physician.
- (jj) Any services provided for which documentation does not exist, for which clear and complete documentation is not readily available at the time of the review, or for which available documentation does not provide sufficient information to document the medical necessity of the service.
- (kk) Service which is considered experimental or investigational as required by section 1862(a)(1) of the Social Security Act which limits reimbursement for services which are considered reasonable and necessary.
- (ll) Services for which there is no Federal Financial Participation.
- (mm) Reserved.
- (nn) Home health services to recipients who are not homebound pursuant to Rule 1200-13-1-.18.
- (oo) Rehabilitation services when provided on an inpatient basis, except when provided on a short-term basis during the treatment and stabilization of an acute illness or injury which results in functional limitation. This exception does not include rehabilitative services aimed at restoring, improving or preventing further loss of an individual's functional capabilities after the acute illness or injury has been treated and stabilized.
- (pp) Hospital outpatient observation bed and related services in excess of twenty-three (23) hours and fifty-nine (59) minutes.
- (qq) Services for the treatment of impotence.
- (rr) Services performed for the treatment of infertility.
- (ss) Electrolysis.
- (tt) Testing that is rerun due to provider equipment failure or operator error of the previous test.

(Rule 1200-13-1-.07, continued)

- (uu) Any services related to organ procurement except autologous bone marrow collection.
- (vv) Any services performed in the absence of a specific medical complaint from the recipient with the following exceptions:
  - 1. EPSDT screening service provided to a recipient under age 21;
  - 2. Screening mammography;
  - 3. Papanicolaou (PAP) smear screens;
  - 4. Screening services performed to diagnose or rule-out disease or injury when there is a specific recipient complaint or when, in accordance with accepted medical practice, the provider clinically suspects that there is a likelihood that disease or injury exists in an individual recipient.
- (ww) Medical, psychiatric, or psychological procedures which have been determined by Medicaid to be a component of another billed procedure, or which have been determined by Medicaid to be reimbursable under another procedure code listing.
- (xx) Autopsy/Necropsy.
- (yy) Services determined by Medicaid to be inappropriate based on the
  - 1. age of the recipient;
  - 2. sex of the recipient;
  - 3. diagnosis;
  - 4. place of service;
  - 5. provider type or specialty.
- (zz) Hypnotherapy or Biofeedback.
- (aaa) The following services which are considered to be part of an office visit and which are not reimbursed separately:
  - 1. Pelvic examination;
  - 2. Pap smear collection;
  - 3. Diet instruction provided as part of the treatment for other medical conditions (e.g., hypertension, diabetics);
  - 4. Pharmacologic management, including prescription, use, and review of medication, with or without minimal psychotherapy.
- (bbb) - (ccc) Reserved.

(Rule 1200-13-1-.07, continued)

- (ddd) Diagnostic or therapeutic endoscopy (e.g., cystoscopy, colonoscopy, arthroscopy) performed other than in a hospital or ambulatory surgical center, unless performed by a physician who has been appropriately trained in the performance and interpretation of the procedure and who has staff privileges at a local hospital to perform the procedure.
- (eee) - (kkk) Reserved.
- (lll) A separate procedure which is commonly carried out as a component part of a larger procedure, unless it is performed alone for a specific procedure that is medically justified;
- (mmm) Component parts of a procedure when a single procedure could have been appropriately billed to include all component parts.
- (nnn) Reserved.
- (ooo) Mammography services except for:
  - 1. A Medicaid eligible recipient age 35 or older, Medicaid will reimburse for only one (1) screening mammography per fiscal year.
  - 2. A Medicaid eligible recipient age 35 or older, Medicaid will reimburse for diagnostic mammography when medically necessary for the diagnosis and evaluation of a breast mass.
  - 3. Medical prior approval is required for any mammography in a Medicaid eligible recipient under age 35. The receipt must have a referring physician (attending physician) other than a referring radiologist. Medicaid Authorization Request Forms may be submitted by either the attending physician or by the radiologist; however, if the radiologist submits the Medicaid Authorization Request Form, the name of the recipient's attending physician must be listed on the form.
- (ppp) Personal computers, peripherals (e.g., printers, modems, monitors, scanners), and software for use by recipients, except for computers and software which have been designed to be used exclusively as Augmentation Communication Devices and which have been approved by the Department.
- (qqq) Reserved.
- (2) For services provided prior to January 1, 1994, the Medicaid exclusion rules as set out at 1200-13-1-.07(l) shall apply. Effective January 1, 1994, the rules of TennCare as set out at rule chapter 1200-13-12 shall govern exclusions.

**Authority:** T.C.A. §§4-5-202, 71-5-.105, 71-5-109 and Public Chapter 358 of the Acts of 1993. **Administrative History:** Original rule filed November 17, 1977; effective December 19, 1977. Amendment filed January 31, 1978; effective March 16, 1979. Amendment filed June 23, 1983; effective July 25, 1983. Amendment filed June 27, 1984; effective July 27, 1984. Amendment filed May 8, 1985; effective August 13, 1985. Amendment filed April 29, 1986; effective May 29, 1986. Amendment filed January 22, 1988; effective March 7, 1988. Amendment filed January 30, 1989; effective March 16, 1989. Amendment filed January 29, 1990; effective March 15, 1990. Amendment filed February 23, 1990; effective April 9, 1990. Amendment filed July 5, 1990; effective August 19, 1990. Amendment filed August 30, 1990; effective October 14, 1990. Amendment filed October 30, 1990; effective December 14, 1990. Amendment filed January 9, 1991; effective February 23, 1991. Amendment filed February 27, 1991; effective April 13, 1991. Amendment filed April 29, 1991; effective June 13, 1991. Amendment filed May 8, 1991; effective June 22, 1991. Amendment filed June 12, 1991; effective July 27, 1991. Amendment filed September 19, 1991; effective November 3, 1991. Amendment filed March 9, 1992; effective April 23, 1992. Amendment filed March 26, 1992;

(Rule 1200-13-1-.07, continued)

*effective May 10, 1992. Amendment filed March 27, 1992; effective May 11, 1992. Amendment filed May 1, 1992; effective June 15, 1992. Amendment filed August 4, 1992; effective September 18, 1992. Amendment filed September 29, 1992; effective November 13, 1992. Amendment filed October 20, 1992; effective December 4, 1992. Amendment filed December 4, 1992; effective January 19, 1993. Amendment filed December 30, 1992; effective February 16, 1993. Amendment filed December 10, 1993; effective February 23, 1994. Amendment filed March 18, 1994; effective June 1, 1994.*

**1200-13-1-.08 ADMISSIONS TO LONG-TERM CARE FACILITIES.**

- (1) Each Long-term Care Facility participating in the medical assistance program must develop and consistently implement policies and procedures regarding its admissions, including the development and maintenance of a single wait list of persons requesting admission to those facilities. This list must at a minimum contain the following information pertaining to each request for admission:
  - (a) The name of the applicant.
  - (b) The name of the contact person or designated representative other than the applicant (if any).
  - (c) The address of the applicant and the contact person or designated representative (if any).
  - (d) The telephone number of the applicant and the contact person or designated representative (if any).
  - (e) The name of the person or agency referring the applicant to the nursing facility.
  - (f) The sex and race of the applicant.
  - (g) The date and time of the request for admission.
  - (h) Reason(s) for refusal/non-acceptance/other-action-taken pertaining to the request for admission.
  - (i) The name and title of the Long-term Care Facility staff person taking the application for admission.
  - (j) A notation stating whether the applicant is anticipated to be Medicaid eligible at time of admission or within one year of admission.
- (2) The wait list should be updated and revised at least once each quarter to remove the names of previous applicants who are no longer interested in admission to the Long-term Care Facility. Following three (3) contacts each separated by a period of at least ten (10) days, the Long-term Care Facility shall, consistent with the written notice required in this section move an applicant to the end of the single admission list whenever an available bed is not accepted at the time of the vacancy, but the applicant wishes to remain on the admissions list. Applicants shall be advised of these policies at the time of their inquiry, and must be notified in writing, in a format approved by the Department, when their name is removed from the list or moved to the end of the list. Such contacts shall be documented in the facility log containing the wait list. The date, time and method of each contact shall be recorded along with the name of the facility staff person making the contact, and the identity of the applicant or contact person contacted. The log of such contacts shall also summarize the communication between the facility staff person and the applicant or contact person.
- (3) Each facility shall send written confirmation that an applicant's name has been entered on the wait list, their position on the wait list, and a notification of their right of access to the wait list as provided in paragraph (8) of these rules. This confirmation shall include at a minimum the date and time of entry on the wait list and shall be mailed by first class postage to the applicant and their designated representative (if any) identified pursuant to the requirements in paragraph (1) above.

(Rule 1200-13-1-.08, continued)

- (4) Each Long-term Care Facility participating in the medical assistance program shall admit applicants in the chronological order in which the referral or request for admission was received by the facility, except as permitted in paragraph (5) of this rule.
- (3) Each facility shall send written confirmation that an applicant's name has been entered on the wait list, their position on the wait list, and a notification of their right of access to the wait list as provided in paragraph (8) of these rules. This confirmation shall include at a minimum the date and time of entry on the wait list and shall be mailed by first class postage to the applicant and their designated representative (if any) identified pursuant to the requirements in paragraph (1) above.
- (4) Each Long-term Care Facility participating in the medical assistance program shall admit applicants in the chronological order in which the referral or request for admission was received by the facility, except as permitted in paragraph (5) of this rule.
- (5) Documentation justifying deviation from the order of the wait list must be maintained for inspection by the Department. Inspection shall include the right to review and/or make copies of these records. Deviation may be based upon:
  - (a) Medical need, including, but not necessarily limited to, the expedited admission of patients being discharged from hospitals and patients who previously resided in a Long-term Care Facility at a different level of care, but who, in both cases, continue to require institutional medical services;
  - (b) The applicant's sex, if the available bed is in a room or a part of the facility that exclusively serves residents of the opposite sex;
  - (c) Necessity to implement the provisions of a plan of affirmative action to admit racial minorities, if the plan has previously been approved by the Department;
  - (d) Emergency placements requested by the Department when evacuating another health care facility or by the Adult Protective Service of the Tennessee Department of Human Services;
  - (e) Other reasons or policies, e.g., previous participation in a community based waiver or other alternative care program, when approved by the Medical Director of the Department's Bureau of Manpower and Facilities; provided, however, that no such approval shall be granted if to do so would in any way impair the Department's or the facility's ability to comply with its obligations under federal and state civil rights laws, regulations or conditions of licensure or participation.
  - (f) If a Medicaid-eligible recipient's hospitalization or therapeutic leave exceeds the period paid for under The Tennessee Medicaid program for the holding of a bed in the facility for the resident and if the resident continues to require the services provided by the Long-term Care Facility, then the resident must be readmitted to the facility immediately upon the first availability of a bed in the facility, consistent with paragraph (5)(b);
  - (g) Where, with the participation and approval of the Department, expedited admission is approved for residents who are being displaced from another facility or its waiting list as a result of that facility's withdrawal from the Medicaid program.
- (6) Telephone request to be placed on the wait list shall be accepted. The information required in paragraph (1) shall be documented.

(Rule 1200-13-1-.08, continued)

- (7) If an applicant, whether on his or her own behalf or acting through another, requests admission or to be placed on a list of applicants awaiting admission, the information on the waiting list must be recorded and preserved.
- (8) Applicants (or their representative), Ombudsmen and appropriate State and Federal personnel shall have access to the wait list when requested. Such access shall include the right to review and/or copy the wait list, and to be informed by telephone of their position on the wait list.
- (9) Any referrals received from the Tennessee Department of Human Services shall be handled in the following manner.
  - (a) Applicants shall be placed on a wait list without formal application until such facility is within sixty (60) days of admission to the facility based on experience.
  - (b) When the applicant is within sixty (60) days of admission to the facility as estimated by the facility based on its experience, the facility shall notify the applicant and the Department of Human Services in writing so that a formal application can be made prior to consideration for admittance.
  - (c) If, after sixty (60) days from the date notification is issued, the facility has not received a completed application then the facility may remove the applicant's name from the wait list.

**Authority:** T.C.A. §§4-5-202, 71-5-105, and 71-5-109. **Administrative History:** Original rule filed May 15, 1980; effective June 29, 1980. Amendment filed May 27, 1983; effective June 27, 1983. Amendment filed February 22, 1991; effective April 9, 1991.

#### **1200-13-1-.09 THIRD PARTY SIGNATURE.**

- (1) No facility may require a third party signature for a Medicaid recipient as a condition of application or admission to, or continued stay in, the facility. However, any person appointed by a court of competent jurisdiction to act on behalf of a recipient may be required to perform all requirements normally required of an applicant.
- (2) If a facility has collected an advance payment or deposit from or on behalf of a person retroactively determined to be eligible for Medicaid, the amount collected less the amount determined by the Department of Human Services to be the patient's liability for that period of time shall be refunded within ten (10) days after receiving payment for retroactive period from the state of its agents.
- (3) The facility must file for such retroactive reimbursement for the full period of retroactive eligibility on the next claim for reimbursement filed by the facility following the date of notification of eligibility.

**Authority:** T.C.A. §§14-1945 and 14-23-109. **Administrative History:** Original rule filed May 15, 1980; effective June 29, 1980. Amendment filed October 8, 1985; effective November 7, 1985.

#### **1200-13-1-.10 CRITERIA FOR MEDICAID REIMBURSEMENT OF CARE IN NURSING FACILITIES.**

- (1) The following definitions shall apply for interpretation of this rule:
  - (a) Certification - a process by which a physician, who is licensed as a doctor of medicine or doctor of osteopathy, signs and dates a PreAdmission Evaluation signifying that the requested level of Nursing Facility care is medically necessary for the individual.
  - (b) Department - the Tennessee Department of Health.

(Rule 1200-13-1-.10, continued)

- (c) Designated Correspondent - a person or agency authorized by an individual to receive correspondence on his/her behalf related to a PreAdmission Evaluation.
- (d) Expiration Date - a date assigned by the Department at the time of approval of a PreAdmission Evaluation after which Medicaid reimbursement will not be made unless a new PreAdmission Evaluation is submitted and approved.
- (e) Inpatient nursing care - nursing services which are available 24 hours per day by or under the supervision of a licensed practical nurse or registered nurse and which, in accordance with general medical practice, are usually and customarily provided on an inpatient basis in a Nursing Facility. Inpatient nursing care includes, but is not limited to, routine nursing services such as observation and assessment of the individual's medical condition, administration of legend drugs, and supervision of nurse aides, and other skilled nursing therapies or services that are performed by a licensed practical nurse or registered nurse.
- (f) Medicaid Eligible - an individual who has been determined by the Tennessee Department of Human Services or the Social Security Administration to be financially eligible to have TennCare make reimbursement for covered services.
- (g) Medically Entitled - an individual who has a PreAdmission Evaluation that has been certified by a physician and that has been approved by the Department.
- (h) Notice of Disposition or Change - a notice issued by the Department of Human Services of an individual's financial eligibility for Medicaid and approved Medicaid vendor date for payments to a Nursing Facility.
- (i) Nursing Facility - a Medicaid-certified nursing facility approved by the Department.
- (j) Nursing Facility Eligible - an individual who has attained Medicaid Eligible status and who is Medically Entitled.
- (k) PAE Approval Date - the beginning date, as indicated on the PreAdmission Evaluation, for which the PreAdmission Evaluation has been approved.
- (l) Patient Liability - the amount determined by the Tennessee Department of Human Services which a Medicaid Eligible is required to pay for covered services provided by a Nursing Facility.
- (m) "Plain language" - any notice or explanation that requires no more than a sixth grade level of education as measured by the Flesch Index, Fog Index, or Flesch-Kincaid Index.
- (n) PreAdmission Evaluation (PAE) - a process of assessment approved by the Bureau of TennCare and used to document an individual's medical condition and eligibility for Medicaid-reimbursed care in a Nursing Facility.
- (o) PreAdmission Screening/Annual Resident Review (PASARR) - the process by which the State determines whether an individual who resides in or seeks admission to a Medicaid-certified Nursing Facility has, or is suspected of having, mental illness or mental retardation, and, if so, whether the individual requires specialized services.
- (p) Skilled nursing service - a physician-ordered nursing service the complexity of which is such that it can only be safely and effectively provided directly by a registered nurse or licensed practical nurse.



(Rule 1200-13-1-.10, continued)

- (q) Skilled rehabilitative service - a physician-ordered rehabilitative service the complexity of which is such that it can only be safely and effectively provided by qualified health care personnel (e.g., registered physical therapist, licensed physical therapist assistant, registered occupational therapist, certified occupational therapist assistant, licensed respiratory therapist, licensed respiratory therapist assistant).
  - (r) Specialized services for individuals with Mental Illness - the implementation of an individualized plan of care developed under and supervised by a physician, provided by a physician and other qualified mental health professionals, that prescribes specific therapies and activities for the treatment of persons who are experiencing an acute episode of severe mental illness, which necessitates continuous supervision by trained mental health personnel. Services to maintain generally independent individuals who are able to function with little supervision or in the absence of a continuous specialized services program are not included.
  - (s) Specialized services for individuals with Mental Retardation and Related Conditions - the implementation of an individualized plan of care specifying a continuous program for each individual, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services that is directed towards the acquisition of the behaviors necessary for the individual to function with as much self-determination and independence as possible; and the prevention or deceleration of regression or loss of current optimal functional status. Services to maintain generally independent individuals who are able to function with little supervision or in the absence of a continuous specialized services program are not included.
  - (t) Transfer Form - a form which is used in lieu of a new PreAdmission Evaluation to document the transfer of a Nursing Facility Eligible having an approved unexpired PreAdmission Evaluation from Medicaid Level 1 at one Nursing Facility to Medicaid Level 1 at another such facility or from Medicaid Level 2 at one Nursing Facility to Medicaid Level 2 at another.
- (2) PreAdmission Evaluations and Transfer Forms
- (a) A PreAdmission Evaluation is required in the following circumstances:
    1. When a Medicaid Eligible is admitted to a Nursing Facility.
    2. When a private-paying resident of a Nursing Facility attains Medicaid Eligible status.
    3. When a Nursing Facility Eligible is changed from Medicaid Level 1 to Medicaid Level 2.
    4. When a Nursing Facility Eligible is changed from Medicaid Level 2 to Medicaid Level 1, unless the individual was previously receiving Medicaid-reimbursed Level 1 care and still has an approved unexpired Level 1 PreAdmission Evaluation.
    5. When a Nursing Facility Eligible requires continuation of the same level of care beyond the expiration date assigned by the Department.
    6. When a Nursing Facility Eligible no longer requires the specific skilled nursing or rehabilitative services for which a Level 2 PreAdmission Evaluation was approved but requires other Level 2 care in a Nursing Facility.
  - (b) A Transfer Form is required in the following circumstances:
    1. When a Medicaid-Eligible having an approved unexpired PreAdmission Evaluation transfers from Medicaid Level 1 at one Nursing Facility to Medicaid Level 1 at another such facility; or

(Rule 1200-13-1-.10, continued)

2. When a Medicaid Eligible having an approved unexpired PreAdmission Evaluation transfers from Medicaid Level 2 at one Nursing Facility to Medicaid Level 2 at another. A Transfer Form may be used only if there is no change in the skilled nursing or rehabilitative service for which the PreAdmission Evaluation was approved. If the skilled nursing or rehabilitative service changes, a new PreAdmission Evaluation is required.
- (c) A PreAdmission Evaluation is not required in the following circumstances:
1. When a Medicaid Eligible with an approved unexpired Level 1 PreAdmission Evaluation returns to the Nursing Facility after being hospitalized.
  2. When a Medicaid Eligible with an approved unexpired Level 2 PreAdmission Evaluation returns to the Nursing Facility after being hospitalized, if there has been no change in the skilled nursing or rehabilitative service for which the PreAdmission Evaluation was approved.
  3. When a Medicaid-Eligible changes from Level 2 to Level 1, if that individual was previously receiving Medicaid-reimbursed Level 1 care and still has an approved unexpired Level 1 PreAdmission Evaluation.
  4. When an individual's financial status changes from Medicaid Eligible to private pay and then back to Medicaid Eligible within a 90-day time period.
  5. To receive Medicaid co-payment when Medicare is the primary payor of Level 2 care.
  6. When a Transfer Form is appropriate in accordance with (2)(b).
- (d) If a Nursing Facility admits or allows continued stay of a Medicaid Eligible without an approved PreAdmission Evaluation, it does so at its own risk and in such event the Nursing Facility shall give the individual a plain language written notice, in a format approved by the Department, that Medicaid reimbursement will not be paid unless the PreAdmission Evaluation is approved and if it is not finally approved the individual can be held financially liable for services provided.
- (e) An approved PreAdmission Evaluation is valid for ninety (90) calendar days beginning with the PAE Approval Date. An approved PreAdmission Evaluation that has not been used within ninety (90) calendar days of the PAE Approval Date can be updated within 365 calendar days of the PAE Approval Date if the physician certifies that the individual's current medical condition is consistent with that described in the approved PreAdmission Evaluation. If the individual's medical condition has significantly improved such that the previously-approved PreAdmission Evaluation does not reasonably reflect the individual's current medical condition and functional capabilities, a new PreAdmission Evaluation shall be required.
- (f) A PreAdmission Evaluation must include a recent history and physical signed by a physician who is licensed as a doctor of medicine or doctor of osteopathy. A history and physical performed within 365 calendar days of the PAE Request Date may be used if the patient's condition has not significantly changed. Additional medical records (progress notes, office records, discharge summaries, etc.) may be used to supplement a history and physical and provide current medical information if changes have occurred since the history and physical was performed.
- (g) A PreAdmission Evaluation may be approved by the Department for a fixed period of time with an expiration date based on an assessment by the Department of the individual's medical

(Rule 1200-13-1-.10, continued)

condition and anticipated continuing need for inpatient nursing care. Notice of appeal rights shall be provided when a PreAdmission Evaluation is approved with an expiration date.

- (h) All individuals who reside in or seek admission to a Medicaid-certified Nursing Facility must have a PASARR Level I assessment for mental illness and mental retardation. If the Level I assessment indicates the need for a PASARR Level II assessment of need for specialized services for mental illness and/or mental retardation, the individual must undergo the PASARR Level II assessment.
  - (i) A Nursing Facility that has entered into a provider agreement with the Department shall assist a resident or applicant as follows:
    - 1. The Nursing Facility shall assist a Nursing Facility resident or an applicant for admission in applying for Medicaid eligibility and in applying for Medicaid-reimbursed Nursing Facility care. This shall include assistance in properly completing all necessary paperwork and in providing relevant Nursing Facility documentation to support the PreAdmission Evaluation. Reasonable accommodations shall be made for an individual with disabilities or, alternatively, for a Designated Correspondent with disabilities when assistance is needed with the proper completion and submission of a PreAdmission Evaluation.
    - 2. The Nursing Facility shall request a Notice of Disposition or Change from the Department of Human Services upon learning that a resident or applicant has, or is likely to have, applied for Medicaid eligibility.
  - (j) The Bureau of TennCare shall process PreAdmission Evaluations independently of determinations of financial eligibility by the Tennessee Department of Human Services; however, Medicaid reimbursement shall not be available until both the PreAdmission Evaluation and financial eligibility for Medicaid vendor payment have been approved.
- (3) Medicaid Reimbursement
- (a) A Nursing Facility that has entered into a provider agreement with the Department is entitled to receive Medicaid reimbursement for covered services provided to a Nursing Facility Eligible if
    - 1. The Department has received an approvable PreAdmission Evaluation for the individual within thirty (30) calendar days of the PAE Request Date or the physician certification date, whichever is earlier.
    - 2. For the same-level transfer (Level 1 to Level 1, Level 2 to Level 2) of an individual having an approved unexpired PreAdmission Evaluation, the Department has received an approvable Transfer Form within thirty (30) calendar days of admission into the same level of care at the admitting Nursing Facility (i.e., the Nursing Facility to which the individual is being transferred).
    - 3. For a retroactive eligibility determination, the Department has received a Notice of Disposition or Change and has received an approvable PreAdmission Evaluation within thirty (30) calendar days of the mailing date of the Notice of Disposition or Change.
  - (b) A Nursing Facility that has entered into a provider agreement with the Department and that admits a Medicaid Eligible without an approved PreAdmission Evaluation or, where applicable, an approved Transfer Form does so without the assurance of reimbursement from the Department.

(Rule 1200-13-1-.10, continued)

- (c) Medicaid reimbursement will only be made to a Nursing Facility on behalf of the Nursing Facility Eligible and not directly to the Nursing Facility Eligible.
  - (d) A Nursing Facility that has entered into a provider agreement with the Department shall admit individuals on a first come, first served basis, except as otherwise permitted by state and federal laws and regulations.
- (4) Criteria for Reimbursement of Medicaid Level 1 Care in a Nursing Facility
- (a) The individual must be determined by the Tennessee Department of Human Services to be financially eligible for Medicaid reimbursement for Nursing Facility Care.
  - (b) An individual must meet both of the following criteria in order to be approved for Medicaid-reimbursed Level 1 care in a Nursing Facility:
    - 1. **MEDICAL NECESSITY OF CARE:** Care in a Nursing Facility must be expected to improve or ameliorate the individual's physical or mental condition, to prevent a deterioration in health status, or to delay progression of a disease or disability, and such care must be ordered and supervised by a physician on an ongoing basis.
    - 2. **NEED FOR INPATIENT NURSING CARE:** The individual must have a physical or mental condition, disability, or impairment that, as a practical matter, requires daily inpatient nursing care. The individual must be unable to self-perform needed nursing care and must meet or equal one or more of the following criteria on an ongoing basis:
      - (i) **TRANSFER** - The individual is incapable of transfer to and from bed, chair, or toilet unless physical assistance is provided by others on an ongoing basis. (daily or multiple times per week).
      - (ii) **MOBILITY** - The individual requires physical assistance from another person for mobility on an ongoing basis (daily or multiple times per week). Mobility is defined as the ability to walk, using mobility aids such as a walker, crutch, or cane if required, or the ability to use a wheelchair if walking is not feasible. The need for a wheelchair, walker, crutch, cane, or other mobility aid shall not by itself be considered to meet this requirement.
      - (iii) **EATING** - The individual requires gastrostomy tube feedings or physical assistance from another person to place food/drink into the mouth. Food preparation, tray set-up, and assistance in cutting up foods shall not be considered to meet this requirement.
      - (iv) **TOILETING** - The individual requires physical assistance from another person to use the toilet or to perform incontinence care, ostomy care, or indwelling catheter care on an ongoing basis (daily or multiple times per week).
      - (v) **EXPRESSIVE AND RECEPTIVE COMMUNICATION** - The individual is incapable of reliably communicating basic needs and wants (e.g., need for assistance with toileting; presence of pain) using verbal or written language; or the individual is incapable of understanding and following very simple instructions and commands (e.g., how to perform or complete basic activities of daily living such as dressing or bathing) without continual staff intervention.
      - (vi) **ORIENTATION** - The individual is disoriented to person (e.g., fails to remember own name, or recognize immediate family members) or is disoriented to place (e.g., does not know residence is a Nursing Facility).

(Rule 1200-13-1-.10, continued)

- (vii) **MEDICATION ADMINISTRATION** - The individual is not mentally or physically capable of self-administering prescribed medications despite the availability of limited assistance from another person. Limited assistance includes, but is not limited to, reminding when to take medications, encouragement to take, reading medication labels, opening bottles, handing to individual, and reassurance of the correct dose.
- (viii) **BEHAVIOR** - The individual requires persistent staff intervention due to an established and persistent pattern of dementia-related behavioral problems (e.g., aggressive physical behavior, disrobing, or repetitive elopement).
- (ix) **SKILLED NURSING OR REHABILITATIVE SERVICES** - The individual requires daily skilled nursing or rehabilitative services at a greater frequency, duration, or intensity than, for practical purposes, would be provided through a daily home health visit.

The intent is that the above criteria should reflect the individual's capabilities on an ongoing basis and not isolated, exceptional, or infrequent limitations of function in a generally independent individual who is able to function with minimal supervision or assistance.

- 3. If an individual who seeks admission to a Nursing Facility has an established and persistent pattern of aggressive behavior that has previously endangered the health or safety of others, there must be a statement attached to the PreAdmission Evaluation that describes such pattern of behavior and outlines specific care needs for the individual to ensure the health and safety of others.
- (c) For continued reimbursement of Medicaid Level 1 care in a Nursing Facility, an individual must continue to be financially eligible for Medicaid reimbursement for Nursing Facility Care and must meet both of the following continued stay criteria:
    - 1. **MEDICAL NECESSITY OF CARE:** Care in a Nursing Facility must be expected to improve or ameliorate the individual's physical or mental condition, to prevent a deterioration in health status, or to delay progression of a disease or disability, and such care must be ordered and supervised by a physician on an ongoing basis.
    - 2. **NEED FOR INPATIENT CARE:** The individual must have a physical or mental condition, disability, or impairment that continues to require the availability of daily inpatient nursing care.
  - (d) A Nursing Facility Eligible admitted to a Nursing Facility before the effective date of this rule must meet continued stay criteria in effect at the time of admission.
- (5) **Criteria for Reimbursement of Medicaid Level 2 Care in a Nursing Facility**
    - (a) The individual must be determined by the Tennessee Department of Human Services to be financially eligible for Medicaid reimbursement for Nursing Facility Care.
    - (b) An individual must meet both of the following criteria in order to be approved for Medicaid-reimbursed Level 2 care in a Nursing Facility:
      - 1. **MEDICAL NECESSITY OF CARE:** Care in a Nursing Facility must be expected to improve or ameliorate the individual's physical or mental condition, to prevent a

(Rule 1200-13-1-.10, continued)

deterioration in health status, or to delay progression of a disease or disability, and such care must be ordered and supervised by a physician on an ongoing basis.

2. **NEED FOR INPATIENT SKILLED NURSING OR REHABILITATIVE SERVICES ON A DAILY BASIS:** The individual must have a physical or mental condition, disability, or impairment that requires skilled nursing or rehabilitative services on a daily basis or skilled rehabilitative services at least five days per week when skilled rehabilitative services constitute the primary basis for the approval of the PreAdmission Evaluation. The individual must require such services at a greater frequency, duration, or intensity than, for practical purposes, would be provided through a daily home health visit. In addition, the individual must be mentally or physically unable to perform the needed skilled services or the individual must require skilled services which, in accordance with accepted medical practice, are not usually and customarily self-performed.

For interpretation of this rule, the following shall apply:

- (i) Administration of oral medications, ophthalmics, otics, inhalers, subcutaneous injections (e.g., fixed-dose insulin, subtherapeutic heparin, and calcitonin), topicals, suppositories, nebulizer treatments, oxygen administration, shall not, in and of itself, be considered sufficient to meet the requirement of (5)(b)2.
  - (ii) Nursing observation and assessment, in and of itself, shall not be considered sufficient to meet the requirement of (5)(b)2. Examples of nursing services for which Level 2 reimbursement might be provided include, but are not limited to, the following:
    - (I) Gastrostomy tube feeding
    - (II) Sterile dressings for Stage 3 or 4 pressure sores
    - (III) Total parenteral nutrition
    - (IV) Intravenous fluid administration
    - (V) Nasopharyngeal and tracheostomy suctioning
    - (VI) Ventilator services.
  - (iii) A skilled rehabilitative service must be expected to improve the individual's condition. Restorative and maintenance nursing procedures (e.g., routine range of motion exercises; stand-by assistance during ambulation; applications of splints/braces by nurses and nurses aides) shall not be considered sufficient to fulfill the requirement of (5)(b)2. Factors to be considered in the decision as to whether a rehabilitative service meets, or continues to meet, the requirement of (5)(b)2. shall include, but not be limited to, an assessment of the type of therapy and its frequency, the remoteness of the injury or impairment, and the reasonable potential for improvement in the individual's functional capabilities or medical condition..
- (6) **PreAdmission Evaluation Denials and Appeal Rights**
- (a) A Medicaid Eligible or the legal representative of the Medicaid Eligible has the right to appeal the denial of a PreAdmission Evaluation and to request a Commissioner's Administrative Hearing by submitting a written letter of appeal to the Bureau of TennCare, Division of Long-Term Care, within thirty (30) calendar days of receipt of the notice of denial.
  - (b) If the Department denies a PreAdmission Evaluation, the individual will be notified in the following manner:

(Rule 1200-13-1-.10, continued)

1. A written notice of denial shall be sent by certified mail, return receipt requested, to the individual and, where applicable, to the designated correspondent. A notice of denial shall also be mailed or faxed to the Nursing Facility. This notice shall advise the individual of the right to appeal the denial decision within thirty (30) calendar days. The notice shall also advise the individual of the right to submit within thirty (30) calendar days either the original PreAdmission Evaluation with additional information for review or a new PreAdmission Evaluation. The notice shall be mailed to the individual's address as it appears upon the PreAdmission Evaluation. If no address appears on the PreAdmission Evaluation and supporting documentation, the notice will be mailed to the Nursing Facility for forwarding to the individual.
  2. If the PreAdmission Evaluation is resubmitted with additional information for review and if the Department continues to deny the PreAdmission Evaluation, another written notice of denial shall be sent as described in (6)(b)1.
- (c) The individual has the right to be represented at the hearing by anyone of their choice. The hearing will be conducted according to the provisions of the Tennessee Uniform Administrative Procedures Act.
  - (d) Reasonable accommodations shall be made for individuals with disabilities who require assistance with an appeal.
  - (e) Any notice required pursuant to this section shall be a plain language written notice.
  - (f) When a PreAdmission Evaluation is approved for a fixed period of time with an expiration date determined by the Department, the individual shall be provided with a notice of appeal rights, including the opportunity to submit an appeal within thirty (30) calendar days prior to the expiration date. Nothing in this section shall preclude the right of the individual to submit a new PreAdmission Evaluation establishing medical necessity of care when the expiration date has been reached.

**Authority:** T.C.A. 4-5-202, 71-5-105, 71-5-109, Executive Order No. 11, and Executive Order No. 23.  
**Administrative History:** Original rule filed October 22, 1981; effective December 7, 1981. Amendment filed March 1, 1982; effective April 15, 1982. Amendment filed June 23, 1983; effective July 25, 1983. Amendment filed May 24, 1985; effective June 23, 1985. Amendment filed November 9, 1988; effective December 24, 1988. Amendment filed March 30, 1995; effective June 15, 1995. Repeal and new rule filed June 29, 2000; effective September 12, 2000. Amendment filed July 24, 2003; effective October 7, 2003. Amendment filed September 30, 2005; effective December 14, 2005.

#### **1200-13-1-.11 RECIPIENT ABUSE AND OVERUTILIZATION OF MEDICAID PROGRAM.**

- (1) Definitions:
  - (a) *Abuse:* Recipient practices or recipient involvement in practices including overutilization of Medicaid Program service that result in costs to the Medicaid Program which are not medically necessary or medically justified.
  - (b) *Commencement of Services:* The time at which the first covered service(s) is rendered to a Medicaid recipient for each individual medical condition.
  - (c) *Emergency:* The sudden and unexpected onset of a medical condition requiring treatment immediately after onset or within 72 hours in order to prevent serious disability or death.
  - (d) *Initiating Provider:* The provider who renders the first covered service to a Medicaid recipient whose current medical condition requires the services of more than one (1) provider.

(Rule 1200-13-1-.11, continued)

- (e) *Lock-in Provider:* A provider whom a recipient on lock-in status has chosen and to whom a recipient is assigned by the Department for purposes of receiving medical services and referral to other providers.
  - (f) *Lock-in Status:* The restriction of a recipient to a specified and limited number of health care providers.
  - (g) *Overutilization:* Recipient initiated use of Medicaid services or items at a frequency or amount that is not medically necessary or medically justified.
  - (h) *Prior Approval Status:* The restriction of a recipient to a procedure wherein all health care services, except in emergency situations, must be approved by the Department prior to the delivery of services.
- (2) When a determination is made by the Department that a recipient committed, attempted to commit or aided in the commission of an abuse or overutilization of the Medicaid Program it shall:
- (a) Restrict the recipient by placing the recipient on lock-in status for an initial period of eighteen (18) months; or
  - (b) Restrict the recipient by placing the recipient on prior approval status for an initial period of eighteen (18) months.
- (3) Activities or practices which may evidence overutilization of the Medicaid Program for which the commission or attempted commission justifies placement on lock-in status of all recipients involved, include but are not limited to:
- (a) Treatment by several physicians for the same diagnosis.
  - (b) Obtaining the same or similar controlled substances from several physicians.
  - (c) Obtaining controlled substances in excess of the maximum recommended dose.
  - (d) Receiving combinations of drugs which act synergistically or belong to the same class.
  - (e) Frequent treatment for diagnoses which are highly susceptible to abuse.
  - (f) Receiving services and/or drugs from numerous providers.
  - (g) Obtaining the same or similar drugs on the same day or at frequent intervals.
  - (h) Frequent use of emergency room in non-emergency situations.
- (4) Activities or practices which may evidence abuse of the Medicaid Program for which the commission or attempted commission justifies placement on prior approval status of all recipients involved, include but are not limited to:
- (a) Trading, swapping or selling of Medicaid cards.
  - (b) Forging or altering drug prescriptions.
  - (c) Selling Medicaid paid prescription drugs.



(Rule 1200-13-1-.11, continued)

- (d) Failing to promptly report loss or theft of a Medicaid card when the recipient knew or should have known the card was lost or stolen.
  - (e) Inability to provide for the security and integrity of assigned Medicaid card.
  - (f) Altering a Medicaid card.
  - (g) Failure to control overutilization activity while on lock-in status.
  - (h) Knowingly providing incomplete, inaccurate or erroneous information during Medicaid financial eligibility determination.
  - (i) Knowingly providing false, incomplete, inaccurate or erroneous information to provider(s) in order to receive covered services for which the recipient is ineligible.
  - (j) The use of a Medicaid card by a recipient other than the recipient to which it is assigned to receive or attempt to receive covered medical services.
- (5) The Department shall conduct a review of all recipients placed on lock-in or prior approval status upon the expiration of the initial and any additional restriction period(s) and shall:
- (a) Remove the recipient from lock-in or prior approval status and reinstate the recipient to the normal Medicaid status, or
  - (b) If the recipient's activity indicates continued or attempted abuse of overutilization, regardless of the exact nature of the activity, during the initial and/or additional restriction period(s),
    - 1. continue the recipient on lock-in or prior approval status for an additional eighteen (18) months; or
    - 2. change the recipient from lock-in or prior approval status for an additional eighteen (18) months; or
    - 3. change the recipient from Prior approval to lock-in status for an additional eighteen (18) months.
  - (c) If at any time during which a recipient is on lock-in status, the recipient's activities indicate continued abuse or attempted abuse of the Medicaid Program, the Department may review the recipient's status and change the recipient from lock-in status to prior approval status for the remainder of the initial or additional restriction period.
  - (d) The Department may reconsider the need to continue a recipient on lock-in or prior approval status upon notification and written verification from a licensed physician that the recipient is suffering from a medical condition including but not limited to:
    - 1. a catastrophic illness such as terminal cancer or renal dialysis; or
    - 2. a condition which necessitates admission to an inpatient facility for an extended period of time.
- (6) A recipient is entitled to a fair hearing in the following circumstances:
- (a) When the Department makes the initial determination to place the recipient on lock-in or prior approval status; and

(Rule 1200-13-1-.11, continued)

- (b) When the Department, after any recipient status review, makes a determination to:
    - 1. continue the recipient on lock-in or prior approval status; or
    - 2. change the recipient from lock-in to prior approval status; or
    - 3. change the recipient from prior approval to lock-in status.
  - (c) When the Department, pursuant to prior approval procedures, denies a prior approval status recipient's claim to or request for the provision of a covered service.
  - (d) When the action of the Department placing a recipient on a restricted status would result or has resulted in the denial of reasonable access to Medicaid services of adequate quality pursuant to subsection (13) of this section.
- (7) Fair Hearing Procedures: The following procedure shall apply when a recipient becomes entitled to a fair hearing pursuant to section (6):
- (a) The Department shall notify the recipient in writing by certified mail, return receipt requested, of its determination. The notice shall contain:
    - 1. the specific and comprehensive reasons for the determination, and
    - 2. a statement of the Department's intended action, and
    - 3. a statement of the recipient's right to a hearing pursuant to the Uniform Administrative Procedures Act (T.C.A. Section 4-5-101 et seq.).
  - (b) A recipient must request a hearing within fifteen (15) days of receipt of the notice by filing such request in writing with the Department. The request for hearings pursuant to subsection 6(c) must be made in writing within fifteen (15) days of the date on which the claim to or request for services is denied.
  - (c) If a recipient fails to request a hearing within the designated time limit the recipient shall forfeit the right to a hearing on the action specified in the notice and the Department shall take such action as it specified in the notice.
  - (d) If a recipient requests a hearing within the designated time limit, the Department shall schedule a hearing and notify the recipient of the time and place. The recipient's then existing status will not change pending a final determination after the hearing.
  - (e) A hearing requested pursuant to subsection (6)(c) shall be scheduled within ten (10) days of receipt of the request.
- (8) Lock-in Status Procedures: For services rendered to any lock-in status recipient the following shall apply:
- (a) The Department shall request the recipient to submit the name(s) of the provider(s) from whom the recipient wishes to receive services.
  - (b) If the recipient's condition necessitates the services of more than one (1) physician, other physicians will be allowed to provide needed services and submit a claim to Medicaid; however, the physicians must be of different specialties and Medicaid program participants.

(Rule 1200-13-1.11, continued)

- (c) The name(s) submitted by the recipient shall become the recipient's lock-in provider(s) unless the department determines that the provider(s) is/are ineligible, unable or unwilling to become the lock-in provider(s) in which case additional provider names will be requested.
  - (d) If the recipient fails to submit the requested provider name(s) within ten (10) days of the receipt of the department's request, the department may assign, as lock-in providers one (1) physician (non-specialist) and one (1) pharmacy from those utilized recently by the recipient, or the recipient will be placed on prior approval status until the requested provider name(s) are received and approved by the department.
  - (e) All referrals from a recipient's lock-in provider to a non-lock-in provider must be reported by telephone or in writing to the department to avoid automatic denial of the referred providers claim.
  - (f) A recipient who is on lock-in status may change providers by giving at least thirty (30) days written notice to the department. Elective changes will only be allowed every six (6) months. Emergency changes (i.e., death of provider, discharge of recipient by provider, etc.) may be accomplished at any time by telephoning the department, but must be followed by a written request within ten (10) days.
  - (g) Upon the change of a lock-in provider pursuant to subsection (8)(f) of this section all referrals to other providers made by the previous lock-in provider shall no longer be valid.
  - (h) All providers are responsible for ascertaining recipient Medicaid status and, except in the case of an emergency or approved referral or admission to a long term care facility, reimbursement for services rendered to a lock-in status recipient by any provider other than the recipient's lock-in provider shall be denied.
- (9) Prior Approval Status Procedures: For services rendered to any prior approval status recipient the following shall apply:
- (a) The provider is responsible for ascertaining the status of any Medicaid recipient.
  - (b) The provider is responsible for securing prior approval by telephone from the department in all cases, except emergencies, by calling the telephone number listed on the recipient's Medicaid care, in accordance with the following:
    - 1. If the commencement of services is during the normal office hours (8:00 a.m. to 4:30 p.m.) on any state working day, approval must be obtained prior to the commencement of services regardless of the number of services or the length of time services are provided.
    - 2. If the commencement of services is during any time state offices are closed, approval must be obtained no later than the closing hour of the next state working day following the commencement of services regardless of the number of services or the length of time services are provided.
  - (c) In either of the circumstances listed in subsection (9)(b) of this section, if a recipient's current medical condition requires the services of more than one (1) provider the following shall apply:
    - 1. If the initiating provider secures prior approval in accordance with the rules, the subsequent provider(s) need not secure prior approval for any medically necessary services rendered.
    - 2. If the initiating provider fails to secure prior approval in accordance with the rules, all other provider claims arising from that medical condition shall be denied except claims

(Rule 1200-13-1-.11, continued)

submitted by any subsequent provider who secures prior approval in accordance with the rules.

- (d) The provider may not seek payment from Medicaid or the recipient for any medical services rendered without prior approval or for services rendered beyond the scope of the services contemplated by any prior approval.
  - (e) A long term care provider is not at risk of a claim denial under this rule for covered services rendered to a prior approval status recipient. Compliance with all other long term care rules is mandatory to provider reimbursement.
  - (f) A provider is not at risk of a claim denial for maintenance prescriptions filled during any time at which state offices are closed, however, prior approval procedures pursuant to subsection (9)(b) must still be followed.
  - (g) Services rendered or to be rendered shall be approved or denied based upon:
    - 1. The securing of prior approval;
    - 2. Medical necessity;
    - 3. The recipient's medical history;
    - 4. The recipient's medical records;
    - 5. The medical timeliness of the services; and
    - 6. Review by the Medicaid Medical Director upon request by the recipient, provider or the Department prior to initial denial.
  - (h) A provider is not at risk of a claim denial for inpatient hospital admission and related medical services if pre-admission approval has been obtained as set out in Rule 1200-13-1-.06(18)(e).
- (10) Emergency Services: Any Medicaid provider may render services to a recipient on lock-in or prior approved status in the event of an emergency, provided however that reimbursement for services provided will be allowed only under the following circumstances:
- (a) The provider notifies the Department by telephone no later than the end of the next state working day following the commencement of services;
  - (b) The provider presents sufficient medical evidence concerning the nature of the emergency to justify reimbursement; and
  - (c) Review by the Medicaid Medical Director upon request by the recipient, provider or the Department prior to initial denial.
- (11) Identification Verification of Medicaid Lock-In and Prior Approval Recipients
- (a) Medicaid Lock-In and Prior Approval Status Cards
    - 1. These special cards are pink in color for ready identification and must be signed by the recipient.
    - 2. The date of birth, eligibility period and sex designations on the card shall be utilized to assist in provider verification of card ownership as well as current eligibility status of the Card holder.
    - 3. Each prescription dispensed shall be noted on the Medicaid card by marking through a circled number on the Medicaid card.

(Rule 1200-13-1.11, continued)

4. Pink cards indicating restrictions of SPECIAL PRIOR APPROVAL ONLY require that before commencement of services, the department must be contacted at the telephone number specified on the card in accordance with the rules contained in subsection (9) of this section.
  5. Pink cards indicating restrictions of SPECIAL LOCK IN/PHARMACY/MD limit service to the providers listed in the additional information block and in accordance with the rules contained in subsection (8) of this section.
- (12) If reimbursement is denied based on a provider's failure to comply with any rules contained in this section the recipient or the recipient's family shall NOT be held financially responsible for payment for any covered services rendered.
- (13) If the placement of a recipient on lock-in or prior approval status would result or has resulted in the denial of reasonable access - taking into account geographic locations and reasonable travel time - to Medicaid services of adequate quality, the department shall:
- (a) Prior to the placement on restricted status, take such action as is necessary to assure reasonable access to services of adequate quality; or
  - (b) Reinstate the recipient to the normal Medicaid status until the department can assure reasonable access to services of adequate quality.
- (14) For services provided prior to January 1, 1994, the rules as set out at 1200-13-1.11(1) - (13) shall apply. Effective January 1, 1994, the rules of TennCare as set out at rule chapter 1200-13-12 shall apply. Effective January 1, 1994, the rules of TennCare as set out at rule chapter 1200-13-12 shall apply with the exceptions of rules applicable to nursing facilities, intermediate care facilities for the mentally retarded (ICF-MR), Home and Community Based Waiver Services, and payment of Medicare premiums, deductibles and copayments for Qualified Medicare Beneficiaries (QMBs) and Special Low-Income Medicare Beneficiaries (SLIMBs) which will continue to be governed by Medicaid rules in effect prior to January 1, 1994, and as may be amended.

**Authority:** T.C.A. §§4-5-202, 71-5-105, 71-5-109, and Public Chapter 358 of the Acts of 1993. **Administrative History:** Original rule filed June 7, 1982; effective July 22, 1982. Repeal and new rule filed February 23, 1987; effective April 9, 1987. Amendment filed March 22, 1989; effective May 16, 1989. Amendment filed June 8, 1990; effective July 23, 1990. Amendment filed March 18, 1994; effective June 1, 1994.

#### **1200-13-1.12 REPEALED.**

**Authority:** T.C.A. §§14-23-105, 14-23-109, 71-5-105, 71-5-109, and 4-5-202. **Administrative History:** Original rule filed March 2, 1983; effective April 4, 1983. Repeal and new rule filed February 4, 1985; effective March 6, 1985. Amendment filed July 5, 1990; effective August 19, 1990. Repeal filed March 18, 1994; effective June 1, 1994.

#### **1200-13-1.13 REPEALED.**

**Authority:** T.C.A. 4-5-202, 71-5-105, 71-5-109, and Executive Order No. 11. **Administrative History:** Original rule filed June 23, 1983; effective July 25, 1983. Amendment filed March 30, 1995; effective June 15, 1995. Repeal filed June 29, 2000; effective September 12, 2000.

**1200-13-1-.14 REPEALED.**

**Authority:** T.C.A. §§4-5-202, 71-5-105, 71-5-109, and Public Chapter 358 of the Acts of 1993. **Administrative History:** Original rule filed February 14, 1984; effective March 15, 1984. Amendment filed August 21, 1984; effective September 20, 1984. Repeal filed March 18, 1994; effective June 1, 1994.

**1200-13-1-.15 CRITERIA FOR MEDICAID REIMBURSEMENT OF CARE IN AN INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED (ICF/MR).**

- (1) The following definitions shall apply for interpretation of this rule:
  - (a) Bureau of TennCare - the Bureau in the Tennessee Department of Health which is responsible for administration of the Title XIX Medicaid program.
  - (b) Certification - a process by which a physician, who is licensed as a doctor of medicine or doctor of osteopathy, signs and dates an ICF/MR PreAdmission Evaluation signifying that care in an Intermediate Care Facility for the Mentally Retarded is medically necessary for the individual.
  - (c) Designated Correspondent - an individual or agency authorized by an individual to receive correspondence on his/her behalf related to an ICF/MR PreAdmission Evaluation.
  - (d) Intermediate Care Facility for the Mentally Retarded (ICF/MR) - a licensed facility approved for Medicaid reimbursement that provides specialized services for individuals with mental retardation or related conditions and that complies with current federal standards and certification requirements for ICF/MR's.
  - (e) ICF/MR Eligible - an individual who has attained Medicaid Eligible status and who is Medically Entitled.
  - (f) ICF/MR PAE Approval Date - the beginning date, as indicated on the ICF/MR PreAdmission Evaluation, for which the ICF/MR PreAdmission Evaluation has been approved.
  - (g) ICF/MR PreAdmission Evaluation (ICF/MR PAE) - a process of assessment approved by the Bureau of TennCare and used to document an individual's medical condition and need for specialized services for mental retardation or related conditions.
  - (h) Medicaid Eligible - an individual who has been determined by the Tennessee Department of Human Services or the Social Security Administration to be financially eligible to have TennCare make reimbursement for covered services.
  - (i) Medically Entitled - an individual who has an ICF/MR PreAdmission Evaluation that has been certified by a physician and that has been approved by the Bureau of TennCare.
  - (j) Mental Retardation - significantly subaverage intellectual functioning with an I.Q. of 70 or below on an individually-administered I.Q. test.
  - (k) Notice of Disposition or Change - a notice issued by the Department of Human Services of an individual's financial eligibility for Medicaid and approved Medicaid vendor date for payments to an ICF/MR.
  - (l) "Plain language" - any notice or explanation that requires no more than a sixth grade level of education as measured by the Flesch Index, Fog Index, or Flesch-Kincaid Index.

(Rule 1200-13-1-.15, continued)

- (m) Qualified Mental Retardation Professional (QMRP) - an individual who meets current federal standards, as published in the Code of Federal Regulations, for a qualified mental retardation professional.
  - (n) Related Conditions - a severe chronic developmental disability likely to continue indefinitely which results in impairment of intellectual functioning equivalent to that of individuals with mental retardation and which requires specialized services similar to those needed by such individuals.
  - (o) Specialized Services for Mental Retardation or Related Conditions - the implementation of an individualized plan of care, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services that is directed towards the acquisition of the behaviors necessary for the individual to function with as much self-determination and independence as possible; and the prevention or deceleration of regression or loss of current optimal functional status.
  - (p) Transfer Form - a Medicaid-approved form used to document the transfer of an ICF/MR Eligible having an approved unexpired ICF/MR PAE from one ICF/MR to another ICF/MR, from the HCBS MR Waiver Program to an ICF/MR, or from an ICF/MR to the HCBS MR Waiver Program.
- (2) ICF/MR PreAdmission Evaluations and Transfer Forms
- (a) An ICF/MR PreAdmission Evaluation is required to be submitted to the Bureau of TennCare for approval when
    1. A Medicaid Eligible is admitted to an ICF/MR.
    2. A private-paying resident of an ICF/MR attains Medicaid Eligible status or applies for Medicaid eligibility. A new ICF/MR PreAdmission Evaluation is not required when an individual's financial status changes from Medicaid Eligible to private pay and then back to Medicaid Eligible within a 90-day time period.
  - (b) A Transfer Form is required to be submitted to the Bureau of TennCare for approval when an ICF/MR Eligible having an approved unexpired ICF/MR PAE transfers from one ICF/MR to another ICF/MR or from the HCBS MR Waiver Program to an ICF/MR. A Transfer Form is required to be submitted to the Division of Mental Retardation Services for approval when an ICF/MR Eligible having an approved unexpired ICF/MR PAE transfers from an ICF/MR to the HCBS MR Waiver Program.
  - (c) An approved ICF/MR PreAdmission Evaluation is valid for ninety (90) calendar days from the ICF/MR PAE Approval Date. An approved ICF/MR PreAdmission Evaluation that has not been used within ninety (90) calendar days of the ICF/MR PAE Approval Date can be updated within 365 calendar days of the ICF/MR PAE Approval Date if the physician certifies that the individual's current medical condition is consistent with that described in the approved ICF/MR PreAdmission Evaluation.
  - (d) An ICF/MR PreAdmission Evaluation must include a recent medical history and physical signed by a physician who is licensed as a doctor of medicine or doctor of osteopathy. A medical history and physical performed within 365 calendar days of the ICF/MR PAE Request Date may be used if the individual's condition has not significantly changed. Additional medical records (progress notes, office records, discharge summaries, etc.) may be used to supplement a history and physical and provide current medical information if changes have occurred since the history and physical was performed.

(Rule 1200-13-1-.15, continued)

- (e) An ICF/MR PreAdmission Evaluation must include a psychological evaluation of need for care performed no more than twelve (12) months before admission. (This does not invalidate the requirement of 42 CFR § 456.370(b) regarding psychological evaluations for individuals admitted to an ICF/MR.)
- (3) Medicaid Reimbursement
- (a) An ICF/MR which has entered into a provider agreement with the Bureau of TennCare is entitled to receive Medicaid reimbursement for covered services provided to an ICF/MR Eligible if
    1. The Bureau of TennCare has received an approvable ICF/MR PreAdmission Evaluation for the individual within thirty (30) calendar days of the ICF/MR PAE Request Date or the physician certification date, whichever is earlier.
    2. For the transfer of an individual having an approved unexpired ICF/MR PreAdmission Evaluation, the Bureau of TennCare has received an approvable Transfer Form within thirty (30) calendar days of the date of the transfer.
    3. For a retroactive eligibility determination, the Bureau of TennCare has received a Notice of Disposition or Change and has received an approvable ICF/MR PreAdmission Evaluation within thirty (30) calendar days of the mailing date of the Notice of Disposition or Change.
  - (b) An ICF/MR that admits a Medicaid Eligible without an approved ICF/MR PreAdmission Evaluation or, where applicable, an approved Transfer Form does so without the assurance of reimbursement from the Bureau of TennCare.
- (4) Criteria for Medicaid-reimbursed Care in an Intermediate Care Facility for the Mentally Retarded (ICF/MR)
- (a) Medicaid Eligible Status: The individual must be determined by the Tennessee Department of Human Services to be financially eligible for Medicaid-reimbursed care in an Intermediate Care Facility for the Mentally Retarded.
  - (b) An individual must meet all of the following criteria in order to be approved for Medicaid-reimbursed care in an Intermediate Care Facility for the Mentally Retarded:
    1. Medical Necessity of Care: Care must be expected to enhance the individual's functional ability or to prevent or delay the deterioration or loss of functional ability. Care in an Intermediate Care Facility for the Mentally Retarded must be ordered and supervised by a physician.
    2. Diagnosis of Mental Retardation or Related Conditions.
    3. Need for Specialized Services for Mental Retardation or Related Conditions: The individual must require a program of specialized services for mental retardation or related conditions provided under the supervision of a qualified mental retardation professional (QMRP). The individual must also have a significant deficit or impairment in adaptive functioning in one of the following areas: communication, comprehension, behavior, or activities of daily living (e.g., toileting, bathing, eating, dressing/grooming, transfer, mobility).
  - (c) Individuals with mental retardation or related conditions who were in an Intermediate Care Facility for the Mentally Retarded or who were in community residential placements funded by



(Rule 1200-13-1-.15, continued)

the Division of Mental Retardation on or prior to the effective date of this rule may be deemed by the Bureau of TennCare to meet the requirements of (4)(b)2. and (4)(b)3.

- (d) For continued Medicaid reimbursement of care in an Intermediate Care Facility for the Mentally Retarded, an individual must continue to meet the criteria specified in (4)(a) and (4)(b), unless otherwise exempted by (4)(c).
- (5) Grievance process
  - (a) A Medicaid Eligible or the legal representative of the Medicaid Eligible has the right to appeal the denial of an ICF/MR PreAdmission Evaluation and to request a Commissioner's Administrative Hearing by submitting a written letter of appeal to the Bureau of TennCare within thirty (30) calendar days of receipt of the notice of denial.
  - (b) If the Bureau of TennCare denies an ICF/MR PreAdmission Evaluation, the individual will be notified in the following manner:
    - 1. A written notice of denial shall be sent by certified mail, return receipt requested, to the individual and, where applicable, to the designated correspondent. A notice of denial shall also be mailed or faxed to the ICF/MR. This notice shall advise the individual of the right to appeal the denial decision within thirty (30) calendar days. The notice shall also advise the individual of the right to submit within thirty (30) calendar days either the original ICF/MR PreAdmission Evaluation with additional information for review or a new ICF/MR PreAdmission Evaluation. The notice shall be mailed to the individual's address as it appears upon the ICF/MR PreAdmission Evaluation. If no address appears on the ICF/MR PreAdmission Evaluation and supporting documentation, the notice will be mailed to the ICF/MR for forwarding to the individual.
    - 2. If an ICF/MR PreAdmission Evaluation is resubmitted with additional information for review and if the Bureau of TennCare continues to deny the ICF/MR PreAdmission Evaluation, another written notice of denial shall be sent as described in (5)(b)1.
  - (c) The individual has the right to be represented at the hearing by anyone of their choice. The hearing will be conducted according to the provisions of the Tennessee Uniform Administrative Procedures Act.
  - (d) Reasonable accommodations shall be made for individuals with disabilities who require assistance with appeals.
  - (e) Any notice required pursuant to this section shall be a plain language written notice.

**Authority:** T.C.A. 4-5-202, 71-5-105, 71-5-109, Executive Order No. 11. **Administrative History:** Original rule filed June 22, 2000; effective September 5, 2000.

#### **1200-13-1-.16 MEDICAID DENTAL PROGRAM.**

##### (1) DEFINITIONS

For the purposes of this rule the following definitions shall apply:

- (a) Dental services shall mean preventive, diagnostic, therapeutic or corrective procedures provided by or under the supervision of a dentist in the practice of dentistry.
- (b) Dentist shall mean any person licensed to practice dentistry in Tennessee as defined in T.C.A. §63-5--108.

(Rule 1200-13-1-.16, continued)

- (c) Dental record shall mean any standard document in a format commonly accepted by the dental profession that includes a recipient’s medical and dental history, charting, diagnosis, radiographs, prognosis, and treatment and progress notes necessary to adequately document claims submitted for Medicaid reimbursement.
- (d) Oral and maxillofacial surgery shall mean that part of dental practice which deals with the diagnosis of, and the surgical and adjunctive treatment of diseases, injuries, and defects of the human jaws and associated structures.
- (e) Oral surgeon or oral and maxillofacial surgeon shall mean a licensed dentist or physician who has received specialized training and certification in the performance of oral surgery and/or oral and maxillofacial surgery.

(2) REIMBURSEMENT

- (a) A licensed dentist, oral surgeon, and/or oral and maxillofacial surgeon may be reimbursed for Medicaid covered services performed within the scope of statutes regulating the practice of dentistry, oral surgery, and oral and maxillofacial surgery and Medicaid rules and regulations.
- (b) Medicaid reimbursement for dental services shall not exceed the lesser of:
  - 1. 100% of the billed amount; or
  - 2. 85% of the usual and customary charges accumulated by each individual dentist; or
  - 3. 85 % of the 75th percentile of the range of weighted customary charges by dentists in the State (Dental profile) for the 1984 calendar year; or
  - 4. 100% of a statewide fee schedule established when usual and customary charges and statewide prevailing charges do not exist.
- (c) Dental reimbursement shall not exceed the amount in effect June 30, 1988.

(3) DENTAL SERVICES FOR RECIPIENTS LESS THAN 21 YEARS OF AGE

- (a) Medicaid will provide reimbursement subject to the limitations and/or restrictions contained elsewhere in these rules, for the dental services outlined in this subparagraph for an eligible recipient less than age 21 years. Services which are medically necessary and which exceed service limitations may be covered with prior authorization from Medicaid.

- 1. Preventive and diagnostic dental services, including radiographs:

<u>Procedure</u>	<u>Limitation</u>
Dental examination	1 every 6 months
Fluoride treatment	1 every 6 months
Prophylaxis (cleaning)	1 every 6 months
Radiographs	
- Panorex (excluding bitewings) or complete intraoral (including bitewings)	1 set every 3 fiscal years
Bitewings	1 set every 6 months
Space Maintainers	As required with prior approval.
- Permanent first molars	2 applications 12 months apart

(Rule 1200-13-1-.16, continued)

- Permanent premolars and second molars 1 application per lifetime

Medicaid will not provide reimbursement for sealants applied to recipients 14 years of age or older.

2. Restorative dental services:

Procedure	Limitation
Amalgam, primary	2 per tooth surface per fiscal year
Amalgam, permanent	2 per tooth surface per fiscal year
Silicate, acrylic, plastic or composite resin (anterior teeth)	2 per tooth surface per fiscal year
Acid etching or Nuva type composite (anterior teeth)	2 per tooth surface per fiscal year

Crowns are covered for single restoration only. Crowns are not covered when used primarily for aesthetic purposes. Stainless steel crowns are covered for primary and permanent teeth and do not require prior approval. Plastic temporary crowns, porcelain to metal crowns, and post and core buildup plastic or amalgam (permanent teeth only) are covered with prior approval. Porcelain to metal crowns are limited to anterior teeth only, and only when a tooth cannot be restored satisfactorily with a filling material; there must be evidence of tooth maturity, i.e., apex formation complete.

3. Endodontic services, excluding Sargenti procedures which are not covered:

Procedures	Limitation
Root canal therapy	1 per tooth per lifetime
Pulpotomy, primary	1 per tooth per lifetime
Pulpotomy, permanent	limited to apexification
Pulp cap, direct	1 per tooth per lifetime

When root canal therapy is performed, adequate pre-treatment and post-treatment x-rays to justify root canal therapy must be maintained in the recipient's dental record.

4. Orthodontic services:

Written prior approval for orthodontic services is required from Medicaid. Medicaid will review on a case-by-case basis requests for orthodontic services and medical documentation submitted to support such requests. Approval may be granted when severe malocclusions result in severe emotional problems or speech impediments, or when such malocclusions have a significant adverse effect on the health of the recipient. When an orthodontic treatment plan is approved prior to the recipient attaining 20 1/2 years of age, and treatment is initiated prior to the recipient attaining 21 years of age, reimbursement shall be made through the completion of the treatment plan. If an orthodontic treatment plan is approved after the recipient has attained 20 1/2 years of age and prior to their 21st birthday, reimbursement shall be limited to those services provided prior to the 21st birthday.

The cost of all x-rays, models, retainers, the preparation of a treatment plan, records, and other items or services associated with the orthodontic treatment are included in the maximum Medicaid allowable reimbursement for approved cases and may not be billed

(Rule 1200-13-1-.16, continued)

separately. If the case is not approved, no payment shall be made for these services, and the associated costs shall be the responsibility of the dentist.

5. Prosthodontic devices:

Written prior approval for prosthodontic devices (e.g., partial and/or complete dentures) is required from Medicaid. Covered repairs for prosthodontic devices do not require prior approval.

6. Oral surgery and oral and maxillofacial surgery:

Oral surgery and oral and maxillofacial surgery is a covered service for recipients less than age 21 years when medical/dental necessity exists for the procedure(s).

7. Adjunctive General Services

(i) Intravenous sedation (prior approval required)

Written prior approval for intravenous sedation is required from Medicaid. Requests for intravenous sedation will be reviewed on a case-by-case basis. Medicaid may approve such requests for recipients having significant physical or mental health problems who cannot reasonably be treated without the use of intravenous sedation. Intravenous sedation must be administered by a physician, or a dentist meeting the qualifications as set forth in *T.C.A. §63-5-108(d)*.

(ii) Non-conforming procedures not listed in the current Tennessee Medicaid Dental Manual, may be reimbursed on a case-by-case basis with prior approval from Medicaid. Documentation (e.g., x-rays, models, photographs, etc.) which supports the medical or dental necessity must be included with the request for authorization.

- (b) For those dental services requiring prior approval, the provider must obtain advance authorization from Medicaid, except for emergency situations. When an emergency situation exists, the provider shall telephone Medicaid for approval on the next working day after provision of the emergency service and submit a written request within 30 days of the telephone request documenting the emergency. An alternative method for requesting approval for an emergency service is provider submission and Medicaid receipt of the claim for emergency services within 14 days of the date of the emergency service. Failure to obtain approval in any one of the methods outlined above shall result in non-payment of the service as described in rule 1200-13-1-.05(1)(d)4.

The basis for granting or denying prior approval shall be determined by the following conditions:

1. whether the item or service is medically necessary, and
2. whether the proposed item or service conforms to commonly accepted standards in the medical community, and
3. whether a less "pensive alternative that conforms to commonly accepted standards in the medical community, would adequately meet the recipient's medical needs without regard to whether or not a provider has initiated a more expensive treatment plan, and
4. whether any further conditions set forth in these rules have been adequately met, and
5. whether requests include sufficient factual data as determined by the Bureau of Medicaid to enable a fair and objective decision.

(Rule 1200-13-1-.16, continued)

- (c) Dental coverages normally limited to persons under age 21 may be provided for persons age 21 or older under the following conditions:
  - 1. Medicaid grants prior approval for a procedure no more than 15 days prior to the recipient's 21st birthday and the approved services are completed not later than 10 days after the recipient's 21st birthday; or
  - 2. Medicaid grants prior approval for an orthodontic treatment plan prior to the recipient attaining 20 1/2 years of age and the treatment is initiated prior to the recipient attaining 21 years of age.
- (4) DENTAL SERVICES FOR RECIPIENTS 21 YEARS OF AGE AND OLDER
  - (a) Medicaid reimbursement for dental services for a recipient age 21 years or older will be provided only when the recipient has a medical condition of such severity that the absence of dental care would reasonably be expected to endanger the life of the recipient or result in severe bodily dysfunction, and such condition must result from one of the following:
    - 1. Neoplasm of the mandible, maxilla, or oral cavity, or
    - 2. Trauma of the mandible, maxilla, or oral cavity, which results in significant injury to the structures themselves and the teeth (breakage of a tooth in and of itself does not meet this requirement); or
    - 3. Infection of the mandible, maxilla, or oral cavity, when the recipient has a medical condition that endangers the life of the recipient and that may be significantly worsened by an intraoral infection, and when such infection is unresponsive to antibiotic therapy of sufficient duration to reasonably expect a therapeutic response, or when antibiotic therapy is contraindicated. Examples of such conditions include, but are not limited to, any disease, disorder, or drug therapy resulting in significant immunosuppression of the recipient (e.g., leukemia, organ transplant); disease or disorder of a heart valve or presence of an artificial heart valve; or hemophilia or other bleeding disorders. Documentation of antibiotic therapy must accompany the request for authorization when infection is given as the need for services.
  - (b) Prior approval from Medicaid is required for any dental service for a recipient age 21 years or older. Except for emergency or life threatening situations, approval will not be granted retroactively. When an emergency situation exists, the provider shall telephone Medicaid for approval on the next working day after provision of the emergency service and submit a written request within 30 days of the telephone request documenting the emergency. An alternative method for requesting approval for an emergency service is provider submission and Medicaid receipt of the claim for the emergency service within 14 days of the date of the emergency service. Failure to obtain approval in any one of the methods outlined above shall result in non-payment of the service as described in rule 1200-13-1-.05(l)(d)4.

The basis for granting or denying prior approval shall be determined by the following conditions:

- 1. whether the item or service is medically necessary, and
- 2. whether the proposed item or service conforms to commonly accepted standards in the medical community, and
- 3. whether a less expensive alternative that conforms to commonly accepted standards in the medical community, would adequately meet the recipient's medical needs without regard to whether or not a provider has initiated a more expensive treatment plan, and

(Rule 1200-13-1-.16, continued)

4. whether any further conditions set forth in these rules have been adequately met, and
  5. whether requests include sufficient factual data as determined by the Bureau of Medicaid to enable a fair and objective decision.
- (c) Dental coverage normally limited to persons under age 21 may be provided for persons age 21 or older under the following conditions:
1. Medicaid grants prior approval for a procedure no more than 15 days prior to the recipient's 21st birthday and the approved service is completed not later than 10 days after the recipient's 21st birthday; or
  2. Medicaid grants prior approval for an orthodontic treatment plan prior to the recipient attaining 20 1/2 years of age and the treatment is initiated prior to the recipient attaining 21 years of age.
- (d) Dental services for a recipient age 21 years or older should be provided by a board-eligible or board-certified oral surgeon and/or oral and maxillofacial surgeon. However, when access to such services is not available in the recipient's area of residence, such services may be provided by a general dentist if such services are within the scope and authority of the dental profession pursuant to TCA. §63-5-108.
- (e) Mental retardation alone or as a primary diagnosis without other medical diagnoses shall not meet the requirements for treatment of an intraoral infection for recipients 21 years of age or older.
- (5) For dental services provided prior to January 1, 1994, the dental rules as set out at 1200-13-1-.16(1) - (4) shall apply. Effective January 1, 1994, the Rules of TennCare as set out at rule chapter 1200-13-12 shall govern dental coverage.

**Authority:** T.C.A. §§4-5-202, 71-5-105, 71-5-109, and Public Chapter 358 of the Acts of 1993. **Administrative History:** Original rule filed September 11, 1987; effective October 31, 1987. Amendment filed March 6, 1991; effective April 20, 1991. Amendment filed September 9, 1991; effective October 24, 1991. Amendment filed November 27, 1991; effective January 11, 1992. Amendment filed October 20, 1992; effective December 4, 1992. Amendment filed December 4, 1992; effective January 19, 1993. Amendment filed March 18, 1994; effective June 1, 1994.

#### **1200-13-1-.17 STATEWIDE HOME AND COMMUNITY BASED SERVICES WAIVER FOR THE ELDERLY AND DISABLED.**

- (1) Definitions. The following definitions shall apply for interpretation of this rule:
- (a) Administrative Lead Agency - the approved agency or agencies with which the Bureau of TennCare contracts for the provision of covered services through the Statewide Home and Community Based Services Waiver for the Elderly and Disabled.
  - (b) Bureau of TennCare - the administrative unit of TennCare which is responsible for the administration of TennCare.
  - (c) Caregiver - one or more adult individuals who sign an agreement with the Administrative Lead Agency to provide services to the Enrollee as outlined in paragraphs (5) and (6) to meet the needs of the Enrollee during the hours when Waiver Services are not being provided by the Administrative Lead Agency.

(Rule 1200-13-1-.17, continued)

- (d) Case Management - standardized process of screening potential applicants to determine if they meet the requirements for enrollment in the Waiver; of assessing an Enrollee's medical, functional, and social needs; of developing, implementing, monitoring, and updating a goal-oriented Individual Plan of Care, including a Safety Plan, that is based on the Enrollee's needs; of arranging and coordinating the provision of Waiver Services and other services regardless of payment source; of evaluating and reevaluating the Enrollee's level of care; and of monitoring the provision of services to assure that Waiver Services and other services are being provided to meet the Enrollee's needs.
- (e) Case Management Team - the multi-disciplinary team of health care professionals that assesses an Enrollee's medical, functional, and social needs after enrollment in the Waiver and develops, monitors, and periodically updates a goal-oriented Individual Plan of Care based on the Enrollee's needs. The multi-disciplinary team shall be composed of the Case Manager, a physician, a registered nurse, a social worker, and other appropriate health care professionals.
- (f) Case Manager - the person who is responsible for screening potential applicants to determine if they meet the requirements for enrollment in the Waiver; overseeing the development, implementation, and monitoring of an Individual Plan of Care based on the Enrollee's medical, functional, and social needs and the Safety Plan; coordinating the provision of Waiver Services and other services regardless of payment source, including securing appropriate service providers; and monitoring to assure that appropriate Waiver Services and other services are being provided; and documenting case management activities.
- (g) Centers for Medicare and Medicaid Services (CMS) (formerly known as HCFA) - the agency within the United States Department of Health and Human Services that is responsible for administering Title XVIII, Title XIX, and Title XXI of the Social Security Act.
- (h) Certification - the process by which a physician, who is licensed as a doctor of medicine or doctor of osteopathy, signs and dates a PreAdmission Evaluation signifying that the individual requires services provided through the Statewide Home and Community Based Services Waiver for the Elderly and Disabled as an alternative to care in a Nursing Facility.
- (i) Department - the Tennessee Department of Finance and Administration.
- (j) Denial - as used in regard to Waiver Services, the term shall mean the termination, suspension, delay, or reduction in amount, scope, and duration of a Waiver Service or a refusal or failure to provide such service.
- (k) Disenrollment - the voluntary or involuntary termination of enrollment in the Waiver of an individual receiving services through the Statewide Home and Community Based Services Waiver for the Elderly and Disabled.
- (l) Enrollee - a Medicaid Eligible who is enrolled in the Statewide Home and Community Based Services Waiver for the Elderly and Disabled in Tennessee.
- (m) Home (of an Enrollee) - the residence or dwelling in which the Enrollee resides in Tennessee, excluding hospitals, nursing facilities, Intermediate Care Facilities for the Mentally Retarded, Assisted Living Facilities, and Homes for the Aged (Residential Homes for the Aged).
- (n) Home Delivered Meals - nutritionally well-balanced meals, other than those provided under Title III C-2 of the Older Americans Act, that provide at least one third but no more than two-thirds of the current daily Recommended Dietary Allowance (as estimated by the Food and Nutrition Board of Sciences - National Research Council) and that will be served in the Enrollee's home. Special diets shall be provided in accordance with the Individual Plan of Care when ordered by the Enrollee's physician.

(Rule 1200-13-1-.17, continued)

- (o) Homemaker Services - services provided by a trained homemaker when the Enrollee is unable to perform such activities and when the individual regularly responsible for these activities is temporarily unable to perform such activities for the Enrollee, consisting of: general household activities and chores (e.g., sweeping, mopping, dusting, making the bed, washing dishes, personal laundry, ironing, mending, and meal preparation and/or education about the preparation of nutritious appetizing meals); assistance with maintenance of a safe environment; and errands essential to the Enrollee's care (e.g., grocery shopping, having prescriptions filled).
- (p) Individual Plan of Care - an individualized written plan of care which serves as the fundamental tool by which the State ensures the health and welfare of Enrollees and which meets the requirements of paragraph (8) herein.
- (q) Medicaid Eligible - an individual who has been determined by the Tennessee Department of Human Services to be financially eligible to have TennCare make reimbursement for covered services.
- (r) Minor Home Modifications - the provision and installation of certain home mobility aids (e.g., ramps, rails, non-skid surfacing, grab bars, and other devices and minor home modifications which facilitate mobility) and modifications to the home environment to enhance safety. Excluded are those adaptations or improvements to the home which are of general utility and which are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.
- (s) Nursing Facility - a Medicaid-certified nursing facility approved by the Bureau.
- (t) Personal Care Services - services provided to assist the Enrollee with activities of daily living, and related essential household tasks (e.g. making the bed, washing soiled linens or bedclothes that require immediate attention), and other activities that enable the Enrollee to remain in the home, as an alternative to Nursing Facility care, including the following:
  - 1. Assistance with activities of daily living (e.g., bathing, grooming, personal hygiene, toileting, feeding, dressing, ambulation);
  - 2. Assistance with cleaning that is an integral part of personal care and is essential to the health and welfare of the Enrollee;
  - 3. Assistance with maintenance of a safe environment.
- (u) Personal Emergency Response Systems (PERS) - electronic devices which enable certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. PERS services are limited to those individuals who are alone for significant parts of the day, who have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.
- (v) Physician's Plan of Care - an individualized written plan of care developed by the Enrollee's physician and included on the PreAdmission Evaluation and reviewed as needed or at least every ninety (90) days.



(Rule 1200-13-1-.17, continued)

- (w) PreAdmission Evaluation (PAE) - a process of assessment approved by the Bureau of TennCare and used to document an individual's current medical condition and eligibility for care in a Nursing Facility.
- (x) PreAdmission Screening/Annual Resident Review (PASARR) - the process by which the State determines whether an individual who resides in or seeks admission to a Medicaid-certified Nursing Facility has, or is suspected of having, mental illness or mental retardation, and, if so, whether the individual requires specialized services.
- (y) Recertification - the process approved by the Bureau of TennCare by which the Enrollee's physician assesses the medical necessity of continuation of Waiver Services and certifies in writing that the Enrollee continues to require Waiver Services.
- (z) Respite Care - services provided to individuals unable to care for themselves when there is an absence or need for relief of those persons normally providing the care. Respite services will be furnished on a short-term basis in a nursing facility or assisted care living facility, not to exceed nine (9) days per waiver year. The intent of Respite is to provide short-term relief for caregiver vacations and emergency situations that may involve the temporary loss of a caregiver (e.g. hospitalization, illness of another relative).
- (aa) Safety Plan - an individualized plan by which the Administrative Lead Agency ensures the health, safety, and welfare of Enrollees who do not have 24-hour caregiver services and which meets the requirements of (5)(c)4.
- (bb) Screening - the process by which the Administrative Lead Agency determines that an applicant meets the requirements for enrollment in the Home and Community Based Services Statewide Waiver for the Elderly and Disabled. The screening process shall include verifying whether an individual is Medicaid eligible in Tennessee; whether an individual is eligible for care in a Nursing Facility; whether an individual with an approved PreAdmission Evaluation is eligible for Waiver Services; whether the individual's medical, functional, and social needs can be met through the Waiver; and whether there is a caregiver available.
- (cc) Statewide Home and Community Based Services Waiver for the Elderly and Disabled - the Home and Community Based Services waiver project approved for Tennessee by the Centers For Medicare and Medicaid Services to provide services to a specified number of Medicaid-eligible individuals who reside in Tennessee, who are aged or disabled, and who meet the Medicaid criteria for placement in a Nursing Facility.
- (dd) Subcontractor - an individual, organized partnership, professional corporation, or other legal association or entity which enters into a written contract with the Administrative Lead Agency to provide Waiver Services to an Enrollee.
- (ee) 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.
- (ff) Waiver - the Statewide Home and Community Based Services Waiver for the Elderly and Disabled as approved by the Centers for Medicare and Medicaid Services for the State of Tennessee.
- (gg) Waiver Eligible - a Medicaid eligible resident of Tennessee who has a PreAdmission Evaluation that has been approved by the Bureau of TennCare for nursing facility level of care.

(Rule 1200-13-1-.17, continued)

(hh) Waiver Services - covered services provided through the Statewide Home and Community Based Services Waiver for the Elderly and Disabled as approved by the Centers for Medicare and Medicaid Services for the State of Tennessee.

(2) Waiver Services. Covered Waiver Services shall include the following:

(a) Case Management. All case management contacts shall be documented in the Enrollee's medical record and shall include one face-to-face visit per month, by a nurse or a social worker, with the Enrollee in the Enrollee's home. At least every 90 days, the home visit shall be made by a registered nurse unless otherwise directed in the waiver. Such monthly documentation shall note that the Individual Plan of Care has been reviewed and revised as appropriate.

(b) Home-delivered Meals.

1. The Administrative Lead Agency shall ensure that providers of home meals are properly licensed or certified by the appropriate regulatory authority and shall require that such providers comply with all laws, ordinances, and codes regarding preparation, handling, and delivery of food.
2. For those Enrollees who require medically prescribed diets, the Administrative Lead Agency shall ensure that such meals are planned by a registered dietitian who provides consultation to the licensed nurse supervising the Enrollee's care.

(c) Minor Home Modifications.

1. Minor home modifications shall not be provided unless specified in the Individual Plan of Care. The Administrative Lead Agency shall notify the Bureau of TennCare and obtain prior authorization for minor home modifications exceeding \$6,000 prior to initiating the intended modification.
2. The Bureau of TennCare shall be the payor of last resort for minor home modifications.

(d) Personal Care Services.

1. Personal care aides shall meet the standards of education and training required by the Administrative Lead Agency and approved by the Bureau of TennCare. Enrollees with a diagnosis of mental retardation shall receive personal care services only from an agency licensed as a personal support services agency or a home care organization.
2. The personal care aide shall report to the Case Manager any significant changes in the Enrollee's physical or mental status.

(e) Personal Emergency Response Systems. Personal Emergency Response Systems shall be provided, as specified in the Individual Plan of Care and Safety Plan, for Enrollees:

1. Who receive daily caregiver services but who are alone for significant parts of the day and who would otherwise require extensive routine supervision; and
2. Who, based on an assessment by the Administrative Lead Agency of the Enrollee's mental and physical capabilities, have the capability to effectively utilize such a system.

(f) Homemaker Services. Homemakers shall meet TennCare standards for education and training.

(g) Respite Care.

(Rule 1200-13-1-.17, continued)

- (3) Documentation of Waiver Services.
  - (a) The Administrative Lead Agency shall ensure that all services are accurately and timely documented.
  - (b) Documentation of Waiver services must adequately demonstrate that services are provided in accordance with the individual plan of care and the approved waiver service definitions.
- (4) Notification. Upon approval of a PreAdmission Evaluation for Nursing Facility care for an individual residing in Tennessee, the Bureau shall provide the individual with the following:
  - (a) A simple explanation of the Waiver and Waiver Services;
  - (b) Notice of the opportunity to apply for enrollment in the Waiver and an explanation of the enrollment process; and
  - (c) A statement that participation in the Waiver program is voluntary.
- (5) Enrollment.
  - (a) When an individual is determined to be likely to require the level of care provided by a Nursing Facility, the Administrative Lead Agency shall inform the individual or the individual's legal representative of all feasible alternatives available under the Waiver and shall offer the choice of either Nursing Facility or Waiver Services.
  - (b) Enrollment in the Waiver shall be voluntary and open to all Waiver Eligibles who reside in Tennessee, but shall be restricted to the maximum number of individuals specified in the Waiver, as approved by the Centers for Medicare and Medicaid Services for the State of Tennessee. Enrollment may also be restricted if sufficient funds are not appropriated by the legislature to support full enrollment.
  - (c) To be eligible for enrollment, an individual must meet all of the following criteria:
    1. The individual must be Medicaid Eligible, must meet the Nursing Facility eligibility criteria specified in TennCare Rule 1200-13-1-.10, and must have a PreAdmission Evaluation approved by the Bureau of TennCare.
      - (i) The PreAdmission Evaluation shall include the physician's initial plan of care which includes, but is not limited to, diagnoses and any orders for medications, diet, activities, treatments, therapies, restorative and rehabilitative services, or other physician-ordered services needed by the Enrollee.
      - (ii) The individual's physician must certify on the PreAdmission Evaluation that the individual requires Waiver Services.
    2. The individual's medical, functional, and social needs must be such that they can be effectively and safely met through the Waiver, as determined by the Administrative Lead Agency based on a pre-enrollment screening.
    3. An individual shall have one or more caregivers, as specified in (6)(a), designated to provide caregiver services each day in the Enrollee's home and, as needed, in other locations to ensure the health, safety, and welfare of the Enrollee. An individual shall have 24-hour caregiver services unless it is determined by an assessment that the needs of the individual can be met, and that the health, safety, and welfare of the individual can be assured, through the provision of daily (but less than 24-hour) caregiver services and

(Rule 1200-13-1-.17, continued)

through provision of a Personal Emergency Response System. Documentation of such assessment shall be included in an individualized Safety Plan that is developed, reviewed, and updated by the Administrative Lead Agency. If it is so determined that the health, safety, and welfare of the individual can be assured without 24-hour caregiver services, the individual shall have caregiver services provided for some portion of the day each day.

4. An individual who does not have 24-hour caregiver services shall have an individualized Safety Plan that is based on an assessment of the individual's medical, functional, and social needs and capabilities and that is approved, monitored, and updated as needed, but no less frequently than annually, by the Administrative Lead Agency. The Safety Plan shall describe:
  - (i) The medical, functional, and social needs and capabilities of the individual and how such can be met without jeopardizing the health, safety, and welfare of the individual;
  - (ii) The type and schedule of caregiver services to be provided each day, specifying hours per day and number of days per week;
  - (iii) Personal Emergency Response Systems which are designed to enable Enrollees, who meet the requirements of (2)(e), to secure help in an emergency; and
  - (iv) Other services, devices, and supports that ensure the health, safety, and welfare of the Enrollee.
5. All homes must provide an environment adequate to reasonably ensure the health, safety, and welfare of the Enrollee.
- (d) An individual who is capable of living alone or independently without waiver services shall not be eligible for enrollment or continued enrollment in the Waiver.
- (e) Enrollment of new Enrollees into the Waiver may be suspended when the average per capita fiscal year expenditure under the Waiver exceeds or is reasonably anticipated to exceed 100% of the average per capita expenditure that would have been made in the fiscal year if the care was provided in a Nursing Facility.
- (6) Caregiver.
  - (a) Caregiver services shall be provided by one or more adult individuals, aged 18 or older, who sign an agreement with the Administrative Lead Agency to provide the following services to the Enrollee, as well as any additional services outlined in the Individual Plan of Care and the Safety Plan, to meet the needs of the Enrollee during the hours when Waiver Services are not being provided by the Administrative Lead Agency:
    1. Assistance with grooming, bathing, feeding, and dressing;
    2. Assistance with medications that are ordinarily self-administered;
    3. Assistance with ambulation as needed;
    4. Household services essential to health care and maintenance in the home;
    5. Meal preparation; and

(Rule 1200-13-1-.17, continued)

6. Any other assistance necessary to support the Enrollee's activities of daily living.
- (b) One or more caregivers shall be available full time or part time each day in the Enrollee's home, as determined appropriate by the Administrative Lead Agency and as specified in the Individual Plan of Care and the Safety Plan, to provide care to the Enrollee. Enrollees who do not have a 24-hour caregiver shall have a Personal Emergency Response System and shall be mentally and physically capable of using it based on an assessment by the Administrative Lead Agency.
- (7) PreAdmission Evaluations, Transfer Forms, and PASARR Assessments.
  - (a) A PreAdmission Evaluation is required when a Medicaid Eligible is admitted to the Waiver.
  - (b) A Transfer Form is required in the following circumstances:
    1. When an Enrollee having an approved unexpired PreAdmission Evaluation transfers from the Waiver to Level 1 care in a Nursing Facility.
    2. When an Enrollee having an approved unexpired PreAdmission Evaluation transfers from one Home and Community Based Services Waiver for the Elderly and Disabled to a different Home and Community Based Services Waiver for the Elderly and Disabled.
    3. When a Waiver Eligible with an approved unexpired PreAdmission Evaluation transfers from a Nursing Facility to the Waiver.
  - (c) A Level I PASARR assessment for mental illness and mental retardation is required when an Enrollee with an approved, unexpired PreAdmission Evaluation transfers from the Waiver to a Nursing Facility. A Level II PASARR evaluation is required if a history of mental illness or mental retardation is indicated by the Level I PASARR assessment, unless criteria for exception are met.
  - (d) An Administrative Lead Agency that enrolls an individual without an approved PreAdmission Evaluation or, where applicable, an approved Transfer Form does so without the assurance of reimbursement. An Administrative Lead Agency that enrolls an individual who has not been determined by the Tennessee Department of Human Services to be financially eligible to have Medicaid make reimbursement for covered services does so without the assurance of reimbursement. If an Administrative Lead Agency enrolls a Medicaid Eligible without an approved PreAdmission Evaluation, the individual must be informed by the Administrative Lead Agency that Medicaid reimbursement will not be paid until and unless the PreAdmission Evaluation is approved.
  - (e) The Administrative Lead Agency shall maintain in its files the original PreAdmission Evaluation and, where applicable, the original Transfer Form.
  - (f) An updated Safety Plan for Enrollees who do not have 24-hour caregiver services shall be required as an attachment to the PreAdmission Evaluation or Transfer Form.
- (8) Individual Plan of Care.
  - (a) The Individual Plan of Care shall be an individualized written plan of care that specifies the services designed to meet the medical, functional, and social needs of the Enrollee and that includes, but is not limited to, the following Enrollee information:
    1. Diagnoses;

(Rule 1200-13-1-.17, continued)

2. A description of Waiver Services and any other services regardless of payment source, including caregiver services, that the Enrollee requires to reside in the community as an alternative to care in a Nursing Facility, including the amount (specific number of hours or units per day rather than a range), frequency (number of days per week), and duration (length of time needed) of services and the type of provider to furnish each service;
  3. Outcome objectives;
  4. Any treatments, therapies, activities, social services, rehabilitative services, nursing related services, home health aide services, specialized equipment, medications (including dosage, frequency, and route of administration), diet, and other services needed by the Enrollee;
  5. The names of each caregiver and each caregiver's schedule, including the amount (specific number of hours per day) and frequency (number of days per week) of caregiver services and provisions for alternate caregivers; and
  6. A Safety Plan for Enrollees who do not have 24-hour caregiver services.
- (b) Within thirty (30) working days after enrollment, the Case Management Team shall review the Physician's Plan of Care and shall develop the Individual Plan of Care. Within ten (10) working days of completion of the Individual Plan of Care, the Administrative Lead Agency shall review and approve the Individual Plan of Care.
- (c) The Individual Plan of Care shall be periodically reviewed to ensure that the Waiver Services furnished are consistent with the nature and severity of the Enrollee's disability and to determine the appropriateness and adequacy of care and achievement of outcome objectives outlined in the Individual Plan of Care. The minimum schedule for reviews shall be as follows:
1. The Individual Plan of Care shall be reviewed by a registered nurse or Social Worker Case Manager as needed, but no less frequently than every ninety (90) calendar days. If a Social Worker Case Manager is utilized, an in-home visit and review of the Plan of Care must be done by a Registered Nurse at least every ninety (90) days.
  2. The Individual Plan of Care shall be reviewed and signed by the Case Management Team as needed, but no less frequently than annually. The attending physician is not required to sign the Individual Plan of Care if current signed physician orders are included with the Individual Plan of Care.
- (d) Waiver Services shall be provided in accordance with the Enrollee's Individual Plan of Care.
- (9) Physician Services.
- (a) The Enrollee's attending physician or other licensed physician shall write new orders for the Enrollee as needed and, at a minimum, every ninety (90) calendar days.
  - (b) The Administrative Lead Agency shall ensure that each Enrollee receives physician services as needed and, at a minimum, an annual medical examination or physician visit, and shall document such in the Enrollee's record.
- (10) Reevaluation and Recertification of Need for Continued Stay.
- (a) The Administrative Lead Agency shall perform reevaluations of the Enrollee's need for continued stay in the Waiver within 365 calendar days of the date of enrollment and at least annually thereafter.

(Rule 1200-13-1.17, continued)

- (b) Recertifications, documented in a format approved by the Bureau of TennCare, shall be performed by the Enrollee's physician within 365 calendar days of the initial certification date and at least annually thereafter. The Administrative Lead Agency shall maintain in its files a copy of the recertification of need for continued stay.

(11) Voluntary Disenrollment.

- (a) Voluntary disenrollment of an Enrollee from the Waiver may occur at any time upon written notice from the Enrollee or the Enrollee's legal representative to the Administrative Lead Agency. A Level I PASARR assessment for mental illness and mental retardation is required when an Enrollee transfers to a Nursing Facility. If the Level I PASARR assessment indicates the need for a PASARR Level II assessment of need for specialized services for mental illness or mental retardation, the Enrollee must undergo the PASARR Level II assessment. Prior to disenrollment, the Administrative Lead Agency shall assist the Enrollee in locating alternate services to provide the appropriate level of care and shall assist in transitioning the enrollee to the new services.
- (b) If the Enrollee's medical condition or social environment deteriorates such that the medical, functional, and social needs cannot be met by the Waiver, the Enrollee or the Enrollee's legal representative may request disenrollment from the Waiver. The Administrative Lead Agency shall assist the individual with placement in the appropriate level of care.
- (c) Upon voluntary disenrollment from the Waiver, the individual shall be entitled to receive Medicaid covered services only if still eligible for Medicaid.

(12) Involuntary Disenrollment.

- (a) An Enrollee may be involuntarily disenrolled from the Waiver for any of the following reasons:
  1. The Statewide Home and Community Based Services Waiver for the Elderly and Disabled is terminated.
  2. An Enrollee becomes ineligible for Medicaid or is found to be erroneously enrolled in the Waiver.
  3. An Enrollee is no longer a resident of Tennessee.
  4. The condition of the Enrollee improves such that the Enrollee no longer requires the level of care provided by the Waiver.
  5. The condition of the Enrollee deteriorates such that the medical, functional, and social needs of the Enrollee cannot be met by the Waiver.
  6. The home or home environment of the Enrollee becomes unsafe to the extent that it would reasonably be expected that Waiver Services could not be provided without significant risk of harm or injury to the Enrollee or to individuals who provide covered services to the Enrollee.
  7. The Enrollee no longer has a caregiver, as defined herein, or the caregiver is unwilling or unable to provide services needed by the Enrollee, and an alternate caregiver cannot be arranged.

(Rule 1200-13-1-.17, continued)

8. The Enrollee or the Enrollee's caregiver refuses to abide by the Individual Plan of Care, the Physician's Plan of Care, or related Waiver policies, resulting in the inability of the Waiver to assure quality care.
  9. A provider of Waiver Services is unwilling or unable to continue to provide services and an appropriate alternate service provider cannot be arranged.
  10. The health, safety, and welfare of the Enrollee cannot be assured due to the lack of an approved Safety Plan or an approved Individual Plan of Care, or the continuing need for Waiver Services is not recertified by the Enrollee's physician.
  11. The Enrollee does not receive waiver services for a period exceeding 120 days due to the need for inpatient services in a hospital, nursing facility, or other institutional setting.
- (b) If the individual is involuntarily disenrolled from the Waiver, the Administrative Lead Agency shall assist the Enrollee in locating a Nursing Facility or other alternative providing the appropriate level of care and in transferring the Enrollee. A Level I PASARR assessment for mental illness and mental retardation is required when an Enrollee transfers to a Nursing Facility. If the Level I PASARR assessment indicates the need for a PASARR Level II assessment of need for specialized services for mental illness or mental retardation, the Enrollee must undergo the PASARR Level II assessment.
  - (c) The Administrative Lead Agency shall notify the Bureau of TennCare in writing a minimum of 2 working days prior to issuing involuntary disenrollment notice to an Enrollee.
  - (d) Waiver Services shall continue until the date of discharge of the Enrollee from the Waiver.
  - (e) The Administrative Lead Agency shall provide an Enrollee written advance notice of involuntary disenrollment with an explanation of the Enrollee's right to a hearing pursuant to T.C.A. §71-5-113.
- (13) Reduction of Services. If the Enrollee's condition substantially improves, the Administrative Lead Agency and the Bureau of TennCare shall have the right to reduce Waiver Services.
- (14) Administration of Services. The Administrative Lead Agency shall ensure the delivery of Waiver Services to Enrollees and shall ensure that related activities including, but not limited to, the following are performed:
- (a) Pre-enrollment screening of individuals, including assessment of the individual's medical, functional, and social capabilities and needs; appropriateness for placement in the Waiver; and the ability of the caregiver to adequately care for the Enrollee in the home setting;
  - (b) Annual reevaluations of the Enrollee's need for continued stay in the Waiver;
  - (c) Enrollment of Waiver Eligibles into the Waiver after screening;
  - (d) Development, implementation, and monitoring of the Individual Plan of Care, including the Safety Plan if a Safety Plan is required;
  - (e) Coordinating and monitoring the total range of services for Enrollees, regardless of payment source;
  - (f) Initial certification by the Enrollee's physician of the Enrollee's need for care in a Nursing Facility and annual recertification of the medical necessity of the continuation of Waiver Services for the Enrollee;



(Rule 1200-13-1-.17, continued)

- (g) Supervision of support service staff;
  - (h) Ongoing monitoring of Enrollee and family situations and needs;
  - (i) Maintenance of comprehensive medical records and documentation of services provided to Enrollees;
  - (j) Expenditure and revenue reporting in accordance with state and federal requirements;
  - (k) Any marketing activities performed for the purpose of providing information about the program to potential Enrollees;
  - (l) Assurance of quality and accessible Waiver services which are provided in accordance with State and Federal Waiver rules, regulations, policies and definitions;
  - (m) Contacts with Enrollees, caregivers, and service providers in accordance with state and federal requirements;
  - (n) Assurance that each Enrollee has appropriate caregiver services provided each day in the Enrollee's home by one or more competent adult individuals who sign an agreement with the Administrative Lead Agency;
  - (o) Assurance of the safety of the Enrollee through appropriate caregiver services, supervision, and other services and supports, as described in the Individual Plan of Care and the Safety Plan;
  - (p) Implementation of an appeals process approved by the Bureau of TennCare;
  - (q) Provision of expert testimony by appropriate professionals during contested case hearings; and
  - (r) Compliance with all applicable rules of the Tennessee Medicaid Program.
- (15) Reimbursement.
- (a) The average per capita fiscal year expenditure under the Waiver shall not exceed 100% of the average per capita expenditure that would have been made in the fiscal year if care was provided in a Nursing Facility. The total Medicaid expenditure for Waiver Services and other Medicaid services provided to Enrollees shall not exceed 100% of the amount that would have been incurred in the fiscal year if care was provided in a Nursing Facility.
  - (b) The provider of Waiver Services shall be reimbursed based on a rate per unit of service.
  - (c) The Administrative Lead Agency shall ensure that a diligent effort is made to collect patient liability if it applies to the Enrollee in accordance with 42 CFR § 435.726. The Administrative Lead Agency shall complete appropriate forms showing the individual's amount of monthly income and shall submit them to the Tennessee Department of Human Services. The Tennessee Department of Human Services shall issue the appropriate forms to the Administrative Lead Agency and to the Bureau of TennCare's fiscal agent, specifying the amount of patient liability to be applied toward the cost of care for the Enrollee.
  - (d) The Provider of waiver services shall submit bills for services to the Bureau of TennCare's fiscal agent using a claim form approved by the Bureau of TennCare. On the claim forms, the waiver service provider shall use a provider number assigned by the Bureau of TennCare.

(Rule 1200-13-1-.17, continued)

- (e) Reimbursement shall not be made to the provider of Waiver Services on behalf of Enrollees for therapeutic leave or fifteen-day hospital leave normally available to Nursing Facility patients pursuant to rule 1200-13-1-.06 (4).
  - (f) Medicaid covered services other than those specified in the Waiver's scope of services shall be reimbursed by the Bureau of TennCare as otherwise provided for by federal and state rules and regulations.
  - (g) The Administrative Lead Agency shall ensure that the physician's initial certification and subsequent recertifications are obtained. Failure to perform recertifications in a timely manner and in the format approved by the Bureau of TennCare shall require a corrective action plan and shall result in full or partial recoupment of all amounts paid by the Bureau of TennCare during the time that recertification has lapsed.
- (16) Subcontractors.
- (a) The Administrative Lead Agency shall ensure that:
    - 1. Services are provided by subcontractors who have signed contracts with the Administrative Lead Agency;
    - 2. Subcontractors comply with the Quality Assurance Guidelines and other state and federal standards, rules, and regulations affecting the provision of Waiver Services; and
    - 3. Subcontractors carry appropriate professional liability insurance and other insurance (e.g., auto insurance if Enrollees are being transported).
  - (b) Contracts between the Administrative Lead Agency and subcontractors for the provision of Waiver Services must be approved in writing by the Bureau of TennCare.
- (17) Appeal Process. Where applicable, the Administrative Lead Agency shall provide an appeal process for Enrollees which shall comply with TennCare rule 1200-13-13-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits.

**Authority:** T.C.A. §§4-5-202, 71-5-105, 71-5-109, and Executive Order No. 23. **Administrative History:** Original rule filed February 12, 1986; effective March 14, 1986. Amendment filed March 1, 1988; effective April 15, 1988. Amendment filed July 28, 2004; effective October 11, 2004.

#### **1200-13-1-.18 CRITERIA FOR MEDICAID REIMBURSEMENT FOR HOME HEALTH.**

- (1) Eligibility of an individual for home health services does not depend upon need for or discharge from institutional care.
- (2) Items and services must be furnished to an individual who is under the care of a physician. This physician may be the patient's private physician, or a physician working under arrangement with an institution which is the patient's residence, or, if the agency is hospital-based, a physician on the hospital or agency staff. The attending physician having personal knowledge of the recipient shall establish a plan of care and also certify/recertify (sign and date) the medical necessity for home health services. A physician may not refer a recipient to a home health agency in which the physician has a 5% or greater interest.
- (3) In determining if an eligible recipient is qualified to receive home health benefits, the attending physician must certify (sign and date) and document in the plan of care that:
  - (a) The services, durable medical equipment and/or medical supplies, are medically necessary;

(Rule 1200-13-1-.18, continued)

- (b) Diagnosis, medical care needs and the physical condition of the patient are related to the current condition which is under active treatment; and
  - (c) The patient is homebound, according to Medicaid criteria.
- (4) In order for a recipient to be eligible to receive covered home health services under Medicaid, the physician is required to certify (sign and date) in all cases that the recipient is confined to his home because of a medical condition and is being treated in accordance with a medically necessary plan of care ordered by the physician. The home health agency is to identify and document in the plan of care for each certification and recertification all recipient activities outside the home and advise the physician of the recipient's ongoing homebound status according to Medicaid criteria.
  - (a) A recipient does not have to be bedridden to be considered confined to home. If the recipient does in fact leave the home, the recipient may nevertheless be considered homebound if the absences from home are very brief, infrequent, and primarily for the purpose of receiving medical care. Individuals who are away from home to attend day care or school are not considered homebound. Individuals who are away from home for purposes of shopping, socializing and/or work are not considered homebound unless such absences are very brief and infrequent.
  - (b) An individual, regardless of age, who does not often travel from home just because of feebleness and/or insecurity is not considered homebound for the purpose of receiving home health services.
  - (c) A diagnosis alone is not sufficient to justify homebound status. The patient's difficulty in functioning that results in restricted activity must meet the Medicaid criteria for homebound.
- (5) Patients must first be homebound and have a physician's plan of care before home health services can be provided. Initially, patients may be considered homebound, but home health agencies must continue to reassess their homebound status and advise the physician immediately once the recipient is no longer homebound and billing shall cease to Medicaid.
- (6) The recipient's place of residence, for the purpose of determining coverage for home health services, equipment and/or medical supplies, is wherever the recipient lives. This may be the recipient's own private home, apartment, relative's home, or home of the aged/boarding home.
  - (a) An institution which meets the definition of a hospital, skilled nursing facility or intermediate care facility or intermediate care facility/mental retardation facility cannot be considered as the recipient's home for the purpose of determining coverage for home health services. The only exception is when physical therapy is provided in an intermediate care facility that does not otherwise furnish or bill for the service.
  - (b) Home health aide services are not reimbursable when performed in skilled nursing facilities, intermediate care facilities, or licensed homes for the aged/boarding homes.
- (7) The patient's individual home health agency record shall include notations of medical services provided by other individuals or institutions during the time of homebound status when the provision of such services is known or could reasonably be expected to be known by the home health agency.
- (8) Home health aide services provided pursuant to a plan of care not requiring skilled services shall require a supervisory visit by a Registered Nurse to the patient's residence at least every thirty (30) days.

(Rule 1200-13-1-.18, continued)

- (9) Home health aide services provided pursuant to a plan of care which also requires skilled services shall require a supervisory visit by a Registered Nurse to the patient's residence at least every two (2) weeks.
- (10) For services provided prior to January 1, 1994, the rules as set out at 1200-13-1-.18(1) - (9) shall apply. Effective January 1, 1994, the rules of TennCare as set out at rule chapter 1200-13-12 shall apply to all services except for nursing facility services, intermediate care facility services for the mentally retarded (ICF-MR), Home and Community Based Waiver Services, and payment of Medicare premiums, deductibles and copayments for QMBs and Special Low-Income Medicare Beneficiaries (SLIMBs) which will continue to be reimbursed in accordance with rules in effect prior to January 1, 1994, and as may be amended.

**Authority:** T.C.A. §§4-5-202, 71-5-105, 71-5-109, and Public Chapter 358 of the Acts of 1993. **Administrative History:** Original rule filed May 1985; effective June 23, 1985. Amendment filed November 5, 1990; effective December 20, 1990. Amendment filed March 18, 1994; effective June 1, 1994.

#### **1200-13-1-.19 MEDICAID ASSURANCE OF TRANSPORTATION.**

- (1) Medicaid will, except as otherwise provided in these rules, assure, through the Tennessee Department of Human Services, necessary transportation for eligible recipient to and from providers in order to obtain Medicaid covered care; to the extent possible such transportation will be furnished by volunteers providing transportation to persons in the community.
- (2) Definitions. The following definitions shall apply in rule 1200-13-1-.19 unless the content requires otherwise.
  - (a) Recipient - any person who has been determined eligible to receive benefits provided under this chapter.
  - (b) Transportation - a means of conveyance or travel to and from a provider of Medicaid covered care in order for the recipient to receive Medicaid covered care as such is defined herein.
  - (c) Medicaid covered care - necessary medical care, services or goods authorized under chapter 1200-13-1 of the Official Compilation of the Rules and Regulations of the State of Tennessee, and for which all conditions of prior approval required by this chapter and/or the appropriate manual are met.
  - (d) Provider - A provider as defined in rule 1200-13-1-.01(4).
  - (e) Volunteer Transporter - Any organization, charitable or otherwise, church group, agency, community group or agency, or person approved by the Department of Human Services to provide transportation under this rule.
- (3) Any recipient who requires transportation which is not otherwise provided by ambulance pursuant to rule 1200-13-1-.03 (1) (y) to a provider in order to obtain necessary Medicaid covered care shall be eligible for the transportation provided herein if:
  - (a) The recipient or a member of the recipient's household does not own, possess or otherwise have available or have access to a motor vehicle to provide the necessary transportation to a Medicaid provider and/or other necessities; and
  - (b) Public transportation including without limitation local bus or taxi, is not available or if available, cannot be used due to recipient's medical condition or the use of such transportation would create an unreasonable medical hardship for the recipient or the recipient's physician has verified that such transportation is not medically indicated for the recipient; and

(Rule 1200-13-1-.19, continued)

- (c) The recipient contacts the local Department of Human Services office to request necessary transportation at least five (5) working days in advance of the recipient's appointment, unless notice of less than five (5) working days is medically indicated by the recipient's medical condition; and
  - (d) Transportation is required and requested for the recipient only and is limited to that necessary to obtain Medicaid covered care as defined in this rule; however transportation may also be provided for an additional person when the recipient's age or disability requires that the recipient be accompanied by another person; and
  - (e) Transportation is requested to an appropriate Medicaid provider located in the recipient's community; however, when a Medicaid medical provider offering the appropriate Medicaid covered care is not available in the recipient's community, transportation will be furnished to a qualified provider of the recipient's choice who is generally available and used by other recipients of the community, except where the recipient's freedom of choice is restricted by other rules in this chapter; and
  - (f) The recipient shall accept the transportation arranged, including type of transportation, offered to the recipient. Said transportation shall be reasonable and appropriate for the medical needs of the recipient. If it is necessary to reschedule a medical appointment in order to secure transportation, a Department of Human Services staff member will offer to assist the recipient in this process by contacting the medical provider and rescheduling an appointment date that is mutually acceptable to all parties.
- (4) Transportation provided under rule 1200-13-1-.19 shall not be available if one of the following conditions exist:
- (a) The Medicaid covered care is not medically, necessary or is not to be provided pursuant to a physician's or provider's plan of care; or
  - (b) Friends, relatives or other persons have normally and customarily provided transportation for the recipient to medical care and/or other necessities and such transportation remains available and accessible; or
  - (c) The Medicaid recipient normally and customarily drives his/her own vehicle and the vehicle remains available and accessible; or
  - (d) Public transportation is available and accessible and recipient's medical condition does not prevent the recipient from using public transportation; or
  - (e) Recipient refuses to comply with the reasonable safety measures, including without limitation the use of seat belts, required by the person or organization transporting the recipient; or
  - (f) The recipient has previously abused the transportation services provided herein.
    - 1. Abuse shall include without limitation, consistent failure of a recipient to utilize the transportation services arranged for the recipient.
  - (g) Transportation requested for recipients to receive Early Periodic Screening, Diagnosis and Treatment care is available from the County Health Department and will not be provided pursuant to this rule.

(Rule 1200-13-1-.19, continued)

- (5) Transportation provided under this rule shall be reimbursed as follows:
  - (a) Volunteer Transporters shall be paid the usual and customary rate the voluntary transporter charges for transporting non-Medicaid riders; provided however that such payment to voluntary riders will not exceed the rate established by the Comprehensive Travel Regulations of the State of Tennessee Department of Finance and Administration.
- (6) For services provided prior to January 1, 1994, the rules as set out at 1200-13-1-.19(l) - (5) shall apply. Effective January 1, 1994, Assurance of Transportation shall be provided through the rules of TennCare as set out at rule chapter 1200-13-12.

**Authority:** T.C.A. §§4-5-202, 71-5-105, 71-5-109, and Public Chapter 358 of the Acts of 1993. **Administrative History:** Original rule filed September 10, 1985; effective October 10, 1985. Amendment filed March 18, 1994; effective June 1, 1994.

#### **1200-13-1-.20 COMMUNICATION AID DEVICE.**

- (1) Definitions:
  - (a) Communication Aid Device - is a device specifically designed to be used in conjunction with a specialized program of activities to assist a person with severe impairments in transmitting spoken language to develop and use alternative methods of communicating. The device may be electronic or non-electronic.
  - (b) Provider - means any medical vendor authorized under Medicaid rules to be enrolled as a provider. A medical vendor may be reimbursed for a communication aid device when furnished to a Medicaid recipient pursuant to a physician's plan of treatment, physician's order, and prior authorization from the Bureau of Medicaid.
- (2) Criteria for receiving a communication aid device are as follows:
  - (a) The recipient must be less than 21 years of age.
  - (b) The device must be medically necessary, as shown by a physician's prescription and a sufficient objective clinical history.
  - (c) The recipient must have congenital and/or other conditions that affect verbal communication, and must have adequate vision acuity, hearing acuity, cognitive skills, neuromotor skills, language skills, and education and/or academic skills that will enable the recipient to utilize the device to its full advantage.
- (3) Medicaid is the last resource for reimbursement of such devices. As an example, services for those recipients certified as handicapped under Public Law 94-142 will continue to be the primary responsibility of the local school system.
- (4) Program Delivery System:
  - (a) The provider of the communication aid device must first get a complete evaluation of:
    1. The recipient's communication needs, both current and future;
    2. The communication technique currently used;

(Rule 1200-13-1-.20, continued)

3. The recipient's potential for using different kinds of standard and special communication aid devices; and
  4. A written recommendation for the specific communication aid device by a Speech and Language Pathologist (holding a current and valid certificate of clinical competence (CCC) in speech and language pathology recognized by American Speech and Hearing Association (ASHA).
- (b) In addition to the evaluation, a written plan of care must be submitted which describes a short term and long term communication goals for the recipient and a discussion of how the device will be integrated into the recipient's total program of medical and educational activities aimed at improving communication skills.
- (5) Prior Authorization:
- Prior authorization by the department pertains only to medical necessity and reasonableness of the equipment, based on the recipient's need and anticipated use of the equipment. The basis for granting or denying prior approval shall be whether the particular device requested is medically necessary and reasonable, whether a less expensive alternative would adequately meet the recipient's communication needs, and whether requests include sufficient factual data as determined by the Bureau of Medicaid to enable a fair and objective decision.
- (6) Reimbursement for Communication Aid Devices will be the lesser of:
- (a) Billed charges; or
  - (b) The Medicaid prevailing fee which is equal to 100% of the Medicare fee at the 75th percentile for the same item; or
  - (c) Where Medicare has not established a fee for the item, a reimbursement amount shall be derived by obtaining suggested retail prices for such items from at least three manufacturers and setting an amount equal to the 50th percentile of these prices.
- (7) For services provided prior to January 1, 1994, the rules as set out at 1200-13-1-.20 (1) - (6) shall apply. Effective January 1, 1994, the rules of TennCare as set out at rule chapter 1200-13-12 will govern coverage of communication aid devices.

**Authority:** T.C.A. §§4-5-202, 71-5-105, 71-5-109, and Public Chapter 358 of the Acts of 1994. **Administrative History:** Original rule filed June 2, 1988; effective July 17, 1988. Amendment filed April 19, 1990; effective June 3, 1990. Amendment filed April 30, 1992; effective June 14, 1992. Amendment filed March 18, 1994; effective June 1, 1994.

#### **1200-13-1-.21 PROVIDER NONCOMPLIANCE OR FRAUD OF MEDICAID PROGRAM.**

- (1) Definitions:
- (a) Agent - means any person who has been delegated the authority to obligate or act on behalf of a provider.
  - (b) Convicted - means that a judgment of conviction has been entered by a federal, state, or local court, regardless of whether an appeal from that judgment is pending.
  - (c) Department - means the Tennessee Department of Health and Environment.

(Rule 1200-13-1-.21, continued)

- (d) Exclusion - means that period of time that a provider is suspended or terminated from participation in the Medicaid program. Any items or services furnished by an excluded provider shall not be reimbursed under Medicaid.
- (e) Flagrant noncompliance - means one or more activities identified in section (3).
- (f) Fraud - means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.
- (g) Managing employee - means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of, an institution, organization, or agency.
- (h) Noncompliance - means provider practices that are inconsistent with sound fiscal or business practices or inconsistent with Medicaid rules and regulations, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.
- (i) Person with an ownership or control interest - means a person or corporation that:
  - 1. has an ownership interest totaling five (5) percent or more in a disclosing entity,
  - 2. has an equity in the capital, the stock or profit (indirect membership) of the disclosing entity equal to five (5) percent or more in a disclosing entity,
  - 3. has a combination of direct and indirect ownership interests equal to five (5) percent or more in a disclosing entity;
  - 4. owns an interest of five (5) percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least five (5) percent of the value of the property or assets of the disclosing entity;
  - 5. is an officer or director of a disclosing entity that is organized as a corporation; or
  - 6. is a partner in a disclosing entity that is organized as a partnership.
- (j) Provider - means an individual or entity which furnishes items or services for which payment is claimed under Medicaid.
- (k) Provider responsibility - means the obligation of any health care provider who furnishes or orders health care services to assure that, to the extent of his influence or control, those services are:
  - 1. furnished only when, and to the extent that, they are medically necessary, and
  - 2. of a quality that meets professionally recognized standards of health care.
- (l) Records - means all paper and electronic media records which contain information relative to medical assistance provided for which payment has been made or sought under the Medicaid program, and/or which contain any other information relative to payments received or sought under the Medicaid program. It shall include records for services which are non-covered or not billed, but which initiate a covered service.



(Rule 1200-13-1-.21, continued)

- (m) Records access - means paper and electronic media records shall be made available during normal business hours by a provider for a stringent onsite review audit and to allow Medicaid to make copies on site in order to review at a later date and/or to document audit findings. Upon written request the provider shall make copies of records (not to exceed five (5) recipients) to document services previously paid. If electronic media records are provided to Medicaid the data layout shall also be provided to Medicaid.
  - (n) Unit - means the Tennessee Bureau of Investigation, Medicaid Fraud Control Unit.
- (2)
- (a) In addition to the sanctions set out in T.C.A. §71-5-118, the provider may be subject to stringent review/audit procedures which may include clinical evaluation of claim services and a prepayment requirement for documentation and for justification of each claim,
  - (b) Medicaid may withhold payments to a provider in cases of fraud, willful misrepresentation, or flagrant noncompliance,
  - (c) Medicaid may refuse to enter into or may suspend a provider participation agreement with a provider 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,
  - (d) Medicaid may refuse to enter into or may suspend a provider participation agreement if it determines 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,
  - (e) Medicaid shall refuse to enter into or shall suspend a provider participation agreement 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,
  - (f) Medicaid shall refuse to enter into or shall suspend a provider participation agreement 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,
  - (g) Medicaid may refuse to enter into or may terminate a provider participation agreement if it is determined that the provider has been flagrantly noncompliant in its violation of segments of section (3) of this chapter, and
  - (h) Medicaid may 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 Medicaid and repayment by the provider to the recipient and/or his family is not made within 30 days of receiving notification from Medicaid to make repayment. If a provider knowingly bills a recipient and/or family for a Medicaid covered service, in total or in part, except as otherwise permitted by State rules, Medicaid may terminate the provider participation agreement.
- (3) In addition to the grounds for actions set out in T.C.A. §71-5-118, activities or practices which justify sanctions against the contract and/or recoupment of monies incorrectly paid shall include, but not be limited to:

(Rule 1200-13-1-.21, continued)

- (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 Medicaid or its agent(s),
- (e) continued provision of poor record keeping or inappropriate/inadequate medical care,
- (f) medical assistance of a quality below recognized standards,
- (g) provider suspension from the Medicare/Medicaid program(s) by the authorized U.S. enforcement agency,
- (h) partial or total loss (voluntary or otherwise) of a providers federal Drug Enforcement Agency (DEA) dispensing or prescribing certification,
- (i) restriction to and/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 and/or evidence from same,
- (k) violation of the responsible state licensing board license and/or certification rules,
- (l) convictions of a felony, conviction of any offense under state or federal drug laws, or conviction of 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 and/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 control 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/dental service when mentally or physically unable to safely do so,
- (q) billing Medicaid an amount that is greater than the provider's usual and customary charge to the general public for that service, and
- (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 Medicaid.
- (s) Reserved.
- (t) Fragmentation or submitting claims separately on the component parts of a procedure instead of claiming the single procedure code, (which includes the entire procedure, or all component parts) when such approach results in Medicaid paying a greater amount for the component(s) than it would for the entire procedure.

(Rule 1200-13-1-.21, continued)

- (u) 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.
- (4) Term of Provider Exclusion
- (a) A provider exclusion based upon either section (2)(c), (d), (e) or (f) shall continue until the excluding re-establishes the license or the Medicare/Medicaid eligibility previously denied or suspended. The provider may resubmit to Medicaid with documentation from the State Board or the U.S. Office of Inspector General - Department of Health and Human Services that the provider's exclusion has been lifted or removed. The provider may then apply to Medicaid for reinstatement consideration as determined by Medicaid.
  - (b) A provider exclusion based upon section (2)(g) shall be eligible for reinstatement as a Medicaid provider as determined by Medicaid.
- (5) Access to Records - The Department shall in the furtherance of the administration of the Medicaid Program have access to all provider records. Such access shall include the right to make copies of those records during normal business hours.
- (6) Confidentiality - The Department shall be bound by all applicable federal and/or state statutes and regulations relative to confidentiality of records.
- (7) Provider Cooperation - The provider is to cooperate, with Medicaid and/or its agent(s) in the provision of records and in the timely completion of any post review audit. Failure to cooperate may subject the provider to actions identified in section (2) of this rule. Cooperation in a post review audit includes but is not limited to:
- (a) the provision of a private work area,
  - (b) the availability of provider personnel at an initial and exit conference,
  - (c) the furnishing of records as needed,
  - (d) the provision of access to provider owned copying equipment to expedite the completion of an on site segment of an audit, and
  - (e) the provision of records, requested in writing, for a desk review where ten (10) or less recipient records are at issue.
- (8) Request for Hearing - All provider hearing requests shall be received by Medicaid within fifteen (15) days of the providers receipt of notification of Medicaid action taken under this chapter.
- (9) For services provided prior to January 1, 1994, the rules as set out at 1200-13-1-.21 (1) - (9) shall apply. Effective January 1, 1994, the rules of TennCare as set out at rule chapter 1200-13-12 shall apply except for noncompliance or fraud of Medicaid program as it relates to nursing facilities, intermediate care facilities for the mentally retarded (ICF-MR), Home and Community Based Waiver Services, and payment of Medicare premiums, deductibles and copayments for QMBs and Special Low-Income Medicare Beneficiaries (SLIMBs) which will continue to be enforced in accordance with Medicaid rules in effect prior to January 1, 1994, and as may be amended.

**Authority:** T.C.A. §§4-5-202, 71-5-105, 71-5-109, and Public Chapter 358 of the Acts of 1993. **Administrative History:** Original rule filed January 29, 1990; effective March 15, 1990. Amendment filed October 24, 1991; effective December 8, 1991. Amendment filed November 27, 1991; effective January 11, 1992. Amendment filed March 10, 1992; effective April 24, 1992. Amendment filed August 4, 1992; effective September 18, 1992.

(Rule 1200-13-1-.21, continued)

*Amendment filed December 4, 1992; effective January 19, 1993. Amendment filed March 18, 1994; effective June 1, 1994.*

#### **1200-13-1-.22 MEDICAID COVERAGE OF SERVICES FOR CERTIFIED NURSE-MIDWIVES.**

- (1) Definitions:
  - (a) Certified Nurse-Midwife: A registered nurse who is a graduate of an accredited program in Nurse-Midwifery. Certified by the American College of Nurse-Midwives (ACNM) and currently licensed by the State of Tennessee Board of Nursing.
  - (b) Maternity Cycle: A period restricted to pregnancy, labor, childbirth and the subsequent 6 week postpartum period.
  - (c) Uncomplicated Maternity Cycle: Where the patient's antenatal course is essentially normal, with onset of labor beyond 37 weeks.
  - (d) Uncomplicated Delivery: A spontaneous vaginal delivery of the fetus in vertex presentation followed by the delivery of the placenta and an essentially normal postpartum period.
  - (e) Routine Newborn Care: Services such as physical exam, ophthalmic prophylaxis, vitamin K therapy, and feeding instructions rendered a normal newborn.
- (2) Protocols: In each joint practice situation, written protocols jointly developed by the nurse-midwife(s) and physician(s), will be executed outlining delegated medical tasks and drug management used in patient care. Protocols shall be individualized according to the physician and certified nurse-midwife using them and represent an agreement between them regarding that practice setting. Protocols shall be reviewed and revised annually, signed and dated by a physician, and jointly signed and dated by the certified nurse-midwife.
- (3) Restriction of Practice: Maternity services performed by the nurse-midwife are not to include the assisting of child birth by any artificial, forcible, surgical or mechanical means not addressed in the protocol. Newborn services are limited to routine newborn care.
- (4) Participation: in order for a nurse-midwife to obtain a Medicaid provider number and receive reimbursement the following requirements must be met:
  - (a) Completions and submission of a nurse-midwife enrollment form which includes a copy of the certification issued by the American College of Nurse-Midwives and a copy of a current Tennessee Registered Nurse license:
  - (b) Submission of a nurse-midwife consultation and referral agreement with a physician(s) actually engaged in the practice of obstetrics and participating in the Tennessee Medicaid program; and
  - (c) Execution of a Medicaid provider agreement.
- (5) Covered Services: Medicaid covered services provided by the nurse-midwives are limited to those diagnoses and procedures related to an uncomplicated maternity cycle, an uncomplicated delivery, and routine newborn care as defined above. Reimbursement for these services will not be made unless one of the diagnoses and procedures listed below are documented on the claim.
  - (a) Covered Classifications are:
    - 1 Supervision of normal first pregnancy;

(Rule 1200-13-1-.22, continued)

2. Supervision of other normal pregnancy.
  3. Single liveborn:
  4. Single liveborn - born in hospital; or
  5. Delivery in a completely normal case.
- (b) Covered Procedures are:
1. Total obstetric care (all-inclusive, “global” care) includes antepartum care, vaginal delivery and postpartum care. This excludes forceps or breech delivery.
  2. Vaginal delivery only including in-hospital postpartum care (separate procedure). This excludes forceps or breech delivery.
  3. Antepartum care only (separate procedure).
  4. Postpartum care only (separate procedure).
  5. Antepartum office visits (new or established patient).
  6. Newborn care in hospital, including physical examination of baby and conference(s) with patient(s).
  7. Assist at surgery for Cesarean delivery.
- (6) Participation Agreement: There will be a signed agreement between the Tennessee Department of Health and Environment, Bureau of Medicaid and the nurse-midwife. The terms for participation in the program will be set out in the agreement.
- (7) Provider Enrollment: There must be on file at the Bureau of Medicaid a completed provider enrollment application which will include the name, Tennessee RN license number, once address, city, state and zip code, telephone, county, and social security number, and the Federal I.D. number. If billing address is different from office address this will also be documented. The signature of the certified nurse-midwife will be documented as well as the date the form was signed.
- (a) The following must be submitted along with the completed application:
1. Copy of certification issued by the American College of Nurse-Midwives,
  2. Copy of a current Tennessee Registered Nurse license;
  3. Certified nurse-midwife provider agreement; and
  4. Copy of fully executed consultation and referral agreement.
- (8) For services provided prior to January 1, 1994, the rules as set out at 1200-13-1-.22 (1) - (7) shall apply. Effective January 1, 1994, the rules of TennCare as set out at rule chapter 1200-13-12 will govern coverage of services for certified nurse-midwives except for Medicare crossover payments which will continue to be covered in accordance with Medicaid rules in effect prior to January 1, 1994, and as may be amended.

(Rule 1200-13-1-.22, continued)

**Authority:** T.C.A. §§4-5-202, 71-5-105, 71-5-109, and Public Chapter 358 of the Acts of 1993. **Administrative History:** Original rule filed December 1, 1988; effective January 15, 1989. Amendment filed January 29, 1990; effective March 15, 1990. Amendment filed March 18, 1994; effective June 1, 1994.

**1200-13-1-.23 NURSING HOME PREADMISSION SCREENINGS FOR MENTAL ILLNESS AND MENTAL RETARDATION.**

- (1) The following definitions shall apply for interpretation of this rule.
  - (a) Identification Screen (Level I) - The identification screen is to determine which nursing facility applicants or residents have mental illness or mental retardation and are subject to preadmission screening/annual resident review (PASARR). Individuals with a supportable primary diagnosis of Alzheimer's disease or dementia will also be detected through the identification screen. Nursing facilities are responsible for ensuring that all applicants receive a Level I identification screen.
  - (b) Preadmission Screening/Annual Resident Review (Level II) - The process whereby a determination is made about whether the individual requires the level of services provided by a nursing facility or another type of facility and, if so, whether the individual requires specialized services. These reviews shall be the responsibility of the State Department of Mental Health and Mental Retardation.
  - (c) Mental Illness - An individual is considered to have mental illness if he/she has a current primary or secondary diagnosis of a major mental disorder (as defined in the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition) limited to schizophrenic, paranoid, major affective, schizoaffective disorders and atypical psychosis, and does not have a primary diagnosis of dementia (including Alzheimer's disease or a related disorder).
  - (d) Mental Retardation and Related Conditions - An individual is considered to be mentally retarded if he/she has a level of retardation (mild, moderate, severe and profound) as described in the American Association on Mental Deficiency's Manual on Classification in Mental Retardation (1983).

Mental Retardation refers to significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.

The provisions of this section also apply to persons with "related conditions", as defined by 42 CFR 435.1009, which states: "Persons with related conditions" means individuals who have a severe, chronic disability that meets all of the following conditions:

1. It is attributable to:
  - (i) Cerebral palsy or epilepsy, or
  - (ii) Any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with mental retardation, and requires treatment or services similar to those required for these persons.
2. It is manifested before the person reaches age 22.
3. It is likely to continue indefinitely.
4. It results in substantial functional limitations in three or more of the following areas of major life activity:

(Rule 1200-13-1-.23, continued)

- (i) Self-care;
  - (ii) Understanding and use of language;
  - (iii) Learning;
  - (iv) Mobility;
  - (v) Self-direction; and
  - (vi) Capacity for independent living.
- (e) Specialized Services for Individuals with Mental Retardation - A continuous program for each individual, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services that is directed towards (1) the acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (2) the prevention or deceleration of regression or loss of current optimal functional status. Specialized services does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous specialized services program.
- (f) Specialized Services for Individuals with Mental Illness - Specialized services is defined as the implementation of an individualized plan of care developed under and supervised by a physician, provided by a physician and other qualified mental health professionals, that prescribes specific therapies and activities for the treatment of persons who are experiencing an acute episode of severe mental illness, which necessitates supervision by trained mental health personnel.
- (2) Medicaid-certified nursing facilities may not admit individuals applying for admission unless these persons are screened to determine if they have mental illness or mental retardation regardless of method of payment or "known diagnosis." A Medicaid-certified nursing facility is prohibited from admitting any new resident who has mental illness or mental retardation (or a related condition), unless that individual has been determined by the Tennessee Department of Mental Health and Mental Retardation not to be in need of specialized services. (The individual must also meet the Tennessee Department of Health's preadmission criteria for nursing facility services). The criteria to be used in making determinations will be categorized into two levels: 1) identification screens (Level 1) and 2) preadmission screening/annual resident reviews (PASARR) (Level II).
- (a) Criteria for Identification Screen (Level 1)
- 1. Prior to admission of any person to a nursing facility, it must be determined if:
    - (i) For Mental Illness
      - (I) The individual has a diagnosis of mental illness. (See prior definition of mental illness).
      - (II) The person has any recent (within the last two years) history of mental illness, or has been prescribed a major tranquilizer on a regular basis in the absence of a justifiable neurological disorder.
      - (III) There is any presenting evidence of mental illness (except primary diagnosis of Alzheimer's disease or dementia) including possible disturbances in orientation, affect, or mood.

(Rule 1200-13-1-.23, continued)

## (ii) For Mental Retardation or Persons with Related Conditions

- (I) The individual has a diagnosis of mental retardation. (See prior definition of mental retardation).
- (II) There is any history of mental retardation or developmental disability in the identified individual's past.
- (III) There is any presenting evidence (cognitive or behavior functions) that may indicate the person has mental retardation or developmental disability.
- (IV) The person is referred by an agency that serves persons with mental retardation (or other developmental disabilities), and the person has been deemed to be eligible for that agency's services.
- (V) The preceding criteria must also be applied to residents of a nursing facility who have not received an identification screen.
- (VI) There must be a record of the identification screen results and interpretation in the nursing home resident's record.
- (VII) Results of the identification screen must be used (unless there is other indisputable evidence that the individual is not mentally ill or mentally retarded) in determining whether an individual is (or is suspected to be) mentally ill or mentally retarded and therefore must be subjected to the PASARR process. Findings from the evaluation should be used in making determinations about whether an individual has mental illness or mental retardation.

- (b) Any individual for whom there is a negative response for all of the identification evaluative criteria for mental retardation or mental illness and for whom there is no other evidence of a condition of mental illness or mental retardation may be admitted to or continue to reside in a Medicaid-certified nursing facility without being determined appropriate for nursing facility placement through the PASARR process (Level II).
- (c) Any individual for whom there is a positive response for any of the identification evaluative criteria for mental retardation or mental illness may not be admitted to or continue to reside in a Medicaid-certified nursing facility without being determined appropriate for nursing facility placement through the PASARR process (Level II).
- (d) Exemptions from Level II Review

An individual who has a diagnosis of mental illness or mental retardation will be exempt from the PASARR process if they meet any of the following criteria:

1. Dementia - This must be a primary diagnosis based on criteria in the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition; or it may be the secondary diagnosis (including Alzheimer's disease and related disorders) as long as the primary diagnosis is not a major mental illness. The primary or secondary diagnosis of dementia (including Alzheimer's disease and related disorders) must be based on a neurological examination. Dementia is not allowed as an exemption if the individual has, or is suspected of having, a diagnosis of mental retardation.
2. Convalescent Care - Any person with mental illness or mental retardation as long as that person is not a danger to self and/or others, may be admitted to a Medicaid-certified



(Rule 1200-13-1-.23, continued)

nursing facility after release from an acute care hospital for a period of recovery without being subjected to the PASARR process for mentally ill or mentally retarded evaluation.

3. Terminal Illness - Under Section 1861(dd)(3)(A) of the Social Security Act, a Medicare beneficiary is considered to be terminally ill if he or she has a medical prognosis that (his/her) life expectancy is six months or less. This same standard is to be applied to Medicaid recipients with mental illness, mental retardation or related conditions who are found to be suffering from a terminal illness. An individual with mental illness or mental retardation, as long as that person is not a danger to self and/or others, may be admitted to or reside in a Medicaid-certified nursing facility without being subjected to the PASARR/MI or PASARR/MR evaluative process if he or she is certified by a physician to be "terminally ill," as that term is defined in Section 1861(dd)(3)(A) of the Social Security Act, and requires continuous nursing care and/or medical supervision and treatment due to his/her physical condition.
4. Severity of Illness - Any person with mental illness or mental retardation who is comatose, ventilator dependent, functions at the brain stem level, or has a diagnosis of: Severe Parkinson's Disease, Huntingdon's Disease, Amyotrophic Lateral Sclerosis, Congestive Heart Failure, or Chronic Obstructive Pulmonary Disease, and any other diagnosis so determined by the Health Care Financing Administration.

- (3) Right to Appeal - Each patient has the right to appeal any decision made. The appeal process will be handled in accordance with T.C.A. §71-5-113.

**Authority:** T.C.A. §§71-5-105, 71-5-109, and 4-5-20. **Administrative History:** Original rule filed June 29, 1989; effective; August 14, 1989. Amendment filed March 30, 1995; effective June 15, 1995.

#### **1200-13-1-.24 CRITERIA FOR MEDICAID REIMBURSEMENT FOR COMMUNITY MENTAL HEALTH CLINICS.**

- (1) Community Mental Health Certification.

The Tennessee Department of Mental Health and Mental Retardation is responsible for certifying community mental health centers for participation in the Medicaid program. Only those centers designated by the Department of Health and the Department of Health and Mental Retardation as rendering services may participate as a provider under these provisions. It is the responsibility of the Department of Health, the Single State Agency, to notify the Comptroller of the Treasury and the Department of Mental Health and Mental Retardation when a provider has been admitted to the program and when participation terminates. See Medicaid Rule 1200-13-4 Payment Rates for Services Provided to Medicaid Patients by Community Mental Health Center, statutory authority: T.C.A. §71-5-105. Certification shall be renewed annually, concurrent with the expiration of the term of the previous provider contract.

- (2) Covered Services are Limited to:

- (a) Individual therapy
- (b) Group therapy
- (c) Family therapy
- (d) Couple therapy
- (e) Medication review
- (f) Day treatment

(Rule 1200-13-1-.24, continued)

- (g) Psychological evaluation
  - (h) Psychiatric evaluation
  - (i) Therapeutic nursery
  - (j) Targeted case management
- (3) Physician Involvement
- (a) An initial face-to-face physician encounter with the client must be documented by the physician and simultaneously signed and dated. All admissions and readmissions must be seen by the physician within 30 days of the initiation of community mental health clinic services to the client. All services rendered during the period can be billed to Medicaid once the physician encounter occurs and is appropriately documented.
  - (b) If the physician's encounter occurs after thirty (30) days, then only that service and those other services that are rendered subsequent to the date of the physician's encounter are billable.
- (4) Treatment Plan
- (a) Treatment plan must be developed for each client and made part of the medical record within thirty (30) days of the first billable service.
  - (b) The plan shall:
    - 1. Be based on a client's strengths and disabilities; and
    - 2. Have short and long range goals; and
    - 3. Designate specific treatment modalities to be utilized; and
    - 4. List all responsible persons involved in implementing the plan.
  - (c) The physician's participation in the treatment plan must be updated at least every six (6) months through a face-to-face physician encounter to demonstrate current, first-hand knowledge of the client. An updated treatment plan with the physician's signed and dated signature must be completed within thirty (30) days of the physician encounter. This evaluation and review process must be completed prior to the six (6) month due date. Services paid during the treatment plan is out of compliance shall be identified and recouped by Medicaid.
- (5) Progress notes shall contain:
- (a) A brief descriptive summary of each contact billed to Medicaid; and
  - (b) The date and duration of contact; and
  - (c) A brief descriptive statement of patient's progress (generic statement such as "client is doing well" is not acceptable); and
  - (d) The signature of the individual therapist who prepared the progress notes.
- (6) Progress notes and treatment plans shall conform to interpretative guidelines established by Medicaid in the provider Community Mental Health Clinic manual and bulletins.

(Rule 1200-13-1-.24, continued)

- (7) Services provided under a Therapeutic Nursery Program must follow the provider proposal/plan as approved by the Department of Mental Health and Mental Retardation.
- (8) Services provided under a Nursing Home Program must follow the providers Nursing Home plan for Community Mental Health as approved by the Department of Mental Health and Mental Retardation and the Bureau of Medicaid.
- (9) Deficiencies subject to recoupment shall include, but are not limited to:
  - (a) Visits billed prior to the physician's initial evaluation of the client if the encounter occurs more than (30) days after intake.
  - (b) Services provided under a treatment plan not timely signed and dated in the physician's handwriting.
  - (c) Absence of a six (6) month re-evaluation of the client by the physician.
  - (d) Services that are not medically necessary or justified.
  - (e) Case management visits which do not follow Tennessee Department of Mental Health and Mental Retardation case management policy and procedures.
  - (f) Recipient no-show visits.
  - (g) Transportation.
  - (h) Medication review by persons other than the physician or the physician's extender (i.e., nurse practitioner, nurse clinician or physician assistant).
  - (i) Day treatment of less than three hours.
  - (j) Services that involves socialization only.
  - (k) Therapeutic nursery and nursing home programs not in compliance with the providers approved proposal/plan in (7) or (8) above.
- (10) For services provided prior to January 1, 1994, the rules as set out at 1200-13-1-.24(1) - (9) shall apply. Effective January 1, 1994, the rules of TennCare will govern reimbursement for community mental health clinics except for Medicare crossover payments which will continue to be governed by the Medicaid rules in effect prior to January 1, 1994, and as may be amended.

**Authority:** T.C.A. §§4-5-202, 71-5-105, 71-5-109, and Public Chapter 358 of the Acts of 1993. **Administrative History:** Original rule filed October 21, 1991; effective December 5, 1991. Amendment filed March 18, 1994; effective June 1, 1994.

**1200-13-1-.25 HOME AND COMMUNITY BASED SERVICES WAIVER FOR THE MENTALLY RETARDED AND DEVELOPMENTALLY DISABLED.**

- (1) Definitions: The following definitions shall apply for interpretation of this rule:
  - (a) Administrative Lead Agency - the approved agency with which the Bureau of TennCare contracts for the provision of covered services through the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled.

(Rule 1200-13-1-.25, continued)

- (b) Assistance with Medications - assistance which includes, but is not limited to, reminding when to take medications, encouragement to take, reading medication labels, opening bottles, handing to individual, and reassurance of the correct dose.
- (c) Behavior Support Plan - a plan developed by a licensed psychiatrist, psychologist, Behavior Specialist, Behavior Analyst, or other qualified professional approved by the Bureau of TennCare that specifies intervention and support strategies for Enrollees during times of behavioral, personal, or external crisis.
- (d) Bureau of TennCare - the Bureau in the Tennessee Department of Finance and Administration which is responsible for administration of the Title XIX Medicaid program.
- (e) Certification - the process by which a physician, who is licensed as a doctor of medicine or doctor of osteopathy, signs and dates an ICF/MR PreAdmission Evaluation signifying that the named individual requires services provided through the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled as an alternative to care in an Intermediate Care Facility for the Mentally Retarded.
- (f) Community Participation Services - training, support, and other services, as specified in the Plan of Care, that provide Enrollees with access to community activities and functions (e.g., community exploration, leisure activities/hobbies, companionship with friends and peers, maintaining family contacts, community events, education, spectator sports).
- (g) Behavior Support Services - services, as specified in the Plan of Care, that are provided in accordance with an individualized Behavior Support Plan to provide an intensive level of intervention and support for Enrollees at times of behavioral, personal, or external crisis. Behavior Support Services may also include evaluation, training, and counseling for the Enrollee, and teaching families and service providers about the implementation strategies outlined in the Plan of Care.
- (h) Day Habilitation Services - individual training and support, as specified in the Plan of Care, in the acquisition, retention, or improvement in daily living, social, communication, self-help, and other adaptive skills.
- (i) Denial - as used in regard to Waiver Services, the term shall mean the termination, suspension, or reduction in amount, scope, and duration of a Waiver Service or a refusal or failure to provide such service.
- (j) Disenrollment - the voluntary or involuntary termination of enrollment of an individual receiving services through the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled.
- (k) Enhanced Dental Services - dental services (e.g., extractions, root canals, periodontics, dentures, and other dental services to relieve pain and infection), as specified in the Plan of Care, the lack of which would result in generalized disease, infection, discomfort, or improper nutrition.
- (l) Enrollee - a Medicaid Eligible who is enrolled in the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled.
- (m) Environmental Accessibility Adaptations - physical adaptations to the home (e.g., installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electrical or plumbing systems to accommodate medical equipment), as specified in the Plan of Care, which are necessary to ensure the health and safety of the Enrollee or which enable the Enrollee to function with greater independence in the Enrollee's home. Excluded are those adaptations or improvements to the home which would increase the total square footage or

(Rule 1200-13-1-.25, continued)

which would be of general utility (e.g., carpeting, roof repair, central air conditioning) rather than a direct medical benefit.

- (n) Family-based Living - services, support, and training, as specified in the Plan of Care, which are provided in a home with a family other than the family of origin and which enable an Enrollee to enjoy a typical life-style at home and in the community.
- (o) Family Education - family education services, as specified in the Plan of Care, which are provided for the family of the Enrollee. Education includes providing information to the family regarding methods of instruction to attain daily living skills, information related to the Enrollee's disability, and instruction about treatment regimens. Education may be provided to individuals other than the Enrollee's family to the extent needed to enable the Enrollee to be cared for outside of an institution. For the purpose of this definition, family is a unit that consists of the Enrollee and the Enrollee's parent, relative, foster family, or other caregiver who resides in the same household. Excluded are individuals (other than the foster family) who are employed to care for the Enrollee.
- (p) Home (of an Enrollee) - the residence or dwelling in which the Enrollee resides, excluding hospitals, nursing facilities, Intermediate Care Facilities for the Mentally Retarded, Assisted Living Facilities, and Homes for the Aged.
- (q) Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled - the Home and Community Based Services waiver project approved for Tennessee by the Health Care Financing Administration to provide services to a specified number of Medicaid-eligible individuals who have mental retardation or developmental disabilities and who meet the criteria for Medicaid reimbursement of care in an Intermediate Care Facility for the Mentally Retarded.
- (r) Home Health Aide Services - services, as specified in the Plan of Care, which are provided by a licensed home care organization and which include the performance of procedures as an extension of therapy services; personal care; nutritional services; ambulation, mobility, and exercises; household services essential to health care at home; and assistance with medications that are ordinarily self-administered. Such services may also be provided in a community setting (e.g., services to assist the Enrollee to access medical appointments with physicians, dentists, or other health care professionals).
- (s) ICF/MR PreAdmission Evaluation (ICF/MR PAE) - a process of assessment approved by the Bureau of TennCare and used to document an individual's current medical and developmental status and eligibility for care in an ICF/MR.
- (t) Intermediate Care Facility for the Mentally Retarded (ICF/MR) - a licensed facility approved for Medicaid vendor reimbursement that provides specialized services for individuals with mental retardation or related conditions and that complies with current federal standards and certification requirements for ICF/MR.
- (u) Medicaid Eligible - an individual who has been determined by the Tennessee Department of Human Services to be financially eligible to have TennCare make reimbursement for covered services.
- (v) Nursing Services - physician-ordered nursing services, as specified in the Plan of Care, which are provided in accordance with paragraph (2)(q) herein by an individual who is licensed in the State of Tennessee as a registered nurse or a licensed practical nurse.

(Rule 1200-13-1-.25, continued)

- (w) Nutrition Services - physician-ordered nutrition services, as specified in the Plan of Care, which are provided in accordance with paragraph (2)(r) herein by a licensed dietitian or a licensed nutritionist.
- (x) Occupational Therapy - physician-ordered occupational therapy services, as specified in the Plan of Care, which are provided in accordance with paragraph (2)(t) herein by a licensed occupational therapist or by a licensed occupational therapist assistant working under the supervision of a licensed occupational therapist.
- (y) Personal Assistance - services, as specified in the Plan of Care, which are provided by an individual other than a spouse or the parent of a minor child that assist an Enrollee with activities of daily living and community access, including but not limited to: attendant care; household services; financial management; personal care services such as grooming, bathing, and dressing; assistance with meal planning and preparation; assistance with medications; supervising and assisting the Enrollee in accessing community activities such as medical appointments, shopping, recreational and leisure activities, and socialization. Personal assistance services differ from day habilitation and residential habilitation services due to the primary emphasis on assistance and support rather than teaching and training.
- (z) Personal Emergency Response Systems - electronic devices (e.g., portable “help” buttons connected to the Enrollee’s telephone and monitored by response centers), as specified in the Safety Plan, which enable Enrollees, who are alone for significant parts of the day and who would otherwise require extensive routine supervision, to secure help in an emergency.
- (aa) Physical Therapy - physician-ordered physical therapy services, as specified in the Plan of Care, which are provided in accordance with paragraph (2)(s) herein by a licensed physical therapist or by a licensed physical therapist assistant working under the supervision of a licensed physical therapist.
- (bb) Plan of Care - an individualized written plan of care which serves as the fundamental tool by which the State ensures the health and welfare of Enrollees and which meets the requirements of paragraph (5) herein.
- (cc) Qualified Mental Retardation Professional (QMRP) - an individual who meets current federal standards, as published in the Code of Federal Regulations, for a qualified mental retardation professional.
- (dd) Reconsideration - the process by which the Administrative Lead Agency reviews and renders a decision regarding an Enrollee’s grievance of the denial of Waiver Services.
- (ee) Reevaluation - the annual process, as approved by the Bureau of TennCare, by which a Qualified Mental Retardation Professional assesses the Enrollee’s need for continued Waiver Services and certifies in writing that the Enrollee continues to require Waiver Services.
- (ff) Residential Habilitation - assistance, as specified in the Plan of Care, with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making, and household chores, eating and food preparation, and the social and adaptive skills necessary to enable the Enrollee to reside in a non-institutional setting.
- (gg) Respite Care - services, as specified in the Plan of Care, provided by an individual to an Enrollee on a temporary short-term basis for the purpose of relieving the family or caregiver.
- (hh) Safety Plan - an individualized plan by which the Administrative Lead Agency ensures the health, safety, and welfare of Enrollees who do not have 24-hour caregiver services and which

(Rule 1200-13-1-.25, continued)

meets the requirements of paragraph (5) herein. The Safety Plan shall be included with and part of the Plan of Care.

- (ii) Specialized Equipment and Supplies and Assistive Technology - assistive devices, adaptive aids, controls, or appliances, as specified in the Plan of Care, which enhance an Enrollee's ability to perform activities of daily living or to perceive, control, or communicate with the Enrollee's environment and to access the community.
- (jj) Speech, Hearing, and Language Services - physician-ordered speech and language services, as specified in the Plan of Care, which are provided in accordance with paragraph (2)(u) herein by a licensed speech language pathologist; and physician-ordered hearing services, as specified in the Plan of Care, which are provided in accordance with paragraph (2)(u) herein by a licensed audiologist.
- (kk) State Plan - the Medicaid State Plan as approved by the Health Care Financing Administration for the State of Tennessee.
- (ll) Subcontractor (Service Provider) - an individual, organized partnership, professional corporation, or other legal association or entity which enters into a written contract with the Administrative Lead Agency to provide Waiver Services to an Enrollee.
- (mm) Support Coordination - the process of facilitating an individualized planning process (the plan of care) and coordinating the activities of planning participants involved in the plan of care and service providers, on behalf of eligible persons and their families, to enable them to determine needed and desired supports and services. Support Coordination assists Enrollees and their families in identifying, locating, and accessing providers of supports and services, and arranging those services and supports in a cost-effective manner. Support Coordination monitors the delivery of supports and services to determine the extent to which the expectations and needs of the Enrollee are being met, including assisting Enrollees and their families in initiating actions and appeals if necessary to remedy inadequate or denied services, periodically reviewing and updating the Plan of Care, and providing assistance with rearranging service options as needed.
- (nn) Support Coordinator - the person who is responsible for developing the Support Plan and participating in the development of, and monitoring and assuring the implementation of, the Plan of Care; who provides Support Coordination services to an Enrollee; and who meets the qualifications for a Support Coordinator as specified in the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled.
- (oo) Supported Employment Services - paid employment, as specified in the Plan of Care, for Enrollees who, because of disability, need intensive ongoing support to perform in a work setting and who would be unlikely to obtain competitive employment at or above the minimum wage. Included are activities to obtain and sustain paid employment for Enrollees, including work site adaptations and coordination, supervision, and training when such activities are required beyond the level normally provided in the work site.
- (pp) Supported Living - services and supports, as specified in the Plan of Care, which enable an Enrollee to remain in a home under the control and responsibility of the Enrollee or the Enrollee's family or legal representative (rather than the provider of services and supports).
- (qq) Support Plan - an individualized written plan that identifies Enrollee preferences, capacities, needs, and resources and that identifies supports and services to meet such needs; and by which Enrollees and their families are assisted to access Waiver and other necessary services.

(Rule 1200-13-1-.25, continued)

- (rr) Transportation - Conveyance services, as specified in the Plan of Care, that provides an Enrollee with access to Waiver Services and community services, activities, and resources. Excluded are medical transportation services to and from health care providers.
  - (ss) Waiver - the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled, as approved by the Health Care Financing Administration for the State of Tennessee.
  - (tt) Waiver Eligibility Determination - the process by which the Bureau of TennCare determines that an applicant meets the requirements for enrollment in the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled, as listed in paragraph (3)(c) herein. The process shall include, but not be limited to, verifying whether an individual has been approved as Medicaid Eligible; whether the individual's habilitative, social, medical, and specialized services needs can be met through the Waiver; and whether an individual has an approved ICF/MR PreAdmission Evaluation (PAE).
  - (uu) Waiver Eligible - a Medicaid Eligible who has an ICF/MR PreAdmission Evaluation (PAE) that has been approved by the Bureau of TennCare or its designee and who meets the Waiver enrollment requirements of paragraph (3)(c) herein.
- (2) Waiver Services. Covered Waiver Services shall include the following:
- (a) Support Coordination.
    - 1. There must be at least one face-to-face Support Coordination visit per month with each Enrollee, and of these at least one face-to-face visit must occur in the Enrollee's home each quarter. In addition, all Support Coordination contacts with, or on behalf of, the Enrollee each month shall be documented in the Enrollee's record.
    - 2. The Administrative Lead Agency shall ensure that Support Coordination services shall be available to the Enrollee twenty-four (24) hours per day seven (7) days per week.
  - (b) Home Health Aide Services.
  - (c) Respite Care. May be provided by respite care providers in the following locations:
    - 1. Enrollee's home or place of residence
    - 2. Family-based living facility
    - 3. Group home
    - 4. Licensed respite care facility
    - 5. Home of an approved respite provider

Respite care providers may accompany an Enrollee on short outings for exercise, recreation, shopping or other purposes while providing respite care.
  - (d) Residential Habilitation.
  - (e) Day Habilitation. In special circumstances, day habilitation services may be provided in the Enrollee's home, when approved by the Administrative Lead Agency. Day habilitation services may also be provided, where appropriate, in community settings such as licensed day habilitation sites, businesses, public transportation, and recreational sites.



(Rule 1200-13-1-.25, continued)

- (f) Supported Employment. Supported employment services do not include services available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142.
- (g) Environmental Accessibility Adaptations.
- (h) Transportation.
- (i) Specialized Equipment and Supplies and Assistive Technology.
- (j) Family Education.
- (k) Community Participation.
- (l) Family-based Living.
- (m) Supported Living. The Enrollee, with the assistance of the Support Coordinator, family, or legal representative, shall select and control the Supported Living service provider(s).
- (n) Behavior Support.
- (o) Personal Assistance.
- (p) Enhanced Dental Services. Enhanced Dental Services shall not include dental services that would otherwise be covered through the State Plan or by a TennCare Managed Care Organization.
- (q) Nursing Services. Coverage is provided, when determined medically necessary, limited to direct face to face nursing services provided to an Enrollee by a registered nurse or a licensed practical nurse who is licensed in Tennessee. Excluded are nursing services provided in a hospital, nursing facility, Intermediate Care Facility for the Mentally Retarded, or other inpatient facility.
- (r) Nutrition Services. Coverage is provided, when determined medically necessary, limited to direct face to face nutrition services evaluations and re-evaluations of the Enrollee and nutrition counseling for the Enrollee and the caregiver who prepares meals for the Enrollee.
- (s) Physical Therapy. Extended State Plan coverage is provided, when determined to be medically necessary by the Administrative Lead Agency or by TennCare, limited to direct face to face physical therapy evaluations, re-evaluations, and therapeutic procedures for an Enrollee.
- (t) Occupational Therapy. Extended State Plan coverage is provided, when determined to be medically necessary by the Administrative Lead Agency or by TennCare, limited to direct face to face occupational therapy evaluations, re-evaluations, and therapeutic procedures for an Enrollee. Occupational therapy shall not include services funded under section 110 of the Rehabilitation Act of 1973.
- (u) Speech, Hearing, and Language Services.
  - 1. Speech and Language Services. Extended State Plan coverage is limited to direct face to face speech and language services evaluations, re-evaluations, and therapeutic procedures for an Enrollee when determined to be medically necessary by the Administrative Lead Agency or by TennCare.
  - 2. Hearing (Audiological) Services. Extended State Plan coverage is limited to direct face to face audiological services evaluations and re-evaluations for an Enrollee when

(Rule 1200-13-1-.25, continued)

determined to be medically necessary by the Administrative Lead Agency or by TennCare.

- (v) Personal Emergency Response Systems. Personal Emergency Response Systems shall be provided, as specified in the Safety Plan, for Enrollees:
    - 1. Who are alone for significant parts of the day and who would otherwise require extensive routine supervision; and
    - 2. Who, based on an assessment by the Administrative Lead Agency (or its designee) of the Enrollee's mental and physical capabilities, have the capability to effectively utilize such a system.
  - (w) Any other services approved by the Health Care Financing Administration for this waiver program.
- (3) Enrollment.
- (a) When an individual is determined to be likely to require the level of care provided by an ICF/MR, the Administrative Lead Agency shall inform the individual or the individual's legal representative of any feasible alternatives available under the Waiver and shall offer the choice of either institutional or Waiver Services. Notice to the individual shall contain:
    - 1. A simple explanation of the Waiver and Waiver Services;
    - 2. Notification of the opportunity to apply for enrollment in the Waiver and an explanation of the procedures for enrollment; and
    - 3. A statement that participation in the Waiver is voluntary.
  - (b) Enrollment in the Waiver shall be voluntary, but shall be restricted to the maximum number of individuals specified in the Waiver, as approved by the Health Care Financing Administration for the State of Tennessee.
  - (c) To be eligible for enrollment, an individual must meet all of the following criteria:
    - 1. The individual must, but for the provision of Waiver Services, require the level of care provided in an ICF/MR, and must meet the ICF/MR eligibility criteria specified in TennCare rule 1200-13-1-.15.
    - 2. The individual's habilitative, social, medical, and specialized services needs must be such that they can be effectively and safely met through the Waiver, as determined by the Administrative Lead Agency based on a pre-enrollment assessment.
    - 3. An ICF/MR PreAdmission Evaluation must be approved by the Bureau of TennCare or by its designee.
      - (i) The individual must have a psychological evaluation of need for care performed no more than twelve (12) calendar months before admission into the Waiver, unless the individual's condition has significantly changed, in which case a psychological exam performed within ninety (90) calendar days preceding the date of admission into the Waiver shall be required.

(Rule 1200-13-1-.25, continued)

- (ii) The ICF/MR PreAdmission Evaluation shall include the physician's initial plan of care which includes, but is not limited to, diagnoses and any orders for medications, diet, treatments, therapies, habilitative or rehabilitative services, or other physician-ordered services needed by the Enrollee and the amount, frequency, and duration of such services.
    - (iii) The individual's physician must certify on the ICF/MR PreAdmission Evaluation that the individual requires Waiver Services.
  - 4. An individual shall have one or more designated adult caregivers who shall be present in the individual's home on a daily basis to observe, evaluate, and provide caregiver services to ensure the health, safety, and welfare of the individual. The amount of time and the frequency that the caregiver is to be present in the individual's home shall be based on an assessment of the individual's habilitative, social, medical, functional, and specialized services needs and capabilities. The caregiver shall be present in the individual's home a reasonable amount of time each day; however, this requirement for caregiver services on a daily basis may be waived in certain circumstances in accordance with guidelines established by the Bureau of TennCare, including, but not limited to, the following:
    - (i) When the requirement for provision of caregiver services on a daily basis has been waived, a caregiver shall be present in the individual's home a reasonable amount of time a minimum of one day each week to observe, evaluate, and provide caregiver services to the individual; and
    - (ii) A written assessment of the individual's habilitative, social, medical, functional, and specialized services needs and capabilities and a written recommendation regarding the individual's capability of living independently without daily caregiver services shall be made by a team comprised of, at a minimum, the Independent Support Coordinator, a behavioral specialist or a psychologist, a licensed nurse, and an individual with knowledge of the individual's capability to live independently without caregiver services on a daily basis. Such assessment and any reassessments shall be incorporated in the individual's Safety Plan. When there is a change in the functional status of the individual that affects the individual's capability of living independently without daily caregiver services, the team shall reassess the individual and make a recommendation regarding caregiver services. Individuals participating in the assessment or reassessment shall sign and date the assessment and recommendation.
  - 5. An individual who does not have 24-hour-per-day caregiver services shall have an individualized Safety Plan, as described in paragraph (5) herein, that is based on an assessment of the individual's habilitative, social, medical, functional, and specialized services needs and capabilities and that is developed, approved, monitored, and updated as needed, but no less frequently than annually, by the Administrative Lead Agency.
  - 6. An individual must have a place of residence with an environment that is adequate to reasonably ensure the health, safety, and welfare of the Enrollee.
- (d) Enrollment of new Enrollees into the Waiver may be suspended when the average per capita fiscal year expenditure under the Waiver exceeds or is reasonably anticipated to exceed 100% of the average per capita expenditure that would have been made in the fiscal year if the care was provided in an ICF/MR.

(Rule 1200-13-1-.25, continued)

- (4) ICF/MR PreAdmission Evaluations and Transfer Forms.
- (a) An ICF/MR PreAdmission Evaluation is required for new admissions.
  - (b) A Transfer Form is required when an Enrollee having an approved unexpired ICF/MR PAE transfers from the Waiver to an ICF/MR or transfers from an ICF/MR to the Waiver.
  - (c) An Administrative Lead Agency that enrolls an individual without an approved ICF/MR PreAdmission Evaluation or, where applicable, an approved Transfer Form does so without the assurance of reimbursement. An Administrative Lead Agency that enrolls an individual who has not been determined by the Tennessee Department of Human Services to be financially eligible to have Medicaid make reimbursement for covered services does so without the assurance of reimbursement.
  - (d) The Administrative Lead Agency or its designee shall maintain in its files the original ICF/MR PreAdmission Evaluation and, where applicable, the original Transfer Form.
  - (e) An updated Safety Plan for Enrollees who do not have 24-hour caregiver services shall be required as an attachment to the ICF/MR PreAdmission Evaluation or Transfer Form.
- (5) Plan of Care.
- (a) Each Enrollee shall have an individualized written Plan of Care that shall be developed for an Enrollee within thirty (30) calendar days of admission into the Waiver. The following items, whether components of separate documents or a single consolidated document, shall in aggregate constitute the Plan of Care:
    - 1. The Enrollee's diagnoses;
    - 2. A list of the Enrollee's medications, including the dosage, frequency, and route of administration for each;
    - 3. The Enrollee's allergies;
    - 4. A description of any nutrition services or medically necessary special diets (e.g., low sodium diet) needed by the Enrollee;
    - 5. A description of the Enrollee's current health status and a description of any health care services (including but not limited to nursing services, home health aide or personal care services, psychological services, dental services, physical therapy, occupational therapy, and speech, hearing, and language services) needed by the Enrollee, specifying the amount, frequency (number of days per week), and duration (hours per day) of services and the type of provider to furnish each service;
    - 6. A description of any environmental accessibility adaptations, specialized equipment and supplies, or assistive technology needed by the Enrollee;
    - 7. The type of each caregiver - both paid and unpaid - and each caregiver's schedule, including the frequency (number of days per week) and duration (hours per day) of caregiver services to be provided each day, and site where services are to be provided. (This can be included as part of the Safety Plan, where applicable.);

(Rule 1200-13-1-.25, continued)

8. A description of any other Waiver Services and other supports and services, regardless of payment source, that the Enrollee requires to reside in the community as an alternative to care in an ICF/MR, including the amount, frequency (number of days per week), and duration (hours per day) of services and the type of provider to furnish each service;
9. A description of Enrollee preferences, functional and cognitive capabilities (strengths and needs), and resources or supports;
10. A description of the Enrollee's social environment and support system;
11. Names of primary care providers;
12. Outcomes;
13. Funding sources; and
14. A Safety Plan for Enrollees who do not have 24-hour caregiver services.

If the above items are maintained as components of separate documents rather than being included in a consolidated document, they shall be readily available for review by the Support Coordinator, the Team, the Administrative Lead Agency, and the Bureau of TennCare.

- (b) To ensure that Waiver Services and other services are being appropriately provided to meet the Enrollee's needs, the components of the Plan of Care specified in paragraph (5)(a) above shall be reviewed on an ongoing basis and shall be updated and signed in accordance with the following:
  1. The Support Coordinator shall review the components of the Plan of Care specified in paragraph (5)(a) above when needed, but no less frequently than once each calendar month, at intervals of not less than twenty-seven (27) days nor more than thirty-three (33) days, in order to update the Plan of Care. The Support Coordinator shall indicate that the components of the Plan of Care have been reviewed and updated by a dated signature indicating such, and the Administrative Lead Agency shall have written policies and procedures to assure such review by the Support Coordinator.
  2. Members of the Team (i.e., the Support Coordinator and other appropriate participants in the development of the Plan of Care) shall review the components of the Plan of Care specified in paragraph (5)(a) above when needed, but no less frequently than every twelve (12) calendar months, in order to update the Plan of Care. Members of the Team shall indicate that the components of the Plan of Care have been reviewed and updated by dated signatures indicating such, and the Administrative Lead Agency shall have written policies and procedures to assure such review by the Team. The annual review by members of the Team shall include, but not be limited to, reviewing outcomes and determining if progress is being made in accordance with the Plan of Care; reviewing the appropriateness of supports and services provided and their sources and discussing whether alternatives should be sought; and reviewing information related to observation, discussion, and assessment to determine further needs of the Enrollee.
- (c) The Safety Plan shall describe:
  1. The type of each caregiver - both paid and unpaid - who shall provide caregiver services in the Enrollee's home and, as needed, in other locations and each caregiver's schedule, including the frequency (number of days per week) and duration (hours per day) of

(Rule 1200-13-1-.25, continued)

- caregiver services to be provided each day, and the site where services are to be provided;
2. Other support services provided to the Enrollee;
  3. Any Personal Emergency Response Systems needed to enable Enrollees, who meet the requirements of (2)(v), to secure help in an emergency; and
  4. Other services, devices, and supports that ensure the health, safety, and welfare of the Enrollee.
- (d) Waiver Services shall be provided in accordance with the Enrollee's Plan of Care. Prior to the development of the initial Plan of Care, services shall be provided in accordance with the approved PreAdmission Evaluation and the physician's initial plan of care.
- (6) Reevaluation of Need for Continued Stay.
- (a) The Administrative Lead Agency shall perform a reevaluation of the Enrollee's need for continued stay in the Waiver within twelve (12) calendar months of the date of enrollment and at least annually thereafter. Annual reevaluation, documented in a format approved by the Bureau of TennCare, shall be performed by a physician or a Qualified Mental Retardation Professional.
  - (b) The Administrative Lead Agency shall maintain in its files for a minimum period of three (3) years a copy of the reevaluations of need for continued stay.
- (7) Physician Services.
- (a) The Administrative Lead Agency shall ensure that each Enrollee receives physician services as needed and that each Enrollee has a medical examination, documented in the Enrollee's record, in accordance with the following schedule:

<u>Age</u>	<u>Minimum frequency of medical examinations</u>
Up to age 21	In accordance with TennCare EPSDT periodicity standards
21-64	Every one (1) to three (3) years, as determined by the Enrollee's physician
Over age 65	Annually
  - (b) Any Enrollee service that requires a physician's order, including but not limited to waiver services, medications, special diets, or treatments, must be reordered by the physician as needed, but no less frequently than annually.
- (8) Voluntary Disenrollment. Voluntary disenrollment of an Enrollee from the Waiver may occur at any time upon written notice from the Enrollee or the Enrollee's legal representative to the Administrative Lead Agency. Prior to disenrollment the Administrative Lead Agency shall provide reasonable assistance to the Enrollee in locating appropriate alternative placement.
- (9) Involuntary Disenrollment.
- (a) An Enrollee may be involuntarily disenrolled from the Waiver for any of the following reasons:

(Rule 1200-13-1-.25, continued)

1. The Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled is terminated.
  2. An Enrollee becomes ineligible for Medicaid or is found to be erroneously enrolled in the Waiver.
  3. An Enrollee moves out of the state of Tennessee.
  4. The condition of the Enrollee improves such that the Enrollee no longer requires the level of care provided by the Waiver.
  5. The condition of the Enrollee deteriorates such that the habilitative, social, medical, and specialized services needs of the Enrollee cannot be met by the Waiver.
  6. The home or home environment of the Enrollee becomes unsafe to the extent that it would reasonably be expected that Waiver Services could not be provided without significant risk of harm or injury to the Enrollee or to individuals who provide covered services to the Enrollee.
  7. The Enrollee or the Enrollee's immediate family, guardian, or caregiver refuses to abide by the Plan of Care or related Waiver policies, resulting in the inability to ensure quality care or the health and safety of the Enrollee.
  8. The Enrollee no longer has a caregiver or the caregiver is unwilling or unable to provide services for the Enrollee, and the Enrollee refuses to have an alternate caregiver.
  9. The health, safety, and welfare of the Enrollee cannot be assured due to the lack of an approved Safety Plan.
- (b) If the individual is involuntarily disenrolled from the Waiver as outlined in paragraphs (9)(a)4.-9., the Administrative Lead Agency shall provide reasonable assistance to the Enrollee in locating appropriate alternative placement.
- (c) The Administrative Lead Agency shall notify the Bureau of TennCare in writing prior to involuntary disenrollment of an Enrollee.
- (d) The Administrative Lead Agency shall give notice to the Enrollee of the intended action and the Enrollee's right to a hearing pursuant to T.C.A. §71-5-113.
- (10) Administration of Services.
- (a) The Administrative Lead Agency shall be responsible for the delivery of Waiver Services to Enrollees and shall be responsible for the following related activities, whether provided directly or through subcontract, including, but not limited to:
1. Pre-enrollment assessment of the individual's habilitative, social, medical, and specialized services needs and appropriateness for placement in the Waiver;
  2. Annual reevaluations of the Enrollee's need for continued stay in the Waiver;
  3. Enrollment of Waiver Eligibles into the Waiver;
  4. Development, implementation, and monitoring of the Plan of Care and Support Plan;

(Rule 1200-13-1-.25, continued)

5. Coordinating and monitoring the total range of services for Enrollees, regardless of payment source;
  6. Initial certification by a physician of the Enrollee's need for care in an Intermediate Care Facility for the Mentally Retarded and annual reevaluations by a physician or a QMRP for continuing need for Waiver Services for the Enrollee;
  7. Supervision of support service staff;
  8. Ongoing monitoring of Enrollee and family situations and needs;
  9. Maintenance of comprehensive records and documentation of services provided to Enrollees;
  10. Expenditure and revenue reporting in accordance with state and federal requirements;
  11. Reimbursement of subcontractors;
  12. Marketing to potential Enrollees;
  13. Assurance of quality and accessible Waiver Services;
  14. Contacts with Enrollees, caretakers, and service providers in accordance with state and federal requirements;
  15. Assurance that each Enrollee has appropriate caregiver services provided in the Enrollee's home by one or more competent adult individuals;
  16. Assurance of the safety of the Enrollee through appropriate caregiver services, supervision, and other services and supports, as described in the Plan of Care;
  17. Assurance that Waiver Services are provided in accordance with Waiver guidelines as approved by the Bureau of TennCare;
  18. Compliance with the Bureau of TennCare appeal process;
  19. Provision of a plain language explanation of appeal rights to each Enrollee upon enrollment in the Waiver; and
  20. Requiring that any licensed facility in which the Enrollee resides must meet all applicable fire and safety codes.
- (11) Reimbursement of Administrative Lead Agency and Subcontractors.
- (a) The average per capita fiscal year expenditure under the Waiver shall not exceed 100% of the average per capita expenditure that would have been made in the fiscal year if care had been provided in an ICF/MR. The total Medicaid expenditure for Waiver Services and other Medicaid services provided to Enrollees shall not exceed 100% of the amount that would have been incurred in the fiscal year if care was provided in an ICF/MR.
  - (b) The Administrative Lead Agency shall be reimbursed for Waiver Services based on a rate per unit of service.
  - (c) In accordance with 42 CFR § 435.726, the Administrative Lead Agency shall make a diligent effort to collect patient liability if it applies to the Enrollee. The Administrative Lead Agency or



(Rule 1200-13-1-.25, continued)

- its designee shall complete appropriate forms showing the individual's amount of monthly income and shall submit them to the Tennessee Department of Human Services. The Tennessee Department of Human Services shall issue the appropriate forms to the Administrative Lead Agency and to the Bureau of TennCare's fiscal agent that processes and pays vendor claims, specifying the amount of patient liability to be applied toward the cost of care for the Enrollee.
- (d) The Administrative Lead Agency shall submit bills for services to the Bureau of TennCare's fiscal agent using a claim form approved by the Bureau of TennCare. On claim forms, the Administrative Lead Agency shall use a provider number assigned by the Bureau of TennCare.
  - (e) Reimbursement shall not be made to the Administrative Lead Agency for therapeutic leave or hospital leave for Enrollees in the Waiver.
  - (f) Reimbursement for Supported Living may be made for a portion of the rent and food that may be reasonably attributed to an unrelated live-in personal caregiver who resides in the same residence with the Enrollee and who provides approved Waiver Services. Reimbursement shall not be made for rent and food for a live-in personal caregiver if the Enrollee lives in the caregiver's home or in a residence that is owned or leased by the caregiver.
  - (g) Reimbursement for Residential Habilitation shall not be made for room and board, the cost of facility maintenance, upkeep and improvement (other than such costs for modifications or adaptations to a facility required to assure the health and safety of the Enrollees), or to meet the requirements of the applicable life safety code. Reimbursement for Residential Habilitation shall not be made for routine care and supervision which would be expected to be provided by a family or group home provider or for activities or supervision for which reimbursement is made by a source other than Medicaid. Also excluded from reimbursement for Residential Habilitation is any payment made directly or indirectly to members of the Enrollee's immediate family.
  - (h) Reimbursement for Specialized Equipment and Supplies and Assistive Technology may include evaluation, consultation, and training in the use of the equipment and supplies, maintenance and replacement of equipment, and modification and repairs not covered by the warranty. Items reimbursed with Waiver funds shall be in addition to any medical equipment and supplies furnished under the State Plan or not normally covered by the Enrollee's TennCare Managed Care Organization.
  - (i) Medicaid covered services other than those specified in the Waiver's scope of services shall be reimbursed by the Bureau of TennCare as otherwise provided for by federal and state rules and regulations.
  - (j) The Administrative Lead Agency shall be responsible for obtaining the physician's initial certification and subsequent Enrollee reevaluations. Failure to perform reevaluations in a timely manner and in the format approved by the Bureau of TennCare shall require a corrective action plan and shall result in partial or full recoupment of all amounts paid by the Bureau of TennCare during the time that reevaluation has lapsed.
  - (k) The Bureau of TennCare shall be responsible for defining and establishing the billing units to be used by the Administrative Lead Agency in billing for Waiver Services.
- (12) Subcontractors. The Administrative Lead Agency shall ensure that:
- (a) Direct services and medical equipment/supplies are provided by subcontractors who have signed contracts with the Administrative Lead Agency;

(Rule 1200-13-1-.25, continued)

- (b) Subcontractors comply with the quality assurance guidelines, as approved by the Health Care Financing Administration, and other state and federal standards, rules, and regulations affecting the provision of Waiver Services; and
  - (c) Subcontractors carry professional liability insurance (malpractice insurance), where applicable, and other appropriate insurance (e.g., auto insurance if Enrollees are being transported).
- (13) Reduction of Services. If the Enrollee's condition substantially improves, the Administrative Lead Agency and the Bureau of TennCare shall have the right to reduce Waiver Services.
- (14) Appeal Process. Where applicable, the Administrative Lead Agency shall provide an appeal process for Enrollees which shall comply with TennCare rule 1200-13-12-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits.

**Authority:** T.C.A. §§4-5-202, 71-5-105, 71-5-109, and Executive Order No. 23. **Administrative History:** Original rule filed July 6, 2001; effective September 19, 2001.

**1200-13-1-.26 HOME AND COMMUNITY BASED SERVICES WAIVER FOR THE ELDERLY AND DISABLED IN DAVIDSON, HAMILTON, AND KNOX COUNTIES.**

- (1) Definitions. The following definitions shall apply for interpretation of this rule:
- (a) Administrative Lead Agency - the approved agency or agencies with which the Bureau of TennCare contracts for the provision of covered services through the Home and Community Based Services Waiver for the Elderly and Disabled in Davidson, Hamilton, and Knox Counties.
  - (b) Bureau of TennCare - the administrative unit of TennCare which is responsible for the administration of TennCare.
  - (c) Caregiver - one or more adult individuals who sign an agreement with the Administrative Lead Agency to provide services to the Enrollee as outlined in paragraphs (5) and (6) to meet the needs of the Enrollee during the hours when Waiver Services are not being provided by the Administrative Lead Agency.
  - (d) Case Management - standardized process of screening potential applicants to determine if they meet the requirements for enrollment in the Waiver; of assessing an Enrollee's medical, functional, and social needs; of developing, implementing, monitoring, and updating a goal-oriented Individual Plan of Care, including a Safety Plan, that is based on the Enrollee's needs; of arranging and coordinating the provision of Waiver Services and other services regardless of payment source; of evaluating and reevaluating the Enrollee's level of care; and of monitoring the provision of services to assure that Waiver Services and other services are being provided to meet the Enrollee's needs.
  - (e) Case Management Team - the multi-disciplinary team of health care professionals that assesses an Enrollee's medical, functional, and social needs after enrollment in the Waiver and develops, monitors, and periodically updates a goal-oriented Individual Plan of Care based on the Enrollee's needs. The multi-disciplinary team shall be composed of the Case Manager, a physician, a registered nurse, a social worker, and other appropriate health care professionals.
  - (f) Case Manager - the person who is responsible for screening potential applicants to determine if they meet the requirements for enrollment in the Waiver; overseeing the development, implementation, and monitoring of an Individual Plan of Care based on the Enrollee's medical, functional, and social needs and the Safety Plan; coordinating the provision of Waiver Services and other services regardless of payment source, including securing appropriate service

(Rule 1200-13-1-.26, continued)

providers; and monitoring to assure that appropriate Waiver Services and other services are being provided; and documenting case management activities.

- (g) Centers for Medicare and Medicaid Services (CMS) (formerly known as HCFA) - the agency within the United States Department of Health and Human Services that is responsible for administering Title XVIII, Title XIX, and Title XXI of the Social Security Act.
- (h) Certification - the process by which a physician, who is licensed as a doctor of medicine or doctor of osteopathy, signs and dates a PreAdmission Evaluation signifying that the individual requires services provided through the Home and Community Based Services Waiver for the Elderly and Disabled in Davidson, Hamilton, and Knox Counties as an alternative to care in a Nursing Facility.
- (i) Department - the Tennessee Department of Finance and Administration.
- (j) Denial - as used in regard to Waiver Services, the term shall mean the termination, suspension, delay, or reduction in amount, scope, and duration of a Waiver Service or a refusal or failure to provide such service.
- (k) Disenrollment - the voluntary or involuntary termination of enrollment in the Waiver of an individual receiving services through the Home and Community Based Services Waiver for the Elderly and Disabled in Davidson, Hamilton, and Knox Counties.
- (l) Enrollee - a Medicaid Eligible who is enrolled in the Home and Community Based Services Waiver for the Elderly and Disabled in Davidson, Hamilton, and Knox Counties.
- (m) Home (of an Enrollee) - the residence or dwelling in which the Enrollee resides in Davidson, Hamilton, or Knox County, Tennessee, excluding hospitals, nursing facilities, Intermediate Care Facilities for the Mentally Retarded, Assisted Living Facilities, and Homes for the Aged (Residential Homes for the Aged).
- (n) Home and Community Based Services Waiver for the Elderly and Disabled in Davidson, Hamilton, and Knox Counties - the Home and Community Based Services waiver project approved for Tennessee by the Centers for Medicare and Medicaid Services to provide services to a specified number of Medicaid-eligible individuals who reside in Davidson, Hamilton, or Knox County in Tennessee, who are aged or disabled, and who meet the Medicaid criteria for placement in a Nursing Facility.
- (o) Home Delivered Meals - nutritionally well-balanced meals, other than those provided under Title III C-2 of the Older Americans Act, that provide at least one third but no more than two-thirds of the current daily Recommended Dietary Allowance (as estimated by the Food and Nutrition Board of Sciences - National Research Council) and that will be served in the Enrollee's home. Special diets shall be provided in accordance with the Individual Plan of Care when ordered by the Enrollee's physician.
- (p) Individual Plan of Care - an individualized written plan of care which serves as the fundamental tool by which the State ensures the health and welfare of Enrollees and which meets the requirements of paragraph (8) herein.
- (q) Medicaid Eligible - an individual who has been determined by the Tennessee Department of Human Services to be financially eligible to have TennCare make reimbursement for covered services.

(Rule 1200-13-1-.26, continued)

- (r) Minor Home Modifications - the provision and installation of certain home mobility aids (e.g., ramps, rails, non-skid surfacing, grab bars, and other devices and minor home modifications which facilitate mobility) and modifications to the home environment to enhance safety. Excluded are those adaptations or improvements to the home which are of general utility and which are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.
- (s) Nursing Facility - a Medicaid-certified nursing facility approved by the Bureau.
- (t) Personal Care Services - services provided to assist the Enrollee with activities of daily living, household tasks, and other activities that enable the Enrollee to remain in the home, as an alternative to Nursing Facility care, including the following:
  - 1. Assistance with activities of daily living (e.g., bathing, grooming, personal hygiene, toileting, feeding, dressing, ambulation);
  - 2. Assistance with routine household tasks (e.g., meal preparation; laundry essential to the comfort and cleanliness of the Enrollee; and cleaning essential to the health and welfare of the Enrollee);
  - 3. Performance of errands essential to the Enrollee's care (e.g., grocery shopping, paying bills, having prescriptions filled, serving as a companion or escort for Enrollees unable to access transportation to medical appointments alone); and
  - 4. Assistance with maintenance of a safe environment
- (u) Personal Emergency Response Systems (PERS) - electronic devices which enable certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. PERS services are limited to those individuals who are alone for significant parts of the day, who have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.
- (v) Physician's Plan of Care - an individualized written plan of care developed by the Enrollee's physician and included on the PreAdmission Evaluation and reviewed as needed or at least every ninety (90) days.
- (w) PreAdmission Evaluation (PAE) - a process of assessment approved by the Bureau of TennCare and used to document an individual's current medical condition and eligibility for care in a Nursing Facility.
- (x) PreAdmission Screening/Annual Resident Review (PASARR) - the process by which the State determines whether an individual who resides in or seeks admission to a Medicaid-certified Nursing Facility has, or is suspected of having, mental illness or mental retardation, and, if so, whether the individual requires specialized services.
- (y) Recertification - the process approved by the Bureau of TennCare by which the Enrollee's physician assesses the medical necessity of continuation of Waiver Services and certifies in writing that the Enrollee continues to require Waiver Services.

(Rule 1200-13-1-.26, continued)

- (z) Safety Plan - an individualized plan by which the Administrative Lead Agency ensures the health, safety, and welfare of Enrollees who do not have 24-hour caregiver services and which meets the requirements of (5)(c)4.
  - (aa) Screening - the process by which the Administrative Lead Agency determines that an applicant meets the requirements for enrollment in the Home and Community Based Services Waiver for the Elderly and Disabled in Davidson, Hamilton, and Knox Counties. The screening process shall include verifying whether an individual is Medicaid eligible; whether the individual resides in Davidson, Hamilton, or Knox County in Tennessee; whether an individual is eligible for care in a Nursing Facility; whether an individual with an approved PreAdmission Evaluation is eligible for Waiver Services; whether the individual's medical, functional, and social needs can be met through the Waiver; and whether there is a caregiver available.
  - (bb) Subcontractor - an individual, organized partnership, professional corporation, or other legal association or entity which enters into a written contract with the Administrative Lead Agency to provide Waiver Services to an Enrollee.
  - (cc) 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.
  - (dd) Waiver - the Home and Community Based Services Waiver for the Elderly and Disabled in Davidson, Hamilton, and Knox Counties, as approved by the Centers for Medicare and Medicaid Services for the State of Tennessee.
  - (ee) Waiver Eligible - a Medicaid eligible who has a PreAdmission Evaluation that has been approved by the Bureau of TennCare for nursing facility level of care and who resides in Davidson, Hamilton, or Knox County in Tennessee.
  - (ff) Waiver Services - covered services provided through the Home and Community Based Services Waiver for the Elderly and Disabled in Davidson, Hamilton, and Knox Counties, as approved by the Centers for Medicare and Medicaid Services for the State of Tennessee.
- (2) Waiver Services. Covered Waiver Services shall include the following:
- (a) Case Management. All case management contacts shall be documented in the Enrollee's medical record and shall include two face-to-face visits per month, one by a registered nurse and one by a social worker, with the Enrollee in the Enrollee's home. Such monthly documentation shall note that the Individual Plan of Care has been reviewed.
  - (b) Home-delivered Meals.
    - 1. The Administrative Lead Agency shall ensure that providers of home meals are properly licensed or certified by the appropriate regulatory authority and shall require that such providers comply with all laws, ordinances, and codes regarding preparation, handling, and delivery of food.
    - 2. For those Enrollees who require medically prescribed diets, the Administrative Lead Agency shall ensure that such meals are planned by a registered dietitian who provides consultation to the licensed nurse supervising the Enrollee's care.
  - (c) Minor Home Modifications.
    - 1. Minor home modifications shall not be provided unless specified in the Individual Plan of Care. The Administrative Lead Agency shall notify the Bureau of TennCare and obtain

(Rule 1200-13-1-.26, continued)

prior authorization for minor home modifications exceeding \$6,000 prior to initiating the intended modification.

2. The Bureau of TennCare shall be the payor of last resort for minor home modifications.

(d) Personal Care Services.

1. Personal care aides shall meet the standards of education and training required by the State of Tennessee for certification as a certified nurse aide or the standards of education and training for a home health aide required by TennCare.

2. The Administrative Lead Agency shall ensure that personal care services are accurately and timely documented.

3. The personal care aide shall report to the Case Manager any significant changes in the Enrollee's physical or mental status.

(e) Personal Emergency Response Systems. Personal Emergency Response Systems shall be provided, as specified in the Individual Plan of Care and Safety Plan, for Enrollees:

1. Who receive daily caregiver services but who are alone for significant parts of the day and who would otherwise require extensive routine supervision; and

2. Who, based on an assessment by the Administrative Lead Agency of the Enrollee's mental and physical capabilities, have the capability to effectively utilize such a system.

(3) Documentation of Waiver Services.

(a) The Administrative Lead Agency shall ensure that all services are accurately and timely documented.

(b) Documentation of Waiver services must adequately demonstrate that services are provided in accordance with the individual plan of care and the approved waiver service definitions.

(4) Notification. Upon approval of a PreAdmission Evaluation for Nursing Facility care for an individual residing in the approved geographic service area, the Bureau shall provide the individual with the following:

(a) A simple explanation of the Waiver and Waiver Services;

(b) Notice of the opportunity to apply for enrollment in the Waiver and an explanation of the enrollment process; and

(c) A statement that participation in the Waiver program is voluntary.

(5) Enrollment.

(a) When an individual is determined to be likely to require the level of care provided by a Nursing Facility, the Administrative Lead Agency shall inform the individual or the individual's legal representative of all feasible alternatives available under the Waiver and shall offer the choice of either Nursing Facility or Waiver Services.

(b) Enrollment in the Waiver shall be voluntary and open to all Waiver Eligibles who reside in Davidson, Hamilton, or Knox County in Tennessee, but shall be restricted to the maximum number of individuals specified in the Waiver, as approved by the Centers for Medicare and

(Rule 1200-13-1-.26, continued)

Medicaid Services for the State of Tennessee. Enrollment may also be restricted if sufficient funds are not appropriated by the legislature to support full enrollment.

- (c) To be eligible for enrollment, an individual must meet all of the following criteria:
1. The individual must be Medicaid Eligible, must meet the Nursing Facility eligibility criteria specified in TennCare Rule 1200-13-1-.10, and must have a PreAdmission Evaluation approved by the Bureau of TennCare.
    - (i) The PreAdmission Evaluation shall include the physician's initial plan of care which includes, but is not limited to, diagnoses and any orders for medications, diet, activities, treatments, therapies, restorative and rehabilitative services, or other physician-ordered services needed by the Enrollee.
    - (ii) The individual's physician must certify on the PreAdmission Evaluation that the individual requires Waiver Services.
  2. The individual's medical, functional, and social needs must be such that they can be effectively and safely met through the Waiver, as determined by the Administrative Lead Agency based on a pre-enrollment screening.
  3. An individual shall have one or more caregivers, as specified in (6)(a), designated to provide caregiver services each day in the Enrollee's home and, as needed, in other locations to ensure the health, safety, and welfare of the Enrollee. An individual shall have 24-hour caregiver services unless it is determined by an assessment that the needs of the individual can be met, and that the health, safety, and welfare of the individual can be assured, through the provision of daily (but less than 24-hour) caregiver services and through provision of a Personal Emergency Response System. Documentation of such assessment shall be included in an individualized Safety Plan that is developed, reviewed, and updated by the Administrative Lead Agency. If it is so determined that the health, safety, and welfare of the individual can be assured without 24-hour caregiver services, the individual shall have caregiver services provided for some portion of the day each day.
  4. An individual who does not have 24-hour caregiver services shall have an individualized Safety Plan that is based on an assessment of the individual's medical, functional, and social needs and capabilities and that is approved, monitored, and updated as needed, but no less frequently than annually, by the Administrative Lead Agency. The Safety Plan shall describe:
    - (i) The medical, functional, and social needs and capabilities of the individual and how such can be met without jeopardizing the health, safety, and welfare of the individual;
    - (ii) The type and schedule of caregiver services to be provided each day, specifying hours per day and number of days per week;
    - (iii) Personal Emergency Response Systems which are designed to enable Enrollees, who meet the requirements of (2)(e), to secure help in an emergency; and
    - (iv) Other services, devices, and supports that ensure the health, safety, and welfare of the Enrollee.

(Rule 1200-13-1-.26, continued)

5. All homes must provide an environment adequate to reasonably ensure the health, safety, and welfare of the Enrollee.
  - (d) An individual who is capable of living alone or independently without Waiver Services shall not be eligible for enrollment or continued enrollment in the Waiver.
  - (e) Enrollment of new Enrollees into the Waiver may be suspended when the average per capita fiscal year expenditure under the Waiver exceeds or is reasonably anticipated to exceed 100% of the average per capita expenditure that would have been made in the fiscal year if the care was provided in a Nursing Facility.
- (6) Caregiver.
- (a) Caregiver services shall be provided by one or more adult individuals aged 18 or older who sign an agreement with the Administrative Lead Agency to provide the following services to the Enrollee, as well as any additional services outlined in the Individual Plan of Care and the Safety Plan, to meet the needs of the Enrollee during the hours when Waiver Services are not being provided by the Administrative Lead Agency:
    1. Assistance with grooming, bathing, feeding, and dressing;
    2. Assistance with medications that are ordinarily self-administered;
    3. Assistance with ambulation as needed;
    4. Household services essential to health care and maintenance in the home;
    5. Meal preparation; and
    6. Any other assistance necessary to support the Enrollee's activities of daily living.
  - (b) One or more caregivers shall be available full time or part time each day in the Enrollee's home, as determined appropriate by the Administrative Lead Agency and as specified in the Individual Plan of Care and the Safety Plan, to provide care to the Enrollee. Enrollees who do not have a 24-hour caregiver shall have a Personal Emergency Response System and shall be mentally and physically capable of using it based on an assessment by the Administrative Lead Agency.
- (7) PreAdmission Evaluations, Transfer Forms, and PASARR Assessments.
- (a) A PreAdmission Evaluation is required when a Medicaid Eligible is admitted to the Waiver.
  - (b) A Transfer Form is required in the following circumstances:
    1. When an Enrollee having an approved unexpired PreAdmission Evaluation transfers from the Waiver to Level 1 care in a Nursing Facility.
    2. When an Enrollee having an approved unexpired PreAdmission Evaluation transfers from one Home and Community Based Services Waiver for the Elderly and Disabled to a different Home and Community Based Services Waiver for the Elderly and Disabled.
    3. When a Waiver Eligible with an approved unexpired PreAdmission Evaluation transfers from a Nursing Facility to the Waiver.
  - (c) A Level I PASARR assessment for mental illness and mental retardation is required when an Enrollee with an approved unexpired PreAdmission Evaluation transfers from the Waiver to a



(Rule 1200-13-1-.26, continued)

Nursing Facility. A Level II PASARR evaluation is required if a history of mental illness or mental retardation is indicated by the Level I PASARR assessment, unless criteria for exception are met.

- (d) An Administrative Lead Agency that enrolls an individual without an approved PreAdmission Evaluation or, where applicable, an approved Transfer Form does so without the assurance of reimbursement. An Administrative Lead Agency that enrolls an individual who has not been determined by the Tennessee Department of Human Services to be financially eligible to have Medicaid make reimbursement for covered services does so without the assurance of reimbursement. If an Administrative Lead Agency enrolls a Medicaid Eligible without an approved PreAdmission Evaluation, the individual must be informed by the Administrative Lead Agency that Medicaid reimbursement will not be paid until and unless the PreAdmission Evaluation is approved.
  - (e) The Administrative Lead Agency shall maintain in its files the original PreAdmission Evaluation and, where applicable, the original Transfer Form.
  - (f) An updated Safety Plan for Enrollees who do not have 24-hour caregiver services shall be required as an attachment to the PreAdmission Evaluation or Transfer Form.
- (8) Individual Plan of Care.
- (a) The Individual Plan of Care shall be an individualized written plan of care that specifies the services designed to meet the medical, functional, and social needs of the Enrollee and that includes, but is not limited to, the following Enrollee information:
    - 1. Diagnoses;
    - 2. A description of Waiver Services and any other services regardless of payment source, including caregiver services, that the Enrollee requires to reside in the community as an alternative to care in a Nursing Facility, including the amount (specific number of hours or units per day rather than a range), frequency (number of days per week), and duration (length of time needed) of services and the type of provider to furnish each service;
    - 3. Outcome objectives;
    - 4. Any treatments, therapies, activities, social services, rehabilitative services, nursing related services, home health aide services, specialized equipment, medications (including dosage, frequency, and route of administration), diet, and other services needed by the Enrollee;
    - 5. The names of each caregiver and each caregiver's schedule, including the amount (specific number of hours per day) and frequency (number of days per week) of caregiver services and provisions for alternate caregivers; and
    - 6. A Safety Plan for Enrollees who do not have 24-hour caregiver services.
  - (b) Within thirty (30) working days after enrollment, the Case Management Team shall review the Physician's Plan of Care and shall develop the Individual Plan of Care. Within ten (10) working days of completion of the Individual Plan of Care, the Administrative Lead Agency shall review and approve the Individual Plan of Care.
  - (c) The Individual Plan of Care shall be periodically reviewed to ensure that the Waiver Services furnished are consistent with the nature and severity of the Enrollee's disability and to

(Rule 1200-13-1-.26, continued)

determine the appropriateness and adequacy of care and achievement of outcome objectives outlined in the Individual Plan of Care. The minimum schedule for reviews shall be as follows:

1. The Individual Plan of Care shall be reviewed by a registered nurse and a social worker -- one of whom shall be the Case Manager -- as needed, but no less frequently than every thirty (30) calendar days.
  2. The Individual Plan of Care shall be reviewed and signed by the Case Management Team as needed, but no less frequently than annually. The attending physician is not required to sign the Individual Plan of Care if current signed physician orders are included with the Individual Plan of Care.
- (d) Waiver Services shall be provided in accordance with the Enrollee's Individual Plan of Care.
- (9) Physician Services.
- (a) The Enrollee's attending physician or other licensed physician shall write new orders for the Enrollee as needed, and, at a minimum, every ninety (90) calendar days.
  - (b) The Administrative Lead Agency shall ensure that each Enrollee receives physician services as needed, and, at a minimum, an annual medical examination or physician visit, and shall document such in the Enrollee's record.
- (10) Reevaluation and Recertification of Need for Continued Stay.
- (a) The Administrative Lead Agency shall perform reevaluations of the Enrollee's need for continued stay in the Waiver within 365 calendar days of the date of enrollment and at least annually thereafter.
  - (b) Recertifications, documented in a format approved by the Bureau of TennCare, shall be performed by the Enrollee's physician within 365 calendar days of the initial certification date and at least annually thereafter. The Administrative Lead Agency shall maintain in its files a copy of the recertification of need for continued stay.
- (11) Voluntary Disenrollment.
- (a) Voluntary disenrollment of an Enrollee from the Waiver may occur at any time upon written notice from the Enrollee or the Enrollee's legal representative to the Administrative Lead Agency. A Level I PASARR assessment for mental illness and mental retardation is required when an Enrollee transfers to a Nursing Facility. If the Level I PASARR assessment indicates the need for a PASARR Level II assessment of need for specialized services for mental illness or mental retardation, the Enrollee must undergo the PASARR Level II assessment. Prior to disenrollment the Administrative Lead Agency shall assist the Enrollee in locating a facility providing the appropriate level of care and in transferring the Enrollee to such facility.
  - (b) If the Enrollee's medical condition or social environment deteriorates such that the medical, functional, and social needs cannot be met by the Waiver, the Enrollee or the Enrollee's legal representative may request disenrollment from the Waiver. The Administrative Lead Agency shall assist the individual with placement in the appropriate level of care.
  - (c) Upon voluntary disenrollment from the Waiver, the individual shall be entitled to receive Medicaid covered services only if still eligible for Medicaid.

(Rule 1200-13-1-.26, continued)

(12) Involuntary Disenrollment.

- (a) An Enrollee may be involuntarily disenrolled from the Waiver for any of the following reasons:
1. The Home and Community Based Services Waiver for the Elderly and Disabled in Davidson, Hamilton, and Knox Counties is terminated.
  2. An Enrollee becomes ineligible for Medicaid or is found to be erroneously enrolled in the Waiver.
  3. An Enrollee moves out of the geographic service area (i.e., Davidson, Hamilton, and Knox Counties in Tennessee).
  4. The condition of the Enrollee improves such that the Enrollee no longer requires the level of care provided by the Waiver.
  5. The condition of the Enrollee deteriorates such that the medical, functional, and social needs of the Enrollee cannot be met by the Waiver.
  6. The home or home environment of the Enrollee becomes unsafe to the extent that it would reasonably be expected that Waiver Services could not be provided without significant risk of harm or injury to the Enrollee or to individuals who provide covered services to the Enrollee.
  7. The Enrollee no longer has a caregiver, as defined herein, or the caregiver is unwilling or unable to provide services needed by the Enrollee, and an alternate caregiver cannot be arranged.
  8. The Enrollee or the Enrollee's caregiver refuses to abide by the Individual Plan of Care, the Physician's Plan of Care, or related Waiver policies, resulting in the inability of the Waiver to assure quality care.
  9. A provider of Waiver Services is unwilling or unable to continue to provide services and an appropriate alternate service provider cannot be arranged.
  10. The health, safety, and welfare of the Enrollee cannot be assured due to the lack of an approved Safety Plan or an approved Individual Plan of Care, or the continuing need for Waiver Services is not recertified by the Enrollee's physician.
- (b) If the individual is involuntarily disenrolled from the Waiver, the Administrative Lead Agency shall assist the Enrollee in locating a Nursing Facility or other alternative providing the appropriate level of care and in transferring the Enrollee. A Level I PASARR assessment for mental illness and mental retardation is required when an Enrollee transfers to a Nursing Facility. If the Level I PASARR assessment indicates the need for a PASARR Level II assessment of need for specialized services for mental illness or mental retardation, the Enrollee must undergo the PASARR Level II assessment.
- (c) The Administrative Lead Agency shall notify the Bureau of TennCare in writing a minimum of 2 working days prior to issuing involuntary disenrollment notice to an Enrollee.
- (d) Waiver Services shall continue until the date of discharge of the Enrollee from the Waiver.

(Rule 1200-13-1-.26, continued)

- (e) The Administrative Lead Agency shall provide an Enrollee written advance notice of involuntary disenrollment with an explanation of the Enrollee's right to a hearing pursuant to T.C.A. §71-5-113.
- (13) Reduction of Services. If the Enrollee's condition substantially improves, the Administrative Lead Agency and the Bureau of TennCare shall have the right to reduce Waiver Services.
- (14) Administration of Services. The Administrative Lead Agency shall be responsible for the delivery of Waiver Services to Enrollees and shall perform related activities including, but not limited to, the following:
  - (a) Pre-enrollment screening of individuals, including assessment of the individual's medical, functional, and social capabilities and needs and appropriateness for placement in the Waiver and an assessment of the ability of the caregiver to care for the Enrollee in the home setting;
  - (b) Annual reevaluations of the Enrollee's need for continued stay in the Waiver;
  - (c) Enrollment of Waiver Eligibles into the Waiver after screening;
  - (d) Development, implementation, and monitoring of the Individual Plan of Care, including the Safety Plan if a Safety Plan is required;
  - (e) Coordinating and monitoring the total range of services for Enrollees, regardless of payment source;
  - (f) Initial certification by the Enrollee's physician of the Enrollee's need for care in a Nursing Facility and annual recertification of the medical necessity of the continuation of Waiver Services for the Enrollee;
  - (g) Supervision of support service staff;
  - (h) Ongoing monitoring of Enrollee and family situations and needs;
  - (i) Maintenance of comprehensive medical records and documentation of services provided to Enrollees;
  - (j) Expenditure and revenue reporting in accordance with state and federal requirements;
  - (k) Reimbursement of subcontractors;
  - (l) Marketing to potential Enrollees;
  - (m) Assurance of quality and accessible Waiver services which are provided in accordance with State and Federal Waiver rules, regulations, policies and definitions;
  - (n) Contacts with Enrollees, caregivers, and service providers in accordance with state and federal requirements;
  - (o) Assurance that each Enrollee has appropriate caregiver services provided each day in the Enrollee's home by one or more competent adult individuals who sign an agreement with the Administrative Lead Agency;
  - (p) Assurance of the safety of the Enrollee through appropriate caregiver services, supervision, and other services and supports, as described in the Individual Plan of Care and the Safety Plan;

(Rule 1200-13-1-.26, continued)

- (q) Implementation of an appeals process approved by the Bureau of TennCare, including provision of expert testimony by appropriate professionals during contested case hearings; and
  - (r) Compliance with all applicable rules of the Tennessee Medicaid Program.
- (15) Reimbursement of Administrative Lead Agency and Subcontractors.
- (a) The average per capita fiscal year expenditure under the Waiver shall not exceed 100% of the average per capita expenditure that would have been made in the fiscal year if care was provided in a Nursing Facility. The total Medicaid expenditure for Waiver Services and other Medicaid services provided to Enrollees shall not exceed 100% of the amount that would have been incurred in the fiscal year if care was provided in a Nursing Facility.
  - (b) The Administrative Lead Agency shall be reimbursed for Waiver Services based on a rate per unit of service. Upon approval by the Department, reimbursement shall include annual cost settlement as determined by the Tennessee Office of the Comptroller.
  - (c) In accordance with 42 CFR § 435.726, the Administrative Lead Agency shall make a diligent effort to collect patient liability if it applies to the Enrollee. The Administrative Lead Agency shall complete appropriate forms showing the individual's amount of monthly income and shall submit them to the Tennessee Department of Human Services. The Tennessee Department of Human Services shall issue the appropriate forms to the Administrative Lead Agency and to the Bureau of TennCare's fiscal agent, specifying the amount of patient liability to be applied toward the cost of care for the Enrollee.
  - (d) The Administrative Lead Agency shall submit bills for services to the Bureau of TennCare's fiscal agent using a claim form approved by the Bureau of TennCare. On claim forms, the Administrative Lead Agency shall use a provider number assigned by the Bureau of TennCare.
  - (e) Reimbursement shall not be made to the Administrative Lead Agency on behalf of Enrollees for therapeutic leave or fifteen-day hospital leave normally available to Nursing Facility patients pursuant to rule 1200-13-1-.06(4).
  - (f) Medicaid covered services other than those specified in the Waiver's scope of services shall be reimbursed by the Bureau of TennCare as otherwise provided for by federal and state rules and regulations.
  - (g) The Administrative Lead Agency shall be responsible for obtaining the physician's initial certification and subsequent recertifications. Failure to perform recertifications in a timely manner and in the format approved by the Bureau of TennCare shall require a corrective action plan and shall result in full or partial recoupment of all amounts paid by the Bureau of TennCare during the time that recertification has lapsed.
- (16) Subcontractors.
- (a) The Administrative Lead Agency shall ensure that:
    - 1. Services are provided by subcontractors who have signed contracts with the Administrative Lead Agency;
    - 2. Subcontractors comply with the Quality Assurance Guidelines and other state and federal standards, rules, and regulations affecting the provision of Waiver Services; and
    - 3. Subcontractors carry appropriate professional liability insurance and other insurance (e.g., auto insurance if Enrollees are being transported).

(Rule 1200-13-1-.26, continued)

- (b) Contracts between the Administrative Lead Agency and subcontractors for the provision of Waiver Services shall be subject to written approval from the Bureau of TennCare.
- (17) Appeal Process. Where applicable, the Administrative Lead Agency shall provide an appeal process for Enrollees which shall comply with TennCare rule 1200-13-13-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits.

**Authority:** T.C.A. §§4-5-202, 71-5-105, 71-5-109, and Executive Order No. 23. **Administrative History:** Original rule filed July 28, 2004; effective October 11, 2004.

**1200-13-1-.27 HOME AND COMMUNITY BASED SERVICES WAIVER FOR THE ELDERLY AND DISABLED IN SHELBY COUNTY.**

- (1) Definitions. The following definitions shall apply for interpretation of this rule:
  - (a) Administrative Lead Agency - the approved agency with which the Bureau of TennCare contracts for the provision of covered services through the Home and Community Based Services Waiver for the Elderly and Disabled in Shelby County.
  - (b) Bureau of TennCare - the administrative unit of TennCare which is responsible for the administration of TennCare.
  - (c) Caregiver - one or more adult individuals who sign an agreement with the Administrative Lead Agency to provide services to the Enrollee as outlined in paragraphs (5) and (6) to meet the needs of the Enrollee during the hours when Waiver Services are not being provided by the Administrative Lead Agency.
  - (d) Case Management - standardized process of screening potential applicants to determine if they meet the requirements for enrollment in the Waiver; of assessing an Enrollee's medical, functional, and social needs; of developing, implementing, monitoring, and updating a goal-oriented Individual Plan of Care, including a Safety Plan, that is based on the Enrollee's needs; of arranging and coordinating the provision of Waiver Services and other services regardless of payment source; of evaluating and reevaluating the Enrollee's level of care; and of monitoring the provision of services to assure that Waiver Services and other services are being provided to meet the Enrollee's needs.
  - (e) Case Management Team - the multi-disciplinary team of health care professionals that assesses an Enrollee's medical, functional, and social needs after enrollment in the Waiver and develops, monitors, and periodically updates a goal-oriented Individual Plan of Care based on the Enrollee's needs. The multi-disciplinary team shall be composed of the Case Manager, a physician, a registered nurse, a social worker, and other appropriate health care professionals.
  - (f) Case Manager - the person who is responsible for screening potential applicants to determine if they meet the requirements for enrollment in the Waiver; overseeing the development, implementation, and monitoring of an Individual Plan of Care based on the Enrollee's medical, functional, and social needs and the Safety Plan; coordinating the provision of Waiver Services and other services regardless of payment source, including securing appropriate service providers; and monitoring to assure that appropriate Waiver Services and other services are being provided; and documenting case management activities.
  - (g) Centers for Medicare and Medicaid Services (CMS) (formerly known as HCFA) - the agency within the United States Department of Health and Human Services that is responsible for administering Title XVIII, Title XIX, and Title XXI of the Social Security Act.

(Rule 1200-13-1-.27, continued)

- (h) Certification - the process by which a physician, who is licensed as a doctor of medicine or doctor of osteopathy, signs and dates a PreAdmission Evaluation signifying that the individual requires services provided through the Home and Community Based Services Waiver for the Elderly and Disabled in Shelby County as an alternative to care in a Nursing Facility.
- (i) Department - the Tennessee Department of Finance and Administration.
- (j) Denial - as used in regard to Waiver Services, the term shall mean the termination, suspension, delay, or reduction in amount, scope, and duration of a Waiver Service or a refusal or failure to provide such service.
- (k) Disenrollment - the voluntary or involuntary termination of enrollment in the Waiver of an individual receiving services through the Home and Community Based Services Waiver for the Elderly and Disabled in Shelby County.
- (l) Enrollee - a Medicaid Eligible who is enrolled in the Home and Community Based Services Waiver for the Elderly and Disabled in Shelby County.
- (m) Home (of an Enrollee) - the residence or dwelling in which the Enrollee resides in Shelby County, Tennessee, excluding hospitals, nursing facilities, Intermediate Care Facilities for the Mentally Retarded, Assisted Living Facilities, and Homes for the Aged (Residential Homes for the Aged).
- (n) Home and Community Based Services Waiver for the Elderly and Disabled in Shelby County - the Home and Community Based Services Waiver project approved for Tennessee by the Centers for Medicare and Medicaid Services to provide services to a specified number of Medicaid-eligible individuals who reside in Shelby County, Tennessee, who are aged or disabled, and who meet the Medicaid criteria for placement in a Nursing Facility.
- (o) Home Delivered Meals - nutritionally well-balanced meals, other than those provided under Title III C-2 of the Older Americans Act, that provide at least one third but no more than two-thirds of the current daily Recommended Dietary Allowance (as estimated by the Food and Nutrition Board of Sciences - National Research Council) and that will be served in the Enrollee's home. Special diets shall be provided in accordance with the Individual Plan of Care when ordered by the Enrollee's physician.
- (p) Homemaker Services - services provided by a trained homemaker when the Enrollee is unable to perform such activities and when the individual regularly responsible for these activities is temporarily unable to perform such activities for the Enrollee, consisting of: general household activities and chores (e.g., sweeping, mopping, dusting, making the bed, washing dishes, personal laundry, ironing, mending, and meal preparation and/or education about the preparation of nutritious appetizing meals); assistance with maintenance of a safe environment; and, errands essential to the Enrollee's care (e.g., grocery shopping, paying bills, having prescriptions filled, serving as a companion or escort for Enrollees unable to access transportation to medical appointments alone).
- (q) Individual Plan of Care - an individualized written plan of care which serves as the fundamental tool by which the State ensures the health and welfare of Enrollees and which meets the requirements of paragraph (8) herein.
- (r) Medicaid Eligible - an individual who has been determined by the Tennessee Department of Human Services to be financially eligible to have TennCare make reimbursement for covered services.

(Rule 1200-13-1-.27, continued)

- (s) Minor Home Modifications - the provision and installation of certain home mobility aides (e.g., ramps, rails, non-skid surfacing, grab bars, and other devices and minor home modifications which facilitate mobility) and modifications to the home environment to enhance safety. Excluded are those adaptations or improvements to the home which are of general utility and which are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.
- (t) Nursing Facility - a Medicaid-certified nursing facility approved by the Bureau.
- (u) Personal Care Services - services provided to assist the Enrollee with activities of daily living, household tasks, and other activities that enable the Enrollee to remain in the home, as an alternative to Nursing Facility care, including the following:
  1. Assistance with activities of daily living (e.g., bathing, grooming, personal hygiene, toileting, feeding, dressing, ambulation);
  2. Assistance with routine household tasks (e.g., meal preparation; laundry essential to the comfort and cleanliness of the Enrollee; and cleaning essential to the health and welfare of the Enrollee);
  3. Performance of errands essential to the Enrollee's care (e.g., grocery shopping, paying bills, having prescriptions filled, serving as a companion or escort for Enrollees unable to access transportation to medical appointments alone); and
  4. Assistance with maintenance of a safe environment.
- (v) Personal Emergency Response Systems (PERS) - electronic devices which enable certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. PERS services are limited to those individuals who are alone for significant parts of the day, who have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.
- (w) Physician's Plan of Care - an individualized written plan of care developed by the Enrollee's physician and included on the PreAdmission Evaluation and reviewed as needed or at least every ninety (90) days.
- (x) PreAdmission Evaluation (PAE) - a process of assessment approved by the Bureau of TennCare and used to document an individual's current medical condition and eligibility for care in a Nursing Facility.
- (y) PreAdmission Screening/Annual Resident Review (PASARR) - the process by which the State determines whether an individual who resides in or seeks admission to a Medicaid-certified Nursing Facility has, or is suspected of having, mental illness or mental retardation, and, if so, whether the individual requires specialized services.
- (z) Recertification - the process approved by the Bureau of TennCare by which the Enrollee's physician assesses the medical necessity of continuation of Waiver Services and certifies in writing that the Enrollee continues to require Waiver Services.



(Rule 1200-13-1-.27, continued)

- (aa) Safety Plan - an individualized plan by which the Administrative Lead Agency ensures the health, safety, and welfare of Enrollees who do not have 24-hour caregiver services and which meets the requirements of (5)(c)4.
  - (bb) Screening - the process by which the Administrative Lead Agency determines that an applicant meets the requirements for enrollment in the Home and Community Based Services Waiver for the Elderly and Disabled in Shelby County. The screening process shall include verifying whether an individual is Medicaid Eligible; whether the individual resides in Shelby County, Tennessee; whether an individual is eligible for care in a Nursing Facility; whether an individual with an approved PreAdmission Evaluation is eligible for Waiver Services; whether the individual's medical, functional, and social needs can be met through the Waiver; and whether there is a caregiver available.
  - (cc) Subcontractor - an individual, organized partnership, professional corporation, or other legal association or entity which enters into a written contract with the Administrative Lead Agency to provide Waiver Services to an Enrollee.
  - (dd) 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.
  - (ee) Waiver - the Home and Community Based Services Waiver for the Elderly and Disabled in Shelby County, as approved by the Centers for Medicare and Medicaid Services for the State of Tennessee.
  - (ff) Waiver Eligible - a Medicaid Eligible who has a PreAdmission Evaluation that has been approved by the Bureau of TennCare for nursing facility level of care and who resides in Shelby County, Tennessee.
  - (gg) Waiver Services - covered services provided through the Home and Community Based Services Waiver for the Elderly and Disabled in Shelby County, as approved by the Centers for Medicare and Medicaid Services for the State of Tennessee.
- (2) Waiver Services. Covered Waiver Services shall include the following:
- (a) Case Management. All case management contacts shall be documented in the Enrollee's medical record and shall include two face-to-face visits per month, one by a registered nurse and one by a social worker, with the Enrollee in the Enrollee's home. Such monthly documentation shall note that the Individual Plan of Care has been reviewed.
  - (b) Home-delivered Meals.
    - 1. The Administrative Lead Agency shall ensure that providers of home meals are properly licensed or certified by the appropriate regulatory authority and shall require that such providers comply with all laws, ordinances, and codes regarding preparation, handling, and delivery of food.
    - 2. For those Enrollees who require medically prescribed diets, the Administrative Lead Agency shall ensure that such meals are planned by a registered dietitian who provides consultation to the licensed nurse supervising the Enrollee's care.
  - (c) Minor Home Modifications.
    - 1. Minor home modifications shall not be provided unless specified in the Individual Plan of Care. The Administrative Lead Agency shall notify the Bureau of TennCare and obtain

(Rule 1200-13-1-.27, continued)

- prior authorization for minor home modifications exceeding \$6,000 prior to initiating the intended modification.
2. The Bureau of TennCare shall be the payor of last resort for minor home modifications.
- (d) Personal Care Services.
1. Personal care aides shall meet the standards of education and training required by the State of Tennessee for certification as a certified nurse aide or the standards of education and training for a home health aide required by TennCare.
  2. The Administrative Lead Agency shall ensure that personal care services are accurately and timely documented.
  3. The personal care aide shall report to the Case Manager any significant changes in the Enrollee's physical or mental status.
- (e) Homemaker Services.
1. Homemakers shall meet TennCare standards of education and training.
  2. The Administrative Lead Agency shall ensure that homemaker services are accurately and timely documented.
- (f) Personal Emergency Response Systems. Personal Emergency Response Systems shall be provided, as specified in the Individual Plan of Care and Safety Plan, for Enrollees:
1. Who receive daily caregiver services but who are alone for significant parts of the day and who would otherwise require extensive routine supervision; and
  2. Who, based on an assessment by the Administrative Lead Agency of the Enrollee's mental and physical capabilities, have the capability to effectively utilize such a system.
- (3) Documentation of Waiver Services.
- (a) The Administrative Lead Agency shall ensure that all services are accurately and timely documented.
  - (b) Documentation of Waiver services must adequately demonstrate that services are provided in accordance with the individual plan of care and the approved waiver service definitions.
- (4) Notification. Upon approval of a PreAdmission Evaluation for Nursing Facility care for an individual residing in Shelby County, Tennessee, the Bureau shall provide the individual with the following:
- (a) A simple explanation of the Waiver and Waiver Services;
  - (b) Notice of the opportunity to apply for enrollment in the Waiver and an explanation of the enrollment process; and
  - (c) A statement that participation in the Waiver program is voluntary.
- (5) Enrollment.
- (a) When an individual is determined to be likely to require the level of care provided by a Nursing Facility, the Administrative Lead Agency shall inform the individual or the individual's legal

(Rule 1200-13-1-.27, continued)

representative of all feasible alternatives available under the Waiver and shall offer the choice of either Nursing Facility or Waiver Services.

- (b) Enrollment in the Waiver shall be voluntary and open to all Waiver Eligibles who reside in Shelby County, Tennessee, but shall be restricted to the maximum number of individuals specified in the Waiver, as approved by the Centers for Medicare and Medicaid Services for the State of Tennessee. Enrollment may also be restricted if sufficient funds are not appropriated by the legislature to support full enrollment.
- (c) To be eligible for enrollment, an individual must meet all of the following criteria:
  - 1. The individual must be Medicaid Eligible, must meet the Nursing Facility eligibility criteria specified in TennCare Rule 1200-13-1-.10, and must have a PreAdmission Evaluation approved by the Bureau of TennCare.
    - (i) The PreAdmission Evaluation shall include the physician's initial plan of care which includes, but is not limited to, diagnoses and any orders for medications, diet, activities, treatments, therapies, restorative and rehabilitative services, or other physician-ordered services needed by the Enrollee.
    - (ii) The individual's physician must certify on the PreAdmission Evaluation that the individual requires Waiver Services.
  - 2. The individual's medical, functional, and social needs must be such that they can be effectively and safely met through the Waiver, as determined by the Administrative Lead Agency based on a pre-enrollment screening.
  - 3. An individual shall have one or more caregivers, as specified in (6)(a), designated to provide caregiver services each day in the Enrollee's home and, as needed, in other locations to ensure the health, safety, and welfare of the Enrollee. An individual shall have 24-hour caregiver services unless it is determined by an assessment that the needs of the individual can be met, and that the health, safety, and welfare of the individual can be assured, through the provision of daily (but less than 24-hour) caregiver services and through provision of a Personal Emergency Response System. Documentation of such assessment shall be included in an individualized Safety Plan that is developed, reviewed, and updated by the Administrative Lead Agency. If it is so determined that the health, safety, and welfare of the individual can be assured without 24-hour caregiver services, the individual shall have caregiver services provided for some portion of the day each day.
  - 4. An individual who does not have 24-hour caregiver services shall have an individualized Safety Plan that is based on an assessment of the individual's medical, functional, and social needs and capabilities and that is approved, monitored, and updated as needed, but no less frequently than annually, by the Administrative Lead Agency. The Safety Plan shall describe:
    - (i) The medical, functional, and social needs and capabilities of the individual and how such can be met without jeopardizing the health, safety, and welfare of the individual;
    - (ii) The type and schedule of caregiver services to be provided each day, specifying hours per day and number of days per week;
    - (iii) Personal Emergency Response Systems which are designed to enable Enrollees, who meet the requirements of (2)(f), to secure help in an emergency; and

(Rule 1200-13-1-.27, continued)

- (iv) Other services, devices, and supports that ensure the health, safety, and welfare of the Enrollee.
  - 5. All homes must provide an environment adequate to reasonably ensure the health, safety, and welfare of the Enrollee.
  - (d) An individual who is capable of living alone or independently without Waiver Services shall not be eligible for enrollment or continued enrollment in the Waiver.
  - (e) Enrollment of new Enrollees into the Waiver may be suspended when the average per capita fiscal year expenditure under the Waiver exceeds or is reasonably anticipated to exceed 100% of the average per capita expenditure that would have been made in the fiscal year if the care was provided in a Nursing Facility.
- (6) Caregiver.
- (a) Caregiver services shall be provided by one or more adult individuals, aged 18 or older, who sign an agreement with the Administrative Lead Agency to provide the following services to the Enrollee, as well as any additional services outlined in the Individual Plan of Care and the Safety Plan, to meet the needs of the Enrollee during the hours when Waiver Services are not being provided by the Administrative Lead Agency:
    - 1. Assistance with grooming, bathing, feeding, and dressing;
    - 2. Assistance with medications that are ordinarily self-administered;
    - 3. Assistance with ambulation as needed;
    - 4. Household services essential to health care and maintenance in the home;
    - 5. Meal preparation; and
    - 6. Any other assistance necessary to support the Enrollee's activities of daily living.
  - (b) One or more caregivers shall be available full time or part time each day in the Enrollee's home, as determined appropriate by the Administrative Lead Agency and as specified in the Individual Plan of Care and the Safety Plan, to provide care to the Enrollee. Enrollees who do not have a 24-hour caregiver shall have a Personal Emergency Response System and shall be mentally and physically capable of using it based on an assessment by the Administrative Lead Agency.
- (7) PreAdmission Evaluations, Transfer Forms, and PASARR Assessments.
- (a) A PreAdmission Evaluation is required when a Medicaid Eligible is admitted to the Waiver.
  - (b) A Transfer Form is required in the following circumstances:
    - 1. When an Enrollee having an approved unexpired PreAdmission Evaluation transfers from the Waiver to Level 1 care in a Nursing Facility.
    - 2. When an Enrollee having an approved unexpired PreAdmission Evaluation transfers from one Home and Community Based Services Waiver for the Elderly and Disabled to a different Home and Community Based Services Waiver for the Elderly and Disabled.

(Rule 1200-13-1-.27, continued)

3. When a Waiver eligible with an approved unexpired PreAdmission Evaluation transfers from a Nursing Facility to the Waiver.
  - (c) A Level I PASARR assessment for mental illness and mental retardation is required when an Enrollee with an approved unexpired PreAdmission Evaluation transfers from the Waiver to a Nursing Facility. A Level II PASARR evaluation is required if a history of mental illness or mental retardation is indicated by the Level I PASAAR assessment, unless criteria for exception are met.
  - (d) An Administrative Lead Agency that enrolls an individual without an approved PreAdmission Evaluation or, where applicable, an approved Transfer Form does so without the assurance of reimbursement. An Administrative Lead Agency that enrolls an individual who has not been determined by the Tennessee Department of Human Services to be financially eligible to have Medicaid make reimbursement for covered services does so without the assurance of reimbursement. If an Administrative Lead Agency enrolls a Medicaid Eligible without an approved PreAdmission Evaluation, the individual must be informed by the Administrative Lead Agency that Medicaid reimbursement will not be paid until and unless the PreAdmission Evaluation is approved.
  - (e) The Administrative Lead Agency shall maintain in its files the original PreAdmission Evaluation and, where applicable, the original Transfer Form.
  - (f) An updated Safety Plan for Enrollees who do not have 24-hour caregiver services shall be required as an attachment to the PreAdmission Evaluation or Transfer Form.
- (8) Individual Plan of Care.
  - (a) The Individual Plan of Care shall be an individualized written plan of care that specifies the services designed to meet the medical, functional, and social needs of the Enrollee and that includes, but is not limited to, the following Enrollee information:
    1. Diagnoses;
    2. A description of Waiver Services and any other services regardless of payment source, including caregiver services, that the Enrollee requires to reside in the community as an alternative to care in a Nursing Facility, including the amount (specific number of hours or units per day rather than a range), frequency (number of days per week), and duration (length of time needed) of services and the type of provider to furnish each service;
    3. Outcome objectives;
    4. Any treatments, therapies, activities, social services, rehabilitative services, nursing related services, home health aide services, specialized equipment, medications (including dosage, frequency, and route of administration), diet, and other services needed by the Enrollee;
    5. The names of each caregiver and each caregiver's schedule, including the amount (specific number of hours per day) and frequency (number of days per week) of caregiver services and provisions for alternate caregivers; and
    6. A Safety Plan for Enrollees who do not have 24-hour caregiver services.
  - (b) Within thirty (30) working days after enrollment, the Case Management Team shall review the Physician's Plan of Care and shall develop the Individual Plan of Care. Within ten (10) working

(Rule 1200-13-1-.27, continued)

days of completion of the Individual Plan of Care, the Administrative Lead Agency shall review and approve the Individual Plan of Care.

- (c) The Individual Plan of Care shall be periodically reviewed to ensure that the Waiver Services furnished are consistent with the nature and severity of the Enrollee's disability and to determine the appropriateness and adequacy of care and achievement of outcome objectives outlined in the Individual Plan of Care. The minimum schedule for reviews shall be as follows:
    - 1. The Individual Plan of Care shall be reviewed by a registered nurse and a social worker -- one of whom shall be the Case Manager -- as needed, but no less frequently than every thirty (30) calendar days.
    - 2. The Individual Plan of Care shall be reviewed and signed by the Case Management Team as needed, but no less frequently than annually. The attending physician is not required to sign the Individual Plan of Care if current signed physician orders are included with the Individual Plan of Care.
  - (d) Waiver Services shall be provided in accordance with the Enrollee's Individual Plan of Care.
- (9) Physician Services.
- (a) The Enrollees' attending physician or other licensed physician shall write new orders for the Enrollee as needed, and, at a minimum, every ninety (90) calendar days.
  - (b) The Administrative Lead Agency shall ensure that each Enrollee receives physician services as needed, and, at a minimum, an annual medical examination or physician visit, and shall document such in the Enrollee's record.
- (10) Reevaluation and Recertification of Need for Continued Stay.
- (a) The Administrative Lead Agency shall perform reevaluations of the Enrollee's need for continued stay in the Waiver within 365 calendar days of the date of enrollment and at least annually thereafter.
  - (b) Recertifications, documented in a format approved by the Bureau of TennCare, shall be performed by the Enrollee's physician within 365 calendar days of the initial certification date and at least annually thereafter. The Administrative Lead Agency shall maintain in its files a copy of the recertification of need for continued stay.
- (11) Voluntary Disenrollment.
- (a) Voluntary disenrollment of an Enrollee from the Waiver may occur at any time upon written notice from the Enrollee or the Enrollee's legal representative to the Administrative Lead Agency. A Level I PASARR assessment for mental illness and mental retardation is required when an Enrollee transfers to a Nursing Facility. If the Level I PASARR assessment indicates the need for a PASARR Level II assessment of need for specialized services for mental illness or mental retardation, the Enrollee must undergo the PASARR Level II assessment. Prior to disenrollment the Administrative Lead Agency shall assist the Enrollee in locating a facility providing the appropriate level of care and in transferring the Enrollee to such facility.
  - (b) If the Enrollee's medical condition or social environment deteriorates such that the medical, functional, and social needs cannot be met by the Waiver, the Enrollee or the Enrollee's legal representative may request disenrollment from the Waiver. The Administrative Lead Agency shall assist the individual with placement in the appropriate level of care.

(Rule 1200-13-1-.27, continued)

- (c) Upon voluntary disenrollment from the Waiver, the individual shall be entitled to receive Medicaid covered services only if still eligible for Medicaid.

(12) Involuntary Disenrollment.

- (a) An Enrollee may be involuntarily disenrolled from the Waiver for any of the following reasons:
  1. The Home and Community Based Services Waiver for the Elderly and Disabled in Shelby County is terminated.
  2. An Enrollee becomes ineligible for Medicaid or is found to be erroneously enrolled in the Waiver.
  3. An Enrollee moves out of Shelby County, Tennessee.
  4. The condition of the Enrollee improves such that the Enrollee no longer requires the level of care provided by the Waiver.
  5. The condition of the Enrollee deteriorates such that the medical, functional, and social needs of the Enrollee cannot be met by the Waiver.
  6. The home or home environment of the Enrollee becomes unsafe to the extent that it would reasonably be expected that Waiver Services could not be provided without significant risk of harm or injury to the Enrollee or to individuals who provide covered services to the Enrollee.
  7. The Enrollee no longer has a caregiver, as defined herein, or the caregiver is unwilling or unable to provide services needed by the Enrollee, and an alternate caregiver cannot be arranged.
  8. The Enrollee or the Enrollee's caregiver refuses to abide by the Individual Plan of Care, the Physician's Plan of Care, or related Waiver policies, resulting in the inability of the Waiver to assure quality care.
  9. A provider of Waiver Services is unwilling or unable to continue to provide services and an appropriate alternate service provider cannot be arranged.
  10. The health, safety, and welfare of the Enrollee cannot be assured due to the lack of an approved Safety Plan or an approved Individual Plan of Care, or the continuing need for Waiver Services is not recertified by the Enrollee's physician.
- (b) If the individual is involuntarily disenrolled from the Waiver, the Administrative Lead Agency shall assist the Enrollee in locating a Nursing Facility or other alternative providing the appropriate level of care and in transferring the Enrollee. A Level I PASARR assessment for mental illness and mental retardation is required when an Enrollee transfers to a Nursing Facility. If the Level I PASARR assessment indicates the need for a PASARR Level II assessment of need for specialized services for mental illness or mental retardation, the Enrollee must undergo the PASARR Level II assessment.
- (c) The Administrative Lead Agency shall notify the Bureau of TennCare in writing a minimum of 2 working days prior to issuing involuntary disenrollment notice to an Enrollee.
- (d) Waiver Services shall continue until the date of discharge of the Enrollee from the Waiver.

(Rule 1200-13-1-.27, continued)

- (e) The Administrative Lead Agency shall provide an Enrollee written advance notice of involuntary disenrollment with an explanation of the Enrollee's right to a hearing pursuant to T.C.A. §71-5-113.
- (13) Reduction of Services. If the Enrollee's condition substantially improves, the Administrative Lead Agency and the Bureau of TennCare shall have the right to reduce Waiver Services.
- (14) Administration of Services. The Administrative Lead Agency shall be responsible for the delivery of Waiver Services to Enrollees and shall perform related activities including, but not limited to, the following:
  - (a) Pre-enrollment screening of individuals, including assessment of the individual's medical, functional, and social capabilities and needs and appropriateness for placement in the Waiver and an assessment of the ability of the caregiver to care for the Enrollee in the home setting;
  - (b) Annual reevaluations of the Enrollee's need for continued stay in the Waiver;
  - (c) Enrollment of Waiver Eligibles into the Waiver after screening;
  - (d) Development, implementation, and monitoring of the Individual Plan of Care, including the Safety Plan if a Safety Plan is required;
  - (e) Coordinating and monitoring the total range of services for Enrollees, regardless of payment source;
  - (f) Initial certification by the Enrollee's physician of the Enrollee's need for care in a Nursing Facility and annual recertification of the medical necessity of the continuation of Waiver Services for the Enrollee;
  - (g) Supervision of support service staff;
  - (h) Ongoing monitoring of Enrollee and family situations and needs;
  - (i) Maintenance of comprehensive medical records and documentation of services provided to Enrollees;
  - (j) Expenditure and revenue reporting in accordance with state and federal requirements;
  - (k) Reimbursement of subcontractors;
  - (l) Marketing to potential Enrollees;
  - (m) Assurance of quality and accessible Waiver services which are provided in accordance with State and Federal Waiver rules, regulations, policies and definitions;
  - (n) Contacts with Enrollees, caregivers, and service providers in accordance with state and federal requirements;
  - (o) Assurance that each Enrollee has appropriate caregiver services provided each day in the Enrollee's home by one or more competent adult individuals who sign an agreement with the Administrative Lead Agency;
  - (p) Assurance of the safety of the Enrollee through appropriate caregiver services, supervision, and other services and supports, as described in the Individual Plan of Care and the Safety Plan;



(Rule 1200-13-1-.27, continued)

- (q) Implementation of an appeals process approved by the Bureau of TennCare, including provision of expert testimony by appropriate professionals during contested case hearings; and
  - (r) Compliance with all applicable rules of the Tennessee Medicaid Program.
- (15) Reimbursement of Administrative Lead Agency and Subcontractors.
- (a) The average per capita fiscal year expenditure under the Waiver shall not exceed 100% of the average per capita expenditure that would have been made in the fiscal year if care was provided in a Nursing Facility. The total Medicaid expenditure for Waiver Services and other Medicaid services provided to Enrollees shall not exceed 100% of the amount that would have been incurred in the fiscal year if care was provided in a Nursing Facility.
  - (b) The Administrative Lead Agency shall be reimbursed for Waiver Services based on a rate per unit of service. Upon approval by the Department, reimbursement shall include annual cost settlement as determined by the Tennessee Office of the Comptroller.
  - (c) In accordance with 42 CFR § 435.726, the Administrative Lead Agency shall make a diligent effort to collect patient liability if it applies to the Enrollee. The Administrative Lead Agency shall complete appropriate forms showing the individual's amount of monthly income and shall submit them to the Tennessee Department of Human Services. The Tennessee Department of Human Services shall issue the appropriate forms to the Administrative Lead Agency and to the Bureau of TennCare's fiscal agent, specifying the amount of patient liability to be applied toward the cost of care for the Enrollee.
  - (d) The Administrative Lead Agency shall submit bills for services to the Bureau of TennCare's fiscal agent using a claim form approved by the Bureau of TennCare. On claim forms, the Administrative Lead Agency shall use a provider number assigned by the Bureau of TennCare.
  - (e) Reimbursement shall not be made to the Administrative Lead Agency on behalf of Enrollees for therapeutic leave or fifteen-day hospital leave normally available to Nursing Facility patients pursuant to rule 1200-13-1-.06(4).
  - (f) Medicaid covered services other than those specified in the Waiver's scope of services shall be reimbursed by the Bureau of TennCare as otherwise provided for by federal and state rules and regulations.
  - (g) The Administrative Lead Agency shall be responsible for obtaining the physician's initial certification and subsequent recertifications. Failure to perform recertifications in a timely manner and in the format approved by the Bureau of TennCare shall require a corrective action plan and shall result in full or partial recoupment of all amounts paid by the Bureau of TennCare during the time that recertification has lapsed.
- (16) Subcontractors.
- (a) The Administrative Lead Agency shall ensure that:
    - 1. Services are provided by subcontractors who have signed contracts with the Administrative Lead Agency;
    - 2. Subcontractors comply with the Quality Assurance Guidelines and other state and federal standards, rules, and regulations affecting the provision of Waiver Services; and
    - 3. Subcontractors carry appropriate professional liability insurance and other insurance (e.g., auto insurance if Enrollees are being transported).

(Rule 1200-13-1-.27, continued)

- (b) Contracts between the Administrative Lead Agency and subcontractors for the provision of Waiver Services shall be subject to written approval from the Bureau of TennCare.
- (17) Appeal Process. Where applicable, the Administrative Lead Agency shall provide an appeal process for Enrollees which shall comply with TennCare rule 1200-13-13-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits.

**Authority:** T.C.A. §§4-5-202, 71-5-105, 71-5-109, and Executive Order No. 23. **Administrative History:** Original rule filed July 28, 2004; effective October 11, 2004.