

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

**CHAPTER 1200-13-13
TENNCARE MEDICAID**

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1200-13-13-.01 DEFINITIONS.

- (1) ABUSE shall mean enrollee practices, or enrollee involvement in practices, including overutilization, waste or fraudulent use/misuse of a TennCare Program that results in cost or utilization which is not medically necessary or medically justified. Abuse of a TennCare Pharmacy Program justifies placement on lock-in or prior approval status for all enrollees involved. Activities or practices which may evidence abuse of the TennCare Pharmacy Program include, but are not limited to, the following: forging or altering drug prescriptions, selling TennCare paid prescription drugs, failure to control pharmacy overutilization activity while on lock-in status and visiting multiple prescribers or pharmacies to obtain prescriptions that are not medically necessary.
- (2) ACCESS TO HEALTH INSURANCE shall mean the opportunity an individual has to obtain group health insurance as defined elsewhere in these rules. If a person could have enrolled in work-related or other group health insurance during an open enrollment period and simply chose not to (or had the choice made for him/her by a family member) that person would not be considered to lack access to insurance once the open enrollment period is closed. Neither the cost of an insurance policy or health plan nor the fact that an insurance policy is not as comprehensive as that of the TennCare Program shall be considered in determining eligibility to enroll in TennCare.
- (3) Administrative Hearing shall mean a contested case proceeding held pursuant to the provisions of the Tennessee Uniform Administrative Procedures Act, Tennessee Code Annotated §§ 4-5-301, et seq., except as noted otherwise herein, to allow an enrollee to appeal an adverse decision of the TennCare Program. An evidentiary hearing is held before an impartial hearing officer or administrative judge who renders an initial order under Tennessee Code Annotated § 4-5-314. If an enrollee appeals the initial order under Tennessee Code Annotated § 4-5-315, the Commissioner may render a final order.
- (4) Adverse Action Affecting TennCare Services or Benefits as it relates to actions under the Grier Revised Consent Decree shall mean, but is not limited to, a delay, denial, reduction, suspension or termination of TennCare benefits, as well as any other act or omission of the TennCare Program which impairs the quality, timeliness, or availability of such benefits.
- (5) Application fee shall mean the fee that applicants must pay in advance for the processing of a TennCare Standard application for coverage as a “medically eligible” person. The fee is established by the Bureau of TennCare and may be periodically changed.
- (6) BENEFITS shall mean the health care package of services developed by the Bureau of TennCare and which define the covered services available to TennCare enrollees.

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

- (7) BHO (BEHAVIORAL HEALTH ORGANIZATION(S)) shall mean a type of managed care contractor approved by the Tennessee Department of Finance and Administration to deliver mental health and substance abuse services to TennCare Medicaid and TennCare Standard enrollees under the TennCare Partners Program.
- (8) BUREAU OF TENNCARE (BUREAU) shall mean the administrative unit of TennCare which is responsible for the administration of TennCare as defined elsewhere in these rules.
- (9) CAPITATION PAYMENT shall mean the fee which is paid by the State to a managed care contractor operating under a risk-based contract for each enrollee covered by the plan for the provision of medical services, whether or not the enrollee utilizes services or without regard to the amount of services utilized during the payment period.
- (10) CAPITATION RATE shall mean the amount established by the State for the purpose of providing payment to participating managed care contractors operating under a risk-based contract.
- (11) CATEGORICALLY NEEDY shall mean that category of TennCare Medicaid-eligibles as defined at 1240-3-2-.02 of the rules of the Tennessee Department of Human Services - Division of Medical Services.
- (12) CMS (CENTERS FOR MEDICARE AND MEDICAID SERVICES) (formerly known as HCFA) shall mean 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.
- (13) COBRA shall mean health insurance coverage provided pursuant to the Consolidated Omnibus Budget Reconciliation Act.
- (14) COMMENCEMENT OF SERVICES shall mean the time at which the first covered service(s) is/are rendered to a TennCare member for each individual medical condition.
- (15) Commissioner shall mean the chief administrative officer of the Tennessee Department where the TennCare Bureau is administratively located, or the Commissioner's designee.
- (16) COMMUNITY SERVICE AREA (CSA) shall mean one (1) or more counties in a defined geographical area in which the managed care contractor is authorized to enroll and service TennCare enrollees residing in that community service area. Community Service Areas shall correspond to Community Health Agency Regions.
- (17) COMPLETED APPLICATION is an application where:
 - (a) All required fields have been completed;
 - (b) It is signed and dated by the applicant or the applicant's parent or guardian;
 - (c) It includes all supporting documentation required by the TDHS or the Bureau to determine TennCare eligibility, technical and financial requirements as set out in these rules;
 - (d) It includes all supporting documentation required to prove TennCare Standard medical eligibility as set out in these rules; and
 - (e) the application fee has been paid (this provision applies only to some persons applying for TennCare Standard as "medically eligible").

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

- (18) CONTINUATION OR REINSTATEMENT shall mean that the following services or benefits are subject to continuation or reinstatement pursuant to an appeal of an adverse decision affecting a TennCare service(s) or benefit(s), unless the services or benefits are otherwise exempt from this requirement as described in rule 1200-13-13-.11, if the enrollee appeals within ten (10) days of the date of the notice of action or prior to the date of the adverse action, whichever is later.
- (a) For services on appeal under Grier Revised Consent Decree:
1. Those services currently or in the case of reinstatement, most recently provided to an enrollee; or
 2. Those services provided to an enrollee in an inpatient psychiatric facility or residential treatment facility where the discharge plan has not been accepted by the enrollee or appropriate step-down services are not available; or
 3. Those services provided to treat an enrollee's chronic condition across a continuum of services when the next appropriate level of covered services is not available; or
 4. Those services prescribed by the enrollee's provider on an open-ended basis or with no specific ending date where the MCC has not reissued prior authorization; or
 5. A different level of covered services, offered by the MCC and accepted by the enrollee, for the same illness or medical condition for which the disputed service has previously been provided.
- (b) For eligibility terminations, coverage will be continued or reinstated for an enrollee currently enrolled in TennCare who has received notice of termination of eligibility and who appeals within ten (10) days of the date of the notice or prior to the date of termination, whichever is later.
- (19) Continuous ENROLLMENT shall mean that certain individuals determined eligible for the TennCare Program may enroll at anytime during the year. These individuals are:
- (a) For TennCare Medicaid:
1. Individuals qualifying for TennCare Medicaid as defined at rule 1240-3-3 of the Tennessee Department of Human Services - Division of Medical Services.
 2. Individuals approved for SSI benefits as determined by the Social Security Administration.
 3. A woman who is uninsured, under age sixty-five (65), a US citizen or qualified alien, is not eligible for any other category of Medicaid, has been diagnosed as the result of a screening at a Centers for Disease Control and Prevention (CDC) site with breast or cervical cancer, including pre-cancerous conditions.
- (b) For TennCare Standard:
1. Individuals qualifying as medically eligible as defined in these rules and whose family income is less than 100% of the poverty level.
 2. An individual who is losing his/her TennCare Medicaid, who is uninsured and whose family income is within the range established by the Bureau of TennCare to qualify for TennCare Standard or as medically eligible at any income.

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

- (20) CONTRACTOR shall mean an organization approved by the Tennessee Department of Finance and Administration to provide TennCare-covered benefits to eligible enrollees in the TennCare Medicaid and TennCare Standard programs.
- (21) CORE MEDICAID POPULATION shall mean individuals eligible under Title XIX of the Social Security Act, 42 U.S.C. §§ 1396, et seq., with the exception of the following groups: individuals receiving SSI benefits as determined by the Social Security Administration; individuals eligible under a Refugee status; individuals eligible for emergency services as an illegal or undocumented alien; individuals receiving interim Medicaid benefits with a pending Medicaid disability determination; individuals with forty-five (45) days of presumptive or immediate eligibility; and children in DCS custody.
- (22) Cost-Effective Alternative Service is a service which is outside the scope of services MCCs are required to cover, but which can be substituted for a more costly covered service without affecting the quality of patient care. Example: MCOs are not required to cover nursing facility care. However, an MCO may choose to provide nursing facility care for a particular patient who would otherwise require hospitalization, if such a choice is medically appropriate for that patient.
- (23) COST SHARING shall mean the amounts that certain enrollees in TennCare are required to pay for his/her TennCare coverage and covered services. Cost sharing includes premiums and copayments. Certain TennCare Medicaid enrollees are required to pay copayments for prescription drugs as of January 1, 2003.
- (24) Covered Services shall mean the services and benefits that:
- (a) TennCare contracted MCC's cover, as set out elsewhere in these rules; or
 - (b) In the instance of enrollees who are eligible for and enrolled in federal Medicaid waivers under Section 1315 of the Social Security Act, the services and benefits that are covered under the terms and conditions of such waivers.
- (25) CPT4 CODES are descriptive terms contained in the Physician's Current Procedural Terminology, used to identify medical services and procedures performed by physicians or other licensed health professionals.
- (26) DBM (DENTAL BENEFITS MANAGER) shall mean a contractor approved by the Tennessee Department of Finance and Administration to provide dental benefits to enrollees in the TennCare Program to the extent such services are covered by TennCare.
- (27) Delay shall mean, but is not limited to:
- (a) Any failure to provide timely receipt of TennCare services, and no specific waiting period may be required before the enrollee can appeal;
 - (b) An MCC's failure to provide timely prior authorization of a TennCare service. A prior authorization decision shall not be deemed timely unless it is granted within fourteen (14) days of the MCC's receipt of a request for such authorization.
- (28) DISENROLLMENT shall mean the discontinuance of an individual's enrollment in TennCare.
- (29) DURABLE MEDICAL EQUIPMENT (DME) shall mean equipment that can stand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of an illness or injury, is appropriate for and used in the patient's home, and is related to the

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

patient's physical disorder. An institution is not considered a patient's or member's home if it meets the definition of a hospital or skilled facility. Orthotics and prosthetic devices, and artificial limbs and eyes are considered DME.

- (30) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) Services, a covered benefit for TennCare Medicaid-enrolled children only, shall mean:
- (a) Screening in accordance with professional standards, and interperiodic, diagnostic services to determine the existence of physical or mental illnesses or conditions of TennCare Medicaid enrollees under age twenty-one (21); and
 - (b) Health care, treatment, and other measures, described in 42 U.S.C. § 1396a(a) to correct or ameliorate any defects and physical and mental illnesses and conditions discovered.
- (31) ELIGIBLE shall mean a person who has been determined to meet the eligibility criteria of TennCare Medicaid or TennCare Standard.
- (32) EMERGENCY MEDICAL CONDITION, including emergency mental health and substance abuse emergency treatment services, shall mean the sudden and unexpected onset of 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; or
 - (b) Serious impairment to bodily functions; or
 - (c) Serious dysfunction of any bodily organ or part.

For Medicaid enrollees only, copayments are not required for emergency services.

- (33) ENROLLEE shall mean an individual eligible for and enrolled in the TennCare program or in any Tennessee federal Medicaid waiver program approved by the Secretary of the US Department of Health and Human Services pursuant to Sections 1115 or 1915 of the Social Security Act. As concerns MCC compliance with these rules, the term only applies to those individuals for whom the MCC has received at least one day's prior written or electronic notice from the TennCare Bureau of the individual's assignment to the MCC.
- (34) ENROLLMENT shall mean the process by which a TennCare-eligible person becomes enrolled in TennCare.
- (35) FAMILY shall mean that as defined in the rules of the Tennessee Department of Human Services found at 1240-1-3 and 1240-1-4, Family Assistance Division, and 1240-3-3, Division of Medical Services.
- (36) FEDERAL FINANCIAL PARTICIPATION (FFP) shall mean the Federal Government's share of a state's expenditure under the Title XIX Medicaid Program.
- (37) FINAL AGENCY ACTION shall mean the resolution of an appeal by the TennCare Bureau or an initial decision on the merits of an appeal by an impartial administrative judge or hearing officer when such initial decision is not modified or overturned by the TennCare Bureau. Final agency action shall be treated as binding for purposes of these rules.

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

- (38) FRAUD shall mean an intentional deception or misrepresentation made by a person who knows or should have known 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.
- (39) GROUP HEALTH INSURANCE shall mean an employee welfare benefit plan to the extent that the plan provides medical care to employees or their dependents (as defined under the terms of the plan) directly through insurance reimbursement mechanism. This definition includes those types of health insurance found in the Health Insurance Portability And Accountability Act of 1996, as amended, definition of creditable coverage (with the exception that the 50 or more participants criteria does not apply), which includes Medicare and TRICARE. Health insurance benefits obtained through COBRA are included in this definition. It also covers group health insurance available to an individual through membership in a professional organization or a school.
- (40) Handicapping Malocclusion, for the purposes of determining eligibility under these regulations shall mean the presence of abnormal dental development that has at least one of the following:
- (a) A medical condition and/or a nutritional deficiency with medical physiological impact, that is documented in the physician progress notes that predate the diagnosis and request for orthodontics. The condition must be non-responsive to medical treatment without orthodontic treatment.
 - (b) The presence of a speech pathology, that is documented in speech therapy progress notes that predate the diagnosis and request for orthodontics. The condition must be non-responsive to speech therapy without orthodontic treatment.
 - (c) Palatal tissue laceration from a deep impinging overbite where lower incisor teeth contact palatal mucosa. This does not include occasional biting of the cheek.

Anecdotal information is insufficient to document the presence of a handicapping malocclusion. Anecdotal information is represented by statements that are not supported by professional progress notes that the patient has difficulty with eating, chewing, or speaking. These conditions may be caused by other medical conditions in addition to the misalignment of the teeth.

- (41) HEALTH INSURANCE, for the purposes of determining eligibility under these regulations:
- (a) Shall mean:
 - 1. any hospital and medical expense-incurred policy;
 - 2. Medicare;
 - 3. TRICARE;
 - 4. COBRA;
 - 5. Medicaid;
 - 6. State health risk pool;
 - 7. Nonprofit health care service plan contract;
 - 8. health maintenance organization subscriber contracts;

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

9. An employee welfare benefit plan to the extent that the plan provides medical care to an employee or his/her dependents (as defined under the terms of the plan) directly through insurance, any form of self insurance, or a reimbursement mechanism;
 10. Coverage available to an individual through membership in a professional organization or a school;
 11. Coverage under a policy covering one person or all the members of a family under a single policy where the contract exists solely between the individual and the insurance company;
 12. Any of the above types of policies where:
 - (i) The policy contains a type of benefit (such as mental health benefits) which has been completely exhausted;
 - (ii) The policy contains a type of benefit (such as pharmacy) for which an annual limitation has been reached;
 - (iii) The policy has a specific exclusion or rider of non-coverage based on a specific prior existing condition or an existing condition or treatment of such a condition; or
 13. Any of the types of policies listed above will be considered health insurance even if one or more of the following circumstances exists:
 - (i) The policy contains fewer benefits than TennCare;
 - (ii) The policy costs more than TennCare; or
 - (iii) The policy is one the individual could have bought during a specified period of time (such as COBRA) but chose not to do so.
- (b) Shall not mean:
1. Short-term coverage;
 2. Accident coverage;
 3. Fixed indemnity insurance;
 4. Long-term care insurance;
 5. Disability income contracts;
 6. Limited benefits policies as defined elsewhere in these rules;
 7. Credit insurance;
 8. School-sponsored sports-related injury coverage;
 9. Coverage issued as a supplemental to liability insurance;
 10. Automobile medical payment insurance;

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

11. insurance under which benefits are payable with or without regard to fault and which are statutorily required to be contained in any liability insurance policy or equivalent self-insurance;
 12. A medical care program of the Indian Health Services (IHS) or a tribal organization;
 13. Benefits received through the Veteran's Administration; or
 14. Health care provided through a government clinic or program such as, but not limited to, vaccinations, flu shots, mammograms, and care or services received through a disease- or condition-specific program such as, but not limited to, the Ryan White Care Act.
- (42) HEALTH PLAN shall mean a managed care organization authorized by the Tennessee Department of Finance and Administration to provide medical services to enrollees in the TennCare Program.
- (43) HEALTH MAINTENANCE ORGANIZATION (HMO) shall mean an entity licensed by the Tennessee Department of Commerce and Insurance under applicable provisions of Tennessee Code Annotated (T.C.A.) Title 56, Chapter 32 to provide health care services.
- (44) HIPAA shall mean the Health Insurance Portability and Accountability Act of 1996, as amended.
- (45) HOME HEALTH SERVICES shall mean the following services provided by a licensed home health agency at a recipient's place of residence and by physician's orders:
- (a) Part-time or intermittent nursing services;
 - (b) Home health aide services provided by a home health agency;
 - (c) Medical supplies, equipment, and appliances suitable for use in the home; or
 - (d) Physical therapy, occupational therapy, or speech pathology and audiology services.
- (46) Impartial Hearing Officer shall mean an administrative judge or hearing officer who is not an employee, agent or representative of the MCC and who did not participate in, nor was consulted about, any TennCare Bureau review prior to the Administrative Hearing.
- (47) INCOME shall mean that definition of income in rule 1240-1-4 of the Tennessee Department of Human Services - Family Assistance Division.
- (48) INDIVIDUAL HEALTH INSURANCE shall mean health insurance coverage under a policy covering one person or all the members of a family under a single policy where the contract exists solely between that person and the insurance company.
- (49) INITIATING PROVIDER shall mean the provider who renders the first covered service to a TennCare member whose current medical condition requires the services of more than one (1) provider.
- (50) INMATE shall mean an individual confined in a local, state, or federal prison, jail, youth development center, or other penal or correctional facility, including a furlough from such facility.
- (51) Inpatient Rehabilitation Facilities shall mean rehabilitation hospitals and distinct parts of hospitals that are designated as 'IRFs' by Medicare.

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

- (52) LICENSED MENTAL HEALTH PROFESSIONAL shall mean a Board eligible or a Board certified psychiatrist or a person with at least a Master's degree and/or clinical training in an accepted mental health field which includes, but is not limited to, counseling, nursing, occupational therapy, psychology, social work, vocational rehabilitation, or activity therapy with a current valid license by the Tennessee Licensing Board for the Healing Arts.
- (53) LIMITED BENEFITS POLICY shall mean a policy of health coverage for a specific disease (e.g., cancer), or an accident occurring while engaged in a specified activity (e.g., school-based sports), or which provides for a cash benefit payable directly to the insured in the event of an accident or hospitalization (e.g., hospital indemnity).
- (54) LOCK-IN PROVIDER shall mean a provider, either pharmacy or physician, who an enrollee on pharmacy lock-in status has chosen and to whom an enrollee is assigned by TennCare or the MCO for purposes of receiving covered pharmacy services.
- (55) LOCK-IN STATUS shall mean the restriction of an enrollee to a specified and limited number of pharmacy providers.
- (56) LONG TERM CARE shall mean institutional services of a nursing facility, an intermediate care facility for the mentally retarded, and services provided through a Home and Community Based Services Waiver.
- (57) MCC (MANAGED CARE CONTRACTOR) shall mean:
- (a) A managed care organization, behavioral health organization, pharmacy benefits manager, and/or a dental benefits manager which has signed a TennCare Contractor Risk Agreement with the State and operates a provider network and provides covered health services to TennCare enrollees; or
 - (b) A pharmacy benefits manager or dental benefits manager which subcontracts with a managed care organization or behavioral health organization to provide services; or
 - (c) A State government agency (i.e., Department of Children's Services and Division of Mental Retardation Services) that contracts with TennCare for the provision of services.
- (58) MCO (MANAGED CARE ORGANIZATION) shall mean an appropriately licensed Health Maintenance Organization (HMO) approved by the Bureau of TennCare as capable of providing medical services in the TennCare Program.
- (59) MEDICAID shall mean the federal- and state-financed, state-run program of medical assistance pursuant to Title XIX of the Social Security Act. Medicaid eligibility in Tennessee is determined by the Tennessee Department of Human Services, under contract to the Tennessee Department of Finance and Administration. Tennessee residents determined eligible for SSI benefits by the Social Security Administration are also enrolled in Tennessee's TennCare Medicaid program.
- (60) MEDICAID "ROLLOVER" ENROLLEE shall mean a TennCare Medicaid enrollee who no longer meets technical eligibility requirements for Medicaid and will be afforded an opportunity to enroll in TennCare Standard in accordance with the provisions of these rules.
- (61) Medical Assistance shall mean health care, services and supplies furnished to an enrollee and funded in whole or in part under Title XIX of the Social Security Act, 42 U.S.C. §§ 1396, et seq. and Tennessee Code Annotated § 71-5-101, et seq. Medical assistance includes the payment of the cost of care, services, drugs and supplies. Such care, services, drugs, and supplies shall include services of qualified providers who have contracted with an MCC or are otherwise authorized to provide services

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

to TennCare enrollees (i.e., emergency services provided out-of-network or medically necessary services obtained out-of-network because of an MCC's failure to provide adequate access to services in-network).

- (62) MEDICAL RECORDS shall mean current information such as medical histories, records, reports and summaries, diagnoses, prognoses, records of treatment and medication ordered and given, x-ray and radiology interpretations, physical therapy charts and notes, and lab reports necessary to determine a specific diagnosis.
- (63) MEDICAL SUPPLIES shall mean covered medical supplies that are deemed medically necessary and appropriate and are prescribed for use in the diagnosis and treatment of medical conditions. Medically necessary medical supplies not included as part of institutional services shall be covered only when provided by or through a licensed home health agency, by or through a licensed medical vendor supplier or by or through a licensed pharmacist.
- (64) Medically Contraindicated shall mean a TennCare benefit or service which it is necessary to withhold in order to safeguard the health or safety of the enrollee.
- (65) MEDICALLY ELIGIBLE shall mean a person who has met the medical eligibility criteria for the TennCare Standard program through a mechanism permitted under the provisions of these rules.
- (66) MEDICALLY NECESSARY shall mean services or supplies provided by an institution, physician, or other health care provider that are required to identify or treat a TennCare enrollee's illness or injury and which are:
 - (a) Consistent with the symptoms or diagnosis and treatment of the enrollee's condition, disease, ailment, or injury; and
 - (b) Appropriate with regard to standards of good medical practice; and
 - (c) Not solely for the convenience of an enrollee, physician or other provider; and
 - (d) The most appropriate supply or level of services which can safely be provided to the enrollee. When applied to the care of an inpatient, it further means that services for the enrollee's medical symptoms or condition require that the services cannot be safely provided to the enrollee as an outpatient.
 - (e) When applied to TennCare Medicaid enrollees under twenty-one (21) years of age, services shall be provided in accordance with EPSDT requirements including federal regulations as described in 42 CFR Part 441, Subpart-B, and the Omnibus Budget Reconciliation Act of 1989.
- (67) MEDICALLY NEEDY shall mean that category of TennCare Medicaid-eligibles as defined in rule 1240-3-2-.03 of the Tennessee Department of Human Services - Division of Medical Services.
- (68) MEDICARE shall mean the program administered through the Social Security Administration pursuant to Title XVIII, available to most individuals upon attaining age sixty-five (65), to some disabled individuals under age sixty-five (65), and to individuals having End Stage Renal Disease (ESRD).
- (69) MEMBER shall mean a TennCare Medicaid- or TennCare Standard-eligible individual who is enrolled in a managed care organization.

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

- (70) OPEN ENROLLMENT shall mean a designated period of time, determined by the Bureau of TennCare, during which individuals may apply for enrollment in TennCare Standard. The following individuals may apply for TennCare Standard during periods of open enrollment:
- (a) Uninsured individuals whose income fall within the poverty levels established for the period of open enrollment being held.
 - (b) Individuals qualifying as medically eligible as defined in these rules. These persons may have income at any level.
- (71) OPEN MEDICAID CATEGORIES shall mean those Medicaid eligibility categories for which enrollment has not been closed pursuant to authority granted by CMS as part of the TennCare demonstration project.
- (72) OVERUTILIZATION shall mean any of the following:
- (a) The enrollee initiated use of TennCare services or supplies at a frequency or amount that is not medically necessary or medically justified.
 - (b) Overutilization, or attempted overutilization, of the TennCare Pharmacy Program which justifies placement on lock-in status for all enrollees involved.
 - (c) Activities or practices which may evidence overutilization of the TennCare Pharmacy Program including, but not limited to, the following:
 - 1. Treatment by several physicians for the same diagnosis;
 - 2. Obtaining the same or similar controlled substances from several physicians;
 - 3. Obtaining controlled substances in excess of the maximum recommended dose;
 - 4. Receiving combinations of drugs which act synergistically or belong to the same class;
 - 5. Frequent treatment for diagnoses which are highly susceptible to abuse;
 - 6. Receiving services and/or drugs from numerous providers;
 - 7. Obtaining the same or similar drugs on the same day or at frequent intervals; or
 - 8. Frequent use of the emergency room in non-emergency situations in order to obtain prescription drugs.
- (73) PBM (PHARMACY BENEFITS MANAGER) shall mean an organization approved by the Tennessee Department of Finance and Administration to provide pharmacy benefits to enrollees to the extent such services are covered by the TennCare Program. A PBM may have a signed TennCare Contractor Risk Agreement with the State, or may be a subcontractor to an MCO or BHO.
- (74) PHYSICIAN shall mean a person licensed pursuant to chapter 6 or 9 of title 63 of the Tennessee Code Annotated.
- (75) POVERTY LEVEL shall mean the poverty level established by the Federal Government.
- (76) PRIMARY CARE PHYSICIAN shall mean a physician responsible for supervising, coordinating, and providing initial and primary care to patients; for initiating referrals for specialist care; and for

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

maintaining the continuity of patient care. A primary care physician is a physician who has limited his practice of medicine to general practice or who is a Board Certified or Eligible Internist, Pediatrician, Obstetrician/ Gynecologist, or Family Practitioner.

- (77) PRIMARY CARE PROVIDER shall mean health care professional capable of providing a wide variety of basic health services. Primary care providers include practitioners of family, general, or internal medicine; pediatricians and obstetricians; nurse practitioners; midwives; and physician's assistant in general or family practice.
- (78) PRIOR APPROVAL STATUS shall mean the restriction of an enrollee to a procedure wherein services, except in emergency situations, must be approved by the TennCare Bureau or the MCC prior to the delivery of services.
- (79) PRIOR AUTHORIZATION shall mean the process under which services, except in emergency situations, must be approved by the TennCare Bureau or the MCC prior to the delivery in order for such services to be covered by the TennCare program.
- (80) PRIVATE DUTY NURSING SERVICES shall mean nursing services for recipients who require individual and continuous care and that are provided by a registered nurse or a licensed practical nurse, under the direction of the recipient's physician, and to a recipient in his or her own home.
- (81) PROSPECTIVE ENROLLMENT shall mean the future date when the applicant's/enrollee's actual enrollment and eligibility to receive TennCare-covered services begins, subject to collection of the initial month's premium if appropriate.
- (82) PROVIDER shall mean an institution, facility, agency, person, corporation, partnership, or association which accepts as payment in full for providing benefits to a TennCare enrollee, the amounts paid pursuant to an approved agreement with an MCC. Such payment may include copayments from the enrollee or the enrollee's responsible party.
- (83) Provider-Initiated Reduction, Termination or Suspension of Services shall mean a decision to reduce, terminate, or suspend an enrollee's TennCare services which is initiated by the enrollee's provider, rather than by the MCC.
- (84) Provider with Prescribing Authority shall mean, in the context of TennCare pharmacy services, a health care professional authorized by law or regulation to order prescription medications for his/her patients, and who:
 - (a) Participates in the provider network of the MCC in which the enrollee is enrolled; or
 - (b) Has received a referral of the enrollee, approved by the MCC, authorizing her to treat the enrollee; or
 - (c) In the case of a TennCare enrollee who is also enrolled in Medicare, is authorized to treat Medicare patients.
- (85) Prudent Lay Person shall mean a reasonable person who possesses an average knowledge of health and medicine.
- (86) QUALIFYING MEDICAL CONDITION shall mean a medical condition which is included among a list of conditions established by the Bureau and which will render a qualified uninsured applicant medically eligible.

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

- (87) **QUALIFIED UNINSURED PERSON** shall mean an uninsured person who meets the technical, financial, and insurance requirements for the TennCare Standard Program.
- (88) **Readable** shall mean no more than a sixth grade level of reading proficiency is needed to understand notices or other written communications, as measured by the Fogg index, the Flesch Index, the Flesch-Kincaid Index, or other recognized readability instrument. The preprinted language approved by the US District Court following entry of the Grier Revised Consent Decree and distributed to MCCs as templates is deemed readable. It is the responsibility of the entity issuing the notice to ensure that text added to the template is deemed readable, with the exception of medical, clinical or legal terminology.
- (89) **REASSIGNMENT** shall mean the process by which the Bureau of TennCare transfers an enrollee from one MCO to another as described in these rules.
- (90) **Receipt of Mailed NoticeS** shall mean that receipt of mailed notices is presumed to occur within five (5) days of mailing.
- (91) **RECERTIFICATION** shall mean the process by which TDHS evaluates the ongoing eligibility status of TennCare Medicaid and TennCare Standard enrollees. This is a periodic process that is conducted at specified intervals or when an enrollee's circumstances change. The process is conducted in accordance with TennCare's, or its designee's, policies and procedures.
- (92) **Reconsideration** shall mean the process by which an MCC reviews and renders a decision regarding an enrollee's appeal of the MCC's adverse action affecting TennCare benefits.
- (93) **REDETERMINATION** shall mean the process by which TDHS initially determines whether waiver-eligible TennCare (non-Medicaid) enrollees who were enrolled in the TennCare Program as of June 30, 2002, are eligible for TennCare Medicaid or TennCare Standard under the terms of the waiver program in effect as of July 1, 2002.
- (94) **Reduction, Suspension or Termination** shall mean the acts or omissions by TennCare or others acting on its behalf which result in the interruption of a course of necessary clinical treatment for a continuing spell of illness or medical condition. MCCs are responsible for the management and provision of medically necessary covered services throughout an enrollee's illness or need for such services, and across the continuum of covered services, including, but not limited to behavioral health services and appropriate transition plans specified in the applicable TennCare contract. The fact that an enrollee's medical condition requires a change in the site or type of TennCare service does not lessen the MCC's obligation to provide covered treatment on a continuous and ongoing basis as medically necessary.
- (95) **RESOURCES FOR MEDICAID-ELIGIBLE INDIVIDUALS** shall mean those resources as defined in Chapter 1240-3-3-.05 - .06 of the rules of the Tennessee Department of Human Services - Division of Medical Services.
- (96) **SERIOUSLY EMOTIONALLY DISTURBED (SED)** shall mean persons who have been identified by the Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD) or its designee as meeting the criteria provided below.
- (a) Age from birth to age eighteen (18), and
 - (b) Currently, or at any time during the past year, has had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the DSM-IV-TR (and subsequent revisions) of the American Psychiatric Association, with the exception of the DSM-IV-TR (and subsequent revisions) "V" codes, substance abuse, and developmental disorders, unless these disorders co-occur with another diagnosable serious emotional

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disturbance. All of these disorders have episodic, recurrent, or persistent features; however, the disorders may vary in terms of severity and disabling effects; and

- (c) The diagnosable mental, behavioral, or emotional disorder identified above has resulted in functional impairment, which substantially interferes with or limits the child's role or functioning in family, school, and community activities. Functional impairment is defined as difficulties that substantially interfere with or limit a child or adolescent in achieving or maintaining developmentally appropriate social, behavioral, cognitive, communicative, or adapted skills and is evidenced by a Global Assessment of Functioning score of fifty (50) or less in accordance with the DSM-IV-TR (and subsequent revisions).
- (97) SEVERELY AND/OR PERSISTENTLY MENTALLY ILL (SPMI) shall mean individuals who have been identified by the Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD) or its designee as meeting the criteria in (a) below. These persons will be identified as belonging in one of Clinically Related Groups listed in (b) below.
- (a) Criteria
 - 1. Age eighteen (18) and over; and
 - 2. Currently, or at any time during the past year, has had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the diagnostic criteria specified within the DSM-IV-TR (and subsequent revisions) of the American Psychiatric Association, with the exception of the DSM-IV-TR (and subsequent revisions) "V" codes, substance abuse, and developmental disorders, unless these disorders co-occur with another diagnosable serious emotional disturbance. All of these disorders have episodic, recurrent, or persistent features; however, the disorders may vary in terms of severity and disabling effects; and
 - 3. The diagnosable mental, behavioral, or emotional disorder identified above has resulted in functional impairment which substantially interferes with or limits major life activities. Functional impairment is defined as difficulties that substantially interfere with or limit role functioning in major life activities including the basic living skills (e.g., eating, bathing, dressing); instrumental living skills (maintaining a household, managing money, getting around in the community, taking prescribed medication); and functioning in social, family, and vocational/educational contexts. This definition includes adults who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services.
 - (b) Definitions of Clinically Related Groups (CRGs).
 - 1. Clinically Related Group 1. Any person eighteen (18) years or older whose functioning is, or in the last six (6) months has been, severely impaired and the duration of the impairment totals six (6) months or longer in the past year. This person requires constant assistance or supervision with daily living activities and displays an inability to relate to others which interferes with his/her ability to work and his/her family relationships and usually results in social isolation in the community. Changes in the environment are stressful and may result in further withdrawal or dysfunction in other areas. Support is needed to insure the person's safety and survival.
 - 2. Clinically Related Group 2. Any person eighteen (18) years or older whose functioning is, or in the last six (6) months has been, severely impaired and the duration of the impairment totals six (6) months or longer in the past year. This individual has extensive problems with performing daily routine activities and requires frequent assistance. S/he

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has substantial impairment in his/her ability to take part in social activities or relationships, which often results in social isolation in the community. The person has extensive difficulty in adjusting to change. Assistance with activities of daily living is necessary to survival in the community. This person has difficulty completing simple tasks but with assistance could work in a highly supervised setting.

3. Clinically Related Group 3. Any person eighteen (18) years or older whose functioning has not been severely impaired recently (within the last six (6) months), but has been severely impaired in the past to the extent that he or she needs services to prevent relapse. This individual generally needs long term continued support. Characteristics of this population may include regular or frequent problems performing daily routine activities. S/he may require some supervision although s/he can survive without it. This person has noticeable disruption in social relations, although he or she is capable of taking part in a variety of social activities. Inadequate social skills have a serious negative impact on the person's life; however, some social roles are maintained with support. This person can complete tasks without prompting and help and can function in the workplace with assistance even though the experience may be stressful. There is sometimes noticeable difficulty in accepting and adjusting to change, and the person may require some intervention.
- (98) SSI (SUPPLEMENTAL SECURITY INCOME) BENEFITS shall mean the benefits provided through a program administered by the Social Security Administration for those meeting program eligibility requirements. Tennessee residents determined eligible for SSI benefits are automatically enrolled in TennCare Medicaid.
- (99) TDHS or DHS (TENNESSEE DEPARTMENT OF HUMAN SERVICES) shall mean the State Agency under contract with the Bureau of TennCare to determine eligibility for individuals applying for TennCare Medicaid or TennCare Standard, except for those determined to be eligible for SSI benefits by the Social Security Administration. Medical eligibility for TennCare Standard is not determined by TDHS, but by an entity designated by the Bureau of TennCare.
- (100) TDMHDD (TENNESSEE DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES) shall mean the State Agency responsible for the provision of services to individuals with neurobiological brain disorders, mental illnesses and mental retardation/developmental disabilities.
- (101) TECHNICAL ELIGIBILITY REQUIREMENTS shall mean the eligibility requirements applicable to the appropriate category of medical assistance as discussed in Chapter 1240-3-3-.03 of the rules of the TDHS - Division of Medical Services, and the additional eligibility requirements set forth in these rules.
- (102) TennCare shall mean 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.
- (103) TENNCARE APPEAL FORM shall mean the TennCare form(s) which are completed by an enrollee or by a person authorized by the enrollee to do so, when an enrollee appeals an adverse action affecting TennCare services.
- (104) TennCare MEDICAID shall mean that part of the TennCare program, which covers persons eligible for Medicaid under Tennessee's Title XIX State Plan for Medical Assistance. The following persons are eligible for TennCare Medicaid:

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- (a) Tennessee residents determined to be eligible for Medicaid in accordance with 1240-3-3 of the rules of the Tennessee Department of Human Services - Division of Medical Services.
 - (b) Individuals who qualify as dually eligible for Medicare and Medicaid are enrolled in TennCare Medicaid.
 - (c) A Tennessee resident who is an uninsured woman, under age sixty-five (65), a US citizen or qualified alien, is not eligible for any other category of Medicaid, has been diagnosed as the result of a screening at a Centers for Disease Control and Prevention (CDC) site with breast or cervical cancer, including pre-cancerous conditions.
 - (d) Tennessee residents determined eligible for SSI benefits by the Social Security Administration are automatically enrolled in TennCare Medicaid.
- (105) TENNCARE MEDICAID ELIGIBILITY REFORMS shall mean the amendments to the TennCare demonstration project approved by CMS on March 24, 2005, to close enrollment into TennCare Medicaid for non-pregnant adults age twenty-one (21) or older who qualify as Medically Needy under Tennessee's Title XIX State Plan for Medical Assistance and to disenroll non-pregnant adults age twenty-one (21) or older who qualify as Medically Needy under Tennessee's Title XIX State Plan for Medical Assistance after completion of their twelve (12) months of eligibility.
- (106) TENNCARE PARTNERS PROGRAM shall mean that component of the TennCare Program that provides mental health and substance abuse services.
- (107) TENNCARE PHARMACY PROGRAMS shall mean any TennCare pharmacy carve-outs, including, but not limited to, enrollees with dual eligibility, the behavioral health pharmacy benefit, and all pharmacy services provided by the TennCare managed care organizations (MCOs).
- (108) TennCare SELECT shall mean a state self-insured HMO established by the Bureau of TennCare and administered by a contractor to provide medical services to certain eligible enrollees.
- (109) TennCare Services or TennCare Benefits, for purposes of this rule, shall mean any medical assistance that is administered by the Bureau of TennCare or its contractors and which is funded wholly or in part with federal funds under the Medicaid Act or any waiver thereof, but excluding:
- (a) Medical assistance that can be appealed through an appeal of a pre-admission evaluation (PAE) determination; and
 - (b) Medicare cost sharing services that do not involve utilization review by the Bureau of TennCare or its contractors.
- (110) TennCare STANDARD shall mean that part of the TennCare Program, which provides health coverage for Tennessee residents who:
- (a) are uninsured, do not have access to group health insurance (either directly or indirectly through another family member), and whose income is less than the poverty level for which Federal and State appropriations are made available; or
 - (b) are uninsured, do not have or have access to group health insurance (either directly or indirectly through another family member), and have proven that s/he meets the appropriate Medical Eligibility criteria for his/her circumstances; or

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- (c) Are uninsured children under age nineteen (19), whose family income is less than 200% poverty, who have access to insurance but have not purchased it, and who have been continuously enrolled in this category since December 31, 2001; or
 - (d) Had Medicare as of December 31, 2001 (but not Medicaid) and were enrolled in the TennCare Program as of December 31, 2001, and who continue to meet the definition of “uninsurable” in effect at that time. Effective January 1, 2003 these individuals are eligible only for the TennCare Standard pharmacy benefit package; or
 - (e) Were enrolled as dislocated workers on June 30, 2002, have not purchased other insurance, and have incomes that do not exceed the amount established for redetermination during the waiver transition period in Rule 1200-13-14-.02(7).
- (111) TERMINATION shall mean the discontinuance of an enrollee’s coverage under the TennCare Medicaid or TennCare standard program.
- (112) THIRD PARTY shall mean any entity or funding source other than the enrollee or his/her responsible party, which is or may be liable to pay for all or a part of the costs of medical care of the enrollee.
- (113) TIME-SENSITIVE CARE shall mean (1) the TennCare Bureau has determined that the care is time-sensitive or (2) the enrollees’ treating physician certifies in writing that if enrollees do not get this care within ninety (90) days:
- (a) They will be at risk of serious health problems or death,
 - (b) The delay will cause serious problems with their heart, lungs, or other parts of their body, or
 - (c) They will need to go to the hospital.
- (114) TRANSITION PERIOD shall mean the period from July 1, 2002 through December 31, 2002 during which time the Bureau will transition enrollees and applicants from the old waiver program to the new waiver program.
- (115) Treating Physician (or Clinician) shall mean a health care provider who has provided diagnostic or treatment services for an enrollee (whether or not those services were covered by TennCare), for purposes of treating, or supporting the treatment of, a known or suspected medical condition. The term excludes providers who have evaluated an enrollee’s medical condition primarily or exclusively for the purposes of supporting or participating in a decision regarding TennCare coverage.
- (116) UNINSURED shall mean any person who does not have health insurance directly or indirectly through another family member, or who does not have access to group health insurance. For purposes of the Medicaid eligibility category of women under 65 requiring treatment for breast or cervical cancer, “Uninsured” shall mean any person who does not have health insurance or access to health insurance which covers treatment for breast or cervical cancer.
- (117) VALID FACTUAL DISPUTE shall mean a dispute which, if resolved in favor of the enrollee, would result in the proposed action not being taken.
- (118) WAIVER ELIGIBLE shall mean a person who is not eligible for Medicaid, is enrolled in the TennCare program as of June 30, 2002 and whose eligibility was determined based on the terms of the waiver in effect as of June 30, 2002. Effective July 1, 2002 all waiver-eligibles are considered TennCare Standard enrollees for the purposes of these rules.

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

Authority: T.C.A. §§4-5-202, 4-5-209, 71-5-105, 71-5-109, 71-5-134, and Executive Order No. 23. **Administrative History:** Original rule filed September 30, 2002; to be effective December 14, 2002; however, on December 9, 2002, the House Government Operations Committee of the General Assembly stayed rule 1200-13-13-.01; new effective date February 12, 2003. Amendment filed April 9, 2003; effective June 23, 2003. Public necessity rule filed May 5, 2005; effective through October 17, 2005. Public necessity rule filed June 3, 2005; effective through November 15, 2005. Amendment filed July 14, 2005; effective September 27, 2005. Amendment filed July 20, 2005; effective October 3, 2005. Amendment filed July 28, 2005; effective October 11, 2005. Amendment filed September 1, 2005; effective November 15, 2005. Public necessity rule filed December 9, 2005; effective through May 23, 2006. Public necessity rule filed December 29, 2005; effective through June 12, 2006. Public necessity rule filed March 3, 2006; effective through August 15, 2006. Amendment filed March 3, 2006; effective May 17, 2006.

1200-13-13-.02 ELIGIBILITY.

- (1) Delineation of Agency Roles and Responsibilities.
 - (a) The Tennessee Department of Finance and Administration is the lead State agency for the TennCare Program and is responsible for establishing policy and procedural requirements and criteria.
 - (b) The TDHS is under contract with the Department of Finance and Administration to determine TennCare Medicaid eligibility and eligibility for TennCare Standard, with the exception of determining the presence of a qualifying medical condition for those applying as medically eligible persons.
 - (c) The Social Security Administration determines eligibility for the Supplemental Security Income (SSI) Program. Tennessee residents determined eligible for SSI benefits are automatically eligible for and enrolled in TennCare Medicaid benefits.
 - (d) The Tennessee Department of Mental health and Developmental Disabilities (TDMHDD) is the lead agency for establishing policy and procedural requirements and criteria for the TennCare Partners Program.
- (2) Technical and Financial Eligibility Requirements for TennCare Medicaid.
 - (a) To be eligible for TennCare Medicaid, each individual must:
 1. Meet all technical requirements applicable to the appropriate category of medical assistance as described in Chapter 1240-3-3-.03 of the rules of the TDHS - Division of Medical Assistance, and all financial eligibility requirements applicable to the appropriate category of medical assistance as described in Chapter 1240-3-3-.03 of the rules of the TDHS - Division of Medical Assistance; or
 2. Meet the financial eligibility requirements of the SSI Program of the Social Security Administration and be approved for SSI benefits by the Social Security Administration; or
 3. Be a woman who
 - (i) Is under age sixty-five (65),
 - (ii) Is uninsured,
 - (iii) Is not eligible for Medicaid under any other category,

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- (iv) Is a U.S. citizen or qualified alien,
 - (v) Has been diagnosed by a screening at a Centers for Disease Control and Prevention (CDC) site with breast or cervical cancer, including pre-cancerous conditions, and needs treatment, and
 - (b) The Bureau of TennCare will also have access to third party information on current TennCare Medicaid eligibles. MCCs will release insurance information from their files to the Bureau of TennCare on a regular basis, as required in the contract between the MCCs and the Tennessee Department of Finance and Administration.
 - (c) By applying for TennCare Medicaid, an applicant grants permission and authorizes release of information to the Bureau, or its designee, to investigate any and all information provided, or any information not provided if it could affect eligibility, to determine TennCare eligibility; and if approved, what cost sharing, if any, may be required of the applicant as found in these rules. Information may be verified through, but not limited to, the following sources:
 - 1. The United States Internal Revenue Service (IRS);
 - 2. State income tax records for Tennessee or any other state where income is earned;
 - 3. The Tennessee Department of Labor and Work Force Development, and other employment security offices within any state whereby the applicant may have received wages or been employed;
 - 4. Credit bureaus;
 - 5. Insurance companies;
 - 6. Any other governmental agency, or public or private source of information where such information may impact an applicant's eligibility or cost sharing requirements for the TennCare Program.
 - (d) Under Tennessee Code Annotated (T.C.A.) 71-5-118 it is a felony offense to obtain TennCare coverage under false means or to help anyone get on TennCare under false means.
- (3) Covered Groups under TennCare Medicaid.
 - (a) Eligibility for TennCare Medicaid is limited to individuals who meet the following criteria:
 - 1. Tennessee residents who are eligible for Medicaid as defined in rule 1240-3-3 of the TDHS - Division of Medical Assistance;
 - (i) Individuals enrolled as categorically needy, as defined at 1200-13-13-.01 of these rules, will be eligible for TennCare Medicaid for a period determined by his/her eligibility category.
 - (ii) Individuals enrolled as medically needy, as defined at 1200-13-13-.01 of these rules, will be enrolled in TennCare Medicaid for one year. At the end of that year, eligibility either in TennCare Medicaid or TennCare Standard must be re-established in order for these individuals to continue in the program.

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- (iii) A TennCare Medicaid enrollee in Parts 1.(i) and 2.(ii) above, must be recertified for TennCare Medicaid prior to the expiration of his/her eligibility and qualify to remain in TennCare Medicaid, or apply for and be approved for TennCare Standard in order to maintain his/her benefits in the TennCare Program without a break in coverage.
 - 2. Tennessee residents who are determined eligible for the SSI Program by the Social Security Administration.
 - 3. Women who have been enrolled as a result of needing treatment for breast or cervical cancer and who meet the technical requirements found at 1200-13-13-.02(2)(a)3.
 - (b) Effective date of eligibility
 - 1. For SSI eligibles, the date determined by the Social Security Administration in approving the individual for SSI coverage.
 - 2. For all other Medicaid eligibles, the date of the application or the date of the qualifying event (such as the date that a spend-down obligation is met), whichever is later.
 - 3. For persons applying for Medicaid eligibility during a period when the DHS offices are not open, the date his/her faxed application is received at DHS, but only when the faxed application is followed up on the next business day with a complete application at DHS.
 - (c) Notwithstanding anything in these rules or in the Department of Human Services rules to the contrary, specifically including Chapter 1240-3-2 concerning eligibility of individuals in a Medically Needy category, effective at the close of business of the offices of the State of Tennessee on April 29, 2005, enrollment in the Medically Needy category is closed to all enrollees except for: (a) individuals under the age of twenty-one (21); and (b) pregnant women. Individuals who have filed an application for a Medically Needy category that is open for enrollment prior to the close of business of the offices of the State of Tennessee on April 29, 2005, will be allowed to enroll in such category if it is determined that they have met the eligibility criteria for such category prior to the close of business of the offices of the State of Tennessee on April 29, 2005, even if such determination is made after the close of business of the offices of the State of Tennessee on April 29, 2005. Any individual whose application is approved for enrollment in a Medically Needy category will be enrolled in the Medically Needy category for a period of twelve (12) months from the latter of: (a) the date of his or her application; or (b) the date spenddown eligibility is met, so long as either (a) and (b), as applicable, occurs prior to the close of business of the offices of the State of Tennessee on April 29, 2005.
- (4) Loss of Eligibility.
- Eligibility for TennCare Medicaid shall cease when:
- (a) The individual no longer qualifies for TennCare Medicaid as specified in Chapter 1240-3-3 of the rules of TDHS; or
 - (b) A woman determined to be eligible under 1200-13-13-.02(2)(a)3. of these rules:
 - 1. Reaches age sixty-five (65); or
 - 2. Gains access to group health insurance as defined elsewhere in these rules; or

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3. It has been determined that she no longer needs treatment for breast or cervical cancer, including pre-cancerous conditions.
- (c) In implementing TennCare Medicaid Eligibility Reforms, an individual who is eligible as a non-pregnant Medically Needy adult in accordance with Rule 1240-3-2-.03 of the Tennessee Department of Human Services is found to meet all the following criteria:
- 1 S/he is aged twenty-one (21) or older,
 2. S/he has completed his/her twelve (12) months of eligibility for TennCare,
 3. S/he is eligible for Medicare,
 4. S/he is not receiving TennCare-reimbursed services in either a Nursing Facility, Intermediate Care Facility for the Mentally Retarded or Home and Community Based Services waiver as of December 31, 2005, and
 5. S/he has not been determined eligible in an open Medicaid category.
- (5) TennCare Partners Program.

A person who is enrolled in the TennCare Medicaid Program will receive his/her behavioral health services through the assigned Behavioral Health Organization.

- (6) Recertification of TennCare Medicaid Eligibility.
- (a) An enrollee who qualifies for TennCare Medicaid through the TDHS shall recertify his/her TennCare Medicaid eligibility as required by the appropriate category of medical assistance as described in Chapter 1240-3-3 of the rules of the TDHS - Division of Medical Assistance. Prior to termination of Medicaid eligibility for enrollees of the Core Medicaid Population, enrollees' eligibility will be reviewed in accordance with the following process:
1. Request for Information.
 - (i) At least thirty (30) days prior to the expiration of their current eligibility period, the Bureau of TennCare will send a Request for Information to all Core Medicaid enrollees. The Request for Information will include a form to be completed with information needed to determine eligibility for open Medicaid categories.
 - (ii) Enrollees will be given thirty (30) days inclusive of mail time from the date of the Request for Information to return the completed form to TDHS and to provide TDHS with the necessary verifications to determine eligibility for open Medicaid categories.
 - (iii) Enrollees with a health, mental health, learning problem or a disability will be given the opportunity to request assistance in responding to the Request for Information. Enrollees with Limited English Proficiency will have the opportunity to request translation assistance for responding to the Request for Information.
 - (iv) If an enrollee provides some but not all of the necessary information to TDHS to determine his/her eligibility for open Medicaid categories during the thirty (30) day period following the Request for Information, TDHS will send the enrollee a Verification Request. The Verification Request will provide the enrollee with ten

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(10) days inclusive of mail time to submit any missing information as identified in the Verification Request.

- (v) Enrollees who respond to the Request for Information within the thirty (30) day period shall retain their eligibility for TennCare Medicaid (subject to any changes in covered services generally applicable to enrollees in their Medicaid category) while TDHS reviews their eligibility for open Medicaid categories.
- (vi) TDHS shall review all information and verifications provided within the requisite time period by an enrollee pursuant to the Request for Information and/or the Verification Request to determine whether the enrollee is eligible for any open Medicaid categories. If TDHS determines that the enrollee remains eligible for his/her current Medicaid category, the enrollee will remain enrolled in such Medicaid category. If TDHS makes a determination that the enrollee is eligible for a different open Medicaid category, TDHS will so notify the enrollee and the enrollee will be enrolled in the appropriate TennCare Medicaid category. When the enrollee is enrolled in the new appropriate TennCare Medicaid category, his/her eligibility in the previous category shall be terminated without additional notice. If a child is reviewed for Medicaid eligibility and is found not to be eligible for any open Medicaid category, the child will be reviewed for eligibility for TennCare Standard under Rule 1200-13-14-.02(3). If TDHS makes a determination that the enrollee is not eligible for any open Medicaid categories or if an enrollee does not respond to the Request for Information within the requisite thirty (30) day time period the TennCare Bureau will send the enrollee a twenty (20) day advance Termination Notice.
- (vii) Enrollees who respond to the Request for Information or the Verification Request after the requisite time period specified in those notices but before the date of termination shall retain their eligibility for TennCare Medicaid (subject to any changes in covered services generally applicable to enrollees in their Medicaid category) while TDHS reviews their eligibility for open Medicaid categories. If TDHS determines that the enrollee remains eligible for his/her current Medicaid category, the enrollee will remain enrolled in such Medicaid category. If TDHS makes a determination that the enrollee is eligible for a different open Medicaid category, TDHS will so notify the enrollee and the enrollee will be enrolled in the new appropriate TennCare Medicaid category. When the enrollee is enrolled in the appropriate TennCare Medicaid category, his/her eligibility in the previous category shall be terminated without additional notice. If a child is reviewed for Medicaid eligibility and is found not to be eligible for any open Medicaid category, the child will be reviewed for eligibility for TennCare Standard under Rule 1200-13-14-.02(3). If TDHS makes a determination that the enrollee is not eligible for any open Medicaid categories, the TennCare Bureau will send the enrollee a twenty (20) day advance Termination Notice.
- (viii) Individuals may provide the information and verifications specified in the Request for Information after termination of eligibility. TDHS shall review all such information pursuant to the rules, policies and procedures of TDHS and the Bureau of TennCare applicable to new applicants for TennCare Medicaid coverage. The individual shall not be entitled to be reinstated into TennCare Medicaid pending this review. If the individual is subsequently determined to be eligible for an open Medicaid category, s/he shall be granted retroactive coverage to the date of application, or in the case of spend down eligibility for Medically Needy pregnant women and children, to the latter of (a) the date of his or her application, or (b) the date spend down eligibility is met.

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2. Termination Notice

- (i) The TennCare Bureau will send Termination Notices to all Core Medicaid Population enrollees being terminated pursuant to state and federal law who are not determined to be eligible for open Medicaid categories pursuant to the Request for Information processes described in Rule 1200-13-13-.02(6)(a)1.
- (ii) Termination Notices will be sent twenty (20) days in advance of the date upon which the coverage will be terminated.
- (iii) Termination Notices will provide enrollees with forty (40) days from the date of the notice to appeal the termination and will inform enrollees how they may request a hearing. Appeals will be processed by TDHS in accordance with Rule 1200-13-13-.12.
- (iv) Enrollees with a health, mental health, learning problem or a disability will be given the opportunity to request additional assistance for their appeal. Enrollees with Limited English Proficiency will have the opportunity to request translation assistance for their appeal.

(b) A woman, who has been determined eligible for TennCare Medicaid under 1200-13-13-.02(2)(a)3. of these rules, shall annually recertify her eligibility in terms of changes to her address, her and her family's if appropriate, income, and access to health insurance.

(c) Enrollees eligible for TennCare Medicaid as a result of being eligible for SSI benefits shall follow the recertification requirements of the Social Security Administration.

(7) Disenrollment Related to TennCare Medicaid Eligibility Reforms.

Prior to the disenrollment of adult non-pregnant Medically Needy TennCare enrollees based on coverage terminations resulting from TennCare Medicaid Eligibility Reforms, Medicaid eligibility shall be reviewed in accordance with the following:

(a) Ex Parte Review.

TDHS will conduct an ex parte review of eligibility for open Medicaid categories for all non-pregnant adult Medically Needy enrollees in eligibility groups due to be terminated as part of the TennCare Medicaid eligibility reforms. Such ex parte review shall be conducted in accordance with federal requirements as set forth by CMS in the Special Terms and Conditions of the TennCare demonstration project.

(b) Request for Information.

- 1. At least thirty (30) days prior to the expiration of their current eligibility period, the Bureau of TennCare will send a Request for Information to all non-pregnant adult Medically Needy enrollees in eligibility groups being terminated pursuant to the TennCare Medicaid eligibility reforms. The Request for Information will include a form to be completed with information needed to determine eligibility for open Medicaid categories as well as a list of the types of proof needed to verify certain information.
- 2. Enrollees will be given thirty (30) days inclusive of mail time from the date of the Request for Information to return the completed form to TDHS and to provide TDHS with the necessary verifications to determine eligibility for open Medicaid categories.

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

3. Enrollees with a health, mental health, learning problem or a disability will be given the opportunity to request assistance in responding to the Request for Information. Enrollees with Limited English Proficiency will have the opportunity to request translation assistance for responding to the Request for Information.
4. Enrollees will be given an opportunity until the date of termination to request one extension for good cause of the thirty (30) day time frame for responding to the Request for Information. The good cause extension is intended to allow a limited avenue for possible relief for certain enrollees who face significant unforeseen circumstances, or who, as a result of a health, mental health, learning problem, disability or limited English proficiency, are unable to respond timely, as an alternative to imposing a standard with no exceptions whatsoever. The good cause exception does not confer an entitlement upon enrollees and the application of this exception will be within the discretion of TDHS. Only one thirty (30) day good cause extension can be granted to each enrollee. Good cause is determined by TDHS eligibility staff. Good cause is not requested nor determined through filing an appeal. Requests for an extension of the thirty (30) day time frame to respond to the Request for Information must be initiated by the enrollee. However, the enrollee may receive assistance in initiating such request. TDHS will not accept a request for extension of the thirty (30) day time frame submitted by a family member, advocate, provider or CMHC, acting on the enrollee's behalf without the involvement and knowledge of the enrollee, for example, to allow time for such entity to locate the enrollee if his/her whereabouts are unknown. All requests for good cause extension must be made prior to termination of Medicaid eligibility. A good cause extension will be granted if TDHS determines that a health, mental health, learning problem, disability or limited English proficiency prevented an enrollee from understanding or responding timely to the Request for Information. Except in the aforementioned circumstances, a good cause extension will only be granted if such request is submitted in writing to TDHS prior to termination of Medicaid eligibility and TDHS determines that serious personal circumstances such as illness or death prevent an enrollee from responding to the Request for Information for an extended period of time. Proof of the serious personal circumstances is required with the submission of the written request in order for a good cause extension to be granted. Good cause extensions will be granted at the sole discretion of TDHS and if granted shall provide the enrollee with an additional thirty (30) days inclusive of mail time from the date of TDHS's decision to grant the good cause extension. TDHS will send the enrollee a letter granting or denying the request for good cause extension. TDHS's decisions with respect to good cause extension shall not be appealable.
5. If an enrollee provides some but not all of the necessary information to TDHS to determine his/her eligibility for open Medicaid categories during the thirty (30) day period following the Request for Information, TDHS will send the enrollee a Verification Request. The Verification Request will provide the enrollee with ten (10) days inclusive of mail time to submit any missing information as identified in the Verification Request. Enrollees will not have the opportunity to request an extension for good cause of the ten (10) day time frame for responding to the Verification Request.
6. Enrollees who respond to the Request for Information within the thirty (30) day period or within any extension of such period granted by TDHS shall retain their eligibility for TennCare Medicaid (subject to any changes in covered services generally applicable to enrollees in their Medicaid category) while TDHS reviews their eligibility for open Medicaid categories.

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

7. TDHS shall review all information and verifications provided within the requisite time period by an enrollee pursuant to the Request for Information and/or the Verification Request to determine whether the enrollee is eligible for any open Medicaid categories. If TDHS makes a determination that the enrollee is eligible for an open Medicaid category, TDHS will so notify the enrollee and the enrollee will be enrolled in the appropriate TennCare Medicaid category. When the enrollee is enrolled in the appropriate TennCare Medicaid category, his/her eligibility as a non-pregnant Medically Needy adult shall be terminated without additional notice. If TDHS makes a determination that the enrollee is not eligible for any open Medicaid categories or if an enrollee does not respond to the Request for Information within the requisite thirty (30) day time period or any extension of such period granted by TDHS, the TennCare Bureau will send the enrollee a twenty (20) day advance Termination Notice.
 8. Enrollees who respond to the Request for Information or the Verification Request after the requisite time period specified in those notices or after any extension of such time period granted by TDHS but before the date of termination shall retain their eligibility for TennCare Medicaid (subject to any changes in covered services generally applicable to enrollees in their Medicaid category) while TDHS reviews their eligibility for open Medicaid categories. If TDHS makes a determination that the enrollee is eligible for an open Medicaid category, TDHS will so notify the enrollee and the enrollee will be enrolled in the appropriate TennCare Medicaid category. When the enrollee is enrolled in the appropriate TennCare Medicaid category, his/her eligibility as a non-pregnant Medically Needy adult shall be terminated without additional notice. If TDHS makes a determination that the enrollee is not eligible for any open Medicaid categories, the TennCare Bureau will send the enrollee a twenty (20) day advance Termination Notice.
 9. Individuals may provide the information and verifications specified in the Request for Information after termination of eligibility. TDHS shall review all such information pursuant to the rules, policies and procedures of TDHS and the Bureau of TennCare applicable to new applicants for TennCare coverage. The individual shall not be entitled to be reinstated into TennCare pending this review. If the individual is subsequently determined to be eligible for an open Medicaid category, s/he shall be granted retroactive coverage to the date of application, or in the case of spend down eligibility for Medically Needy pregnant women and children, to the latter of (a) the date of his or her application, or (b) the date spend down eligibility is met.
- (c) Termination Notice.
1. The TennCare Bureau will send Termination Notices to all non-pregnant adult Medically Needy enrollees being terminated pursuant to the TennCare Medicaid eligibility reforms who are not determined to be eligible for open Medicaid categories pursuant to the Ex Parte Review or Request for Information processes described in this subsection.
 2. Termination Notices will be sent twenty (20) days in advance of the date upon which the coverage will be terminated.
 3. Termination Notices will provide enrollees with forty (40) days from the date of the notice to appeal valid factual disputes related to the disenrollment and will inform enrollees how they may request a hearing.
 4. Enrollees with a health, mental health, learning problem or a disability will be given the opportunity to request additional assistance for their appeal. Enrollees with Limited English Proficiency will have the opportunity to request translation assistance for their appeal.

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

5. Enrollees will not have the opportunity to request an extension for good cause of the forty (40) day time frame in which to request a hearing.

Authority: T.C.A. §§4-5-202, 4-5-209, 71-5-105, 71-5-109, 71-5-134, and Executive Order No. 23. **Administrative History:** Original rule filed September 30, 2002; to be effective December 14, 2002; however, on December 9, 2002, the House Government Operations Committee of the General Assembly stayed rule 1200-13-13-.02; new effective date February 12, 2003. Amendment filed April 9, 2003; effective June 23, 2003. Public necessity rule filed April 29, 2005, effective through October 11, 2005. Public necessity rule filed June 3, 2005; effective through November 15, 2005. Amendment filed July 28, 2005; effective October 11, 2005. Amendments filed September 1, 2005; effective November 15, 2005. Public necessity rule filed December 9, 2005; effective through May 23, 2006. Public necessity rule filed March 3, 2006; effective through August 15, 2006. Amendment filed March 3, 2006; effective May 17, 2006.

1200-13-13-.03 ENROLLMENT, DISENROLLMENT, RE-ENROLLMENT, AND REASSIGNMENT.

(1) Enrollment.

Persons determined eligible for TennCare Medicaid by the TDHS or the Social Security Administration, as eligible for SSI benefits, shall enroll in accordance with the following:

- (a) Individuals who are approved for TennCare Medicaid by the TDHS or the Social Security Administration (for SSI benefits) shall be allowed to enroll in TennCare Medicaid at any time throughout the year.
- (b) TennCare Medicaid enrollees will have a forty-five (45) day period after initially selecting or being assigned to a health plan to change plans. No additional changes will be allowed except as otherwise specified in these rules.
- (c) If an individual is approved for TennCare Medicaid and has another family member already enrolled in the TennCare Program, that individual shall be placed in the same health plan as the currently enrolled family member. To the extent possible, all identifiable family members shall be placed in the same health plan. The exception will be any family members assigned to TennCare Select by the Bureau of TennCare. If the newly enrolled family member opts to change MCOs during the 45-day change period as stated in (b) above, all family members on the case will be transferred to the new MCO.
- (d) Enrollees in TennCare Medicaid shall be given his/her choice of health plans when possible. If no MCO is available to enroll new members in the enrollee's region, the enrollee will be assigned to TennCare Select until such time as another MCO becomes available. The Bureau may also elect to assign certain TennCare Medicaid children with special health needs to TennCare Select. Once the 45-day change period, as stated in (b) above expires, an individual shall remain a member of the designated plan until:
 1. Recertification if s/he is TDHS-eligible for TennCare Medicaid. During the recertification process, the enrollee will be given the opportunity to change health plans if s/he chooses to do so. Enrollees who must recertify TennCare Medicaid eligibility more often than annually will only be allowed to change health plans one (1) time per twelve (12) months, except as otherwise provided for in these rules; or
 2. S/he, if eligible for TennCare Medicaid as a result of being eligible for SSI benefits, is given the opportunity to change health plans annually during a period specified by the Bureau of TennCare; or

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

3. S/he loses eligibility to participate in the TennCare Program, whichever comes first.

However, enrollees, after going through the appeal process as described in (4)(b) below, and obtaining the approval of the Bureau of TennCare, may be permitted to change enrollment to a different health plan. In the event that an enrollee elects to change health plans, the enrollee's medical care will be the responsibility of the original health plan until enrollment in the subsequent health plan is deemed complete.

- (e) All changes in health plan assignments are subject to the requested health plan's ability and capacity to accept additional enrollees. If the requested health plan cannot accept additional enrollees, the enrollee will be assigned to another health plan, or remain in the same health plan of which s/he is a current member.
- (f) TennCare Medicaid enrollees shall be enrolled in a BHO for his/her mental health and substance abuse services.
- (g) TennCare Medicaid enrollees shall be accepted by an MCO regardless of his/her health condition at the time of enrollment.
- (h) Individuals or families determined eligible for TennCare Medicaid shall select a health plan at the time of application. Individuals enrolled as a result of being eligible for SSI benefits will be assigned to a health plan as s/he does not have the opportunity to select a health plan prior to the effective date of coverage. All TennCare Medicaid enrollees have a forty-five (45) day period, effective with the effective date of coverage, to request a change of health plans.
- (i) Enrollment shall be effective on the date provided to the Bureau of TennCare by the TDHS or the Social Security Administration, in accordance with these rules, and the eligible person has selected or been assigned to a health plan from those available where the person resides. In the event that an individual fails to select a health plan or the requested health plan is unable to accept additional enrollees, s/he shall be assigned to a health plan by the Bureau of TennCare.
- (j) MCOs shall offer enrollees to the extent possible, freedom of choice among providers participating in the MCO's respective health plans. If after notification of enrollment the enrollee has not chosen a primary care provider, one may be chosen for him/her by the MCO. The period during which an enrollee may choose his/her primary care provider shall not be less than fifteen (15) calendar days.
- (k) A TennCare Medicaid enrollee is given his/her choice of health plans when possible. Once enrolled, the enrollee shall remain a member of the designated health plan until s/he is given an opportunity to change during an annual recertification period, or during a Bureau of TennCare-specific time for those who are SSI-eligible to participate in TennCare Medicaid. Only one (1) change is permitted every twelve (12) months, except where otherwise provided for in these rules.
- (l) Prior to the expiration of TDHS Medicaid eligibility, such enrollee will be sent a notice by TDHS that s/he needs to be redetermined as to continued Medicaid eligibility. The Bureau of TennCare will also send a notice to the enrollee at his/her last address on file. This notice will remind the enrollee that s/he is at risk of losing Medicaid and TennCare Medicaid coverage. In order to retain eligibility for TennCare, the enrollee must complete one of the following and be approved for Medicaid and/or TennCare.
 - 1. Make and keep an appointment with the TDHS office of the county where s/he resides. The worker will review the information presented by the enrollee to determine if s/he

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

meets the eligibility criteria in any Medicaid-eligible category. The enrollee will be informed by TDHS of eligibility status.

2. An individual who is losing eligibility for TennCare Medicaid may apply for enrollment in TennCare Standard as a Medicaid “Rollover”, regardless of income levels, as defined herein:
 - (i) A notice will be sent by the Bureau of TennCare thirty (30) days prior to the expiration of the individual’s TennCare Medicaid eligibility period. This letter will tell the individual that eligibility for Medicaid is ending, and to continue in the TennCare Program, s/he must go to his/her county TDHS office and reapply as instructed in the notice.
 - (ii) When the individual reapplies, s/he will first be screened for TennCare Medicaid eligibility.
 - (iii) If the individual is no longer TennCare Medicaid eligible, s/he will then be screened for eligibility as a Medicaid “Rollover”. Such enrollees submitting an application to TDHS will have sixty (60) additional days (inclusive of mail time) to complete the process (from the date the application is received at TDHS). This includes scheduling an appointment with the TDHS office in the county where s/he resides and completing the application process. An enrollee under age nineteen (19) who submits an application prior to the end date of Medicaid eligibility and who is found eligible as a Medicaid “Rollover” may be enrolled in TennCare Standard during periods of closed enrollment if s/he meets the technical and financial requirements found at 1200-13-14-.02 of the Rules of TennCare Standard.
 - (iv) If determined to be eligible for TennCare Standard, the individual will be subject to premium and copayment requirements as appropriate.
- (m) Notwithstanding anything in these rules or in the Department of Human Services rules to the contrary, specifically including Chapter 1240-3-2 concerning eligibility of individuals in a Medically Needy category, effective at the close of business of the offices of the State of Tennessee on April 29, 2005, enrollment in the Medically Needy category is closed to all enrollees except for: (a) individuals under the age of twenty-one (21); and (b) pregnant women. Individuals who have filed an application for a Medically Needy category that is open for enrollment prior to the close of business of the offices of the State of Tennessee on April 29, 2005, will be allowed to enroll in such category if it is determined that they have met the eligibility criteria for such category prior to the close of business of the offices of the State of Tennessee on April 29, 2005, even if such determination is made after the close of business of the offices of the State of Tennessee on April 29, 2005. Any individual whose application is approved for enrollment in a Medically Needy category will be enrolled in the Medically Needy category for a period of twelve (12) months from the latter of: (a) the date of his or her application; or (b) the date spenddown eligibility is met, so long as either (a) and (b), as applicable, occurs prior to the close of business of the State of Tennessee on April 29, 2005.
- (2) Disenrollment.
 - (a) A TennCare Medicaid enrollee may be disenrolled from a designated health plan only when authorized to do so by the Bureau of TennCare.
 - (b) Coverage shall cease at 12:00 midnight, local time, on the date that the individual is disenrolled.

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

- (c) An MCO may not request the disenrollment of a TennCare Medicaid enrollee for any of the following reasons:
 - 1. Adverse changes in the enrollee's health;
 - 2. Pre-existing medical conditions; or
 - 3. High cost medical bills.
- (3) Re-enrollment.
 - (a) A TennCare Standard enrollee who is terminated from the TennCare Standard Program for failure to pay applicable premiums may be re-enrolled in TennCare Medicaid if eligible, without having to pay the outstanding arrearages as a condition of re-enrollment; however,
 - (b) Nothing in this provision shall eliminate the enrollee's responsibility for premium arrearages incurred during any previous period of TennCare Standard eligibility. The arrearages will not be used to impede enrollment in TennCare Medicaid, however, should the enrollee become eligible for Medicaid.
- (4) Reassignment.
 - (a) Reassignment to a health plan other than the current health plan in which the TennCare Medicaid enrollee is placed is subject to another health's plan capacity to accept new enrollees, must be approved by the Bureau of TennCare, and is the result of one of the following:
 - 1. During the initial forty-five (45) day period of enrollment, a TennCare Medicaid enrollee may request transfer to a health plan other than the one s/he selected or to which s/he was assigned.
 - 2. A TennCare Medicaid enrollee must change health plans if s/he moves outside of the health plan's Community Services Area (CSA), and that health plan is not authorized to operate in the TennCare Medicaid enrollee's new place of residence. Until the TennCare Medicaid enrollee selects or is assigned to a new health plan and his/her enrollment is deemed complete, his/her medical care will remain the responsibility of the original health plan. Once reassigned, a TennCare Medicaid enrollee will have forty-five (45) calendar days to change his/her choice of health plans in the new CSA.
 - 3. TennCare Medicaid enrollees will be given the opportunity to select a new health plan if his/her health plan withdraws from participation in the TennCare Program if more than one (1) health plan is available as being able to accept new enrollees. If no MCO is available to accept enrollees from an exiting MCO, the enrollees will be assigned to TennCare Select until such time as another MCO becomes available. If the enrollee does not make a selection within the allotted time frame, or if circumstances exist which do not permit the Bureau to allow time for a selection period, the Bureau of TennCare will assign him/her to a health plan operating in his/her CSA.
 - 4. A TennCare Medicaid enrollee will be given an opportunity to change MCOs only once per twelve (12) months regardless of how often Medicaid eligibility is required to be recertified. Only one (1) health plan change is permitted every twelve (12) months, unless the Bureau authorizes a change as the result of the resolution of an appeal requesting a "hardship" reassignment. When an enrollee changes health plans, the enrollee's medical care will be the responsibility of the current health plan until enrolled in the requested health plan.

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

- (b) A TennCare Medicaid enrollee may change health plans if the TennCare Bureau has granted a request for a change in health plans or an appeal of a denial of a request for a change in health plans has been resolved in his/her favor based on hardship criteria. Requests for hardship MCO reassignments must meet all of the following six (6) hardship criteria for reassignment. Determinations will be made on an individual basis.
1. A member has a medical condition that requires complex, extensive, and ongoing care; and
 2. The member's PCP and/or specialist has stopped participating in the member's current MCO network and has refused continuation of care to the member in his/her current MCO assignment; and
 3. The ongoing medical condition of the member is such that another physician or provider with appropriate expertise would be unable to take over his/her care without significant and negative impact on his/her care; and
 4. The current MCO has been unable to negotiate continued care for this member with the current PCP or specialist; and
 5. The current provider of services is in the network of one or more alternative MCOs; and
 6. An alternative MCO is available to enrolled members (i.e., has not given notice of withdrawal from the TennCare Program, is not in receivership, and is not at member capacity for the member's region).

A hardship MCO change request will not be granted to a Medicare beneficiary who, with the exception of pharmacy services, may utilize his/her choice of providers, regardless of network affiliation.

Requests to change MCCs submitted by TennCare enrollees shall be evaluated in accordance with the hardship criteria referenced above. Upon denial of a request to change MCCs, enrollees shall be provided notice and appeal rights as described in applicable provisions of rule 1200-13-13-.11.

- (c) Enrollees who are out-of-state on a temporary basis, but maintain his/her status as a Tennessee resident under state and federal laws, shall be reassigned to TennCare Select for the period of time s/he is out-of-state.

Authority: T.C.A. §§4-5-202, 4-5-209, 71-5-105, 71-5-109, 71-5-134, and Executive Order No. 23. **Administrative History:** Original rule filed September 30, 2002; to be effective December 14, 2002; however, on December 9, 2002, the House Government Operations Committee of the General Assembly stayed rule 1200-13-13-.03; new effective date February 12, 2003. Public necessity rule filed April 19, 2005; effective through October 11, 2005. Amendments filed July 28, 2005; effective October 11, 2005. Public necessity rule filed December 29, 2005; effective through June 12, 2006.

1200-13-13-.04 COVERED SERVICES.

- (1) Benefits covered under the managed care program
- (a) TennCare managed care contractors (MCCs) shall cover the following services and benefits subject to any applicable limitations described herein.

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

- (i) Any and all medically necessary services may require prior authorization or approval by the MCC, except where prohibited by law.

There are two instances in which an MCC may not refuse to pay for a service solely because of a lack of prior authorization. These instances are as follows:

- (I) EPSDT services. In the event a service requiring prior authorization is delivered without prior authorization and is proven to be a medically necessary covered service, the MCC cannot deny payment for the service solely because the provider did not obtain prior authorization or approval from the enrollee’s MCC.
 - (II) Emergency services. MCCs shall not require prior authorization or approval for covered services rendered in the event of an emergency, as defined in these rules. Such emergency services may be reviewed on the basis of medical necessity or other MCC administrator requirements, but cannot be denied solely because the provider did not obtain prior authorization or approval from the enrollee’s MCC.
- (ii) MCCs shall not impose any service limitations that are more restrictive than those described herein; however, this shall not limit the MCC’s ability to establish procedures for the determination of medical necessity.
 - (iii) Services for which there is no federal financial participation (FFP) are not covered.
 - (iv) Non-covered services are non-covered regardless of medical necessity.

- (b) The following physical health and mental health benefits are covered under the TennCare managed care program. There are some exclusions to these benefits. The exclusions are listed in this rule and in Rule 1200-13-13-.10.

SERVICE	BENEFIT FOR PERSONS UNDER AGE 21	BENEFIT FOR PERSONS AGED 21 AND OLDER
1. Ambulance Services.	See “Emergency Air and Ground Transportation” and “Non-Emergency Ambulance Transportation.”	See “Emergency Air and Ground Transportation” and “Non-Emergency Ambulance Transportation.”
2. Bariatric Surgery, defined as surgery to induce weight loss.	Covered as medically necessary and in accordance with clinical guidelines established by the Bureau of TennCare.	Covered as medically necessary and in accordance with clinical guidelines established by the Bureau of TennCare.
3. Chiropractic Services [defined at 42 CFR §440.60(b)].	Covered as medically necessary.	Not covered.
4. Community Health Services, [defined at 42 CFR §440.20(b) and (c) and 42 CFR §440.90].	Covered as medically necessary.	Covered as medically necessary.
5. Convalescent Care [defined as care provided in a nursing facility after a hospitalization].	Upon receipt of proof that an enrollee has incurred medically necessary expenses related to convalescent care, TennCare shall pay for up to and including the one hundredth (100th) day of confinement during any calendar year for convalescent facility room, board, and general nursing care,	Not covered.

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

SERVICE	BENEFIT FOR PERSONS UNDER AGE 21	BENEFIT FOR PERSONS AGED 21 AND OLDER
	<p>provided that: (A) a physician recommends confinement for convalescence; (B) the enrollee is under the continuous care of a physician during the entire period of convalescence; and (C) the confinement is required for other than custodial care.</p>	
<p>6. Dental Services [defined at 42 CFR §440.100].</p>	<p>Preventive, diagnostic, and treatment services covered as medically necessary.</p> <p>Dental services under EPSDT, including dental screens, are provided in accordance with the state's periodicity schedule as determined after consultation with recognized dental organizations and at other intervals as medically necessary.</p> <p>Orthodontic services must be prior approved and are limited to individuals under age 21 requiring these services for one of the following reasons:</p> <p>(1) because of a handicapping malocclusion or another developmental anomaly or injury resulting in severe misalignment or handicapping malocclusion of teeth. The Salzmann Index will be used to measure the severity of the malocclusion. A Salzmann score of 28 will be used as the threshold value for making orthodontic determinations of medical necessity. In addition, individual consideration will be applied for those unique orthodontic cases that may not be accounted for solely by the Salzmann Index;</p> <p>(2) following repair of an enrollee's cleft palate.</p> <p>Orthodontic treatment will not be authorized for cosmetic purposes. Orthodontic treatment will be paid for by TennCare only as long as the individual remains eligible for TennCare.</p> <p>If the orthodontic treatment plan is</p>	<p>Not covered, except for orthodontic treatment when an orthodontic treatment plan was approved prior to the enrollee's attaining 20 ½ years of age, and treatment was initiated prior to the enrollee's attaining 21 years of age; such treatment may continue as long as the enrollee remains eligible for TennCare.</p>

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

SERVICE	BENEFIT FOR PERSONS UNDER AGE 21	BENEFIT FOR PERSONS AGED 21 AND OLDER
	<p>approved prior to the enrollee’s attaining 20 ½ years of age, and treatment is initiated prior to the enrollee’s attaining 21 years of age, such treatment may continue as long as the enrollee remains eligible for TennCare.</p> <p>The MCO is responsible for the provision of transportation to and from covered dental services, as well as the medical and anesthesia services related to the covered dental services.</p>	
<p>7. Durable Medical Equipment [defined at 42 CFR §440.70(b)(3) and 42 CFR §440.120(c)].</p>	<p>Covered as medically necessary.</p>	<p>Covered as medically necessary.</p>
<p>8. Emergency Air and Ground Transportation [defined at 42 CFR §440.170(a)(1) and (3)].</p>	<p>Covered as medically necessary.</p>	<p>Covered as medically necessary.</p>
<p>9. EPSDT Services, [defined at 42 CFR 441, Subpart B].</p>	<p>Screening and interperiodic screening covered in accordance with federal regulations. (Interperiodic screens are screens in between regular checkups which are covered if a parent or caregiver suspects there may be a problem.)</p> <p>Diagnostic and follow-up treatment services covered as medically necessary and in accordance with federal regulations.</p> <p>The periodicity schedule for child health screens is that set forth in the latest “American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care.” All components of the screens must be consistent with the latest “American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care.”</p>	<p>Not applicable. (EPSDT is for persons under age 21.)</p>

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

<p>10. Home Health Care [defined at 42 CFR §440.70(a), (b), (c), and (e)].</p>	<p>Covered as medically necessary.</p> <p>All home health care must be delivered by a licensed Home Health Agency, as defined by 42 CFR §440.70.</p> <p>A home health visit includes any of the following: Skilled Nursing, Physical Therapy, Occupational Therapy, Speech Pathology and Audiology Services, and Home Health Aide.</p>	<p>Covered as medically necessary.</p> <p>All home health care must be delivered by a licensed Home Health Agency, as defined by 42 CFR §440.70.</p> <p>A home health visit includes any of the following: Skilled Nursing, Physical Therapy, Occupational Therapy, Speech Pathology and Audiology Services, and Home Health Aide.</p>
<p>11. Hospice Care [defined at 42 CFR, Part 418].</p>	<p>Covered as medically necessary.</p> <p>Must be provided by an organization certified pursuant to Medicare Hospice requirements.</p>	<p>Covered as medically necessary.</p> <p>Must be provided by an organization certified pursuant to Medicare Hospice requirements.</p>
<p>12. Inpatient and Outpatient Substance Abuse Benefits [defined as services for the treatment of substance abuse that are provided (a) in an inpatient hospital (as defined at 42 CFR §440.10) or (b) as outpatient hospital services (see 42 CFR §440.20(a)).</p>	<p>Covered as medically necessary.</p>	<p>Covered as medically necessary, with a maximum lifetime limitation of ten (10) detoxification days and \$30,000 in substance abuse benefits (inpatient, residential, and outpatient).</p> <p>When medically appropriate and cost effective as determined by the BHO, services in a licensed substance abuse residential treatment facility may be provided as a substitute for inpatient substance abuse services.</p>
<p>13. Inpatient Hospital Services [defined at 42 CFR §440.10].</p>	<p>Covered as medically necessary.</p> <p>Preadmission and concurrent reviews allowed.</p>	<p>Covered as medically necessary.</p> <p>Preadmission and concurrent reviews allowed.</p>
<p>14. Inpatient Rehabilitation Facility Services.</p>	<p>See “Inpatient Hospital Services.”</p>	<p>Not covered.</p>
<p>15. Lab and X-ray Services [defined at 42 CFR §440.30].</p>	<p>Covered as medically necessary.</p>	<p>Covered as medically necessary.</p>
<p>16. Medical Supplies [defined at 42 CFR §440.70(b)(3)].</p>	<p>Covered as medically necessary.</p>	<p>Covered as medically necessary.</p>
<p>17. Mental Health Case Management Services [defined as services rendered to support outpatient mental health clinical services].</p>	<p>Covered as medically necessary.</p>	<p>Covered as medically necessary.</p>

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

<p>18. Mental Health Crisis Services [defined as services rendered to alleviate a psychiatric emergency].</p>	<p>Covered as medically necessary.</p>	<p>Covered as medically necessary.</p>
<p>19. Methadone Clinic Services [defined as services provided by a methadone clinic].</p>	<p>Covered as medically necessary.</p>	<p>Not covered.</p>
<p>20. Non-Emergency Ambulance Transportation, [defined at 42 CFR §440.170(a)(1) and (3)].</p>	<p>Covered as medically necessary.</p>	<p>Covered as medically necessary.</p>
<p>21. Non-Emergency Transportation [defined at 42 CFR §440.170(a)(1) and (3)].</p>	<p>Covered as necessary for enrollees lacking accessible transportation for covered services.</p> <p>The travel to access primary care and dental services must meet the requirements of the TennCare demonstration project terms and conditions. The availability of specialty services as related to travel distance should meet the usual and customary standards for the community. However, in the event the MCC is unable to negotiate such an arrangement for an enrollee, transportation must be provided regardless of whether the enrollee has access to transportation.</p> <p>If the enrollee is a minor child, transportation must be provided for the child and an accompanying adult. However, transportation for a minor child shall not be denied pursuant to any policy which poses a blanket restriction due to enrollee’s age or lack of parental accompaniment. Any decision to deny transportation of a minor child due to an enrollee’s age or lack of parental accompaniment must be made on a case-by-case basis and must be based on the individual facts surrounding the request. As with any denial, all notices and actions must be in accordance with the appeals process.</p> <p>Tennessee recognizes the “mature</p>	<p>Covered as necessary for enrollees lacking accessible transportation for covered services.</p> <p>The travel to access primary care and dental services must meet the requirements of the TennCare demonstration project terms and conditions. The availability of specialty services as related to travel distance should meet the usual and customary standards for the community. However, in the event the MCC is unable to negotiate such an arrangement for an enrollee, transportation must be provided regardless of whether the enrollee has access to transportation.</p>

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

	<p>minor exception” to permission for medical treatment.</p> <p>The provision of transportation to and from covered dental services is the responsibility of the MCO.</p>	
22. Occupational Therapy [defined at 42 CFR §440.110(b)].	Covered as medically necessary, by a Licensed Occupational Therapist, to restore, improve, stabilize or ameliorate impaired functions.	Covered as medically necessary, by a Licensed Occupational Therapist, to restore, improve, or stabilize impaired functions.
23. Organ and Tissue Transplant Services and Donor Organ/Tissue Procurement Services [defined as the transfer of an organ or tissue from an individual to a TennCare enrollee].	<p>Covered as medically necessary.</p> <p>Experimental or investigational transplants are not covered.</p>	<p>Covered as medically necessary when coverable by Medicare.</p> <p>Experimental or investigational transplants are not covered.</p>
24. Outpatient Hospital Services [defined at 42 CFR §440.20(a)].	Covered as medically necessary.	Covered as medically necessary.
25. Outpatient Mental Health Services (including Physician Services), [defined at 42 CFR §440.20(a), 42 CFR §440.50, and 42 CFR §440.90].	Covered as medically necessary.	Covered as medically necessary.
26. Pharmacy Services [defined at 42 CFR §440.120(a) and obtained directly from an ambulatory retail pharmacy setting, outpatient hospital pharmacy, mail order pharmacy, or those administered to a long-term care facility (nursing facility) resident].	<p>Covered as medically necessary. Certain drugs (known as DESI, LTE, IRS drugs) are excluded from coverage. Persons dually eligible for Medicaid and Medicare will receive their pharmacy services through Medicare Part D.</p> <p>Pharmacy services are the responsibility of the PBM, except for pharmaceuticals supplied and administered in a doctor’s office. For persons who are not dually eligible for Medicare and Medicaid, pharmaceuticals supplied and administered in a doctor’s office are the responsibility of the MCO. For persons who are dually eligible for Medicare and Medicaid, pharmaceuticals supplied and administered in a doctor’s office are the responsibility of the MCO if not covered by Medicare.</p>	<p>Covered as medically necessary, subject to the limitations set out below. Certain drugs (known as DESI, LTE, IRS drugs) are excluded from coverage. Persons dually eligible for Medicaid and Medicare will receive their pharmacy services through Medicare Part D.</p> <p>Pharmacy services are the responsibility of the PBM, except for pharmaceuticals supplied and administered in a doctor’s office. For persons who are not dually eligible for Medicare and Medicaid, pharmaceuticals supplied and administered in a doctor’s office are the responsibility of the MCO. For persons who are dually eligible for Medicare and Medicaid, pharmaceuticals supplied and administered in a doctor’s office are not covered by TennCare.</p>

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

		<p>(A) Pharmacy services for individuals receiving TennCare-reimbursed services in a Nursing Facility, Intermediate Care Facility for the Mentally Retarded, or a Home and Community Based Services waiver have no quantity limits on the number of prescriptions per month.</p> <p>(B) Subject to (A) above, pharmacy services for Medicaid adults age 21 and older are limited to five (5) prescriptions and/or refills per enrollee per month, of which no more than two (2) of the five (5) can be brand name drugs. Additional drugs for individuals in (B) shall not be covered.</p> <p>Prescriptions shall be counted beginning on the first of each calendar month. Each prescription and/or refill counts as one (1). A prescription or refill can be for no more than a thirty-one (31) day supply.</p> <p>The Bureau of TennCare shall maintain a "Pharmacy Short List" of pharmacy services which shall not count against such limit. The Pharmacy Short List may be modified at the discretion of the Bureau of TennCare. The most current version of the Pharmacy Short List will be made available to enrollees via the internet from the TennCare website and upon request by mail through the DHS Family Service Assistance Centers. Only drugs that are specified on the version of the Pharmacy Short List that is available on the TennCare website located on the World Wide Web at www.state.tn.us/tenncare and indicated as current as of the date of service shall be considered exempt from applicable pharmacy limits.</p> <p>Unless specified on the version of the Pharmacy Short List which is current as of the date of the pharmacy service, pharmacy services in excess of five (5) prescriptions and/or refills per enrollee per month or two (2) brand name drugs per enrollee per month are non-</p>
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(Rule 1200-13-13-.04, continued)

		covered services. (C) Over-the-counter drugs for Medicaid adults are not covered even if the enrollee has a prescription for such service, except for prenatal vitamins for pregnant women.
27. Physical Therapy [defined at 42 CFR §440.110(a)].	Covered as medically necessary, by a Licensed Physical Therapist, to restore, improve, stabilize or ameliorate impaired functions,	Covered as medically necessary, by a Licensed Physical Therapist, to restore, improve, or stabilize impaired functions.
28. Physician Inpatient Services [defined at 42 CFR §440.50].	Covered as medically necessary.	Covered as medically necessary.
29. Physician Outpatient Services/Community Health Clinics/Other Clinic Services [defined at 42 CFR §440.20(b), 42 CFR §440.50, and 42 CFR §440.90].	Covered as medically necessary. Services provided by a Primary Care Provider when the enrollee has a primary behavioral health diagnosis (ICD-9-CM 290.xx-319.xx) are the responsibility of the MCO. Medical evaluations provided by a neurologist, as approved by the MCO, and/or an emergency room provider to establish a primary behavioral health diagnosis are the responsibility of the MCO.	Covered as medically necessary, except see “Methadone Clinic Services.” Services provided by a Primary Care Provider when the enrollee has a primary behavioral health diagnosis (ICD-9-CM 290.xx-319.xx) are the responsibility of the MCO. Medical evaluations provided by a neurologist, as approved by the MCO, and/or an emergency room provider to establish a primary behavioral health diagnosis are the responsibility of the MCO.
30. Private Duty Nursing [defined at 42 CFR §440.80].	Covered as medically necessary when prescribed by an attending physician for treatment and services rendered by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.), who is not an immediate relative.	Covered as medically necessary when prescribed by an attending physician for treatment and services rendered by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.), who is not an immediate relative.
31. Psychiatric Inpatient Facility Services [defined at 42 CFR §441, Subparts C and D and including services for persons of all ages].	Covered as medically necessary, Preadmission and concurrent reviews by the MCC are allowed.	Covered as medically necessary, Preadmission and concurrent reviews by the MCC are allowed.
32. Psychiatric Pharmacy.	See “Pharmacy Services.”	See “Pharmacy Services.”
33. Psychiatric Rehabilitation Services [defined as psychiatric services delivered in accordance with 42 CFR §440.130(d)].	Covered as medically necessary.	Covered as medically necessary.

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

34. Psychiatric Physician Inpatient Services [defined at 42 CFR §440.50].	Covered as medically necessary.	Covered as medically necessary.
35. Psychiatric Physician Outpatient Services.	See “Outpatient Mental Health Services.”	See “Outpatient Mental Health Services.”
36. Psychiatric Residential Treatment Services [defined at 42 CFR §483.352] and including services for persons of all ages].	Covered as medically necessary.	Covered as medically necessary.
37. Reconstructive Breast Surgery [defined in accordance with Tenn. Code Ann. § 56-7-2507].	Covered in accordance with Tenn. Code Ann. § 56-7-2507 which requires coverage of all stages of reconstructive breast surgery on a diseased breast as a result of a mastectomy as well as any surgical procedure on the non-diseased breast deemed necessary to establish symmetry between the two breasts in the manner chosen by the physician. The surgical procedure performed on a non-diseased breast to establish symmetry with the diseased breast will only be covered if the surgical procedure performed on a non-diseased breast occurs within five (5) years of the date the reconstructive breast surgery was performed on a diseased breast.	Covered in accordance with Tenn. Code Ann. §56-7-2507 which requires coverage of all stages of reconstructive breast surgery on a diseased breast as a result of a mastectomy as well as any surgical procedure on the non-diseased breast deemed necessary to establish symmetry between the two breasts in the manner chosen by the physician. The surgical procedure performed on a non-diseased breast to establish symmetry with the diseased breast will only be covered if the surgical procedure performed on a non-diseased breast occurs within five (5) years of the date the reconstructive breast surgery was performed on a diseased breast.
38. Rehabilitation services	See “Occupational Therapy,” “Physical Therapy,” and “Speech Therapy,” and “Inpatient Rehabilitation Facility Services.”	See “Occupational Therapy,” “Physical Therapy,” and “Speech Therapy.”
39. Renal Dialysis Clinic Services [defined at 42 CFR §440.90].	Covered as medically necessary. Generally limited to the beginning ninety (90) day period prior to the enrollee’s becoming eligible for coverage by the Medicare program.	Covered as medically necessary. Generally limited to the beginning ninety (90) day period prior to the enrollee’s becoming eligible for coverage by the Medicare program.
40. Sitter Services [defined as nursing services provided in the hospital by a nurse who is not an employee of the hospital].	Covered as medically necessary when a sitter who is not a relative is needed for an enrollee who is confined to a hospital as a bed patient. Certification must be made by a network physician that an R.N. or L.P.N. is needed, and neither is available.	Not covered.

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

41. Speech Therapy [defined at 42 CFR §440.110(c)].	Covered as medically necessary, by a Licensed Speech Therapist to restore, improve, stabilize or ameliorate impaired functions.	Covered as medically necessary, as long as there is continued medical progress, by a Licensed Speech Therapist to restore speech after a loss or impairment.
42. Transportation.	See “Emergency Air and Ground Transportation,” “Non-Emergency Ambulance Transportation,” and “Non-Emergency Transportation.”	See “Emergency Air and Ground Transportation,” “Non-Emergency Ambulance Transportation,” and “Non-Emergency Transportation.”
43. Vision Services [defined as services to treat conditions of the eyes].	Preventive, diagnostic, and treatment services (including eyeglasses) covered as medically necessary.	<p>Medical eye care, meaning evaluation and management of abnormal conditions, diseases, and disorders of the eye (not including evaluation and treatment of the refractive state) is covered. Routine, periodic assessment, evaluation or screening of normal eyes, and examinations for the purpose of prescribing, fitting, or changing eyeglasses and/or contact lenses are not covered.</p> <p>One pair of cataract glasses or lenses is covered for adults following cataract surgery.</p>

(c) Pharmacy

TennCare is permitted under the terms and conditions of the demonstration project approved by the federal government to restrict coverage of prescription and non-prescription drugs to a TennCare-approved list of drugs known as a drug formulary. TennCare must make this list of covered drugs available to the public. Through the use of a formulary, the following drugs or classes of drugs, or their medical uses, shall be excluded from coverage or otherwise restricted by TennCare as described in Section 1927 of the Social Security Act [42 U.S.C. §1396r-8]:

1. Agents for weight loss or weight gain.
2. Agents to promote fertility or for the treatment of impotence or infertility or for the reversal of sterilization.
3. Agents for cosmetic purposes or hair growth.
4. Agents for symptomatic relief of coughs and colds.
5. Agents to promote smoking cessation.
6. Agents which are benzodiazepines or barbiturates.
7. Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.
8. Nonprescription drugs.

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

9. Covered outpatient drugs, which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or his designee.

TennCare shall not cover drugs considered by the FDA to be Less Than Effective (LTE) and DESI drugs, or drugs considered to be Identical, Related and Similar (IRS) to DESI and LTE drugs or any other pharmacy services for which federal financial participation (FFP) is not available. The exclusion of drugs for which no FFP is available extends to all TennCare enrollees regardless of the enrollee's age. TennCare shall not cover experimental or investigational drugs which have not received final approval from the FDA.

- (d) The MCC shall be allowed to use alternative services when such services have been approved by CMS for use as cost-effective alternatives and approved by TennCare for use by the MCC.
- (2) The managed care organization shall be allowed to use alternative services, whether listed as covered or non-covered, when the use of alternative services is medically appropriate and cost-effective.
- (3) The following preventive medical services (identified by applicable CPT procedure codes) shall be covered subject to any limitations described herein, within the scope of standard medical practice, and shall be exempt from any deductibles and copayments as described herein.

Dental services and laboratory services not specifically listed herein, which are required pursuant to the Medicaid Early Periodic Screening, Diagnosis and Treatment (EPSDT) program for persons under age 21, shall be provided in accordance with the TennCare periodicity schedule for such services.

(a) Office Visits

1. NEW PATIENT

99381 - Initial evaluation
 99382 - age 1 through 4 years
 99383 - age 5 through 11 years
 99384 - age 12 through 17 years
 99385 - age 18 through 39 years
 99386 - age 40 through 64 years
 99387 - age 65 years and over

2. ESTABLISHED PATIENT

99391 - Periodic reevaluation
 99392 - age 1 through 4 years
 99393 - age 5 through 11 years
 99394 - age 12 through 17 years
 99395 - age 18 through 39 years
 99396 - age 40 through 64 years
 99397 - age 65 years and over

(b) Counseling and Risk Factor Reduction Intervention

1. INDIVIDUAL

99401 - approximately 15 minutes
 99402 - approximately 30 minutes

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

- 99403 - approximately 45 minutes
- 99404 - approximately 60 minutes

2. GROUP

- 99411 - approximately 30 minutes
- 99412 - approximately 60 minutes

(c) Family Planning Services if not part of a Preventive Services office visit, should be billed using the codes in (b)1. above.

(d) Prenatal Care

- 59400 Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care
- 59410 Vaginal delivery only (with or without episiotomy and/or forceps) including postpartum care
- 59430 Postpartum care only (separate procedure)
- 59510 Routine obstetric care including antepartum care, cesarean delivery, and postpartum care
- 59515 Cesarean delivery only including postpartum care

(e) Other preventive services

- 99420 Administration and interpretation of health risk assessment instrument (e.g., health hazard appraisal)
- 90700 through 90742 - Immunizations
- 92551 Screening test, pure tone, air only (Audiologic function)
- 92552 Pure tone audiometry (threshold); air only

Any laboratory test or procedure listed in the preventive services periodicity schedule when the service CPT code is one of the above preventive medicine codes. This includes mammography screening (76092) as indicated in the periodicity schedule.

(4) Maximum Lifetime Limitations.

The following maximum lifetime limitations shall apply to the services outlined in paragraphs (1) and (2) above. The managed care organizations shall not impose service limitations that are more restrictive than those described herein but benefits may be provided in excess of these amounts at the managed care organization’s discretion. Determination of these limitations shall be based upon the managed care organization’s payments for those services and shall exclude payments made by the enrollee in the form of deductibles, copayments, and/or special fees. Children under age 21 are exempt from limitations on substance abuse services.

Detoxification	Ten (10) days per lifetime
Substance abuse benefits (Inpatient and outpatient)	\$30,000

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

- (5) Emergency Medical Services shall be available twenty-four (24) hours per day, seven (7) days per week. Coverage of emergency medical services shall not be subject to prior authorization by the managed care organization but may include a requirement that notice be given to the managed care organization of use of out-of-plan emergency services. However, such notice requirements shall provide at least a 24-hour time frame after the emergency for notice to be given to the managed care organization.
- (6) Managed Care Organizations may not offer incentives such as a greater variety and/or quantity of health care services and benefits as a means of promoting enrollment in their respective plans.
- (7) TennCare Maintenance Drug List as of January 1, 2003.

TennCare will develop and publish a list of generic, multi-source drugs used in the maintenance of chronic conditions that may be dispensed in quantities of one hundred (100) units or a three (3) month supply, whichever is greater. This maintenance drug list will allow dispensing pharmacies to provide greater supplies of chronic medications to members and reduce copayments for enrollees with appropriate, yet high utilization needs.

- (8) Use of Alternative Services as of January 1, 2003.

MCCs shall be allowed, but are not required, to use alternative services, whether listed as covered or non-covered, when the use of alternative services is medically appropriate and cost-effective and provided in accordance with the TennCare/MCC Contract.

- (9) Preventive Medical Services as of January 1, 2003.

The following preventive services (identified by applicable CPT procedure codes) shall be covered subject to any limitations described herein, within the scope of standard medical practice.

(a) Office Visits.

1. New Patient

- 99381 - Initial evaluation
- 99382 - ages 1 through 4 years
- 99383 - ages 5 through 11 years
- 99384 - ages 12 through 17 years
- 99385 - ages 18 through 39 years
- 99386 - ages 40 through 64 years
- 99387 - ages 65 years and older

2. Established Patient

- 99391 - Periodic evaluation
- 99392 - ages 1 through 4 years
- 99393 - ages 5 through 11 years
- 99394 - ages 12 through 17 years
- 99395 - ages 18 through 39 years
- 99396 - ages 40 through 64 years
- 99397 - ages 65 years and older

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

- (b) Counseling and Risk Factor Reduction Intervention.
 - 1. Individual
 - 99401 - approximately 15 minutes
 - 99402 - approximately 30 minutes
 - 99403 - approximately 45 minutes
 - 99404 - approximately 60 minutes
 - 2. Group
 - 99411 - approximately 30 minutes
 - 99412 - approximately 60 minutes
- (c) Family Planning Services if not part of a preventive services office, should be billed by using the codes in (b)1. above.
- (d) Prenatal Care
 - 59400 Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care
 - 59410 Vaginal delivery only (with or without episiotomy, and/or forceps) including postpartum care
 - 59425 Antepartum care only, 4 - 6 visits
 - 59426 Antepartum care only, 7 or more visits
 - 59430 Postpartum care only (separate procedure)
 - 59510 Routine obstetric care including antepartum care, cesarean delivery, and postpartum care
 - 59515 Cesarean delivery only including postpartum care
 - 59610 Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy and/or forceps) and postpartum, after previous cesarean delivery
 - 59618 Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery
- (e) Other Preventive Services
 - 99173 Vision
 - 96110 Developmental Code - Limited
 - 99420 Administration and interpretation of health risk assessment instrument (e.g., health hazard appraisal)
 - 99431 Newborn - Initial Hospitalization

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

99435	Newborn - Assessment and Discharge Same Day
90700	through 90744 Immunizations
92551	Screening test, pure tone, air only (Audiologic function)
92552	Pure tone audiometry (threshold); air only

Any laboratory test procedure listed in the preventive services periodicity schedule when the services CPT code is one of the above preventive medicine codes. This includes mammography screening (76092) as indicated in the periodicity schedule.

(10) Maximum Lifetime Limitations as of January 1, 2003

The following maximum lifetime limitations shall apply to the services outlined in paragraphs (7)(b) and (10) above. The MCCs shall not impose services limitations that are more restrictive than those described herein but benefits may be provided in excess of these amounts at the MCC's discretion. Determination of these limitations shall be based upon the MCC's payments for those services. This limit shall not apply to children under EPSDT guidelines.

Detoxification	Ten (10) days
Substance Abuse Benefits (Inpatient and outpatient)	\$30,000

(11) Emergency Medical Services as of January 1, 2003.

Emergency medical services shall be available twenty-four (24) hours per day, seven (7) days per week. Coverage of emergency medical services shall not be subject to prior authorization by the MCC but may include a requirement that notice be given to the MCC of use of out-of-plan emergency services. However, such requirements shall provide at least a twenty-four (24) hour time frame after the emergency for notice to be given to the MCC.

(12) Hospital Discharges as of January 1, 2003.

Hospital discharges of mothers and newborn babies following delivery shall take into consideration the following guidelines:

- (a) The decision to discharge postpartum mothers and newborns less than 24 - 48 hours after delivery should be made based upon discharge criteria collaboratively developed and adopted by obstetricians, pediatricians, family practitioners, delivery hospitals, and health plans. The criteria must be contingent upon appropriate preparation, meeting in hospital criteria for both mother and baby, and the planning and implementation of appropriate follow-up. An individualized plan of care must include identification of a primary care provider for both mother and baby and arrangements for follow-up evaluation of the newborn.

Length of hospital stay is only one factor to consider when attempting to optimize patient outcomes for postpartum women and newborns. Excellent outcomes are possible even when length of stay is very brief (less than 24 hours) if perinatal health care is well planned, allows for continuity of care, and patients are well chosen. Some postpartum patients and/or newborns may require extended hospitalization (greater than 48-72 hours) despite meticulous care due to medical, obstetric, or neonatal complications. The decision for time of discharge must be individualized and made by the physicians caring for the mother-baby pair. The following guidelines have been developed to aid in the identification of postpartum mothers and newborns

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

who may be candidates for discharge prior to 24 - 48 hours. The guidelines also provide examples where discharge is inappropriate.

Principles of patient care should be based upon data obtained by clinical research. Regarding the question of postpartum and newborn length of hospitalization, there are inadequate studies available to provide clear direction for clinical decision-making. Clinical guidelines represent an attempt to conceptualize what is, in reality, a dynamic process of health care refinement. Review of these guidelines is desirable and expected.

No provider shall be denied participation, reimbursement or reduction in reimbursement within a network solely related to his/her compliance with the "Guidelines for Discharge of Postpartum Mothers and Newborns."

(b) Guidelines for Discharge of Postpartum Mothers and Newborns.

1. Discharge Planning.

(i) Discharge planning should occur in a planned and systematic fashion for all postpartum women and newborns in order to enhance care, prevent complications and minimize the need for rehospitalization. Prior to discharge a discussion should be held between the physician or another health care provider and the mother (and father if possible) about any expected perinatal problems and ways to cope with them. Plans for future and immediate care as well as instructions to follow in the event of an emergency or complication should be discussed.

(ii) Follow-up care must be planned for both mother and baby at the time of discharge. For patients leaving the hospital prior to 24 - 48 hours, contact within 48 - 72 hours of discharge is recommended and may include appropriate follow-up within 48 - 72 hours as deemed necessary by the attending provider, depending upon individual patient need. This follow-up visit will be acknowledged as a provider encounter.

(I) Maternal Considerations:

I. Prior to discharge, the patient should be informed of normal postpartum events including but not limited to:

A. Lochial patterns;

B. Range of activity and exercise;

C. Breast care;

D. Bladder care;

E. Dietary needs;

F. Perineal care;

G. Emotional responses;

H. What to report to physician or other health care provider including:

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

- (A) Elevation of temperature,
 - (B) Chills,
 - (C) Leg pains, and
 - (D) Increased vaginal bleeding.
 - I. Method of contraception;
 - J. Coitus resumption; and
 - K. Specific instructions for follow-up (routine and emergent)
- (II) Neonatal Considerations:
- I. Prior to discharge, the following points should be reviewed with the mother or, preferably, with both parents:
 - A. Condition of the neonate;
 - B. Immediate needs of the neonate, (e.g., feeding methods and environmental supports);
 - C. Instructions to follow in the event of a newborn complication or emergency;
 - D. Feeding techniques;
 - E. Skin care, including cord care and genital care;
 - F. Temperature assessment and measurement with the thermometer; and
 - G. Assessment of neonatal well-being;
 - H. Recognition of illness including jaundice;
 - I. Proper infant safety including use of car seat and sleeping position;
 - J. Reasonable expectations for the future; and
 - K. Importance of maintaining immunization begun with initial dose of hepatitis B vaccine.
2. Criteria for Maternal Discharge Less Than 24 - 48 Hours Following Delivery.
- (i) Prior to discharge of the mother, the following should occur:
 - (I) The mother should have been observed after delivery for a sufficient time to ensure that her condition is stable, that she has sufficiently recovered and may be safely transferred to outpatient care.

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

- (II) Laboratory evaluations should be obtained and include ABO blood group and Rh typing with appropriate use of Rh immune globulin; and hematocrit or hemoglobin.
- (III) The mother should have received adequate preparation for and be able to assume self and immediate neonatal care.
- (ii) Factors which may exclude maternal discharge prior to 24 - 48 hours include:
 - (I) Abnormal bleeding.
 - (II) Fever equal to or greater than 100.4 degrees.
 - (III) Inadequate or no prenatal care.
 - (IV) Cesarean section.
 - (V) Untreated or unstable maternal medical condition.
 - (VI) Uncontrolled hypertension.
 - (VII) Inability to void.
 - (VIII) Inability to tolerate solid foods.
 - (IX) Adolescent mother without adequate support and where appropriate follow-up has not been established. A nurse home visit within 24 - 48 hours of discharge would act as appropriate follow-up.
 - (X) All efforts should be made to keep mother and infant together to ensure simultaneous discharge.
 - (XI) Psychosocial problems (maternal or family) which have been identified prenatally or in hospital. Where appropriate follow-up has not been established, a nurse home visit within 24 - 48 hours of discharge would act as appropriate follow-up.
- 3. Criteria for Neonatal Discharge Less than 24-48 Hours Following Delivery.

The nursery stay is planned to allow the identification of early problems and to reinforce instruction in preparation for care of the infant at home. Complications often are not predictable by prenatal and intrapartum events. Because many neonatal problems do not become apparent until several days after birth there is an element of medical risk in early neonatal discharge. Most problems are manifest during the first 12 hours, and discharge at or prior to 24 hours is appropriate for many newborns.

- (i) Prior to discharge of the newborn at 24-48 hours, the following should have occurred:
 - (I) The course of antepartum, intrapartum, and postpartum care for both mother and fetus should be without problems, which may lead to newborn complications.

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

- (II) The baby is a single birth at 37 to 42 weeks' gestation and the birth weight is appropriate for gestational age according to appropriate intrauterine growth curves.
 - (III) The baby's vital signs are documented as being normal and stable for the 12 hours preceding discharge, including a respiratory rate below 60/minute, a heart rate of 100 to 160 beats per minute, and an axillary temperature of 36.1 degrees C in an open crib with appropriate clothing.
 - (IV) The baby has urinated and passed at least one stool.
 - (V) No evidence of excessive bleeding after circumcision greater than 2 hours.
 - (VI) The baby has completed at least two successful feedings, with documentation that the baby is able to coordinate sucking, swallowing, and breathing while feeding.
 - (VII) No evidence of significant jaundice in the first 24 hours of life.
 - (VIII) The parent's or caretaker's knowledge, ability, and confidence to provide adequate care for her baby are documented.
 - (IX) Laboratory data are available and reviewed including:
 - I. Maternal syphilis and hepatitis B surface antigen status.
 - II. Cord or infant blood type and direct Coomb's test result as clinically indicated.
 - (X) Screening tests are performed in accordance with state regulations. If the test is performed before 24 hours of milk feeding, a system for repeating the test must be assured during the follow-up visit.
 - (XI) Initial hepatitis B vaccine is administered or a scheduled appointment for its administration has been made.
 - (XII) A physician-directed source of continuing medical care for both the mother and the baby is identified. For newborns discharged less than 24-48 hours after delivery, a definitive plan for contact within 48-72 hours after discharge has been made. A nurse home visit within 24-48 hours would be considered appropriate follow-up.
- (ii) Maternal factors which may exclude discharge of the newborn prior to 24-48 hours include:
- (I) Inadequate or no prenatal care,
 - (II) Medical conditions that pose a significant risk to the infant,
 - (III) Group B streptococcus colonization,
 - (IV) Untreated syphilis,
 - (V) Suspected active genital herpes,

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

- (VI) HIV,
 - (VII) Adolescent without adequate support and where appropriate follow-up has not been established (a nurse home visit within 24-48 hours of discharge will act as appropriate follow-up),
 - (VIII) Mental retardation or psychiatric illness, and
 - (IX) Requirements for continued maternal hospitalization.
- (iii) Newborn factors which may exclude discharge of the newborn prior to 24-48 hours include:
- (I) Preterm gestation (less than 37 weeks);
 - (II) Small for gestational age;
 - (III) Large for gestational age;
 - (IV) Abnormal physical exam, vital signs, colors, activity, feeding or stooling;
 - (V) Significant congenital malformations; and
 - (VI) Abnormal laboratory finding:
 - I. Hypoglycemia,
 - II. Hyperbilirubinemia,
 - III. Polycythemia,
 - IV. Anemia, and
 - V. Rapid plasma reagin positive.
- (13) Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services for TennCare Medicaid Enrollees under the age of Twenty-one (21).

The Bureau of TennCare, through its contracts with managed care organizations (MCOs), behavioral health organizations (BHOs) and other contractors (also referred to collectively as Contractors), operates an EPSDT program to provide health care services as required by 42 C.F.R. Part 441, Subpart B, and the "Omnibus Budget Reconciliation Act of 1989" to TennCare Medicaid-eligible enrollees under the age of twenty-one (21).

- (a) Responsibilities of the Bureau of TennCare.
1. The Bureau will:
 - (i) Keep Contractors informed as to changes to the requirements for the operation of the EPSDT program;
 - (ii) Make changes to TennCare policy when necessary to keep the EPSDT program in compliance with federal and state requirements;

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

- (iii) Provide policy clarification when needed; and
 - (iv) Oversee the activities of the Contractors to assure compliance with all aspects of the EPSDT program.
2. The Bureau, through local health departments, shall provide information on covered services to adolescent prenatal patients who enter TennCare Medicaid through presumptive eligibility. Assistance will be offered to presumptive eligibles on the day eligibility is determined in making a timely first prenatal appointment. For a woman past her first trimester, this appointment should occur within fifteen (15) days.
 3. The Bureau, through the Department of Children's Services, shall inform foster parents and institutions or other residential treatment settings with a number of eligible children, annually or more often when the need arises, including when a change of administrators, social workers, or foster parents occur, of the availability of EPSDT services.
- (b) Responsibilities of Contractors.

1. Contractors shall aggressively and effectively inform TennCare Medicaid enrollees of the existence of the EPSDT program, including the availability of specific EPSDT screening and treatment services. Such informing shall occur in a timely manner, generally within sixty (60) days of the MCC's receipt of notification of the child's enrollment in its plan and if no one eligible in the family has utilized EPSDT services, at least annually thereafter.

Contractors shall document to the Bureau the contractor's outreach activities and what efforts were made to inform TennCare Medicaid enrollees and/or the enrollee's responsible party about the availability of EPSDT services and how to access such services. All children, particularly those who have not received complete screenings timely, shall be the target of outreach efforts by the MCOs which are reasonably calculated to insure the child's participation in EPSDT. Failure to timely submit the requested data may result in liquidated damages as described in the contracts between the Bureau of TennCare and the Contractors.

2. Contractors shall use clear and non-technical terms to provide a combination of written and oral information so that the program is clearly and easily understandable.
3. Contractors shall use effective methods (developed through collaboration with agencies which have established procedures for working with such individuals) to inform TennCare Medicaid individuals who are illiterate, blind, deaf, or cannot understand English, about the availability of EPSDT services.
4. Contractors shall design and conduct outreach to inform all TennCare Medicaid-eligible individuals about what services are available under EPSDT, the benefits of preventive health care, where services are available, and how to obtain them; and that necessary transportation and scheduling assistance is available.
5. Contractors shall create a system so that TennCare Medicaid families can readily access an accurate list of names and phone numbers of contract providers who are currently accepting TennCare.

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

6. Contractors shall make known and offer to a TennCare Medicaid-covered child and the child's responsible party of the availability for both transportation and scheduling assistance prior to the due date of the TennCare Medicaid child's periodic examination.
7. Contractors shall provide TennCare Medicaid enrollees assistance in scheduling appointments, and obtaining transportation prior to the date of each periodic examination as requested and necessary.
8. Contractors shall document services declined by a parent or guardian of a TennCare Medicaid-eligible child or a mature competent child, specifying the particular service declined so that outreach and education for other EPSDT services continues.
9. Contractors shall maintain records of the efforts taken to outreach TennCare Medicaid children who have missed screening appointments when scheduled or who have failed to schedule regular check-ups. These records shall be made available to the Bureau and other parties as directed.
10. Contractors shall treat a TennCare Medicaid-eligible woman's request for EPSDT services during pregnancy as a request for EPSDT services for the child at birth. If the pregnant woman is under age twenty-one (21), she may request EPSDT services for herself.

(c) Compliance.

Contractors must document and maintain records of all outreach efforts made to inform TennCare Medicaid enrollees about the availability of EPSDT services.

Authority: T.C.A. §§4-5-202, 4-5-209, 71-5-105, 71-5-109, 71-5-134, and Executive Order No. 23. **Administrative History:** Original rule filed September 30, 2002; to be effective December 14, 2002; however, on December 9, 2002, the House Government Operations Committee of the General Assembly stayed rule 1200-13-13-.04; new effective date February 12, 2003. Public necessity rule filed July 1, 2005; effective through December 13, 2005. Public necessity rule filed September 7, 2005; effective through February 19, 2006. Amendments filed September 29, 2005; effective December 13, 2005. Public necessity rules filed December 29, 2005; effective through June 12, 2006. Public necessity rule filed March 13, 2006; effective through August 25, 2006. Public necessity rule filed May 3, 2006; effective through October 15, 2006.

1200-13-13-.05 ENROLLEE COST SHARING.

- (1) TennCare Medicaid enrollees do not have cost sharing responsibilities for TennCare coverage and covered services, except that effective August 1, 2005, TennCare Medicaid adults (age 21 and older) who receive pharmacy services will have nominal copays for these services. The copays will be \$3.00 (three dollars) for each branded drug and \$0 (zero dollars) for each covered generic drug. Generic drugs which exceed the limit of five (5) prescriptions or refills per enrollee per month are not covered. Family planning drugs and emergency services are exempt from copay. Enrollees may not be denied a service for inability to pay a copay. There is no Out-of-Pocket Maximum on copays.
- (2) The following adult groups are exempt from copay:
 - (a) Individuals receiving hospice services who provide verbal notification of such to the pharmacy provider at the point of service;
 - (b) Individuals who are pregnant who provide verbal notification of such to the pharmacy provider at the point of service; and

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

- (c) Individuals who are receiving services in a Nursing Facility, an Intermediate Care Facility for the Mentally Retarded, or a Home and Community Based Services waiver.

Authority: T.C.A. §§4-5-202, 4-5-209, 71-5-105, 71-5-109, Acts of 2003, Public Chapter 412, §1(c), and Executive Order No. 23. **Administrative History:** Original rule filed September 30, 2002; to be effective December 14, 2002; however, on December 9, 2002, the House Government Operations Committee of the General Assembly stayed rule 1200-13-13-.05; new effective date February 12, 2003. Amendment by Acts of 2003, Public Chapter 412, §1(c) filed and effective June 25, 2003. Public necessity rule filed July 1, 2005; effective through December 13, 2005. Amendment filed September 26, 2005; effective December 10, 2005.

1200-13-13-.06 MANAGED CARE ORGANIZATIONS.

Managed care organizations participating in TennCare will be limited to Health Maintenance Organizations that are appropriately licensed to operate within the state of Tennessee to provide medical services in the TennCare program. Managed Care Organizations shall have a fully executed contract with the Tennessee Department of Finance and Administration. Behavioral Health Organizations shall have a fully executed contract with the Tennessee Department of Mental Health and Developmental Disabilities. MCOs, BHOs, DBMs and PBMs shall agree to comply with all applicable rules, policies, and contract requirements as specified by the Tennessee Department of Finance and Administration and the Tennessee Department of Mental Health and Developmental Disabilities as applicable. Managed care organizations must continually demonstrate a sufficient provider network based on the standards set by the Bureau of TennCare to remain in the program and must reasonably meet all quality of care requirements established by the Bureau of TennCare.

Authority: T.C.A. §§4-5-202, 71-5-105, 71-5-109, and Executive Order No. 23. **Administrative History:** Original rule filed September 30, 2002; to be effective December 14, 2002; however, on December 9, 2002, the House Government Operations Committee of the General Assembly stayed rule 1200-13-13-.06; new effective date February 12, 2003.

1200-13-13-.07 MANAGED CARE ORGANIZATION PAYMENT.

Managed care organizations will be paid pursuant to the contract the MCO has fully executed with the Tennessee Department of Finance and Administration.

Authority: T.C.A. §§4-5-202, 71-5-105, 71-5-109, and Executive Order No. 23. **Administrative History:** Original rule filed September 30, 2002; to be effective December 14, 2002; however, on December 9, 2002, the House Government Operations Committee of the General Assembly stayed rule 1200-13-13-.07; new effective date February 12, 2003.

1200-13-13-.08 PROVIDERS.

- (1) Payment in full.
 - (a) All MCC participating network providers must accept as payment in full for provision of covered services to TennCare enrollees, the amounts paid by the MCC plus any deductible or copayment required by the TennCare Program to be paid by the individual.
 - (b) Any non-participating providers who provide TennCare Program covered services by authorization from an MCC must accept as payment in full for provision of covered services to TennCare enrollees, the amounts paid by the MCC plus any deductible or copayment required by the TennCare Program to be paid by the individual.
- (2) In situations where a MCC authorizes a service to be rendered by a provider who is not a participating network provider with the MCC, payment to the provider shall be no less than eighty percent (80%) of the lowest rate paid by the MCC to equivalent participating network providers for the same service.

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

For emergency services provided to an enrollee by a provider who is not a participating network provider, the MCC shall reimburse the provider at the rate of 100% of the lowest rate paid to the MCC's network providers. Emergency care to enrollees shall not require preauthorization.

- (3) Participation in the TennCare program will be limited to providers who:
- (a) Accept, as payment in full, the amounts paid by the managed care contractor, including copays from the enrollee, or the amounts paid in lieu of the managed care contractor by a third party (Medicare, insurance, etc.);
 - (b) Maintain Tennessee, or the State in which s/he practices, medical licenses and/or certifications as required by his/her practice, or licensure by the TDMHDD, if appropriate;
 - (c) Are not under a federal Drug Enforcement Agency (DEA) restriction of his/her prescribing and/or dispensing certification for scheduled drugs (relative to physicians, osteopaths, dentists and pharmacists);
 - (d) Agree to maintain and provide access to TennCare and/or its agent all TennCare enrollee medical records for five (5) years from the date of service or upon written authorization from TennCare following an audit, whichever is shorter;
 - (e) Provide medical assistance at or above recognized standards of practice; and
 - (f) Comply with all contractual terms between the provider and the managed care contractor and TennCare policies as outlined in federal and state rules and regulations and TennCare provider manuals and bulletins.
 - (g) Failure to comply with any of the above provisions (a) through (f) may subject a provider to the following actions:
 - 1. Sanctions set out in T.C.A. §71-5-118. In addition, the provider may be subject to stringent review/audit procedures, which may include clinical evaluation of services and a prepayment requirement for documentation and justification for each claim.
 - 2. The Bureau of TennCare may withhold or recover payments to managed care contractors in cases of provider fraud, willful misrepresentation, or flagrant non-compliance with contractual requirements and/or TennCare policies.
 - 3. The Bureau of TennCare may refuse to approve or may suspend provider participation 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 US Title XX Services Program.
 - 4. The Bureau of TennCare may refuse to approve or may suspend provider participation 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 US Title XX Services Program since the inception of these programs.
 - 5. The Bureau of TennCare shall refuse to approve or shall suspend provider participation 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.

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

6. The Bureau of TennCare shall refuse to approve or shall suspend provider participation upon notification by the US Office of Inspector General Department of Health and Human Services that the provider is not eligible under Medicare or Medicaid for federal financial participation.
 7. The Bureau of TennCare may recover from a managed care contractor any payments made by an enrollee and/or his family for a covered service, in total or in part, except as permitted. If a provider knowingly bills an enrollee and/or his family for a covered service, in total or in part, except as permitted, the Bureau of TennCare may terminate the provider's participation in TennCare.
- (4) Solicitations and Referrals.
- (a) Managed care contractors and providers shall not solicit TennCare enrollees by any method offering as enticements other goods and services (free or otherwise) for the opportunity of providing the enrollee with TennCare covered services that are not medically necessary and/or that overutilize the TennCare program.
 - (b) A managed care contractor may request a waiver from this restriction in writing to TennCare. TennCare shall determine the value of a waiver request based upon the medical necessity and need for the solicitation. The managed care contractor may implement the solicitation only upon receipt of a written waiver approval from TennCare. This waiver is not transferable and may be canceled by TennCare upon written notice.
 - (c) TennCare payments for services related to a non-waivered solicitation enticement shall be considered by TennCare as a non-covered service and recouped. Neither the managed care contractor nor the provider may bill the enrollee for non-covered services recouped under this authority.
 - (d) A provider shall not offer or receive remuneration in any form related to the volume or value of referrals made or received from or to another provider.
- (5) Providers may seek payment from a TennCare enrollee only under the following circumstances:
- (a) If the services are not covered by the TennCare program and, prior to providing the services, the provider informed the enrollee that the services were not covered; or
 - (b) If the services are not covered because they are in excess of an enrollee's benefit limit and one of the following circumstances applies:
 1. The provider determines effective on the date of service that the enrollee has reached his/her benefit limit for the particular service being requested and, prior to providing the service, informs the enrollee that the service is not covered and the service will not be paid for by TennCare. The source of the provider's information must be a database listed on the TennCare website as approved by TennCare on the date of the provider's inquiry.
 2. The provider has information in his/her own records to support the fact that the enrollee has reached his/her benefit limit for the particular service being requested and, prior to providing the service, informs the enrollee that the service is not covered and will not be paid for by TennCare. This information may include:

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

- (i) A previous written denial of a claim on the basis that the service was in excess of the enrollee's benefit limit for a service within the same benefit category as the service being requested, if the time period applicable to that benefit limit is still in effect;
 - (ii) That the provider had previously examined the database referenced in part 1. above and determined that the enrollee had reached his/her benefit limit for the particular service being requested, if the time period applicable to that benefit limit is still in effect; or
 - (iii) That the provider had personally provided services to the enrollee in excess of his/her benefit limit within the same benefit category as the service being requested, if the time period applicable to that benefit limit is still in effect.
 3. The provider submits a claim for service to the appropriate managed care contractor (MCC) and receives a written denial of that claim on the basis that the service exceeds the enrollee's benefit limit. Thereafter, within the remainder of the period applicable to that benefit limit, the provider may continue to bill the enrollee for services within that same exhausted benefit category without having to submit, for repeated MCC denial, claims for those subsequent services.
 4. The provider had previously taken the steps in parts 1., 2., or 3. above and determined that the enrollee had reached his/her benefit limit for the particular service being requested, if the time period applicable to that benefit limit is still in effect, and informs the enrollee, prior to providing the service, that the service is not covered and will not be paid for by TennCare.
- (6) Providers may not seek payment from a TennCare enrollee under the following conditions:
- (a) The provider knew or should have known about the patient's TennCare eligibility or pending eligibility prior to providing services.
 - (b) The claim(s) submitted to TennCare or the enrollee's managed care contractor for payment was/were denied due to provider billing error or a TennCare claim processing error.
 - (c) The provider accepted TennCare assignment on a claim and it is determined that another payor paid an amount equal to or greater than the TennCare allowable amount.
 - (d) The provider failed to comply with TennCare policies and procedures or provided a service which lacks medical necessity or justification.
 - (e) The provider failed to submit or resubmit claims for payment within the time periods required by the managed care contractor or TennCare.
 - (f) The provider failed to ascertain the existence of TennCare eligibility or pending eligibility prior to providing non-emergency services. Even if the enrollee presents another form of insurance, the provider must determine whether the patient is covered under TennCare.
 - (g) The provider failed to inform the enrollee prior to providing a service not covered by TennCare that the service was not covered and the enrollee may be responsible for the cost of the service. Services which are non-covered by virtue of exceeding limitations are exempt from this requirement. Notwithstanding this exemption, providers shall remain obligated to provide notice to enrollees who have exceeded benefit limits in accordance with rule 1200-13-13-.11.

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

- (h) The enrollee failed to keep a scheduled appointment(s).
- (7) Providers may seek payment from a person whose TennCare eligibility is pending at the time services are provided if the provider informs the person that TennCare assignment will not be accepted whether or not eligibility is established retroactively.
- (8) Providers may seek payment from a person whose TennCare eligibility is pending at the time services are provided. Providers may bill such persons at the provider's usual and customary rate for the services rendered. However, all monies collected for TennCare-covered services rendered during a period of TennCare eligibility must be refunded when a claim is submitted to TennCare if the provider agreed to accept TennCare assignment once retroactive TennCare eligibility was established.
- (9) 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 TennCare Program; in the case of hospitals, the hospital must meet state licensure requirements and be approved by TennCare as an acute care hospital as of the date of enrollment in TennCare. Children's hospitals and State mental hospitals may participate in TennCare without having been Medicare approved; however, the hospital must be approved by the Joint Commission for Accreditation of Health Care Organizations as a condition of participation.
- (10) Pharmacy providers may not waive pharmacy copayments for TennCare Standard enrollees as a means of attracting business to their establishments. This does not prohibit a pharmacy from exercising professional judgment in cases where an enrollee may have a temporary or acute need for a prescribed drug, but is unable, at that moment, to pay the required copayment.
- (11) Providers shall not deny services for a Medicaid enrollee's failure to make copayments.

Authority: T.C.A. §§4-5-202, 4-5-209, 71-5-105, 71-5-109, 71-5-134, Acts of 2003, Public Chapter 412, §1(c), and Executive Order No. 23. **Administrative History:** Original rule filed September 30, 2002; to be effective December 14, 2002; however, on December 9, 2002, the House Government Operations Committee of the General Assembly stayed rule 1200-13-13-.08; new effective date February 12, 2003. Amendment by Acts of 2003, Public Chapter 412, §1(c) filed and effective June 25, 2003. Amendment filed October 12, 2004; effective December 26, 2004. Public necessity rule filed July 29, 2005; effective through January 10, 2006. Public necessity rule filed December 29, 2005; effective through June 12, 2006. Amendment filed October 27, 2005; effective January 10, 2006.

1200-13-13-.09 THIRD PARTY RESOURCES.

- (1) Individuals applying for TennCare Medicaid or TennCare Standard coverage shall disclose the availability of any third party health care coverage to the agency responsible for determining the individual's eligibility for TennCare.
- (2) An individual enrolled in TennCare Medicaid or TennCare Standard shall disclose access to third party resources to his/her specified Managed Care Contractors as soon as s/he becomes aware of the existence of any third party resources.
- (3) Managed Care Contractors under contract with the Tennessee Departments of Finance and Administration or Mental Health and Developmental Disabilities shall provide all third party resource information obtained from the plan's enrollees to the Bureau of TennCare on a regular basis as required by their contracts.
- (4) Managed Care Contractors shall enforce TennCare subrogation rights pursuant to T.C.A. § 71-5-117.

(Rule 1200-13-13-.09, continued)

- (5) Managed Care Contractors may pay health insurance premiums for their enrollees if such payments are determined by the Bureau to be cost effective.
- (6) TennCare shall be the payor of last resort, except where contrary to federal or state law.

Authority: T.C.A. §§4-5-202, 71-5-105, 71-5-109, 71-5-117, and Executive Order No. 23. **Administrative History:** Original rule filed September 30, 2002; to be effective December 14, 2002; however, on December 9, 2002, the House Government Operations Committee of the General Assembly stayed rule 1200-13-13-.09; new effective date February 12, 2003.

1200-13-13-.10 EXCLUSIONS.

- (1) General exclusions. The following items and services shall not be considered covered services by TennCare:
 - (a) Provision of medical assistance which is outside the scope of benefits as defined in these rules.
 - (b) Provision of services to persons who are not enrolled in TennCare, either on the date the services are delivered or retroactively to the date the services are delivered, except for limited special appeal provisions pertaining to children who are placed in Youth Development Centers as defined in the Grier Revised Consent Decree, Section C.15.f. and pursuant to the DCS Interagency Agreement.
 - (c) Services for which there is no Federal Financial Participation (FFP).
 - (d) Services provided outside the United States or its territories.
 - (e) Services provided outside the geographic borders of Tennessee, including transportation to return to Tennessee to receive medical care except in the following circumstances:
 1. Emergency medical services are needed because of an emergency medical condition;
 2. Non-emergency urgent care services are requested because the recipient's health would be endangered if he were required to travel, but only upon the explicit prior authorization of the MCC;
 3. The covered medical service would not be readily available within Tennessee if the enrollee was physically located in Tennessee at the time of need and the covered service is explicitly prior authorized by the enrollee's TennCare MCC; or
 4. The out-of-state provider is participating in the enrollee's MCC network.
 - (f) Investigative or experimental services or procedures including, but not limited to:
 1. Drug or device that lacks FDA approval except when medically necessary as defined by TennCare;
 2. Drug or device that lacks approval of facility's Institutional Review Board;
 3. Requested treatment that is the subject of Phase I or Phase II clinical trials or the investigational arm of Phase III clinical trials; or

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

4. A requested service about which prevailing opinion among experts is that further study is required to determine safety, efficacy, or long-term clinical outcomes of requested service.
 - (g) Services which are delivered in connection with, or required by, an item or service not covered by TennCare, including the transportation to receive such non-covered services, except that treatment of conditions resulting from the provision of non-covered services may be covered if medically necessary, notwithstanding the exclusions set out herein.
 - (h) Items or services furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury.
 - (i) Non-emergency services that are ordered or furnished by an out-of-network provider and that have not been approved by the enrollee's MCC for out-of-network care.
 - (j) Services that are free to the public, with the exception of services delivered in the schools pursuant to the Individuals with Disabilities in Education Act (IDEA).
 - (k) Items or services ordered, prescribed, administered, supplied, or provided by an individual or entity that has been excluded from participation in the Medicaid program under the authority of the United States Department of Health and Human Services or the Bureau of TennCare.
 - (l) Items or services ordered, prescribed, administered, supplied, or provided by an individual or entity that is not licensed by the appropriate licensing board.
 - (m) Items or services outside the scope and/or authority of a provider's specialty and/or area of practice.
 - (n) Items or services to the extent that Medicare or a third party payer is legally responsible to pay or would have been legally responsible to pay except for the enrollee's or the treating provider's failure to comply with the requirements for coverage of such services.
 - (o) Medical services for inmates confined in a local, state, or federal prison, jail, or other penal or correctional facility, including a furlough from such facility.
- (2) Exception to General and Specific Exclusions: COST EFFECTIVE ALTERNATIVE. As approved by CMS and/or authorized by TSOP 032, each MCC has sole discretionary authority to provide certain cost effective alternatives when providing appropriate medically necessary care. These services are otherwise excluded and are not covered services unless the MCC has followed the procedures set forth in TSOP 032 and opts at its sole discretion to provide such requested item or service.
- (3) Specific exclusions. The following services, products, and supplies are specifically excluded from coverage under the TennCare Section 1115(a) waiver program unless excepted by paragraph (2) herein. Some of these services may be covered outside TennCare under a Home and Community Based Services waiver when provided as part of an approved plan of care, in accordance with the appropriate TennCare Home and Community Based Services rule.
 - (a) Services, products, and supplies that are specifically excluded from coverage except as medically necessary for children under the age of 21
 1. Air cleaners, purifiers, or HEPA filters
 2. Audiological therapy or training

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

3. Augmentative communication devices
4. Beds and bedding equipment as follows:
 - (i) Powered air flotation beds, air fluidized beds (including Clinitron beds), water pressure mattress, or gel mattress

For persons age 21 and older: Not covered unless a member has both severely impaired mobility (i.e., unable to make independent changes in body position to alleviate pain or pressure) and any stage pressure ulcer on the trunk or pelvis combined with at least one of the following: impaired nutritional status, fecal or urinary incontinence, altered sensory perception, or compromised circulatory status.
 - (ii) Bead beds, or similar devices
 - (iii) Bed boards
 - (iv) Bedding and bed casings
 - (v) Ortho-prone beds
 - (vi) Oscillating beds
 - (vii) Pillows, hypoallergenic
 - (viii) Springbase beds
 - (ix) Vail beds, or similar bed
5. Bed baths and Sitz baths
6. Chiropractor's services
7. Convalescent care
8. Cushions, pads, and mattresses as follows:
 - (i) Aquamatic K Pads
 - (ii) Elbow protectors
 - (iii) Heat and massage foam cushion pads
 - (iv) Heating pads
 - (v) Heel protectors
 - (vi) Lamb's wool pads
 - (vii) Steam packs
9. Diagnostic tests conducted solely for the purpose of evaluating the need for a service which is excluded from coverage under these rules.

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

10. Ear plugs
11. Floor standers
12. Food supplements and substitutes including formulas

For persons 21 years of age and older: Not covered, except that Parenteral Nutrition formulas, Enteral Nutrition formulas for tube feedings and phenylalanine-free formulas (not foods) used to treat PKU, as required by TCA 56-7-2505, are covered for adults. In addition, oral liquid nutrition may be covered when medically necessary for adults with swallowing or breathing disorders who are severely underweight ($BMI < 15 \text{ kg/m}^2$) and physically incapable of otherwise consuming a sufficient intake of food to meet basic nutritional requirements.
13. Hearing aids, including the prescribing, fitting, or changing of hearing aids
14. Humidifiers (central or room) and dehumidifiers
15. Inpatient rehabilitation facility services
16. Medical supplies, over-the-counter, as follows:
 - (i) Alcohol, rubbing
 - (ii) Band-aids
 - (iii) Cotton balls
 - (iv) Eyewash
 - (v) Peroxide
 - (vi) Q-tips or cotton swabs
17. Methadone clinic services
18. Nutritional supplements and vitamins, over-the-counter, except that prenatal vitamins for pregnant women and folic acid for women of childbearing age are covered
19. Orthodontic services, except as defined in Rule 1200-13-13-.04(1)(b)6. or 1200-13-14-.04(1)(b)6.
20. Certain pharmacy items as follows:
 - (i) Agents when used for anorexia or weight loss
 - (ii) Agents when used to promote fertility
 - (iii) Agents when used for cosmetic purposes or hair growth
 - (iv) Agents when used for the symptomatic relief of cough and colds
 - (v) Agents when use to promote smoking cessation

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

- (vi) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee
 - (vii) Nonprescription drugs
 - (viii) Barbiturates
 - (ix) Benzodiazepines
21. Purchase, repair, or replacement of materials or equipment when the reason for the purchase, repair, or replacement is the result of enrollee abuse
 22. Purchase, repair, or replacement of materials or equipment that has been stolen or destroyed except when the following documentation is provided:
 - (i) Explanation of continuing medical necessity for the item, and
 - (ii) Explanation that the item was stolen or destroyed, and
 - (iii) Copy of police, fire department, or insurance report if applicable
 23. Radial keratotomy
 24. Reimbursement to a provider or enrollee for the replacement of a rented durable medical equipment (DME) item that is stolen or destroyed
 25. Repair of DME items not covered by TennCare
 26. Repair of DME items covered under the provider's or manufacturer's warranty
 27. Repair of a rented DME item
 28. Sitter services
 29. Speech, language, and hearing services to address speech problems caused by mental, psychoneurotic, or personality disorders
 30. Standing tables
 31. Vision services for persons 21 years of age and older that are not needed to treat a systemic disease process including, but not limited to:
 - (i) Eyeglasses, sunglasses, and/or contact lenses for persons aged 21 and older, including eye examinations for the purpose of prescribing, fitting, or changing eyeglasses, sunglasses, and/or contact lenses; procedures performed to determine the refractive state of the eye(s); one pair of cataract glasses or lenses is covered for adults following cataract surgery
 - (ii) LASIK
 - (iii) Orthoptics

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

- (iv) Vision perception training
 - (v) Vision therapy
- (b) Services, products, and supplies that are specifically excluded from coverage under the TennCare program.
1. Alcoholic beverages
 2. Animal therapy including, but not limited to:
 - (i) Dolphin therapy
 - (ii) Equine therapy
 - (iii) Hippo therapy
 - (iv) Pet therapy
 3. Art therapy
 4. Autopsy
 5. Bathtub equipment and supplies as follows:
 - (i) Paraffin baths
 - (ii) Sauna baths
 6. Beds and bedding equipment as follows:
 - (i) Adjust-a-Beds, lounge beds, or similar devices
 - (ii) Waterbeds
 7. Bioenergetic therapy
 8. Biofeedback
 9. Body adornment and enhancement services including, but not limited to:
 - (i) Body piercing
 - (ii) Breast augmentation
 - (iii) Breast capsulectomy
 - (iv) Breast implant removal
 - (v) Ear piercing
 - (vi) Hair transplantation, and agents for hair growth
 - (vii) Tattoos or removal of tattoos

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

- (viii) Tongue splitting or repair of tongue splitting
- (ix) Wigs or hairpieces
- 10. Breathing equipment as follows:
 - (i) Intrapulmonary Percussive Ventilators (IPVs)
 - (ii) Spirometers, except for peak flow meters for medical management of asthma
 - (iii) Vaporizers
- 11. Carbon dioxide therapy
- 12. Care facilities or services, the primary purpose of which is non-medical, including, but not limited to:
 - (i) Day care
 - (ii) Evening care centers
 - (iii) Respite care, with the exception of crisis respite offered as a component of mental health crisis services
 - (iv) Rest cures
 - (v) Social or diversion services related to the judicial system
- 13. Carotid body tumor, excision of, as treatment for asthma
- 14. Chelation therapy, except for the treatment of heavy metal poisoning or secondary hemochromatosis in selected settings. Chelation therapy for treatment of arteriosclerosis or autism is not covered. Chelation therapy for asymptomatic individuals is not covered. In the case of lead poisoning, the lead levels must be extremely high. For children, a minimum level of 45 ug/dl is recommended. Because chelation therapy and its after-effects must be continuously monitored for possible adverse reactions, chelation therapy is covered only in inpatient or outpatient hospital settings, renal dialysis facilities, and skilled nursing facilities. It is not covered in an office setting, an ambulatory surgical center, or a home setting.
- 15. Clothing, including adaptive clothing
- 16. Cold therapy devices
- 17. Comfort and convenience items including, but not limited to:
 - (i) Corn plasters
 - (ii) Garter belts
 - (iii) Incontinence products (diapers/liners/underpads) for persons younger than 3 years of age

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

- (iv) Support stockings, when light or medium weight or prescribed for relief of tired or aching legs or treatment of spider/varicose veins. Surgical weight stockings prescribed by a doctor or other qualified licensed health care practitioner for the treatment of chronic foot/ankle swelling, venous insufficiencies, or other medical conditions and thrombo-embolic deterrent support stockings for pre- and post-surgical procedures are covered as medically necessary.
18. Computers, personal, and peripherals including, but not limited to printers, modems, monitors, scanners, and software, including their use in conjunction with an Augmentative Communication Device
 19. Cosmetic dentistry, cosmetic oral surgery, and cosmetic orthodontic services
 20. Cosmetic prosthetic devices
 21. Cosmetic surgery or surgical procedures primarily for the purpose of changing the appearance of any part of the body to improve appearance or self-esteem, including scar revision. The following services are not considered cosmetic services:
 - (i) Reconstructive surgery to correct the results of an injury or disease
 - (ii) Surgery to treat congenital defects (such as cleft lip and cleft palate) to restore normal bodily function
 - (iii) Surgery to reconstruct a breast after mastectomy that was done to treat a disease, or as a continuation of a staged reconstructive procedure
 - (iv) In accordance with Tennessee law, surgery of the non-diseased breast following mastectomy and reconstruction to create symmetrical appearance
 - (v) Surgery for the improvement of the functioning of a malformed body member
 - (vi) Reduction mammoplasty, when the minimum amount of breast material to be removed is equal to or greater than the 22nd percentile of the Schnur Sliding Scale based on the individual's body surface area.
 22. Dance therapy
 23. Dental services for adults age 21 and older
 24. Services provided solely or primarily for educational purposes, including, but not limited to:
 - (i) Academic performance testing
 - (ii) Educational tests and training programs
 - (iii) Habilitation
 - (iv) Job training
 - (v) Lamaze classes
 - (vi) Lovaas therapy

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

- (vii) Picture illustrations
 - (viii) Remedial education
 - (ix) Sign language instruction
 - (x) Special education
 - (xi) Tutors
25. Encounter groups or workshops
26. Environmental modifications including, but not limited to:
- (i) Air conditioners, central or unit
 - (ii) Micronaire environmentals, and similar devices
 - (iii) Pollen extractors
 - (iv) Portable room heaters
 - (v) Vacuum systems for dust filtering
 - (vi) Water purifiers
 - (vii) Water softeners
27. Exercise equipment including, but not limited to:
- (i) Exercise equipment
 - (ii) Exercycles (including cardiac use)
 - (iii) Functional electrical stimulation
 - (iv) Gravitronic traction devices
 - (v) Gravity guidance inversion boots
 - (vi) Parallel bars
 - (vii) Pulse tachometers
 - (viii) Tilt tables
 - (ix) Training balls
 - (x) Treadmill exercisers
 - (xi) Weighted quad boots

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

28. Food and food products (distinct from food supplements or substitutes, as defined in rule 1200-13-13-.10(3)(a)12. including but not limited to specialty food items for use in diets such as:
 - (i) Low-phenylalanine or phenylalanine-free
 - (ii) Gluten-free
 - (iii) Casein-free
 - (iv) Ketogenic
29. Grooming services including, but not limited to:
 - (i) Barber services
 - (ii) Beauty services
 - (iii) Electrolysis
 - (iv) Hairpieces or wigs
 - (v) Manicures
 - (vi) Pedicures
30. Hair analysis
31. Home modifications and items for use in the home
 - (i) Decks
 - (ii) Enlarged doorways
 - (iii) Environmental accessibility modifications such as grab bars and ramps
 - (iv) Fences
 - (v) Furniture, indoor or outdoor
 - (vi) Handrails
 - (vii) Meals
 - (viii) Overbed tables
 - (ix) Patios, sidewalks, driveways, and concrete slabs
 - (x) Plexiglass
 - (xi) Plumbing repairs
 - (xii) Porch gliders

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

- (xiii) Rollabout chairs
 - (xiv) Room additions and room expansions
 - (xv) Telephone alert systems
 - (xvi) Telephone arms
 - (xvii) Telephone service in home
 - (xviii) Televisions
 - (xix) Tilt tables
 - (xx) Toilet trainers and potty chairs. Positioning commodes and toilet supports are covered as medically necessary.
 - (xxi) Utilities (gas, electric, water, etc.)
32. Homemaker services
33. Hospital inpatient items that are not directly related to the treatment of an injury or illness (such as radios, TVs, movies, telephones, massage, guest beds, haircuts, hair styling, guest trays, etc.)
34. Hotel charges, unless pre-approved in conjunction with a transplant or as part of a non-emergency transportation service
35. Hypnosis or hypnotherapy
36. Icterus index
37. Infant/child car seats, except that adaptive car seats may be covered for a person with disabilities such as severe cerebral palsy, spina bifida, muscular dystrophy, and similar disorders who meets all of the following conditions:
- (i) Cannot sit upright unassisted, and
 - (ii) Infant/child care seats are too small or do not provide adequate support, and
 - (iii) Safe automobile transport is not otherwise possible.
38. Infertility or impotence services including, but not limited to:
- (i) Artificial insemination services
 - (ii) Purchase of donor sperm and any charges for the storage of sperm
 - (iii) Purchase of donor eggs, and any charges associated with care of the donor required for donor egg retrievals or transfers of gestational carriers
 - (iv) Cryopreservation and storage of cryopreserved embryos

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

- (v) Services associated with a gestational carrier program (surrogate parenting) for the recipient or the gestational carrier
 - (vi) Fertility drugs
 - (vii) Home ovulation prediction kits
 - (viii) Services for couples in which one of the partners has had a previous sterilization procedure, with or without reversal
 - (ix) Reversal of sterilization procedures
 - (x) Any other service or procedure intended to create a pregnancy
 - (xi) Testing and/or treatment, including therapy, supplies, and counseling, for frigidity or impotence
39. Lamps such as:
- (i) Heating lamps
 - (ii) Lava lamps
 - (iii) Sunlamps
 - (iv) Ultraviolet lamps
40. Lifts as follows:
- (i) Automobile van lifts
 - (ii) Electric powered recliner, elevating seats, and lift chairs
 - (iii) Elevators
 - (iv) Overhead or ceiling lifts, ceiling track system lifts, or wall mounted lifts when installation would require significant structural modification and/or renovation to the dwelling (e.g., moving walls, enlarging passageways, strengthening ceilings and supports). The request for prior authorization must include a specific breakdown of equipment and installation costs, specifying all required structural modifications (however minor) and the cost associated thereto.
 - (v) Stairway lifts, stair glides, and platform lifts, including but not limited to Wheel-O-Vators
41. Ligation of mammary arteries, unilateral or bilateral
42. Megavitamin therapy
43. Motor vehicle parts and services including, but not limited to:
- (i) Automobile controls
 - (ii) Automobile repairs or modifications

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

44. Music therapy
45. Nail analysis
46. Naturopathic services
47. Necropsy
48. Nerve stimulators, except for vagus nerve stimulators after conventional therapy has failed in treating partial onset of seizures
49. Organ and tissue transplants that have been determined experimental or investigational
50. Organ and tissue donor services provided in connection with organ or tissue transplants covered pursuant to Rule 1200-13-13-.04(1)(b)23., including, but not limited to:
 - (i) Transplants from a donor who is a living TennCare enrollee and the transplant is to a non-TennCare enrollee
 - (ii) Donor services other than the direct services related to organ procurement (such as, hospitalization, physician services, anesthesia)
 - (iii) Hotels, meals, or similar items provided outside the hospital setting for the donor
 - (iv) Any costs incurred by the next of kin of the donor
 - (v) Any services provided outside of any “bundled rates” after the donor is discharged from the hospital
51. Oxygen, except when provided under the order of a physician and administered under the direction of a physician
52. Oxygen, preset system (flow rate not adjustable)
53. Certain pharmacy items as follows: DESI, LTE, and IRS drugs
54. Play therapy
55. Primal therapy
56. Psychodrama
57. Psychogenic sexual dysfunction or transformation services
58. Purging
59. Recertification of patients in Level 1 and Level II Nursing Facilities
60. Recreational therapy
61. Religious counseling
62. Retreats for mental disorders

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

63. Rolfing
64. Routine health services which may be required by an employer; or by a facility where an individual lives, goes to school, or works; or by the enrollee's intent to travel
 - (i) Drug screenings
 - (ii) Employment and pre-employment physicals
 - (iii) Fitness to duty examinations
 - (iv) Immunizations related to travel or work
 - (v) Insurance physicals
 - (vi) Job related illness or injury covered by workers' compensation
65. Sensitivity training or workshops
66. Sensory integration therapy and equipment used in sensory integration therapy including, but not limited to:
 - (i) Ankle weights
 - (ii) Floor mats
 - (iii) Mini-trampolines
 - (iv) Poof chairs
 - (v) Sensory balls
 - (vi) Sky chairs
 - (vii) Suspension swings
 - (viii) Trampolines
 - (ix) Therapy balls
 - (x) Weighted blankets or weighted vests
67. Sensory stimulation services
68. Services provided by immediate relatives, i.e., a spouse, parent, grandparent, stepparent, child, grandchild, brother, sister, half brother, half sister, a spouse's parents or stepparents, or members of the recipient's household
69. Sex change or transformation surgery
70. Sexual dysfunction or inadequacy services and medicine, including drugs for erectile dysfunctions and penile implant devices

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

71. Speech devices as follows:
 - (i) Phone mirror handivoice
 - (ii) Speech software
 - (iii) Speech teaching machines
72. Sphygmomanometers (blood pressure cuffs)
73. Stethoscopes
74. Supports
 - (i) Cervical pillows
 - (ii) Orthotrac pneumatic vests
75. Thermograms
76. Thermography
77. Time involved in completing necessary forms, claims, or reports
78. Tinnitus maskers
79. Toy equipment such as:

Flash switches (for toys)
80. Transportation costs as follows:
 - (i) Transportation to a provider who is outside the geographical access standards that the MCC is required to meet when a network provider is available within such geographical access standards or, in the case of Medicare beneficiaries, transportation to Medicare providers who are outside the geographical access standards of the TennCare program when there are Medicare providers available within those standards
 - (ii) Mileage reimbursement, car rental fees, or other reimbursement for use of a private vehicle unless prior authorized by the MCC in lieu of contracted transportation services
 - (iii) Transportation back to Tennessee from vacation or other travel out-of-state in order to access non-emergency covered services (unless authorized by the MCC)
81. Transsexual surgery
82. Weight loss or weight gain and physical fitness programs including, but not limited to:
 - (i) Dietary programs of weight loss programs, including, but not limited to, Optifast, Nutrisystem, and other similar programs or exercise programs. Food supplements will not be authorized for use in weight loss programs or for weight gain.

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

- (ii) Health clubs, membership fees (e.g., YMCA)
 - (iii) Marathons, activity and entry fees
 - (iv) Swimming pools
83. Wheelchairs as follows:
- (i) Wheelchairs defined by CMS as power operated vehicles (POVs), namely, scooters and devices with three (3) or four (4) wheels that have tiller steering and limited seat modification capabilities (i.e., provide little or no back support). Powered wheelchairs, meaning four (4) wheeled, battery operated vehicles that provide back support and that are steered by an electronic device or joystick that controls direction and turning, are covered as medically necessary.
 - (ii) Standing wheelchairs
 - (iii) Stair-climbing wheelchairs
 - (iv) Recreational wheelchairs
84. Whirlpools and whirlpool equipment such as:
- (i) Action bath hydro massage
 - (ii) Aero massage
 - (iii) Aqua whirl
 - (iv) Aquasage pump, or similar devices
 - (v) Hand-D-Jets, or similar devices
 - (vi) Jacuzzis, or similar devices
 - (vii) Turbojets
 - (viii) Whirlpool bath equipment
 - (ix) Whirlpool pumps

Authority: T.C.A. §§4-5-202,4-5-209, 71-5-105, 71-5-109, and Executive Order No. 23. **Administrative History:** Original rule filed September 30, 2002; to be effective December 14, 2002; however, on December 9, 2002, the House Government Operations Committee of the General Assembly stayed rule 1200-13-13-.10; new effective date February 12, 2003. Repeal and new rule filed October 27, 2005; effective January 10, 2006. Public necessity rule filed May 3, 2006; effective through October 15, 2006.

1200-13-13-.11 APPEAL OF ADVERSE ACTIONS AFFECTING TENNCARE SERVICES OR BENEFITS.

- (1) Notice Requirements.
 - (a) When Written Notice is Required.

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

1. A written notice shall be given to an enrollee by his/her MCC of any adverse action taken by the MCC to deny, reduce, suspend, or terminate medical assistance.
2. A written notice shall be given to an enrollee whenever his/her MCC has reason to expect that covered medical assistance for the enrollee will be delayed beyond the time lines prescribed by the TennCare contract or the terms and conditions of the TennCare waiver. Actions which can reasonably be anticipated to delay or disrupt access to medical assistance include:
 - (i) Change of primary care provider;
 - (ii) Pharmacy “lock-in”;
 - (iii) Decisions affecting the designation of a person as severely and persistently mentally ill (SPMI) or severely emotionally disturbed (SED);
 - (iv) Termination of a provider’s contract, by either party to the contract; or
 - (v) Inability to provide an adequate provider network.
3. A written notice shall be given to an enrollee of any MCC-initiated reduction, termination or suspension of inpatient hospital care.
4. A written notice shall be given to an enrollee of any provider-initiated reduction, termination or suspension of:
 - (i) Any behavioral health service for a severely and persistently mentally ill (SPMI) adult enrollee or severely emotionally disturbed (SED) child;
 - (ii) Any inpatient psychiatric 24-hour or residential service;
 - (iii) Any service being provided to treat a patient’s chronic condition across a continuum of services when the next appropriate level of medical service is not immediately available; or
 - (iv) Home health services.

The enrollee’s MCC shall be promptly notified of a provider’s proposal to reduce, terminate or suspend one of the above services and of the recommended discharge plan, if any, to insure compliance with this rule.
5. Appropriate notice shall be given to an enrollee by the State or MCC when an enrollee exceeds a benefit limit. Such notice shall not be subject to the requirements of rule 1200-13-13-.11(1)(c)1. During the applicable time period for each benefit limit, such notice shall only be provided the first time a claim is denied because an enrollee has exceeded a benefit limit. The State or MCC will not be required to provide any notice when an enrollee is approaching or reaches a benefit limit.
6. Appropriate notice shall be given to an enrollee by a provider when an enrollee exceeds a non-pharmacy benefit limit in the following circumstances:
 - (i) The provider denies the request for a non-pharmacy service because an enrollee has exceeded the applicable benefit limit; or

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

- (ii) The provider informs an enrollee that the non-pharmacy service will not be covered by TennCare because he/she has exceeded the applicable benefit limit and the enrollee chooses not to receive the service.

During the applicable time period for each non-pharmacy benefit limit, providers shall only be required to provide this notice the first time an enrollee does not receive a non-pharmacy service from the provider because he/she has exceeded the applicable benefit limit. Such notice shall not be subject to the requirements of rule 1200-13-13-.11(1)(c)1. Providers will not be required to provide any notice when an enrollee is approaching or reaches a non-pharmacy benefit limit.

(b) Timing of Written Notice.

1. Written notice of MCC-initiated reduction, termination or suspension of medical assistance must be provided to an enrollee within the time frames required by 42 C.F.R. §§431.210 - .214 (usually ten (10) days in advance). However, in instances of MCC-initiated reduction, termination or suspension of inpatient hospital treatment, the notice must be provided to an enrollee at least two business days in advance of the proposed action. Where applicable and not in conflict with this rule, the exceptions set out at 42 C.F.R. § § 431.211 - .214 permit or require reduction of the time frames within which advance notice must be provided.
2. An MCC must notify an enrollee of its decision in response to a request by or on behalf of an enrollee for medical or related services within fourteen (14) days of receipt of the request for prior authorization. If the request for prior authorization is denied, the MCC shall provide a written notice to the enrollee.
3. Written notice of delay of covered medical assistance must be provided to an enrollee immediately upon an MCC's receipt of information leading it to expect that such delay will occur.
4. Where required by paragraph (1)(a)4. of this rule, written notice of provider-initiated reduction, termination or suspension of services must be provided to an enrollee at least two (2) business days in advance of the proposed action.
5. Written notice is deemed to be provided to an enrollee upon deposit with the US Postal Service or other commercial mail carrier, or upon hand-delivery to an enrollee or his/her representative.

(c) Notice Contents.

1. Whenever this rule requires that a TennCare enrollee receive written notice of an adverse action affecting medical assistance, the notice must contain the following elements, written in concise, readable terms:
 - (i) The type and amount of TennCare services at issue and the identity of the individual, if any, who prescribed the services.
 - (ii) A statement of reasons for the proposed action. The statement of reasons shall include the specific facts, personal to the enrollee, which support the proposed action and sources from which such facts are derived. If the proposed action turns on a determination of medical necessity or other clinical decision, the statement of reasons shall:

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

- (I) Identify by name those clinicians who were consulted in reaching the decision at issue;
 - (II) Identify specifically those medical records upon which those clinicians relied in reaching his/her decision; and
 - (III) Specify what part(s) of the criteria for medical necessity or coverage was not met.
- (iii) Reference to the legal or policy basis for a proposed adverse action, including a plain and concise statement of, and official citation to, the applicable law, federal waiver provision, or TennCare contract provision relied upon.
 - (iv) Inform the enrollee about the opportunity to contest the decision, including the right to an expedited appeal in the case of time-sensitive care and the right to continuation or reinstatement of benefits pending appeal, when applicable.
 - (v) If the enrollee has an ongoing illness or condition requiring medical care and the MCC or its network provider is under a duty to provide a discharge plan or otherwise arrange for the continuation of treatment following the proposed adverse action, the notice must include a readable explanation of the discharge plan, if any, and a description of the specific arrangements in place to provide for the enrollee's continuing care.
2. Remedying of Notice. If a notice of adverse action provided to an enrollee does not meet the notice content requirements of 1200-13-13-.11(1)(c)1., TennCare will not automatically resolve the appeal in favor of the enrollee. TennCare or the MCC may cure any such deficiencies by providing one corrected notice to enrollees. If a corrected notice is provided to an enrollee, the reviewing authority shall consider only the factual reasons and legal authorities cited in the corrected notice, except that additional evidence beneficial to the enrollee may be considered on appeal.
- (d) Special Provisions Pertaining to Pharmacy Notice
- 1. If an enrollee does not receive medication of the type and amount prescribed because the pharmacy services are not covered by TennCare, the enrollee shall receive appropriate notice as described below. Such notice shall not be subject to the requirements of rule 1200-13-13-.11(1)(c)1.
 - (i) When the enrollee has exceeded a benefit limit. Pharmacists will verify TennCare coverage for all prescriptions presented by TennCare enrollees through the PBM. If the PBM denies coverage because an enrollee has exceeded the applicable pharmacy benefit limit and the drug is not included on the Pharmacy Short List, the PBM will provide appropriate notice to the enrollee, informing him/her of the right to appeal the denial. This notice will only be provided upon the first denial of coverage of a pharmacy service sought by the enrollee that exceeds the applicable monthly limits.
 - (ii) When a request for prior authorization for a prescription has already been denied. Pharmacists will verify TennCare coverage for all prescriptions presented by TennCare enrollees. If the PBM denies coverage because a prior authorization request has already been denied, the enrollee will receive notice as described in rule 1200-13-13-.11(1)(d)1.(II). No additional notice will be provided to the enrollee.

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

- (iii) When a request for prior authorization has not been obtained for a prescription. Pharmacists will verify TennCare coverage for all prescriptions presented by TennCare enrollees. If the pharmacist denies coverage because a request for prior authorization has not been obtained, the following will apply:
 - (I) The pharmacists will attempt to contact the prescribing physician to seek prior authorization from the PBM or make a change in the prescription. If the pharmacist remains unable to resolve the enrollee's request for the prescription:
 - I. The pharmacist will dispense a 72-hour interim supply of the medication in an emergency situation if such supply would not exceed applicable pharmacy benefit limits. An emergency situation is a situation that, in the judgment of dispensing pharmacists, involves an immediate threat of severe adverse consequences to the enrollee, or the continuation of immediate and severe adverse consequences to the enrollee, if the outpatient drug is not dispensed when the prescription is submitted. The 72-hour interim supply shall only be dispensed by the pharmacist once per prescription. If the pharmacist determines that an emergency situation does not exist, the pharmacist will not dispense the 72-hour interim supply and shall not provide a written notice to the enrollee for this determination. Enrollees may not appeal the denial by the pharmacist of a 72-hour interim supply of a prescription.
 - II. The pharmacist will provide the enrollee with a notice that advises the enrollee how prior authorization may be requested for the prescription.
 - (II) If the prescribing physician seeks prior authorization for the prescription, the PBM will respond to this request within twenty-four hours of receipt if the prescribing physician has provided all of the information necessary to facilitate the determination. If the PBM grants this request, the PBM will provide notice to the enrollee informing him/her of this resolution. If the PBM denies this request, the PBM will provide the enrollee with appropriate notice, informing him/her of the right to appeal the denial and to continuation or reinstatement of benefits, when applicable.
 - (III) If an enrollee seeks prior authorization before he/she contacted the prescribing physician, the PBM will advise the enrollee that he/she must attempt to contact the prescribing physician and allow twenty-four (24) hours to lapse from the denial of coverage for the prescription.
 - (IV) If an enrollee seeks prior authorization after attempting to contact the prescribing physician and has allowed twenty-four (24) hours to lapse since the denial of coverage for the prescription, the PBM will review this request within three business days of its receipt. If the request is resolved as a result of the prescribing physician making a therapy change, the PBM will provide notice to the enrollee informing him/her of this resolution. If the PBM denies this request, the PBM will provide the enrollee with appropriate notice, informing him/her of the right to appeal the denial and to continue or reinstate benefits, when applicable.

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

- (iv) When the requested drug is not a category or class of drugs covered by TennCare. Pharmacists will verify TennCare coverage for all prescriptions presented by TennCare enrollees. If the PBM denies coverage because the drug is not a category or class of drugs covered by TennCare, the PBM will provide appropriate notice to the enrollee, informing him/her of the right to appeal the denial.
- (v) When the enrollee has been locked-into one pharmacy, as described in rule 1200-13-13-.13 and the enrollee seeks to fill a prescription at another pharmacy. Pharmacists will verify TennCare coverage for all prescriptions presented by TennCare enrollees. If the PBM denies coverage because the pharmacy is not the enrollee's "lock-in" pharmacy, the PBM will provide appropriate notice to the enrollee, informing him/her of the right to appeal the denial.
- (vi) When an enrollee submits a pharmacy reimbursement and billing claim:
 - (I) TennCare will first determine whether the claim has been previously denied. If the claim was paid upon approval of prior authorization or the enrollee received an alternative prescription ordered by his/her prescribing physician, TennCare will provide appropriate notice to the enrollee, informing them that the request has already been resolved.
 - (II) If the claim had already been denied, TennCare will determine the reason for such denial and follow the applicable processes identified in sections 1200-13-13-.11(1)(d)1.(i) to 1.(iii).
 - (III) If a claim had not already been submitted to the MCC or TennCare, TennCare will determine whether such claim is eligible for reimbursement. If TennCare denies the claim, TennCare will determine the reason for such denial and follow the applicable processes identified in rule 1200-13-13-.11(1)(d)1.(i) to 1.(iii).
- (e) Notice of Rights. The Bureau of TennCare shall provide annual notice to TennCare enrollees of his/her notice and appeal rights established by this rule, including the enrollee's recourse when billed by a provider for TennCare covered services. Additionally, upon enrollment in an MCC, the MCC shall give the enrollee a plain language explanation of appeal rights.
- (f) Proper use of the approved template notices designated by the Grier Revised Consent Decree shall be deemed to satisfy the notice requirements specified by this rule.
- (g) Violation of Notice Requirements and Corrective Action.
 1. No adverse action affecting TennCare services shall be effective unless the notice requirements of the federal regulations (42 C.F.R. § § 431.210 - .214), as enhanced or otherwise modified herein, have been complied with. TennCare shall not withhold, or permit others acting on its behalf to withhold, any TennCare services in violation of this requirement.
 2. Whenever it comes to the attention of the Bureau of TennCare or an MCC that a TennCare covered service will be or has been delayed, denied, reduced, suspended or terminated in violation of any of the notice requirements of this rule, TennCare or the MCC will immediately provide that service in the quantity and for the duration prescribed, subject to TennCare's or the MCC's right to reduce or terminate the service in accordance with the procedures required by this rule.

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

3. In the event that the enrollee lacks a prescription for the covered TennCare service which has been delayed, denied, reduced, suspended or terminated in violation of notice requirements, the following shall occur:
 - (i) The enrollee will be immediately afforded access, at the earliest time practicable, to a qualified provider to determine whether the service should be prescribed;
 - (ii) The provider will be informed that the service will be authorized if prescribed; and
 - (iii) Entitlement to the service will not be controlled by the MCC's utilization review process.
 4. In the event that the notice violation has occurred with regard to a delay of access to a physician to secure the requested medical assistance, such access shall be provided as soon as practicable. The enrollee shall be entitled to continue to receive such service until such time as the MCC takes those actions required by federal regulations and this rule as a prerequisite to taking any adverse action affecting TennCare services.
- (2) Appeal Rights of Enrollees. Enrollees have the following rights:
- (a) To appeal adverse actions affecting TennCare services.
 - (b) To have oral or written expressions by the enrollee, or on his behalf, of dissatisfaction or disagreement with adverse actions that have been taken or are proposed to be taken, treated as appeals, including instances in which:
 1. The enrollee lacks an order or prescription from a provider supporting the appeal;
 2. TennCare or an MCC has agreed to cover a prescribed service in an amount that is less than the amount or duration sought by the enrollee;
 3. TennCare or an MCC has agreed to provide a covered service that is different from that sought by the enrollee;
 4. An enrollee seeks to contest a delay or denial of care resulting from the MCC's failure or refusal to make a needed service available, due to the inadequacy of the MCC's provider network;
 5. An enrollee seeks to contest a denial of his right under the TennCare waiver to choose his own primary care provider (PCP) from among a panel offered by the MCC, or seeks to contest a delay or denial of care resulting from the involuntary assignment of a PCP;
 6. An enrollee seeks to contest denial of TennCare coverage for services already received, regardless of the cost or value of the services at issue;
 7. An enrollee seeks to contest a decision granting or withholding designation as severely and persistently mentally ill (SPMI) or severely emotionally disturbed (SED); and
 8. An enrollee seeks to change health plans after the initial forty-five (45) days pursuant to criteria (4)(b)1. and 2. at 1200-13-13-.03.
 - (c) To have the appeal rights that are prescribed by 42 C.F.R. Part 431, Subpart E and Tennessee Code Annotated §§ 4-5-301, et seq.

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

- (d) To be allowed thirty (30) days from receipt of written notice or, if no notice is provided, from the time the enrollee becomes aware of an adverse action, to appeal any adverse action affecting TennCare services.
 - (e) To appeal in person, by telephone, or in writing. Reasonable accommodations shall be made for any person with disabilities who requires assistance with his/her appeal, such as an appeal by TDD services or other communication device for people with disabilities. Written requests for appeals made at county TDHS offices shall be stamped, and immediately forwarded to the TennCare Bureau for processing and entry in the central registry. Oral appeals shall be followed up with a written, signed appeal; however, if the enrollee does not follow up in writing, the appeal will continue for resolution or for hearing;
 - (f) To file an appeal through a toll-free phone number on a twenty-four (24) hours a day, seven (7) days a week basis. Resolution of appeals outside of regular business hours will be available only in cases of emergency medical condition.
 - (g) For ongoing services, have the right to continuation or reinstatement of services, pursuant to 42 C.F.R. §§ 431.230 - .231 as modified by this rule, pending appeal when the enrollee submits a timely appeal and request for such services. When an enrollee is so entitled to continuation or reinstatement of services, this right may not be denied for any reason, including:
 - 1. An MCC's failure to inform an enrollee of the availability of such continued services;
 - 2. An MCC's failure to reimburse providers for delivering services pending appeal; or
 - 3. An MCC's failure to provide such services when timely requested.
 - (h) To an impartial appeals process. But for initial reconsideration by an MCC as permitted by this rule, no person who is an employee, agent or representative of an MCC may participate in deciding the outcome of a TennCare appeal. No state official may participate in deciding the outcome of an enrollee's appeal who was directly involved in the initial determination of the action in question.
- (3) Special Provisions Relating to Appeals.
- (a) Individualized Decisions Required. Neither the TennCare program nor its MCCs may employ utilization control guidelines or other quantitative coverage limits, whether explicit or de facto, unless supported by an individualized determination of medical necessity based upon the needs of each TennCare enrollee and his or her medical history.
 - (b) Decisions to be Supported by Substantial and Material Evidence. Throughout all stages of an appeal of an adverse action affecting TennCare services, decisions shall be based upon substantial and material evidence. In cases involving clinical judgments, this requirement means that:
 - 1. Appeal decision must be supported by medical evidence, and it is the MCCs' and TennCare's responsibility to elicit from enrollees and his/her treating providers all pertinent medical records that support an appeal; and
 - 2. The decisions or opinions of an enrollee's treating physician or other prescribing clinician shall not be overruled by either the MCC initially or TennCare upon review, unless there is substantial and material medical evidence, documented in the enrollee's medical records, to justify such action. Reliance upon insurance industry guidelines or utilization control criteria of general application, without consideration of the individual

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enrollee's medical history, does not satisfy this requirement and cannot be relied upon to support an adverse action affecting TennCare services.

- (c) Record on Review. When TennCare receives an appeal from an enrollee regarding an adverse action affecting TennCare services, TennCare is responsible for obtaining from the MCC any and all records or documents pertaining to the MCC's decision to take the contested action. TennCare shall correct any violation of this rule that is evident from a review of those records.
- (d) Valid Factual Disputes. When TennCare receives an appeal from an enrollee, TennCare will dismiss this appeal unless the enrollee has established a valid factual dispute relating to an adverse action affecting TennCare services.
 - 1. Processing of Appeals. TennCare shall screen all appeals submitted by TennCare enrollees to determine if the enrollees have presented a valid factual dispute. If TennCare determines that an enrollee failed to present a valid factual dispute, TennCare will immediately provide the enrollee with a notice, informing him/her that the enrollee must provide additional information as identified in the notice. If the enrollee does not provide this information, the appeal shall be dismissed without the opportunity for a fair hearing within ten (10) days of the date of the notice. If the enrollee adequately responds to this notice, TennCare shall inform the enrollee that the appeal will proceed to a hearing. If the enrollee responds but fails to provide adequate information, TennCare will provide a notice to the enrollee, informing him/her that the appeal is dismissed without the opportunity for a fair hearing. If the enrollee does not respond, the appeal will be dismissed without the opportunity for a fair hearing, without further notice to the enrollee.
 - 2. Information Required to Establish Valid Factual Disputes. In order to establish a valid factual dispute, TennCare enrollees must provide the following information: Enrollee's name; member SSN or TennCare ID#; address and phone; identification of the service or item that is the subject of the adverse action; and the reason for the appeal, including any factual error the enrollee believes TennCare or the MCC has made. For reimbursement and billing appeals, enrollees must also provide the date the service was provided, the name of the provider, copies of receipts which prove that the enrollee paid for the services or copies of a bill for the services, whichever is applicable.
- (e) Appeals When Enrollees Lack a Prescription. If a TennCare enrollee appeals an adverse action and TennCare determines that the basis of the appeal is that the enrollee lacks a prescription the following will apply:
 - 1. TennCare will provide appropriate notice to the enrollee to inform him/her that he/she will be required to complete an administrative process. Such administrative process requires the enrollee to contact the MCC to make an appointment with a provider to evaluate the request for the service. The MCC shall be required to make such appointment for the enrollee within a 3-week period or forty-eight (48) hours for urgent care from the date the enrollee contacts the MCC. Appeal timeframes will be tolled during this administrative process.
 - 2. In order for this appeal to continue, the enrollee shall be required to contact TennCare after attending the appointment with a physician and demonstrate that he/she remains without a prescription for the service. If the enrollee fails to contact TennCare within sixty (60) days from the date of the notice described in subparagraph (e)1., TennCare will dismiss the appeal without providing an opportunity for a hearing for the enrollee.

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- (f) Appeals When No Adverse Action is Taken. Enrollees shall not possess the right to appeal when no adverse action has been taken related to TennCare services. If enrollees request a hearing when no adverse action has been taken, their request shall be denied by the TennCare bureau without the opportunity for a hearing. Such circumstances include but are not limited to when enrollees appeal and no claim for services had previously been denied.

(4) Hearing Rights of Enrollees.

- (a) TennCare shall inform enrollees that they have the right to an in-person hearing, a telephone hearing or other hearing accommodation as may be required for enrollees with disabilities;
- (b) Enrollees shall be entitled to a hearing before an impartial hearing officer that affords each enrollee the right to:
 - 1. Representation at the hearing by anyone of his/her choice, including a lawyer;
 - 2. Review information and facts relied on for the decisions by the MCC and the TennCare Bureau before the hearing;
 - 3. Cross-examine adverse witnesses;
 - 4. Present evidence, including the right to compel attendance of witnesses at hearings;
 - 5. Review and present information from his/her medical records;
 - 6. Present evidence at the hearing challenging the adverse decision by his/her MCC;
 - 7. Ask for an independent medical opinion, at no expense to the enrollee;
 - 8. Continue or reinstate ongoing services pending a hearing decision, as specified in this rule;
 - 9. A written decision setting out the impartial hearing officer's rulings on findings of fact and conclusions of law; and
 - 10. Final agency action within ninety (90) days for standard appeals or thirty-one (31) days (or forty-five (45) days when additional time is required to obtain an enrollee's medical records) for expedited appeals, from the date of receipt of the appeal.
- (c) TennCare shall not impair the ability of an enrollee to appeal an adverse hearing decision by requiring that the enrollee bear the expense of purchasing a hearing transcript when such purchase would be a financial hardship for the enrollee.
- (d) Parties to an Appeal. Under this rule, the parties to an administrative hearing are limited to those permitted by federal regulations. The purpose of the hearing is to focus on the enrollee's medical needs. MCCs are not permitted to intervene or participate as parties in an enrollee's hearing. However, MCC employees may participate as witnesses in hearings. Further, nothing in this provision bars participation by an MCC in any informal resolution phase of the appeal process prior to a hearing before the impartial hearing officer.
- (e) Consistent with the Code of Judicial Conduct, impartial hearing officers shall assist pro se enrollees in developing the factual record and shall have authority to order second medical opinions at no expense to the enrollee.

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(f) Review of Hearing Decisions

1. Impartial hearing officers shall promptly issue an Order of their decision. Impartial hearing officers shall provide enrollees with copies of such Orders.
2. The TennCare Bureau shall have the opportunity to review all decisions of impartial hearing officers to determine whether such decisions are contrary to applicable law, regulations or policy interpretations, which shall include but not be limited to decisions regarding the defined package of covered benefits, determinations of medical necessity and decisions based on the application of the Grier Revised Consent Decree.
 - (i) Any such review shall be completed by TennCare within five (5) days of the issuance of the decision of the impartial hearing officer.
 - (ii) If TennCare modifies or overturns the decision of the impartial hearing officer, TennCare shall issue a written decision that will be provided to the enrollee and the impartial hearing officer. TennCare's decision shall constitute final agency action.
 - (iii) If TennCare does not modify or overturn the decision of the impartial hearing officer, the impartial hearing officer's decision shall constitute final agency action without additional notice to the enrollee.
 - (iv) Review of final agency action shall be available to enrollees pursuant to the Tennessee Administrative Procedures Act, Tennessee Code Annotated §§ 4-5-301, et seq.
 - (v) An impartial hearing officer's decision in an enrollee's appeal shall not be deemed precedent for future appeals.

(g) Continuation or Reinstatement of TennCare Services.

1. Except as permitted under 42 C.F.R. §§ 431.213, 431.214 and 431.220, as modified by this rule, TennCare services shall continue or be reinstated until an initial hearing decision if the enrollee appeals and requests:
 - (i) Continuation of services within two (2) business days of the receipt of MCC-initiated notice of action to terminate, suspend or reduce ongoing inpatient hospital treatment; or
 - (ii) Continuation of services within two (2) business days of the receipt of provider-initiated notice of action to terminate, suspend or reduce any behavioral health service for a severely and persistently mentally ill (SPMI) adult enrollee or severely emotionally disturbed (SED) child, any inpatient psychiatric or residential service, any service being provided to treat a patient's chronic condition across a continuum of services when the next appropriate level of medical service is not immediately available, or home health services; or
 - (iii) Continuation or reinstatement of services within ten (10) days of the receipt of MCC-initiated notice of action to terminate, suspend or reduce other ongoing services.
2. In the case of a timely request for continuation or reinstatement of the TennCare services described in paragraph (4)(g)1.(ii) above, the enrollee shall be afforded access to a

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written second medical opinion from a qualified provider who participates in the MCC's network. If there has not already been a break in receipt of the services, the benefits shall continue until receipt of the written second medical opinion. Services shall continue or be reinstated thereafter pending appeal only if and to the extent prescribed by the second provider.

3. In the case of a timely request for continuation or reinstatement of the TennCare services described in paragraph (4)(g)1.(i) and (iii) above, the services shall continue or be reinstated pending appeal only if and to the extent prescribed by the enrollee's treating clinician.
4. Services shall not continue, but may be immediately reduced, terminated, or suspended if the services are determined medically contraindicated in accordance with the provisions of paragraph (8) below.
5. Expedited appeals shall be concluded within thirty-one (31) days or forty-five (45) days when additional time is required to obtain an enrollee's medical records, from the date the appeal is received from the enrollee. If an enrollee makes a timely request for continuation or reinstatement of a disputed TennCare service pending appeal, receives the continued or reinstated service, and subsequently requests a continuance of the proceedings without presenting a compelling justification, the impartial hearing officer shall grant the request for continuance conditionally. The condition of such continuance is the enrollee's waiver of his right to continue receiving the disputed service pending a decision if:
 - (i) The impartial hearing officer finds that such continuance is not necessitated by acts or omissions on the part of the State or MCC;
 - (ii) The enrollee lacks a compelling justification for the requested delay; and
 - (iii) The enrollee received at least three (3) weeks notice of the hearing, in the case of a standard appeal, or at least one (1) week's notice, in the case of an expedited appeal.
6. Notwithstanding the requirements of this part, TennCare enrollees are not entitled to continuation or reinstatement of services pending an appeal related to the following:
 - (i) When a service is denied because the enrollee has exceeded the benefit limit applicable to that service;
 - (ii) When a request for prior authorization is denied for a prescription drug, with the exception of:
 - (I) Pharmacists shall provide a single 72-hour interim supply in emergency situations for the non-authorized drug, unless such supply would exceed applicable pharmacy benefit limits; or
 - (II) When the drug has been prescribed on an ongoing basis or with unlimited refills and becomes subject to prior authorization requirements.
 - (iii) When coverage of a prescription drug is denied because the requested drug is not a category or class of drugs covered by TennCare;

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- (iv) When coverage for a prescription drug is denied because the enrollee has been locked into one pharmacy and the enrollee seeks to fill a prescription at another pharmacy;
 - (v) When a request for reimbursement is denied and the enrollee appeals this denial;
 - (vi) When a physician has failed to prescribe or order the service or level of service for which continuation or reinstatement is requested; or
 - (vii) If TennCare had not paid for the service for which continuation or reinstatement is requested prior to the appeal.
- (h) Expedited appeals.
1. Expedited appeals of any action involving time-sensitive care must be resolved within thirty-one (31) days, or forty-five (45) days when additional time is required to obtain an enrollee's medical records, from the date the appeal is received. If the appeal is not resolved within these timeframes, the appeal shall not be automatically resolved in favor of the enrollee, provided the appeal is resolved within ninety days (90) from the date the appeal is received.
 2. Care will only qualify as time-sensitive if the enrollee's treating physician determines that if the enrollee does not receive the care within ninety (90) days:
 - (i) They will be at risk of serious health problems or death.
 - (ii) The delay will cause serious problems with their heart, lungs, or other parts of their body, or
 - (iii) They will need to go to the hospital.
 3. MCCs shall complete reconsideration of expedited appeals within five (5) days, or within fourteen (14) days when additional time is required to obtain an enrollee's medical records, after receiving notification of the appeal. If the MCC does not complete reconsideration within these timeframes, the appeal shall not automatically be resolved in favor of the enrollee, provided the appeal is resolved within ninety (90) days from the date the appeal is received.
- (5) Special Provisions Pertaining to Pharmacy
- (a) When a provider with prescribing authority prescribes a medication for an enrollee, and the prescription is presented at a pharmacy that participates in the enrollee's MCC, the enrollee is entitled to:
 1. The drug as prescribed, if the drug is on the MCC's formulary and does not require prior authorization.
 2. The drug as prescribed, if the prescribing provider has obtained prior authorization.
 3. An alternative medication, if the pharmacist consults the prescribing provider when the enrollee presents the prescription to be filled, and the provider prescribes a substituted drug; or

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4. Subject to the provisions of rule 1200-13-13-.11(1)(d), if the pharmacist is unable to obtain the prescribing physicians approval to substitute a drug or authorization for the original prescription, the pharmacist will dispense a seventy-two (72) hour interim supply of the medication in an emergency situation and shall not impose any cost sharing obligations upon the enrollee for this supply. Such supply shall count towards the enrollee's applicable pharmacy benefit limit and the pharmacist shall not dispense this supply if the supply would otherwise exceed these limits. In the event that a prescribing physician obtains prior authorization or changes the drug to an alternative that does not require prior authorization, the remainder of the drug shall not count towards the enrollee's applicable pharmacy benefit limit if the enrollee receives the prescription drug within fourteen (14) days of dispensing the seventy-two (72) hour interim supply.
- (b) A pharmacist shall dispense a seventy-two (72) hour interim supply of the prescribed drug, as mandated by the preceding paragraph, provided that:
1. The medication is not classified by the FDA as Less Than Effective (LTE) and DESI drugs or any drugs considered to be Identical, Related and Similar (IRS) to DESI or LTE drugs or any medication for which no federal financial participation (FFP) is available. The exclusion of drugs for which no FFP is available extends to all TennCare enrollees regardless of the enrollee's age; or
 2. The medication is not a drug in one of the non-covered TennCare therapeutic categories that include:
 - (i) agents for weight loss or weight gain;
 - (ii) agents to promote fertility or to treat impotence;
 - (iii) agents for cosmetic purposes or hair growth;
 - (iv) agents for the symptomatic relief of coughs and colds;
 - (v) agents to promote smoking cessation;
 - (vi) prescription vitamins and mineral products except prenatal vitamins and fluoride preparations;
 - (vii) nonprescription drugs;
 - (viii) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee; or
 - (ix) barbiturates or benzodiazepines.
 3. Use of the medication has not been determined to be medically contraindicated because of the patient's medical condition or possible adverse drug interaction; or
 4. If the prescription is for a total quantity less than a seventy-two (72) hour supply, the pharmacist must provide a supply up to the amount prescribed.
 5. In some circumstances, it is not feasible for the pharmacist to dispense a seventy-two (72) hour supply because the drug is packaged by the manufacturer to be sold as the original unit or because the usual and customary pharmacy practice would be to dispense

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the drug in the original packaging. Examples would include, but not be limited to, inhalers, eye drops, ear drops, injections, topicals (creams, ointments, sprays), drugs packaged in special dispensers (birth control pills, steroid dose packs), and drugs that require reconstitution before dispensing (antibiotic powder for oral suspension). When coverage of a seventy-two (72) hour supply of a prescription would otherwise be required and when, as described above, it is not feasible for the pharmacist to dispense a seventy-two (72) hour supply, it is the responsibility of the MCC to provide coverage for either the seventy-two (72) hour supply or the usual dispensing amount, whichever is greater.

6. The Bureau of TennCare shall establish a tolerance level for early refills of prescriptions. Such established tolerance level may be more stringent for narcotic substances. Notwithstanding the requirements of this subsection, if an enrollee requests a refill of a prescription prior to the tolerance level for early refills established by the Bureau, the pharmacy will deny this request as a service which is non-covered until the applicable tolerance period has lapsed, and will not provide a seventy-two (72) hour supply of the prescribed drug.

(6) Release of Enrollees' Medical Records.

- (a) When a request is made, by or on behalf of a TennCare enrollee, for approval of a TennCare service or for an appeal of an adverse action affecting TennCare services, the enrollee is deemed to have consented to release of his/her relevant medical records to his/her MCC and the TennCare Bureau for the purposes of acting upon the enrollee's request.
- (b) Providers shall promptly provide copies of an enrollee's medical records to the enrollee's MCC(s) and to the TennCare Bureau upon being informed by the MCC(s) or TennCare Bureau that the records have been requested for the purpose of acting upon an enrollee's request for approval of a TennCare service or an enrollee's appeal of an adverse action affecting TennCare services.
- (c) An enrollee's consent to release of his/her medical records may be evidenced by his signature (or his provider's or authorized representative's signature) upon the enrollee's initial application for TennCare, upon his TennCare appeal form or other written request for authorization or appeal, or, in the event of an appeal by telephone, by a TennCare Bureau employee's signing of an appeal form on behalf of an enrollee with documentation of consent to do so.
- (d) The medical records obtained by MCCs and the TennCare Bureau under this rule remain confidential. MCCs and the TennCare Bureau may use and disclose the records only as necessary in their consideration of the enrollee's request for approval of a TennCare service or the enrollee's appeal of an adverse action affecting TennCare services.

(7) Time Requirements and Corrective Action.

- (a) MCCs must act upon a request for prior authorization within fourteen (14) days as provided in rule 1200-13-13-.11(1)(b)2. Failure by an MCC to act upon a request for a prior authorization within twenty-one (21) days shall result in automatic authorization of the requested service, subject to the provision of (7)(e) below, and to provisions relating to medical contraindication at rule 1200-13-13-.11(8).
- (b) MCCs must complete reconsideration of non-expedited appeals within fourteen (14) days. MCCs must complete reconsideration of expedited appeals involving time sensitive care within five (5) days, which shall be extended to fourteen (14) days if additional time is required to

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obtain an enrollee's medical records. Failure by the MCCs to meet these deadlines shall not result in an immediate resolution of the appeal in favor of the enrollee.

- (c) All standard appeals, including, if not previously resolved in favor of the enrollee, a hearing before an impartial hearing officer, shall be resolved within ninety (90) days of receipt of the enrollee's request for an appeal. All expedited appeals involving time-sensitive care shall be resolved within thirty-one (31) days of receipt of the request for appeal, unless extended to forty-five days when additional time is required to obtain an enrollee's medical records. Calculation of the ninety (90) day, thirty-one (31) day or forty-five (45) day deadline may be adjusted so that TennCare is not charged with any delays attributable to the enrollee. However, no delay may be attributed to an enrollee's request for a continuance of the hearing, if s/he received less than three (3) weeks' notice of the hearing, in the case of a standard appeal, or less than one (1) week's notice, in the case of an expedited appeal involving time-sensitive care. An enrollee may only be charged with the amount of delay occasioned by his/her acts or omissions, and any other delays shall be deemed to be the responsibility of TennCare.
- (d) Failure to meet the ninety (90) day deadline, as applicable, shall result in automatic TennCare coverage of the services at issue pending a decision by the impartial hearing officer, subject to the provisions of subparagraphs (7)(e) and (f) below, and to provisions relating to medical contraindication rule 1200-13-13-.11 (8). This conditional authorization will neither moot the pending appeal nor be evidence of the enrollee's satisfaction of the criteria for disposing of the case, but is simply a compliance mechanism for disposing of appeals within the required time frames. In the event that the appeal is ultimately decided against the enrollee, s/he shall not be liable for the cost of services provided during the period required to resolve of the appeal. Notwithstanding, upon resolving an appeal against an enrollee, TennCare may immediately implement such decision, thereby reducing, suspending, terminating the provision or payment of the service.
- (e) When, under the provisions of rule 1200-13-13-.11(7)(d), a failure to comply with the time frames would require the immediate provision of a disputed service, TennCare may decline to provide the service pending a contrary order on appeal, based upon a determination that the disputed service is not a TennCare-covered service. A determination that a disputed service is not a TennCare-covered service may not be based upon a finding that the service is not medically necessary. Rather, it may only be made with regard to a service that:
 - 1. Is subject to an exclusion that has been reviewed and approved by the federal Center for Medicare and Medicaid Services (CMS) and incorporated into a properly promulgated state regulation, or
 - 2. Which, under Title XIX of the Social Security Act, is never federally reimbursable in any Medicaid program.
- (f) Except upon a showing by an MCC of good cause requiring a longer period of time, within five (5) days of a decision in favor of an enrollee at any stage of the appeal process, the MCC take corrective action to implement the decision. Corrective action to implement the decision includes:
 - 1. The enrollee's receipt of the services at issue, or acceptance and receipt of alternative services; or
 - 2. Reimbursement for the enrollee's cost of services, if the enrollee has already received the services at her own cost; or

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3. If the enrollee has already received the service, but has not paid the provider, ensuring that the enrollee is not billed for the service and ensuring that the enrollee's care is not jeopardized by non-payment.

In the event that a decision in favor of an enrollee is modified or overturned within ninety (90) days from receipt of such appeal, TennCare shall possess the authority to immediately implement such decision, thereby reducing, suspending, or terminating the provision or payment of the service in dispute.

- (g) In no circumstance will a directive be issued by the TennCare Solutions Unit or an impartial hearing officer to provide a service to an enrollee if, when the appeal is resolved, the service is no longer covered by TennCare for the enrollee. A directive also will not be issued by TennCare Solutions Unit if the service cannot reasonably be provided to the enrollee before the date when the service is no longer covered by TennCare for the enrollee and such appeal will proceed to a hearing.
- (8) Medical Contraindication.
- (a) Whenever the terms of this rule require the provision of TennCare benefits or services to an enrollee, such obligation shall be relieved upon the written certification of a provider who is familiar with the beneficiary's medical condition that the TennCare benefit or service in question is medically contraindicated. The provider must either be employed by the state or, if a licensed pharmacist determining contraindication with regard to a prescribed drug, must be making such determination consistent with pre-established standards and procedures approved by the state.
 - (b) If a TennCare service is determined to be medically contraindicated as set out above, written notice must be immediately provided to the enrollee, and the notice must be accompanied by the provider's certification that the service must be withheld in order to protect the enrollee's health or safety. A copy of the notice and provider certification must be forwarded to the Tennessee Justice Center.
- (9) Special Provisions Relating to Children in State Custody.

In addition to the rights and protections established by 42 C.F.R. Part 431, Subpart E and the terms of this rule, children in state custody shall also receive the following enhanced notice and appeal rights:

- (a) The Tennessee Department of Children's Services (DCS) must provide notice of any delay in providing a TennCare service that is administered by DCS. Such delay is immediately appealable on that child's behalf and cannot be required to last a particular length of time before issuance of the notice or processing of an appeal.
- (b) Whenever there is an adverse action affecting TennCare services (regardless of which contractor or government agency is administering such services), timely notices required by this rule must be sent to the individuals specified in the DCS implementation plan which was approved by the Court in Grier Revised Consent Decree. In the case of services administered by MCCs other than DCS, the responsible MCC shall provide notice to DCS, which shall ensure that timely notice is provided to the required individuals. Delivery of notice triggering the right to appeal is not complete until notice is received by those individuals.
- (c) An appeal from any individual specified in paragraph (9)(b) above must be accepted as an appeal on behalf of the child.

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Authority: T.C.A. §§4-5-202, 4-5-209, 71-5-105, 71-5-109, 71-5-134, and Executive Order No. 23. **Administrative History:** Original rule filed September 30, 2002; to be effective December 14, 2002; however, on December 9, 2002, the House Government Operations Committee of the General Assembly stayed rule 1200-13-13-.11; new effective date February 12, 2003. Public necessity rule filed May 5, 2005; effective through October 17, 2005. Public necessity rule filed July 29, 2006; effective through January 10, 2006. Amendments filed July 28, 2005; effective October 11, 2005. Public necessity rules filed December 29, 2005; effective through June 12, 2006. Amendments filed October 27, 2005; effective January 10, 2006. However, Notice of Withdrawal of permanent rule amendments (1)(d)3., (1)(d)4., (4)(g)6., (5)(a)5., (5)(e), (5)(f), and (7)(h) filed and effective January 6, 2006 (to have been effective January 10, 2006). Public necessity rule filed May 17, 2006; effective through October 29, 2006.

1200-13-13-.12 OTHER APPEALS BY TENNCARE APPLICANTS AND ENROLLEES.

- (1) Appeal Rights of TennCare Medicaid Applicants or Enrollees.
 - (a) Appeal Time; Continuation of Services.
 1. TennCare Medicaid Appeals.
 - (i) TennCare Medicaid applicants or enrollees will be given the opportunity to have an administrative hearing before a Hearing Officer or an Administrative Judge, as determined by the Department of Human Services, regarding valid factual disputes concerning denial of his/her application, cost sharing disputes, limitation, reduction, suspension or termination of eligibility, failure to act upon a request or application within required timeframes, and disputes regarding disenrollment from TennCare Medicaid. A valid factual dispute is a dispute that, if resolved in favor of the appellant, would prevent the state from taking the action that is the subject of the appeal. The TennCare Bureau designates TDHS to review each request for a hearing to determine if it is based on a valid factual dispute. If TDHS determines that an appeal does not present a valid factual dispute, then TDHS will send the appellant a letter asking him or her to submit additional clarification regarding the appeal within ten (10) days (inclusive of mail time). Unless such clarification is timely received and is determined by TDHS to establish a valid factual dispute, TDHS will dismiss the appeal. TDHS' decisions with respect to determination of whether an appeal raises a valid factual dispute shall not be appealable.
 - (ii) Requests for appeals must be made within forty (40) calendar days (inclusive of mail time) of the date of the notice to the applicant/enrollee regarding the intended action or prior to the date of action specified in the notice, whichever is later, notwithstanding anything else in these rules or in the Department of Human Services' administrative procedures rules to the contrary.
 - (iii) Enrollees who request a hearing within twenty (20) calendar days (inclusive of mail time) of the date of the notice or prior to the date of action specified in the notice, whichever is later, shall retain their eligibility (subject to any changes in covered services generally applicable to enrollees in their TennCare category) pending a determination that the enrollee has not raised a valid factual dispute or until the appeal is otherwise resolved, whichever comes first. If the appeal results in the State's action being sustained, the State reserves its right to recover from the enrollee the cost of services provided to the enrollee during the pendency of the appeal.
 - (iv) Enrollees disputing the applicability of changes in coverage to their current TennCare category who request a hearing within twenty (20) calendar days

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(inclusive of mail time) of the date of the notice or prior to the date of action specified in the notice, whichever is later, shall, notwithstanding subsection (1)(a)1.(iii), continue to receive benefits at the level for the eligibility category alleged by the enrollee to be currently applicable, pending a determination that the enrollee has not raised a valid factual dispute or until the appeal is otherwise resolved, whichever comes first. If the enrollee does not clearly allege the applicability of a particular eligibility category, benefits will be continued at the level for Non-Institutionalized Medicaid Adults pending a determination that the enrollee has not raised a valid factual dispute or until the appeal is otherwise resolved, whichever comes first. If TDHS subsequently determines that the enrollee is alleging that a particular eligibility category is currently applicable, benefits will be prospectively continued at the level for such eligibility category pending a determination that the enrollee has not raised a valid factual dispute or until the appeal is otherwise resolved, whichever comes first.

- (b) To the extent not otherwise modified by this rule, such appeals will be conducted by the Department of Human Services for TennCare Medicaid applicants/enrollees under the Department of Human Services' administrative procedures rules, and in accordance with any other applicable rules, laws or court orders governing those programs, provided that the finality of initial orders shall be governed by the provisions of Tennessee Code Annotated Section 4-5-314(b).
- (c) Appeal Rights for Disenrollment Related to TennCare Medicaid Eligibility Reforms.
 - 1. TennCare Medicaid enrollees, who have not been determined eligible for open Medicaid categories pursuant to the Ex Parte Review or Request for Information processes described in 1200-13-13-.02, will have the right to request a hearing for 40 days (inclusive of mail time) from the date of the Termination Notice, notwithstanding anything else in these rules or in the Department of Human Services' administrative procedures rules to the contrary.
 - 2. To the extent not otherwise modified by this rule, such appeals will be conducted by the Department of Human Services for TennCare Medicaid applicants/enrollees under the Department of Human Services' administrative procedures rules, and in accordance with any other applicable rules, laws or court orders governing those programs, provided that the finality of initial orders shall be governed by the provisions of Tennessee Code Annotated Section 4-5-314(b).
 - 3. Enrollees will not have the opportunity to request an extension for good cause of the forty (40) day timeframe in which to request a hearing.
 - 4. Enrollees who request a hearing within twenty (20) calendar days (inclusive of mail time) of the date of notice or prior to the date of termination specified in the Termination Notice, whichever is later, shall retain their eligibility (subject to any changes in covered services generally applicable to enrollees in their TennCare Medicaid category) pending a determination that the enrollee has not raised a valid factual dispute or until the appeal is otherwise resolved, whichever comes first.
 - 5. The TennCare Bureau designates TDHS to review each request for hearing to determine if it is based on a valid factual dispute. Enrollees will be given the opportunity to have an administrative hearing before a Hearing Officer or an Administrative Judge, as determined by TDHS, regarding valid factual disputes related to termination. If TDHS makes an initial determination that the request for a hearing is not based on a valid factual dispute, the appellant will receive a notice which provides ten (10) days

(Rule 1200-13-13-.12, continued)

(inclusive of mail time) to provide additional clarification of any factual dispute on which his/her appeal is based. Unless such clarification is timely received and is determined by TDHS to establish a valid factual dispute, a fair hearing will not be granted.

6. TDHS will grant hearings only for those enrollees raising valid factual disputes related to the action of disenrollment. A valid factual dispute is a dispute that, if resolved in favor of the appellant, would prevent the state from taking the action that is the subject of the appeal. Appeals that do not raise a valid factual dispute will not proceed to a hearing. Valid factual disputes include, but are not limited to:
 - (i) Enrollee received the Termination Notice in error (e.g., they are currently enrolled in a TennCare Medicaid category that is not ending);
 - (ii) TDHS failed to timely process information submitted by the enrollee during the requisite time period following the Request for Information or Verification Request;
 - (iii) TDHS granted a “good cause” extension of time to reply to the Request for Information Notice but failed to extend the time (this is the only circumstance surrounding good cause which can be appealed) ;
 - (iv) Enrollees requested assistance because of a health, mental health, learning problem or disability but did not receive this assistance; or
 - (v) The TennCare Bureau sent the Request for Information or Termination Notice to the wrong address as defined under state law.
 7. If the enrollee does not appeal prior to the date of termination as identified in the Termination Notice, the enrollee will be terminated from TennCare Medicaid.
 8. If the enrollee is granted a hearing and the hearing decision sustains the State’s action, the State reserves its right to recover from the enrollee the cost of services provided during the hearing process.
- (2) Other Appeals. Enrollees applying for Seriously and Persistently Mentally Ill (SPMI) or Seriously Emotionally Disturbed (SED) determination shall apply for each determination to the Department of Mental Health and Developmental Disabilities unless otherwise directed by the Commissioner. SPMI and SED determinations for the state only category shall be appealed in accordance with the provisions of state and federal law.

Authority: T.C.A. §§4-5-202, 4-5-209, 71-5-105, 71-5-109, and Executive Order No. 23. **Administrative History:** Original rule filed September 30, 2002; to be effective December 14, 2002; however, on December 9, 2002, the House Government Operations Committee of the General Assembly stayed rule 1200-13-13-.12; new effective date February 12, 2003. Public necessity rule filed June 8, 2005; effective through November 20, 2005. Amendment to public necessity rule filed July 6, 2005; effective through November 20, 2005. Amendment filed September 6, 2005; effective November 20, 2005.

1200-13-13-.13 MEMBER ABUSE AND OVERUTILIZATION OF THE TENNCARE PROGRAM.

- (1) The TennCare Bureau and the MCCs shall possess the authority to restrict or lock-in TennCare enrollees to a specified and limited number of pharmacy providers if the TennCare Bureau or the MCCs has determined that the enrollee has abused the TennCare Pharmacy Program. Such abuse includes, but shall not be limited to the following:

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

- (a) Forging or altering prescription drugs;
 - (b) Selling TennCare paid prescription drugs;
 - (c) Filing to control pharmacy overutilization activity while on lock-in status; or
 - (d) Visiting multiple prescribers or pharmacies to obtain controlled substances.
- (2) All pharmacy lock-in programs established by the TennCare Bureau or the MCCs must contain at least the following elements:
- (a) Criteria for selection of abusive or overutilizing enrollees - Pharmacy lock-in program must demonstrate, in detail, how the program will identify lock-in candidates.
 - (b) Methods of evaluation of potential lock-in candidates - Pharmacy lock-in programs must describe how the program will review lock-in candidates to ensure appropriate patterns of health care utilization are not misconstrued as abusive or overutilization.
 - (c) Lock-in status - Pharmacy lock-in programs must describe the exact process used to notify the lock-in enrollee, notify the lock-in pharmacy and physician providers, coordinate the lock-in activities with the appropriate case managers, when appropriate, and continually review the enrollee's utilization patterns.
 - (d) Prior approval status - Pharmacy lock-in programs may include placing an enrollee in a prior approval status in which some or all prescriptions such as controlled substances, require prior authorization. The program must describe the exact process used to notify the enrollee of prior approval status, notify the pharmacy of the enrollee's prior approval status, coordinate the prior approval status activities with the appropriate case managers, when appropriate, and continually review the enrollee's utilization patterns.
 - (e) Emergency Services - Pharmacy lock-in programs must describe, in detail, how pharmacy services will be delivered to enrollees on lock-in or prior approval status in the event of an emergency.
- (3) Pharmacy lock-in program procedures shall include:
- (a) Prior to imposing lock-in status upon a TennCare enrollee, the TennCare Bureau or the MCC shall provide appropriate notice to TennCare enrollees, informing enrollees that they may only use one pharmacy provider and of their right to appeal this action.
 - (b) If the enrollee fails to appeal this lock-in or the appeal of the lock-in is not resolved in his/her favor, the enrollee will only receive coverage for his/her prescription drugs at the lock-in pharmacy.
 - (c) If the enrollee attempts to fill a prescription at any pharmacy other than his/her lock-in pharmacy, the PBM will deny coverage for the prescription and the enrollee will be entitled to notice and appeal rights as described in rule 1200-13-13-.11.
 - (d) The MCC shall monitor and evaluate the TennCare enrollee subject to the lock-in in accordance with the criteria identified in paragraph (2) above.

Authority: T.C.A. §§4-5-202, 4-5-209, 71-5-105, 71-5-109, 71-5-134, and Executive Order No. 23. **Administrative History:** Original rule filed September 30, 2002; to be effective December 14, 2002; however, on December 9,

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

2002, the House Government Operations Committee of the General Assembly stayed rule 1200-13-13-.13; new effective date February 12, 2003. Public necessity rule filed December 29, 2005; effective through June 12, 2006.

1200-13-13-.14 REPEALED.

Authority: T.C.A. §§4-5-202, 4-5-209, 71-5-105, 71-5-109, 71-5-134, and Executive Order No. 23. **Administrative History:** Original rule filed September 30, 2002; to be effective December 14, 2002; however, on December 9, 2002, the House Government Operations Committee of the General Assembly stayed rule 1200-13-13-.14; new effective date February 12, 2003. Public necessity rule (repeal) filed August 18, 2005; effective through January 30, 2006. Repeal filed November 15, 2005; effective January 29, 2006.