RULES
OF
TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE

CHAPTER 1200-13-14
TENNCARE STANDARD

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1200-13-14-.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.

(Rule 1200-13-14-.01, continued)

(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.

(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").

(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 1200-13-14-.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.

(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) 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.

(22) 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.

(23) 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.

(24) 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.

(25) 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.

(26) 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.

(27) DISENROLLMENT shall mean the discontinuance of an individual's enrollment in TennCare.

(28) 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 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.

(Rule 1200-13-14-.01, continued)

(29) 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.

(30) ELIGIBLE shall mean a person who has been determined to meet the eligibility criteria of TennCare Medicaid or TennCare Standard.

(31) 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.

(32) 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 rule**s**, 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.

(33) ENROLLMENT shall mean the process by which a TennCare-eligible person becomes enrolled in TennCare.

(34) 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.

(35) FEDERAL FINANCIAL PARTICIPATION (FFP) shall mean the Federal Government's share of a state's expenditure under the Title XIX Medicaid Program.

(36) 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.

(37) 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.

(Rule 1200-13-14-.01, continued)

(38) 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.

(39) 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.

(40) 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;

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;

(Rule 1200-13-14-.01, continued)

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;

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.

(41) 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.

(42) 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.

(43) HIPAA shall mean the Health Insurance Portability and Accountability Act of 1996, as amended.

(44) 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.

(45) 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.

(46) INCOME shall mean that definition of income in rule 1240-1-4 of the Tennessee Department of Human Services - Family Assistance Division.

(47) 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.

(48) 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.

(49) 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.

(50) INPATIENT REHABILITATION FACILITIES shall mean rehabilitation hospitals and distinct parts of hospitals that are designated as 'IRFs' by Medicare.

(51) 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.

(52) 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).

(53) 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.

(54) LOCK-IN STATUS shall mean the restriction of an enrollee to a specified and limited number of pharmacy providers.

(55) 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.

(56) 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.

(57) 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.

(58) 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.

(59) 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.

(60) 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 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).

(61) 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.

(62) 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.

(63) 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.

(64) 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.

(65) 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.

(66) 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.

(67) 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).

(68) MEMBER shall mean a TennCare Medicaid- or TennCare Standard-eligible individual who is enrolled in a managed care organization.

(69) 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:

(Rule 1200-13-14-.01, continued)

(a) Uninsured individuals whose incomes 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.

(70) 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.

(71) 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.

(72) 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.

(73) PHYSICIAN shall mean a person licensed pursuant to chapter 6 or 9 of title 63 of the Tennessee Code Annotated.

(74) POVERTY LEVEL shall mean the poverty level established by the Federal Government.

(75) 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 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.

(Rule 1200-13-14-.01, continued)

(76) 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.

(77) 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.

(78) 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.

(79) 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.

(80) 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.

(81) 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.

(82) 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.

(83) 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.

(84) PRUDENT LAY PERSON shall mean a reasonable person who possesses an average knowledge of health and medicine.

(85) 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.

(86) QUALIFIED UNINSURED PERSON shall mean an uninsured person who meets the technical, financial, and insurance requirements for the TennCare Standard Program.

(87) 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 *GrierRevised 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.

(88) REASSIGNMENT shall mean the process by which the Bureau of TennCare transfers an enrollee from one MCO to another as described in these rules.

(89) RECEIPT OF MAILED NOTICES shall mean that receipt of mailed notices is presumed to occur within five (5) days of mailing.

(90) 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.

(91) 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.

(92) 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.

(93) 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.

(94) 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.

(95) 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 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).

(96) 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 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.

(97) 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.

(98) 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.

(99) 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.

(100) 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.

(101) 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.

(102) 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.

(103) 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:

(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.

(104) TENNCARE PARTNERS PROGRAM shall mean that component of the TennCare Program that provides mental health and substance abuse services.

(105) 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).

(106) 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.

(107) 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.

(108) 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

(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

(Rule 1200-13-14-.01, continued)

(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).

(109) TENNCARE STANDARD ELIGIBILITY REFORMS shall mean the amendments to the TennCare demonstration project approved by CMS on March 24, 2005, to terminate coverage for adults aged 19 and older in TennCare Standard eligibility groups.

(110) TERMINATION shall mean the discontinuance of an enrollee's coverage under the TennCare Medicaid or TennCare standard program.

(111) 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.

(112) 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.

(113) 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.

(114) 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.

(115) 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.

(116) VALID FACTUAL DISPUTE shall mean a dispute which, if resolved in favor of the enrollee, would result in the proposed action not being taken.

(117) 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.

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 1200-13-14-.01; new effective date February 12, 2003. Amendment filed April 9, 2003; effective June 23, 2003. Public necessity rule*

(Rule 1200-13-14-.01, continued)

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 29, 2005; effective through June 12, 2006.

1200-13-14-.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.

(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 Standard.

(a) To be eligible for TennCare Standard, each individual must:

1. Not be eligible for Medicaid as determined by TDHS.

2. Provide a statement from his/her employer, if employed, concerning the availability of group health insurance.

3. Be a U.S. citizen, lawfully admitted alien, or an alien permanently residing in the U.S. under color of law.

4. Be a Tennessee resident as described under federal and state law.

5. Present a Social Security number or proof of having applied for one, or assist the TDHS caseworker in applying for a Social Security number, for each person applying for TennCare Standard.

6. Not be an inmate as defined in these rules.

7. Not be eligible for TRICARE.

8. Not be enrolled in, or eligible for participation in, Medicare, with the following exception: If the individual was enrolled in TennCare on December 31, 2001, had Medicare on December 31, 2001, and was not eligible for Medicaid. These enrollees will continue on TennCare Standard with uninterrupted coverage for the pharmacy benefit only, effective January 1, 2003, as long as they lack access to health insurance

other than Medicare and they abide by all TennCare program requirements, such as payment of premiums. This is a "grandfathered" eligibility category for waiver transition purposes only. At such time as a person loses eligibility in this category, he will not be able to re-enroll in it.

9. Not be enrolled in, or eligible for participation in, health insurance as defined elsewhere in these rules, except in the following instances:

(i) Has been continuously enrolled in TennCare since at least December 31, 2001, as an uninsured child under the age of nineteen (19) whose family income is below 200% poverty and who continues to meet these requirements.

(ii) Was enrolled in TennCare on June 30, 2002, as a dislocated worker, whose family income is within the requirements for waiver eligibles being redetermined during the waiver transition period (see Rule 1200-13-14-.02(7), and who continues to meet these requirements.

Both of the above categories are "grandfathered" eligibility categories for waiver transition purposes only. At such time as a person loses eligibility in either of these categories, s/he will not be able to re-enroll in it.

(b) TennCare Standard enrollees must report to the TDHS any material change affecting any information, such as, but not limited to, changes in address, income, family size, employment, or access to health insurance, given by the applicant/enrollee to TDHS at the time of application or other changes occurring subsequent to the application. The applicant/enrollee shall mail, or present in person, documentation of any such change, within the time frame established at T.C.A. 71-5-110 for reporting changes, to the TDHS county office where the enrollee resides.

(c) By applying for TennCare Standard, 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 Standard eligibility and if approved, what cost sharing 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; or,

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 Standard Program.

(d) Under *Tennessee Code Annotated (T.C.A.)* 71-5-118 it is a felony offense to obtain TennCare Standard coverage under false means or to help anyone get on TennCare Standard under false means.

(Rule 1200-13-14-.02, continued)

(3) Covered groups under TennCare Standard during periods of closed enrollment.

Eligibility for TennCare Standard is limited to individuals who are not eligible for Medicaid and meet the following criteria:

(a) Tennessee residents who are medically eligible and have income below one hundred (100%) percent of the poverty level. Effective at the close of business of the offices of the State of Tennessee on April 29, 2005, the TennCare Standard category of "Medically Eligible" is closed to enrollment for adults and children, notwithstanding anything in these rules to the contrary.

(b) Tennessee residents who were enrolled in TennCare as dislocated workers on June 30, 2001, who meet the criteria for persons being redetermined eligible during the waiver transition period (see Rule 1200-13-14-.02(7)), and who continue to meet these criteria. These individuals can remain on TennCare, even if they have access to insurance, as long as they do not purchase insurance and they continue to meet the criteria for the category. At such time as they leave this category, they will not be able to re-enroll in this particular TennCare category.

(c) Tennessee residents eligible for Medicare and enrolled in TennCare as an uninsured person on December 31, 2001 and who do not qualify for Medicaid. S/he will have to prove that s/he is uninsurable to remain eligible for TennCare. TennCare will send a notice to all individuals meeting these criteria.

1. These enrollees must complete the redetermination process in the TDHS office in the county where s/he resides. This includes, but is not limited to, a review of his/her access to other health insurance (except Medicare), his/her current residency, and changes in income and family composition.

2. Enrollees who have access to other health insurance will lose his/her eligibility for TennCare Standard.

3. Enrollees will be required to prove that s/he is uninsurable by providing a denial letter for health insurance from an insurance company or its authorized agent.

4. Enrollees failing to complete the redetermination process or failing to provide proof of his/her uninsurable status will be terminated from TennCare Standard; s/he will not be able to reapply for TennCare Standard.

These individuals can remain on TennCare, even if they have access to Medicare, as long as they do not purchase other insurance, and they continue to meet the criteria for the category. At such time as they leave this category, they will not be able to re-enroll in this particular TennCare category.

Tennessee residents, who were eligible for Medicare, enrolled in TennCare as an uninsurable as of December 31, 2001, and who do not qualify for Medicaid must complete a redetermination process at the TDHS office in the county where s/he resides. This includes, but is not limited to, a review of access to other health insurance (except Medicare), address, change in income, and any change in family size and composition. An enrollee who has access to other health insurance**,** as defined elsewhere in these rules, will lose his/her eligibility for TennCare Standard. However, an enrollee in this category will not be required to re-prove his/her uninsurable status. These individuals can remain on TennCare, even if they have access to Medicare, as long as they do not purchase other insurance, and they continue to meet the criteria for the category. At such time as they leave this category, they will not be able to re-enroll in this particular TennCare category.

(Rule 1200-13-14-.02, continued)

(d) Tennessee residents who were enrolled in TennCare on December 31, 2001, as uninsured children under age nineteen (19) with family incomes below 200% of poverty and who have remained continuously enrolled in that category can remain on TennCare, even if they have access to insurance, as long as they do not purchase insurance and they continue to meet the criteria for the category. At such time as they leave this category, they will not be able to re-enroll in this particular TennCare category.

(e) An individual who is losing eligibility for TennCare Medicaid may apply for enrollment in TennCare Standard as a Medicaid "Rollover" as defined herein:

1. 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.

2. When the individual reapplies, s/he will first be screened for TennCare Medicaid eligibility.

3. 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) found eligible as a Medicaid "Rollover" may be enrolled in TennCare Standard even during periods of closed enrollment if s/he meets the technical and financial requirements found herein. Such enrollee will be allowed to enroll in TennCare Standard at any time up to (forty (40) days inclusive of mail time) following expiration of TennCare Medicaid.

4. If determined to be eligible for TennCare Standard, the individual will be subject to premium and copayment requirements as appropriate.

5. Effective at the close of business of the offices of the State of Tennessee on April 29, 2005, the TennCare Standard category of Medicaid "Rollover" is closed to enrollment for adults aged nineteen (19) and older, notwithstanding anything in these rules to the contrary.

(f) If a Medicaid enrollee under age (19) whose Medicaid eligibility is ending is determined to otherwise meet technical eligibility requirements for TennCare Standard, but is not eligible as uninsured because his/her income is above the level specified by the Legislature, s/he will be sent a letter denying TennCare Standard coverage as uninsured and notifying the enrollee that s/he may qualify as Medically Eligible. The enrollee will have forty (40) days (inclusive of mail time) to appeal the denial of TennCare Standard as uninsured. The enrollee will be sent a medical eligibility packet with explanation regarding how to apply for TennCare Standard as a medically eligible person. The enrollee will have sixty (60) days (inclusive of mail time) to submit his/her medical eligibility packet and the required documentation for determination of medical eligibility. If the individual is determined to qualify as Medically Eligible, coverage will be provided throughout the eligibility determination period and will continue with no break. Effective at the close of business of the offices of the State of Tennessee on April 29, 2005, the TennCare Standard category of "Medically Eligible" is closed to new enrollment for adults and children, notwithstanding anything in these rules to the contrary.

(Rule 1200-13-14-.02, continued)

(g) Tennessee residents who were enrolled in TennCare as dislocated workers pursuant to TennCare rule 1200-13-12-.02 as of June 30, 2002, will be allowed to remain in TennCare Standard effective July 1, 2002. Such individuals qualifying as "medically eligible" may enroll regardless of their income level. Even though these individuals had access to COBRA benefits as dislocated workers, such is not the basis for termination of coverage. Such enrollees must go through the redetermination of eligibility process as all other previously enrolled members of the waiver population. At that time, the enrollee's case will be reviewed for changes in family size and composition, income, address, and access to other health insurance other than COBRA. The enrollee must meet the eligibility criteria, other than access to COBRA benefits, in effect at the time of the review to be eligible to remain in TennCare. The enrollee's income will be reviewed based on the income standard in effect at the time of the eligibility determination, as approved by the General Assembly.

(h) Effective July 6, 2005, all TennCare Standard eligibility groups for adults aged nineteen (19) and older are terminated, notwithstanding anything in these rules to the contrary.

(4) Covered groups eligible under TennCare Standard during periods of open enrollment.

In addition to the groups listed in paragraph (3) above, the following groups are eligible to enroll during periods of open enrollment:

Tennessee residents who meet the technical eligibility criteria for TennCare Standard, do not have health insurance or access to health insurance and have excess income (defined as income above the level established annually by the legislature for the program), must establish their medical eligibility in accordance with the process described in these rules.

(a) Effective July 6, 2005, all TennCare Standard eligibility groups for adults aged nineteen (19) and older are terminated, notwithstanding anything in these rules to the contrary.

(5) Loss of eligibility.

Eligibility for TennCare Standard shall cease when, in accordance with due process:

(a) The enrollee is not a member of one of the "grandfathered" groups (see Rule 1200-13-14-.02(3)(b)-(e)) and becomes eligible for participation in a group health insurance plan, as defined in these rules, either directly or indirectly through a family member.

(b) The enrollee becomes eligible for Medicare;

(c) The enrollee is determined eligible for Medicaid;

(d) The enrollee becomes eligible for TRICARE;

(e) The enrollee purchases an individual health insurance plan as defined by these rules;

(f) It is determined that the enrollee falsified the information given at the time of application for TennCare Standard and approval was based on this false information;

(g) The enrollee fails to pay the required premium to enroll and/or remain enrolled in TennCare Standard. Enrollees who are in arrears two (2) months in premium payments will be terminated from TennCare Standard without the availability of a payment plan;

(h) The enrollee has failed to pay applicable copayments for services received and the Bureau of TennCare has authorized disenrollment;

(i) It is determined that an enrollee has abused the TennCare Program by allowing an ineligible person to utilize the enrollee's TennCare Standard identification card to obtain services, subject to federal and state laws and regulations;

(j) The individual fails to comply with TennCare Program requirements, subject to federal and state laws and regulations;

(k) It is determined that the enrollee has abused the TennCare Program by using his/her TennCare Standard identification card to seek or obtain drugs or supplies illegally or for resale, subject to federal and state laws and regulations;

(l) Death of the enrollee;

(m) It is determined that any of the technical eligibility requirements found in these rules are no longer met;

(n) The enrollee has failed to respond to a recertification process requirement, as described in these rules, to assure that the enrollee, and other family members as appropriate, remains eligible for TennCare Standard;

(o) When the TDHS county office receives a voluntary written request for termination of eligibility from a TennCare Standard enrollee;

(p) When the enrollee no longer qualifies as a resident of Tennessee under federal and state law;

(q) The enrollee fails to complete the reverification process within the timeframes specified in paragraph (7) or (9), as appropriate, below;

(r) When an enrollee becomes incarcerated as an inmate; or

(s) When the Bureau determines that the individual does not actually have the medical condition(s) which rendered him/her "medically eligible" for TennCare Standard.

(t) The individual who is eligible for TennCare Standard in accordance with paragraphs (3) and (4) of this section is found to meet the following criteria:

1. S/he is aged nineteen (19) or older,

2. His/her eligibility category has been terminated from TennCare, and

3. S/he has not been determined eligible in an open Medicaid category.

(6) TennCare Partners Program.

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

(7) Processing of new applications for TennCare during the waiver transition period from the former waiver to the new waiver during the period from July 1, 2002 to December 31, 2002.

During the transition period from July 1, 2002 to December 31, 2002, the Bureau will process new applications for the TennCare program in accordance with the following procedures:

(Rule 1200-13-14-.02, continued)

(a) An application for TennCare must be requested from the enrollee's local DHS office or the TennCare Bureau. Applicants will receive instructions on what to bring to the DHS interview and information that explains the eligibility process for demonstrating medical eligibility for TennCare Standard.

(b) Applications received on or after July 1, 2002 are processed by DHS in the county in which applicant resides. Applications received by TennCare will be date stamped and forwarded to DHS. Applications received by DHS will be date stamped by DHS. These dates will be the official application date.

(c) The applicant has forty-five (45) days from receipt of the application by the State to schedule an appointment, in order to complete the application process; those with special needs may request other arrangements. The DHS caseworker will review the applicant's eligibility information, including income, social security number, address, existence or lack of access to other health insurance, household composition information and other required information to determine eligibility. The applicant who does not complete the entire application process by the forty-fifth (45^{th}) day, including the appointment process, will have his/her application denied and will be sent a denial notice that includes appropriate appeal rights. The only exception to the forty-five (45) day limit is a good cause extension. DHS may grant a good cause extension in accordance with Bureau/DHS policies.

(d) The DHS caseworker will review the applicant's eligibility for Medicaid. If the enrollee meets the TennCare Medicaid eligibility requirements, s/he will be enrolled in TennCare Medicaid with the effective date being in accordance with DHS policies.

(e) If the enrollee does not meet the Medicaid criteria, s/he will be denied for TennCare Medicaid and will receive a denial notice from DHS with appeal rights. All appeals of TennCare Medicaid applications are handled by DHS.

(f) If needed, TDHS will provide assistance to an applicant/enrollee in verifying asset/resource valuation information. In addition, TDHS will accept a self-declaration of resources in excess of the Medicaid limit, allowing the TDHS caseworker to immediately determine ineligibility for Medicaid and proceed on to the determination of eligibility for TennCare Standard. If the applicant/enrollee fails or is not able to verify resources or self-declare disqualifying resources, Medicaid eligibility will be denied and the process will then continue to a consideration of TennCare Standard eligibility.

(g) If the applicant does not qualify for TennCare Standard because s/he does not meet the technical eligibility requirements, has health insurance or access to health insurance, or excess income the Bureau will mail the applicant a denial notice with appropriate appeal rights. The applicant has thirty (30) days from the date of the notice to appeal.

Applicants who do not meet the technical requirements for TennCare Standard or who have access to health insurance or excess income will not be allowed to apply as a medically eligible person. Medical eligibility applications received from persons not meeting the technical requirements for TennCare Standard will be denied with a notice that includes appeal rights.

(h) If the applicant meets the technical eligibility requirements of TennCare Standard, is uninsured, lacks access to health insurance, and has income below one hundred (100%) percent of poverty for both adults and children, s/he can only enroll if it can be proved that s/he is medically eligible. When applicant applies as a medically eligible person, the DHS caseworker will flag the system, prompting TennCare to mail a Medical Eligibility Determination packet to the applicant. The applicant has forty-five (45) days from the receipt of the packet to submit a completed packet to the Bureau. Packets which are not completed by the forty-fifth (45) day

will be denied with a notice with appeal rights and the "good cause" reasons for not completing the process timely, which include:

1. The enrollee was sick.

2. Somebody in the enrollee's immediate family was very sick.

3. The enrollee had a family emergency or tragedy.

4. The enrollee could not get the medical records s/he needed from a provider. It was not his/her fault.

5. The enrollee asked for help because s/he has a disability. Neither the Bureau nor TDHS gave the help that the enrollee needed.

6. The enrollee asked for help because s/he does not speak English. Neither the Bureau nor TDHS gave the help that the enrollee needed.

Packets received by the Bureau after the forty-five (45) day period will also be automatically determined as untimely. The Bureau will send the applicant a denial notice with appeal rights.

(i) Applicants have two (2) options for proving medical eligibility:

1. Submit a non-refundable application fee of twenty-five ($25.00) dollars, as well as a completed medical eligibility application and medical records to support any medical condition listed with a signed release for medical records in the event additional medical records are needed.

2. Have a current CRG 1, 2, 3/TPG 2 assessment on file with the Bureau.

Incomplete applications received within forty-five (45) days will be returned to the applicant. The applicant may resubmit his/her medical eligibility packets to the Bureau as long as the completed packet is ultimately received within the forty-five (45) days of the date when the medically eligible packet was mailed to the enrollee.

(j) The Bureau will forward the completed medical eligibility packet to its contracted carrier for processing. Evaluation of completed packets will be made within thirty (30) days of receipt from the Bureau. The carrier will deem the applicant insurable or uninsurable based on health insurance underwriting guidelines. Applicants who are deemed to be insurable by the contracted carrier will not be eligible for TennCare Standard. This applicant will receive a denial notice from the Bureau, which includes his/her appeal rights. Applicants denied for TennCare Standard as medically eligible have thirty (30) days from receipt of the denial letter to appeal. Appeals received by the Bureau after thirty (30) days will be considered untimely and will not be forwarded for hearing.

(k) Applicants deemed uninsurable by the contracted carrier will be approved as medically eligible. The Bureau will send the applicant an approval notice with a fixed end date of coverage, before which time the enrollee must complete the renewal/reapplication process.

(l) All applicants approved for TennCare Standard during periods of closed enrollment will have an effective date of coverage which is the date s/he was determined medically eligible for the program by the Bureau.

(Rule 1200-13-14-.02, continued)

(m) All enrollees will have to reapply and have his/her TennCare coverage renewed based on the approved policies and procedures in effect at the time of his/her next scheduled renewal/reapplication process.

(8) Renewal of TennCare Standard eligibility after December 31, 2002.

(a) A TennCare Standard enrollee shall be required to renew his/her eligibility for TennCare Standard prior to the expiration date of the current period of coverage. A TennCare Standard enrollee must renew his/her eligibility for the program as instructed by the TDHS. The enrollee's continued eligibility for TennCare Standard is determined as of the date of the renewal appointment or a later date if the enrollee does not submit all required documentation at the initial renewal appointment. (The later date must be before the date of expiration of coverage.)

(b) The renewal process requires that the enrollee or responsible party arrange for an appointment at the TDHS office in the county in which s/he resides. A reminder notice will be sent to the latest address of record that the Bureau of TennCare has on file for that individual sixty (60) days prior to the end date of coverage. (TennCare Standard enrollees must timely report changes of address as stated in T.C.A. 71-5-110.) That reminder notice will inform the enrollee of the process for reapplying and renewing his/her TennCare coverage.

(c) Reasonable accommodations will be made for persons with disabilities who require assistance in responding to a renewal request. Assistance will also be provided for enrollees with limited English proficiency who request such assistance during the renewal process.

(d) Information to be recertified includes changes in address, income, employment, family size, and access to health insurance. Renewal appointments must be scheduled and kept regardless of whether any changes have occurred. It is the responsibility of the enrollee to furnish all information requested. The notice reminding the enrollee that s/he must renew his/her eligibility will inform the enrollee of what documentation is to be brought to the appointment.

(e) The enrollee must complete the entire renewal process prior to the expiration date of his/her coverage. A failure to do so will result in coverage lapsing as of the expiration date. The enrollee will not be permitted to appeal the expiration of his/her coverage in this situation. However, s/he may appeal on the grounds that:

1. S/he did, in fact, complete the renewal process but an administrative error on the part of the State resulted in his/her coverage expiring, or

2. S/he was prevented from completing the renewal process by specific acts or omissions of state employees; however, this ground for appeal does not include challenges to relevant TennCare rules, policies or timeframes.

The individual will receive a notice of the expiration of his/her coverage and his/her right to appeal as set out above, within ten (10) days. There will be no continuation or reinstatement of coverage pending appeal.

(f) Enrollees approved for TennCare Standard as medically eligible persons shall also be required to resubmit proof of continued medical eligibility. Documentation shall be that as required elsewhere in these rules. If as a result of the renewal appointment it is found that any enrollee no longer meets the technical eligibility requirements as set out at 1200-13-14-.02 of these rules, such enrollee(s) will be disenrolled from TennCare Standard. The enrollee will be sent a notice of termination, and the enrollee has the right to appeal the decision within thirty (30)

calendar days of the receipt of the letter informing the enrollee of the loss eligibility. The enrollee's right to appeal is set out at rule 1200-13-14-.12.

(9) Disenrollment Related to TennCare Standard Eligibility Reforms.

Prior to the disenrollment of TennCare Standard enrollees based on coverage terminations resulting from TennCare Standard 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 TennCare Standard enrollees in eligibility groups due to be terminated as part of the TennCare Standard 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 TennCare Standard enrollees in eligibility groups being terminated pursuant to the TennCare Standard 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 provide TDHS with the necessary verifications to determine eligibility for open Medicaid categories.

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 TennCare 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 TennCare 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 extensions 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 Standard (subject to any changes in covered services generally applicable to enrollees in their TennCare Standard category) while TDHS reviews their eligibility for open Medicaid categories.

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 TennCare Medicaid, his/her TennCare Standard eligibility 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. TDHS shall, pursuant to the rules, policies and procedures of TDHS and the Bureau of TennCare applicable to new applicants for TennCare coverage, review all information and verifications provided by an enrollee after the thirty (30) day period following the Request for Information or after any extension of such period granted by TDHS, but the enrollee shall not be entitled to retain eligibility for TennCare Standard 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.

(Rule 1200-13-14-.02, continued)

1. The TennCare Bureau will send Termination Notices to all TennCare Standard enrollees being terminated pursuant to the TennCare Standard 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.

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.

(10) Delineation of a TennCare Standard Enrollee's Responsibilities.

A TennCare Standard Enrollee must:

(a) Report substantial changes in circumstances including but not limited to changes in address, income, family size, employment or access to or the purchase of health insurance given at the time of application.

(b) Report to his/her provider that s/he is a TennCare enrollee.

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 1200-13-14-.02; new effective date February 12, 2003. Public necessity rules filed April 29, 2005; effective through October 11, 2005. Public necessity rules filed June 3, 2005; effective through November 15, 2005. Amendments filed July 28, 2005; effective October 11, 2005. Amendments filed September 1, 2005; effective November 15, 2005.*

1200-13-14-.03 ENROLLMENT, DISENROLLMENT, RE-ENROLLMENT AND REASSIGNMENT.

(1) Enrollment during a period of open enrollment after January 1, 2003.

Individuals determined to be eligible for TennCare Standard shall be permitted to enroll as follows:

(a) All individuals eligible for TennCare as of June 30, 2002, whose eligibility was not based on Medicaid eligibility, but was based on waiver eligibility, shall be required to re-apply for TennCare using the TDHS TennCare Medicaid/TennCare Standard application. Applications in use by the Bureau of TennCare prior to July 1, 2002 (former application format) shall become obsolete. However, applications submitted to the Bureau in the former application format after 12:00 Midnight on June 30, 2002, will be forwarded to the Department of Human Services (TDHS) for initial processing. Current TennCare waiver enrollees will be notified by the Bureau that they must complete the new, expanded TDHS TennCare Medicaid/TennCare Standard application at their local DHS county office.

(Rule 1200-13-14-.03, continued)

(b) A new applicant will first be screened for TennCare Medicaid eligibility. If the applicant is determined not to be eligible for TennCare Medicaid, the applicant will then be screened for eligibility for TennCare Standard. If denied enrollment as a qualified uninsured person, the applicant may apply for TennCare Standard as a medically eligible person. A person may apply for Medicaid as medically needy and for TennCare Standard as a medically eligible person at the same time if s/he chooses. If the person is subsequently approved for Medicaid disability, s/he will be enrolled in TennCare Medicaid.

(c) If the applicant fails to provide all of the information needed at time of application, s/he shall have up to forty-five (45) days from the date the application was submitted to TDHS to provide the information. If the information is not received within that time, the application shall be denied, unless an extension of time has been granted by DHS in accordance with the good cause policy and procedure established by the Bureau. The applicant must wait until the next open enrollment period to reapply. However, the applicant may apply at any time for Medicaid or for TennCare Standard as a medically eligible if the family income is below one hundred (100%) percent of the poverty level.

(d) As a condition of enrollment, the premium for the first month's coverage, if applicable, must be paid in full and received by the due date. The due date is forty-five (45) days from the date enrollment is closed following a period of open enrollment. For example, if open enrollment occurs during the month of October, the due date for the first month's premium is December 15th, for an effective date of January 1. If the first month's premium is not paid in full and received by the due date, the applicant will not be enrolled and the applicant must wait until the next open enrollment period to reapply. If the enrollee believes s/he is being charged the wrong premium amount, s/he must still pay the first month's premium as assessed by the Bureau and subsequently appeal the premium amount. If the enrollee prevails in that appeal, the overpayment will be refunded or credited to future premiums due.

(e) Individuals or families determined eligible for TennCare Standard shall select a health plan at the time of application. If an enrollee elects family coverage through TennCare, all identifiable enrollees in the family shall be enrolled in the same health plan with the exception of a family member assigned by the Bureau to TennCare Select. An enrollee is given his/her choice of health plans when possible. If the requested health plan cannot accept new enrollees, the Bureau will assign each enrollee to a health plan that is accepting new enrollees. If no MCO is available to enroll new members in the enrollee's CSA, the enrollee will be assigned to TennCare Select until such time as another MCO becomes available. The Bureau may also assign TennCare Standard children with special health care needs to TennCare Select.

(f) A TennCare Standard enrollee may change MCOs one (1) time during the initial forty-five (45) days of enrollment, commencing with the effective date of eligibility, if there is another MCO in the enrollee's CSA who is currently permitted by the Bureau to accept new enrollees.

An enrollee shall remain a member of the designated plan until s/he is given an opportunity to change during an annual redetermination of eligibility. Thereafter, 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 as specified in (4)(b) below. 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.

(g) TennCare Standard enrollees enrolled as of July 1, 2002, will be given an opportunity to change his/her MCO only during the first redetermination of eligibility during calendar year 2003, and annually thereafter.

(Rule 1200-13-14-.03, continued)

(h) A person whose income is less than one hundred (100%) percent of the poverty level shall be permitted to enroll in TennCare Standard as a medically eligible person at any time, with an effective date that is the date the eligibility determination was made.

(i) A person whose income is at or greater than one hundred (100%) percent of the poverty level shall be permitted to enroll in TennCare Standard as a medically eligible only during a period of open enrollment, with an effective date of coverage consistent with the date announced for the open enrollment period.

(j) Persons who meet the definition of uninsured as found in these rules, shall be permitted to apply and enroll in TennCare Standard only during a period of open enrollment. Individuals/families whose income is at or exceeds one hundred (100%) percent of the poverty level will have a monthly premium and copayments on most services received through TennCare Standard.

(k) To qualify for TennCare Standard as medically eligible the applicant must complete a Medical Eligibility Determination packet. Packets will be sent to a qualified applicant who has indicated that s/he wishes to apply as a medically eligible person in his/her interview with the DHS caseworker. The applicant must meet the requirements specified in one of the following three options. The applicant must submit the completed Medical Eligibility Determination packet and pay the required application fee in full. The application fee must be included with the required medical eligibility form(s) and supporting documentation as required in Option I, II, or III. If the full application fee is not included with the application, the application and the partial fee (if any) will be returned to the applicant via U.S. Mail to the address on the application. The effective date of coverage shall be the date described in (h) or (i) above but in no event more than thirty (30) days after receipt of the completed medical eligibility documentation, for persons applying during periods of closed enrollment with incomes less than one hundred (100%) percent of poverty.

The required information and the application fee (in full) must be returned to the address specified within forty-five (45) days from the date of the letter included in the packet. Partial payments are not permitted. A medical eligibility form and documentation received after that time will not be processed as it exceeds the timely filing requirement. Packets which are not completed by the forty-fifth (45) day will be denied with a notice with appeal rights and the "good cause" reasons for not completing the process timely, which include:

1. The enrollee was sick.

2. Somebody in the enrollee's immediate family was very sick.

3. The enrollee had a family emergency or tragedy.

4. The enrollee could not get the medical records s/he needed from a provider. It was not his/her fault.

5. The enrollee asked for help because s/he has a disability. Neither the Bureau nor TDHS gave the help that the enrollee needed.

6. The enrollee asked for help because s/he does not speak English. Neither the Bureau nor TDHS gave the help that the enrollee needed.

Documentation required for a medically eligible determination.

1. Option I - a disease/condition as listed on the Medical Eligibility Determination form developed and periodically updated by the Bureau of TennCare.

(i) The applicant must submit a signed and completed Medical Eligibility Determination form. The form must also be signed by the applicant's physician attesting to the fact that the applicant has one or more qualifying medical diseases/conditions on the list., and

(ii) The applicant must submit copies of medical records to support the disease/condition from the list of diseases/conditions of Option I of the Medical Eligibility Determination form. Medical records that substantiate conditions other than those on the Medical Eligibility Determination form are not required and should not be submitted.

2. Option II - Mental or Emotional Health Problem.

(i) The applicant must submit a signed and completed Medical Eligibility Determination form. The form must also be completed and signed by the individual's licensed mental health professional; and

(ii) The applicant must submit the following: a current level 1, 2, or 3 CRG assessment, medical records and the licensed mental health professional attestation form that supports the diagnosis, which is the basis of the assessment; or,

(iii) The applicant must submit the following: a current level 2 TPG assessment, medical records and the licensed mental health professional attestation form that supports the diagnosis, which is the basis of the assessment.

(iv) There is no application fee for those applying under this option.

3. Option III - Denial for private health insurance.

(i) The applicant must submit a signed and completed Medical Eligibility Determination form; and

(ii) The applicant must sign a release for medical records, which will allow the Bureau at its discretion to obtain such records to substantiate the disease or medical/physical/behavioral condition described or listed on the application that was the basis for the declination for health insurance; and

(iii) The applicant must submit a declination letter dated within the past two (2) months from an underwriting department or authorized agent of an insurance company licensed and authorized to sell individual or association health insurance policies in the State of Tennessee, which includes the specific medical reason why coverage was denied; or

(iv) The applicant must submit a signed copy of the actual application for health insurance, which describes the medical/physical/behavioral condition upon which the denial of health insurance was based (if the denial letter does not specify the reason).

(l) 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 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.

(m) TennCare Standard enrollees shall be enrolled in a BHO for his/her mental health and substance abuse services.

(n) Effective July 1, 2002, the Bureau of TennCare may announce and hold one (1) open enrollment period per calendar year for those wishing to apply for TennCare Standard as either uninsured or as medically eligible. The ability to add new enrollees (program enrollment capacity) shall be determined by the availability of federal and state funding. Such open enrollment period (if held) will be for a period of no more than sixty (60) days. If program enrollment capacity is reached before the expiration of the open enrollment period, open enrollment will cease and all applications received but not processed and approved by that date will be denied for closed enrollment. If program enrollment capacity is not reached by the date the open enrollment period ends, applications that are completed within forty-five (45) days of the original submission date to TDHS will continue to be processed so long as such applications were submitted to TDHS prior to the closing of the open enrollment period.

(2) Disenrollment.

(a) TennCare will disenroll individuals from TennCare Standard when it has been determined that the individual no longer meets the criteria for the program as outlined in these rules. Such disenrollment action will be accompanied by appropriate due process procedures as described elsewhere in these rules.

(b) TennCare may disenroll individuals from a designated health plan and place them in another health plan as described elsewhere in these rules. A TennCare health plan may not disenroll an enrollee without the permission of TennCare. A TennCare health plan shall not request the disenrollment of a TennCare Standard 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.

(c) Coverage shall cease at 12:00 midnight, local time, on the date that an individual is disenrolled from TennCare.

(d) Coverage by a particular health plan shall cease at 12:00 midnight local time on the date that an individual has been disenrolled by TennCare from one health plan and placed in another plan. Coverage by the new health plan will begin when coverage by the old health plan ends.

(e) Effective July 1, 2002, TennCare will not bill enrollees for unpaid premiums for dates of eligibility prior to July 1, 2002. Unpaid premiums for the dates of eligibility prior to July 1, 2002 shall not affect the eligibility of an enrollee. This does not prohibit the State from using other methods for collecting any outstanding premiums from a current or former TennCare enrollee.

(3) Re-enrollment after the new waiver is implemented on July 1, 2002.

(a) A TennCare Standard enrollee who is disenrolled due to failure to pay the required premiums shall be required to pay all unpaid premiums in order to be re-enrolled in TennCare Standard. For purposes of this subparagraph, "all unpaid premiums" shall refer to those premiums accrued beginning with the first month of unpaid premiums (after June 30, 2002) until the date the Bureau terminated TennCare eligibility. Payment plans are not available. A disenrolled

individual must re-apply for TennCare Standard after paying all back premiums, under current eligibility criteria, and can only do so during periods of authorized open enrollment. The application of such an individual shall be processed in the same manner as all other applications.

(b) TennCare Standard enrollees who are not eligible for TennCare Medicaid and who are disenrolled because of abuse of the TennCare program by allowing an ineligible person to utilize the enrollee's TennCare Standard identification card to obtain services, and enrollees who use his/her TennCare Standard identification card to seek or obtain drugs or supplies illegally or for resale shall not be allowed to re-enroll in TennCare Standard.

(c) TennCare Standard enrollees who are not eligible for TennCare Medicaid and who are disenrolled for failure to pay applicable copayments may be allowed to re-enroll in TennCare Standard at the next period of open enrollment, provided the amount of any copayments for which s/he was responsible during the preceding period of TennCare Standard eligibility are paid in full. The application of such persons shall be processed in the same manner as all other applications. Persons who re-enroll pursuant to this section shall not be permitted to re-enroll retroactively.

(d) An individual enrolled in the TennCare program on or after July 1, 2002 who was terminated for failure to pay premiums, for themselves or for any other person for which s/he was financially responsible, shall not be permitted to enroll in TennCare Standard until all such past due payments have been made. Once paid, such individuals may apply for TennCare Standard during the next period of open enrollment and his/her application will be processed in accordance with current eligibility criteria, unless his/her income is below one hundred (100%) percent of the poverty level, in which case s/he can apply as a medically eligible person at any time.

(e) TennCare Standard enrollees who are disenrolled from TennCare pursuant to these rules shall be allowed to re-enroll in the TennCare program at any time if s/he become TennCare Medicaid-eligible and shall not be required to pay arrearages as a condition of re-enrollment. However, nothing in this provision shall eliminate the enrollee's responsibility for deductibles, copayments or special fees incurred under any previous period of non-TennCare Medicaid eligibility.

(f) Children who are not eligible for TennCare Medicaid and are under age nineteen (19), whose parental TennCare coverage was terminated due to non-payment of premiums at any time since July 1, 2002, may re-apply for TennCare Standard under current eligibility criteria during a period of open enrollment. Children under age nineteen (19) shall not be denied TennCare Standard eligibility because of arrearages accumulated by a parent(s). Such application shall be processed in the same manner as all other applications.

(4) Reassignment.

(a) Reassignment to a health plan other than the current plan in which the TennCare Standard enrollee is enrolled is subject to another health plan's 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) days of enrollment, beginning with the effective date of eligibility, a TennCare Standard enrollee may request a change of health plans.

2. A TennCare Standard enrollee must change health plans if s/he moves outside the health plan's community service area (CSA), and that health plan is not authorized to operate in the enrollee's new place of residence. Until the TennCare Standard 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.

3. TennCare Standard enrollees will be given the opportunity to select a new health plan if his/her health plan withdraws from participation in the TennCare Program and 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 plan, 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 frames, the Bureau will assign him/her to a health plan operating in his/her CSA.

4. A TennCare Standard enrollee will be given an opportunity to change health plans during the annual redetermination of eligibility. 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.

(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 1200-13-14-.11.

(Rule 1200-13-14-.03, continued)

(c) Enrollees who are out-of-state on a temporary basis, but maintain his/her status as a Tennessee resident under federal and state laws, shall be reassigned to TennCare Select for the period 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 1200-13-14-.03; new effective date February 12, 2003. Public necessity rule filed December 29, 2005; effective through June 12, 2006.*

1200-13-14-.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.

(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) Preventive, diagnostic, and treatment services for persons under age 21. 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 1200-13-14-.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	Covered as medically necessary and in accordance with clinical guidelines established by the Bureau of

(Rule 1200-13-14-.04, continued)

SERVICE	BENEFIT FOR PERSONS UNDER AGE 21	BENEFIT FOR PERSONS AGED 21 AND OLDER
	TennCare.	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 (100^{th}) day of confinement during any calendar year for convalescent facility room, board, and general nursing care, 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.	Not covered.
6. Dental Services [defined at 42 CFR §440.100].	Preventive, diagnostic, and treatment services covered as medically necessary. Dental services, 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. Orthodontic services must be prior approved and are limited to individuals under age 21 requiring these services: (1) because of a severe handicapping malocclusion or another developmental anomaly or injury resulting in severe misalignment or severe handicapping malocclusion of teeth, documented by at least 28 points on the Salzmann Scale, or any other method that is approved by TennCare; or (2) following repair of an enrollee's cleft palate. Orthodontic treatment will not be authorized for cosmetic purposes. Orthodontic treatment will be paid for by TennCare only as long as the	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.

(Rule 1200-13-14-.04, continued)

SERVICE	BENEFIT FOR PERSONS UNDER AGE 21	BENEFIT FOR PERSONS AGED 21 AND OLDER
	individual remains eligible for TennCare. If the orthodontic treatment plan is 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. 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.	
7. Durable Medical Equipment [defined at 42 CFR §440.70(b)(3) and 42 CFR §440.120(c)].	Covered as medically necessary.	Covered as medically necessary.
8. Emergency Air and Ground Transportation [defined at 42 CFR §440.170(a)(1) and (3)].	Covered as medically necessary.	Covered as medically necessary.
9. Preventive, Diagnostic, and Treatment Services for Persons Under Age 21.	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.) Diagnostic and follow-up treatment services covered as medically necessary and in accordance with federal regulations. 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."	Not applicable.
10. Home Health Care [defined at 42 CFR §440.70(a), (b), (c), and (e)].	Covered as medically necessary. All home health care must be delivered by a licensed Home Health Agency, as	Covered as medically necessary. All home health care must be delivered by a licensed Home Health Agency, as

(Rule 1200-13-14-.04, continued)

SERVICE	BENEFIT FOR PERSONS UNDER AGE 21	BENEFIT FOR PERSONS AGED 21 AND OLDER
	defined by 42 CFR §440.70. A home health visit includes any of the following: Skilled Nursing, Physical Therapy, Occupational Therapy, Speech Pathology and Audiology Services, and Home Health Aide.	defined by 42 CFR §440.70. A home health visit includes any of the following: Skilled Nursing, Physical Therapy, Occupational Therapy, Speech Pathology and Audiology Services, and Home Health Aide.
11. Hospice Care [defined at 42 CFR, Part 418].	Covered as medically necessary. Must be provided by an organization certified pursuant to Medicare Hospice requirements.	Covered as medically necessary. Must be provided by an organization certified pursuant to Medicare Hospice requirements.
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)].	Covered as medically necessary.	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). 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.
13. Inpatient Hospital Services [defined at 42 CFR §440.10].	Covered as medically necessary. Preadmission and concurrent reviews allowed.	Covered as medically necessary. Preadmission and concurrent reviews allowed. Inpatient Rehabilitation Facility services may be covered when determined to be a cost effective alternative by the MCO.
14. Inpatient Rehabilitation Facility Services.	See “Inpatient Hospital Services.”	See “Inpatient Hospital Services.”
15. Lab and X-ray Services [defined at 42 CFR §440.30].	Covered as medically necessary.	Covered as medically necessary.
16. Medical Supplies [defined at 42 CFR §440.70(b)(3)].	Covered as medically necessary.	Covered as medically necessary.
17. Mental Health Case Management Services [defined as services rendered to support outpatient mental health clinical services].	Covered as medically necessary.	Covered as medically necessary.
18. Mental Health Crisis Services	Covered as medically necessary.	Covered as medically necessary.

(Rule 1200-13-14-.04, continued)

SERVICE	BENEFIT FOR PERSONS UNDER AGE 21	BENEFIT FOR PERSONS AGED 21 AND OLDER
[defined as services rendered to alleviate a psychiatric emergency].		
19. Methadone Clinic Services [defined as services provided by a methadone clinic].	Covered as medically necessary.	Not covered.
20. Non-Emergency Ambulance Transportation, [defined at 42 CFR §440.170(a)(1) and (3)].	Covered as medically necessary.	Covered as medically necessary.
21. Non-Emergency Transportation [defined at 42 CFR §440.170(a)(1) and (3)].	Covered as necessary for enrollees lacking accessible transportation for covered services. 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. 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. Tennessee recognizes the "mature minor exception" to permission for	Covered as necessary for enrollees lacking accessible transportation for covered services. 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.

(Rule 1200-13-14-.04, continued)

SERVICE	BENEFIT FOR PERSONS UNDER AGE 21	BENEFIT FOR PERSONS AGED 21 AND OLDER
	medical treatment. The provision of transportation to and from covered dental services is the responsibility of the MCO.	
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 one individual to another].	Covered as medically necessary. Experimental or investigational transplants are not covered.	Covered as medically necessary when coverable by Medicare. Experimental or investigational transplants are not covered.
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].	Covered as medically necessary. Certain drugs (known as DESI, LTE, IRS drugs) are excluded from coverage. Pharmacy services are the responsibility of the PBM, except for pharmaceuticals supplied and administered in a doctor's office, which are the responsibility of the MCO.	Not covered.
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	Covered as medically necessary.	Covered as medically necessary,

(Rule 1200-13-14-.04, continued)

SERVICE	BENEFIT FOR PERSONS UNDER AGE 21	BENEFIT FOR PERSONS AGED 21 AND OLDER
Outpatient Services/Community Health Clinics/Other Clinic Services [defined at 42 CFR §440.20(b), 42 CFR §440.50, and 42 CFR §440.90].	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.	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.
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	Covered in accordance with Tenn. Code Ann. § 56-7-2507 which requires	Covered in accordance with Tenn. Code Ann. § 56-7-2507 which requires

(Rule 1200-13-14-.04, continued)

SERVICE	BENEFIT FOR PERSONS UNDER AGE 21	BENEFIT FOR PERSONS AGED 21 AND OLDER
[defined in accordance with Tenn. Code Ann. § 56-7-2507].	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.	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 "Inpatient Rehabilitation Facility," "Occupational Therapy," "Physical Therapy," and "Speech Therapy."	See "Inpatient Rehabilitation Facility," "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.
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.	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.

(Rule 1200-13-14-.04, continued)

SERVICE	BENEFIT FOR PERSONS UNDER AGE 21	BENEFIT FOR PERSONS AGED 21 AND OLDER
		One pair of cataract glasses or lenses is covered for adults following cataract surgery.

(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.

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 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 in 1200-13-14-.05(3).

(Rule 1200-13-14-.04, continued)

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
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.

(3) 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. Persons who are determined to be Seriously and/or Persistently Mentally Ill or Seriously Emotionally Disturbed by TennCare are exempt from limitations on substance abuse services. Children under age 21 are also exempt from limitations on substance abuse services.

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

(4) 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.

(5) 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.

(6) Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT) for Individuals Under 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 eligible enrollees under the age of 21.

(Rule 1200-13-14-.04, continued)

(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 the rules of TennCare when necessary to keep the EPSDT program in compliance with federal and state requirements;

(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 inform families of uninsured children who are enrolled in TennCare, of the benefits covered under TennCare and the importance of accessing preventive services.

3. The Bureau, through local health departments, shall provide information on covered services to adolescent prenatal patients who enter TennCare 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.

4. 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 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 MCO'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 enrollees and/or the enrollee's responsible party about the availability of EPSDT services and how to access such services. 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 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 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 families can readily access an accurate list of names and phone numbers of contract providers who are currently accepting TennCare.

6. Contractors shall offer both transportation and scheduling assistance prior to the due date of the child's periodic examination.

7. Contractors shall provide 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 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 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 by TennCare.

10. Contractors shall inform families of the costs, if any, of EPSDT services.

11. Contractors shall treat a TennCare-eligible woman's request for EPSDT services during pregnancy as a request for EPSDT services for the child at birth.

(c) Compliance

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

(7) 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 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:

(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.

(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.

(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,

(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.

(8) 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.

(9) 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.

(10) 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

(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 visit, 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