

**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.

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

- (5) APPLICATION FEE shall mean the fee that applicants must pay in advance for the processing of a TennCare Standard application for coverage as a “medically eligible” person. The fee is established by the Bureau of TennCare and may be periodically changed.
- (6) BENEFITS shall mean the health care package of services developed by the Bureau of TennCare and which define the covered services available to TennCare enrollees.
- (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;

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

- (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:

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

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 shall mean a service that is not a covered service but that is approved by TennCare and CMS and provided at an MCC's discretion. TennCare enrollees are not entitled to receive these services. Cost-effective alternative services may be provided because they are either (1) alternatives to covered Medicaid services that, in the MCC's judgment, are cost-effective or (2) preventative in nature and offered to avoid the development of conditions that, in the MCC's judgment, would require more costly treatment in the future. Cost-effective alternative services need not be determined medically necessary except to the extent that they are provided as an alternative to covered Medicaid services. Even if medically necessary, cost effective alternative services are not covered services and are provided only at an MCC's discretion.
- (22) COST SHARING shall mean the amounts that certain enrollees in TennCare are required to pay for their TennCare coverage and covered services. Cost sharing includes premiums and/or copayments.
- (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 may be deemed a delay when such decision is not granted within fourteen (14) days of the MCC's receipt of a request for such authorization or as expeditiously as the enrollee's health condition requires.
- (27) DEMAND LETTER shall mean a letter sent by TennCare to a TennCare Standard enrollee with premium obligations notifying the enrollee that he is at least 60 days delinquent in his premium payments.
- (28) DISENROLLMENT shall mean the discontinuance of an individual's enrollment in TennCare.

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

- (29) DURABLE MEDICAL EQUIPMENT (DME) shall mean equipment that can stand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of an illness or injury, is appropriate for and used in the patient's home, and is related to the patient's physical disorder. An institution is not considered a patient's or member's home if it meets the definition of a hospital or skilled facility. Orthotics and prosthetic devices, and artificial limbs and eyes are considered DME.
- (30) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) SERVICES, a covered benefit for TennCare Medicaid-enrolled children only, shall mean:
- (a) Screening in accordance with professional standards, and interperiodic, diagnostic services to determine the existence of physical or mental illnesses or conditions of TennCare Medicaid-enrollees under age twenty-one (21); and
 - (b) Health care, treatment, and other measures, described in 42 U.S.C. § 1396a(a) to correct or ameliorate any defects and physical and mental illnesses and conditions discovered.
- (31) ELIGIBLE shall mean a person who has been determined to meet the eligibility criteria of TennCare Medicaid or TennCare Standard.
- (32) EMERGENCY MEDICAL CONDITION, including emergency mental health and substance abuse emergency treatment services, shall mean the sudden and unexpected onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to potentially result in:
- (a) Placing the person's (or with respect to a pregnant woman, her unborn child's) health in serious jeopardy; or
 - (b) Serious impairment to bodily functions; or
 - (c) Serious dysfunction of any bodily organ or part.

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

- (33) ENROLLEE shall mean an individual eligible for and enrolled in the TennCare program or in any Tennessee federal Medicaid waiver program approved by the Secretary of the US Department of Health and Human Services pursuant to Sections 1115 or 1915 of the Social Security Act. As concerns MCC compliance with these rules, the term only applies to those individuals for whom the MCC has received at least one day's prior written or electronic notice from the TennCare Bureau of the individual's assignment to the MCC.
- (34) ENROLLMENT shall mean the process by which a TennCare-eligible person becomes enrolled in TennCare.
- (35) FAMILY shall mean that as defined in the rules of the Tennessee Department of Human Services found at 1240-1-3 and 1240-1-4, Family Assistance Division, and 1240-3-3, Division of Medical Services.
- (36) FEDERAL FINANCIAL PARTICIPATION (FFP) shall mean the Federal Government's share of a state's expenditure under the Title XIX Medicaid Program.
- (37) FINAL AGENCY ACTION shall mean the resolution of an appeal by the TennCare Bureau or an initial decision on the merits of an appeal by an impartial administrative judge or hearing officer when

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

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.

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

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

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

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

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

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

11. Insurance under which benefits are payable with or without regard to fault and which are statutorily required to be contained in any liability insurance policy or equivalent self-insurance;
 12. A medical care program of the Indian Health Services (IHS) or a tribal organization;
 13. Benefits received through the Veteran's Administration; or
 14. Health care provided through a government clinic or program such as, but not limited to, vaccinations, flu shots, mammograms, and care or services received through a disease- or condition-specific program such as, but not limited to, the Ryan White Care Act.
- (42) HEALTH PLAN shall mean a managed care organization authorized by the Tennessee Department of Finance and Administration to provide medical services to enrollees in the TennCare Program.
- (43) HEALTH MAINTENANCE ORGANIZATION (HMO) shall mean an entity licensed by the Tennessee Department of Commerce and Insurance under applicable provisions of *Tennessee Code Annotated (T.C.A.)* Title 56, Chapter 32 to provide health care services.
- (44) HIPAA shall mean the Health Insurance Portability and Accountability Act of 1996, as amended.
- (45) HOME HEALTH SERVICES shall mean:
- (a) Any of the following services ordered by a treating physician and provided by a licensed home health agency pursuant to a plan of care at an enrollee's place of residence:
 1. Part-time or intermittent nursing services;
 2. Home health aide services; or
 3. Physical therapy, occupational therapy, or speech pathology and audiology services.
 - (b) Medical supplies, equipment, and appliances ordered by a treating physician and suitable for use at an enrollee's place of residence.
 - (c) Home health providers may only provide services to the recipient that have been ordered by the treating physician and are pursuant to a plan of care and may not provide other services such as general child care services, cleaning services or preparation of meals, or services to other household members. For this reason and to the extent that home health services are provided to a person under 18 years of age, a responsible adult (other than the home healthcare provider) must be present at all times in the home during provision of home health services.
- (46) IMPARTIAL HEARING OFFICER shall mean an administrative judge or hearing officer who is not an employee, agent or representative of the MCC and who did not participate in, nor was consulted about, any TennCare Bureau review prior to the Administrative Hearing.
- (47) INCOME shall mean that definition of income in rule 1240-1-4 of the Tennessee Department of Human Services - Family Assistance Division.
- (48) INDIVIDUAL HEALTH INSURANCE shall mean health insurance coverage under a policy covering one person or all the members of a family under a single policy where the contract exists solely between that person and the insurance company.

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

- (49) INITIATING PROVIDER shall mean the provider who renders the first covered service to a TennCare member whose current medical condition requires the services of more than one (1) provider.
- (50) INMATE shall mean an individual confined in a local, state, or federal prison, jail, youth development center, or other penal or correctional facility, including a furlough from such facility.
- (51) INPATIENT REHABILITATION FACILITIES shall mean rehabilitation hospitals and distinct parts of hospitals that are designated as 'IRFs' by Medicare.
- (52) LICENSED MENTAL HEALTH PROFESSIONAL shall mean a Board eligible or a Board certified psychiatrist or a person with at least a Master's degree and/or clinical training in an accepted mental health field which includes, but is not limited to, counseling, nursing, occupational therapy, psychology, social work, vocational rehabilitation, or activity therapy with a current valid license by the Tennessee Licensing Board for the Healing Arts.
- (53) LIMITED BENEFITS POLICY shall mean a policy of health coverage for a specific disease (e.g., cancer), or an accident occurring while engaged in a specified activity (e.g., school-based sports), or which provides for a cash benefit payable directly to the insured in the event of an accident or hospitalization (e.g., hospital indemnity).
- (54) LOCK-IN PROVIDER shall mean a provider, either pharmacy or physician, who an enrollee on pharmacy lock-in status has chosen and to whom an enrollee is assigned by TennCare or the MCO for purposes of receiving covered pharmacy services.
- (55) LOCK-IN STATUS shall mean the restriction of an enrollee to a specified and limited number of pharmacy providers.
- (56) LONG TERM CARE shall mean institutional services of a nursing facility, an intermediate care facility for the mentally retarded, and services provided through a Home and Community Based Services Waiver.
- (57) MCC (MANAGED CARE CONTRACTOR) shall mean:
 - (a) A managed care organization, behavioral health organization, pharmacy benefits manager, and/or a dental benefits manager which has signed a TennCare Contractor Risk Agreement with the State and operates a provider network and provides covered health services to TennCare enrollees; or
 - (b) A pharmacy benefits manager or dental benefits manager which subcontracts with a managed care organization or behavioral health organization to provide services; or
 - (c) A State government agency (i.e., Department of Children's Services and Division of Mental Retardation Services) that contracts with TennCare for the provision of services.
- (58) MCO (MANAGED CARE ORGANIZATION) shall mean an appropriately licensed Health Maintenance Organization (HMO) approved by the Bureau of TennCare as capable of providing medical services in the TennCare Program.
- (59) MEDICAID shall mean the federal- and state-financed, state-run program of medical assistance pursuant to Title XIX of the Social Security Act. Medicaid eligibility in Tennessee is determined by the Tennessee Department of Human Services, under contract to the Tennessee Department of Finance and Administration. Tennessee residents determined eligible for SSI benefits by the Social Security Administration are also enrolled in Tennessee's TennCare Medicaid program.

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

- (60) MEDICAID “ROLLOVER” ENROLLEE shall mean a TennCare Medicaid enrollee who no longer meets technical eligibility requirements for Medicaid and will be afforded an opportunity to enroll in TennCare Standard in accordance with the provisions of these rules.
- (61) MEDICAL ASSISTANCE shall mean health care, services and supplies furnished to an enrollee and funded in whole or in part under Title XIX of the Social Security Act, 42 U.S.C. §§ 1396, et seq. and Tennessee Code Annotated § 71-5-101, et seq. Medical assistance includes the payment of the cost of care, services, drugs and supplies. Such care, services, drugs, and supplies shall include services of qualified providers who have contracted with an MCC or are otherwise authorized to provide services to TennCare enrollees (i.e., emergency services provided out-of-network or medically necessary services obtained out-of-network because of an MCC’s failure to provide adequate access to services in-network).
- (62) MEDICAL RECORD shall mean all 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; lab reports; other individualized medical documentation in written or electronic format; and analyses of such information.
- (63) MEDICAL SUPPLIES shall mean covered medical supplies that are deemed medically necessary and appropriate and are prescribed for use in the diagnosis and treatment of medical conditions. Medically necessary medical supplies not included as part of institutional services shall be covered only when provided by or through a licensed home health agency, by or through a licensed medical vendor supplier or by or through a licensed pharmacist.
- (64) MEDICALLY CONTRAINDICATED shall mean a TennCare benefit or service which it is necessary to withhold in order to safeguard the health or safety of the enrollee.
- (65) MEDICALLY ELIGIBLE shall mean a person who has met the medical eligibility criteria for the TennCare Standard program through a mechanism permitted under the provisions of these rules.
- (66) MEDICALLY NECESSARY is defined by Tennessee Code Annotated, Section 71-5-144, and shall describe a medical item or service that meets the criteria set forth in that statute. The term “medically necessary,” as defined by Tennessee Code Annotated, Section 71-5-144, applies to TennCare enrollees. Implementation of the term “medically necessary” is provided for in these regulations, consistent with the statutory provisions, which control in case of ambiguity. No enrollee shall be entitled to receive and TennCare shall not be required to pay for any items or services that fail fully to satisfy all criteria of “medically necessary” items or services, as defined either in the statute or in the Medical Necessity regulations at 1200-13-16.
- (67) MEDICALLY NEEDY shall mean that category of TennCare Medicaid-eligibles as defined in rule 1240-3-2-.03 of the Tennessee Department of Human Services - Division of Medical Services.
- (68) MEDICARE shall mean the program administered through the Social Security Administration pursuant to Title XVIII, available to most individuals upon attaining age sixty-five (65), to some disabled individuals under age sixty-five (65), and to individuals having End Stage Renal Disease (ESRD).
- (69) MEMBER shall mean a TennCare Medicaid- or TennCare Standard-eligible individual who is enrolled in a managed care organization.
- (70) OPEN ENROLLMENT shall mean a designated period of time, determined by the Bureau of TennCare, during which individuals may apply for enrollment in TennCare Standard. The following individuals may apply for TennCare Standard during periods of open enrollment:

(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.
- (71) OPEN MEDICAID CATEGORIES shall mean those Medicaid eligibility categories for which enrollment has not been closed pursuant to authority granted by CMS as part of the TennCare demonstration project.
- (72) OVERUTILIZATION shall mean any of the following:
- (a) The enrollee initiated use of TennCare services or supplies at a frequency or amount that is not medically necessary or medically justified.
 - (b) Overutilization, or attempted overutilization, of the TennCare Pharmacy Program which justifies placement on lock-in status for all enrollees involved.
 - (c) Activities or practices which may evidence overutilization of the TennCare Pharmacy Program including, but not limited to, the following:
 - 1. Treatment by several physicians for the same diagnosis;
 - 2. Obtaining the same or similar controlled substances from several physicians;
 - 3. Obtaining controlled substances in excess of the maximum recommended dose;
 - 4. Receiving combinations of drugs which act synergistically or belong to the same class;
 - 5. Frequent treatment for diagnoses which are highly susceptible to abuse;
 - 6. Receiving services and/or drugs from numerous providers;
 - 7. Obtaining the same or similar drugs on the same day or at frequent intervals; or
 - 8. Frequent use of the emergency room in non-emergency situations in order to obtain prescription drugs.
- (73) PBM (PHARMACY BENEFITS MANAGER) shall mean an organization approved by the Tennessee Department of Finance and Administration to provide pharmacy benefits to enrollees to the extent such services are covered by the TennCare Program. A PBM may have a signed TennCare Contractor Risk Agreement with the State, or may be a subcontractor to an MCO or BHO.
- (74) PERSONAL CARE SERVICES shall refer to an optional Medicaid benefit defined at 42 CFR 440.167 that, per the Tennessee Medicaid State Plan, Tennessee has not elected to include in the TennCare benefit package. To the extent that such services are available to children under the age of 21 when medically necessary under the provisions of EPSDT, the Bureau of TennCare designates home health aides as the providers qualified to deliver such services. When medically necessary, personal care services may be authorized outside of the home setting when normal life activities temporarily take the recipient outside of that setting. Normal life activity for a child under the age of 21 means routine work (including work in supported or sheltered work settings); licensed child care; school and school-related activities; religious services and related activities; and outpatient health care services (including services delivered through a TennCare home and community based services waiver program). The

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

home health aide providing personal care services may accompany the recipient but may not drive. Normal life activities do not include non-routine or extended home absences.

- (75) **PHYSICIAN** shall mean a person licensed pursuant to chapter 6 or 9 of title 63 of the Tennessee Code Annotated.
- (76) **POVERTY LEVEL** shall mean the poverty level established by the Federal Government.
- (77) **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.
- (78) **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.
- (79) **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.
- (80) **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.
- (81) **PRIVATE DUTY NURSING SERVICES** shall mean nursing services for recipients who require continuous skilled nursing care. Skilled nursing care is provided by a registered nurse or licensed practical nurse under the direction of the recipient's physician to the recipient and not to other household members. An individual who needs eight (8) or more hours of skilled nursing care during a 24-hour period shall be determined to need continuous skilled nursing care. As a general rule, only an individual who is dependent on technology-based medical equipment requiring frequent interventions will be determined to need continuous care. An individual who needs less than eight (8) hours of skilled nursing care will receive those services as an intermittent service under home health. If it is determined by the MCO to be cost effective, non-skilled services may be provided by a nurse rather than a home health aide. Furthermore, if it is determined by the MCO to be cost effective, the nurse may remain in the home during the intervals between the delivery of intermittent services, rather than traveling back and forth to the home. However, it is the total number of hours of skilled nursing services, not the number of hours that the nurse is in the home, which determines whether the nursing services shall be considered continuous or intermittent. To the extent that private duty nursing services are provided to a person under 18 years of age, a responsible adult (other than the private duty nurse) must be present at all times in the home during the provision of the private duty nursing services in order to assure the child's non-healthcare needs are addressed. General childcare services and other non-hands-on assistance such as cleaning and meal preparation will not be provided by a private duty nurse.
- (82) **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.
- (83) **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.

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- (84) 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.
- (85) 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.
- (86) PRUDENT LAY PERSON shall mean a reasonable person who possesses an average knowledge of health and medicine.
- (87) 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.
- (88) QUALIFIED UNINSURED PERSON shall mean an uninsured person who meets the technical, financial, and insurance requirements for the TennCare Standard Program.
- (89) READABLE shall mean no more than a sixth grade level of reading proficiency is needed to understand notices or other written communications, as measured by the Fogg index, the Flesch Index, the Flesch-Kincaid Index, or other recognized readability instrument. The preprinted language approved by the US District Court following entry of the *Grier Revised Consent Decree* and distributed to MCCs as templates is deemed readable. It is the responsibility of the entity issuing the notice to ensure that text added to the template is deemed readable, with the exception of medical, clinical or legal terminology.
- (90) REASSIGNMENT shall mean the process by which the Bureau of TennCare transfers an enrollee from one MCO to another as described in these rules.
- (91) RECEIPT OF MAILED NOTICES shall mean that receipt of mailed notices is presumed to occur within five (5) days of mailing.
- (92) 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.
- (93) 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.
- (94) 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.

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- (95) **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.
- (96) **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.
- (97) **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).
- (98) **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

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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.

(99) 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.

(100) 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 bene-

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- fits 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.
- (101) 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.
- (102) 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.
- (103) 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.
- (104) 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.
- (105) 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.
- (106) TENNCARE PARTNERS PROGRAM shall mean that component of the TennCare Program that provides mental health and substance abuse services.
- (107) TENNCARE PHARMACY PROGRAMS shall mean any TennCare pharmacy carve-outs, including, but not limited to, enrollees with dual eligibility, the behavioral health pharmacy benefit, and all pharmacy services provided by the TennCare managed care organizations (MCOs).
- (108) TENNCARE SELECT shall mean a state self-insured HMO established by the Bureau of TennCare and administered by a contractor to provide medical services to certain eligible enrollees.
- (109) TENNCARE SERVICES OR BENEFITS for purposes of this rule shall mean any medical assistance that is administered by the Bureau of TennCare or its contactors 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

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- (b) Medicare cost sharing services that do not involve utilization review by the Bureau of TennCare or its contractors.
- (110) TENNCARE STANDARD shall mean that part of the TennCare Program which provided coverage for Tennessee residents who are not eligible for Medicaid but who meet the requirements for TennCare Standard that are outlined in these rules.
- (111) 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.
- (112) TERMINATION shall mean the discontinuance of an enrollee's coverage under the TennCare Medicaid or TennCare standard program.
- (113) 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.
- (114) TIME-SENSITIVE CARE shall mean care which requires a prompt medical response in light of the beneficiary's condition and the urgency of her need, as defined by a prudent lay person; provided, however, that a case may be treated as non-time sensitive upon written certification of the beneficiary's treating physician.
- (115) 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.
- (116) 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.
- (117) 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.
- (118) VALID FACTUAL DISPUTE shall mean a dispute which, if resolved in favor of the enrollee, would result in the proposed action not being taken.
- (119) 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 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

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1, 2005; effective November 15, 2005. Public necessity rule filed December 29, 2005; effective through June 12, 2006. Public necessity rule filed December 29, 2005, expired June 12, 2006. On June 13, 2006, affected rules reverted to status on December 28, 2005. Amendments filed March 31, 2006; effective June 14, 2006. Public Necessity rule filed December 1, 2006; expires May 15, 2007. Public necessity rule filed February 1, 2007; expires July 16, 2007. Public necessity rule filed March 21, 2007, effective through September 2, 2007.

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

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

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

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.

- (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 re-

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

mained 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.
- (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

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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;

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- (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:

- (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.

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

- (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 (45th) 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.

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

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.
- (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.

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

- (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.

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

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 circum-

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

stances 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.
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.

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

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.
- (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.

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

- (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.
- (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.

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

- (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

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

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 capac-

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

ity 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.

- (o) In the event an enrollee entering a MCO's plan is receiving medically necessary prenatal care the day before enrollment, the MCO shall be responsible for the costs of continuation of such medically necessary services, without any form of prior approval and without regard to whether such services are being provided within or outside the MCO's provider network until such time as the MCO can reasonably transfer the enrollee to a service and/or network provider without impeding service delivery that might be harmful to the enrollee's health.

In the event an enrollee entering the MCO's plan is in her second or third trimester of pregnancy and is receiving medically necessary prenatal care services the day before enrollment, the MCO shall be responsible for providing continued access to the provider (regardless of network affiliation) through the postpartum period. Reimbursement to an out-of-network provider shall be as set out in rule 1200-13-14-.08.

(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

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

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

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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 Standard 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.

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- (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, 71-5-105, 71-5-109, 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. Public necessity rule filed December 29, 2005, expired June 12, 2006. On June 13, 2006, affected rules reverted to status on December 28, 2005. Amendment filed March 31, 2006; effective June 14, 2006. Amendment filed August 14, 2006; effective October 28, 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
I. Ambulance Services.	See “Emergency Air and Ground Transportation” and “Non-Emergency	See “Emergency Air and Ground Transportation” and “Non-Emergency

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SERVICE	BENEFIT FOR PERSONS UNDER AGE 21	BENEFIT FOR PERSONS AGED 21 AND OLDER
	Ambulance Transportation.”	Ambulance Transportation.”
2. Bariatric Surgery, defined as surgery to induce weight loss.	Covered as medically necessary and in accordance with clinical guidelines established by the Bureau of TennCare.	Covered as medically necessary and in accordance with clinical guidelines established by the Bureau of TennCare.
3. Chiropractic Services [defined at 42 CFR §440.60(b)].	Covered as medically necessary.	Not covered.
4. Community Health Services, [defined at 42 CFR §440.20(b) and (c) and 42 CFR §440.90].	Covered as medically necessary.	Covered as medically necessary.
5. Convalescent Care [defined as care provided in a nursing facility after a hospitalization].	<p>Upon receipt of proof that an enrollee has incurred medically necessary expenses related to convalescent care, TennCare shall pay for up to and including the one hundredth (100th) day of confinement during any calendar year for convalescent facility room, board, and general nursing care, provided that: (A) a physician recommends confinement for convalescence; (B) the enrollee is under the continuous care of a physician during the entire period of convalescence; and (C) the confinement is required for other than custodial care.</p> <p>Effective February 1, 2007 not covered.</p>	Not covered.
6. Dental Services [defined at 42 CFR §440.100].	<p>Preventive, diagnostic, and treatment services covered as medically necessary.</p> <p>Dental services under EPSDT, including dental screens, are provided in accordance with the state’s periodicity schedule as determined after consultation with recognized dental organizations and at other intervals as medically necessary.</p> <p>Orthodontic services must be prior approved and are limited to individuals under age 21 requiring these services for one of the following reasons:</p> <p>(1) because of a handicapping malocclusion or another developmental anomaly or injury resulting in severe misalignment or handicapping maloc-</p>	Not covered, except for orthodontic treatment when an orthodontic treatment plan was approved prior to the enrollee’s attaining 20 ½ years of age, and treatment was initiated prior to the enrollee’s attaining 21 years of age; such treatment may continue as long as the enrollee remains eligible for TennCare.

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

SERVICE	BENEFIT FOR PERSONS UNDER AGE 21	BENEFIT FOR PERSONS AGED 21 AND OLDER
	<p>clusion of teeth. The Salzmann Index will be used to measure the severity of the malocclusion. A Salzmann score of 28 will be used as the threshold value for making orthodontic determinations of medical necessity. In addition, individual consideration will be applied for those unique orthodontic cases that may not be accounted for solely by the Salzmann Index;</p> <p>(2) following repair of an enrollee's cleft palate.</p> <p>Orthodontic treatment will not be authorized for cosmetic purposes. Orthodontic treatment will be paid for by TennCare only as long as the individual remains eligible for TennCare.</p> <p>If the orthodontic treatment plan is approved prior to the enrollee's attaining 20 ½ years of age, and treatment is initiated prior to the enrollee's attaining 21 years of age, such treatment may continue as long as the enrollee remains eligible for TennCare.</p> <p>The MCO is responsible for the provision of transportation to and from covered dental services, as well as the medical and anesthesia services related to the covered dental services.</p>	
<p>7. Durable Medical Equipment [defined at 42 CFR §440.70(b)(3) and 42 CFR §440.120(c)].</p>	<p>Covered as medically necessary.</p>	<p>Covered as medically necessary.</p>
<p>8. Emergency Air and Ground Transportation [defined at 42 CFR §440.170(a)(1) and (3)].</p>	<p>Covered as medically necessary.</p>	<p>Covered as medically necessary.</p>
<p>9. Preventive, Diagnostic, and Treatment Services for Persons Under Age 21.</p>	<p>Screening and interperiodic screening covered in accordance with federal regulations. (Interperiodic screens are screens in between regular checkups which are covered if a parent or caregiver suspects there may be a problem.)</p> <p>Diagnostic and follow-up treatment</p>	<p>Not applicable.</p>

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

SERVICE	BENEFIT FOR PERSONS UNDER AGE 21	BENEFIT FOR PERSONS AGED 21 AND OLDER
	<p>services covered as medically necessary and in accordance with federal regulations.</p> <p>The periodicity schedule for child health screens is that set forth in the latest “American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care.” All components of the screens must be consistent with the latest “American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care.”</p>	
<p>10. Home Health Care [defined at 42 CFR §440.70(a), (b), (c), and (e)].</p>	<p>Covered as medically necessary.</p> <p>All home health care must be delivered by a licensed Home Health Agency, as defined by 42 CFR §440.70.</p> <p>A home health visit includes any of the following: Skilled Nursing, Physical Therapy, Occupational Therapy, Speech Pathology and Audiology Services, and Home Health Aide.</p>	<p>Covered as medically necessary.</p> <p>All home health care must be delivered by a licensed Home Health Agency, as defined by 42 CFR §440.70.</p> <p>A home health visit includes any of the following: Skilled Nursing, Physical Therapy, Occupational Therapy, Speech Pathology and Audiology Services, and Home Health Aide.</p>
<p>11. Hospice Care [defined at 42 CFR, Part 418].</p>	<p>Covered as medically necessary.</p> <p>Must be provided by an organization certified pursuant to Medicare Hospice requirements.</p>	<p>Covered as medically necessary.</p> <p>Must be provided by an organization certified pursuant to Medicare Hospice requirements.</p>
<p>12. Inpatient and Outpatient Substance Abuse Benefits [defined as services for the treatment of substance abuse that are provided (a) in an inpatient hospital (as defined at 42 CFR §440.10) or (b) as outpatient hospital services (see 42 CFR §440.20(a)].</p>	<p>Covered as medically necessary.</p>	<p>Covered as medically necessary, with a maximum lifetime limitation of ten (10) detoxification days and \$30,000 in substance abuse benefits (inpatient, residential, and outpatient).</p> <p>When medically appropriate and cost effective as determined by the BHO, services in a licensed substance abuse residential treatment facility may be provided as a substitute for inpatient substance abuse services.</p>
<p>13. Inpatient Hospital Services [defined at 42 CFR §440.10].</p>	<p>Covered as medically necessary.</p> <p>Preadmission and concurrent reviews allowed.</p>	<p>Covered as medically necessary.</p> <p>Preadmission and concurrent reviews allowed.</p>
<p>14. Inpatient Rehabilitation Facility Services</p>	<p>See “Inpatient Hospital Services.”</p>	<p>Not covered.</p>
<p>15. Lab and X-ray Services [defined at 42 CFR §440.30].</p>	<p>Covered as medically necessary.</p>	<p>Covered as medically necessary.</p>
<p>16. Medical Supplies</p>	<p>Covered as medically necessary.</p>	<p>Covered as medically necessary.</p>

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

SERVICE	BENEFIT FOR PERSONS UNDER AGE 21	BENEFIT FOR PERSONS AGED 21 AND OLDER
[defined at 42 CFR §440.70(b)(3)].		
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 [defined as services rendered to alleviate a psychiatric emergency].	Covered as medically necessary.	Covered as medically necessary.
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)].	<p>Covered as necessary for enrollees lacking accessible transportation for covered services.</p> <p>The travel to access primary care and dental services must meet the requirements of the TennCare demonstration project terms and conditions. The availability of specialty services as related to travel distance should meet the usual and customary standards for the community. However, in the event the MCC is unable to negotiate such an arrangement for an enrollee, transportation must be provided regardless of whether the enrollee has access to transportation.</p> <p>If the enrollee is a minor child, transportation must be provided for the child and an accompanying adult. However, transportation for a minor child shall not be denied pursuant to any policy which poses a blanket restriction due to enrollee’s age or lack of parental accompaniment. Any decision to deny transportation of a minor child due to an enrollee’s age or lack of parental accompaniment must be</p>	<p>Covered as necessary for enrollees lacking accessible transportation for covered services.</p> <p>The travel to access primary care and dental services must meet the requirements of the TennCare demonstration project terms and conditions. The availability of specialty services as related to travel distance should meet the usual and customary standards for the community. However, in the event the MCC is unable to negotiate such an arrangement for an enrollee, transportation must be provided regardless of whether the enrollee has access to transportation.</p>

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

SERVICE	BENEFIT FOR PERSONS UNDER AGE 21	BENEFIT FOR PERSONS AGED 21 AND OLDER
	<p>made on a case-by-case basis and must be based on the individual facts surrounding the request. As with any denial, all notices and actions must be in accordance with the appeals process.</p> <p>Tennessee recognizes the “mature minor exception” to permission for medical treatment.</p> <p>The provision of transportation to and from covered dental services is the responsibility of the MCO.</p>	
<p>22. Occupational Therapy [defined at 42 CFR §440.110(b)].</p>	<p>Covered as medically necessary, by a Licensed Occupational Therapist, to restore, improve, stabilize or ameliorate impaired functions.</p>	<p>Covered as medically necessary, by a Licensed Occupational Therapist, to restore, improve, or stabilize impaired functions.</p>
<p>23. Organ and Tissue Transplant Services and Donor Organ/Tissue Procurement Services [defined as the transfer of an organ or tissue from an individual to a TennCare enrollee].</p>	<p>Covered as medically necessary.</p> <p>Experimental or investigational transplants are not covered.</p>	<p>Covered as medically necessary when coverable by Medicare.</p> <p>Experimental or investigational transplants are not covered.</p>
<p>24. Outpatient Hospital Services [defined at 42 CFR §440.20(a)].</p>	<p>Covered as medically necessary.</p>	<p>Covered as medically necessary.</p>
<p>25. Outpatient Mental Health Services (including Physician Services), [defined at 42 CFR §440.20(a), 42 CFR §440.50, and 42 CFR §440.90].</p>	<p>Covered as medically necessary.</p>	<p>Covered as medically necessary.</p>
<p>26. Pharmacy Services [defined at 42 CFR §440.120(a) and obtained directly from an ambulatory retail pharmacy setting, outpatient hospital pharmacy, mail order pharmacy, or those administered to a long-term care facility (nursing facility) resident].</p>	<p>Covered as medically necessary. Certain drugs (known as DESI, LTE, IRS drugs) are excluded from coverage.</p> <p>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.</p>	<p>Not covered.</p>

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

SERVICE	BENEFIT FOR PERSONS UNDER AGE 21	BENEFIT FOR PERSONS AGED 21 AND OLDER
27. Physical Therapy [defined at 42 CFR §440.110(a)].	Covered as medically necessary, by a Licensed Physical Therapist, to restore, improve, stabilize or ameliorate impaired functions,	Covered as medically necessary, by a Licensed Physical Therapist, to restore, improve, or stabilize impaired functions.
28. Physician Inpatient Services [defined at 42 CFR §440.50].	Covered as medically necessary.	Covered as medically necessary.
29. Physician Outpatient Services/Community Health Clinics/Other Clinic Services [defined at 42 CFR §440.20(b), 42 CFR §440.50, and 42 CFR §440.90].	<p>Covered as medically necessary.</p> <p>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.</p> <p>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.</p>	<p>Covered as medically necessary, except see “Methadone Clinic Services.”</p> <p>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.</p> <p>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.</p>
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.”

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

SERVICE	BENEFIT FOR PERSONS UNDER AGE 21	BENEFIT FOR PERSONS AGED 21 AND OLDER
36. Psychiatric Residential Treatment Services [defined at 42 CFR §483.352] and including services for persons of all ages].	Covered as medically necessary.	Covered as medically necessary.
37. Reconstructive Breast Surgery [defined in accordance with Tenn. Code Ann. § 56-7-2507].	Covered in accordance with Tenn. Code Ann. § 56-7-2507 which requires coverage of all stages of reconstructive breast surgery on a diseased breast as a result of a mastectomy as well as any surgical procedure on the non-diseased breast deemed necessary to establish symmetry between the two breasts in the manner chosen by the physician. The surgical procedure performed on a non-diseased breast to establish symmetry with the diseased breast will only be covered if the surgical procedure performed on a non-diseased breast occurs within five (5) years of the date the reconstructive breast surgery was performed on a diseased breast.	Covered in accordance with Tenn. Code Ann. § 56-7-2507 which requires coverage of all stages of reconstructive breast surgery on a diseased breast as a result of a mastectomy as well as any surgical procedure on the non-diseased breast deemed necessary to establish symmetry between the two breasts in the manner chosen by the physician. The surgical procedure performed on a non-diseased breast to establish symmetry with the diseased breast will only be covered if the surgical procedure performed on a non-diseased breast occurs within five (5) years of the date the reconstructive breast surgery was performed on a diseased breast.
38. Rehabilitation services	See “Occupational Therapy,” “Physical Therapy,” and “Speech Therapy,” and “Inpatient Rehabilitation Facility Services”	See “Occupational Therapy,” “Physical Therapy,” and “Speech Therapy.”
39. Renal Dialysis Clinic Services [defined at 42 CFR §440.90].	Covered as medically necessary. Generally limited to the beginning ninety (90) day period prior to the enrollee’s becoming eligible for coverage by the Medicare program.	Covered as medically necessary. Generally limited to the beginning ninety (90) day period prior to the enrollee’s becoming eligible for coverage by the Medicare program.
40. Sitter Services [defined as nursing services provided in the hospital by a nurse who is not an employee of the hospital].	Covered as medically necessary when a sitter who is not a relative is needed for an enrollee who is confined to a hospital as a bed patient. Certification must be made by a network physician that an R.N. or L.P.N. is needed, and neither is available. Effective February 1, 2007 not covered.	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.”

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

SERVICE	BENEFIT FOR PERSONS UNDER AGE 21	BENEFIT FOR PERSONS AGED 21 AND OLDER
43. Vision Services [defined as services to treat conditions of the eyes].	Preventive, diagnostic, and treatment services (including eyeglasses) covered as medically necessary.	<p>Medical eye care, meaning evaluation and management of abnormal conditions, diseases, and disorders of the eye (not including evaluation and treatment of the refractive state) is covered. Routine, periodic assessment, evaluation or screening of normal eyes, and examinations for the purpose of prescribing, fitting, or changing eyeglasses and/or contact lenses are not covered.</p> <p>One pair of cataract glasses or lenses is covered for adults following cataract surgery.</p>

(c) Pharmacy

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

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

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

perimental or investigational drugs which have not received final approval from the FDA.

- (d) The MCC shall be allowed to provide cost effective alternative services as defined in rule 1200-13-14-.01(21). Cost effective alternative services are not covered services.
- (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).

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

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

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

Detoxification	Ten (10) days
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).

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

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.

(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.

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

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 medi-

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

cal, 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;

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

- 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:

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

- (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:

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

- (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,

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

- (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.

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

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

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

- 59430 Postpartum care only (separate procedure)
- 59510 Routine obstetric care including antepartum care, cesarean delivery, and postpartum care
- 59515 Cesarean delivery only including postpartum care
- 59610 Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy and/or forceps) and postpartum, after previous cesarean delivery
- 59618 Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery

(e) Other Preventive Services

- 90700 through 90744 - Immunizations
- 92551 Screening test, pure tone, air only (Audiologic function)
- 92552 Pure tone audiometry (threshold); air only
- 96110 Developmental Code Limited
- 99173 Vision
- 99420 Administration and interpretation of health risk assessment instrument (e.g., health hazard appraisal)
- 99431 Newborn - Initial Hospitalization
- 99435 Newborn - Assessment and Discharge Same Day

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

(11) Maximum Lifetime Limitations as of January 1, 2003.

The following maximum lifetime limitations shall apply to the services outlined in paragraphs (9)(b) and (12) above. The MCCs shall not impose services limitations that are more restrictive than those described herein but benefits may be provided in excess of these amounts at the MCC's discretion. Determination of these limitations shall be based upon the MCC's payments for those services.

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

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

Emergency medical services shall be available twenty-four (24) hours per day, seven (7) days per week. Coverage of emergency medical services shall not be subject to prior authorization by the MCC but may include a requirement that notice be given to the MCC of use of out-of-plan emergency ser-

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

vices. However, such requirements shall provide at least a twenty-four (24) hour time frame after the emergency for notice to be given to the MCC.

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

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

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

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

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.

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

- (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: skin care, including cord care and genital care; temperature assessment and measurement with the thermometer; and assessment of neonatal well-being; recognition

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

of illness including jaundice; proper infant safety including use of car seat and sleeping position;

- E. Reasonable expectations for the future; and
- F. 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.

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

- (i) 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 twelve (12) hours, and discharge at or prior to twenty-four (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 twelve (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 two (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 twenty-four (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:
 - A. Maternal syphilis and hepatitis B surface antigen status.
 - B. 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 twenty-four (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.

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

- 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, color, activity, feeding or stooling;
 - V. Significant congenital malformations; and
 - VI. Abnormal laboratory finding:
 - A. Hypoglycemia,
 - B. Hyperbilirubinemia,
 - C. Polycythemia,
 - D. Anemia, and

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

E. Rapid plasma reagin positive.

- (14) Prior Authorization for Home Health Nurse, Home Health Aide, and Private Duty Nursing Services. Prior authorization by the MCO must be obtained in order to establish the medical necessity of all requested home health nurse, home health aide, and private duty nursing services.
- (a) The following information must be provided when seeking prior authorization for all home health nurse, home health aide, and private duty nursing services:
1. Name of physician prescribing the service(s);
 2. Specific information regarding the patient's medical condition and any associated disability that creates the need for the requested service(s).
 3. Specific information regarding the service(s) the nurse or aide is expected to perform including the frequency with which each service must be performed (e.g., tube feeding patient 7:00 am, 12:00 pm, and 5:00 pm daily; bathe patient once per day; administer medications three (3) times per day; catheterize patient as needed from 8:00 am to 5:00 pm Monday through Friday; change dressing on wound three (3) times per week). Such information should also include the total period of time that the services are anticipated to be medically necessary by the treating physician (e.g., total number of weeks or months).
- (b) Home health nurses and aides and private duty nurses will never be authorized to personally transport a TennCare enrollee. Home health nurses will never be authorized to accompany an enrollee outside the home. Home health aides will never be authorized to accompany an enrollee twenty-one (21) years of age or older outside the home.
- (c) Private duty nursing services are limited to services provided in the recipient's own home, with the following two exceptions:
1. A recipient age twenty-one (21) or older who requires eight (8) or more hours of skilled nursing care in a 24-hour period and is authorized to receive private duty nursing services in the home setting may make use of the approved hours outside of that setting in order for the nurse to accompany the recipient to:
 - (i) Outpatient health care services (including services delivered through a TennCare home and community based services waiver program);
 - (ii) Public or private secondary school or credit classes at an accredited vocational or technical school or institute of higher education;
 - (iii) Work at their place of employment.
 2. A recipient under the age of twenty-one (21) who requires eight (8) or more hours of continuous skilled nursing care in a 24-hour period and is authorized to receive these services in the home setting may make use of the approved hours outside of that setting when normal life activities temporarily take him or her outside of that setting. Normal life activity for a child under the age of 21 means routine work (including work in supported or sheltered work settings); licensed child care; school and school-related activities; religious services and related activities; and outpatient health care services (including services delivered through a TennCare home and community based services waiver program). Normal life activities do not include non-routine or extended home absences.

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

- (d) A private duty nurse may accompany a recipient in the circumstances outlined in (c)1. and (c)2. immediately above, but may not drive.
- (e) Private duty nursing services include services to teach and train the recipient and the recipient's family or other caregivers how to manage the treatment regimen. Having a caregiver willing to learn the tasks necessary to provide a safe environment and quality in home care is essential to assuring the recipient is properly attended to when a nurse or other paid caregiver is not present, including those times when the recipient chooses to attend community activities to which these rules do not specifically permit the private duty nurse or other paid caregiver to accompany the patient.
- (f) Nursing services (provided as part of home health services or by a private duty nurse) will be approved only if the requested service(s) is of the type that must be provided by a nurse as opposed to an aide, except that the MCO may elect to have a nurse perform home health aide services in addition to nursing services if the MCO determines that this is a less costly alternative than providing the services of both a nurse and an aide. Examples of appropriate nursing services include, but are not limited to, medication administration, catheterization, and ventilator management.
- (g) Home health aide services will only be approved if the requested service(s) meet all medical necessity requirements including the requirements of 1200-13-16-.05(4)(d). Thus, home health aide services will not be approved to provide child care services, prepare meals, perform housework, or generally supervise patients. Examples of appropriate home health aide services include, but are not limited to, patient transfers and bathing.

Authority: T.C.A. §§4-5-209, 71-5-105, 71-5-109, 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-.04; new effective date February 12, 2003. Public necessity rule filed July 1, 2005; effective through December 13, 2005. Amendments filed September 29, 2005; effective December 13, 2005. Public necessity rule filed December 29, 2005; effective through June 12, 2006. Public necessity rule filed March 13, 2006; effective through August 25, 2006. Public necessity rule filed May 3, 2006; effective through October 15, 2006. Public necessity rule filed December 29, 2005, expired June 12, 2006. On June 13, 2006, affected rules reverted to status on December 28, 2005. Amendments filed March 31, 2006; effective June 14, 2006. Amendment filed June 12, 2006; effective August 26, 2006. Amendment filed July 28, 2006; effective October 11, 2006. Public Necessity rule filed December 1, 2006; expires May 15, 2007. Public necessity rule filed February 1, 2007; expires July 16, 2007.

1200-13-14-.05 ENROLLEE COST SHARING.

- (1) Persons who are enrolled in TennCare Standard have premium obligations corresponding to their family size and income. The premium schedule is shown below:

Percentage of Poverty	0% - 99%	100% - 149%	150% - 199%	200% - 249%	250% -299%
Monthly Premium (Individual)	\$0	\$20	\$35	\$100	\$150
Monthly Premium (Family of 2 or more)	\$0	\$40	\$70	\$250	\$375

Percentage of Poverty	300% - 349%	350% - 399%	400% - 499%	500% - 599%	600% and over
Monthly Pre-	\$200	\$250	\$350	\$450	\$550

(Rule 1200-13-14-.05, continued)

mium (Individual)					
Monthly Premium (Family of 2 or more)	\$500	\$625	\$875	\$1,125	\$1,375

(2) Premium requirements.

- (a) Individuals determined eligible for TennCare and who are required to pay premiums will be sent a notice indicating the amount of the premium. Premium payments are due on the first day of each month.
- (b) Monthly premium statements are sent to enrollees with premium obligations. If the enrollee is delinquent in his payments, the monthly premium statements will so advise him.
- (c) At such time as (1) the enrollee has received at least two premium statements advising him of his arrearage AND (2) he is 60 days in arrears on his premium payments, coverage may be terminated for non-payment of premiums.
 1. Enrollees who are in arrears two months in premium payments will be sent a notice of delinquency (a “demand letter”). The notice will identify the specific payments, including month and amount, that are past due. The demand letter will serve as notice to the individual that he will be terminated from TennCare Standard unless he pays the amount due within 30 days. The enrollee has the right to appeal that he is in fact current with his payments or that the premium amounts being charged are not the premium amounts he has been assigned.
 2. If at least partial payment is received by the Bureau of TennCare within 30 days after the date of the demand letter, the enrollee will no longer be 60 days in arrears, and coverage will continue without interruption. “Partial payment” will be payment sufficient to make the enrollee no longer 60 days in arrears. However, remaining past due amounts will continue to accrue. If the enrollee is again 60 days in arrears when the next cycle of demand letters is processed, the enrollee will again receive a demand letter and may subsequently be terminated in accordance with these rules.
 3. If an enrollee files an appeal in response to his demand letter by the 30th day following the date of the notice, coverage will not be terminated on the 30th day, pending resolution of the appeal. The premium appeal will be processed by DHS in accordance with its rules at 1240-5.
 4. If the enrollee does not pay at least a partial payment or file an appeal by the 30th day following the demand letter, his TennCare Standard coverage will be terminated. A termination notice will be sent with due process appeal rights. The date of termination is the date of the termination notice. An enrollee may appeal his notice of termination, but he is not entitled to continuation of benefits during the appeal. If the appeal is decided in his favor, he will be reinstated retroactively to the date of termination.

(3) There are no deductibles or out-of-pocket maximums in TennCare Standard.

(4) Copayments.

- (a) TennCare Standard enrollees whose income is equal to or greater than 100% of poverty shall pay copayments for services other than preventive services. Preventive services are identified in Rule 1200-13-14-.04(2).

(Rule 1200-13-14-.05, continued)

(b) Copayment amounts are as shown below:

Benefit	Copayment if income is 0%-99% of poverty	Copayment if income is 100%-199% of poverty	Copayment if income is 200% of poverty or above
Hospital emergency room use for non-emergency services	\$0	\$25 (waived if admitted)	\$50 (waived if admitted)
Primary care provider services other than preventive care	\$0	\$5	\$10
Community Mental Health Agency services other than preventive care	\$0	\$5	\$10
Physician specialists	\$0	\$15	\$25
Prescription or refill (see (f) below)	\$0	\$3 for covered branded prescription; \$0 for covered generics	\$3 for covered branded prescription; \$0 for covered generics
Inpatient hospital admission	\$0	\$100	\$200

- (c) Managed care contractors participating in the TennCare program shall be specifically prohibited from waiving, or discouraging TennCare enrollees from paying, the amounts described in this paragraph.
- (d) Providers may not refuse to deliver a covered service to an enrollee because of the enrollee's failure or inability to make his copay.
- (e) Enrollees who receive financial settlements, awards or judgments shall have their income levels adjusted retroactively to the date of the incident resulting in the settlement or other payment, and may be assessed additional cost sharing obligations commensurate with their adjusted income level retroactive to that date.
- (f) Pharmacy and psychiatric pharmacy copayments.
 1. All TennCare Standard enrollees with incomes at or above poverty who receive pharmacy services have nominal copayments for the services. The copays are \$3.00 for each covered branded drug and \$0 for each covered generic drug. Drugs which exceed the limit of five (5) prescriptions or refills per month per enrollee are not covered unless they are on the Automatic Exception List. Family planning drugs and emergency services are exempt from copay.
 2. The following groups (adults and children) are exempt from pharmacy copays:
 - (i) Individuals receiving hospice services who provide verbal or written notification of such to the pharmacy provider at the point of service;
 - (ii) Individuals who are pregnant who provide verbal or written notification of such to the pharmacy provider at the point of service; and

(Rule 1200-13-14-.05, continued)

- (iii) Individuals who are receiving services in a Nursing Facility, an Intermediate Care Facility for the Mentally Retarded, or a Home and Community Based Services waiver.
3. The seventy-two (72) hour emergency supply of a medication in an emergency situation, as described in rule 1200-13-14-.11, shall not be subject to the pharmacy copayment requirement.

Authority: T.C.A. 4-5-209, 71-5-105, 71-5-109, 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-.05; new effective date February 12, 2003. Public necessity rules filed June 3, 2005; effective through November 15, 2005. Public necessity rule filed July 1, 2005; effective through December 13, 2005. Amendments filed September 1, 2005; effective November 15, 2005. Amendments filed September 26, 2005; effective December 10, 2005. Public necessity rule filed December 29, 2005; effective through June 12, 2006. Public necessity rule filed December 29, 2005, expired June 12, 2006. On June 13, 2006, affected rules reverted to status on December 28, 2005. Amendment filed March 31, 2006; effective June 14, 2006. Public necessity rule filed March 21, 2007; effective through September 2, 2007.

1200-13-14-.06 MANAGED CARE ORGANIZATIONS.

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

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

1200-13-14-.07 MANAGED CARE ORGANIZATION PAYMENT.

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

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

1200-13-14-.08 PROVIDERS.

- (1) Payment in full.
 - (a) All MCC participating network providers must accept as payment in full for provision of covered services to TennCare enrollees, the amounts paid by the MCC plus any deductible or copayment required by the TennCare Program to be paid by the individual.

(Rule 1200-13-14-.08, continued)

- (b) Any non-participating providers who provide TennCare Program covered services by authorization from an MCC must accept as payment in full for provision of covered services to TennCare enrollees, the amounts paid by the MCC plus any deductible or copayment required by the TennCare Program to be paid by the individual.
- (2) In situations where a MCC authorizes a service to be rendered by a provider who is not a participating network provider with the MCC, payment to the provider shall be no less than eighty percent (80%) of the lowest rate paid by the MCC to equivalent participating network providers for the same service. For emergency services provided to an enrollee by a provider who is not a participating network provider, the MCC shall reimburse the provider at the rate of 100% of the lowest rate paid to the MCC's network providers. Emergency care to enrollees shall not require preauthorization.
- (3) Participation in the TennCare program will be limited to providers who:
- (a) Accept, as payment in full, the amounts paid by the managed care contractor, including copays from the enrollee, or the amounts paid in lieu of the managed care contractor by a third party (Medicare, insurance, etc.);
 - (b) Maintain Tennessee, or the State in which s/he practices, medical licenses and/or certifications as required by his/her practice, or licensure by the TDMHDD, if appropriate;
 - (c) Are not under a federal Drug Enforcement Agency (DEA) restriction of his/her prescribing and/or dispensing certification for scheduled drugs (relative to physicians, osteopaths, dentists and pharmacists);
 - (d) Agree to maintain and provide access to TennCare and/or its agent all TennCare enrollee medical records for five (5) years from the date of service or upon written authorization from TennCare following an audit, whichever is shorter;
 - (e) Provide medical assistance at or above recognized standards of practice; and
 - (f) Comply with all contractual terms between the provider and the managed care contractor and TennCare policies as outlined in federal and state rules and regulations and TennCare provider manuals and bulletins.
 - (g) Failure to comply with any of the above provisions (a) through (f) may subject a provider to the following actions:
 - 1. Sanctions set out in T.C.A. §71-5-118. In addition, the provider may be subject to stringent review/audit procedures, which may include clinical evaluation of services and a prepayment requirement for documentation and justification for each claim.
 - 2. The Bureau of TennCare may withhold or recover payments to managed care contractors in cases of provider fraud, willful misrepresentation, or flagrant non-compliance with contractual requirements and/or TennCare policies.
 - 3. The Bureau of TennCare may refuse to approve or may suspend provider participation with a provider if any person who has an ownership or controlling interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the US Title XX Services Program.
 - 4. The Bureau of TennCare may refuse to approve or may suspend provider participation if it determines that the provider did not fully and accurately make any disclosure of any person who has ownership or controlling interest in the provider, or is an agent or man-

(Rule 1200-13-14-.08, continued)

aging employee of the provider and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the US Title XX Services Program since the inception of these programs.

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

(Rule 1200-13-14-.08, continued)

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

(Rule 1200-13-14-.08, continued)

Services which are non-covered by virtue of exceeding limitations are exempt from this requirement. Notwithstanding this exemption, providers shall remain obligated to provide notice to enrollees who have exceeded benefit limits in accordance with rule 1200-13-14-.11.

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

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-.08; new effective date February 12, 2003. Amendment filed October 12, 2004; effective December 26, 2004. Public necessity rule filed July 29, 2005; effective through January 10, 2006. Public necessity rule filed December 29, 2005; effective through June 12, 2006. Amendment filed October 27, 2005; effective January 10, 2006. Public necessity rule filed December 29, 2005, expired June 12, 2006. On June 13, 2006, affected rules reverted to status on December 28, 2005. Amendment filed March 31, 2006; effective June 14, 2006.

1200-13-14-.09 THIRD PARTY RESOURCES.

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

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

1200-13-14-.10 EXCLUSIONS.

- (1) General exclusions. The following items and services shall not be considered covered services by TennCare:
 - (a) Provision of medical assistance which is outside the scope of benefits as defined in these rules.
 - (b) Provision of services to persons who are not enrolled in TennCare, either on the date the services are delivered or retroactively to the date the services are delivered, except for limited special appeal provisions pertaining to children who are placed in Youth Development Centers as defined in the Grier Revised Consent Decree, Section C.15.f. and pursuant to the DCS Interagency Agreement.
 - (c) Services for which there is no Federal Financial Participation (FFP).
 - (d) Services provided outside the United States or its territories.
 - (e) Services provided outside the geographic borders of Tennessee, including transportation to return to Tennessee to receive medical care except in the following circumstances:
 1. Emergency medical services are needed because of an emergency medical condition;
 2. Non-emergency urgent care services are requested because the recipient's health would be endangered if he were required to travel, but only upon the explicit prior authorization of the MCC;

(Rule 120-13-14-.10, continued)

3. The covered medical service would not be readily available within Tennessee if the enrollee was physically located in Tennessee at the time of need and the covered service is explicitly prior authorized by the enrollee's TennCare MCC; or
 4. The out-of-state provider is participating in the enrollee's MCC network.
- (f) Investigative or experimental services or procedures including, but not limited to:
1. Drug or device that lacks FDA approval except when medically necessary as defined by TennCare;
 2. Drug or device that lacks approval of facility's Institutional Review Board;
 3. Requested treatment that is the subject of Phase I or Phase II clinical trials or the investigational arm of Phase III clinical trials; or
 4. A requested service about which prevailing opinion among experts is that further study is required to determine safety, efficacy, or long-term clinical outcomes of requested service.
- (g) Services which are delivered in connection with, or required by, an item or service not covered by TennCare, including the transportation to receive such non-covered services, except that treatment of conditions resulting from the provision of non-covered services may be covered if medically necessary, notwithstanding the exclusions set out herein.
- (h) Items or services furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury.
- (i) Non-emergency services that are ordered or furnished by an out-of-network provider and that have not been approved by the enrollee's MCC for out-of-network care.
- (j) Services that are free to the public, with the exception of services delivered in the schools pursuant to the Individuals with Disabilities in Education Act (IDEA).
- (k) Items or services ordered, prescribed, administered, supplied, or provided by an individual or entity that has been excluded from participation in the Medicaid program under the authority of the United States Department of Health and Human Services or the Bureau of TennCare.
- (l) Items or services ordered, prescribed, administered, supplied, or provided by an individual or entity that is not licensed by the appropriate licensing board.
- (m) Items or services outside the scope and/or authority of a provider's specialty and/or area of practice.
- (n) Items or services to the extent that Medicare or a third party payer is legally responsible to pay or would have been legally responsible to pay except for the enrollee's or the treating provider's failure to comply with the requirements for coverage of such services.
- (o) Medical services for inmates confined in a local, state, or federal prison, jail, or other penal or correctional facility, including a furlough from such facility.
- (2) Exception to General and Specific Exclusions: COST EFFECTIVE ALTERNATIVE. As approved by CMS and/or authorized by TSOP 032, each MCC has sole discretionary authority to provide certain cost effective alternatives when providing appropriate medically necessary care. These services are

(Rule 120-13-14-.10, continued)

otherwise excluded and are not covered services unless the MCC has followed the procedures set forth in TSOP 032 and opts at its sole discretion to provide such requested item or service.

(3) Specific exclusions. The following services, products, and supplies are specifically excluded from coverage under the TennCare Section 1115(a) waiver program unless excepted by paragraph (2) herein. Some of these services may be covered outside TennCare under a Home and Community Based Services waiver when provided as part of an approved plan of care, in accordance with the appropriate TennCare Home and Community Based Services rule.

(a) Services, products, and supplies that are specifically excluded from coverage except as medically necessary for children under the age of 21

1. Air cleaners, purifiers, or HEPA filters

2. Audiological therapy or training

3. Augmentative communication devices

4. Beds and bedding equipment as follows:

(i) Powered air flotation beds, air fluidized beds (including Clinitron beds), water pressure mattress, or gel mattress

For persons age 21 and older: Not covered unless a member has both severely impaired mobility (i.e., unable to make independent changes in body position to alleviate pain or pressure) and any stage pressure ulcer on the trunk or pelvis combined with at least one of the following: impaired nutritional status, fecal or urinary incontinence, altered sensory perception, or compromised circulatory status.

(ii) Bead beds, or similar devices

(iii) Bed boards

(iv) Bedding and bed casings

(v) Ortho-prone beds

(vi) Oscillating beds

(vii) Pillows, hypoallergenic

(viii) Springbase beds

(ix) Vail beds, or similar bed

5. Bed baths and Sitz baths

6. Chiropractor's services

7. Cushions, pads, and mattresses as follows:

(i) Aquamatic K Pads

(Rule 120-13-14-.10, continued)

- (ii) Elbow protectors
 - (iii) Heat and massage foam cushion pads
 - (iv) Heating pads
 - (v) Heel protectors
 - (vi) Lamb's wool pads
 - (vii) Steam packs
9. Diagnostic tests conducted solely for the purpose of evaluating the need for a service which is excluded from coverage under these rules.
10. Ear plugs
11. Floor standers
12. Food supplements and substitutes including formulas
- For persons 21 years of age and older: Not covered, except that Parenteral Nutrition formulas, Enteral Nutrition formulas for tube feedings and phenylalanine-free formulas (not foods) used to treat PKU, as required by TCA 56-7-2505, are covered for adults. In addition, oral liquid nutrition may be covered when medically necessary for adults with swallowing or breathing disorders who are severely underweight ($BMI < 15 \text{ kg/m}^2$) and physically incapable of otherwise consuming a sufficient intake of food to meet basic nutritional requirements.
13. Hearing aids, including the prescribing, fitting, or changing of hearing aids
14. Humidifiers (central or room) and dehumidifiers
15. Inpatient rehabilitation facility services
16. Medical supplies, over-the-counter, as follows:
- (i) Alcohol, rubbing
 - (ii) Band-aids
 - (iii) Cotton balls
 - (iv) Eyewash
 - (v) Peroxide
 - (vi) Q-tips or cotton swabs
17. Methadone clinic services
18. Nutritional supplements and vitamins, over-the-counter, except that prenatal vitamins for pregnant women and folic acid for women of childbearing age are covered

(Rule 120-13-14-.10, continued)

19. Orthodontic services, except as defined in Rule 1200-13-13-.04(1)(b)6. or 1200-13-14-.04(1)(b)6.
20. Certain pharmacy items as follows:
 - (i) Agents when used for anorexia or weight loss
 - (ii) Agents when used to promote fertility
 - (iii) Agents when used for cosmetic purposes or hair growth
 - (iv) Agents when used for the symptomatic relief of cough and colds
 - (v) Agents when use to promote smoking cessation
 - (vi) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee
 - (vii) Nonprescription drugs
 - (viii) Barbiturates
 - (ix) Benzodiazepines
21. Purchase, repair, or replacement of materials or equipment when the reason for the purchase, repair, or replacement is the result of enrollee abuse
22. Purchase, repair, or replacement of materials or equipment that has been stolen or destroyed except when the following documentation is provided:
 - (i) Explanation of continuing medical necessity for the item, and
 - (ii) Explanation that the item was stolen or destroyed, and
 - (iii) Copy of police, fire department, or insurance report if applicable
23. Radial keratotomy
24. Reimbursement to a provider or enrollee for the replacement of a rented durable medical equipment (DME) item that is stolen or destroyed
25. Repair of DME items not covered by TennCare
26. Repair of DME items covered under the provider's or manufacturer's warranty
27. Repair of a rented DME item
28. Speech, language, and hearing services to address speech problems caused by mental, psychoneurotic, or personality disorders
29. Standing tables

(Rule 120-13-14-.10, continued)

30. Vision services for persons 21 years of age and older that are not needed to treat a systemic disease process including, but not limited to:
 - (i) Eyeglasses, sunglasses, and/or contact lenses for persons aged 21 and older, including eye examinations for the purpose of prescribing, fitting, or changing eyeglasses, sunglasses, and/or contact lenses; procedures performed to determine the refractive state of the eye(s); one pair of cataract glasses or lenses is covered for adults following cataract surgery
 - (ii) LASIK
 - (iii) Orthoptics
 - (iv) Vision perception training
 - (v) Vision therapy
- (b) Services, products, and supplies that are specifically excluded from coverage under the TennCare program.
 1. Alcoholic beverages
 2. Animal therapy including, but not limited to:
 - (i) Dolphin therapy
 - (ii) Equine therapy
 - (iii) Hippo therapy
 - (iv) Pet therapy
 3. Art therapy
 4. Autopsy
 5. Bathtub equipment and supplies as follows:
 - (i) Paraffin baths
 - (ii) Sauna baths
 6. Beds and bedding equipment as follows:
 - (i) Adjust-a-Beds, lounge beds, or similar devices
 - (ii) Waterbeds
 7. Bioenergetic therapy
 8. Biofeedback
 9. Body adornment and enhancement services including, but not limited to:

(Rule 120-13-14-.10, continued)

- (i) Body piercing
 - (ii) Breast augmentation
 - (iii) Breast capsulectomy
 - (iv) Breast implant removal
 - (v) Ear piercing
 - (vi) Hair transplantation, and agents for hair growth
 - (vii) Tattoos or removal of tattoos
 - (viii) Tongue splitting or repair of tongue splitting
 - (ix) Wigs or hairpieces
10. Breathing equipment as follows:
- (i) Intrapulmonary Percussive Ventilators (IPVs)
 - (ii) Spirometers, except for peak flow meters for medical management of asthma
 - (iii) Vaporizers
11. Carbon dioxide therapy
12. Care facilities or services, the primary purpose of which is non-medical, including, but not limited to:
- (i) Day care
 - (ii) Evening care centers
 - (iii) Respite care, with the exception of crisis respite offered as a component of mental health crisis services
 - (iv) Rest cures
 - (v) Social or diversion services related to the judicial system
13. Carotid body tumor, excision of, as treatment for asthma
14. Chelation therapy, except for the treatment of heavy metal poisoning or secondary hemochromatosis in selected settings. Chelation therapy for treatment of arteriosclerosis or autism is not covered. Chelation therapy for asymptomatic individuals is not covered. In the case of lead poisoning, the lead levels must be extremely high. For children, a minimum level of 45 ug/dl is recommended. Because chelation therapy and its after-effects must be continuously monitored for possible adverse reactions, chelation therapy is covered only in inpatient or outpatient hospital settings, renal dialysis facilities, and skilled nursing facilities. It is not covered in an office setting, an ambulatory surgical center, or a home setting.

(Rule 120-13-14-.10, continued)

15. Clothing, including adaptive clothing
16. Cold therapy devices
17. Comfort and convenience items including, but not limited to:
 - (i) Corn plasters
 - (ii) Garter belts
 - (iii) Incontinence products (diapers/liners/underpads) for persons younger than 3 years of age
 - (iv) Support stockings, when light or medium weight or prescribed for relief of tired or aching legs or treatment of spider/varicose veins. Surgical weight stockings prescribed by a doctor or other qualified licensed health care practitioner for the treatment of chronic foot/ankle swelling, venous insufficiencies, or other medical conditions and thrombo-embolic deterrent support stockings for pre- and post-surgical procedures are covered as medically necessary.
18. Computers, personal, and peripherals including, but not limited to printers, modems, monitors, scanners, and software, including their use in conjunction with an Augmentative Communication Device
19. Convalescent care.
20. Cosmetic dentistry, cosmetic oral surgery, and cosmetic orthodontic services
21. Cosmetic prosthetic devices
22. Cosmetic surgery or surgical procedures primarily for the purpose of changing the appearance of any part of the body to improve appearance or self-esteem, including scar revision. The following services are not considered cosmetic services:
 - (i) Reconstructive surgery to correct the results of an injury or disease
 - (ii) Surgery to treat congenital defects (such as cleft lip and cleft palate) to restore normal bodily function
 - (iii) Surgery to reconstruct a breast after mastectomy that was done to treat a disease, or as a continuation of a staged reconstructive procedure
 - (iv) In accordance with Tennessee law, surgery of the non-diseased breast following mastectomy and reconstruction to create symmetrical appearance
 - (v) Surgery for the improvement of the functioning of a malformed body member
 - (vi) Reduction mammoplasty, when the minimum amount of breast material to be removed is equal to or greater than the 22nd percentile of the Schnur Sliding Scale based on the individual's body surface area.
23. Dance therapy
24. Dental services for adults age 21 and older

(Rule 120-13-14-.10, continued)

25. Services provided solely or primarily for educational purposes, including, but not limited to:
 - (i) Academic performance testing
 - (ii) Educational tests and training programs
 - (iii) Habilitation
 - (iv) Job training
 - (v) Lamaze classes
 - (vi) Lovaas therapy
 - (vii) Picture illustrations
 - (viii) Remedial education
 - (ix) Sign language instruction
 - (x) Special education
 - (xi) Tutors
26. Encounter groups or workshops
27. Environmental modifications including, but not limited to:
 - (i) Air conditioners, central or unit
 - (ii) Micronaire environmentals, and similar devices
 - (iii) Pollen extractors
 - (iv) Portable room heaters
 - (v) Vacuum systems for dust filtering
 - (vi) Water purifiers
 - (vii) Water softeners
28. Exercise equipment including, but not limited to:
 - (i) Exercise equipment
 - (ii) Exercycles (including cardiac use)
 - (iii) Functional electrical stimulation
 - (iv) Gravitronic traction devices
 - (v) Gravity guidance inversion boots

(Rule 120-13-14-.10, continued)

- (vi) Parallel bars
 - (vii) Pulse tachometers
 - (viii) Tilt tables
 - (ix) Training balls
 - (x) Treadmill exercisers
 - (xi) Weighted quad boots
29. Food and food products (distinct from food supplements or substitutes, as defined in rule 1200-13-14-.10(3)(a)12. including but not limited to specialty food items for use in diets such as:
- (i) Low-phenylalanine or phenylalanine-free
 - (ii) Gluten-free
 - (iii) Casein-free
 - (iv) Ketogenic
30. Grooming services including, but not limited to:
- (i) Barber services
 - (ii) Beauty services
 - (iii) Electrolysis
 - (iv) Hairpieces or wigs
 - (v) Manicures
 - (vi) Pedicures
31. Hair analysis
32. Home modifications and items for use in the home
- (i) Decks
 - (ii) Enlarged doorways
 - (iii) Environmental accessibility modifications such as grab bars and ramps
 - (iv) Fences
 - (v) Furniture, indoor or outdoor
 - (vi) Handrails

(Rule 120-13-14-.10, continued)

- (vii) Meals
 - (viii) Overbed tables
 - (ix) Patios, sidewalks, driveways, and concrete slabs
 - (x) Plexiglass
 - (xi) Plumbing repairs
 - (xii) Porch gliders
 - (xiii) Rollabout chairs
 - (xiv) Room additions and room expansions
 - (xv) Telephone alert systems
 - (xvi) Telephone arms
 - (xvii) Telephone service in home
 - (xviii) Televisions
 - (xix) Tilt tables
 - (xx) Toilet trainers and potty chairs. Positioning commodes and toilet supports are covered as medically necessary.
 - (xxi) Utilities (gas, electric, water, etc.)
33. Homemaker services
34. Hospital inpatient items that are not directly related to the treatment of an injury or illness (such as radios, TVs, movies, telephones, massage, guest beds, haircuts, hair styling, guest trays, etc.)
35. Hotel charges, unless pre-approved in conjunction with a transplant or as part of a non-emergency transportation service
36. Hypnosis or hypnotherapy
37. Icterus index
38. Infant/child car seats, except that adaptive car seats may be covered for a person with disabilities such as severe cerebral palsy, spina bifida, muscular dystrophy, and similar disorders who meets all of the following conditions:
- (i) Cannot sit upright unassisted, and
 - (ii) Infant/child care seats are too small or do not provide adequate support, and
 - (iii) Safe automobile transport is not otherwise possible.

(Rule 120-13-14-.10, continued)

39. Infertility or impotence services including, but not limited to:
 - (i) Artificial insemination services
 - (ii) Purchase of donor sperm and any charges for the storage of sperm
 - (iii) Purchase of donor eggs, and any charges associated with care of the donor required for donor egg retrievals or transfers of gestational carriers
 - (iv) Cryopreservation and storage of cryopreserved embryos
 - (v) Services associated with a gestational carrier program (surrogate parenting) for the recipient or the gestational carrier
 - (vi) Fertility drugs
 - (vii) Home ovulation prediction kits
 - (viii) Services for couples in which one of the partners has had a previous sterilization procedure, with or without reversal
 - (ix) Reversal of sterilization procedures
 - (x) Any other service or procedure intended to create a pregnancy
 - (xi) Testing and/or treatment, including therapy, supplies, and counseling, for frigidity or impotence
40. Lamps such as:
 - (i) Heating lamps
 - (ii) Lava lamps
 - (iii) Sunlamps
 - (iv) Ultraviolet lamps
41. Lifts as follows:
 - (i) Automobile van lifts
 - (ii) Electric powered recliner, elevating seats, and lift chairs
 - (iii) Elevators
 - (iv) Overhead or ceiling lifts, ceiling track system lifts, or wall mounted lifts when installation would require significant structural modification and/or renovation to the dwelling (e.g., moving walls, enlarging passageways, strengthening ceilings and supports). The request for prior authorization must include a specific breakdown of equipment and installation costs, specifying all required structural modifications (however minor) and the cost associated thereto.

(Rule 120-13-14-.10, continued)

- (v) Stairway lifts, stair glides, and platform lifts, including but not limited to Wheel-O-Vators
42. Ligation of mammary arteries, unilateral or bilateral
 43. Megavitamin therapy
 44. Motor vehicle parts and services including, but not limited to:
 - (i) Automobile controls
 - (ii) Automobile repairs or modifications
 45. Music therapy
 46. Nail analysis
 47. Naturopathic services
 48. Necropsy
 49. Nerve stimulators, except for vagus nerve stimulators after conventional therapy has failed in treating partial onset of seizures
 50. Organ and tissue transplants that have been determined experimental or investigational
 51. Organ and tissue donor services provided in connection with organ or tissue transplants covered pursuant to Rule 1200-13-14-.04(1)(b)23., including, but not limited to:
 - (i) Transplants from a donor who is a living TennCare enrollee and the transplant is to a non-TennCare enrollee
 - (ii) Donor services other than the direct services related to organ procurement (such as, hospitalization, physician services, anesthesia)
 - (iii) Hotels, meals, or similar items provided outside the hospital setting for the donor
 - (iv) Any costs incurred by the next of kin of the donor
 - (v) Any services provided outside of any “bundled rates” after the donor is discharged from the hospital
 52. Oxygen, except when provided under the order of a physician and administered under the direction of a physician
 53. Oxygen, preset system (flow rate not adjustable)
 54. Certain pharmacy items as follows: DESI, LTE, and IRS drugs
 55. Play therapy
 56. Primal therapy
 57. Psychodrama

(Rule 120-13-14-.10, continued)

58. Psychogenic sexual dysfunction or transformation services
59. Purging
60. Recertification of patients in Level 1 and Level II Nursing Facilities
61. Recreational therapy
62. Religious counseling
63. Retreats for mental disorders
64. Rolfing
65. Routine health services which may be required by an employer; or by a facility where an individual lives, goes to school, or works; or by the enrollee's intent to travel
 - (i) Drug screenings
 - (ii) Employment and pre-employment physicals
 - (iii) Fitness to duty examinations
 - (iv) Immunizations related to travel or work
 - (v) Insurance physicals
 - (vi) Job related illness or injury covered by workers' compensation
66. Sensitivity training or workshops
67. Sensory integration therapy and equipment used in sensory integration therapy including, but not limited to:
 - (i) Ankle weights
 - (ii) Floor mats
 - (iii) Mini-trampolines
 - (iv) Poof chairs
 - (v) Sensory balls
 - (vi) Sky chairs
 - (vii) Suspension swings
 - (viii) Trampolines
 - (ix) Therapy balls
 - (x) Weighted blankets or weighted vests

(Rule 120-13-14-.10, continued)

68. Sensory stimulation services
69. Services provided by immediate relatives, i.e., a spouse, parent, grandparent, stepparent, child, grandchild, brother, sister, half brother, half sister, a spouse's parents or stepparents, or members of the recipient's household
70. Sex change or transformation surgery
71. Sexual dysfunction or inadequacy services and medicine, including drugs for erectile dysfunctions and penile implant devices
72. Sitter services.
73. Speech devices as follows:
 - (i) Phone mirror handivoice
 - (ii) Speech software
 - (iii) Speech teaching machines
74. Sphygmomanometers (blood pressure cuffs)
75. Stethoscopes
76. Supports
 - (i) Cervical pillows
 - (ii) Orthotrac pneumatic vests
77. Thermograms
78. Thermography
79. Time involved in completing necessary forms, claims, or reports
80. Tinnitus maskers
81. Toy equipment such as:

Flash switches (for toys)
82. Transportation costs as follows:
 - (i) Transportation to a provider who is outside the geographical access standards that the MCC is required to meet when a network provider is available within such geographical access standards or, in the case of Medicare beneficiaries, transportation to Medicare providers who are outside the geographical access standards of the TennCare program when there are Medicare providers available within those standards

(Rule 120-13-14-.10, continued)

- (ii) Mileage reimbursement, car rental fees, or other reimbursement for use of a private vehicle unless prior authorized by the MCC in lieu of contracted transportation services
 - (iii) Transportation back to Tennessee from vacation or other travel out-of-state in order to access non-emergency covered services (unless authorized by the MCC)
- 83. Transsexual surgery
- 84. Weight loss or weight gain and physical fitness programs including, but not limited to:
 - (i) Dietary programs of weight loss programs, including, but not limited to, Optifast, Nutrisystem, and other similar programs or exercise programs. Food supplements will not be authorized for use in weight loss programs or for weight gain.
 - (ii) Health clubs, membership fees (e.g., YMCA)
 - (iii) Marathons, activity and entry fees
 - (iv) Swimming pools
- 85. Wheelchairs as follows:
 - (i) Wheelchairs defined by CMS as power operated vehicles (POVs), namely, scooters and devices with three (3) or four (4) wheels that have tiller steering and limited seat modification capabilities (i.e., provide little or no back support). Powered wheelchairs, meaning four (4) wheeled, battery operated vehicles that provide back support and that are steered by an electronic device or joystick that controls direction and turning, are covered as medically necessary.
 - (ii) Standing wheelchairs
 - (iii) Stair-climbing wheelchairs
 - (iv) Recreational wheelchairs
- 86. Whirlpools and whirlpool equipment such as:
 - (i) Action bath hydro massage
 - (ii) Aero massage
 - (iii) Aqua whirl
 - (iv) Aquasage pump, or similar devices
 - (v) Hand-D-Jets, or similar devices
 - (vi) Jacuzzis, or similar devices
 - (vii) Turbojets
 - (viii) Whirlpool bath equipment

(Rule 120-13-14-.10, continued)

(ix) Whirlpool pumps

Authority: T.C.A. §§4-5-202, 4-5-209, 71-5-105, 71-5-109, and Executive Order No. 23. **Administrative History:** Original rule filed September 30, 2002; to be effective December 14, 2002; however, on December 9, 2002, the House Government Operations Committee of the General Assembly stayed rule 1200-13-14-.10; new effective date February 12, 2003. Repeal and new rule filed October 27, 2005; effective January 10, 2006. Public necessity rule filed May 3, 2006; effective through October 15, 2006. Amendment filed July 28, 2006; effective October 11, 2006. Public necessity rule filed February 1, 2007; expires July 16, 2007.

1200-13-14-.11 APPEAL OF ADVERSE ACTIONS AFFECTING TennCare SERVICES OR BENEFITS.

(1) Notice Requirements.

(a) When Written Notice is Required.

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

(Rule 1200-13-14-.11, continued)

The enrollee's MCC shall be promptly notified of a provider's proposal to reduce, terminate or suspend one of the above services and of the recommended discharge plan, if any, to insure compliance with this rule.

5. Appropriate notice shall be given to an enrollee by the State or MCC when a claim for service or reimbursement is denied because an enrollee has exceeded a benefit limit. Such notice shall not be subject to the requirements of rule 1200-13-14-.11(1)(c)1. During the applicable time period for each benefit limit, such notice shall only be provided the first time a claim is denied because an enrollee has exceeded a benefit limit. The State or MCC will not be required to provide any notice when an enrollee is approaching or reaches a benefit limit.
6. Appropriate notice shall be given to an enrollee by a provider when an enrollee exceeds a non-pharmacy benefit limit in the following circumstances:
 - (i) The provider denies the request for a non-pharmacy service because an enrollee has exceeded the applicable benefit limit; or
 - (ii) The provider informs an enrollee that the non-pharmacy service will not be covered by TennCare because he/she has exceeded the applicable benefit limit and the enrollee chooses not to receive the service.
 - (iii) Pursuant to approved 1115 waiver authority, applicable non-pharmacy services for which a provider may deny a claim for service because a benefit limit has been reached include Inpatient and Outpatient Substance Abuse Benefits (including detoxification days) for adults age 21 and older as set out at rule 1200-13-14-.04.

During the applicable time period for each non-pharmacy benefit limit, providers shall only be required to issue this notice the first time an enrollee does not receive a non-pharmacy service from the provider because he/she has exceeded the applicable benefit limit. Such notice shall not be subject to the requirements of rule 1200-13-14-.11(1)(c)1. Providers will not be required to issue any notice when an enrollee is approaching or reaches a non-pharmacy benefit limit.

(b) Timing of Written Notice.

1. Written notice of MCC-initiated reduction, termination or suspension of medical assistance must be provided to an enrollee within the time frames required by 42 C.F.R. §§ 431.210 - .214 (usually ten (10) days in advance). However, in instances of MCC-initiated reduction, termination or suspension of inpatient hospital treatment, the notice must be provided to an enrollee at least two business days in advance of the proposed action. Where applicable and not in conflict with this rule, the exceptions set out at 42 C.F.R. § 431.211 - .214 permit or require reduction of the time frames within which advance notice must be provided.
2. An MCC must notify an enrollee of its decision in response to a request by or on behalf of an enrollee for medical or related services within fourteen (14) days of the request for prior authorization, or as expeditiously as the enrollee's health condition requires. If the request for prior authorization is denied, the MCC shall provide a written notice to the enrollee.

(Rule 1200-13-14-.11, continued)

3. Written notice of delay of covered medical assistance must be provided to an enrollee immediately upon an MCC's receipt of information leading it to expect that such delay will occur.
 4. Where required by paragraph (1)(a)4. of this rule, written notice of provider-initiated reduction, termination or suspension of services must be provided to an enrollee at least two (2) business days in advance of the proposed action.
 5. Written notice is deemed to be provided to an enrollee upon deposit with the US Postal Service or other commercial mail carrier, or upon hand-delivery to an enrollee or his/her representative.
- (c) Notice Contents.
1. Whenever this rule requires that a TennCare enrollee receive written notice of an adverse action affecting medical assistance, the notice must contain the following elements, written in concise, readable terms:
 - (i) The type and amount of TennCare services at issue and the identity of the individual, if any, who prescribed the services, so long as such information is applicable and has been provided to the MCC.
 - (ii) A statement of reasons for the proposed action. The statement of reasons shall include the specific facts, personal to the enrollee, which support the proposed action and sources from which such facts are derived. If the proposed action turns on a determination of medical necessity or other clinical decision regarding a medical item or service that has been recommended by the treating physician, the statement of reasons shall:
 - (I) Identify by name those clinicians who were consulted in reaching the decision at issue;
 - (II) Identify specifically those medical records upon which those clinicians relied in reaching his/her decision; and
 - (III) Specify what part(s) of the criteria for medical necessity or coverage was not met; and
 - (IV) Include a statement of reasons for the weight given to the treating provider. Such criteria may be satisfied by:
 - I. Citing an MCC policy that:
 - A. Lists the UM approval criteria for the requested service; and
 - B. Includes references to the evidence on which the policy is based; and
 - II. Explaining how the enrollee can obtain a copy of the policy; and
 - III. Explaining why the service was denied in light of the enrollee's individual circumstances (i.e., how the treating physician's recommendation deviated significantly from the MCC's evidence-based criteria).

(Rule 1200-13-14-.11, continued)

- (iii) Reference to the legal or policy basis for a proposed adverse action, including a plain and concise statement of, and official citation to, the applicable law, federal waiver provision, or TennCare contract provision relied upon.
 - (iv) To the extent that the initial notice of adverse action is issued prior to the member's filing a medical appeal, inform the enrollee about the opportunity to contest the decision, including the right to an expedited appeal in the case of time-sensitive care and the right to continuation or reinstatement of benefits pending appeal, when applicable.
 - (v) If the enrollee has an ongoing illness or condition requiring medical care and the MCC or its network provider is under a duty to provide a discharge plan or otherwise arrange for the continuation of treatment following the proposed adverse action, the notice must include a readable explanation of the discharge plan, if any, and a description of the specific arrangements in place to provide for the enrollee's continuing care.
2. Remedying of Notice. If a notice of adverse action provided to an enrollee does not meet the notice content requirements of rule 1200-13-14-.11(1)(c)1., TennCare will not automatically resolve the appeal in favor of the enrollee. TennCare or the MCC may cure any such deficiencies by providing one corrected notice to enrollees prior to issuance of the notice of hearing. If a corrected notice is provided to an enrollee, the reviewing authority shall consider only the factual reasons and legal authorities cited in the corrected notice, except that additional evidence beneficial to the enrollee may be considered on appeal.
3. If a determination that a notice of adverse action fails to satisfy notice content requirements of rule 1200-13-14-.11(1)(c)1. is made after issuance of the notice of hearing or after a corrected notice has already been provided to an enrollee, unless the service at issue is non-covered or medically contraindicated, TennCare will automatically resolve the appeal in favor of the enrollee, subject to the MCC's right to take subsequent adverse action following the issuance of a new notice of action.
- (d) Special Provisions Pertaining to Pharmacy Notice.

If an enrollee does not receive medication of the type and amount prescribed because the pharmacy services are not covered by TennCare, the enrollee shall receive appropriate notice as described below. Such notice shall not be subject to the requirements of rule 1200-13-14-.11(1)(c)1.

- 1. When a request for prior authorization for a prescription has already been denied. Pharmacists will verify TennCare coverage for all prescriptions presented by TennCare enrollees. If the PBM denies coverage because a prior authorization request has already been denied, the enrollee will receive notice as described in rule 1200-13-14-.11(1)(d)2.(ii). No additional notice will be provided to the enrollee.
- 2. When a request for prior authorization has not been obtained for a prescription. Pharmacists will verify TennCare coverage for all prescriptions presented by TennCare enrollees. If the pharmacist denies coverage because a request for prior authorization has not been obtained, the following will apply:
 - (i) The pharmacists will attempt to contact the prescribing physician to seek prior authorization from the PBM or make a change in the prescription. If the pharmacist remains unable to resolve the enrollee's request for the prescription:

(Rule 1200-13-14-.11, continued)

- (I) The pharmacist will dispense a 72-hour interim supply of the medication in an emergency situation if such supply would not exceed applicable pharmacy benefit limits. An emergency situation is a situation that, in the judgment of dispensing pharmacists, involves an immediate threat of severe adverse consequences to the enrollee, or the continuation of immediate and severe adverse consequences to the enrollee, if the outpatient drug is not dispensed when the prescription is submitted. The 72-hour interim supply shall only be dispensed by the pharmacist once per prescription. If the pharmacist determines that an emergency situation does not exist, the pharmacist will not dispense the 72-hour interim supply and shall not provide a written notice to the enrollee for this determination. Enrollees may not appeal the denial by the pharmacist of a seventy-two (72) hour interim supply of a prescription
 - (II) The pharmacist will provide the enrollee with a notice that advises the enrollee how prior authorization may be requested for the prescription.
 - (ii) If the prescribing physician seeks prior authorization for the prescription, the PBM will respond to this request within twenty-four (24) hours of receipt if the prescribing physician has provided all of the information necessary to facilitate the determination. If the PBM grants this request, the PBM will provide notice to the enrollee informing him/her of this resolution. If the PBM denies this request, the PBM will provide the enrollee with appropriate notice, informing him/her of the right to appeal the denial and to continuation or reinstatement of benefits, when applicable.
 - (iii) If an enrollee seeks prior authorization before he/she contacted the prescribing physician, the PBM will advise the enrollee that he/she must attempt to contact the prescribing physician and allow twenty-four (24) hours to lapse from the denial of coverage for the prescription.
 - (iv) If an enrollee seeks prior authorization after attempting to contact the prescribing physician and has allowed twenty-four (24) hours to lapse since the denial of coverage for the prescription, the PBM will review this request. A decision will be made within twenty-four (24) hours of receipt of a complete prior authorization request, but no more than three (3) business days after receipt of the enrollee's call seeking prior authorization. If the request is resolved as a result of the prescribing physician making a therapy change, the PBM will provide notice to the enrollee informing him/her of this resolution. If the PBM denies this request, the PBM will provide the enrollee with appropriate notice, informing him/her of the right to appeal the denial and to continue or reinstate benefits, when applicable.
3. When the requested drug is not a category or class of drugs covered by TennCare. Pharmacists will verify TennCare coverage for all prescriptions presented by TennCare enrollees. If the PBM denies coverage because the drug is not a category or class of drugs covered by TennCare, the PBM will provide appropriate notice to the enrollee, informing him/her of the right to appeal the denial.
 4. When the enrollee has been locked-into one pharmacy, as described in rule 1200-13-14-.13 and the enrollee seeks to fill a prescription at another pharmacy. Pharmacists will verify TennCare coverage for all prescriptions presented by TennCare enrollees. If the PBM denies coverage because the pharmacy is not the enrollee's "lock-in" pharmacy,

(Rule 1200-13-14-.11, continued)

the PBM will provide appropriate notice to the enrollee, informing him/her of the right to appeal the denial.

5. When an enrollee submits a pharmacy reimbursement and billing claim:
 - (i) TennCare will first determine whether the claim has been previously denied or whether a request for prior authorization has been denied. If the claim was paid upon approval of prior authorization or the enrollee received an alternative prescription ordered by his/her prescribing physician, TennCare will provide appropriate notice to the enrollee, informing them that the request has already been resolved.
 - (ii) If the claim or request for prior authorization had already been denied, TennCare will determine the reason for such denial and follow the applicable processes identified in rule 1200-13-14-.11(1)(d) 1. to 3.
 - (iii) If a claim had not already been submitted to the MCC or TennCare, TennCare will determine whether such claim is eligible for reimbursement. If TennCare denies the claim, TennCare will determine the reason for such denial and follow the applicable processes identified in rule 1200-13-14-.11(1)(d)1. to 3.
- (e) Notice of Rights. The Bureau of TennCare shall provide annual notice to TennCare enrollees of his/her notice and appeal rights established by this rule, including the enrollee's recourse when billed by a provider for TennCare covered services. Additionally, upon enrollment in an MCC, the MCC shall give the enrollee a plain language explanation of appeal rights.
- (f) Proper use of the approved template notices designated by the *Grier Revised Consent Decree* shall be deemed to satisfy the notice requirements specified by this rule.
- (g) Violation of Notice Requirements and Corrective Action.
 1. No adverse action affecting TennCare services shall be effective unless the notice requirements of the federal regulations (42 C.F.R. §§ 431.210 - .214), as enhanced or otherwise modified herein, have been complied with. TennCare shall not withhold, or permit others acting on its behalf to withhold, any TennCare services in violation of this requirement.
 2. Whenever it comes to the attention of the Bureau of TennCare or an MCC that a TennCare covered service will be or has been delayed, denied, reduced, suspended or terminated in violation of any of the notice requirements of this rule:
 - (i) Prior to an appeal or in the early stages of an appeal (i.e., before issuance of a timely notice of hearing), TennCare or the MCC may cure any such deficiencies by providing one corrected notice to a TennCare beneficiary. If the beneficiary has not yet filed an appeal, the time limit permitted for the beneficiary's response will be restarted upon issuance of the corrected notice;
 - (ii) In the later stages of an appeal (i.e., after issuance of a timely notice of hearing), TennCare or the MCC will immediately provide that service in the quantity and for the duration prescribed, subject to TennCare's or the MCC's right to reduce or terminate the service in accordance with the procedures required by this rule.

(Rule 1200-13-14-.11, continued)

3. In the event that the enrollee lacks a prescription for the covered TennCare service which has been delayed, denied, reduced, suspended or terminated in violation of notice requirements, the following shall occur:
 - (i) The enrollee will be immediately afforded access, at the earliest time practicable, to a qualified provider to determine whether the service should be prescribed;
 - (ii) The provider will be informed that the service will be authorized if prescribed and found to be medically necessary; and
 - (iii) Entitlement to the service will not be controlled by the MCC's utilization review process.
 4. In the event that the notice violation has occurred with regard to a delay of access to a physician to secure the requested medical assistance, such access shall be provided as soon as practicable. The enrollee shall be entitled to continue to receive such service until such time as the MCC takes those actions required by federal regulations and this rule as a prerequisite to taking any adverse action affecting TennCare services.
- (2) Appeal Rights of Enrollees. Enrollees have the following rights:
- (a) To appeal adverse actions affecting TennCare services.
 - (b) An enrollee's request for appeal, including oral or written expressions by the enrollee, or on his behalf, of dissatisfaction or disagreement with adverse actions that have been taken or are proposed to be taken, may not be denied, including instances in which:
 1. The enrollee lacks an order or prescription from a provider supporting the appeal, provided however, that the State may create an administrative grievance or other informal process to address appeals by enrollees without an order or prescription;
 2. TennCare or an MCC has agreed to cover a prescribed service in an amount that is less than the amount or duration sought by the enrollee;
 3. TennCare or an MCC has agreed to provide a covered service that is different from that sought by the enrollee;
 4. An enrollee seeks to contest a delay or denial of care resulting from the MCC's failure or refusal to make a needed service available, due to the inadequacy of the MCC's provider network;
 5. An enrollee seeks to contest a denial of his right under the TennCare waiver to choose his own primary care provider (PCP) from among a panel offered by the MCC, or seeks to contest a delay or denial of care resulting from the involuntary assignment of a PCP;
 6. An enrollee seeks to contest denial of TennCare coverage for services already received, regardless of the cost or value of the services at issue;
 7. An enrollee seeks to contest a decision granting or withholding designation as severely and persistently mentally ill (SPMI) or severely emotionally disturbed (SED); and
 8. An enrollee seeks to change health plans after the initial forty-five (45) days pursuant to criteria as described herein.

(Rule 1200-13-14-.11, continued)

- (c) To have the appeal rights that are prescribed by 42 C.F.R. Part 431, Subpart E and Tennessee Code Annotated §§4-5-301, et seq.
 - (d) To be allowed thirty (30) days from receipt of written notice or, if no notice is provided, from the time the enrollee becomes aware of an adverse action, to appeal any adverse action affecting TennCare services.
 - (e) To appeal in person, by telephone, or in writing. Reasonable accommodations shall be made for any person with disabilities who requires assistance with his/her appeal, such as an appeal by TDD services or other communication device for people with disabilities. Written requests for appeals made at county TDHS offices shall be stamped and immediately forwarded to the TennCare Bureau for processing and entry in the central registry.
 - (f) To file an appeal through a toll-free phone number on a twenty-four (24) hours a day, seven (7) days a week basis. Resolution of appeals outside of regular business hours will be available only in cases of emergency medical condition.
 - (g) For ongoing services, have the right to continuation or reinstatement of services, pursuant to 42 C.F.R §§ 431.230-.231 as modified by this rule, pending appeal when the enrollee submits a timely appeal and timely request for such services. When an enrollee is so entitled to continuation or reinstatement of services, this right may not be denied for any reason, including:
 - 1. An MCC's failure to inform an enrollee of the availability of such continued services;
 - 2. An MCC's failure to reimburse providers for delivering services pending appeal; or
 - 3. An MCC's failure to provide such services when timely requested.
 - (h) To an impartial appeals process. But for initial reconsideration by an MCC as permitted by this rule, no person who is an employee, agent or representative of an MCC may participate in deciding the outcome of a TennCare appeal. No state official may participate in deciding the outcome of an enrollee's appeal who was directly involved in the initial determination of the action in question.
- (3) Special Provisions Relating to Appeals.
- (a) Individualized Decisions Required. Neither the TennCare program nor its MCCs may employ utilization control guidelines or other quantitative coverage limits, whether explicit or de facto, unless supported by an individualized determination of medical necessity based upon the needs of each TennCare enrollee and his or her medical history.
 - (b) Decisions to be Supported by Substantial and Material Evidence. Throughout all stages of an appeal of an adverse action affecting TennCare services, decisions shall be based upon substantial and material evidence. In cases involving clinical judgments, this requirement means that:
 - 1. Appeal decision must be supported by medical evidence, and it is the MCCs' and TennCare's responsibility to elicit from the enrollee and his/her treating providers all pertinent medical records that support an appeal; and
 - 2. Medical opinions shall be evaluated in accordance with the Grier Revised Consent Decree and pursuant to TennCare Medical Necessity rule 1200-13-16. Reliance upon insurance industry guidelines or utilization control criteria of general application, without consideration of the individual enrollee's medical history, does not satisfy this requirement and cannot be relied upon to support an adverse action affecting TennCare services.

(Rule 1200-13-14-.11, continued)

- (c) Record on Review. When TennCare receives an appeal from an enrollee regarding an adverse action affecting TennCare services, TennCare is responsible for obtaining from the MCC any and all records or documents pertaining to the MCC's decision to take the contested action. TennCare shall correct any violation of this rule that is evident from a review of those records.
- (d) Valid Factual Disputes. When TennCare receives an appeal from an enrollee, TennCare will dismiss this appeal unless the enrollee has established a valid factual dispute relating to an adverse action affecting TennCare services.
 - 1. Processing of Appeals. TennCare shall screen all appeals submitted by TennCare enrollees to determine if the enrollees have presented a valid factual dispute. If TennCare determines that an enrollee failed to present a valid factual dispute, TennCare will immediately provide the enrollee with a notice, informing him/her that the enrollee must provide additional information as identified in the notice. If the enrollee does not provide this information, the appeal shall be dismissed without the opportunity for a fair hearing within ten (10) days of the date of the notice. If the enrollee adequately responds to this notice, TennCare shall inform the enrollee that the appeal will proceed to a hearing. If the enrollee responds but fails to provide adequate information, TennCare will provide a notice to the enrollee, informing him/her that the appeal is dismissed without the opportunity for a fair hearing. If the enrollee does not respond, the appeal will be dismissed without the opportunity for a fair hearing, without further notice to the enrollee.
 - 2. Information Required to Establish Valid Factual Disputes. In order to establish a valid factual dispute, TennCare enrollees must provide the following information: Enrollee's name; member SSN or TennCare ID#; address and phone; identification of the service or item that is the subject of the adverse action; and the reason for the appeal, including any factual error the enrollee believes TennCare or the MCC has made. For reimbursement and billing appeals, enrollees must also provide the date the service was provided, the name of the provider, copies of receipts which prove that the enrollee paid for the services or copies of a bill for the services, whichever is applicable.
- (e) Appeals When Enrollees Lack a Prescription. If a TennCare enrollee appeals an adverse action and TennCare determines that the basis of the appeal is that the enrollee lacks a prescription, TennCare may require the enrollee to exhaust the following administrative process before an appeal can proceed:
 - 1. TennCare will provide appropriate notice to the enrollee informing him/her that he/she will be required to complete an administrative process. Such administrative process requires the enrollee to contact the MCC to make an appointment with a provider to evaluate the request for the service. The MCC shall be required to make such appointment for the enrollee within a 3-week period or forty-eight (48) hours for urgent care from the date the enrollee contacts the MCC. Appeal timeframes will be tolled during this administrative process.
 - 2. In order for this appeal to continue, the enrollee shall be required to contact TennCare after attending the appointment with a physician and demonstrate that he/she remains without a prescription for the service. If the enrollee fails to contact TennCare within sixty (60) days from the date of the notice described in subparagraph (e)1., TennCare will dismiss the appeal without providing an opportunity for a hearing for the enrollee.
- (f) Appeals When No Adverse Action Is Taken. Enrollees shall not possess the right to appeal when no adverse action has been taken related to TennCare services. If enrollees request a hearing when no adverse action has been taken, their request shall be denied by the TennCare Bu-

(Rule 1200-13-14-.11, continued)

reau without the opportunity for a hearing. Such circumstances include but are not limited to when enrollees appeal and no claim for services had previously been denied.

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

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1. Impartial hearing officers shall promptly issue an Order of their decision. Impartial hearing officers shall provide enrollees with copies of such Orders.
 2. The TennCare Bureau shall have the opportunity to review all decisions of impartial hearing officers to determine whether such decisions are contrary to applicable law, regulations or policy interpretations, which shall include but not be limited to decisions regarding the defined package of covered benefits, determinations of medical necessity and decisions based on the application of the *Grier Revised Consent Decree*.
 - (i) TennCare shall attempt to complete such review within five (5) days of the issuance of the decision of the impartial hearing officer.
 - (ii) If TennCare is unable to take final agency action within five (5) days of the issuance of such decision, prompt corrective action by the fifth (5th) day is required, pursuant to rule 1200-13-14-.11(7)(f). However, the State shall not be prohibited from taking final agency action as expeditiously as possible and may immediately implement such final agency action to reduce, suspend, or terminate a service for which corrective action had been provided.
 - (iii) If TennCare modifies or overturns the decision of the impartial hearing officer, TennCare shall issue a written decision that will be provided to the enrollee and the impartial hearing officer. TennCare's decision shall constitute final agency action.
 - (iv) If TennCare does not modify or overturn the decision of the impartial hearing officer, the impartial hearing officer's decision shall constitute final agency action without additional notice to the enrollee.
 - (v) Review of final agency action shall be available to enrollees pursuant to the Tennessee Administrative Procedures Act, Tennessee Code Annotated §§4-5-301, et seq.
 - (vi) An impartial hearing officer's decision in an enrollee's appeal shall not be deemed precedent for future appeals.
- (g) Continuation or Reinstatement of TennCare Services.
1. Except as permitted under 42 C.F.R. §§431.213, 431.214 and 431.220, as modified by this rule, TennCare services shall continue or be reinstated until an initial hearing decision if the enrollee appeals and requests:
 - (i) Continuation of services within two (2) business days of the receipt of MCC-initiated notice of action to terminate, suspend or reduce ongoing inpatient hospital treatment; or
 - (ii) Continuation of services within two (2) business days of the receipt of provider-initiated notice of action to terminate, suspend or reduce any behavioral health service for a severely and persistently mentally ill (SPMI) adult enrollee or severely emotionally disturbed (SED) child, any inpatient psychiatric or residential service, any service being provided to treat a patient's chronic condition across a continuum of services when the next appropriate level of medical service is not immediately available, or home health services; or

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- (iii) Continuation of reinstatement of services within ten (10) days of MCC-initiated notice of action to terminate, suspend or reduce other ongoing services or prior to the date of action.
2. In the case of a timely request for continuation or reinstatement of the TennCare services described in paragraph (4)(g)1.(ii) above, the enrollee shall be afforded access to a written second medical opinion from a qualified provider who participates in the MCC's network. If there has not already been a break in receipt of the services, the benefits shall continue until receipt of the written second medical opinion. Services shall continue or be reinstated thereafter pending appeal only if and to the extent prescribed by the second provider.
3. In the case of a timely request for continuation or reinstatement of the TennCare services described herein, the services shall continue or be reinstated pending appeal only if and to the extent prescribed by the enrollee's treating clinician.
4. Services shall not continue, but may be immediately reduced, terminated, or suspended if the services are determined medically contraindicated in accordance with the provisions of paragraph (8) below.
5. Resolution, including a hearing with an ALJ if the case has not been previously resolved in favor of the enrollee, of expedited appeals shall be provided within thirty-one (31) days or forty-five (45) days when additional time is required to obtain an enrollee's medical records, from the date the appeal is received from the enrollee. TennCare is permitted to seek final agency review by the TennCare Commissioner or his designee in any appeal in which the enrollee prevails by a decision of an administrative law judge (ALJ) who is not an employee or official of the Department of Finance and Administration or Bureau of TennCare. Provided however, that if the enrollee prevails at any stage of the appeal process and TennCare seeks final agency review, the State may not await the conclusion of this review before providing prompt corrective action. If an enrollee makes a timely request for continuation or reinstatement of a disputed TennCare service pending appeal, receives the continued or reinstated service, and subsequently requests a continuance of the proceedings without presenting a compelling justification, the impartial hearing officer shall grant the request for continuance conditionally. The condition of such continuance is the enrollee's waiver of his right to continue receiving the disputed service pending a decision if:
 - (i) The impartial hearing officer finds that such continuance is not necessitated by acts or omissions on the part of the State or MCC;
 - (ii) The enrollee lacks a compelling justification for the requested delay; and
 - (iii) The enrollee received at least three (3) weeks notice of the hearing, in the case of a standard appeal, or at least one (1) week's notice, in the case of an expedited appeal.
6. Notwithstanding the requirements of this part, TennCare enrollees are not entitled to continuation or reinstatement of services pending an appeal related to the following:
 - (i) When a service is denied because the enrollee has exceeded the benefit limit applicable to that service;
 - (ii) When a request for prior authorization is denied for a prescription drug, with the exception of:

(Rule 1200-13-14-.11, continued)

- (I) Pharmacists shall provide a single 72-hour interim supply in emergency situations for the non-authorized drug unless such supply would exceed applicable pharmacy benefit limits; or
 - (II) When the drug has been prescribed on an ongoing basis or with unlimited refills and becomes subject to prior authorization requirements.
 - (iii) When coverage of a prescription drug or service is denied because the requested drug or service is not a category or class of drugs or services covered by TennCare;
 - (iv) When coverage for a prescription drug is denied because the enrollee has been locked into one pharmacy and the enrollee seeks to fill a prescription at another pharmacy;
 - (v) When a request for reimbursement is denied and the enrollee appeals this denial;
 - (vi) When a physician has failed to prescribe or order the service or level of service for which continuation or reinstatement is requested; or
 - (vii) If TennCare had not paid for the type and amount of service for which continuation or reinstatement is requested prior to the appeal.
- (h) Expedited appeals.
1. Expedited appeals of any action involving time-sensitive care must be resolved within thirty-one (31) days, or forty-five (45) days when additional time is required to obtain an enrollee's medical records, from the date the appeal is received.
 2. Care will only qualify as time-sensitive if a covered benefit has been delayed, denied, terminated or suspended; the service is not defined by TennCare policy as never constituting an emergency; and in the judgment of a member's treating physician or in the judgment of a prudent layperson that is not subsequently overturned by written physician certification, waiting ninety (90) days to receive such benefit will result in:
 - (i) Serious health problems or death;
 - (ii) Serious dysfunction of a bodily organ or part; or
 - (iii) Hospitalization.
 3. MCCs shall complete reconsideration of expedited appeals within five (5) days, or within fourteen (14) days when additional time is required to obtain an enrollee's medical records, after receiving notification of the appeal. If the MCC does not complete reconsideration within these timeframes, the appeal shall not be automatically resolved in favor of the enrollee, provided that the missed deadline may be remedied early in the appeals process such that the appeal is resolved within ninety (90) days from the date the appeal is received.
- (5) Special Provisions Pertaining to Pharmacy.
- (a) When a provider with prescribing authority prescribes a medication for an enrollee, and the prescription is presented at a pharmacy that participates in the enrollee's MCC, the enrollee is entitled to:

(Rule 1200-13-14-.11, continued)

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

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3. Use of the medication has not been determined to be medically contraindicated because of the patient's medical condition or possible adverse drug interaction; or
 4. If the prescription is for a total quantity less than a seventy-two (72) hour supply, the pharmacist must provide a supply up to the amount prescribed.
 5. In some circumstances, it is not feasible for the pharmacist to dispense a seventy-two (72) hour supply because the drug is packaged by the manufacturer to be sold as the original unit or because the usual and customary pharmacy practice would be to dispense the drug in the original packaging. Examples would include, but not be limited to, inhalers, eye drops, ear drops, injections, topicals (creams, ointments, sprays), drugs packaged in special dispensers (birth control pills, steroid dose packs), and drugs that require reconstitution before dispensing (antibiotic powder for oral suspension). When coverage of a seventy-two (72) hour supply of a prescription would otherwise be required and when, as described above, it is not feasible for the pharmacist to dispense a seventy-two (72) hour supply, it is the responsibility of the MCC to provide coverage for either the seventy-two (72) hour supply or the usual dispensing amount, whichever is greater.
 6. The Bureau of TennCare shall establish a tolerance level for early refills of prescriptions. Such established tolerance level may be more stringent for narcotic substances. Notwithstanding the requirements of this part, if an enrollee requests a refill of a prescription prior to the tolerance level for early refills established by the Bureau, the pharmacy will deny this request as a service which is non-covered until the applicable tolerance period has lapsed, and will not provide a seventy-two (72) hour supply of the prescribed drug.
- (6) Release of Enrollee's Medical Records.
- (a) When a request is made, by or on behalf of a TennCare enrollee, for approval of a TennCare service or for an appeal of an adverse action affecting TennCare services, the enrollee is deemed to have consented to release of his/her relevant medical records to his/her MCC and the TennCare Bureau for the purposes of acting upon the enrollee's request.
 - (b) Providers shall promptly provide copies of an enrollee's medical records to the enrollee's MCC(s) and to the TennCare Bureau upon being informed by the MCC(s) or TennCare Bureau that the records have been requested for the purpose of acting upon an enrollee's request for approval of a TennCare service or an enrollee's appeal of an adverse action affecting TennCare services.
 - (c) An enrollee's consent to release of his/her medical records may be evidenced by his signature (or his provider's or authorized representative's signature) upon the enrollee's initial application for TennCare, upon his TennCare appeal form or other written request for authorization or appeal, or, in the event of an appeal by telephone, by a TennCare Bureau employee's signing of an appeal form on behalf of an enrollee with documentation of consent to do so.
 - (d) The medical records obtained by MCCs and the TennCare Bureau under this rule remain confidential. MCCs and the TennCare Bureau may use and disclose the records only as necessary in their consideration of the enrollee's request for approval of a TennCare service or the enrollee's appeal of an adverse action affecting TennCare services.
- (7) Time Requirements and Corrective Action.
- (a) MCCs must act upon a request for prior authorization within fourteen (14) days as provided in rule 1200-13-14-.11(1)(b)2. or as expeditiously as the enrollee's health condition requires. Failure by the MCCs to act upon a request for prior authorization within twenty-one (21) days shall

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result in an automatic authorization of the requested service, subject to the provision of (7)(e) below, and to provisions relating to medical contraindication at rule 1200-13-14-.11(8).

- (b) MCCs must complete reconsideration of non-expedited appeals within fourteen (14) days. MCCs must complete reconsideration of expedited appeals involving time sensitive care within five (5) days, which shall be extended to fourteen (14) days if additional time is required to obtain an enrollee's medical records. Failure by the MCCs to meet these deadlines shall not result in an immediate resolution of the appeal in favor of the enrollee provided that the missed deadline may be remedied early in the appeals process such that the appeal is resolved within ninety (90) days from the date the appeal is received.
- (c) All standard appeals, including, if not previously resolved in favor of the enrollee, a hearing before an impartial hearing officer, shall be resolved within ninety (90) days of receipt of the enrollee's request for an appeal. All expedited appeals involving time-sensitive care shall be resolved within thirty-one (31) days of receipt of the request for appeal, unless extended to forty-five days when additional time is required to obtain an enrollee's medical records. Calculation of the ninety (90) day, thirty-one (31) day or forty-five (45) day deadline may be adjusted so that TennCare is not charged with any delays attributable to the enrollee. However, no delay may be attributed to an enrollee's request for a continuance of the hearing, if s/he received less than three (3) weeks' notice of the hearing, in the case of a standard appeal, or less than one (1) week's notice, in the case of an expedited appeal involving time-sensitive care. An enrollee may only be charged with the amount of delay occasioned by his/her acts or omissions, and any other delays shall be deemed to be the responsibility of TennCare.
- (d) Failure to meet the ninety (90) day or thirty-one (31) day (extended to forty-five (45) calendar days when necessary to allow sufficient time to obtain the enrollee's medical records) deadline, as applicable, shall result in automatic TennCare coverage of the services at issue pending a decision by the impartial hearing officer, subject to the provisions of subparagraphs (7)(e) and (f) below, and to provisions relating to medical contraindication rule 1200-13-14-.11 (8). This conditional authorization will neither moot the pending appeal nor be evidence of the enrollee's satisfaction of the criteria for disposing of the case, but is simply a compliance mechanism for disposing of appeals within the required time frames. In the event that the appeal is ultimately decided against the enrollee, s/he shall not be liable for the cost of services provided during the period required to resolve the appeal. Notwithstanding, upon resolving an appeal against an enrollee, TennCare may immediately implement such decision, thereby reducing, suspending, terminating the provision or payment of the service.
- (e) When, under the provisions of rule 1200-13-14-.11(7)(a) or (d), a failure to comply with the time frames would require the immediate provision of a disputed service, TennCare may decline to provide the service pending a contrary order on appeal, based upon a determination that the disputed service is not a TennCare-covered service. A determination that a disputed service is not a TennCare-covered service may not be based upon a finding that the service is not medically necessary. Rather, it may only be made with regard to a service that:
 - 1. Is subject to an exclusion that has been reviewed and approved by the federal Center for Medicare and Medicaid Services (CMS) and incorporated into a properly promulgated state regulation, or
 - 2. Which, under Title XIX of the Social Security Act, is never federally reimbursable in any Medicaid program.
- (f) Except upon a showing by an MCC of good cause requiring a longer period of time, within five (5) days of a decision in favor of an enrollee at any stage of the appeal process, the MCC take

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corrective action to implement the decision. For purposes of meeting the five (5) day time limit for corrective action, the MCC shall take steps necessary to ensure:

1. The enrollee's receipt of the services at issue, or acceptance and receipt of alternative services; or
2. Reimbursement for the enrollee's cost of services, if the enrollee has already received the services at his/her own cost; or
3. If the enrollee has already received the service, but has not paid the provider, that the enrollee is not billed for the service and that the enrollee's care is not jeopardized by non-payment.

In the event that a decision in favor of an enrollee is modified or overturned, TennCare shall possess the authority to immediately implement such decision, thereby reducing, suspending, or terminating the provision or payment of the service in dispute.

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

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

- (a) The Tennessee Department of Children's Services (DCS) must provide notice of any delay in providing a TennCare service that is administered by DCS. Such delay is immediately appealable on that child's behalf and cannot be required to last a particular length of time before issuance of the notice or processing of an appeal.
- (b) Whenever there is an adverse action affecting TennCare services (regardless of which contractor or government agency is administering such services), timely notices required by this rule must be sent to the individuals specified in the DCS implementation plan which was approved by the Court in the *Grier Revised Consent Decree*. In the case of services administered by

(Rule 1200-13-14-.11, continued)

MCCs other than DCS, the responsible MCC shall provide notice to DCS, which shall ensure that timely notice is provided to the required individuals. Delivery of notice triggering the right to appeal is not complete until notice is received by those individuals.

- (c) An appeal from any individual specified in the paragraph above must be accepted as an appeal on behalf of the child.

Authority: T.C.A. §§4-5-202, 71-5-105, 71-5-109, 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-.11; new effective date February 12, 2003. Public necessity rule filed May 5, 2005; effective through October 17, 2005. Public necessity rule filed July 29, 2005; effective through January 10, 2006. Amendments filed July 28, 2005; effective October 11, 2005. Public necessity rule filed December 29, 2005; effective through June 12, 2006. Amendments filed October 27, 2005; effective January 10, 2006. However, Notice of Withdrawal of permanent rule amendments (1)(d)3., (1)(d)4., (4)(g)6., (5)(a)5., (5)(e), (5)(f), and (7)(h) filed and effective January 6, 2006 (to have been effective January 10, 2006). Public necessity rule filed May 17, 2006; effective through October 29, 2006. Public necessity rule filed December 29, 2005, expired June 12, 2006. On June 13, 2006, affected rules reverted to status on December 28, 2005. Amendments filed March 31, 2006; effective June 14, 2006. Amendment filed August 14, 2006; effective October 28, 2006. Public Necessity rule filed December 1, 2006; expires May 15, 2007.

1200-13-14-.12 OTHER APPEALS BY TENNCARE APPLICANTS AND ENROLLEES.

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

(Rule 1200-13-14-.12, continued)

covered services generally applicable to enrollees in their TennCare category) pending a determination that the enrollee has not raised a valid factual dispute or until the appeal is otherwise resolved, whichever comes first. If the appeal results in the State's action being sustained, the State reserves its right to recover from the enrollee the cost of services provided to the enrollee during the pendency of the appeal.

- (iv) Enrollees disputing the applicability of changes in coverage to their current TennCare category who request a hearing within twenty (20) calendar days (inclusive of mail time) of the date of the notice or prior to the date of action specified in the notice, whichever is later, shall, notwithstanding subsection (1)(a)1.(iii), continue to receive benefits at the level for the eligibility category alleged by the enrollee to be currently applicable, pending a determination that the enrollee has not raised a valid factual dispute or until the appeal is otherwise resolved, whichever comes first. If the enrollee does not clearly allege the applicability of a particular eligibility category, benefits will be continued at the level for Non-Institutionalized Medicaid Adults pending a determination that the enrollee has not raised a valid factual dispute or until the appeal is otherwise resolved, whichever comes first. If TDHS subsequently determines that the enrollee is alleging that a particular eligibility category is currently applicable, benefits will be prospectively continued at the level for such eligibility category pending a determination that the enrollee has not raised a valid factual dispute or until the appeal is otherwise resolved, whichever comes first.
- (b) To the extent not otherwise modified by this rule, such appeals will be conducted by the Department of Human Services for TennCare Standard applicants/enrollees under the Department of Human Services' administrative procedures rules, and in accordance with any other applicable rules, laws or court orders governing those programs, provided that the finality of initial orders shall be governed by the provisions of Tennessee Code Annotated Section §4-5-314(b).
- (c) Appeal Rights for Disenrollment Related to TennCare Standard Eligibility Reforms.
 1. TennCare Standard enrollees, who have not been determined eligible for open Medicaid categories pursuant to the Ex Parte Review or Request for Information processes described in 1200-13-14-.02, will have the right to request a hearing for 40 days (inclusive of mail time) from the date of the Termination Notice, notwithstanding anything else in these rules or in the Department of Human Services' administrative procedures rules to the contrary.
 2. To the extent not otherwise modified by this rule, such appeals will be conducted by the Department of Human Services for TennCare Standard applicants/enrollees under the Department of Human Services' administrative procedures rules, and in accordance with any other applicable rules, laws or court orders governing those programs, provided that the finality of initial orders shall be governed by the provisions of Tennessee Code Annotated Section 4-5-314(b).
 3. Enrollees will not have the opportunity to request an extension for good cause of the forty (40) day timeframe in which to request a hearing.
 4. Enrollees who request a hearing within twenty (20) calendar days (inclusive of mail time) of the date of notice or prior to the date of termination specified in the Termination Notice, whichever is later, shall retain their eligibility (subject to any changes in covered services generally applicable to enrollees in their TennCare category) pending a determination that the enrollee has not raised a valid factual dispute or until the appeal is otherwise resolved, whichever comes first.

(Rule 1200-13-14-.12, continued)

5. The TennCare Bureau designates TDHS to review each request for hearing to determine if it is based on a valid factual dispute. Enrollees will be given the opportunity to have an administrative hearing before a Hearing Officer or an Administrative Judge, as determined by TDHS, regarding valid factual disputes related to termination. If TDHS makes an initial determination that the request for a hearing is not based on a valid factual dispute, the appellant will receive a notice which provides 10 days (inclusive of mail time) to provide additional clarification of any factual dispute on which his/her appeal is based. Unless such clarification is timely received and is determined by TDHS to establish a valid factual dispute, a fair hearing will not be granted.
 6. TDHS will grant hearings only for those enrollees raising valid factual disputes related to the action of disenrollment. A valid factual dispute is a dispute that, if resolved in favor of the appellant, would prevent the state from taking the action that is the subject of the appeal. Appeals that do not raise a valid factual dispute will not proceed to a hearing. Valid factual disputes include, but are not limited to:
 - (i) Enrollee received the Termination Notice in error (e.g., they are currently enrolled in a TennCare Medicaid or TennCare Standard category that is not ending);
 - (ii) TDHS failed to timely process information submitted by the enrollee during the requisite time period following the Request for Information or Verification Request;
 - (iii) TDHS granted a “good cause” extension of time to reply to the Request for Information Notice but failed to extend the time (this is the only circumstance surrounding good cause which can be appealed) ;
 - (iv) Enrollees requested assistance because of a health, mental health, learning problem or disability but did not receive this assistance; or
 - (v) The TennCare Bureau sent the Request for Information or Termination Notice to the wrong address as defined under state law.
 7. If the enrollee does not appeal prior to the date of termination as identified in the Termination Notice, the enrollee will be terminated from TennCare.
 8. If the enrollee is granted a hearing and the hearing decision sustains the State’s action, the State reserves its right to recover from the enrollee the cost of services provided during the hearing process.
- (d) Notice requirements. Whenever the Bureau of TennCare denies an application for TennCare Standard enrollment in TennCare Standard or determines an enrollee will be terminated from the program, it will send the TennCare Standard applicant written notice of the right to request an appeal to the Commissioner, as provided by these rules. The notice must contain:
1. An individual’s right to a hearing.
 2. The method by which s/he may obtain a hearing.
 3. That s/he may represent him/herself or use legal counsel, a relative, a friend, or other spokesperson.
 4. A statement of the action intended to be taken by the Bureau of TennCare.

(Rule 1200-13-14-.12, continued)

5. The reasons for the action.
 6. The specific laws/regulations which support, or the change in such, that support the action.
 7. That the individual may request an evidentiary hearing, and an explanation of the circumstances under which coverage can be continued when a hearing is requested.
- (e) TennCare Standard enrollees 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. Enrollees 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. This ground for appeal does not include challenges to relevant TennCare rules, policies, or timeframes.

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

- (2) Other Appeals. Enrollees applying for Seriously and Persistently Mentally Ill (SPMI) or Seriously Emotionally Disturbed (SED) determination shall apply for each determination to the Department of Mental Health and Developmental Disabilities unless otherwise directed by the Commissioner. SPMI and SED determinations for the state only category shall be appealed in accordance with the provisions of state and federal law.

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

1200-13-14-.13 MEMBERS ABUSE AND OVERUTILIZATION OF THE TENNCARE PROGRAM.

- (1) The TennCare Bureau and the MCCs shall possess the authority to restrict or lock-in TennCare enrollees to a specified and limited number of pharmacy providers if the TennCare Bureau or the MCCs has determined that the enrollee has abused the TennCare Pharmacy Program. Such abuse includes, but shall not be limited to the following:
 - (a) Forging or altering prescription drugs;
 - (b) Selling TennCare paid prescription drugs;
 - (c) Filing to control pharmacy overutilization activity while on lock-in status; or
 - (d) Visiting multiple prescribers or pharmacies to obtain controlled substances.
- (2) All pharmacy lock-in programs established by the TennCare Bureau or the MCCs must contain at least the following elements:

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

- (a) Criteria for selection of abusive or overutilizing enrollees - Pharmacy lock-in program must demonstrate, in detail, how the program will identify lock-in candidates.
 - (b) Methods of evaluation of potential lock-in candidates - Pharmacy lock-in programs must describe how the program will review lock-in candidates to ensure appropriate patterns of health care utilization are not misconstrued as abusive or overutilization.
 - (c) Lock-in status - Pharmacy lock-in programs must describe the exact process used to notify the lock-in enrollee, notify the lock-in pharmacy and physician providers, coordinate the lock-in activities with the appropriate case managers, when appropriate, and continually review the enrollee's utilization patterns.
 - (d) Prior approval status - Pharmacy lock-in programs may include placing an enrollee in a prior approval status in which some or all prescriptions such as controlled substances, require prior authorization. The program must describe the exact process used to notify the enrollee of prior approval status, notify the pharmacy of the enrollee's prior approval status, coordinate the prior approval status activities with the appropriate case managers, when appropriate, and continually review the enrollee's utilization patterns.
 - (e) Emergency Services - Pharmacy lock-in programs must describe, in detail, how pharmacy services will be delivered to enrollees on lock-in or prior approval status in the event of an emergency.
- (3) Pharmacy lock-in program procedures shall include:
- (a) Prior to imposing lock-in status upon a TennCare enrollee, the TennCare Bureau or the MCC shall provide appropriate notice to TennCare enrollees, informing enrollees that they may only use one pharmacy provider and of their right to appeal this action.
 - (b) If the enrollee fails to appeal this lock-in or the appeal of the lock-in is not resolved in his/her favor, the enrollee will only receive coverage for his/her prescription drugs at the lock-in pharmacy.
 - (c) If the enrollee attempts to fill a prescription at any pharmacy other than his/her lock-in pharmacy, the PBM will deny coverage for the prescription and the enrollee will be entitled to notice and appeal rights as described in rule 1200-13-14-.11.
 - (d) The MCC shall monitor and evaluate the TennCare enrollee subject to the lock-in in accordance with the criteria identified in paragraph (2) above.

Authority: T.C.A. §§4-5-202, 71-5-105, 71-5-109, 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-.13; new effective date February 12, 2003. Public necessity rule filed December 29, 2005; effective through June 12, 2006. Public necessity rule filed December 29, 2005, expired June 12, 2006. On June 13, 2006, affected rules reverted to status on December 28, 2005. Repeal and new rule filed March 31, 2006; effective June 14, 2006.

1200-13-14-.14 REPEALED.

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