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Sequence Number: 03-06-14
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Effective Date: 6/15/14

Rulemaking Hearing Rule(s) Filing Form

Rulemaking Hearing Rules are rules filed after and as a result of a rulemaking hearing. T.C.A. § 4-5-205

Agency/Board/Commission:	Tennessee Department of Finance and Administration
Division:	Bureau of TennCare
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Revision Type (check all that apply):

X Amendments
___ New
___ Repeal

Rule(s) Revised (**ALL** chapters and rules contained in filing must be listed here. If needed, copy and paste additional tables to accommodate multiple chapters. Please enter only **ONE** Rule Number/Rule Title per row)

Chapter Number	**Chapter Title**
0620-05-01	Cover Kids Rules
Rule Number	**Rule Title**
0620-05-01-.06	Providers

(Place substance of rules and other info here. Statutory authority must be given for each rule change. For information on formatting rules go to http://state.tn.us/sos/rules/1360/1360.htm)

Rule Chapter 0620-05-01 is amended by adding Rule 0620-05-01-.06 Providers which shall read as follows:

0620-05-01-.06 Providers.

(1) This rule shall be in effect from October 1, 2013.

(2) For purposes of this rule, the following definitions shall apply:

(a) Covered services. Benefits listed in Rule 0620-05-01-.03 and authorized by the Plan Administrator ("PA").

(b) CoverKids network. A group of health care providers that have entered into contracts with the PA to furnish covered services to CoverKids enrollees. These contracts may take the form of general contracts or single case agreements.

(c) CoverKids provider. An appropriately licensed institution, facility, agency, person, corporation, partnership, or association that delivers health care services and that participates in the PA's network.

(d) Emergency services, including emergency mental health and substance abuse emergency treatment services. Services to treat 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:

1. Placing the person's (or with respect to a pregnant woman, her unborn child's) health in serious jeopardy; or

2. Serious impairment to bodily functions; or

3. Serious dysfunction of any bodily organ or part.

(e) HealthyTNBabies. The program that provides coverage of maternity care for pregnant CoverKids enrollees, including the unborn children of pregnant women with no source of coverage who meet the CoverKids eligibility requirements.

(f) Non-CoverKids provider. A health care provider of non-emergency services that does not participate in the PA's network.

(3) Payment in full.

(a) All CoverKids providers, as defined in this rule, must accept as payment in full for provision of covered services to a CoverKids enrollee, the amount paid by the PA, plus any copayment required by the CoverKids program to be paid by the individual.

(b) Any non-CoverKids providers who furnish CoverKids covered services by authorization from the PA must accept as payment in full for provision of covered services to CoverKids enrollees the amounts paid by the PA plus any copayment required by the CoverKids program to be paid by the individual.

(c) CoverKids will not pay for non-emergency services furnished by non-CoverKids providers unless these services are authorized by the PA. Any non-CoverKids provider who furnishes CoverKids Program covered non-emergency services to a CoverKids enrollee without authorization from the PA does so at his own risk. He may not bill the patient for such services except as provided for in Paragraph (5).

(4) Non-CoverKids Providers.

(a) In situations where the PA authorizes a service to be rendered by a non-CoverKids provider, payment to the provider shall be no less than 80% of the lowest rate paid by the PA to equivalent participating CoverKids network providers for the same service, consistent with the methodology contained in Rule 1200-13-13-.08(2)(a).

(b) Covered medically necessary outpatient emergency services, when provided to CoverKids enrollees by non-CoverKids network hospitals, shall be reimbursed at 74% of the 2006 Medicare rates for the services, consistent with the methodology contained in Rule 1200-13-13-.08(2)(b). Emergency care to enrollees shall not require preauthorization.

(c) Covered medically necessary inpatient hospital admissions required as the result of emergency outpatient services, when provided to CoverKids enrollees by non-CoverKids network hospitals, shall be reimbursed at 57% of the 2008 Medicare DRG rates (excluding Medical Education and Disproportionate Share components) determined according to 42 CFR § 412 for the services, consistent with the methodology contained in Rule 1200-13-13-.08(2)(c). Such an inpatient stay will continue until no longer medically necessary or until the patient can be safely transported to a network hospital, whichever comes first.

(5) Providers may seek payment from a CoverKids enrollee only under the following circumstances. These circumstances include situations where the enrollee may choose to seek a specific covered service from a non-CoverKids provider.

(a) If the services are not covered by the CoverKids program and, prior to providing the services, the provider informed the enrollee that the services were not covered.

(b) If the services are not covered because they are in excess of an enrollee's benefit limit and one of the following circumstances applies:

1. The provider has information in her own records to support the fact that the enrollee has reached his benefit limit for the particular service being requested and, prior to providing the service, informs the enrollee that the service is not covered and will not be paid for by CoverKids. This information may include:

(i) A previous written denial of a claim on the basis that the service was in excess of the enrollee's benefit limit for a service within the same benefit category as the service being requested, if the time period applicable to the benefit limit is still in effect; or

(ii) That the provider had personally provided services to the enrollee in excess of his benefit limit within the same benefit category as the service being requested, if the time period applicable to that benefit period is still in effect; or

(iii) The enrollee's PA has provided confirmation to the provider that the enrollee has reached his benefit limit for the applicable service.

2. The provider submits a claim for service to the PA and receives a written denial of that claim on the basis that the service exceeds the enrollee's benefit limit. After informing the enrollee and within the remainder of the period applicable to that benefit limit, the provider may bill the enrollee for services within that same exhausted benefit category without having to submit claims for those subsequent services for repeated PA denial. If the provider informed the enrollee prior to providing the service for which the claim was denied that the service would exceed the enrollee's benefit limit and would not be paid for by CoverKids, the provider may bill the enrollee for that service.

3. The provider had previously taken the steps in parts 1. or 2. above and determined that the enrollee had reached his benefit limit for the particular service being requested, if the time period applicable to the benefit limit is still in effect, and informs the enrollee, prior to providing the service, that the service is not covered and will not be paid for by CoverKids.

(c) If the services are covered only with prior authorization and prior authorization has been requested but denied, or is requested and a specified lesser level of care is approved, and the provider has given prior notice to the enrollee that the services are not covered, the enrollee may elect to receive those services for which prior authorization has been denied or which exceed the authorized level of care and be billed by the provider for such services.

(6) Providers may not seek payment from a CoverKids enrollee under the following conditions:

(a) The provider knew or should have known about the patient's CoverKids enrollment prior to providing services.

(b) The claim submitted to the PA for payment was denied due to provider billing error or a CoverKids claim processing error.

(c) The provider accepted CoverKids assignment on a claim and it is determined that another payer paid an amount equal to or greater than the CoverKids allowable amount.

(d) The provider failed to comply with CoverKids policies and procedures or provided a service which lacks medical necessity or justification.

(e) The provider failed to submit or resubmit claims for payment within the time periods required by the PA or CoverKids.

(f) The provider failed to inform the enrollee prior to providing a service not covered by CoverKids that the service was not covered and the enrollee may be responsible for the cost of the service. Services which are non-covered by virtue of exceeding limitations are exempt from this requirement if the provider has complied with paragraph (5) above.

(g) The enrollee failed to keep a scheduled appointment(s).

(7) Pharmacy providers may not waive pharmacy copayments for CoverKids enrollees as a means of attracting business to their establishments. This does not prohibit a pharmacy from exercising professional judgment in cases where an enrollee may have a temporary or acute need for a prescribed drug, but is unable, at that moment, to pay the required copayment.

Statutory Authority: T.C.A. §§ 4-5-202, 71-3-1104, 71-3-1106 and 71-3-1110.

I certify that this is an accurate and complete copy of rulemaking hearing rules, lawfully promulgated and adopted by the Tennessee Department of Finance and Administration (board/commission/ other authority) on 03/12/2014 (mm/dd/yyyy), and is in compliance with the provisions of T.C.A. § 4-5-222.

I further certify the following:

Notice of Rulemaking Hearing filed with the Department of State on: 12/20/13

Rulemaking Hearing(s) Conducted on: (add more dates). 02/26/14

Date: 3/12/2014

Signature:

Name of Officer: Darin J. Gordon

Title of Officer: Director, Bureau of TennCare
Tennessee Department of Finance and Administration

CHERYL D. KLINE
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY

Subscribed and sworn to before me on: 3/12/14

Notary Public Signature: Cheryl D Kline

My commission expires on: AUG 2 3 2016

All rulemaking hearing rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

Robert E. Cooper, Jr.
Attorney General and Reporter

3-17-14
Date

Department of State Use Only

2014 MAR 17 PM 3:41
OFFICE OF SECRETARY OF STATE

Filed with the Department of State on: 3/17/14

Effective on: 6/15/14

Tre Hargett
Secretary of State

Public Hearing Comments

One copy of a document containing responses to comments made at the public hearing must accompany the filing pursuant to T.C.A. § 4-5-222. Agencies shall include only their responses to public hearing comments, which can be summarized. No letters of inquiry from parties questioning the rule will be accepted. When no comments are received at the public hearing, the agency need only draft a memorandum stating such and include it with the Rulemaking Hearing Rule filing. Minutes of the meeting will not be accepted. Transcripts are not acceptable.

There were no public comments on this rule.

Regulatory Flexibility Addendum

Pursuant to T.C.A. §§ 4-5-401 through 4-5-404, prior to initiating the rule making process as described in T.C.A. § 4-5-202(a)(3) and T.C.A. § 4-5-202(a), all agencies shall conduct a review of whether a proposed rule or rule affects small businesses.

The proposed rule reflects a requirement in the Appropriations Act, Public Chapter 453, effective July 1, 2013, to reduce expenditures for CoverKids. The reduction was to be accomplished by transitioning the persons enrolled in the CoverKids program from a commercial network of providers to the TennCare Select Medicaid network, effective October 1, 2013. The transition was not to result in a loss of covered services.

The transition was intended to save $9,540,000 in annual state expenditures. Many providers of TennCare Select services are small businesses. However, due to a number of unknown factors including the variation in payment rates offered by TennCare Select to specific small business providers in comparison to those offered by the commercial network to these providers prior to October 1, 2013, the exact overall impact of this proposed rule on small businesses cannot be determined.

Impact on Local Governments

Pursuant to T.C.A. §§ 4-5-220 and 4-5-228 "any rule proposed to be promulgated shall state in a simple declarative sentence, without additional comments on the merits of the policy of the rules or regulation, whether the rule or regulation may have a projected impact on local governments." (See Public Chapter Number 1070 (http://state.tn.us/sos/acts/106/pub/pc1070.pdf) of the 2010 Session of the General Assembly)

The rule is not anticipated to have an impact on local governments.

Additional Information Required by Joint Government Operations Committee

All agencies, upon filing a rule, must also submit the following pursuant to T.C.A. § 4-5-226(i)(1).

(A) A brief summary of the rule and a description of all relevant changes in previous regulations effectuated by such rule;

The rule replaces an emergency rule that allowed for the reduction in expenditures for the CoverKids program by changing from a commercial network to the TennCare Select Medicaid network, effective October 1, 2013.

(B) A citation to and brief description of any federal law or regulation or any state law or regulation mandating promulgation of such rule or establishing guidelines relevant thereto;

The rule is lawfully adopted by the Bureau of TennCare as a rulemaking hearing rule under T.C.A § 4-5-202, under CoverKids rulemaking authority at T.C.A. §§ 71-3-1104 and 71-3-1110.

(C) Identification of persons, organizations, corporations or governmental entities most directly affected by this rule, and whether those persons, organizations, corporations or governmental entities urge adoption or rejection of this rule;

The persons and entities most directly affected by this rule are CoverKids enrollees, providers and TennCare Select. The governmental entity most directly affected by this rule is the Division of Health Care Finance and Administration of the Tennessee Department of Finance and Administration.

(D) Identification of any opinions of the attorney general and reporter or any judicial ruling that directly relates to the rule;

The Rule was approved by the Tennessee Attorney General. No additional opinion was given or requested.

(E) An estimate of the probable increase or decrease in state and local government revenues and expenditures, if any, resulting from the promulgation of this rule, and assumptions and reasoning upon which the estimate is based. An agency shall not state that the fiscal impact is minimal if the fiscal impact is more than two percent (2%) of the agency's annual budget or five hundred thousand dollars ($500,000), whichever is less;

The adoption of this rule is anticipated to decrease state annual expenditures by $9,540,000.

(F) Identification of the appropriate agency representative or representatives, possessing substantial knowledge and understanding of the rule;

Donna K. Tidwell
Deputy General Counsel

(G) Identification of the appropriate agency representative or representatives who will explain the rule at a scheduled meeting of the committees;

Donna K. Tidwell
Deputy General Counsel

(H) Office address, telephone number, and email address of the agency representative or representatives who will explain the rule at a scheduled meeting of the committees; and

310 Great Circle Road
Nashville, TN 37243
(615) 507-6852
donna.tidwell@tn.gov

(l) Any additional information relevant to the rule proposed for continuation that the committee requests.

GW10114050

0620-05-01-.06 Providers.

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2. Serious impairment to bodily functions; or

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(b) Any non-CoverKids providers who furnish CoverKids covered services by authorization from the PA must accept as payment in full for provision of covered services to CoverKids enrollees the amounts paid by the PA plus any copayment required by the CoverKids program to be paid by the individual.

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(c) Covered medically necessary inpatient hospital admissions required as the result of emergency outpatient services, when provided to CoverKids enrollees by non-CoverKids network hospitals, shall be reimbursed at 57% of the 2008 Medicare DRG rates (excluding Medical Education and Disproportionate Share components) determined according to 42 CFR § 412 for the services, consistent with the methodology contained in Rule 1200-13-13-.08(2)(c). Such an inpatient stay will continue until no longer medically necessary or until the patient can be safely transported to a network hospital, whichever comes first.

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(b) If the services are not covered because they are in excess of an enrollee's benefit limit and one of the following circumstances applies:

1. The provider has information in her own records to support the fact that the enrollee has reached his benefit limit for the particular service being requested and, prior to providing the service, informs the enrollee that the service is not covered and will not be paid for by CoverKids. This information may include:

(i) A previous written denial of a claim on the basis that the service was in excess of the enrollee's benefit limit for a service within the same benefit category as the service being requested, if the time period applicable to the benefit limit is still in effect; or

(ii) That the provider had personally provided services to the enrollee in excess of his benefit limit within the same benefit category as the service being requested, if the time period applicable to that benefit period is still in effect; or

(iii) The enrollee's PA has provided confirmation to the provider that the enrollee has reached his benefit limit for the applicable service.

2. The provider submits a claim for service to the PA and receives a written denial of that claim on the basis that the service exceeds the enrollee's benefit limit. After informing the enrollee and within the remainder of the period applicable to that benefit limit, the provider may bill the enrollee for services within that same exhausted benefit category without having to submit claims for those subsequent services for repeated PA denial. If the provider informed the enrollee prior to providing the service for which the claim was denied that the service would exceed the enrollee's benefit limit and would not be paid for by CoverKids, the provider may bill the enrollee for that service.

3. The provider had previously taken the steps in parts 1. or 2. above and determined that the enrollee had reached his benefit limit for the particular service being requested, if the time period applicable to the benefit limit is still in effect, and informs the enrollee, prior to providing the service, that the service is not covered and will not be paid for by CoverKids.

(c) If the services are covered only with prior authorization and prior authorization has been requested but denied, or is requested and a specified lesser level of care is approved, and the provider has given prior notice to the enrollee that the services are not covered, the enrollee may elect to receive those services for which prior authorization has been denied or which exceed the authorized level of care and be billed by the provider for such services.

(6) Providers may not seek payment from a CoverKids enrollee under the following conditions:

(a) The provider knew or should have known about the patient's CoverKids enrollment prior to providing services.

(b) The claim submitted to the PA for payment was denied due to provider billing error or a CoverKids claim processing error.

(c) The provider accepted CoverKids assignment on a claim and it is determined that another payer paid an amount equal to or greater than the CoverKids allowable amount.

(d) The provider failed to comply with CoverKids policies and procedures or provided a service which lacks medical necessity or justification.

(e) The provider failed to submit or resubmit claims for payment within the time periods required by the PA or CoverKids.

(f) The provider failed to inform the enrollee prior to providing a service not covered by CoverKids that the service was not covered and the enrollee may be responsible for the cost of the service. Services which are non-covered by virtue of exceeding limitations are exempt from this requirement if the provider has complied with paragraph (5) above.

(g) The enrollee failed to keep a scheduled appointment(s).

(7) Pharmacy providers may not waive pharmacy copayments for CoverKids enrollees as a means of attracting business to their establishments. This does not prohibit a pharmacy from exercising professional judgment in cases where an enrollee may have a temporary or acute need for a prescribed drug, but is unable, at that moment, to pay the required copayment.