Rulemaking Hearing Rule(s) Filing Form

Rulemaking Hearing Rules are rules filed after and as a result of a rulemaking hearing (Tenn. Code Ann. § 4-5-205).

Pursuant to Tenn. Code Ann. § 4-5-229, any new fee or fee increase promulgated by state agency rule shall take effect on July 1, following the expiration of the ninety (90) day period as provided in § 4-5-207. This section shall not apply to rules that implement new fees or fee increases that are promulgated as emergency rules pursuant to § 4-5-208(a) and to subsequent rules that make permanent such emergency rules, as amended during the rulemaking process. In addition, this section shall not apply to state agencies that did not, during the preceding two (2) fiscal years, collect fees in an amount sufficient to pay the cost of operating the board, commission or entity in accordance with § 4-29-121(b).

Agency/Board/Commission: Tennessee Department of Finance and Administration
Division: Division of TennCare
Contact Person: George Woods
Address: Division of TennCare
310 Great Circle Road
Nashville, TN 37243
Phone: (615) 507-6446
Email: george.woods@tn.gov

Revision Type (check all that apply):

- [X] Amendments
- [ ] New
- [ ] Repeal

Rule(s) (ALL chapters and rules contained in filing must be listed here. If needed, copy and paste additional tables to accommodate multiple chapters. Please make sure that ALL new rule and repealed rule numbers are listed in the chart below. Please enter only ONE Rule Number/Rule Title per row.)

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<tr>
<th>Rule Number</th>
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<td>1200-13-13-.01</td>
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</table>
Paragraph (10) Caretaker Relative of Rule 1200-13-13-.01 Definitions is amended by deleting “153” in “§ 71-3-153” and replacing it with “103” so as amended Paragraph (10) shall read as follows:

(10) Caretaker Relative shall mean that individual as defined at Tennessee Code Annotated § 71-3-103.

Paragraph (38) Durable Medical Equipment (DME) of Rule 1200-13-13-.01 Definitions is amended by deleting the word “stand” after the words “that can” and replacing it with the word “withstand” and by adding the phrase and comma “can be removable,” after the words and comma “repeated use,” in the first sentence and by deleting the sentence “Orthotics and prosthetic devices, and artificial limbs and eyes are considered DME.” and by deleting the words and commas “orthotics, prosthetics,” in the last sentence after the word “Customized” so as amended Paragraph (38) shall read as follows:

(38) Durable Medical Equipment (DME) shall mean equipment that can withstand repeated use, can be removable, 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 suitable for use in any non-institutional setting in which everyday life activities take place, and is related to the patient’s physical disorder. Non-institutional settings do not include a hospital or nursing facility (NF). Routine DME items, including but not limited to wheelchairs (except as defined below), walkers, hospital beds, canes, commodes, traction equipment, suction machines, patient lifts, weight scales, and other items provided to a member receiving services in a NF that are within the scope of per diem reimbursement for NF services shall not be covered or reimbursable under the Medicaid program separate and apart from payment for the NF service. Customized wheelchairs, wheelchair seating systems, and other items that are beyond the scope of Medicaid reimbursement for NF services shall be covered by the member’s managed care organization, so long as such items:

Paragraph (87) Out-of-State Emergency Provider of Rule 1200-13-13-.01 Definitions is amended by deleting from the second sentence the language “is not required to enroll with TennCare, but for the episode for which he is recognized as an Out-of-State Emergency Provider, he” and by adding the phrase “they must enroll with TennCare” after the word and comma “delivered,” and before the words “and they” in the third sentence so as amended Paragraph (87) shall read as follows:

(87) Out-of-State Emergency Provider shall mean a provider outside the State of Tennessee who does not participate in TennCare in any way except to bill for emergency services, as defined in this Chapter, provided out-of-state to a particular MCC’s enrollee. An Out-of-State Emergency Provider must abide by all TennCare rules and regulations, including those concerning provider billing of enrollees as found in Rule 1200-13-13-.08. In order to receive payment from TennCare, Out-of-State Emergency Providers must be appropriately licensed in the state in which the emergency services were delivered, they must enroll with TennCare and they must not be excluded from participation in Medicare or Medicaid.

Rule 1200-13-13-.01 Definitions is amended by adding a new Paragraph (114) and renumbering the current Paragraph (114) Responsible Party(ies) and all subsequent paragraphs appropriately so as amended the new Paragraph (114) shall read as follows:

(114) Request for Reimbursement shall mean a request from an enrollee for reimbursement of amounts paid out of pocket to providers for medical, dental or pharmacy services received. Enrollees seeking reimbursement are required to submit receipts or bills that include the following information: the amount paid by enrollee, a description of the prescriptions, care or services received, the date the prescriptions, care or services were received, and the name of the provider or pharmacy. All required information must be received from enrollees within the sixty (60) day timeframe to request reimbursement as prescribed by Rule 1200-13-13-.11(2)(d).

Paragraph (127), renumbered as (128), TennCare Provider of Rule 1200-13-13-.01 Definitions is amended by deleting the phrase “Except in the case of Out-of-State Emergency Providers, as defined in this Rule, a” and by adding an “s” to the word “provider” after the word “TennCare” in the third sentence and by de-capitalizing the word “Provider” after the word “TennCare” in the last sentence so as amended Paragraph (128) shall read as follows:
(128) TennCare Provider shall mean a provider who accepts as payment in full for furnishing benefits to a TennCare enrollee, the amounts paid pursuant to an approved agreement with an MCC or TennCare. Such payment may include copayments from the enrollee or the enrollee’s responsible party. TennCare providers must be enrolled with TennCare. TennCare providers must abide by all TennCare rules and regulations, including requirements regarding provider billing of patients as found in Rule 1200-13-13-.08. TennCare providers must be appropriately licensed for the services they deliver and must not be providers who have been excluded from participation in Medicare or Medicaid.


Part 2 of Subparagraph (a) of Paragraph (1) of Rule 1200-13-13-.03 Enrollment, Reassignment, and Disenrollment with Managed Care Contractors (MCCs) is amended by deleting “forty-five (45)” in the first sentence and replacing it with “ninety (90)” as so amended Part 2 shall read as follows:

2. Except as provided in subparagraph (c), a TennCare enrollee may change MCOs one (1) time within the initial ninety (90) calendar days (inclusive of mail time) from the date of the letter informing him of his MCO assignment, if there is another MCO in the enrollee’s Grand Division that is currently permitted by the Bureau to accept new enrollees. No additional changes will be allowed except as otherwise specified in these rules. An enrollee shall remain a member of the designated plan until he is given an opportunity to change once each year during an annual change period. The annual change period will occur each year in March for enrollees in West Tennessee, in May for enrollees in Middle Tennessee, and in July for enrollees in East Tennessee. Thereafter, an MCO change is permitted only during an annual change period, unless the Bureau authorizes a change as the result of the resolution of an appeal requesting a “hardship” reassignment as specified in paragraph (2)(b) below. When an enrollee changes MCOs, the enrollee’s medical care will be the responsibility of the current MCO until he is enrolled in the requested MCO.

Part 1 of Subparagraph (a) of Paragraph (2) of Rule 1200-13-13-.03 Enrollment, Reassignment, and Disenrollment with Managed Care Contractors (MCCs) is amended by deleting “forty-five (45)” and replacing it with “ninety (90)” as so amended Part 1 shall read as follows:

1. During the initial ninety (90) day period following notification of MCO assignment as described at rule 1200-13-13-.03, a TennCare enrollee may request a change of MCOs.

Part 3 of Subparagraph (a) of Paragraph (2) of Rule 1200-13-13-.03 Enrollment, Reassignment, and Disenrollment with Managed Care Contractors (MCCs) is amended by deleting “forty-five (45)” and replacing it with “ninety (90)” as so amended Part 3 shall read as follows:

3. If an enrollee’s MCO withdraws from participation in the TennCare Program, TennCare will assign him to a MCO operating in his Grand Division, if one is available. The enrollee will be provided notice of the change and will have ninety (90) days to select another MCO in his Grand Division. 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.


Part 6 Durable Medical Equipment of column one “Service” of Subparagraph (b) of Paragraph (1) of Rule 1200-13-13-.04 Covered Services is amended by deleting “and 42 C.F.R. § 440.120(c)” at the end of the part in column one so as amended Part 6 shall read as follows:

<table>
<thead>
<tr>
<th>6. Durable Medical Equipment [defined at 42 C.F.R. § 440.70(b)(3)].</th>
<th>Covered as medically necessary.</th>
<th>Covered as medically necessary.</th>
</tr>
</thead>
</table>

Subparagraph (b) of Paragraph (1) of Rule 1200-13-13-.04 Covered Services is amended by adding a new Part 9 and the current Part 9 and subsequent parts are renumbered appropriately so as amended the new Part 9 shall read as follows:
9. Health Home Services for Persons with Serious and Persistent Mental Illness [described at 42 U.S.C. § 1396w-4(h)(4)]. Covered as medically necessary. Covered as medically necessary.

Part 16 Mental Health Case Management Services of Subparagraph (b) of Paragraph (1) of Rule 1200-13-13-.04 Covered Services is deleted in its entirety.

Column three “Benefits for Persons Aged 21 and Older” of Part 18 Methadone Clinic Services of Subparagraph (b) of Paragraph (1) of Rule 1200-13-13-.04 Covered Services is amended by deleting “Not covered” and replacing it with “Covered as medically necessary” so as amended Part 18 shall read as follows:

18. Methadone Clinic Services [defined as services provided by a methadone clinic]. Covered as medically necessary. Covered as medically necessary.

(B) of Column three “Benefits for Persons Aged 21 and Older” of Part 25 Pharmacy Services of Subparagraph (b) of Paragraph (1) of Rule 1200-13-13-.04 Covered Services is amended by deleting the last two sentences “For persons who are not dually eligible for Medicare and Medicaid, pharmaceuticals supplied and administered in a doctor’s office are the responsibility of the MCO. For persons who are dually eligible for Medicare and Medicaid, pharmaceuticals supplied and administered in a doctor’s office are not covered by TennCare.” so as amended (B) shall read as follows:

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>BENEFIT FOR PERSONS UNDER AGE 21</th>
<th>BENEFIT FOR PERSONS AGED 21 AND OLDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>25. Pharmacy Services [defined at 42 C.F.R. § 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].</td>
<td>(B) Pharmacy services are the responsibility of the PBM, except for pharmaceuticals supplied and administered in a doctor’s office.</td>
<td></td>
</tr>
</tbody>
</table>

First paragraph of column three “Benefits for Persons Aged 21 and Older” of Part 28 Physician Outpatient Services/Community Health Clinics/Other Clinic Services of Subparagraph (b) of Paragraph (1) of Rule 1200-13-13-.04 Covered Services is amended by deleting the punctuation and phrase “except see “Methadone Clinic Services” “ at the end of the paragraph so as amended the first paragraph shall read as follows:
<table>
<thead>
<tr>
<th>SERVICE</th>
<th>BENEFIT FOR PERSONS UNDER AGE 21</th>
<th>BENEFIT FOR PERSONS AGED 21 AND OLDER</th>
</tr>
</thead>
</table>

Subparagraph (b) of Paragraph (1) of Rule 1200-13-13-.04 Covered Services is amended by adding a new Part 30 Prosthetic Devices and the current Part 30 and subsequent parts are renumbered appropriately so as amended the new Part 30 shall read as follows:

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>BENEFIT FOR PERSONS UNDER AGE 21</th>
<th>BENEFIT FOR PERSONS AGED 21 AND OLDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>30. Prosthetic Devices [defined at 42 C.F.R. § 440.120(c)].</td>
<td>Covered as medically necessary.</td>
<td>Covered as medically necessary.</td>
</tr>
</tbody>
</table>


Part 2 Augmentative communication devices of Subparagraph (a) of Paragraph (3) of Rule 1200-13-13-.10 Exclusions is deleted in its entirety and the subsequent Part 3 and other parts are renumbered appropriately.

Part 9 "Floor standers, meaning stationary devices not attached to a wheelchair base and not built into the operating system of a power wheelchair that are designed to hold in an upright position an Enrollee who uses a wheelchair and who has limited or no ability to stand on his own" of Subparagraph (a) of Paragraph (3) of Rule 1200-13-13-.10 Exclusions is deleted in its entirety and the subsequent Part 10 and other parts are renumbered appropriately.

Part 11 "Hearing services, including the prescribing, fitting or changing of hearing aids" of Subparagraph (a) of Paragraph (3) of Rule 1200-13-13-.10 Exclusions is amended by adding the words "and cochlear implants" so as amended Part 11, renumbered appropriately, shall read as follows:

9. Hearing services, including the prescribing, fitting, or changing of hearing aids and cochlear implants

Part 15 Methadone clinic services renumbered as 13 of Subparagraph (a) of Paragraph (3) of Rule 1200-13-13-.10 Exclusions is deleted in its entirety and subsequent parts are renumbered appropriately.

Subpart (ii) Orthotrac pneumatic vests of Part 78 Supports of Subparagraph (b) of Paragraph (3) of Rule 1200-13-13-.10 Exclusions is deleted in its entirety, and the remaining Part is amended to remove the unnecessary numeral (i) so that as amended Part 78 shall read as follows:

78. Supports: Cervical pillows

Part 87 "Urine drug screens in excess of twelve (12), four (4) confirmation urine screens and two (2) specific assay tests during a calendar year." of Subparagraph (b) of Paragraph (3) of Rule 1200-13-13-.10 Exclusions is deleted in its entirety and replaced with the following:

87. Urine Drug testing that, within a calendar year, is in excess of twenty-four (24) presumptive urine drug tests using optical observation, and twelve (12) presumptive urine drug tests using instrument chemistry analyzers, and twelve (12) definitive drug urine tests
Subparagraph (d) of Paragraph (2) of Rule 1200-13-13-.11 Appeal of Adverse Benefit Determinations is amended by deleting the words "receipt of" after the words "days from" and replacing them with the words "the date on the" and is further amended by adding two new sentences at the end of the subparagraph so as amended. Subparagraph (d) shall read as follows:

(d) To be allowed sixty (60) days from the date on the written notice or, if no notice is provided, from the time the enrollee becomes aware of an adverse benefit determination, to appeal any adverse benefit determination. To file a Request for Reimbursement for expenses incurred between the effective eligibility date and the date that notice of eligibility is provided, the enrollee must request reimbursement and provide complete information to TennCare, as prescribed by Rule .01, within sixty (60) days from the date of the written notification of the effective eligibility date or, if no written notice is provided, within sixty (60) days from the date the enrollee becomes aware of the effective eligibility date. For all other Requests for Reimbursement, the enrollee must request reimbursement and provide complete information, as prescribed by Rule .01, within sixty (60) days from the date the enrollee paid out of pocket for covered services.

I certify that this is an accurate and complete copy of rulemaking hearing rules, lawfully promulgated and adopted by the Division of TennCare (board/commission/other authority) on 06/01/2021 (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: 09/28/2020

Rulemaking Hearing(s) Conducted on: (add more dates). 11/19/2020

Date: June 1, 2021

Signature:

Name of Officer: Stephen Smith
Director, Division of TennCare
Title of Officer: Tennessee Department of Finance and Administration

Agency/Board/Commission: Division of TennCare
Rule Chapter Number(s): 1200-13-13

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.

Herbert H. Slatery III
Attorney General and Reporter

Date

Department of State Use Only

Filed with the Department of State on: 7/8/2021
Effective on: 10/6/2021

Tre Hargett
Secretary of State

SS-7039 (March 2020) 7  RDA 1693
Public Hearing Comments

One copy of a document that satisfies T.C.A. § 4-5-222 must accompany the filing.

The Division of TennCare received comments from five organizations or individuals in response to this rulemaking. These comments, and the Division of TennCare's responses, are summarized below.

Two commenters expressed support for removing augmentative communication devices from the list of items and services excluded from TennCare coverage for adults. TennCare thanked these commenters for their support. No changes were made to the rule based on these comments.

Two commenters expressed support for removing floor standers from the list of items and services excluded from TennCare coverage for adults. TennCare thanked these commenters for their support. No changes were made to the rule based on these comments.

One commenter recommended clarifications to the language in the rule regarding urine drug screens. This commenter also requested additional flexibility in TennCare's coverage of urine drug screens. In response, TennCare updated the description of urine drug screens in the rule and provided additional flexibility in the quantity of covered drug screens.
Regulatory Flexibility Addendum

Pursuant to T.C.A. §§ 4-5-401 through 4-5-404, prior to initiating the rule making process, all agencies shall conduct a review of whether a proposed rule or rule affects small business.

The rule amendments do not specifically affect small businesses.
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://publications.tnsosfiles.com/acts/106/pub/pc1070.pdf) of the 2010 Session of the General Assembly.)

The rules are 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 rules are being amended to:
- Clarify several definitions related to the TennCare program;
- Update the time period during which a new enrollee may change MCOs from 45 days to 90 days;
- Update the TennCare's list of covered services as it relates to methadone clinic services, health home services for persons with serious and persistent mental illness, pharmacy services and prosthetic devices;
- Update TennCare’s list of excluded services; and
- Clarify the timeframe for appealing and adverse benefit determination, as well as submitting a request for reimbursement.

(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 rules are lawfully adopted by the Division of TennCare in accordance with T.C.A §§ 4-5-202, 71-5-105, 71-5-109 and 42 C.F.R. Part 455 Subpart E.

(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 these rule amendments are TennCare enrollees, providers, and managed care contractors. The governmental entity most directly affected by these rules is the Division of TennCare, Tennessee Department of Finance & Administration.

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

The rules were 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 rules are anticipated to increase TennCare Medicaid and TennCare Standard state expenditures by $2,359,350.

(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
(I) Any additional information relevant to the rule proposed for continuation that the committee requests.
RULES OF TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION BUREAU OF TENNCARE

CHAPTER 1200-13-13 TENNCARE MEDICAID

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1200-13-13-.01 Definitions.

(10) CARETAKER RELATIVE shall mean that individual as defined at Tennessee Code Annotated § 71-3-153103.

(38) DURABLE MEDICAL EQUIPMENT (DME) shall mean equipment that can stand withstand repeated use, can be removable, 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 suitable for use in any non-institutional setting in which everyday life activities take place, and is related to the patient's physical disorder. Orthotics and prosthetic devices, and artificial limbs and eyes are considered DME. Non-institutional settings do not include a hospital or nursing facility (NF). Routine DME items, including but not limited to wheelchairs (except as defined below), walkers, hospital beds, canes, commodes, traction equipment, suction machines, patient lifts, weight scales, and other items provided to a member receiving services in a NF that are within the scope of per diem reimbursement for NF services shall not be covered or reimbursable under the Medicaid program separate and apart from payment for the NF service. Customized orthotics, prosthetics, wheelchairs, wheelchair seating systems, and other items that are beyond the scope of Medicaid reimbursement for NF services shall be covered by the member's managed care organization, so long as such items:

(87) OUT-OF-STATE EMERGENCY PROVIDER shall mean a provider outside the State of Tennessee who does not participate in TennCare in any way except to bill for emergency services, as defined in this Chapter, provided out-of-state to a particular MCC's enrollee. An Out-of-State Emergency Provider is not required to enroll with TennCare, but for the episode for which he is recognized as an Out-of-State Emergency Provider, he must abide by all TennCare rules and regulations, including those concerning provider billing of enrollees as found in Rule 1200-13-13-.08. In order to receive payment from TennCare, Out-of-State Emergency Providers must be appropriately licensed in the state in which the emergency services were delivered, they must enroll with TennCare and they must not be excluded from participation in Medicare or Medicaid.

(114) Request for Reimbursement shall mean a request from an enrollee for reimbursement of amounts paid out of pocket to providers for medical, dental or pharmacy services received. Enrollees seeking reimbursement are required to submit receipts or bills that include the...
(Rule 1200-13-13-.03, continued)

following information: the amount paid by enrollee, a description of the prescriptions, care or services received, the date the prescriptions, care or services were received, and the name of the provider or pharmacy. All required information must be received from enrollees within the sixty (60) day timeframe to request reimbursement as prescribed by Rule 1200-13-13-.11(2)(d).

(427:128) TENNCARE PROVIDER shall mean a provider who accepts as payment in full for furnishing benefits to a TennCare enrollee, the amounts paid pursuant to an approved agreement with an MCC or TennCare. Such payment may include copayments from the enrollee or the enrollee’s responsible party. Except in the case of Out-of-State Emergency Providers, as defined in this Rule, a TennCare provider must be enrolled with TennCare. TennCare providers must abide by all TennCare rules and regulations, including requirements regarding provider billing of patients as found in Rule 1200-13-13-.08. TennCare providers must be appropriately licensed for the services they deliver and must not be providers who have been excluded from participation in Medicare or Medicaid.

1200-13-13-.03 ENROLLMENT, REASSIGNMENT, AND DISENROLLMENT WITH MANAGED CARE CONTRACTORS (MCCS).

1. During the initial forty-five (45) ninety (90) day period following notification of MCO assignment as described at rule 1200-13-13-.03, a TennCare enrollee may request a change of MCOs.

2. Except as provided in subparagraph (c), a TennCare enrollee may change MCOs one (1) time within the initial forty-five (45) ninety (90) calendar days (inclusive of mail time) from the date of the letter informing him of his MCO assignment, if there is another MCO in the enrollee’s Grand Division that is currently permitted by the Bureau to accept new enrollees. No additional changes will be allowed except as otherwise specified in these rules. An enrollee shall remain a member of the designated plan until he is given an opportunity to change once each year during an annual change period. The annual change period will occur each year in March for enrollees in West Tennessee, in May for enrollees in Middle Tennessee, and in July for enrollees in East Tennessee. Thereafter, an MCO change is permitted only during an annual change period, unless the Bureau authorizes a change as the result of the resolution of an appeal requesting a “hardship” reassignment as specified in paragraph (2)(b) below. When an enrollee changes MCOs, the enrollee’s medical care will be the responsibility of the current MCO until he is enrolled in the requested MCO.

3. If an enrollee’s MCO withdraws from participation in the TennCare Program, TennCare will assign him to a MCO operating in his Grand Division, if one is available. The enrollee will be provided notice of the change and will have forty-five (45) ninety (90) days to select another MCO in his Grand Division. 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.

1200-13-13-.04 COVERED SERVICES.
<table>
<thead>
<tr>
<th>SERVICE</th>
<th>BENEFIT FOR PERSONS UNDER AGE 21</th>
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</tr>
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<tbody>
<tr>
<td>6. Durable Medical Equipment [defined at 42 C.F.R. § 440.70(b)(3) and 42 C.F.R. § 440.120(c)]</td>
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<td>9. Health Home Services for Persons with Serious and Persistent Mental Illness [described at 42 U.S.C. § 1396w-4(h)(4)]</td>
<td>Covered as medically necessary.</td>
<td>Covered as medically necessary.</td>
</tr>
<tr>
<td>16. Mental Health Case Management Services [defined as services rendered to support outpatient mental health clinical services]</td>
<td>Covered as medically necessary.</td>
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<tr>
<td>25. Pharmacy Services [defined at 42 C.F.R. § 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]</td>
<td>Covered as medically necessary. Certain drugs (known as DESI, LTE, IRS drugs) are excluded from coverage. Persons dually eligible for Medicaid and Medicare will receive their pharmacy services through Medicare Part D. Pharmacy services are the responsibility of the PBM, except for pharmaceuticals supplied and administered in a doctor's office. For persons who are not dually eligible for Medicare and Medicaid, pharmaceuticals supplied and administered in a doctor's office are the responsibility of the MCO. For persons who are dually eligible for Medicare and Medicaid, pharmaceuticals supplied and administered in a doctor's office are the responsibility of the MCO if not covered by Medicare. (B) Pharmacy services are the responsibility of the PBM, except for pharmaceuticals supplied and administered in a doctor's office. For persons who are not dually eligible for Medicare and Medicaid, pharmaceuticals supplied and administered in a doctor's office are the responsibility of the MCO. For persons who are dually eligible for Medicare and Medicaid, pharmaceuticals supplied and administered in a doctor's office are not covered by TennCare.</td>
<td></td>
</tr>
<tr>
<td>28. Physician Outpatient Services/Community Health Clinics/Other Clinic</td>
<td>Covered as medically necessary. Services provided by a Primary Care Provider when</td>
<td>Covered as medically necessary, except see &quot;Methadone Clinic Services&quot;. Services provided by a Primary Care Provider when</td>
</tr>
</tbody>
</table>
(Rule 1200-13-13-.04, continued)

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>BENEFIT FOR PERSONS UNDER AGE 21</th>
<th>BENEFIT FOR PERSONS AGED 21 AND OLDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services [defined at 42 C.F.R. §440.20(b), 42 C.F.R. § 440.50, and 42 C.F.R. §440.90].</td>
<td>the enrollee has a primary behavioral health diagnosis (ICD-9-CM 290.xx-319.xx) are the responsibility of the MCO. Medical evaluations provided by a neurologist, as approved by the MCO, and/or an emergency room provider to establish a primary behavioral health diagnosis are the responsibility of the MCO.</td>
<td>Provider when the enrollee has a primary behavioral health diagnosis (ICD-9-CM 290.xx-319.xx) are the responsibility of the MCO. Medical evaluations provided by a neurologist, as approved by the MCO, and/or an emergency room provider to establish a primary behavioral health diagnosis are the responsibility of the MCO.</td>
</tr>
<tr>
<td>30. Prosthetic Devices [defined at 42 C.F.R. §440.120(c)].</td>
<td>Covered as medically necessary.</td>
<td>Covered as medically necessary.</td>
</tr>
</tbody>
</table>

1200-13-13-.10 EXCLUSIONS.

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

- Augmentative communication devices
- Floor standers, meaning stationary devices not attached to a wheelchair base and not built into the operating system of a power wheelchair that are designed to hold in an upright position an Enrollee who uses a wheelchair and who has limited or no ability to stand on his own
- Hearing services, including the prescribing, fitting, or changing of hearing aids and cochlear implants
- Methadone clinic services

(b) Services, products, and supplies that are specifically excluded from coverage under the TennCare program.

- Supports:
  - Cervical pillows
  - Orthotrac pneumatic vests

- Urine drug screens in excess of twelve (12), four (4) confirmation urine screens and two (2) specific assay tests during a calendar year.

- Urine Drug testing that, within a calendar year, is in excess of twenty-four (24) presumptive urine drug tests using optical observation, and twelve (12)
(Rule 1200-13-13-.14, continued)

presumptive urine drug tests using instrument chemistry analyzers, and twelve
(12) definitive drug urine tests

1200-13-13-.11 APPEAL OF ADVERSE BENEFIT DETERMINATIONS.

(2) Appeal Rights of Enrollees. Enrollees have the following rights:

(d) To be allowed sixty (60) days from receipt of the date on the written notice or, if no
notice is provided, from the time the enrollee becomes aware of an adverse benefit
determination, to appeal any adverse benefit determination. To file a Request for
Reimbursement for expenses incurred between the effective eligibility date and the
date that notice of eligibility is provided, the enrollee must request reimbursement and
provide complete information to TennCare, as prescribed by Rule .01, within sixty (60)
days from the date of the written notification of the effective eligibility date or, if no
written notice is provided, within sixty (60) days from the date the enrollee becomes
aware of the effective eligibility date. For all other Requests for Reimbursement, the
enrollee must request reimbursement and provide complete information, as prescribed
by Rule .01, within sixty (60) days from the date the enrollee paid out of pocket for
covered services.