Department of State
Division of Publications
312 Rosa L. Parks Ave., 8th Floor, Snodgrass/TN Tower
Nashville, TN 37243
Phone: 615-741-2650
Email: publications.information@tn.gov

For Department of State Use Only

Sequence Number: 09-22-20
Notice ID(s): 3184
File Date: 9/28/2020

Notice of Rulemaking Hearing

Hearings will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, T.C.A. § 4-5-204. For questions and copies of the notice, contact the person listed below.

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

Any Individuals with disabilities who wish to participate in these proceedings (to review these filings) and may require aid to facilitate such participation should contact the following at least 10 days prior to the hearing:

ADA Contact:	Talley A. Olson, Director TennCare Office of Civil Rights Compliance
Address:	Division of TennCare 310 Great Circle Road Nashville, TN 37243
Phone:	(855) 857-1673 TTY dial 711 and ask for 855-857-1673
Email:	hcfa.fairtreatment@tn.gov

Hearing Location(s) (for additional locations, copy and paste table)

Address 1:	Division of TennCare 310 Great Circle Road, Conference Room 1 East A		
City:	Nashville, TN		
Zip:	37243		
Hearing Date:	November 19, 2020		
Hearing Time:	5:00 p.m.	X CST/CDT ___EST/EDT	

Additional Hearing Information:

Members of the public may submit written comments for consideration at the hearing until 5:00 p.m. Central Time on November 19, 2020. Written comments should be sent via email to george.woods@tn.gov.

If attending in-person, please bring identification so that you may be checked into the building.

COVID Building Entry Protocols:

As part of the Tennessee Pledge, TennCare observes and is compliant with the following building entry protocols:

- At this time, all persons working or meeting in the TennCare building are required to wear a face mask.
- We recommend meeting attendees bring their own mask, however, if an attendee does not have one, a mask will be provided to any attendee upon entry.
- Additional personal protection equipment (PPE) such as a face shield are permitted but are not a

replacement for a face mask.

- Upon entry, persons are required to complete a health screening by answering the following questions:
    1. Have you been in close contact with a confirmed case of COVID-19 in the past 14 days? (Note: This does not apply to medical personnel, first responders, or other individuals who encounter COVID-19 as part of their professional or caregiving duties while wearing appropriate PPE.)
    2. Are you experiencing a cough, shortness of breath or sore throat?
    3. Have you had a fever in the last 48 hours?
    4. Have you had new loss of taste or smell?
    5. Have you had vomiting or diarrhea in the last 24 hours?
- Persons working or meeting in the TennCare building are also required to submit to a temperature screening; persons with temperatures 100.4 degrees or higher will not be permitted to enter the building. However, an opportunity will be provided to submit comments in writing instead of in-person.

*****NOTICE*****

Currently, Governor Lee's Emergency Order pertaining to COVID-19 that allows State Boards to hold their meetings electronically is set to expire September 30, 2020. If it does expire on that date, then this hearing will be an in-person hearing at the location and time denoted just above. If the Emergency Order is extended beyond the scheduled date of this hearing, then this hearing will be held electronically via WebEx.

In the event of an electronic hearing, members of the public may join the WebEx at the following link:

https://tngov.webex.com/tngov/j.php?MTID=m486504f11a96f15b141893b90f1d3ef3

The link above should take users directly to the rulemaking hearing. If prompted for a meeting number or password, use:

Meeting number (access code): 171 073 8020
Meeting password: tenncare

It is recommended that interested persons join the WebEx several minutes early to ensure adequate time to install any mandatory plugins in order to attend the electronic rulemaking hearing.

Revision Type (check all that apply):

X Amendments
___ New
___ Repeal

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

Chapter Number	**Chapter Title**
1200-13-14	TennCare Standard
Rule Number	**Rule Title**
1200-13-14-.01	Definitions
1200-13-14-.03	Enrollment, Reassignment, and Disenrollment with Managed Care Contractors (MCCS)
1200-13-14-.04	Covered Services
1200-13-14-.10	Exclusions
1200-13-14-.11	Appeal of Adverse Benefit Determinations

Place substance of rules and other info here. Statutory authority must be given for each rule change. For information on formatting rules go to https://sos.tn.gov/products/division-publications/rulemaking-guidelines.

Paragraph (11) Caretaker Relative of Rule 1200-13-14-.01 Definitions is amended by deleting "153" in "§ 71-3-153" and replacing it with "103" so as amended Paragraph (11) shall read as follows:

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

Paragraph (43) Durable Medical Equipment (DME) of Rule 1200-13-14-.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 (43) shall read as follows:

(43) 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 (92) Out-of-State Emergency Provider of Rule 1200-13-14-.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 (92) shall read as follows:

(92) 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 1200-13-14-.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 1200-13-14-.01 Definitions is amended by adding a new Paragraph (121) and renumbering the current Paragraph (121) Responsible Party(ies) and all subsequent paragraphs appropriately so as amended the new Paragraph (121) shall read as follows:

(121) 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 1200-13-14-.11(2)(d).

Paragraph (134), renumbered as (135), TennCare Provider of Rule 1200-13-14-.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 (135) shall read as follows:

(135) 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 1200-13-14-.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.

Statutory Authority: T. C. A. §§ 4-5-202, 4-5-203, 71-5-105, 71-5-109 and 42 C.F.R. Part 455 Subpart E.

Part 2 of Subparagraph (a) of Paragraph (1) of Rule 1200-13-14-.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)" so as 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 1200-13-14-.03 Enrollment, Reassignment, and Disenrollment with Managed Care Contractors (MCCS) is amended by deleting "forty-five (45)" and replacing it with "ninety (90)" so as amended Part 1 shall read as follows:

1. During the initial ninety (90) day period following notification of MCO assignment as described at rule 1200-13-14-.03, a TennCare Standard enrollee may request a change of MCOs.

Part 3 of Subparagraph (a) of Paragraph (2) of Rule 1200-13-14-.03 Enrollment, Reassignment, and Disenrollment with Managed Care Contractors (MCCS) is amended by deleting "forty-five (45)" and replacing it with "ninety (90)" so as 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.

Statutory Authority: T. C. A. §§ 4-5-202, 4-5-203, 71-5-105 and 71-5-109.

Part 6 Durable Medical Equipment of column one "Service" of Subparagraph (b) of Paragraph (1) of Rule 1200-13-14-.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:

6. Durable Medical Equipment [defined at 42 C.F.R. § 440.70(b)(3)].	Covered as medically necessary.	Covered as medically necessary.

Subparagraph (b) of Paragraph (1) of Rule 1200-13-14-.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	Covered as medically necessary.	Covered as medically necessary.

Persons with Serious and Persistent Mental Illness [described at 42 U.S.C. § 1396w-4(h)(4)].		

Part 16 Mental Health Case Management Services of Subparagraph (b) of Paragraph (1) of Rule 1200-13-14-.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 1200-13-14-.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 1200-13-14-.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:

SERVICE	BENEFIT FOR PERSONS UNDER AGE 21	BENEFIT FOR PERSONS AGED 21 AND OLDER
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].		(B) Pharmacy services are the responsibility of the PBM, except for pharmaceuticals supplied and administered in a doctor’s office.

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 1200-13-14-.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:

SERVICE	BENEFIT FOR PERSONS UNDER AGE 21	BENEFIT FOR PERSONS AGED 21 AND OLDER
28. Physician Outpatient Services/ Community Health		Covered as medically necessary.

SERVICE	BENEFIT FOR PERSONS UNDER AGE 21	BENEFIT FOR PERSONS AGED 21 AND OLDER
Clinics/Other Clinic Services [defined at 42 C.F.R. §440.20(b), 42 C.F.R. § 440.50, and 42 C.F.R. §440.90].		

Subparagraph (b) of Paragraph (1) of Rule 1200-13-14-.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:

30. Prosthetic Devices [defined at 42 C.F.R. § 440.120(c)].	Covered as medically necessary.	Covered as medically necessary.

Statutory Authority: T. C. A. §§ 4-5-202, 4-5-203, 71-5-105 and 71-5-109.

Part 2 Augmentative communication devices of Subparagraph (a) of Paragraph (3) of Rule 1200-13-14-.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 1200-13-14-.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 1200-13-14-.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 1200-13-14 Exclusions is deleted in its entirety and subsequent parts are renumbered appropriately.

Subpart (ii) Pillows of Part 6 of Subparagraph (b) of Paragraph (3) of Rule 1200-13-14-.10 Exclusions is deleted in its entirety and the subsequent Subpart (iii) is renumbered as (ii) Sauna baths.

Part 7 “Beds and bedding equipment as follows” of Subparagraph (b) of Paragraph (3) of Rule 1200-13-14-.10 Exclusions is amended by adding a new Subpart (ii) and the current Subpart (ii) is renumbered as Subpart (iii) so as amended Part 7 shall read as follows:

7. Beds and bedding equipment as follows:

   (i) Adjust-a-Beds, lounge beds, or similar devices

   (ii) Pillows

   (iii) Waterbeds

Subpart (ii) Orthotrac pneumatic vests of Part 78 Supports of Subparagraph (b) of Paragraph (3) of Rule 1200-13-14-.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 1200-13-14-.10 Exclusions is amended by deleting “twelve (12), four (4)” and replacing it with “twenty-four (24), eight (8)”and by deleting “two (2)” and replacing it with “eight (8) total” so as amended Part 87 shall read as follows:

87. Urine drug screens in excess of twenty-four (24), eight (8) confirmation urine screens, and eight (8) total specific assay tests during a calendar year.

Statutory Authority: T. C. A. §§ 4-5-202, 4-5-203, 71-5-105 and 71-5-109.

Subparagraph (d) of Paragraph (2) of Rule 1200-13-14-.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, 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.

Statutory Authority: T. C. A. §§ 4-5-202, 4-5-203, 71-5-105 and 71-5-109.

I certify that the information included in this filing is an accurate and complete representation of the intent and scope of rulemaking proposed by the agency.

Date: September 28, 2020

Signature: 

Name of Officer: Stephen Smith

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

Department of State Use Only

Filed with the Department of State on: 9/28/2020

Tre Hargett
Secretary of State

GW10320269

RECEIVED

2020 SEP 28 PM 3:32

SECRETARY OF STATE
PUBLICATIONS