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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 & Administration
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Revision Type (check all that apply):

- 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 Please make sure that ALL new rule and repealed rule numbers are listed in the chart below.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)

Chapter Number	Chapter Title
1200-13-14	TennCare Standard
Rule Number	Rule Title
1200-13-14-.01	Definitions
1200-13-14-.10	Exclusions
1200-13-14-.11	Appeal of Adverse Actions Affecting TennCare Services or Benefits
1200-13-14-.12	Other Appeals By TennCare Applicants and Enrollees

(Place substance of rules and other info here. Please be sure to include a detailed explanation of the changes being made to the listed rule(s). Statutory authority must be given for each rule change. For information on formatting rules go to http://sos.tn.gov/sites/default/files/forms/Rulemaking_Guidelines_August2014.pdf)

Chapter 1200-13-14 TennCare Standard Table of Contents is amended by deleting the title of rule 1200-13-14-.11 "Appeal of Adverse Actions Affecting TennCare Services or Benefits" and by substituting instead the language "Appeal of Adverse Benefit Determinations" so that, as amended, the Table of Contents title of rule 1200-13-14-.11 shall read as follows:

1200-13-14-.11 Appeal of Adverse Benefit Determinations

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105 and 71-5-113.

Rule 1200-13-14-.01 Definitions paragraph (3) Administrative Hearing is amended by deleting it in its entirety and renumbering the following paragraphs appropriately.

Rule 1200-13-14-.01 Definitions paragraph (4) Adverse Action Affecting TennCare Services or Benefits is amended by deleting the language "Action Affecting TennCare Services or Benefits as it relates to actions under the Grier Revised Consent Decree" and by substituting instead the language "Benefit Determination" and is further amended by deleting the punctuation and phrase ", as well as any other act or omission of the TennCare Program which impairs the quality, timeliness, or availability of such benefits" and by adding the sentence "See 42 C.F.R. § 438.400." so that, as amended, paragraph (4) shall read as follows:

(4) Adverse Benefit Determination shall mean, but is not limited to, a delay, denial, reduction, suspension or termination of TennCare benefits. See 42 C.F.R. § 438.400.

Rule 1200-13-14-.01 Definitions paragraph (26) Continuation or Reinstatement is amended by deleting the paragraph and its subparagraphs in their entirety and by substituting instead the following language, so that, as amended, paragraph (26) shall read as follows:

(26) Continuation or Reinstatement of Benefits (COB) shall mean the circumstances under which an enrollee may keep receiving, or, in the case of reinstatement, get back and keep receiving, the benefit under appeal until the appeal is resolved. See 42 C.F.R. §§ 431.230, 431.231 and 438.420.

Rule 1200-13-14-.01 Definitions paragraph (40) Delay is amended by deleting the punctuation and language ", but not limited to: (a) Any" and by substituting instead the word "any" and is further amended by deleting the punctuation "," following the word "appeal" and by substituting instead the punctuation "." and is further amended by deleting subparagraph (b) in its entirety, so that, as amended, paragraph (40) shall read as follows:

(40) Delay shall mean any failure to provide timely receipt of TennCare services, and no specific waiting period may be required before the enrollee can appeal.

Rule 1200-13-14-.01 Definitions paragraph (47) Emergency Medical Condition is amended by deleting it in its entirety and renumbering the following paragraphs appropriately.

Rule 1200-13-14-.01 Definitions paragraph (54) Final Agency Action is amended by deleting the word "impartial" so that, as amended, paragraph (54) shall read as follows:

(54) 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 administrative judge or hearing officer when such initial decision is not modified or overturned by the TennCare Bureau. Final agency action shall be treated as binding for purposes of these rules.

Rule 1200-13-14-.01 Definitions paragraph (64) Impartial Hearing Officer is amended by deleting the word "Impartial" and by deleting the word "and" and replacing it with the word "or" and is further amended by deleting the word "Administrative" preceding the word "Hearing" and substituting instead the words "State Fair" and by adding the punctuation and letters "(SFH)" at the end of the paragraph, so that, as amended, paragraph (64) shall read as follows:

(64) Hearing Officer shall mean an administrative judge or hearing officer who is not an employee, agent or representative of the MCC or who did not participate in, nor was consulted about, any TennCare Bureau

review prior to the State Fair Hearing (SFH).

Rule 1200-13-14-.01 Definitions paragraph (76) MCC (Managed Care Contractor) subparagraph (c) is amended by deleting the language "(i.e., Department of Children's Services and Division of Intellectual Disabilities Services)" so that, as amended, paragraph (76) subparagraph (c) shall read as follows:

(c) A State government agency that contracts with TennCare for the provision of services.

Rule 1200-13-14-.01 Definitions paragraph (83) Medically Contraindicated is amended by deleting it in its entirety and renumbering the following paragraphs appropriately.

Rule 1200-13-14-.01 Definitions paragraph (118) Readable is amended by deleting all the language following "shall mean" and by substituting instead the following language, so that, as amended, paragraph (118) shall read as follows:

(118) Readable shall mean easily understood language and format. See 42 C.F.R. § 438.10.

Rule 1200-13-14-.01 Definitions paragraph (122) Reconsideration is deleted in its entirety and replaced with a new paragraph (122) which shall read as follows:

(122) Reconsideration shall mean the mandatory process, triggered by an enrollee's request for a SFH, by which an MCC reviews and renders a decision affirming or reversing the MCC's adverse benefit determination. An MCC satisfies the plan-level requirements of 42 C.F.R. Part 438 Subpart F when the review includes all available, relevant, clinical documentation (including documentation which may not have been considered in the original review); is performed by a physician other than the original reviewing physician; and produces a timely written finding. See June 5, 2017, CMS letter from Jackie Glaze to Wendy Long, M.D., M.P.H.

Rule 1200-13-14-.01 Definitions paragraph (124) Reduction, Suspension or Termination is amended by deleting it in its entirety and renumbering the following paragraphs appropriately.

Rule 1200-13-14-.01 Definitions paragraph (125) Resources for Medicaid-Eligible Individuals is amended by deleting it in its entirety and renumbering the following paragraphs appropriately.

Rule 1200-13-14-.01 Definitions paragraph (127) Seriously Emotionally Disturbed (SED) is amended by deleting it in its entirety and renumbering the following paragraphs appropriately.

Rule 1200-13-14-.01 Definitions paragraph (128) Severely and/or Persistently Mentally Ill (SPMI) is amended by deleting it in its entirety and renumbering the following paragraphs appropriately.

Rule 1200-13-14-.01 Definitions paragraph (131) Target Population Group (TPG) is amended by deleting it in its entirety and renumbering the following paragraphs appropriately.

Rule 1200-13-14-.01 Definitions paragraph (134) TDHS or DHS (Tennessee Department of Human Services) is amended by deleting it in its entirety and renumbering the following paragraphs appropriately.

Rule 1200-13-14-.01 Definitions paragraph (137) TennCare Appeal Form is amended by deleting the language "action affecting TennCare services" and by substituting instead the language "benefit determination" so that, as amended, paragraph (137) shall read as follows:

(137) 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 benefit determination.

Rule 1200-13-14-.01 Definitions paragraph (150) Time-Sensitive Care is amended by deleting it in its entirety and renumbering the following paragraphs appropriately.

Rule 1200-13-14-.01 Definitions is amended by inserting alphabetically the following language as a new appropriately numbered paragraph as follows:

() State Fair Hearing (SFH) shall mean an evidentiary hearing requested by or on behalf of an enrollee to allow the enrollee to appeal an adverse benefit determination, which is conducted in accordance with 42

C.F.R. Part 431 Subpart E and the Tennessee Uniform Administrative Procedures Act, T.C.A. §§ 4-5-301, et seq. An initial order under T.C.A. § 4-5-314 shall be entered when an evidentiary hearing is held before a hearing officer. If any party appeals the initial order under T.C.A. § 4-5-315, the Commissioner may render a final order.

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105, 71-5-109, 71-5-113, 42 C.F.R. Part 431 Subpart E and 42 C.F.R. Part 438 Subpart F.

Rule 1200-13-14-.10 Exclusions paragraph (1) subparagraph (b) is amended by deleting the punctuation and language ", 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" so that, as amended, paragraph (1) subparagraph (b) shall read as follows:

- (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.

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105, 71-5-109, 71-5-113, 42 C.F.R. Part 431 Subpart E and 42 C.F.R. Part 438 Subpart F.

Rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits is amended by deleting the title and by substituting instead a new title "Appeal of Adverse Benefit Determinations" so that, as amended, the title of Rule 1200-13-14-.11 shall read as follows:

1200-13-14-.11 Appeal of Adverse Benefit Determinations.

Rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits paragraph (1) subparagraph (a) part 1 is amended by deleting the language "action taken by the MCC to deny, reduce, suspend, or terminate medical assistance" and by substituting instead the language "benefit determination" so that, as amended, paragraph (1) subparagraph (a) part 1 shall read as follows:

1. A written notice shall be given to an enrollee by his/her MCC of any adverse benefit determination.

Rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits paragraph (1) subparagraph (a) part 2 is amended by deleting it in its entirety and renumbering the following parts appropriately.

Rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits paragraph (1) subparagraph (a) part 4 is amended by deleting the word and punctuation "of:" and all remaining subparts and language and by substituting instead the punctuation "." so that, as amended, paragraph (1) subparagraph (a) part 4 shall read as follows:

4. A written notice shall be given to an enrollee of any provider-initiated reduction, termination or suspension.

Rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits paragraph (1) subparagraph (b) part 1 is amended by inserting the numbers "431" before the punctuation and numbers ".214" wherever they appear and by deleting the word "must" in the second sentence and replacing it with the word "may" and by deleting the phrase "at least two business days in advance" in the second sentence and replacing it with the phrase "the same day" so that, as amended, paragraph (1) subparagraph (b) part 1 shall read as follows:

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 - 431.214 (usually ten (10) days in advance). However, in instances of MCC-initiated reduction, termination or suspension of inpatient hospital treatment, the notice may be provided to an enrollee the same day of the proposed action. Where applicable and not in conflict with this rule, the exceptions set out at 42 C.F.R. §§ 431.211 - 431.214 permit or require reduction of the time frames within which advance notice must be provided.

Rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits paragraph (1) subparagraph (b) part 2 is amended by deleting the language following the words "enrollee for" and by substituting instead the new language "prior authorization for medical or related services as set out in 42 C.F.R. §

438.210(d)" so that, as amended, paragraph (1) subparagraph (b) part 2 shall read as follows:

2. An MCC must notify an enrollee of its decision in response to a request by or on behalf of an enrollee for prior authorization for medical or related services as set out in 42 C.F.R. § 438.210(d).

Rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits paragraph (1) subparagraph (b) part 4 is amended by deleting the introductory phrase "Where required by paragraph (1)(a)4. of this rule," and by deleting the lower case letter "w" and substituting an upper case letter "W" in "written" and further amended by deleting the language "at least two (2) business days in advance of the proposed action" and by substituting instead the new language "in compliance with 42 C.F.R. §§ 431.211, 431.213 and 431.214" so that, as amended, paragraph (1) subparagraph (b) part 4 shall read as follows:

4. Written notice of provider-initiated reduction, termination or suspension of services must be provided to an enrollee in compliance with 42 C.F.R. §§ 431.211, 431.213 and 431.214.

Rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits paragraph (1) subparagraph (c) part 1 is amended by deleting the language "action affecting medical assistance" and by substituting instead the language "benefit determination" and is further amended by deleting the language "contain the following elements, written in concise, readable terms:" and by substituting instead the language "be readable and must comply with the requirements of 42 C.F.R. §§ 431.210 and 438.404." and further amended by deleting all of subparts (i) through (v) so that, as amended, paragraph (1) subparagraph (c) part 1 shall read as follows:

1. Whenever this rule requires that a TennCare enrollee receive written notice of an adverse benefit determination, the notice must be readable and must comply with the requirements of 42 C.F.R. §§ 431.210 and 438.404.

Rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits paragraph (1) subparagraph (c) part 2 is amended by deleting the word "action" and by substituting instead the language "benefit determination" and is further amended by deleting the language "will not automatically resolve the appeal in favor of the enrollee. TennCare" and "prior to issuance of the notice of hearing" so that, as amended, paragraph (1) subparagraph (c) part 2 shall read as follows:

2. Remedying of Notice. If a notice of adverse benefit determination provided to an enrollee does not meet the notice content requirements of rule 1200-13-14-.11(1)(c)1., TennCare or the MCC may cure any such deficiencies by providing one corrected notice to enrollees. 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.

Rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits paragraph (1) subparagraph (c) part 3 is deleted in its entirety.

Rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits paragraph (1) subparagraphs (d) through (g) are deleted in their entirety.

Rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits paragraph (2) subparagraph (a) is amended by deleting the language "actions affecting TennCare services" and by substituting instead the language "benefit determinations" so that, as amended, paragraph (2) subparagraph (a) shall read as follows:

- (a) To appeal adverse benefit determinations.

Rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits paragraph (2) subparagraph (b) is amended by deleting the word "actions" and by substituting instead the language "benefit determinations" and is amended by deleting the word "taken" wherever it appears and by substituting the word "made" and is further amended by deleting the punctuation and language ", including instances in which:" and deleting parts 1 through 8 and by substituting instead the punctuation "." so that, as amended, paragraph (2) subparagraph (b) shall read as follows:

- (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 benefit determinations that have been made or are proposed to be made, may not be denied.

Rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits paragraph (2), subparagraph (d) is deleted in its entirety and replaced with a new subparagraph (d) which shall read as follows:

- (d) To be allowed sixty (60) days from receipt of 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.

Rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits paragraph (2) subparagraph (f) is amended by deleting it in its entirety and renumbering the following subparagraphs appropriately.

Rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits paragraph (2) subparagraph (g) is amended by adding the phrase "resolution of the" after the word "pending" and before the word "appeal" and by adding "COB" after the words "request for" and deleting the words "such services" so as amended subparagraph (g) shall read as follows:

- (g) For ongoing services, have the right to continuation or reinstatement of services, pursuant to 42 C.F.R. §§ 431.230 and 431.231 as modified by this rule, pending resolution of the appeal when the enrollee submits a timely appeal and timely request for COB. When an enrollee is so entitled to continuation or reinstatement of services, this right may not be denied for any reason, including:

Rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits paragraph (2) subparagraph (h) is amended by deleting the word "impartial" and further by deleting the words "TennCare appeal" and by substituting instead "SFH" and further by deleting the phrase "who was directly involved in the initial determination of the action in question" from the end of the last sentence and placing it between the words "official" and "may" in the last sentence so that, as amended, paragraph (2) subparagraph (h) shall read as follows:

- (h) To an 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 SFH. No state official who was directly involved in the initial determination of the action in question may participate in deciding the outcome of an enrollee's appeal.

Rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits paragraph (3) subparagraph (b) is amended by inserting the word "Medical" as the first word of the subparagraph and by deleting the language "Decisions to be Supported by Substantial and Material" and by deleting the language "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:" so that, as amended, paragraph (3) subparagraph (b) shall read as follows:

- (b) Medical Evidence.

Rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits paragraph (3) subparagraph (b) part 1 is amended by deleting the current language and by substituting instead the following language so that, as amended, paragraph (3) subparagraph (b) part 1 shall read as follows:

1. Appeal decisions must be based on an evaluation of pertinent medical evidence. TennCare and the MCCs shall elicit from enrollees and their treating providers all pertinent medical records that support an appeal; and

Rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits paragraph (3) subparagraph (b) part 2 is amended by deleting the language "in accordance with the Grier Revised Consent Decree and" and further by deleting the language "action affecting TennCare services" and by substituting instead the language "benefit determination" so that, as amended, paragraph (3) subparagraph (b) part 2 shall read as follows:

2. Medical opinions shall be evaluated 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 benefit determination.

Rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits paragraph (3) subparagraph (c) and subparagraph (d) are amended by deleting the language "action affecting TennCare services" and by substituting instead the language "benefit determination" so that, as amended, paragraph (3) subparagraph (c) and subparagraph (d) shall read as follows:

- (c) Record on Review. When TennCare receives an appeal from an enrollee regarding an adverse benefit determination, 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 benefit determination.

Rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits paragraph (3) subparagraph (d) part 1 is amended by inserting the word "state" before the words "fair hearing" wherever they appear so that, as amended, paragraph (3) subparagraph (d) part 1 shall read as follows:

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 state 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 state fair hearing. If the enrollee does not respond, the appeal will be dismissed without the opportunity for a state fair hearing, without further notice to the enrollee.

Rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits paragraph (3) subparagraph (d) part 2 is amended by deleting the word "action" and by substituting instead the language "benefit determination" so that, as amended, paragraph (3) subparagraph (d) part 2 shall read as follows:

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 benefit determination; 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.

Rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits paragraph (3) subparagraph (e) is amended by deleting the word "If" and by substituting instead the word "When" and further amended by deleting the language "appeals an adverse action and TennCare determines that the basis of the appeal is that" and by substituting instead the language "attempts to lodge an appeal for a benefit for which" so that, as amended, paragraph (3) subparagraph (e) shall read as follows:

- (e) Appeals When Enrollees Lack a Prescription. When a TennCare enrollee attempts to lodge an appeal for a benefit for which the enrollee lacks a prescription, TennCare may require the enrollee to exhaust the following administrative process before an appeal can proceed:

Rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits paragraph (3) subparagraph (f) is amended in the first sentence by deleting the language "Action is Taken" and by substituting SS-7039 (June 2016)

instead the language "Benefit Determination Has Been Made" and in the second sentence by deleting the language "action has been taken related to TennCare services" and by substituting instead the language "benefit determination has been made" and in the third sentence by deleting the language "when no adverse action has been taken" and by substituting instead the language "in this circumstance" and further amended in the fourth sentence by deleting the word "claim" and by substituting instead the word "request" so that, as amended, paragraph (3) subparagraph (f) shall read as follows:

- (f) Appeals When No Adverse Benefit Determination Has Been Made. Enrollees shall not possess the right to appeal when no adverse benefit determination has been made. If enrollees request a hearing in this circumstance, their request shall be denied by the TennCare bureau without the opportunity for a hearing. Such circumstances include but are not limited to when enrollees appeal and no request for services had previously been denied.

Rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits paragraph (4) subparagraph (a) is amended by deleting the language "that they have the right to an in-person hearing, a telephone hearing" and by substituting instead the language "of their state fair hearing rights" and further amended by deleting the language "or other hearing accommodation as may be required for enrollees with disabilities" so that, as amended, paragraph (4) subparagraph (a) shall read as follows:

- (a) TennCare shall inform enrollees of their state fair hearing rights;

Rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits paragraph (4) subparagraph (b) is amended by deleting the language "an impartial" and by substituting instead the word "a" so that, as amended, paragraph (4) subparagraph (b) shall read as follows:

- (b) Enrollees shall be entitled to a hearing before a hearing officer that affords each enrollee the right to:

Rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits paragraph (4) subparagraph (b) part 9 is amended by deleting the word "impartial" so that, as amended, paragraph (4) subparagraph (b) part 9 shall read as follows:

- 9. A written decision setting out the hearing officer's rulings on findings of fact and conclusions of law; and

Rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits paragraph (4) subparagraph (b) part 10 is amended by deleting the language "with an ALJ" and by substituting instead the language "before a hearing officer" and is further amended by deleting the language "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" and by substituting instead the language "pursuant to 42 C.F.R. § 431.244" so that, as amended, paragraph (4) subparagraph (b) part 10 shall read as follows:

- 10. Resolution, including a hearing before a hearing officer if the case has not been previously resolved in favor of the enrollee, pursuant to 42 C.F.R. § 431.244.

Rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits paragraph (4) subparagraph (d) is amended by deleting the language "an administrative" and by substituting instead the language "a state fair" and by adding the phrase "the enrollee and TennCare," after the words "limited to" and by deleting the word "those" and by adding the phrase "as modified by CMS letter dated June 5, 2017" after the words "federal regulations" and further by deleting the last three sentences of the subparagraph in their entirety so that, as amended, paragraph (4) subparagraph (d) shall read as follows:

- (d) Parties to an Appeal. Under this rule, the parties to a state fair hearing are limited to the enrollee and TennCare, permitted by federal regulations as modified by CMS letter dated June 5, 2017. The purpose of the hearing is to focus on the enrollee's medical needs.

Rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits paragraph (4) subparagraph (e) is amended by deleting the word "impartial" so that, as amended, paragraph (4) subparagraph (e) shall read as follows:

- (e) Consistent with the Code of Judicial Conduct, 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.

Rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits paragraph (4) subparagraph (f) part 1 is amended by deleting the part in its entirety and by substituting instead the following language, so that, as amended, part 1 shall read as follows:

1. Hearing officers shall promptly issue an Order of their decision. Any Order delivered orally from the bench in an expedited hearing by a hearing officer shall be effective immediately as to the provision or denial of benefits. In accordance with 42 C.F.R. Part 431 Subpart E and 42 C.F.R. Part 438 Subpart F, the hearing officer shall enter a written order as soon as practicable and shall provide the parties with copies of such Orders. The time for appealing any oral Order shall not begin to run until entry of the written Order.

Rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits paragraph (4) subparagraph (f) part 2 is amended by deleting the word "impartial" and is further amended by inserting after the word "officers" the punctuation and language ", in accordance with T.C.A. §§ 4-5-314 and 4-5-315," and is further amended by deleting the language "the Grier Revised Consent Decree" and by substituting instead the language "this chapter and 42 C.F.R. Part 431 Subpart E and 42 C.F.R. Part 438 Subpart F" so that, as amended, paragraph (4) subparagraph (f) part 2 shall read as follows:

2. The TennCare Bureau shall have the opportunity to review all decisions of hearing officers, in accordance with T.C.A. §§ 4-5-314 and 4-5-315, 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 this chapter and 42 C.F.R. Part 431 Subpart E and 42 C.F.R. Part 438 Subpart F.

Rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits paragraph (4) subparagraph (f) part 2 is amended by deleting subparts (i) and (ii) in their entirety and by renumbering the remaining subparts appropriately.

Rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits paragraph (4) subparagraph (f) part 2 subparts (iii) and (iv) are amended by deleting the word "impartial" so that, as amended, paragraph (4) subparagraph (f) part 2 subparts (iii) and (iv) shall read as follows:

- (iii) If TennCare modifies or overturns the decision of the hearing officer, TennCare shall issue a written decision that will be provided to the enrollee and the hearing officer. TennCare's decision shall constitute final agency action.
- (iv) If TennCare does not modify or overturn the decision of the hearing officer, the hearing officer's decision shall constitute final agency action without additional notice to the enrollee.

Rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits paragraph (4) subparagraph (f) part 2 subpart (v) is amended by deleting the language "the Tennessee Administrative Procedures Act, Tennessee Code Annotated §§ 4-5-301, et seq" and by inserting the language "T.C.A. § 4-5-322" so that, as amended, paragraph (4) subparagraph (f) part 2 subpart (v) shall read as follows:

- (v) Review of final agency action shall be available to enrollees pursuant to T.C.A. § 4-5-322.

Rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits paragraph (4) subparagraph (f) part 2 subpart (vi) is amended by deleting the words "An impartial" and by substituting the word "A" so that, as amended, paragraph (4) subparagraph (f) part 2 subpart (vi) shall read as follows:

- (vi) A hearing officer's decision in an enrollee's appeal shall not be deemed precedent for future appeals.

Rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits paragraph (4) subparagraph (g) part 1 is amended by deleting the language "Except as" and by substituting instead the word

"As" and by deleting the numbers and language "431.213, 431.214 and 431.220, as modified by this rule," and by substituting instead the language and numbers "431.230, 431.231 and 438.420, if required or if the enrollee requests," and by inserting the language "the earlier of dismissal of the appeal through the valid factual dispute process, enrollee's withdrawal of the appeal, or" after the words "reinstated until" and before the words "an initial" and deleting the language "if the enrollee appeals and requests" and by adding the language "adverse to the enrollee." by deleting the punctuation ":" and by deleting subparts (i), (ii) and (iii) in their entirety so that, as amended, paragraph (4) subparagraph (g) part 1 shall read as follows:

1. As permitted under 42 C.F.R. §§ 431.230, 431.231 and 438.420, if required or if the enrollee requests, TennCare services shall continue or be reinstated until the earlier of dismissal of the appeal through the valid factual dispute process, enrollee's withdrawal of the appeal, or an initial hearing decision adverse to the enrollee.

Rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits paragraph (4) subparagraph (g) part 2 is amended by deleting it in its entirety and by renumbering the remaining parts appropriately.

Rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits paragraph (4) subparagraph (g) part 3 is amended by deleting the word "herein" and replacing it with the language "in paragraph (4)(g)1 above" and further amended by deleting the words "pending appeal" so as amended part 3 shall read as follows:

3. In the case of a timely request for continuation or reinstatement of the TennCare services described in paragraph (4)(g)1 above, the services shall continue or be reinstated only if and to the extent prescribed by the enrollee's treating clinician.

Rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits paragraph (4) subparagraph (g) is amended by deleting parts 4 and 5 in their entirety and by renumbering the remaining parts appropriately.

Rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits paragraph (4) subparagraph (h) Expedited appeals is amended by deleting it in its entirety and substituting the following:

(h) Reserved.

Rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits paragraph (5) Special Provisions Pertaining to Pharmacy is amended by deleting it in its entirety and substituting instead the following:

(5) Reserved.

Rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits paragraph (6) Release of Enrollees' Medical Records subparagraphs (a), (b) and (d) are amended by deleting the language "action affecting TennCare services" and by substituting instead the language "benefit determination" so that, as amended, paragraph (6) subparagraphs (a), (b) and (d) shall read as follows:

- (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 benefit determination, 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 benefit determination.
- (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 benefit determination.

Rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits paragraph (7) Time

Requirements and Corrective Action is amended by deleting the language "and Corrective Action" so that, as amended, paragraph (7) shall read as follows:

(7) Time Requirements.

Rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits paragraph (7) Time Requirements and Corrective Action subparagraph (a) is amended by deleting the language "within fourteen (14) days" and is further amended by deleting the language "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 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)" and by substituting instead the language "42 C.F.R. § 438.210" so that, as amended, paragraph (7) subparagraph (a) shall read as follows:

- (a) MCCs must act upon a request for prior authorization as provided in 42 C.F.R. § 438.210.

Rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits paragraph (7) Time Requirements and Corrective Action subparagraph (b) is amended by deleting subparagraph (b) in its entirety and replacing it with a new subparagraph (b) which shall read as follows:

- (b) MCCs must complete reconsideration of standard appeals within fourteen (14) calendar days of the request from TennCare. MCCs must complete reconsideration of expedited appeals within seventy-two (72) hours of the request for SFH.

Rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits paragraph (7) Time Requirements and Corrective Action subparagraph (c) is amended by deleting subparagraph (c) in its entirety and replacing it with a new subparagraph (c) which shall read as follows:

- (c) All standard and expedited appeals not previously resolved in favor of the enrollee during reconsideration, shall be set for hearing before a hearing officer, and shall be resolved pursuant to the timeframes set forth in 42 C.F.R. § 431.244. In accordance with 42 C.F.R. § 438.410(a) and 42 C.F.R. § 431.244(f)(2), SFH requests which are approved for expedited resolution and which are not resolved in the enrollee's favor during MCC's reconsideration, shall be resolved by TennCare within three (3) working days from the date of the MCC's reconsideration determination. TennCare is not charged with any delays attributable to the enrollee.

Rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits paragraph (7) Time Requirements and Corrective Action subparagraphs (d), (e) and (f) are amended by deleting them in their entirety and by renumbering the remaining subparagraphs appropriately.

Rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits paragraph (7) Time Requirements and Corrective Action subparagraph (g) is amended by deleting the words "Solutions Unit" wherever they appear and by substituting instead the word "Bureau" and by deleting the words "an impartial" and by substituting instead the word "a" and by inserting the word "the" in the second sentence between the words "issued by" and "TennCare" and is further amended by deleting the language "and such appeal will proceed to a hearing" so that, as amended, paragraph (7) subparagraph (g) shall read as follows:

- (g) In no circumstance will a directive be issued by the TennCare Bureau or a 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 the TennCare Bureau 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.

Rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits paragraph (8) Medical Contraindication is amended by deleting it in its entirety and substituting instead the following:

(8) Reserved.

Rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits paragraph (9) Special Provisions Relating to Children in State Custody is amended by deleting the language "In addition to" and by substituting instead the language "Children in the custody of the State have" and by deleting the language and

punctuation "and the terms of this rule, children in state custody shall also receive the following enhanced notice and appeal rights:" and by substituting instead the language and punctuation "regarding TennCare services and benefits." and is further amended by deleting subparagraphs (a) through (c) in their entirety so that, as amended, paragraph (9) shall read as follows:

- (9) Special Provisions Relating to Children in State Custody. Children in the custody of the State have the rights and protections established by 42 C.F.R. Part 431, Subpart E regarding TennCare services and benefits.

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105, 71-5-109, 71-5-113, 42 C.F.R. Part 431 Subpart E and 42 C.F.R. Part 438 Subpart F.

Rule 1200-13-14-.12 Other Appeals by TennCare Applicants and Enrollees is amended by deleting paragraphs 1 and 2 in their entirety and substituting instead the language "Notwithstanding Rule 1200-13-19-.01, or any rule to the contrary, appeals by applicants and enrollees of all non-medical eligibility matters are removed to Rule Chapter 1200-13-19, effective upon expiration of the TDHS contract to determine eligibility matters." as follows:

1200-13-14-.12 Other Appeals by TennCare Applicants and Enrollees. Notwithstanding Rule 1200-13-19-.01, or any rule to the contrary, appeals by applicants and enrollees of all non-medical eligibility matters are removed to Rule Chapter 1200-13-19, effective upon expiration of the TDHS contract to determine eligibility matters.

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105, 71-5-109, 71-5-113, 42 C.F.R. Part 431 Subpart E and 42 C.F.R. Part 438 Subpart F.

I certify that this is an accurate and complete copy of rulemaking hearing rules, lawfully promulgated and adopted by the Tennessee Department of Finance & Administration (board/commission/ other authority) on 07/26/2017 (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: 01/04/17

Rulemaking Hearing(s) Conducted on: (add more dates). 02/28/17

Date: 7/26/17

Signature: [Handwritten Signature]

Name of Officer: John G. Roberts
Deputy Director

Title of Officer: Tennessee Department of Finance & Administration

Subscribed and sworn to before me on: 7/26/17

Notary Public Signature: [Handwritten Signature]

My commission expires on: 1/8/2019



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.

[Handwritten Signature]

Herbert H. Slatery III
Attorney General and Reporter

9/20/2017
Date

Department of State Use Only

Filed with the Department of State on: 9/25/17

Effective on: 12/24/17

[Handwritten Signature]
Tre Hargett
Secretary of State

RECEIVED
2017 SEP 25 AM 10: 22
SECRETARY OF STATE
PUBLICATIONS

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.

HCFA received comments from two individuals or entities concerning these rules. The comments and HCFA's responses to the comments are summarized below.

Two commenters expressed concern about the deletion of the modifier "impartial" from the description of hearing officer in the rule and suggested this deletion may be a violation of due process. HCFA noted that it is updating the terminology in its rules to match the terminology used in federal regulations and that this change in terminology does not relieve HCFA of its obligation to comply with state and federal due process requirements. The fair hearing process provided for in the rule is an impartial process.

One commenter expressed concern that the definition of "state fair hearing" in the rule does not explicitly include the right to an in-person hearing, and that a reference to in-person hearings elsewhere in the rule is deleted. In response, HCFA noted that the definition of "state fair hearing" in the rule specifically references the state and federal requirements for the conduct of hearings, which clearly afford enrollees the right to an in-person hearing. HCFA will not withhold an in-person hearing from any enrollee who requests it during the course of an appeal.

One commenter expressed concern that the definition of "readable" in the rule is too vague, and suggested that HCFA retain existing language in the rule referring to specific reading proficiency levels. The commenter also noted that other state Medicaid programs commonly use specific reading proficiency levels to draft their written materials. HCFA noted that the definition in the rule is taken directly from federal regulation concerning enrollee information; this regulation entails a broader set of requirements than reading proficiency level of written materials.

One commenter expressed concern about the use of citations to federal regulations in the rule to denote required timeframes, rather than specifying the timeframes within the rule itself. This commenter suggested that the rule's reliance on federal regulations is problematic because applicants and enrollees would be required to refer to federal regulations to discern the applicable timeframes. In response, HCFA noted that the Code of Federal Regulations is readily accessible online, including through links on HCFA's web site, and that it is unnecessary for HCFA to duplicate requirements from federal regulations in its rules. In addition, enrollee handbooks provide information about required timeframes in an accessible manner, and it is more likely that enrollees and applicants would refer to these and other member materials rather than federal regulations or state rules.

Two commenters expressed concern that the rule deletes the right of enrollees to receive a written notice when their managed care contractor expects there will be a delay in receiving covered services. These commenters suggested that this deletion is inconsistent with federal Medicaid requirements. In response, HCFA clarified that the deletion of the language referenced by the commenters conforms the rule to federal regulations. The rule does not delete the requirement to provide notice of delay, but rather deletes the requirement to provide notice of an anticipated delay. HCFA noted that an expectation of delay is not included within the definition of adverse benefit determination.

Two commenters expressed concern about the deletion of certain requirements for the content of written notices, and suggested that certain information must be provided in notices for them to be constitutionally adequate. In response, HCFA noted that the federal regulations cited in the rule provide adequate guidance for the content of notices and that it is unnecessary for HCFA to duplicate federal regulations in its rules.

Two commenters expressed concern that the rule deletes information about pharmaceuticals dispensed on a short-term basis in emergency situations and noted that this coverage is required by federal law. In response, HCFA noted that it is unnecessary to duplicate this federal requirement in its rules.

Two commenters expressed concern that the rule deletes information about the obligation of prescribing providers (not enrollees) to obtain prior authorizations for prescription medications, as well as the obligations of pharmacists in situations when an enrollee's provider did not obtain prior authorization. In response, HCFA noted that the paragraph in question pertains to pharmacy operations and was not appropriately placed in a rule governing

enrollee appeals. HCFA further noted that participating pharmacies are required to comply with the notice requirements expressed in federal regulations, as well as other federal requirements for pharmacy providers, and that it is not necessary for HCFA to duplicate these federal requirements in its rules.

Two commenters suggested that HCFA should continue to provide annual notice of notice and appeal rights to TennCare enrollees. In response, HCFA noted that notice of appeal rights is provided to TennCare enrollees as required by federal law.

Two commenters expressed concern that the rule deletes corrective action requirements for managed care contractors that violate requirements related to notices or resolution of appeals. These commenters suggested that corrective action requirements provide necessary incentives to HCFA and its contractors to comply with rules regarding the content and timing of notices. In response, HCFA noted that the failure of contractors to adhere to contract requirements is more appropriately addressed in the contracting process rather than in rules.

One commenter opposed the deletion of information in the rule about an enrollee's right to appeal when the enrollee seeks to contest denial of TennCare coverage for services already received, regardless of the cost or value of the services at issue. This commenter noted that there are multiple circumstances in which a TennCare enrollee may receive services before those services have been approved, and yet have a right to coverage of those services. In response, HCFA clarified that the language cited by the commenter is not being deleted.*

One commenter expressed concern about the deletion of certain corrective action requirements when TennCare or its managed care contractors fail to timely act on requests for prior authorization or fail to resolve appeals timely. This commenter suggested that such corrective action requirements provide valuable incentives to TennCare and its contractors. This commenter acknowledged that the deleted language emanated from a series of consent decrees that have now been vacated, but stated that the requirements were informed by historical efforts to comply with due process requirements and should therefore be retained. In response, HCFA thanked the commenter for its expression of concern and advice and noted that the updates to its rules reflect current federal regulations governing Medicaid managed care programs.

*During legal review of the rule amendments, it was determined that since an enrollee's request for appeal of dissatisfaction or disagreement with adverse benefit determinations made or proposed may not be denied, the listing of instances in which an appeal may be made is unnecessary. The rule was amended to remove the non-exclusive list, Parts 1 through 8, of reasons for appeal in favor of the more expansive language contained in Subparagraph (b) of Paragraph (2).

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 rules are not anticipated to have an effect on 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://state.tn.us/sos/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;

These rules are being promulgated to bring the TennCare rules into compliance with federal regulations regarding appeals and state fair hearings under Title XIX, following the vacatur of the federal court order known as "Grier" which previously controlled the conduct of TennCare medical service appeals.

- (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;

These rules are lawfully adopted by the Bureau of TennCare in accordance with T.C.A. §§ 4-5-202, 71-5-105, 71-5-109, 71-5-113, 42 C.F.R. Part 431 Subpart E and 42 C.F.R. Part 438 Subpart F.

- (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 Rules are TennCare enrollees, providers, and managed care contractors. The governmental entity most directly affected by these Rules is the Bureau 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 promulgation of these rules is not anticipated to affect State expenditures.

- (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.

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**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.

- (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~~ BENEFIT DETERMINATION 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. See 42 C.F.R. § 438.400.
- (26) CONTINUATION OR REINSTATEMENT of BENEFITS (COB) 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 1200-13-13-.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 the circumstances under which an enrollee may keep receiving, or, in the case of reinstatement, get back and keep receiving, the benefit under appeal until the appeal is resolved. See 42 C.F.R. §§ 431.230, 431.231 and 438.420.
- (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~~

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

- 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.~~
- (40) DELAY shall mean, ~~but is not limited to:~~
- (a) ~~Any, 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.~~
- (47) ~~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.~~
- (54) FINAL AGENCY ACTION shall mean the resolution of an appeal by the TennCare Bureau or an initial decision on the merits of an appeal by an **impartial** administrative judge or hearing officer when such initial decision is not modified or overturned by the TennCare Bureau. Final agency action shall be treated as binding for purposes of these rules.
- (64) **IMPARTIAL HEARING OFFICER** shall mean an administrative judge or hearing officer who is not an employee, agent or representative of the MCC **and or** who did not participate in, nor was consulted about, any TennCare Bureau review prior to the **Administrative State Fair Hearing (SFH)**.
- (76) MCC (MANAGED CARE CONTRACTOR) shall mean:
- (a) A Managed Care Organization, Pharmacy Benefits Manager and/or a Dental Benefits Manager which has signed a TennCare Contractor Risk Agreement with the State and

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

- operates a provider network and provides covered health services to TennCare enrollees; or
- (b) A Pharmacy Benefits Manager, Behavioral Health Organization or Dental Benefits Manager which subcontracts with a Managed Care Organization to provide services; or
- (c) A State government agency (~~i.e., Department of Children's Services and Division of Intellectual Disabilities Services~~) that contracts with TennCare for the provision of services.
- ~~(83) 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.~~
- (118) ~~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 easily understood language and format. See 42 C.F.R. § 438.10.~~
- (122) RECONSIDERATION shall mean the mandatory process, triggered by an enrollee's request for a SFH, by which an MCC reviews and renders a decision regarding affirming or reversing an enrollee's appeal of the MCC's adverse action benefit determination affecting TennCare benefits. An MCC satisfies the plan-level requirements of 42 C.F.R. Part 438 Subpart F when the review includes all available, relevant, clinical documentation (including documentation which may not have been considered in the original review); is performed by a physician other than the original reviewing physician; and produces a timely written finding. See June 5, 2017, CMS letter from Jackie Glaze to Wendy Long, M.D., M.P.H.
- ~~(124) 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.~~
- ~~(125) RESOURCES FOR MEDICAID-ELIGIBLE INDIVIDUALS shall mean those resources as defined in Chapter 1240-03-03-.05-.06 of the rules of the Tennessee Department of Human Services - Division of Medical Services.~~
- ~~(127) 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"~~

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

~~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).~~

~~(128) SEVERELY AND/OR PERSISTENTLY MENTALLY ILL (SPMI) shall mean individuals who have been identified by the Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD) or its designee as meeting the criteria in (a) below. These persons will be identified as belonging in one of Clinically Related Groups listed in (b) below.~~

~~(a) Criteria~~

- ~~1. Age eighteen (18) and over; and~~
- ~~2. Currently, or at any time during the past year, has had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the diagnostic criteria specified within the DSM-IV-TR (and subsequent revisions) of the American Psychiatric Association, with the exception of the DSM-IV-TR (and subsequent revisions) "V" codes, substance abuse, and developmental disorders, unless these disorders co-occur with another diagnosable serious emotional disturbance. All of these disorders have episodic, recurrent, or persistent features; however, the disorders may vary in terms of severity and disabling effects; and~~
- ~~3. The diagnosable mental, behavioral, or emotional disorder identified above has resulted in functional impairment which substantially interferes with or limits major life activities. Functional impairment is defined as difficulties that substantially interfere with or limit role functioning in major life activities including the basic living skills (e.g., eating, bathing, dressing); instrumental living skills (maintaining a household, managing money, getting around in the community, taking prescribed medication); and functioning in social, family, and vocational/educational contexts. This definition includes adults who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services.~~

~~(b) Definitions of Clinically Related Groups (CRGs).~~

- ~~1. Clinically Related Group 1. Any person eighteen (18) years or older whose functioning is, or in the last six (6) months has been, severely impaired and the duration of the impairment totals six (6) months or longer in the past year. This person requires constant assistance or supervision with daily living activities and displays an inability to relate to others which interferes with his/her ability to work and his/her family relationships and usually results in social isolation in the community. Changes in the environment are stressful and may result in further withdrawal or dysfunction in other areas. Support is needed to insure the person's safety and survival.~~

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

- ~~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.~~

~~(i) STATE FAIR HEARING (SFH) shall mean an evidentiary hearing requested by or on behalf of an enrollee to allow the enrollee to appeal an adverse benefit determination, which is conducted in accordance with 42 C.F.R. Part 431 Subpart E and the Tennessee Uniform Administrative Procedures Act, T.C.A. §§ 4-5-301, et seq. An initial order under T.C.A. § 4-5-314 shall be entered when an evidentiary hearing is held before a hearing officer. If any party appeals the initial order under T.C.A. § 4-5-315, the Commissioner may render a final order.~~

~~(131) TARGET POPULATION GROUP (TPG) shall mean a group identified by means of an assessment mechanism for children and adolescents under the age of eighteen (18) which determines a service recipient's level of functioning and severity of impairment due to mental illness. Based on the assessment criteria, there are two (2) target population groups:~~

~~(a) TPG 2: Seriously Emotionally Disturbed (SED):~~

~~— These are children and adolescents who are under eighteen (18) years of age with a valid DSM-IV-TR (and subsequent revisions) diagnosis excluding substance use disorders, developmental disorders or V-codes. These children are currently severely impaired as evidenced by a Global Assessment of Functioning score of 50 or less.~~

~~(b) TPG 3: At Risk of being SED:~~

~~— These are children and adolescents who are under eighteen (18) years of age without a valid DSM-IV-TR (and subsequent revisions) diagnosis excluding substance use disorders, developmental disorders or V-codes. These children may or may not be currently seriously impaired as evidenced by a Global Assessment of Functioning. These children have psychosocial issues that can potentially place them at risk of becoming SED.~~

~~(134) 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~~

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

~~applying for TennCare Medicaid or TennCare Standard, except for those determined to be eligible for SSI benefits by the Social Security Administration. DHS is not responsible for making decisions about the presence of a qualifying medical condition for those applying as medically eligible persons under TennCare Standard.~~

(137) 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~~ benefit determination.

~~(150) 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.~~

1200-13-14-.10 EXCLUSIONS.

- (1) General exclusions. The following items and services shall not be considered covered services by TennCare:
 - (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.~~

1200-13-14-.11 ~~—APPEAL OF ADVERSE ACTIONS AFFECTING TENNCARE SERVICES OR BENEFITS~~ APPEAL OF ADVERSE BENEFIT DETERMINATIONS.

- (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~~ benefit determination ~~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.

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

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.~~
- ~~— 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.

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 - 431.214 (usually ten (10) days in advance). However, in instances of MCC-initiated reduction, termination or suspension of inpatient hospital treatment, the notice ~~must~~ may be provided to an enrollee ~~at least two business days in advance the same day~~ of the proposed action. Where applicable and not in conflict with this rule, the exceptions set out at 42 C.F.R. §§ 431.211 - 431.214 permit or require reduction of the time frames within which advance notice must be provided.

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

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 prior authorization for medical or related services as set out in 42 C.F.R. § 438.210(d).~~
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, w~~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 in compliance with 42 C.F.R. §§ 431.211, 431.213 and 431.214.~~
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 benefit determination~~, the notice must ~~contain the following elements, written in concise, readable terms: be readable and must comply with the requirements of 42 C.F.R. §§ 431.210 and 438.404.~~
 - (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 the 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~~~~~~~~

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

- ~~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).~~
- ~~(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~~ benefit determination 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~~

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

~~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:
 - ~~(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~~

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

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, 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.~~

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

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.~~~~
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~~ benefit determinations.
- (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~~ benefit determinations that have been ~~taken made~~ or are proposed to be ~~taken made~~, 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;~~

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

- ~~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; and~~
 - ~~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 1200-13-14-.03(2)(b)2.~~
- (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)~~ sixty (60) days from receipt of written notice or, if no notice is provided, from the time the enrollee becomes aware of an adverse ~~action~~ benefit determination, to appeal any adverse ~~action affecting TennCare services~~ benefit determination.
 - (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 and 431.231 as modified by this rule, pending resolution of the appeal when the enrollee submits a timely appeal and timely request for COB 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~~SFH. No state official who

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

~~was directly involved in the initial determination of the action in question~~ 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) ~~Medical 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 enrollees and his/her treating providers all pertinent medical records that support an appeal; and Appeal decisions must be based on an evaluation of pertinent medical evidence. TennCare and the MCCs shall elicit from enrollees and their 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 ~~benefit determination action affecting TennCare services.~~
- (c) Record on Review. When TennCare receives an appeal from an enrollee regarding an adverse ~~action affecting TennCare services~~ benefit determination, 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~~ benefit determination.
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 state 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 state fair hearing. If the enrollee does not respond, the appeal will be dismissed without the opportunity for a state fair hearing, without further notice to the enrollee.

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

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 benefit determination~~; 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 When a TennCare enrollee appeals an adverse action and TennCare determines that the basis of the appeal is that attempts to lodge an appeal for a benefit for which 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~~ Benefit Determination Has Been Made. Enrollees shall not possess the right to appeal when no adverse ~~action has been taken related to TennCare services benefit determination has been made~~. If enrollees request a hearing ~~when no adverse action has been taken in this circumstance~~, their request shall be denied by the TennCare Bureau without the opportunity for a hearing. Such circumstances include but are not limited to when enrollees appeal and no ~~claim request~~ for services had previously been denied.
- (4) Hearing Rights of Enrollees.
- (a) TennCare shall inform enrollees ~~of their that they have the right to an in-person hearing, a telephone hearing state fair hearing rights or other hearing accommodation as may be required for enrollees with disabilities;~~
 - (b) Enrollees shall be entitled to a hearing before ~~an impartial a~~ 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;

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

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 before a hearing officer~~ 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 pursuant to 42 C.F.R. § 431.244.~~
- (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 a state fair~~ hearing are limited to the enrollee and TennCare, ~~those~~ permitted by federal regulations as modified by CMS letter dated June 5, 2017. 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.
1. ~~Impartial hearing officers shall promptly issue an Order of their decision. Impartial hearing officers shall provide enrollees with copies of such Orders. Hearing officers shall promptly issue an Order of their decision. Any Order delivered orally from the bench in an expedited hearing by a hearing officer shall be effective immediately as to the provision or denial of benefits. In accordance with 42 C.F.R. Part 431 Subpart E and 42 C.F.R. Part 438 Subpart F, the hearing officer shall enter a written order as soon as practicable and shall provide the parties with copies of such Orders. The time for appealing any oral Order shall not begin to run until entry of the written Order.~~
 2. The TennCare Bureau shall have the opportunity to review all decisions of **impartial** hearing officers, in accordance with T.C.A. §§ 4-5-314 and 4-5-315, 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

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

and decisions based on the application of ~~the Grier Revised Consent Decree this chapter and 42 C.F.R. Part 431 Subpart E and 42 C.F.R. Part 438 Subpart F.~~

- ~~(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 T.C.A. § 4-5-322.~~
 - (vi) ~~An impartial A~~ 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 As permitted under 42 C.F.R. §§ 431.213, 431.214 and 431.220, as modified by this rule, 431.230, 431.231 and 438.420, if required or if the enrollee requests, TennCare services shall continue or be reinstated until the earlier of dismissal of the appeal through the valid factual dispute process, enrollee's withdrawal of the appeal, or an initial hearing decision if the enrollee appeals and requests: adverse to the enrollee.~~
 - ~~(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~~
 - ~~(iii) Continuation or reinstatement of services within ten (10) days of MCC-initiated notice of adverse benefit determination to terminate, suspend or reduce other ongoing services or prior to the date of action.~~

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

- ~~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 in paragraph (4)(g)1 above 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. Reserved.~~
- ~~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 the time constraints set out at 42 C.F.R. § 431.244. An enrollee may request an expedited appeal, and the MGC shall grant the request, if he/she meets the criteria for expedited resolution as set forth in 42 C.F.R. §§ 431.244 and 438.410.~~
 - ~~2. An enrollee may request an expedited appeal, applying a prudent layperson's understanding regarding whether the care at issue is time sensitive, i.e., whether such care constitutes an "emergency". In this context, an emergency is a situation in which a covered benefit has been delayed, denied, terminated or suspended and in the judgment of the enrollee's treating physician or a prudent layperson, waiting 90 days to receive such service will result in:~~
 - ~~(i) Serious health problems or death;~~
 - ~~(ii) Serious dysfunction of a bodily organ or part; or~~
 - ~~(iii) Hospitalization.~~
 - ~~3. The enrollee may (but is not required to) submit with his/her request for an expedited appeal, certification by his/her treating physician that such appeal is an emergency.~~
 - ~~4. An enrollee's request for an expedited appeal may be overcome only if:~~
 - ~~(i) The item or service at issue is not a covered benefit;~~

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

- (ii) ~~The enrollee's treating provider certifies in writing that the appeal is not an emergency; or~~
 - (iii) ~~The service is one which, by its nature, never constitutes an emergency, and is specified on a list of non-emergency items or services by the Bureau of TennCare and made available upon request to providers, enrollees, and the public.~~
- (5) Special Provisions Pertaining to Pharmacy. Reserved.
- (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 MCG, the enrollee is entitled to:~~
 - 1. ~~The drug as prescribed, if the drug is on the MCG'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 of 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;~~

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

- ~~(v) prescription vitamins and mineral products except prenatal vitamins and fluoride preparations;~~
 - ~~(vi) nonprescription drugs; or~~
 - ~~(vii) 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.~~
- ~~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~~ benefit determination, 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~~ benefit determination.
- (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

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

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 benefit determination.~~

(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 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) 42 C.F.R. § 438.210.~~
- (b) MCCs must complete reconsideration of ~~non-expedited standard~~ appeals within fourteen (14) calendar days of the request from TennCare. MCCs must complete reconsideration of expedited appeals ~~involving time sensitive care within seventy-two (72) hours of the request for SFH, 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 the 31, 45 or 90-day deadline, whichever is appropriate.~~
- (c) All standard and expedited appeals, ~~including, if not previously resolved in favor of the enrollee during reconsideration, shall be set for, a hearing before an impartial a hearing officer, and 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 pursuant to the timeframes set forth in 42 C.F.R. § 431.244. In accordance with 42 C.F.R. § 438.410(a) and 42 C.F.R. § 431.244(f)(2), SFH requests which are approved for expedited resolution and which are not resolved in the enrollee's favor during MCC's reconsideration, shall be resolved by TennCare within three (3) working days from the date of the MCC's reconsideration determination. 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 at 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~~

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

~~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, or 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 MGC 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 MGC shall take corrective action to implement the decision. For purposes of meeting the five (5) day time limit for corrective action, the State and/or its MGCs shall ensure, whenever an appeal is resolved in favor of the beneficiary:~~

~~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 expense; 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 Bureau or an impartial a 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 the TennCare Solutions Unit Bureau 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: Reserved.~~

~~(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~~

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

~~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 Children in the custody of the State have 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: regarding TennCare services and benefits.~~

- ~~(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 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.~~

1200-13-14-.12 OTHER APPEALS BY TENNCARE APPLICANTS AND ENROLLEES. Notwithstanding Rule 1200-13-19-.01 or any rule to the contrary, appeals by applicants and enrollees of all non-medical eligibility matters are removed to Rule Chapter 1200-13-19, effective upon expiration of the TDHS contract to determine eligibility matters.

~~(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 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.~~
- ~~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.~~

~~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.~~