Department of State
Division of Publications
312 Rosa L. Parks Avenue, 8th Floor Tennessee Tower
Nashville, TN 37243
Phone: 615-741-2650
Fax: 615-741-5133
Email: sos.information@state.tn.us

For Department of State Use Only

Sequence Number: 12-01-08
Rule ID(s): 3901
File Date: 12/05/08
Effective Date: 02/18/09

Rulemaking Hearing Rule(s) Filing Form

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

Revision Type (check all that apply):
X Amendments
___ New
___ Repeal

Chapter Number	**Chapter Title**
1200-13-13	TennCare Medicaid
Rule Number	**Rule Title**
1200-13-13-.01(52)	Definitions

Chapter Number	**Chapter Title**
1200-13-13	TennCare Medicaid
Rule Number	**Rule Title**
1200-13-13-.01(88)	Definitions

Chapter Number	**Chapter Title**
1200-13-13	TennCare Medicaid
Rule Number	**Rule Title**
1200-13-13-.04(1)(b)10. & 30.	Covered Services

Chapter Number	**Chapter Title**
1200-13-13	TennCare Medicaid
Rule Number	**Rule Title**
1200-13-13-.04(7)	Covered Services

Chapter Number	Chapter Title
1200-13-13	TennCare Medicaid
Rule Number	**Rule Title**
1200-13-13-.08(5)	Providers

Chapter 1200-13-13
TennCare Medicaid

Amendments

Paragraph (52) of rule 1200-13-13-.01 Definitions is deleted in its entirety and replaced with a new paragraph (52) which shall read as follows:

(52) Home Health Services shall mean:

(a) Any of the services identified in 42 CFR 440.70 and delivered in accordance with the provisions of 42 CFR 440.70. "Part-time or intermittent nursing services" and "home health aide services" are covered only as defined specifically in these rules.

1. Part-time or intermittent nursing services.

(i) To be considered "part-time or intermittent," nursing services must be provided as no more than one visit per day, with each visit lasting less than eight (8) hours, and no more than 27 total hours of nursing care may be provided per week. In addition, nursing services and home health aide services combined must total less than or equal to eight (8) hours per day and 35 or fewer hours per week. On a case-by-case basis, the weekly total for nursing services may be increased to 30 hours and the weekly total for nursing services and home health aide services combined may be increased to 40 hours for patients qualifying for Level 2 skilled nursing care.

(ii) Part-time or intermittent nursing services are not covered if the only skilled nursing function needed is administration of medications on a p.r.n. (as needed) basis. Nursing services may include medication administration; however, a nursing visit will not be extended in order to administer medication or perform other skilled nursing functions at more than one point during the day, unless skilled nursing services are medically necessary throughout the intervening period. If there is more than one person in a household who is determined to require TennCare-reimbursed home health nursing services, it is not necessary to have multiple nurses providing the services. A single nurse may provide services to multiple enrollees in the same home and during the same hours, as long as he can provide these services safely and appropriately to each enrollee.

(iii) The above limits may be exceeded when medically necessary for children under the age of 21.

2. Home health aide services.

(i) Home health aide services must be provided as no more than two visits per day with care provided less than or equal to eight (8) hours per day. Nursing services and home health aide services combined must total

less than or equal to eight (8) hours per day and 35 or fewer hours per week. On a case-by-case basis, the weekly total may be increased to 40 hours for patients qualifying for Level 2 skilled nursing care. If there is more than one person in a household who is determined to require TennCare-reimbursed home health aide services, it is not necessary to have multiple home health aides providing the services. A single home health aide may provide services to multiple enrollees in the same home and during the same hours, as long as he can provide these services safely and appropriately to each enrollee.

(ii) The above limits may be exceeded when medically necessary for children under the age of 21.

(b) Home health providers shall only provide services to the recipient that have been ordered by the treating physician and are pursuant to a plan of care and shall not provide other services such as general child care services, cleaning services, preparation of meals, or services to other household members. Because children typically have non-medical care needs which must be met, to the extent that home health services are provided to a person under 18 years of age, a responsible adult (other than the home health care provider) must be present at all times in the home during the provision of home health services unless all of the following criteria are met:

1. The child is non-ambulatory; and

2. The child has no or extremely limited ability to interact with caregivers; and

3. The child shall not reasonably be expected to have needs that fall outside the scope of medically necessary TennCare covered benefits (e.g. the child has no need for general supervision or meal preparation) during the time the home health provider is present in the home without the presence of another responsible adult; and

4. No other children shall be present in the home during the time the home health provider is present in the home without the presence of another responsible adult, unless these children meet all the criteria stated above and are also receiving TennCare-reimbursed home health services.

Paragraph (88) of rule 1200-13-13-.01 Definitions is deleted in its entirety and replaced with a new paragraph (88) which shall read as follows:

(88) Private Duty Nursing Services shall mean nursing services for recipients who require eight (8) or more hours of continuous skilled nursing care during a 24-hour period.

(a) A person who needs intermittent skilled nursing functions at specified intervals, but who does not require continuous skilled nursing care throughout the period between each interval, shall not be determined to need continuous skilled nursing care. Skilled nursing care is provided by a registered nurse or licensed practical nurse under the direction of the recipient's physician to the recipient and not to other household members. If there is more than one person in a household who is determined to require TennCare-reimbursed private duty nursing services, it is not necessary to have multiple nurses providing the services. A single nurse may provide services to multiple enrollees in the same home and during the same hours, as long as he can provide these services safely and appropriately to each enrollee.

(b) If it is determined by the MCO to be cost-effective, non-skilled services may be provided by a nurse rather than a home health aide. However, it is the total number of hours of

skilled nursing services, not the number of hours that the nurse is in the home, that determines whether the nursing services are continuous or intermittent.

(c) Private duty nursing services are covered for adults aged 21 and older only when medically necessary to support the use of ventilator equipment or other life-sustaining medical technology when constant nursing supervision, visual assessment, and monitoring of both equipment and patient are required. For purposes of this rule, an adult is considered to be using ventilator equipment or other life-sustaining medical technology if he:

1. Is ventilator dependent for at least 12 hours each day with an invasive patient end of the circuit (i.e., tracheostomy cannula); or

2. Has a functioning tracheostomy:

(i) Requiring suctioning; and

(ii) Oxygen supplementation; and

(iii) Receiving nebulizer treatments or requiring the use of Cough Assist/ in-exsufflator devices; and

(iv) In addition, at least one subitem from each of the following items (I and II) must be met:

(I) Medication:

I. Receiving medication via a gastrostomy tube (G-tube); or

II. Receiving medication via a Peripherally Inserted Central Catheter (PICC) line or central port; and

(II) Nutrition:

I. Receiving bolus or continuous feedings via a permanent access such as a G-tube, Mickey Button, or Gastrojejunostomy tube (G-J tube); or

II. Receiving total parenteral nutrition.

(d) Private duty nursing services are covered as medically necessary for children under the age of 21 in accordance with EPSDT requirements. As a general rule, only a child who is dependent upon technology-based medical equipment requiring constant nursing supervision, visual assessment, and monitoring of both equipment and child will be determined to need private duty nursing services. However, determinations of medical necessity will continue to be made on an individualized basis.

(e) A child who needs less than eight (8) hours of continuous skilled nursing care during a 24-hour period or an adult who needs nursing care but does not qualify for private duty nursing care per the requirements of these rules may receive medically necessary nursing care as an intermittent service under home health.

(f) General childcare services and other non-hands-on assistance such as cleaning and meal preparation shall not be provided by a private duty nurse. Because children typically have non-medical care needs which must be met, to the extent that private duty

nursing services are provided to a person or persons under 18 years of age, a responsible adult (other than the private duty nurse) must be present at all times in the home during the provision of private duty nursing services unless all of the following criteria are met:

1. The child is non-ambulatory; and

2. The child has no or extremely limited ability to interact with caregivers; and

3. The child shall not reasonably be expected to have needs that fall outside the scope of medically necessary TennCare covered benefits (e.g., the child has no need for general supervision or meal preparation) during the time the private duty nurse is present in the home without the presence of another responsible adult; and

4. No other children shall be present in the home during the time the private duty nurse is present in the home without the presence of another responsible adult, unless these children meet all of the criteria stated above and are also receiving TennCare-reimbursed private duty nursing services.

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

Parts 10. and 30. of subparagraph (b) of paragraph (1) of rule 1200-13-13-.04 Covered Services are deleted in their entirety and replaced with new parts 10. and 30. which shall read as follows:

	BENEFIT FOR PERSONS UNDER AGE 21	**BENEFIT FOR PERSONS AGED 21 AND OLDER**
10. Home Health Care [defined at 42 CFR §440.70(a), (b), (c), and (e) and at Rule 1200-13-13-.01].	Covered as medically necessary in accordance with the definition of Home Health Care at Rule 1200-13-13-.01. Prior authorization required for home health nurse and home health aide services, as described in Paragraph (7) of this rule. All home health care must be delivered by a licensed Home Health Agency, as defined by 42 CFR § 440.70.	Covered as medically necessary in accordance with the definition of Home Health Care at Rule 1200-13-13-.01. Prior authorization required for home health nurse and home health aide services, as described in Paragraph (7) of this rule. All home health care must be delivered by a licensed Home Health Agency, as defined by 42 CFR § 440.70.
30. Private Duty Nursing [defined at 42 CFR §440.80 and at Rule 1200-13-13-.01].	Covered as medically necessary in accordance with the definition of Private Duty Nursing at Rule 1200-13-13-.01, when prescribed by an attending physician for treatment and services rendered by a Registered Nurse (R.N.) or a licensed practical nurse (L.P.N.) who is not an immediate relative. Prior authorization required, as described in Paragraph (7) of this rule.	Covered as medically necessary in accordance with the definition of Private Duty Nursing at Rule 1200-13-13-.01, when prescribed by an attending physician for treatment and services rendered by a Registered Nurse (R.N.) or a licensed practical nurse (L.P.N.) who is not an immediate relative. Private duty nursing services are limited to services that support the use of ventilator equipment or other life-sustaining technology when constant nursing supervision, visual assessment, and monitoring of both equipment and patient are

	BENEFIT FOR PERSONS UNDER AGE 21	BENEFIT FOR PERSONS AGED 21 AND OLDER
		required. Prior authorization required, as described in Paragraph (7) of this rule.

Paragraph (7) of rule 1200-13-13-.04 Covered Services is deleted in its entirety and replaced with a new paragraph (7) which shall read as follows:

(7) Prior Authorization for Home Health Nurse, Home Health Aide, and Private Duty Nursing Services. Prior authorization by the MCC must be obtained in order to establish the medical necessity of all requested home health nurse, home health aide, and private duty nursing services.

(a) The following information must be provided when seeking prior authorization for home health nurse, home health aide, and private duty nursing services:

1. Name of physician prescribing the service(s);

2. Specific information regarding the patient's medical condition and any associated disability that creates the need for the requested service(s); and

3. Specific information regarding the service(s) the nurse or aide is expected to perform, including the frequency with which each service must be performed (e.g., tube feeding patient 7:00 a.m., 12:00 p.m., and 5:00 p.m. daily; bathe patient once per day; administer medications three (3) times per day; catheterize patient as needed from 8:00 a.m. to 5:00 p.m. Monday through Friday; change dressing on wound three (3) times per week). Such information should also include the total period of time that the services are anticipated to be medically necessary by the treating physician (e.g., total number of weeks or months).

(b) Home health nurses and aides and private duty nurses will never be authorized to personally transport a TennCare enrollee. Home health nurses will never be authorized to accompany an enrollee outside the home. Home health aides will never be authorized to accompany an enrollee twenty-one (21) years of age or older outside the home.

(c) Private duty nursing services are limited to services provided in the recipient's own home, with the following two exceptions:

1. A recipient age twenty-one (21) or older who requires eight (8) or more hours of skilled nursing care in a 24-hour period and is authorized to receive private duty nursing services in the home setting may make use of the approved hours outside of that setting in order for the nurse to accompany the recipient to:

(i) Outpatient health care services (including services delivered through a TennCare home and community based services waiver program);

(ii) Public or private secondary school or credit classes at an accredited vocational or technical school or institute of higher education; or,

(iii) Work at his place of employment.

2. A recipient under the age of twenty-one (21) who requires eight (8) or more hours of continuous skilled nursing care in a 24-hour period and is authorized to receive those services in the home setting may make use of the approved hours outside

of that setting when normal life activities temporarily take him outside of that setting. Normal life activity for a child under the age of twenty-one (21) means routine work (including work in supported or sheltered work settings); licensed child care; school and school-related activities; religious services and related activities; and outpatient health care services (including services delivered through a TennCare home and community based services waiver program). Normal life activities do not include non-routine or extended home absences.

(d) A private duty nurse may accompany a recipient in the circumstances outlined in subparagraph (c) immediately above, but may not drive.

(e) Private duty nursing services will only be authorized when there are competent family members or caregivers as indicated below:

1. Private duty nursing services include services to teach and train the recipient and the recipient's family or other caregivers how to manage the treatment regimen. Having a caregiver willing to learn the tasks necessary to provide a safe environment and quality in home care is essential to assuring the recipient is properly attended to when a nurse or other paid caregiver is not present, including those times when the recipient chooses to attend community activities to which these rules do not specifically permit the private duty nurse or other paid caregiver to accompany the patient.

2. To ensure the health, safety, and welfare of the individual, in order to receive private duty nursing services, the recipient must have family or caregivers who:

(i) Have a demonstrated understanding, ability, and commitment in the care of the individual related to ventilator management, support of other life-sustaining technology, medication administration and feeding, or in the case of children, other medically necessary skilled nursing functions, as applicable; and

(ii) Are trained and willing to meet the recipient's nursing needs during the hours when paid nursing care is not provided, and to provide backup in the event of an emergency; and

(iii) Are willing and available as needed to meet the recipient's non-nursing support needs.

(iv) In the case of children under the age of 18, the parent or guardian will be expected to fill this role. In the case of an adult age 18 and older, if the health, safety, and welfare of the individual cannot be assured because the recipient does not have such family or caregiver, private duty nursing services may be denied, subject to items (I) and (II) below. However, it shall be the responsibility of the MCO to:

(I) Arrange for the appropriate level of care, which may include nursing facility care, if applicable; and

(II) In the case of a person currently receiving private duty nursing services, facilitate transition to such appropriate level of care prior to termination of the private duty nursing service.

(f) Nursing services (provided as part of home health services or by a private duty nurse) will be approved only if the requested service(s) is of the type that must be provided by a nurse as opposed to an aide, except that the MCO may elect to have a nurse perform

home health aide services in addition to nursing services if the MCO determines that this is a less costly alternative than providing the services of both a nurse and an aide. Examples of appropriate nursing services include, but are not limited to, management of ventilator equipment or other life-sustaining medical technology, medication management, and tube feedings.

(g) Home health aide services will only be approved if the requested service(s) meet all medical necessity requirements including the requirements of 1200-13-16-.05(4)(d). Thus, home health aide services will not be approved to provide child care services, prepare meals, perform housework, or generally supervise patients. Examples of appropriate home health aide services include, but are not limited to, patient transfers and bathing.

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

Paragraph (5) of rule 1200-13-13-.08 Providers is deleted in its entirety and replaced with a new paragraph (5) which shall read as follows:

(5) Providers may seek payment from a TennCare enrollee only under the following circumstances:

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

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

1. The provider determines effective on the date of service that the enrollee has reached his/her benefit limit for the particular service being requested and, prior to providing the service, informs the enrollee that the service is not covered and the service will not be paid for by TennCare. The source of the provider's information must be a database listed on the TennCare website as approved by TennCare on the date of the provider's inquiry.

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

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

(ii) That the provider had previously examined the database referenced in part 1. above and determined that the enrollee had reached his/her benefit limit for the particular service being requested, if the time period applicable to that benefit limit is still in effect; or

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

(iv) The enrollee's MCO has provided confirmation to the provider that the enrollee has reached his/her benefit limit for the applicable service.

3. The provider submits a claim for service to the appropriate managed care contractor (MCC) and receives a written denial of that claim on the basis that the service exceeds the enrollee's benefit limit. Thereafter, following informing the enrollee and within the remainder of the period applicable to that benefit limit, the provider may bill the enrollee for services within that same exhausted benefit category without having to submit, for repeated MCC denial, claims for those subsequent services. If the provider informed the enrollee prior to providing the service for which the claim was denied that the service would exceed the enrollee's benefit limit and would not be paid for by TennCare, the provider may bill the enrollee for that service.

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

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

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

GW1018324

Signature of the agency officer or officers directly responsible for proposing and/or drafting these rules.

Darin Gordon W2

Darin J. Gordon
Director, Bureau of TennCare
Tennessee Department of Finance and Administration

I certify that this is an accurate and complete copy of rulemaking hearing rules, lawfully promulgated and adopted by the Tennessee Department of Finance and Administration on 12/03/2008 (mm/dd/yyyy), and is in compliance with the provisions of T.C.A 4-5-222.

I further certify the following:

Notice of Rulemaking Hearing filed with the Department of State on: 09/08/08

Notice published in the Tennessee Administrative Register on: 10/15/08

Rulemaking Hearing(s) Conducted on: (add more dates). 11/18/08

Date: 12/3/08

Signature: M. D. Goetz, Jr.

Name of Officer: M. D. Goetz, Jr.

Title of Officer: Commissioner

Subscribed and sworn to before me on: 12-2-08

Notary Public Signature: Pat Pentecost

My commission expires on: 1-3-2011

NOTARY PUBLIC STATE OF TENNESSEE DAVIDSON COUNTY

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

Robert E. Cooper, Jr. AH

Robert E. Cooper, Jr.
Attorney General and Reporter

12/4/08
Date

Department of State Use Only

Filed with the Department of State on: 12/5/08

Effective on: 2/18/09

Riley C. Darnell

Riley C. Darnell
Secretary of State

RECEIVED
2008 DEC -5 PM 12:30
SECRETARY OF STATE
PUBLICATIONS

RULES 1200-13-13-01(52) and (88) DEFINITIONS; 1200-13-13-.04(1)(b)10. and 30., .04(7) COVERED SERVICES; 1200-13-13-.08(5) PROVIDERS – TENNCARE MEDICAID.

STATEMENT OF ECONOMIC IMPACT TO SMALL BUSINESSES

1. **Name of Bureau:** Bureau of TennCare

2. **Rulemaking hearing date:** November 18, 2008

3. Types of small businesses that will be directly affected by, bear the cost of, and/or directly benefit from the proposed rules:

Small businesses that will potentially be impacted are home health agencies which will lose revenue due to TennCare placing certain limits on coverage of home health services and private duty nursing services for adults in the TennCare program.

4. A description of how small businesses will be adversely impacted: There is the potential that home health agencies providing services to TennCare enrollees will lose revenue due to limits being placed on coverage of home health services and private duty nursing services.

5. Whether , and to what extent, alternative means exist for accomplishing the objectives of the proposed rule that might be less burdensome to small businesses, and why such alternatives are not being proposed:

It is not in the best financial interest of the State to continue paying home health services and private duty nursing services that are more liberal than other states. CMS suggested that we address the issue by revising our definition of the home health benefit and by seeking limit to the optional private duty nursing benefit.

6. A comparison of the proposed rule with federal or state counterparts:

We are promulgating rules that are consistent with Amendment #6 of TennCare II demonstration 1115 waiver submitted to CMS on February 29, 2008 and approved by CMS on July 22, 2008. The rules re-define the home health benefit to be more consistent with the Medicare home health benefit. The rule revises the private duty nursing benefit for adults to indicate that private duty nursing services will be available when medically necessary to support the use of ventilator equipment or other life-sustaining medical technology when constant nursing supervision, visual assessment, and monitoring of both equipment and patient are required. The rule provide clarification on when a provider can bill an enrollee who has exceeded their benefit limit.

GW1048171

STATE OF TENNESSEE
BUREAU OF TENNCARE
DEPARTMENT OF FINANCE AND ADMINISTRATION
310 Great Circle Road
NASHVILLE, TENNESSEE 37243

November 24, 2008

Mr. Mike Dietrich
Vice President
Tennessee Hospital Association
500 Interstate Boulevard, South
Nashville, Tennessee 37210-4634

RE: Rulemaking Hearing on November 18, 2008

Dear Mr. Dietrich:

Thank you for your comments on the rules presented at hearing on November 18, 2008.

The question you raise is one that has come up during implementation of the changes in home health benefits. We have advised the MCOs that if they determine that additional daily visits are medically necessary and absent the additional visits the patient would need to be hospitalized or receive other more expensive care, they could cover the additional visits as a cost effective alternative. Authorizing cost effective alternatives is done, as you may know, at the sole discretion of the MCO.

I hope this information is helpful to you.

Again, we appreciate your comments.

Sincerely,

Darin Gordon/ ml2

Darin J. Gordon
Director, Bureau of TennCare

Tennessee Hospital Association

November 18, 2008

Rulemaking Hearing
Tennessee Departent of Finance and Administration
Bureau of TennCare

To Whom It May Concern:

On behalf of the hospitals and health systems in Tennessee, the Tennessee Hospital Association would like to submit the following comments regarding the proposed rules for home health and private duty services.

Re: TennCare Medicaid (52)(a)1(i) and
TennCare Standard (52)(a)1(i) Rules relative to the definition of Part-time or intermittent nursing services

THA strongly opposes the proposal to limit part-time or intermittent nursing services to one visit per day. Home health is a vital service for TennCare patients coming out of our hospitals. The typical post-acute patient needing home care will receive only one visit per day for a relatively short duration and/or 2-3 times per week for such things as wound care or IV antibiotics. These visits typically last 45 to 75 minutes. On fairly rare occurrences, however, these home therapies require two visits per day for at least a couple of days to properly teach/train the caregiver or patient to deliver the care.

More often than the scheduled BID (twice a day) visits, however, are unscheduled "emergency" visits delivered to the home due to a patient crisis. The typical patient/caregiver in this situation is experiencing anxiety about their care or has a complication and calls their home care provider to come back to the home to assist them. If these rules are implemented as written, the home care providers will have no choice but to send the patient to the hospital emergency room to resolve the crisis – a crisis that typically can be handled in the home by trained home health professionals.

Therefore, we see this as very short-sighted policy being developed by the TennCare Bureau and request that the traditional skilled, intermittent home care visits be excluded from the rule. Sending these patients to the hospital emergency room is a more costly, less clinically effective option that puts unnecessary burdens on the patients and the hospital ER.

Sincerely,

Mike Dietrich
Vice President

STATE OF TENNESSEE
BUREAU OF TENNCARE
DEPARTMENT OF FINANCE AND ADMINISTRATION
310 Great Circle Road
NASHVILLE, TENNESSEE 37243

November 24, 2008

Ms. Gayla Sasser
Tennessee Association for Home Care
131 Donelson Pike
Nashville, Tennessee 37214

RE: Rulemaking Hearing on November 18, 2008

Dear Ms. Sasser:

We appreciated your comments regarding the rules that were presented at hearing on November 18, 2008.

Your question has come up during implementation of the changes in home health benefits. We have advised the MCOs that if they determine that additional daily visits are medically necessary and absent the additional visits the patient would need to be hospitalized or receive other more expensive care, they could cover the additional visits as a cost effective alternative. Authorizing cost effective alternatives is done, as you may know, at the sole discretion of the MCO.

I hope this information is helpful to you.

Again, we appreciate your comments.

Sincerely,

Darin Gordon / WJ

Darin J. Gordon
Director, Bureau of TennCare