

Tennessee Department of Finance and Administration

Bureau of TennCare

Chapter 1200-13-13
TennCare Medicaid

Statement of Necessity Requiring Public Necessity Rules

I am herewith submitting amendments to the rules of the Tennessee Department of Finance and Administration, Bureau of TennCare, for promulgation pursuant to the public necessity provisions of the Uniform Administrative Procedures Act, T.C.A. § 4-5-209, and 2004 amendments to the Medical Assistance Act, T.C.A. §§ 71-5-101, *et seq.*

Tennessee Code Annotated, Section 71-5-144, enacted by and through Public Chapter 673 of the Acts of 2004, amended the Medical Assistance Act by creating a new medical necessity definition to be used by the Bureau of TennCare to evaluate medical items and services requested by TennCare enrollees. In accordance with Tennessee Code Annotated, Section 71-5-144(f) and Section 29 of Public Chapter 673, which specifically authorizes the Commissioner of Finance and Administration to promulgate all rules and regulations provided for in the Act as public necessity rules pursuant to T.C.A. § 4-5-209, these rules are necessary to implement the provisions of the medical necessity definition and to comply with all new Grier orders.

For a copy of this public necessity rule, contact George Woods at the Bureau of TennCare by mail at 310 Great Circle Road, Nashville, Tennessee 37243 or by telephone at (615) 507-6446.

Darin J. Gordon
Deputy Commissioner
Tennessee Department of Finance
and Administration

Public Necessity Rules
of
Tennessee Department of Finance and Administration
Bureau of TennCare
Chapter 1200-13-13
TennCare Medicaid
Amendments

Part 5. and 6. of subparagraph (a) of paragraph (1) of rule 1200-13-13-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits are deleted in their entirety and replaced with new parts 5. and 6. which shall read as follows:

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 1200-13-13-.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.
 - (iii) Pursuant to approved 1115 waiver authority, applicable non-pharmacy services for which a provider may deny a claim for service because a benefit limit has been reached include Inpatient and Outpatient Substance Abuse Benefits (including detoxification days) for adults age 21 and older as set out at rule 1200-13-13-.04.

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 1200-13-13-.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.

Subparagraph (c) of paragraph (1) of rule 1200-13-13-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits is deleted in its entirety and replaced with a new subparagraph (c) which shall read as follows:

- (c) Notice Contents.

1. Whenever this rule requires that a TennCare enrollee receive written notice of an adverse action affecting medical assistance, the notice must contain the following elements, written in concise, readable terms:
 - (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 his/her 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
 - 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 provided to an enrollee does not meet the notice content requirements of rule 1200-13-13-.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 1200-13-13-.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.

Subpart (iv) of part 3. of subparagraph (d) of paragraph (1) of rule 1200-13-13-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits is deleted in its entirety and replaced by a new subpart (iv) which shall read as follows:

- (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 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.

Subparts (i) and (ii) of part 6. of subparagraph (d) of paragraph (1) of rule 1200-13-13-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits are deleted in their entirety and replaced with new subparts (i) and (ii) which shall read as follows:

- (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 1200-13-13-.11(1)(d) 1. to 3.

Part 2. of subparagraph (g) of paragraph (1) of rule 1200-13-13-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits is deleted in its entirety and replaced with a new part 2. which shall read as follows:

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.

Subpart (ii) of part 3. of subparagraph (g) of paragraph (1) of rule 1200-13-13-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits is deleted in its entirety and replaced with a new subpart (ii) which all read as follows:

- (ii) The provider will be informed that the service will be authorized if prescribed and found to be medically necessary; and

The introductory sentence of subparagraph (b) and part 1. of subparagraph (b) of paragraph (2) of rule 1200-13-13-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits are deleted in their entirety and replaced with new introductory sentence and new part 1. of subparagraph (b) which 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 actions that have been taken or are proposed to be taken, 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;

Subparagraph (e) of paragraph (2) of rule 1200-13-13-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits is amended by deleting the last sentence so as amended subparagraph (e) shall read as follows:

- (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.

The introductory paragraph to subparagraph (g) of paragraph (2) of rule 1200-13-13-.11 Appeal of Adverse Action Affecting TennCare Services or Benefits is deleted in its entirety and replaced with a new introductory paragraph which 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-.231 as modified by this rule, pending appeal when the enrollee submits a timely appeal and timely request for such services. When an enrollee is so entitled to continuation or reinstatement of services, this right may not be denied for any reason, including:

Part 2. of subparagraph (b) of paragraph (3) of rule 1200-13-13-.11 Appeal of Adverse Action Affecting TennCare Services or Benefits is deleted in its entirety and replaced with a new part 2. which shall read as follows:

- 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 action affecting TennCare services.

The introductory paragraph to subparagraph (e) of paragraph (3) of rule 1200-13-13-.11 Appeal of Adverse Action Affecting TennCare Services or Benefits is deleted in its entirety and replaced with a new introductory paragraph to subparagraph (e) which shall read as follows:.

- (e) Appeals When Enrollees Lack a Prescription. If a TennCare enrollee appeals an adverse action and TennCare determines that the basis of the appeal is that the enrollee lacks a prescription, TennCare may require the enrollee to exhaust the following administrative process before an appeal can proceed:

Part 1. of subparagraph (e) of paragraph (3) of rule 1200-13-13-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits is amended by adding "ing" to the word "inform" in the first sentence so as amended part 1. shall read as follows:

- 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.

Part 10. of subparagraph (b) of paragraph (4) of rule 1200-13-13-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits is deleted in its entirety and replaced with a new part 10. which shall read as follows:

- 10. Resolution, including a hearing with an ALJ 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.

Subpart (i) of part 2. of subparagraph (f) of paragraph (4) of rule 1200-13-13-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits is deleted in its entirety and replaced with a new subpart (i) which shall read as follows:

- (i) TennCare shall attempt to complete such review within five (5) days of the issuance of the decision of the impartial hearing officer.

Part 2. of subparagraph (f) of paragraph (4) of rule 1200-13-13-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits is amended by adding a new subpart (ii) and relettering the present (ii) as (iii) and subsequent subparts relettered accordingly so as amended the new subpart (ii) shall read as follows:

- (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 1200-13-13-.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.

Subpart (iii) of part 1. of subparagraph (g) of paragraph (4) of rule 1200-13-13-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits is deleted in its entirety and replaced by a new subpart (iii) which shall read as follows:

- (iii) Continuation of reinstatement of services within ten (10) days of MCC-initiated notice of action to terminate, suspend or reduce other ongoing services or prior to the date of action.

The introductory paragraph to part 5. of subparagraph (g) of paragraph (4) of rule 1200-13-13-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits is deleted in its entirety and replaced with a new introductory paragraph to part 5. which shall read as follows:

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 or 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:

Subparts (iii) and (vii) of part 6. of subparagraph (g) of paragraph (4) of rule 1200-13-13-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits are deleted in their entirety and replaced with new subparts (iii) and (vii) which shall read as follows:

- (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;
- (vii) If TennCare had not paid for the type and amount of service for which continuation or reinstatement is requested prior to the appeal.

Subparagraph (h) of paragraph (4) of rule 1200-13-13-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits is deleted in its entirety and replaced with a new subparagraph (h) which shall read as follows:

- (h) Expedited appeals.
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.
 2. Care will only qualify as time-sensitive if a covered benefit has been delayed, denied, terminated or suspended; the service is not defined by TennCare policy as never constituting an emergency; and in the judgment of a member's treating physician or in the judgment of a prudent layperson that is not subsequently overturned by written physician certification, waiting ninety (90) days to receive such benefit will result in:
 - (i) Serious health problems or death;
 - (ii) Serious dysfunction of a bodily organ or part; or
 - (iii) Hospitalization.
 3. MCCs shall complete reconsideration of expedited appeals within five (5) days, or within fourteen (14) days when additional time is required to obtain an enrollee's medical records, after receiving notification of the appeal. If the MCC does not complete reconsideration within these timeframes, the appeal shall not be automatically resolved 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 ninety (90) days from the date the appeal is received.

Subparagraphs (a), (b), (d), and (f) of paragraph (7) of rule 1200-13-13-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits are deleted in their entirety and replaced by new subparagraphs (a), (b), (d), and (f) which shall read as follows:

- (a) MCCs must act upon a request for prior authorization within fourteen (14) days as provided in rule 1200-13-13-.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 1200-13-13-.11(8).
- (b) MCCs must complete reconsideration of non-expedited appeals within fourteen (14) days. MCCs must complete reconsideration of expedited appeals involving time sensitive care within 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 ninety (90) days from the date the appeal is received.
- (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 rule 1200-13-13-.11 (8). This conditional authorization will neither moot the pending appeal nor be evidence of the enrollee's satisfaction of the criteria for 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, terminating the provision or payment of the service.

- (f) Except upon a showing by an MCC 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 MCC take corrective action to implement the decision. For purposes of meeting the five (5) day time limit for corrective action, the MCC shall take steps necessary to ensure:
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 cost; 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.

Statutory Authority: T.C.A. 4-5-209, 71-5-105, 71-5-109, Executive Order No. 23.

The Public Necessity rules set out herein were properly filed in the Department of State on the 1st day of December, 2006, and will be effective from the date of filing for a period of 165 days. The Public Necessity rules remain in effect through the 15th day of May, 2007. (12-02-06)