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Sequence Number: 12-24-13
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File Date: 12/20/13

Notice of Rulemaking Hearing

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

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

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

ADA Contact:	ADA Coordinator
Address:	Bureau of TennCare 310 Great Circle Road Nashville, TN 37243
Phone:	(615) 507-6474
Email:	helen.moore@tn.gov

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

Address 1:	310 Great Circle Road, Conference Room 1 East A		
City:	Nashville, TN		
Zip:	37243		
Hearing Date :	February 26, 2014		
Hearing Time:	9:00 a.m.	X CST/CDT	EST/EDT

Additional Hearing Information:

Revision Type (check all that apply):

___ Amendments
X New
___ Repeal

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

Chapter Number	Chapter Title
0620-05-01	Cover Kids Rules
Rule Number	**Rule Title**
0620-05-01-.06	Providers

(Place substance of rules and other info here. Statutory authority must be given for each rule change. For information on formatting rules go to http://state.tn.us/sos/rules/1360/1360.htm)

Rule Chapter 0620-05-01 is amended by adding Rule 0620-05-01-.06 Providers which shall read as follows:

0620-05-01-.06 Providers.

(1) This rule shall be in effect from October 1, 2013.

(2) For purposes of this rule, the following definitions shall apply:

(a) Covered services. Services listed in Rule 0620-05-01-.03 and authorized by the Plan Administrator ("PA").

(b) CoverKids network. A group of health care providers that have entered into contracts with the PA to furnish covered services to CoverKids enrollees. These contracts may take the form of general contracts or single case agreements.

(c) CoverKids provider. An appropriately licensed institution, facility, agency, person, corporation, partnership, or association that delivers health care services and that participates in the PA's network.

(d) Emergency services, including emergency mental health and substance abuse emergency treatment services. Services to treat 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:

1. Placing the person's (or with respect to a pregnant woman, her unborn child's) health in serious jeopardy; or

2. Serious impairment to bodily functions; or

3. Serious dysfunction of any bodily organ or part.

(e) HealthyTNBabies. The program that provides coverage of maternity care for pregnant CoverKids enrollees, including the unborn children of pregnant women with no source of coverage who meet the CoverKids eligibility requirements.

(f) Non-CoverKids provider. A health care provider of non-emergency services that does not participate in the PA's network.

(3) Payment in full.

(a) All CoverKids providers, as defined in this rule, must accept as payment in full for provision of covered services to a CoverKids enrollee, the amount paid by the PA, plus any copayment required by the CoverKids program to be paid by the individual.

(b) Any non-CoverKids providers who furnish CoverKids covered services by authorization from the PA must accept as payment in full for provision of covered services to CoverKids enrollees the amounts paid by the PA plus any copayment required by the CoverKids program to be paid by the individual.

(c) CoverKids will not pay for non-emergency services furnished by non-CoverKids providers unless these services are authorized by the PA. Any non-CoverKids provider who furnishes CoverKids

Program covered non-emergency services to a CoverKids enrollee without authorization from the PA does so at his own risk. He may not bill the patient for such services except as provided for in Paragraph (5).

(4) Non-CoverKids Providers

(a) In situations where the PA authorizes a service to be rendered by a non-CoverKids provider, payment to the provider shall be no less than 80% of the lowest rate paid by the PA to equivalent participating CoverKids network providers for the same service, consistent with the methodology contained in Rule 1200-13-13-.08(2)(a).

(b) Covered medically necessary outpatient emergency services, when provided to CoverKids enrollees by non-CoverKids network hospitals, shall be reimbursed at 74% of the 2006 Medicare rates for the services, consistent with the methodology contained in Rule 1200-13-13-.08(2)(b). Emergency care to enrollees shall not require preauthorization.

(c) Covered medically necessary inpatient hospital admissions required as the result of emergency outpatient services, when provided to CoverKids enrollees by non-CoverKids network hospitals, shall be reimbursed at 57% of the 2008 Medicare DRG rates (excluding Medical Education and Disproportionate Share components) determined according to 42 CFR § 412 for the services, consistent with the methodology contained in Rule 1200-13-13-.08(2)(c). Such an inpatient stay will continue until no longer medically necessary or until the patient can be safely transported to a network hospital, whichever comes first.

(5) Providers may seek payment from a CoverKids enrollee only under the following circumstances. These circumstances include situations where the enrollee may choose to seek a specific covered service from a non-CoverKids provider.

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

(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 has information in her own records to support the fact that the enrollee has reached his 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 CoverKids. 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 personally provided services to the enrollee in excess of his 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

(iii) The enrollee's PA has provided confirmation to the provider that the enrollee has reached his benefit limit for the applicable service.

2. The provider submits a claim for service to the PA and receives a written denial of that claim on the basis that the service exceeds the enrollee's benefit limit. After 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 claims for those subsequent services for repeated PA denial. 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 CoverKids, the provider may bill the enrollee for that service.

3. The provider had previously taken the steps in parts 1. or 2. above and determined that the enrollee had reached his 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 CoverKids.

(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.

(6) Providers may not seek payment from a CoverKids enrollee under the following conditions:

(a) The provider knew or should have known about the patient's CoverKids enrollment prior to providing services.

(b) The claim submitted to the PA for payment was denied due to provider billing error or a CoverKids claim processing error.

(c) The provider accepted CoverKids assignment on a claim and it is determined that another payer paid an amount equal to or greater than the CoverKids allowable amount.

(d) The provider failed to comply with CoverKids policies and procedures or provided a service which lacks medical necessity or justification.

(e) The provider failed to submit or resubmit claims for payment within the time periods required by the PA or CoverKids.

(f) The provider failed to inform the enrollee prior to providing a service not covered by CoverKids that the service was not covered and the enrollee may be responsible for the cost of the service. Services which are non-covered by virtue of exceeding limitations are exempt from this requirement if the provider has complied with paragraph (5) above.

(g) The enrollee failed to keep a scheduled appointment(s).

(7) Pharmacy providers may not waive pharmacy copayments for CoverKids enrollees as a means of attracting business to their establishments. This does not prohibit a pharmacy from exercising professional judgment in cases where an enrollee may have a temporary or acute need for a prescribed drug, but is unable, at that moment, to pay the required copayment.

Statutory Authority: T.C.A. §§ 4-5-202, 4-5-203, 71-3-1104 and 71-3-1110.

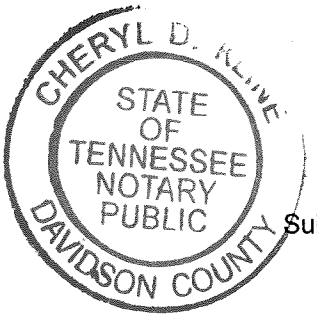
I certify that the information included in this filing is an accurate and complete representation of the intent and scope of rulemaking proposed by the agency.

Date: 12/9/2013

Signature:

Name of Officer: Darin J. Gordon

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



Subscribed and sworn to before me on: 12/9/13

Notary Public Signature:

My commission expires on: AUG 23 2016

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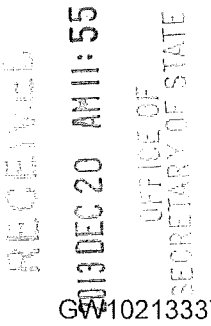
Filed with the Department of State on: 12/20/13

Tre Hargett
Secretary of State



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