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 the Medical Assistance Act, T.C.A. § 71-5-134.

On June 8, 2005, the State of Tennessee received federal approval for certain amendments to the benefits covered under the TennCare Demonstration Project (No. 11-W-0015 1/4). Approval of the project modification is granted under the authority of Section 1115 (a) of the Social Security Act. The amendments are approved through the period ending June 30, 2007. The TennCare program is a managed care program for both the Medicaid population and the expansion population.

Tennessee Code Annotated, Section 71-5-134, states that in order to comply with or to implement the provisions of any federal waiver or state plan amendment obtained pursuant to the Medical Assistance Act as amended by Acts 1993, the Commissioner of Finance and Administration is authorized to promulgate public necessity rules pursuant to Tennessee Code Annotated, Section 4-5-209.

I have made a finding that these amendments are required to conform the current TennCare Medicaid rules to reflect changes resulting from the amendment of the TennCare waiver.

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.

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J. D. Hickey
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

Amendments

Rule 1200-13-13-.04 Covered Services is amended by adding a new paragraph (8) and renumbering the present paragraph (8) as (9) and subsequent paragraphs renumbered according so as amended the new paragraph (8) shall read as follows:

(8) Effective August 1, 2005**,** the covered benefits for TennCare Medicaid will be as follows:

(a) TennCare managed care contractors shall cover, at a minimum, the following services and benefits subject to any applicable limitations described herein effective August 1, 2005. Any and all medically necessary services may require prior authorization or approval by the managed care contractor, except where prohibited by law. In accordance with the *John B.* Court Order, MCCs may not deny medically necessary EPSDT services due to lack of prior authorization. As stated elsewhere in these rules, managed care organizations shall not require prior authorization or approval for services rendered in the event of an emergency need of the enrollee. Such emergency services may be reviewed on the basis of medical necessity or other MCO administrator requirements, but cannot be denied solely because the provider did not obtain prior authorization or approval from the enrollee's managed care organization. Managed care contractors shall not impose any service limitations that are more restrictive than those described herein; however, this provision shall not limit the managed care contractor's ability to establish procedures for the determination of medical necessity. Services for which there is no federal financial participation (FFP) are not covered.

(b) Physical Health and Mental Health Services

SERVICE	BENEFIT
1. Chiropractic Services	Under age 21: Covered as medically necessary. Age 21 and older: Covered when determined cost effective by the MCO.
2. Community Health Services	Under age 21: Covered as medically necessary. Age 21 and older: As medically necessary, except that effective August 1, 2005, Methadone Clinic services for adults age 21 and older are not covered, even if medically necessary. This includes services that have been prior authorized and/or initiated, but not completed as of August 1, 2005.
3. Convalescent Care	Under age 21: Upon receipt of proof that an enrollee has

SERVICE	BENEFIT
	incurred medically necessary expenses related to convalescent care, TennCare shall pay for up to and including the one-hundredth (100^{th}) day of confinement during any calendar year for convalescent facility(ies) room, board, and general nursing care, provided: (A) a physician recommends confinement for convalescence; (B) the enrollee is under the continuous care of a physician during the entire period of confinement; and (C) the confinement is required for other than custodial care. Age 21 and older: Effective August 1, 2005, not covered, even if medically necessary. This includes services that have been prior authorized and/or initiated, but not completed as of August 1, 2005.
4. Dental Services	Under age 21: Preventive, diagnostic, and treatment services. Orthodontic services must be prior approved and are limited to individuals under age 21 diagnosed with: (1) a severe handicapping malocclusion or another developmental anomaly or injury resulting in severe malalignment or severe handicapping malocclusion of teeth, documented by at least 28 points on the Salzmann Scale, or any other method that is approved by TennCare, or (2) following repair of an enrollee's cleft palate. Orthodontic treatment will not be authorized for cosmetic purposes. Orthodontic treatment will only be paid for by TennCare as long as the individual remains eligible. If the orthodontic treatment plan is approved prior to the enrollee obtaining 20 ½ years of age, and treatment is initiated prior to the enrollee obtaining 21 years of age, such treatment may continue as long as the enrollee remains eligible. Age 21 and older: Effective August 1, 2005, not covered, even if medically necessary. This includes services which have been prior authorized and/or initiated, but not completed as of August 1, 2005, except for orthodontic treatment as specified above.
5. Durable Medical Equipment	As medically necessary.
6. Emergency Air and Ground Transportation	As medically necessary.
7. EPSDT Services	Under age 21: Covered as medically necessary. Screening, interperiodic screening, diagnostic and follow-up treatment services as medically necessary in accordance with federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989 for enrollees under age 21. Except for Dental services, screens shall be in accordance with the periodicity schedule set forth in the latest "American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care" and all components of the

SERVICE	BENEFIT
	screens must be consistent with the latest "American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care." Dental screens shall be in accordance with the latest periodicity schedule set forth by either the American Academy of Pediatric Dentistry or the American Academy of Pediatrics and all components of the screens must be consistent with the latest recommendations by the American Academy of Pediatric Dentistry or the American Academy of Pediatrics. Age 21 and older: Not covered.
8. Home Health Care	Under age 21: As medically necessary. Age 21 and older: As medically necessary, all home health care as delivered by a licensed Home Health Agency, as defined by 42 CFR §440.70. A home health visit includes any of the following: Skilled Nursing, Physical Therapy, Occupational Therapy, Speech Pathology and Audiology Services, and Home Health Aide. Full-time nursing services are not covered for adults 21 years of age and older, except as part of home respiratory therapy services for ventilator-dependent enrollees. (See item 34 in the chart.)
9. Hospice Care	As medically necessary. Must be provided by an organization certified pursuant to Medicare Hospice requirements.
10. Inpatient and Outpatient Substance Abuse Benefits	Under age 21: As medically necessary. Age 21 and older: As medically necessary, except that effective August 1, 2005, Methadone Clinic services for adults age 21 and older are not covered even if medically necessary. This includes services that have been prior authorized and/or initiated, but not completed as of August 1, 2005. Covered substance abuse treatment services are limited to ten (10) days detox, with a $30,000 limit in lifetime medically necessary benefits. This limit on covered services does not apply to persons who are Severely and/or Persistently Mentally Ill.
11. Inpatient Hospital Services	As medically necessary. MCO may conduct concurrent and retrospective reviews.
12. Inpatient Rehabilitation Facilities	Under age 21: As medically necessary. Age 21 and older: Inpatient Rehabilitation Facilities services may be covered when determined to be a cost effective alternative by the MCO.
13. Lab and X-ray Services	As medically necessary.
14. Medical Supplies	As medically necessary.
15. Non-Emergency	As medically necessary.

SERVICE	BENEFIT
Ambulance Transportation	
16. Non-Emergency Transportation	As necessary to get an enrollee to and from covered services, for enrollees not having access to transportation. MCOs may require advance notice of the need in order to timely arrange transportation. The travel to access primary care and dental services must meet the requirements of the waiver terms and conditions. The availability of specialty services is related to travel distance should meet the usual and customary standards for the community. However, in the event the MCO is unable to negotiate such an arrangement for an enrollee transportation must be provided regardless of whether or not the enrollee has access to transportation. If the enrollee is a child, transportation must be provided for the child and an accompanying adult. However, transportation for a child shall not be denied pursuant to any policy which poses a blanket restriction due to enrollee's age or lack of parental accompaniment. (Note: Tennessee recognizes the "mature minor exception" to permission for medical treatment.) Any decision to deny transportation of a child due to an enrollee's age or lack of parental accompaniment must be made on a case-by-case basis and must be based on the individual facts surrounding the request. As with any denial, all notices and actions must be in accordance with the appeal process. The provision of transportation to and from dental services shall remain with the MCO.
17. Occupational Therapy	Under age 21: Covered as medically necessary. Age 21 and older: Covered as medically necessary, by a Licensed Occupational Therapist, to restore, improve, or stabilize impaired functions.
18. Organ Transplant and Donor Organ Procurement	Under age 21: Covered as medically necessary. Experimental or investigational transplants are not covered. Age 21 and older: All medically necessary and non-investigational/experimental organ transplants are covered. These include, but may not be limited to: Bone Marrow/Stem Cell Cornea Heart Heart/Lung Kidney Kidney/Pancreas Liver Lung Pancreas

SERVICE	BENEFIT
	Small bowel/Multi-visceral
19. Outpatient Hospital Services	As medically necessary.
20. Outpatient Mental Health Services (including physician services)	As medically necessary.
21. Pharmacy Services (obtained directly from an ambulatory retail pharmacy setting, outpatient hospital pharmacy, mail order pharmacy or those administered to a long term care facility resident (nursing facility))	As medically necessary, subject to the limitations set out below. Certain drugs (known as DESI, LTE, IRS drugs) are excluded from coverage, or as provided herein at 1200-13-13-.04(7) and 1200-13-13-.10. The following limitations (A) – (D) are effective as of August 1, 2005. (A) Pharmacy services for all children and for individuals receiving TennCare-reimbursed services in a Nursing Facility or Intermediate Care Facility for the Mentally Retarded, or a Home and Community Based Services waiver have no quantity limits on the number of prescriptions per month. (B) Subject to (A) above, pharmacy services for Categorically Needy adults age 21 and older who are not in the Medically Needy category and included in (A) above or who are eligible in the Medically Needy category as pregnant women are limited to five (5) prescriptions and/or refills per enrollee per month, of which no more than two (2) of the five (5) can be brand name drugs. As of August 1, 2005, additional drugs for individuals in (B) shall not be covered even if medically necessary. This includes services that have been prior authorized and/or initiated, but not completed as of August 1, 2005 and/or drugs for which the initial prescription but not all applicable refills, or the interim supply, but not the balance thereof, has been received as of August 1, 2005. Prescriptions shall be counted beginning on the first of each calendar month. Each prescription or refill counts as one (1). A prescription or refill can be no more than a 30-day supply. The Bureau of TennCare shall maintain a "Pharmacy Short List" of pharmacy services which shall not count against such pharmacy limit. The Pharmacy Short List may be modified at the discretion of the Bureau of TennCare. The most current version of the Pharmacy Short List will be made available to enrollees via the internet on the TennCare website and upon request by mail through the DHS Family Assistance Centers. Only drugs that are specified on the version of the Pharmacy Short List that is current as of the date of service shall not count against applicable pharmacy limits. TennCare will not cover drugs on the Pharmacy Short List for enrollees whose pharmacy

SERVICE	BENEFIT
	services are not covered. Unless specified on the version of the Pharmacy Short List which is current as of the date of pharmacy service, pharmacy services in excess of five (5) prescriptions and/or refills per enrollee per month or two (2) brand name drugs per enrollee per month are non-covered services. (C) Subject to (A) and (B) above, pharmacy services are not covered for Medically Needy adults (age 21 and older) even if medically necessary. This includes services that have been prior authorized and/or initiated but not completed as of August 1, 2005, and/or drugs for which the initial prescription but not all applicable refills, or the interim supply, but not the balance thereof, have been received as of August 1, 2005. (D) Over-the-counter drugs for Medicaid adults (age 21 and older) are not covered even if the enrollee has a prescription for such service, except for prenatal vitamins. TennCare is responsible for the provision and payment of pharmacy benefits to individuals who are enrolled in the TennCare Program in the category of TennCare Medicaid/Medicare dual eligible. However, this does not include pharmaceuticals administered in a doctor's office or administered by other vendors under contract with the MCO.
22. Physical Therapy	Under age 21: Covered as medically necessary. Age 21 and older: Covered as medically necessary, by a Licensed Physical Therapist, to restore, improve, or stabilize impaired functions.
23. Physician Inpatient Services	As medically necessary.
24. Physician Outpatient Services/Community Health Clinics/Other Clinic Services	Under age 21: As medically necessary. Age 21 and older: As medically necessary, except that effective August 1, 2005, Methadone Clinic services for adults age 21 and older are not covered, even if medically necessary. This includes services that have been prior authorized and/or initiated, but not completed as of August 1, 2005.
25. Private Duty Nursing	Under age 21: Covered as medically necessary 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. Age 21 and older: Effective August 1, 2005, not covered even if medically necessary. This includes services which have been prior authorized and/or initiated, but not completed as of August 1, 2005.

SERVICE	BENEFIT
26. Psychiatric Inpatient Services	As medically necessary.
27. Psychiatric Physician Inpatient Services	As medically necessary.
28. Psychiatric Rehabilitation Services	As medically necessary.
29. Reconstructive Breast Surgery	Covered in accordance with Tenn. Code Ann. § 56-7-2507 which requires coverage of all stages of reconstructive breast surgery on a diseased breast as a result of a mastectomy as well as any surgical procedure on the non-diseased breast deemed necessary to establish symmetry between the two breasts in the manner chosen by the physician. The surgical procedure performed on a non-diseased breast to establish symmetry with the diseased breast will only be covered if the surgical procedure performed on a non-diseased breast occurs within five (5) years of the date the reconstructive breast surgery was performed on a diseased breast.
30. Renal Dialysis Services	As medically necessary, for the first ninety (90) days prior to being covered by Medicare.
31. Sitter Services	Under age 21: As medically necessary, a sitter who is not a relative may be used where an enrollee is confined to a hospital as a bed patient and certification is made by a network physician that R.N. or L.P.N. is needed and neither is available. Age 21 and older: As of August 1, 2005, not covered even if medically necessary. This includes services that have been prior authorized and/or initiated, but not completed as of August 1, 2005.
32. Speech Therapy	Under age 21: Covered as medically necessary. Age 21 and older: Covered as medically necessary, by a Licensed Speech Therapist to restore speech (as long as there is continued medical progress) after a loss or impairment.
33. 24-Hour Psychiatric Residential Treatment	As medically necessary.

SERVICE	BENEFIT
34. Ventilator Services	Under 21: As medically necessary. Age 21 and older. Medically necessary home and community-based respiratory therapy services provided outside an institutional setting for ventilator-dependent enrollees, to include nursing services when necessary to prevent institutionalization. Prior approval required.
35. Vision Services	Under 21: Preventive, diagnostic, and treatment services (including eyeglasses) are covered as medically necessary Age 21 and older: Medical eye care, meaning evaluation and management of abnormal conditions, diseases, and disorders of the eye (not including evaluation and treatment of refractive state), will be covered. Routine, periodic assessment, evaluation, or screening of normal eyes and examinations for the purpose of prescribing, fitting, or changing eyeglasses and/or contact lenses will not be covered.

(c) Pharmacy

TennCare is permitted under the terms and conditions of the demonstration project approved by the federal government to restrict coverage of prescription and non-prescription drugs to a TennCare-approved list of drugs known as a drug formulary. TennCare must make this list of covered drugs available to the public. Through the use of a formulary, the following drugs or classes of drugs, or their medical uses, shall be excluded from coverage or otherwise restricted by TennCare as described in Section 1927 of the Social Security Act [42 U.S.C. §1396r-8]:

1. Agents for weight loss or weight gain.

2. Agents to promote fertility or for the treatment of impotence or infertility or for the reversal of sterilization.

3. Agents for cosmetic purposes or hair growth.

4. Agents for symptomatic relief of coughs and colds.

5. Agents to promote smoking cessation.

6. Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.

7. Nonprescription drugs.

8. 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.

TennCare shall not cover drugs considered by the FDA to be Less Than Effective (LTE) and DESI drugs, or drugs considered to be Identical, Related and Similar (IRS) to DESI and LTE drugs or any other pharmacy services for which federal financial participation (FFP) is not available. The exclusion of drugs for which no FFP is available extends to all TennCare enrollees regardless of the enrollee's age. TennCare shall not cover experimental or investigational drugs, which have not received final approval from the FDA.

Statutory Authority: T.C.A. 4-5-209, 71-5-105, 71-5-109, 71-5-134, Executive Order No. 23.

The Public Necessity rules set out herein were properly filed in the Department of State on the 1st day of July, 2005, and will be effective from the date of filing for a period of 165 days. The Public Necessity rules remain in effect through the 13th day of December, 2005.