

Rulemaking Hearing Rules  
of  
Tennessee Department of Finance and Administration  
  
Bureau of TennCare  
  
Chapter 1200-13-14  
TennCare Standard  
  
Amendments

Paragraph (5) of rule 1200-13-14-.01 Definitions (Application Fee) is deleted in its entirety and subsequent paragraphs renumbered accordingly.

Paragraph (17) renumbered as (16) of rule 1200-13-14-.01 Definitions is amended by deleting subparagraph (e) in its entirety so as amended the renumbered paragraph (16) shall read as follows:

- (16) COMPLETED APPLICATION is an application where:
- (a) All required fields have been completed;
  - (b) It is signed and dated by the applicant or the applicant's parent or guardian;
  - (c) It includes all supporting documentation required by TDHS or the Bureau to determine TennCare eligibility, technical and financial requirements as set out in these rules; and
  - (d) It includes all supporting documentation required to prove TennCare Standard medical eligibility as set out in these rules.

Subparagraph (d) of paragraph (109) to be renumbered as paragraph (108) of rule 1200-13-14-.01 Definitions (TennCare Standard) is amended by deleting the last sentence so as amended subparagraph (d) shall read as follows:

- (d) Had Medicare as of December 31, 2001 (but not Medicaid) and were enrolled in the TennCare Program as of December 31, 2001, and who continue to meet the definition of "uninsurable" in effect at that time; or

Statutory Authority: T.C.A. 4-5-202, 71-5-105, 71-5-109, Executive Order No. 23.

Part 8. of subparagraph (a) of paragraph (2) of rule 1200-13-14-.02 Eligibility is amended by deleting the phrase "for the pharmacy benefit only, effective January 1, 2003," in the third sentence so as amended part 8. shall read as follows:

- 8. Not be enrolled in, or eligible for participation in, Medicare, with the following exception: If the individual was enrolled in TennCare on December 31, 2001, had Medicare on December 31, 2001, and was not eligible for Medicaid. These enrollees will continue on TennCare Standard with uninterrupted coverage as long as they lack access to health insurance other than Medicare and they abide by all TennCare program requirements, such as payment of premiums. This is a "grandfathered" eligibility category for waiver transition purposes only. At such time as a person loses eligibility in this category, he will not be able to re-enroll in it.

Part 3. of subparagraph (c) of paragraph (3) of rule 1200-13-14-.02 Eligibility is deleted in its entirety and replaced with a new part 3. which shall read as follows:

3. Enrollees will be required to prove that s/he is uninsurable by providing proof of a qualifying medical condition or providing medical records for consideration by the Bureau.

Statutory Authority: T.C.A. 4-5-202, 71-5-105, 71-5-109, Executive Order No. 23.

Subparagraphs (h), (i) and (k) of paragraph (1) of rule 1200-13-14-.03 Enrollment, Disenrollment Re-enrollment and Reassignment are deleted in their entirety and replaced with new subparagraphs (h), (i) and (k) which shall read as follows:

- (h) A person whose income is less than one hundred (100%) percent of the poverty level shall be permitted to enroll in TennCare Standard as a medically eligible person at any time with the effective date of coverage being the date of application.
- (i) A person whose income is at or greater than one hundred (100%) percent of the poverty level shall be permitted to enroll in TennCare Standard as a medically eligible person only during a period of open enrollment, with the effective date of coverage being the date of application which must be within the announced open enrollment period.
- (k) To qualify for TennCare Standard as medically eligible the applicant must complete a Medical Eligibility Determination packet. Packets will be sent to a qualified applicant who has indicated that s/he wishes to apply as a medically eligible person in his/her interview with the DHS caseworker. The applicant must meet the requirements specified in one of the following three (3) options. The applicant must submit the completed Medical Eligibility Determination packet, the required medical eligibility form(s) and supporting documentation as required in Option I, II, or III.

The required information must be returned to the address specified within sixty (60) days from the date of the letter included in the packet. A medical eligibility form and documentation received after that time will not be processed as it exceeds the timely filing requirement. Packets which are not completed by the sixtieth (60th) day will be denied with a notice with appeal rights and the "good cause" reasons for not completing the process timely, which include:

1. The applicant was sick.
2. Somebody in the applicant's immediate family was very sick.
3. The applicant had a family emergency or tragedy.
4. The applicant could not get the medical records s/he needed from a provider. It was not his/her fault.
5. The applicant asked for help because s/he has a disability. Neither the Bureau nor TDHS gave the help that the applicant needed.
6. The applicant asked for help because s/he does not speak English. Neither the Bureau nor TDHS gave the help that the applicant needed.

Documentation required for a medically eligible determination.

1. Option I – a disease/condition as listed on the Medical Eligibility Determination form developed and periodically updated by the Bureau of TennCare.
  - (i) The applicant must submit a signed and completed Medical Eligibility Determination form. The form must also be signed by the applicant's physician attesting to the fact that the applicant has one or more qualifying medical diseases/conditions on the list; and
  - (ii) The applicant must submit copies of medical records to support the disease/condition from the list of diseases/conditions of Option I of the Medical Eligibility Determination form. Medical records that substantiate conditions other than those on the Medical Eligibility Determination form are not required and should not be submitted.
2. Option II – Mental or Emotional Health Problem.
  - (i) The applicant must submit a signed and completed Medical Eligibility Determination form. The form must also be completed and signed by the individual's licensed mental health professional; and
  - (ii) The applicant must submit the following: a current level 1, 2, or 3 CRG assessment, medical records and the licensed mental health professional attestation form that supports the diagnosis, which is the basis of the assessment; or,
  - (iii) The applicant must submit the following: a current level 2 TPG assessment, medical records and the licensed mental health professional attestation form that supports the diagnosis, which is the basis of the assessment.
3. Option III –Submission of Medical Records to support a qualifying medical/physical/behavioral condition.
  - (i) The applicant must submit a signed and completed Medical Eligibility Determination form; and
  - (ii) The applicant must sign a release for medical records, which will allow the Bureau at its discretion to obtain such records to substantiate the disease or medical/physical/behavioral condition; and
  - (iii) The applicant must submit copies of medical records to support their medical or behavioral disease/ condition.

Statutory Authority: T.C.A. 4-5-202, 71-5-105, 71-5-109, Executive Order No. 23.

The rulemaking hearing rules set out herein were properly filed in the Department of State on the 26th day of January, 2007 and will become effective on the 11th day of April, 2007. (FS 01-36-07, DBID 2328)