RULES
OF
THE TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE

CHAPTER 1200-13-13
TENNCARE MEDICAID

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1200-13-13-.01 DEFINITIONS.

(1) ABUSE shall mean enrollee practices, or enrollee involvement in practices, including overutilization, waste or fraudulent use/misuse of a TennCare Program that results in cost or utilization which is not medically necessary or medically justified. Abuse of a TennCare Pharmacy Program justifies placement on lock-in or prior approval status for all enrollees involved. Activities or practices which may evidence abuse of the TennCare Pharmacy Program include, but are not limited to, the following: forging or altering drug prescriptions, selling TennCare paid prescription drugs, failure to control pharmacy overutilization activity while on lock-in status and visiting multiple prescribers or pharmacies to obtain prescriptions that are not medically necessary.

(2) ACCESS TO HEALTH INSURANCE shall mean the opportunity an individual has to obtain group health insurance as defined elsewhere in these rules. If a person could have enrolled in work-related or other group health insurance during an employer's or group's open enrollment period and chose not to enroll (or had the choice made for him by a family member) that person shall not be considered to lack access to insurance upon closure of the open enrollment period. Neither the cost of an insurance policy or health plan nor the fact that an insurance policy is not as comprehensive as that of the TennCare Program shall be considered in determining eligibility to enroll in any TennCare category where being uninsured is an eligibility prerequisite.

(3) ADVERSE BENEFIT DETERMINATION shall mean, but is not limited to, a delay, denial, reduction, suspension or termination of TennCare benefits. See 42 C.F.R. § 438.400.

(4) APPLICATION PERIOD shall mean a specific time period determined by the Bureau of TennCare during which the Bureau will accept applications for the TennCare Standard Spend Down category as described in the Bureau's rules at 1200-13-14-.02.

(5) BENEFITS shall mean the health care package of services developed by the Bureau of TennCare and which define the covered services available to TennCare enrollees. Additional benefits are available through the TennCare CHOICES program, as described in Rule 1200-13-01-.05, and the ECF CHOICES program, as described in Rule 1200-13-01-.31. CHOICES benefits are available only to persons who qualify for and are enrolled in the CHOICES program. ECF CHOICES benefits are available only to persons who qualify for and are enrolled in the ECF CHOICES program.

(Rule 1200-13-13-.01, continued)

(6) BUPRENORPHINE ENHANCED SUPPORTIVE MEDICATION-ASSISTED RECOVERY AND TREATMENT ("BESMART"). A treatment model comprised of comprehensive treatment and recovery related supports for adult (21 and older) enrollees with opioid use disorder (OUD) ("participants").

(7) BUREAU OF TENNCARE (BUREAU) shall mean the administrative unit of TennCare which is responsible for the administration of TennCare as defined elsewhere in these rules.

(8) CALL-IN LINE shall mean the toll-free telephone line used as the single point of entry during an open application period to accept new applications for the Standard Spend Down Program.

(9) CAPITATION PAYMENT shall mean the fee which is paid by the State to a managed care contractor operating under a risk-based contract for each enrollee covered by the plan for the provision of medical services, whether or not the enrollee utilizes services or without regard to the amount of services utilized during the payment period.

(10) CAPITATION RATE shall mean the amount established by the State for the purpose of providing payment to participating managed care contractors operating under a risk-based contract.

(11) CARETAKER RELATIVE shall mean that individual as defined at Tennessee Code Annotated § 71-3-103.

(12) CATEGORICALLY NEEDY shall mean that category of TennCare Medicaid-eligibles as defined at 1240-03-02-.02 of the rules of the Tennessee Department of Human Services - Division of Medical Services.

(13) CHOICES. See "TennCare CHOICES in Long-Term Care."

(14) CHOICES 217-Like Group. See definition in Rule 1200-13-01-.02.

(15) CHOICES Group 1. See definition in Rule 1200-13-01-.02.

(16) CHOICES Group 2. See definition in Rule 1200-13-01-.02.

(17) CMS (CENTERS FOR MEDICARE AND MEDICAID SERVICES) (formerly known as HCFA) shall mean the agency within the United States Department of Health and Human Services that is responsible for administering Title XVIII, Title XIX, and Title XXI of the Social Security Act.

(18) COBRA shall mean health insurance coverage provided pursuant to the Consolidated Omnibus Budget Reconciliation Act.

(19) CODE OF FEDERAL REGULATIONS (C.F.R.) shall mean Federal regulations promulgated to explain specific requirements of Federal law.

(20) COMMENCEMENT OF SERVICES shall mean the time at which the first covered service(s) is/are rendered to a TennCare member for each individual medical condition.

(21) COMMISSIONER shall mean the chief administrative officer of the Tennessee Department where the TennCare Bureau is administratively located, or the Commissioner's designee.

(22) COMPLETED APPLICATION is an application where:

(a) All required fields have been completed;

(Rule 1200-13-13-.01, continued)

(b) It is signed and dated by the applicant or the applicant's parent or guardian;

(c) It includes all supporting documentation required by the 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.

(23) CONTINUATION OR REINSTATEMENT OF BENEFITS (COB) shall mean the circumstances under which an enrollee may keep receiving, or, in the case of reinstatement, get back and keep receiving, the benefit under appeal until the appeal is resolved. See 42 C.F.R. §§ 431.230, 431.231 and 438.420.

(24) CONTINUOUS ENROLLMENT shall refer to the ability of certain individuals determined eligible for the TennCare Program to enroll at any time during the year. Continuous enrollment is limited to persons in the following two groups:

(a) TennCare Medicaid enrollees as defined in Rule 1200-13-13-.02.

(b) Individuals who are losing their Medicaid, who are uninsured, who are under nineteen (19) years of age, and who meet the qualification for TennCare Standard as "Medicaid Rollovers," in accordance with the provisions of Rule 1200-13-14-.02.

(25) CONTRACT PROVIDER shall have the same meaning as Participating Provider.

(26) CONTRACTOR shall mean an organization approved by the Tennessee Department of Finance and Administration to provide TennCare-covered benefits to eligible enrollees in the TennCare Medicaid and TennCare Standard programs.

(27) CONTRACTOR RISK AGREEMENT (CRA) shall mean the document delineating the terms of the agreement entered into by the Bureau of TennCare and the Managed Care Contractors.

(28) CONTROLLED SUBSTANCE. A drug, substance, or immediate precursor identified by the U.S. Department of Justice, Drug Enforcement Administration or by the Tennessee Drug Control Act as having the potential for abuse and the likelihood of physical or psychological dependence if used incorrectly.

(29) CORE MEDICAID POPULATION shall mean individuals eligible under Title XIX of the Social Security Act, 42 U.S.C. §§ 1396, et seq., with the exception of the following groups: individuals receiving SSI benefits as determined by the Social Security Administration; individuals eligible under a Refugee status; individuals eligible for emergency services as an illegal or undocumented alien; individuals receiving interim Medicaid benefits with a pending Medicaid disability determination; individuals with forty-five (45) days of presumptive or immediate eligibility; and children in DCS custody.

(30) COST-EFFECTIVE ALTERNATIVE SERVICE shall mean a service that is not a covered service but that is approved by TennCare and CMS and provided at an MCC's discretion. TennCare enrollees are not entitled to receive these services. Cost-effective alternative services may be provided because they are either (1) alternatives to covered Medicaid services that, in the MCC's judgment, are cost-effective or (2) preventative in nature and offered to avoid the development of conditions that, in the MCC's judgment, would require more costly treatment in the future. Cost-effective alternative services need not be determined medically necessary except to the extent that they are provided as an alternative

(Rule 1200-13-13-.01, continued)

to covered Medicaid services. Even if medically necessary, cost effective alternative services are not covered services and are provided only at an MCC's discretion.

(31) COST SHARING shall mean the amounts that certain enrollees in TennCare are required to pay for their TennCare coverage and covered services. Cost sharing includes copayments.

(32) COVERED SERVICES shall mean the services and benefits that:

(a) TennCare contracted MCCs cover, as set out elsewhere in this Chapter and in Rule 1200-13-01-.05; or

(b) In the instance of enrollees who are eligible for and enrolled in federal Medicaid waivers under Section 1915(c) of the Social Security Act, the services and benefits that are covered under the terms and conditions of such waivers.

(33) CPT4 CODES are descriptive terms contained in the Physician's Current Procedural Terminology, used to identify medical services and procedures performed by physicians or other licensed health professionals.

(34) DBM (DENTAL BENEFITS MANAGER) shall mean a contractor approved by the Tennessee Department of Finance and Administration to provide dental benefits to enrollees in the TennCare Program to the extent such services are covered by TennCare.

(35) DELAY shall mean failure to provide timely receipt of TennCare services, and no specific waiting period may be required before the enrollee can appeal.

(36) DEMAND LETTER shall mean a letter sent by TennCare to a TennCare Standard enrollee with premium obligations notifying the enrollee that he is at least sixty (60) days delinquent in his premium payments.

(37) DISCONTINUED DEMONSTRATION GROUP shall mean the group of non-Medicaid eligible individuals who were enrolled in TennCare Standard on April 29, 2005, when the categories in which they were enrolled were terminated, and who have not yet been enrolled in TennCare Medicaid or disenrolled from the TennCare program.

(38) DISENROLLMENT shall mean the discontinuance of an individual's enrollment in TennCare.

(39) DURABLE MEDICAL EQUIPMENT (DME) shall mean equipment that can withstand repeated use, can be removable, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of an illness or injury, is suitable for use in any non-institutional setting in which everyday life activities take place, and is related to the patient's physical disorder. Non-institutional settings do not include a hospital or nursing facility (NF). Routine DME items, including but not limited to wheelchairs (except as defined below), walkers, hospital beds, canes, commodes, traction equipment, suction machines, patient lifts, weight scales, and other items provided to a member receiving services in a NF that are within the scope of per diem reimbursement for NF services shall not be covered or reimbursable under the Medicaid program separate and apart from payment for the NF service. Customized wheelchairs, wheelchair seating systems, and other items that are beyond the scope of Medicaid reimbursement for NF services shall be covered by the member's managed care organization, so long as such items:

(a) Are medically necessary for the continuous care of a member; and

(b) Must be custom-made or modified or may be commercially available, but must be individually measured and selected to address the member's unique and permanent medical need for positioning, support or mobility; and

(c) Are solely for the use of that member and not for other NF residents.

(40) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) SERVICES, a covered benefit for TennCare Medicaid-enrolled children only, shall mean:

(a) Screening in accordance with professional standards, and interperiodic, diagnostic services to determine the existence of physical or mental illnesses or conditions of TennCare Medicaid enrollees under age twenty-one (21); and

(b) Health care, treatment, and other measures, described in 42 U.S.C. § 1396a(a) to correct or ameliorate any defects and physical and mental illnesses and conditions discovered.

(41) ELIGIBLE shall mean a person who has been determined to meet the eligibility criteria of TennCare Medicaid or TennCare Standard.

(42) EMPLOYMENT AND COMMUNITY FIRST (ECF) CHOICES shall mean the program defined in Rule 1200-13-01-.02 and described in Rule 1200-13-01-.31.

(43) ENROLLEE shall mean an individual eligible for and enrolled in the TennCare program or in any Tennessee federal Medicaid waiver program approved by the Secretary of the U.S. Department of Health and Human Services pursuant to Sections 1115 or 1915 of the Social Security Act. As concerns MCC compliance with these rules, the term only applies to those individuals for whom the MCC has received at least one day's prior written or electronic notice from the TennCare Bureau of the individual's assignment to the MCC.

(44) ENROLLMENT shall mean the process by which a TennCare-eligible person becomes enrolled in TennCare.

(45) ESCORT shall mean an individual who accompanies an enrollee to receive a medically necessary service. For the purpose of determining whether an individual may qualify as an escort who may be transported without cost to the enrollee as a covered TennCare benefit, the following criteria apply:

(a) Any person over the age of twelve (12) selected by the enrollee;

(b) Any person under the age of twelve (12) is presumed to be too young to serve as an escort. At the time of request for transportation, this presumption can be overcome by specific facts provided by the enrollee, which would demonstrate to a reasonable person that the proposed escort could in fact be of assistance to the enrollee; and

(c) Any person under the age of six (6) is excluded in all cases from the role of escort.

(46) FAMILY shall mean that as defined in the rules of the Tennessee Department of Human Services found at 1240-01-03 and 1240-01-04, Family Assistance Division, and 1240-03-03, Division of Medical Services.

(47) FEDERAL FINANCIAL PARTICIPATION (FFP) shall mean the Federal Government's share of a state's expenditure under the Title XIX Medicaid Program.

(48) FINAL AGENCY ACTION shall mean the resolution of an appeal by the TennCare Bureau or an initial decision on the merits of an appeal by an administrative judge or hearing officer when such initial decision is not modified or overturned by the TennCare Bureau. Final agency action shall be treated as binding for purposes of these rules.

(Rule 1200-13-13-.01, continued)

(49) FRAUD shall mean an intentional deception or misrepresentation made by a person who knows or should have known that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

(50) GRAND DIVISIONS shall mean the three (3) distinct geographic areas of the State of Tennessee, known as Eastern, Middle, and Western, as designated in Tennessee Code Annotated § 4-1-201.

(51) GROUP HEALTH INSURANCE shall mean an employee welfare benefit plan to the extent that the plan provides medical care to employees or their dependents (as defined under the terms of the plan) directly through insurance reimbursement mechanism. This definition includes those types of health insurance found in the Health Insurance Portability And Accountability Act of 1996, as amended, definition of creditable coverage (with the exception that the 50 or more participants criteria does not apply), which includes Medicare and TRICARE. Health insurance benefits obtained through COBRA are included in this definition. It also covers group health insurance available to an individual through membership in a professional organization or a school.

(52) HANDICAPPING MALOCCLUSION shall mean a malocclusion which causes one of the following medical conditions:

(a) A nutritional deficiency that has proven non-responsive to medical treatment without orthodontic treatment. The nutritional deficiency must have been diagnosed by a qualified treating physician and must have been documented in the qualified treating physician's progress notes. The progress notes that document the nutritional deficiency must predate the treating orthodontist's prior authorization request for orthodontics.

(b) A speech pathology that has proven non-responsive to speech therapy without orthodontic treatment. The speech pathology must have been diagnosed by a qualified speech therapist and must have been documented in the qualified speech therapist's progress notes. The progress notes that document the speech pathology must predate the treating orthodontist's prior authorization request for orthodontics.

(c) Laceration of soft tissue caused by a deep impinging overbite. Occasional cheek biting does not constitute laceration of soft tissue. Laceration of the soft tissue must be documented in the treating orthodontist's progress notes and must predate the treating orthodontist's prior authorization request for orthodontics.

Anecdotal information is insufficient to document the presence of a handicapping malocclusion. The presence of a handicapping malocclusion must be supported by the treating professional's progress notes and patient record.

(53) HEALTH INSURANCE, for the purposes of determining eligibility under these regulations:

(a) Shall mean:

1. Any hospital and medical expense-incurred policy;

2. Medicare;

3. TRICARE;

4. COBRA;

5. Medicaid;

6. State health risk pool;

7. Nonprofit health care service plan contract;

8. Health maintenance organization subscriber contracts;

9. An employee welfare benefit plan to the extent that the plan provides medical care to an employee or his/her dependents (as defined under the terms of the plan) directly through insurance, any form of self insurance, or a reimbursement mechanism;

10. Coverage available to an individual through membership in a professional organization or a school;

11. Coverage under a policy covering one person or all the members of a family under a single policy where the contract exists solely between the individual and the insurance company;

12. Any of the above types of policies where:

    (i) The policy contains a type of benefit (such as mental health benefits) which has been completely exhausted;

    (ii) The policy contains a type of benefit (such as pharmacy) for which an annual limitation has been reached;

    (iii) The policy has a specific exclusion or rider of non-coverage based on a specific prior existing condition or an existing condition or treatment of such a condition; or

13. Any of the types of policies listed above will be considered health insurance even if one or more of the following circumstances exists:

    (i) The policy contains fewer benefits than TennCare;

    (ii) The policy costs more than TennCare; or

    (iii) The policy is one the individual could have bought during a specified period of time (such as COBRA) but chose not to do so.

(b) Shall not mean:

1. Short-term coverage;

2. Accident coverage;

3. Fixed indemnity insurance;

4. Long-term care insurance;

5. Disability income contracts;

6. Limited benefits policies as defined elsewhere in these rules;

7. Credit insurance;

8. School-sponsored sports-related injury coverage;

9. Coverage issued as a supplemental to liability insurance;

10. Automobile medical payment insurance;

11. Insurance under which benefits are payable with or without regard to fault and which are statutorily required to be contained in any liability insurance policy or equivalent self-insurance;

12. A medical care program of the Indian Health Services (IHS) or a tribal organization;

13. Benefits received through the Veteran's Administration; or

14. Health care provided through a government clinic or program such as, but not limited to, vaccinations, flu shots, mammograms, and care or services received through a disease- or condition-specific program such as, but not limited to, the Ryan White Care Act.

(54) HEALTH MAINTENANCE ORGANIZATION (HMO) shall mean an entity licensed by the Tennessee Department of Commerce and Insurance under applicable provisions of Tennessee Code Annotated (T.C.A.) Title 56, Chapter 32 to provide health care services.

(55) HEALTH PLAN shall mean a Managed Care Organization authorized by the Tennessee Department of Finance and Administration to provide medical and behavioral services to enrollees in the TennCare Program.

(56) HEARING OFFICER shall mean an administrative judge or hearing officer who is not an employee, agent or representative of the MCC or who did not participate in, nor was consulted about, any TennCare Bureau review prior to the State Fair Hearing (SFH).

(57) HIPAA shall mean the Health Insurance Portability and Accountability Act of 1996, as amended.

(58) HOME HEALTH SERVICES shall mean:

(a) Any of the services identified in 42 C.F.R. § 440.70 and delivered in accordance with the provisions of 42 C.F.R. § 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.

(Rule 1200-13-13-.01, continued)

(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 requiring adult care or supervision shall be present in the home during the time the home health provider is present in the home without the

(Rule 1200-13-13-.01, continued)

presence of another responsible adult, unless these children meet all the criteria stated above and are also receiving TennCare-reimbursed home health services.

(59) INCOME shall mean that definition of income in Rule 1240-01-04 of the Tennessee Department of Human Services - Family Assistance Division.

(60) INDIVIDUAL HEALTH INSURANCE shall mean health insurance coverage under a policy covering one person or all the members of a family under a single policy where the contract exists solely between that person and the insurance company.

(61) INITIATING PROVIDER shall mean the provider who renders the first covered service to a TennCare member whose current medical condition requires the services of more than one (1) provider.

(62) INMATE shall mean an individual confined in a local, state, or federal prison, jail, youth development center, or other penal or correctional facility, including a furlough from such facility.

(63) IN-NETWORK PROVIDER shall have the same meaning as Participating Provider.

(64) INPATIENT REHABILITATION FACILITIES shall mean rehabilitation hospitals and distinct parts of hospitals that are designated as 'IRFs' by Medicare.

(65) INSTITUTION FOR MENTAL DISEASES (IMD) shall mean a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.

(66) LICENSED MENTAL HEALTH PROFESSIONAL shall mean a Board eligible or a Board certified psychiatrist or a person with at least a Master's degree and/or clinical training in an accepted mental health field which includes, but is not limited to, counseling, nursing, occupational therapy, psychology, social work, vocational rehabilitation, or activity therapy with a current valid license by the Tennessee Licensing Board for the Healing Arts.

(67) LIMITED BENEFITS POLICY shall mean a policy of health coverage for a specific disease (e.g., cancer), or an accident occurring while engaged in a specified activity (e.g., school-based sports), or which provides for a cash benefit payable directly to the insured in the event of an accident or hospitalization (e.g., hospital indemnity).

(68) LOCK-IN PROVIDER. A provider, pharmacy or physician, chosen by an enrollee on pharmacy lock-in status to whom the enrollee is assigned by TennCare for the purpose of receiving covered pharmacy services.

(69) LOCK-IN STATUS. The restriction of an enrollee to a specified physician, or to a specified pharmacy provider at a specified single location.

(70) LONG-TERM CARE shall mean programs and services described under Rule 1200-13-01-.01.

(71) MCC (MANAGED CARE CONTRACTOR) shall mean:

(a) A Managed Care Organization, Pharmacy Benefits Manager and/or a Dental Benefits Manager which has signed a TennCare Contractor Risk Agreement with the State and operates a provider network and provides covered health services to TennCare enrollees; or

(Rule 1200-13-13-.01, continued)

(b) A Pharmacy Benefits Manager, Behavioral Health Organization or Dental Benefits Manager which subcontracts with a Managed Care Organization to provide services; or

(c) A State government agency that contracts with TennCare for the provision of services.

(72) MCO (Managed Care Organization) shall mean an appropriately licensed Health Maintenance Organization (HMO) approved by the Bureau of TennCare as capable of providing medical, behavioral, and long-term care services in the TennCare Program.

(73) MEDICAID shall mean the federal- and state-financed, state-run program of medical assistance pursuant to Title XIX of the Social Security Act. Medicaid eligibility in Tennessee is determined by the Tennessee Department of Human Services, under contract to the Tennessee Department of Finance and Administration. Tennessee residents determined eligible for SSI benefits by the Social Security Administration are also enrolled in Tennessee's TennCare Medicaid program.

(74) MEDICAID "ROLLOVER" ENROLLEE shall mean a TennCare Medicaid enrollee who no longer meets technical eligibility requirements for Medicaid and will be afforded an opportunity to enroll in TennCare Standard in accordance with the provisions of these rules.

(75) MEDICAL ASSISTANCE shall mean health care, services and supplies furnished to an enrollee and funded in whole or in part under Title XIX of the Social Security Act, 42 U.S.C. §§ 1396, et seq. and Tennessee Code Annotated §§ 71-5-101, et seq. Medical assistance includes the payment of the cost of care, services, drugs and supplies. Such care, services, drugs, and supplies shall include services of qualified providers who have contracted with an MCC or are otherwise authorized to provide services to TennCare enrollees (i.e., emergency services provided out-of-network or medically necessary services obtained out-of-network because of an MCC's failure to provide adequate access to services in-network).

(76) MEDICAL RECORD shall mean all medical histories; records, reports and summaries; diagnoses; prognoses; records of treatment and medication ordered and given; x-ray and radiology interpretations; physical therapy charts and notes; lab reports; other individualized medical documentation in written or electronic format; and analyses of such information.

(77) MEDICAL SUPPLIES shall mean covered medical supplies that are deemed medically necessary and appropriate and are prescribed for use in the diagnosis and treatment of medical conditions. Medically necessary medical supplies not included as part of institutional services shall be covered only when provided by or through a licensed home health agency, by or through a licensed medical vendor supplier or by or through a licensed pharmacist.

(78) MEDICALLY ELIGIBLE shall mean a person who has met the medical eligibility criteria for the TennCare Standard program through a mechanism permitted under the provisions of these rules.

(79) MEDICALLY NECESSARY is defined by Tennessee Code Annotated, Section 71-5-144, and shall describe a medical item or service that meets the criteria set forth in that statute. The term "medically necessary," as defined by Tennessee Code Annotated, Section 71-5-144, applies to TennCare enrollees. Implementation of the term "medically necessary" is provided for in these rules, consistent with the statutory provisions, which control in case of ambiguity. No enrollee shall be entitled to receive and TennCare shall not be required to pay for any items or services that fail fully to satisfy all criteria of "medically necessary" items or services, as defined either in the statute or in the Medical Necessity rule chapter at 1200-13-16.

(80) MEDICALLY NEEDY shall mean that category of TennCare Medicaid-eligibles as defined in Rule 1240-03-02-.03 of the Tennessee Department of Human Services - Division of Medical Services.

(Rule 1200-13-13-.01, continued)

(81) MEDICARE shall mean the program administered through the Social Security Administration pursuant to Title XVIII, available to most individuals upon attaining age sixty-five (65), to some disabled individuals under age sixty-five (65), and to individuals having End Stage Renal Disease (ESRD).

(82) MEMBER shall mean a TennCare Medicaid- or TennCare Standard-eligible individual who is enrolled in a managed care organization.

(83) NON-CONTRACT PROVIDER shall have the same meaning as Non-Participating Provider.

(84) NON-PARTICIPATING PROVIDER shall mean a TennCare provider, as defined in this Rule, who is not contracted with a particular enrollee's MCO. This term may include TennCare providers who furnish services outside the managed care program on a fee-for-service basis, as well as TennCare providers who receive Medicare crossover payments from TennCare.

(85) NON-TENNCARE PROVIDER shall mean a provider who is not enrolled in TennCare and who accepts no TennCare reimbursement for any service, including Medicare crossover payments.

(86) OPEN ENROLLMENT shall mean a designated period of time, determined by the Bureau of TennCare, during which persons who are not currently TennCare eligible may apply for the Standard Spend Down program.

(87) OPEN MEDICAID CATEGORIES shall mean those Medicaid eligibility categories for which enrollment has not been closed pursuant to authority granted by CMS as part of the TennCare demonstration project.

(88) OUT-OF-NETWORK PROVIDER shall have the same meaning as Non-Participating Provider.

(89) OUT-OF-STATE EMERGENCY PROVIDER shall mean a provider outside the State of Tennessee who does not participate in TennCare in any way except to bill for emergency services, as defined in this Chapter, provided out-of-state to a particular MCC's enrollee. An Out-of-State Emergency Provider must abide by all TennCare rules and regulations, including those concerning provider billing of enrollees as found in Rule 1200-13-13-.08. In order to receive payment from TennCare, Out-of-State Emergency Providers must be appropriately licensed in the state in which the emergency services were delivered, they must enroll with TennCare and they must not be excluded from participation in Medicare or Medicaid.

(90) OVERUTILIZATION shall mean any of the following:

(a) The enrollee initiated use of TennCare services or supplies at a frequency or amount that is not medically necessary or medically justified.

(b) Overutilization, or attempted overutilization, of the TennCare Pharmacy Program which justifies placement on lock-in status for all enrollees involved.

(c) Activities or practices which may evidence overutilization of the TennCare Pharmacy Program including, but not limited to, the following:

1. Treatment by several physicians for the same diagnosis;

2. Obtaining the same or similar controlled substances from several physicians;

(Rule 1200-13-13-.01, continued)

3. Obtaining controlled substances in excess of the maximum recommended dose;

4. Receiving combinations of drugs which act synergistically or belong to the same class;

5. Frequent treatment for diagnoses which are highly susceptible to abuse;

6. Receiving services and/or drugs from numerous providers;

7. Obtaining the same or similar drugs on the same day or at frequent intervals; or

8. Frequent use of the emergency room in non-emergency situations in order to obtain prescription drugs.

(91) PARTICIPATING PROVIDER shall mean a TennCare provider, as defined in this Rule, who has entered into a contract with an enrollee's Managed Care Contractor.

(92) PBM (PHARMACY BENEFITS MANAGER) shall mean an organization approved by the Tennessee Department of Finance and Administration to administer pharmacy benefits to enrollees to the extent such services are covered by the TennCare Program. A PBM may have a signed TennCare Contractor Risk Agreement with the State, or may be a subcontractor to an MCO.

(93) PERSONAL CARE SERVICES shall refer to an optional Medicaid benefit defined at 42 C.F.R. § 440.167 that, per the Tennessee Medicaid State Plan, Tennessee has not elected to include in the TennCare benefit package. To the extent that such services are available to children under the age of 21 when medically necessary under the provisions of EPSDT, the Bureau of TennCare designates home health aides as the providers qualified to deliver such services. When medically necessary, personal care services may be authorized outside of the home setting when normal life activities temporarily take the recipient outside of that setting. Normal life activity for a child under the age of 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). The home health aide providing personal care services may accompany the recipient but may not drive. Normal life activities do not include non-routine or extended home absences.

(94) PHYSICIAN shall mean a person licensed pursuant to chapter 6 or 9 of title 63 of the Tennessee Code Annotated.

(95) POVERTY LEVEL shall mean the poverty level established by the Federal Government.

(96) POWER SEATING ACCESSORIES. Accessories available to modify a power wheelchair base are covered by TennCare when all listed criteria are met as follows:

(a) Power Seat Elevation System.

1. It is ordered by the Enrollee's treating physician.

2. An assessment conducted by a licensed physical therapist or licensed occupational therapist establishes that:

(i) The Enrollee has the cognitive ability and enough upper extremity function to carry out mobility-related activities of daily living such as feeding, grooming, dressing, and transferring; and

(ii) The activities for which the accessory will be used are conducted primarily in the enrollee's home.

(b) Power Standing System.

1. It is ordered by the Enrollee's treating physician.

2. An assessment conducted by a licensed physical therapist or licensed occupational therapist establishes that the Enrollee:

(i) Has a chronic condition that causes him to have limited or no ability to stand; and

(ii) Has a physical condition that allows him to stand, when supported, for meaningful periods of time, i.e., he will not suffer loss of blood pressure or have problems with bowel or urine retention; and

(iii) Has the cognitive ability and enough upper extremity function to carry out mobility-related activities of daily living such as feeding, grooming, dressing, and transferring; and

(iv) Meets at least one other complex rehabilitation criterion for a power seat accessory such as a tilt seat and also qualifies for a Group 3 base Power Wheelchair.

(97) POWER WHEELCHAIR ACCESSORIES. All powered wheelchair accessories not defined in this rule as Power Seating Accessories are excluded from TennCare coverage but may be provided by an MCO as a cost effective alternative service as defined in this rule.

(98) PRESCRIBER. An individual authorized by law to prescribe drugs.

(99) PRIMARY CARE PHYSICIAN shall mean a physician responsible for supervising, coordinating, and providing initial and primary care to patients; for initiating referrals for specialist care; and for maintaining the continuity of patient care. A primary care physician is a physician who has limited his practice of medicine to general practice or who is a Board Certified or Eligible Internist, Pediatrician, Obstetrician/Gynecologist, or Family Practitioner.

(100) PRIMARY CARE PROVIDER shall mean health care professional capable of providing a wide variety of basic health services. Primary care providers include practitioners of family, general, or internal medicine; pediatricians and obstetricians; nurse practitioners; midwives; and physician's assistant in general or family practice.

(101) PRIOR APPROVAL STATUS shall mean the restriction of an enrollee to a procedure wherein services, except in emergency situations, must be approved by the TennCare Bureau or the MCC prior to the delivery of services.

(102) PRIOR AUTHORIZATION shall mean the process under which services, except in emergency situations, must be approved by the TennCare Bureau or the MCC prior to the delivery in order for such services to be covered by the TennCare program.

(103) 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

(Rule 1200-13-13-.01, continued)

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. Is ventilator dependent with a progressive neuromuscular disorder or spinal cord injury, and is ventilated using noninvasive positive pressure ventilation (NIPPV) by mask or mouthpiece for at least 12 hours each day in order to avoid or delay tracheostomy (requires medical review); or

3. 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.

(Rule 1200-13-13-.01, continued)

(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.

(104) PROVIDER shall mean an appropriately licensed institution, facility, agency, person, corporation, partnership, or association that delivers health care services. Providers are categorized as either TennCare Providers or Non-TennCare Providers. TennCare Providers may be further categorized as being one of the following:

(a) Participating Providers or In-Network Providers

(b) Non-Participating Providers or Out-of-Network Providers

(c) Out-of-State Emergency Providers

Definitions of each of these terms are contained in this Rule.

(105) PROVIDER-INITIATED REDUCTION, TERMINATION OR SUSPENSION OF SERVICES shall mean a decision to reduce, terminate, or suspend an enrollee's TennCare services which is initiated by the enrollee's provider, rather than by the MCC.

(106) PROVIDER WITH PRESCRIBING AUTHORITY shall mean, in the context of TennCare pharmacy services, a health care professional authorized by law or regulation to order prescription medications for his/her patients, and who:

(Rule 1200-13-13-.01, continued)

(a) Participates in the provider network of the MCC in which the enrollee is enrolled; or

(b) Has received a referral of the enrollee, approved by the MCC, authorizing her to treat the enrollee; or

(c) In the case of a TennCare enrollee who is also enrolled in Medicare, is authorized to treat Medicare patients.

(107) PRUDENT LAY PERSON shall mean a reasonable person who possesses an average knowledge of health and medicine.

(108) QUALIFIED LONG TERM CARE INSURANCE POLICY shall mean a long-term care insurance policy issued on or after October 1, 2008, that has been pre-certified by the Tennessee Department of Commerce and Insurance pursuant to Rule 0780-01-61 as:

(a) A policy that meets all applicable Tennessee Long Term Care Partnership requirements; or

(b) A policy that has been issued in another Partnership state and which is covered under a reciprocal agreement between such other state and the State of Tennessee.

(109) QUALIFIED UNINSURED PERSON shall mean an uninsured person who meets the technical, financial, and insurance requirements for the TennCare Standard Program.

(110) QUALIFYING MEDICAL CONDITION shall mean a medical condition which is included among a list of conditions established by the Bureau and which will render a qualified uninsured applicant medically eligible.

(111) READABLE shall mean easily understood language and format. See 42 C.F.R. § 438.10.

(112) REASSIGNMENT shall mean the process by which the Bureau of TennCare transfers an enrollee from one MCO to another as described in these rules.

(113) RECEIPT OF MAILED NOTICES shall mean that receipt of mailed notices is presumed to occur within five (5) days of mailing.

(114) RECERTIFICATION shall have the same meaning as Redetermination.

(115) RECONSIDERATION shall mean the mandatory process, triggered by an enrollee's request for a SFH, by which an MCC reviews and renders a decision affirming or reversing the MCC's adverse benefit determination. An MCC satisfies the plan-level requirements of 42 C.F.R. Part 438 Subpart F when the review includes all available, relevant, clinical documentation (including documentation which may not have been considered in the original review); is performed by a physician other than the original reviewing physician; and produces a timely written finding. See June 5, 2017, CMS letter from Jackie Glaze to Wendy Long, M.D., M.P.H.

(116) REQUEST FOR REIMBURSEMENT shall mean a request from an enrollee for reimbursement of amounts paid out of pocket to providers for medical, dental or pharmacy services received. Enrollees seeking reimbursement are required to submit receipts or bills that include the following information: the amount paid by enrollee, a description of the prescriptions, care or services received, the date the prescriptions, care or services were received, and the name of the provider or pharmacy. All required information must be received from enrollees within the sixty (60) day timeframe to request reimbursement as prescribed by Rule 1200-13-13-.11(2)(d).

(Rule 1200-13-13-.01, continued)

(117) RESPONSIBLE PARTY(IES) shall mean the following individuals, who are representatives and/or relatives of recipients of medical assistance who are not financially eligible to receive benefits: parents, spouses, children, and guardians; as defined at Tennessee Code Annotated § 71-5-103(10).

(118) SSI (SUPPLEMENTAL SECURITY INCOME) BENEFITS shall mean the benefits provided through a program administered by the Social Security Administration for those meeting program eligibility requirements. Tennessee residents determined eligible for SSI benefits are automatically enrolled in TennCare Medicaid.

(119) STANDARD SPEND DOWN (SSD) shall mean the demonstration eligibility category composed of adults age twenty-one (21) and older who have been found to meet the criteria in Rule 1200-13-14-.02.

(120) STATE FAIR HEARING (SFH) shall mean an evidentiary hearing requested by or on behalf of an enrollee to allow the enrollee to appeal an adverse benefit determination, which is conducted in accordance with 42 C.F.R. Part 431 Subpart E and the Tennessee Uniform Administrative Procedures Act, T.C.A. §§ 4-5-301, et seq. An initial order under T.C.A. § 4-5-314 shall be entered when an evidentiary hearing is held before a hearing officer. If any party appeals the initial order under T.C.A. § 4-5-315, the Commissioner may render a final order.

(121) TARGETED PHARMACY. A pharmacy meeting one of the following criteria:

(a) It is located outside the State of Tennessee.

(b) It has had previous controlled substance violations with the Tennessee State Board of Pharmacy.

(c) It appears to be an outlier to the norm in its dispensing of controlled substances.

(d) It has filled controlled substance prescriptions that are covered by TennCare for members locked in to a different pharmacy after being notified that the member was locked in to a different pharmacy.

(122) TARGETED PRESCRIBER. A prescriber with prescribing authority who is ranked as a top prescriber of controlled substances based on multiple factors which may include but are not limited to any of the following:

(a) The percentage of controlled substances prescribed.

(b) The percentage of Schedule II controlled substances prescribed.

(c) The percentage of Schedule III controlled substances prescribed.

(d) The percentage of short acting single ingredient opiates prescribed.

(e) The percentage of short acting combination product opiates prescribed.

(f) The percentage of long acting opiates prescribed.

(g) The average morphine equivalents per day prescribed.

(h) The percentage of rejected claims of controlled substances.

(123) TECHNICAL ELIGIBILITY REQUIREMENTS shall mean the eligibility requirements applicable to the appropriate category of medical assistance as discussed in Chapter 1240-

(Rule 1200-13-13-.01, continued)

03-03-.03 of the rules of the TDHS - Division of Medical Services, and the additional eligibility requirements set forth in these rules.

(124) TENNCARE shall mean the program administered by the Single State agency as designated by the State and CMS pursuant to Title XIX of the Social Security Act and the Section 1115 Research and Demonstration waiver granted to the State of Tennessee.

(125) TENNCARE APPEAL FORM shall mean the TennCare form(s) which are completed by an enrollee or by a person authorized by the enrollee to do so, when an enrollee appeals an adverse benefit determination.

(126) TENNCARE CHOICES in Long-Term Care shall mean the program described in Rule 1200-13-01-.05.

(127) TENNCARE MEDICAID shall mean that part of the TennCare program, which covers persons eligible for Medicaid under Tennessee's Title XIX State Plan for Medical Assistance. The following persons are eligible for TennCare Medicaid:

(a) Tennessee residents determined to be eligible for Medicaid in accordance with 1240-03-03 of the rules of the Tennessee Department of Human Services - Division of Medical Services.

(b) Individuals who qualify as dually eligible for Medicare and Medicaid are enrolled in TennCare Medicaid.

(c) A Tennessee resident who is an uninsured woman, under age sixty-five (65), a U.S. citizen or qualified alien, is not eligible for any other category of Medicaid, has been diagnosed as the result of a screening at a Centers for Disease Control and Prevention (CDC) site with breast or cervical cancer, including pre-cancerous conditions.

(d) Tennessee residents determined eligible for SSI benefits by the Social Security Administration are automatically enrolled in TennCare Medicaid.

(128) TENNCARE MEDICAID ELIGIBILITY REFORMS shall mean the amendments to the TennCare demonstration project approved by CMS on March 24, 2005, to close enrollment into TennCare Medicaid for non-pregnant adults age twenty-one (21) or older who qualify as Medically Needy under Tennessee's Title XIX State Plan for Medical Assistance and to disenroll non-pregnant adults age twenty-one (21) or older who qualify as Medically Needy under Tennessee's Title XIX State Plan for Medical Assistance after completion of their twelve (12) months of eligibility.

(129) TENNCARE PHARMACY PROGRAMS shall mean any TennCare pharmacy carve-outs, including, but not limited to, enrollees with dual eligibility and all pharmacy services provided by the TennCare Managed Care Organizations (MCOs).

(130) TENNCARE PROVIDER shall mean a provider who accepts as payment in full for furnishing benefits to a TennCare enrollee, the amounts paid pursuant to an approved agreement with an MCC or TennCare. Such payment may include copayments from the enrollee or the enrollee's responsible party. TennCare providers must be enrolled with TennCare. TennCare providers must abide by all TennCare rules and regulations, including requirements regarding provider billing of patients as found in Rule 1200-13-13-.08. TennCare providers must be appropriately licensed for the services they deliver and must not be providers who have been excluded from participation in Medicare or Medicaid.

(Rule 1200-13-13-.01, continued)

(131) TENNCARE SELECT shall mean a state self-insured HMO established by the Bureau of TennCare and administered by a contractor to provide medical services to certain eligible enrollees.

(132) TENNCARE SERVICES OR TENNCARE BENEFITS, for purposes of this rule, shall mean any medical assistance that is administered by the Bureau of TennCare or its contractors and which is funded wholly or in part with federal funds under the Medicaid Act or any waiver thereof, but excluding:

(a) Medical assistance that can be appealed through an appeal of a pre-admission evaluation (PAE) determination; and

(b) Medicare cost sharing services that do not involve utilization review by the Bureau of TennCare or its contractors.

(133) TENNCARE STANDARD shall mean that part of the TennCare Program which provides health coverage for Tennessee residents who are not eligible for Medicaid and who meet the eligibility criteria found in Rule 1200-13-14-.02.

(134) TENNCARE STANDARD ELIGIBILITY REFORMS shall mean the amendments to the TennCare demonstration project approved by CMS on March 24, 2005, to terminate coverage for adults aged nineteen (19) and older in TennCare Standard eligibility groups.

(135) TENNderCARE shall mean the name given to the preventive health care program for TennCare children.

(136) TERMINATION shall mean the discontinuance of an enrollee's coverage under the TennCare Medicaid or TennCare standard program.

(137) THIRD PARTY shall mean any entity or funding source other than the enrollee or his/her responsible party, which is or may be liable to pay for all or a part of the costs of medical care of the enrollee.

(138) TRANSITION GROUP shall mean existing Medicaid Medically Needy adults age twenty-one (21) or older enrolled as of October 5, 2007, who have not yet been assessed for transition to the Standard Spend Down Demonstration population for non-pregnant adults age twenty-one (21) or older.

(139) TREATING PHYSICIAN (OR CLINICIAN) shall mean a health care provider who has provided diagnostic or treatment services for an enrollee (whether or not those services were covered by TennCare), for purposes of treating, or supporting the treatment of, a known or suspected medical condition. The term excludes providers who have evaluated an enrollee's medical condition primarily or exclusively for the purposes of supporting or participating in a decision regarding TennCare coverage.

(140) UNINSURED shall mean any person who does not have health insurance directly or indirectly through another family member, or who does not have access to group health insurance. For purposes of the Medicaid eligibility category of women under 65 requiring treatment for breast or cervical cancer, "Uninsured" shall mean any person who does not have health insurance or access to health insurance which covers treatment for breast or cervical cancer.

(141) VALID FACTUAL DISPUTE shall mean a dispute which, if resolved in favor of the enrollee, would result in the proposed action not being taken.

(Rule 1200-13-13-.01, continued)

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 4-5-209, 71-5-105, 71-5-107, 71-5-109, 71-5-113, and 71-5-146; 42 C.F.R. Part 431 Subpart E; 42 C.F.R. Part 438 Subpart F; 42 C.F.R. Part 455 Subpart E; and Executive Order No. 23.* ***Administrative History:*** *Public necessity rule filed July 1, 2002; effective through December 13, 2002. Original rule filed September 30, 2002; to be effective December 14, 2002; however, on December 9, 2002, the House Government Operations Committee of the General Assembly stayed Rule 1200-13-13-.01; new effective date February 12, 2003. Emergency rule filed December 13, 2002; effective through May 27, 2003. Amendment filed April 9, 2003; effective June 23, 2003. Public necessity rule filed May 5, 2005; effective through October 17, 2005. Public necessity rule filed June 3, 2005; effective through November 15, 2005. Amendment filed July 14, 2005; effective September 27, 2005. Amendment filed July 20, 2005; effective October 3, 2005. Amendment filed July 28, 2005; effective October 11, 2005. Amendment filed September 1, 2005; effective November 15, 2005. Public necessity rule filed December 9, 2005; effective through May 23, 2006. Public necessity rule filed December 29, 2005; effective through June 12, 2006. Public necessity rules filed March 3, 2006; effective through August 15, 2006. Amendment filed March 3, 2006; effective May 17, 2006. Public necessity rule filed December 29, 2005; expired June 12, 2006. On June 13, 2006, affected rules reverted to status on December 28, 2005. Amendments filed March 31, 2006; effective June 14, 2006. Amendment filed June 1, 2006; effective August 15, 2006. Public necessity rule filed December 1, 2006; expired May 5, 2007. Public necessity rule filed February 2, 2007; effective through July 16, 2007. Amendment filed January 26, 2007; effective April 11, 2007. Amendment filed May 2, 2007; effective July 16, 2007. Amendment filed June 11, 2007; effective August 25, 2007. Public necessity rule filed October 11, 2007; effective through March 24, 2008. Public necessity rule filed February 8, 2008; effective through July 22, 2008. Amendments filed May 7, 2008; effective July 21, 2008. Public necessity rule filed September 8, 2008; effective through February 20, 2009. Amendment filed December 5, 2008; effective February 18, 2009. Amendment filed February 18, 2009; effective May 4, 2009. Amendments filed September 25, 2009; effective December 24, 2009. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendments filed May 27, 2010; effective August 25, 2010. Amendment filed July 1, 2013; effective September 29, 2013. Amendments filed October 3, 2013; effective January 1, 2014. Amendment filed December 23, 2014; effective March 23, 2015. Emergency rules filed July 1, 2016; effective through December 28, 2016. Amendment filed June 30, 2016; effective September 28, 2016. Amendments filed September 30, 2016; effective December 29, 2016. Amendments filed July 3, 2017; effective October 1, 2017. Amendments filed September 25, 2017; effective, December 24, 2017. Emergency rules filed April 15, 2021; effective through October 12, 2021. Amendments filed June 29, 2021; effective September 27, 2021. Amendments filed July 8, 2021; effective October 6, 2021. Amendments filed October 26, 2021; effective January 24, 2022.*

1200-13-13-.02 ELIGIBILITY.

(1) Delineation of agency roles and responsibilities.

(a) The Tennessee Department of Finance and Administration (F&A) is the lead State agency for the TennCare Program.

(b) The Bureau of TennCare (Bureau) is the administrative unit within F&A with the responsibility for day-to-day operations of the TennCare Program. The Bureau is responsible for establishing policy and procedural requirements and criteria for TennCare.

1. With respect to the eligibility of children applying for TennCare as medically eligible persons, the Bureau is responsible for determining the presence of a qualifying medical condition under TennCare Standard.

2. With respect to the eligibility of individuals applying for the TennCare CHOICES program, the Bureau is responsible for determining that the individual meets level of care eligibility criteria for the long-term care services or reimbursement requested. For enrollment into CHOICES Group 2, the Bureau is also responsible for determining the state's ability to provide appropriate Home and

(Rule 1200-13-13-.02, continued)

Community Based Services (HCBS) as determined by the availability of slots under the established enrollment target in accordance with Rule 1200-13-01-.05 and for confirming a determination by an Area Agency on Aging and Disability or TennCare Managed Care Organization that:

(i) The individual is an adult aged sixty-five (65) or older, or an adult aged twenty-one (21) or older with physical disabilities; and

(ii) Such individual can be safely and appropriately served in the community and at a cost that does not exceed the individual's cost neutrality cap pursuant to Rule 1200-13-01-.05.

3. With respect to the eligibility of individuals applying for the ECF CHOICES program, the Bureau is responsible for determining that the individual meets all applicable eligibility and enrollment criteria, including target population, medical or level of care eligibility, categorical and financial eligibility, the state's ability to provide appropriate ECF HCBS (as defined in Rule 1200-13-01-.02) as determined by the availability of slots under the established enrollment target for each ECF CHOICES Group in accordance with Rule 1200-13-01-.31 and pursuant to intake and enrollment policies and processes described in 1200-13-01-.31 and in TennCare policies and protocols, and for confirming a determination by a TennCare Managed Care Organization that the individual can be safely and appropriately served in the community and at a cost that does not exceed the individual's expenditure cap pursuant to Rule 1200-13-01-.31.

(c) The Tennessee Department of Human Services (DHS) is under contract with the Bureau to determine initial eligibility for TennCare Medicaid and TennCare Standard, as well as to redetermine, at regular intervals, whether eligibility should be continued. DHS is not responsible for making decisions about the presence of a qualifying medical condition for those applying as medically eligible persons under TennCare Standard.

(d) The Social Security Administration determines eligibility for the Supplemental Security Income (SSI) Program. Tennessee residents determined eligible for SSI benefits are automatically eligible for and enrolled in TennCare Medicaid benefits.

(e) The Tennessee Department of Health (DOH) determines presumptive eligibility under TennCare Medicaid for pregnant women and for women diagnosed with breast or cervical cancer through administration of the Breast and Cervical Cancer Screening Program.

(2) Delineation of TennCare enrollee's responsibilities.

(a) It is the responsibility of each TennCare enrollee to report to the DHS any material change affecting any information given by the applicant/enrollee to DHS at the time of application or redetermination of his eligibility. This information includes, but is not limited to, changes in address, income, family size, employment, or access to insurance. The applicant/enrollee shall mail, or present in person, documentation of any such change to the DHS county office where the enrollee resides. This documentation must be presented within the time frame specified in Chapter 1240-01-16 of the rules of DHS.

(b) It is the responsibility of each TennCare enrollee to report to his provider that he is a TennCare enrollee.

(3) Technical and financial eligibility requirements for TennCare Medicaid. To be eligible for TennCare Medicaid, each individual must:

(Rule 1200-13-13-.02, continued)

(a) Meet all technical requirements applicable to the appropriate category of medical assistance as described in the DHS - Division of Medical Services Rule 1240-03-03-.02, and all financial eligibility requirements applicable to the appropriate category of medical assistance as described in the DHS - Division of Medical Services Rule 1240-03-03-.03; or

(b) Meet the financial eligibility requirements of the SSI Program of the Social Security Administration and be approved for SSI benefits by the Social Security Administration; or

(c) Be a woman who:

1. Is under age sixty-five (65);

2. Is uninsured or has health insurance that does not provide coverage for treatment of breast or cervical cancer;

3. Is not eligible for Medicaid;

4. Is a U.S. citizen or qualified alien; and

5. Has been diagnosed with breast or cervical cancer, including a Precancerous condition, by a screening at a Centers for Disease Control and Prevention (CDC) site, and who needs treatment.

(4) General application requirements.

(a) By applying for TennCare Medicaid, an applicant agrees to provide information to the Bureau, or its designee, about any third party coverage. MCCs shall release insurance information from their files to the Bureau of TennCare on a regular basis, as required by contract between the MCCs and the Department of Finance and Administration.

(b) By applying for TennCare Medicaid, an applicant grants permission and authorizes release of information to the Bureau, or its designee, to investigate any and all information provided, or any information not provided if it could affect eligibility, in order to determine TennCare eligibility; and, if approved, the amount of, if any, cost sharing which may be required of the applicant as found in these rules. Information may be verified through, but not limited to, the following sources:

1. The United States Internal Revenue Service (IRS);

2. State income tax records for Tennessee or any other state where income is earned;

3. The Tennessee Department of Labor and Workforce Development, and other employment security offices within any state where the applicant may have received wages or been employed;

4. Credit bureaus;

5. Insurance companies; or

6. Any other governmental agency or public or private source of information where such information may impact an applicant’s eligibility or cost sharing requirements for the TennCare Program.

(c) By applying for TennCare, an applicant understands it is a felony offense, pursuant to Tennessee Code Annotated § 71-5-2601, to obtain TennCare coverage under false means or to help anyone get on TennCare under false means.

(5) Current eligibility groups under TennCare Medicaid.

(a) Eligibility for TennCare Medicaid is currently limited to individuals who are Tennessee residents as defined at 42 C.F.R. § 435.403, Tennessee Code Annotated § 71-5-120, and who are listed in DHS rule Chapter 1240-03-02, Coverage Groups under Medicaid.

1. Individuals enrolled as Categorically Needy, as defined at Rule 1200-13-13-.01.

2. Individuals enrolled as Medically Needy, as defined at Rule 1200-13-13-.01. Enrollment in this category is limited to pregnant women and children under the age of twenty-one (21). Eligibility for this category shall be for a period of one (1) year. At the end of that year, eligibility must be reestablished in order for these individuals to continue in the program. For non-pregnant individuals who are under age 21, eligibility in this category shall end when the individual reaches his twenty-first birthday or the individual reaches the end of his one (1) year eligibility, whichever comes first.

3. Individuals who are determined eligible for the SSI Program by the Social Security Administration.

4. Women who have been enrolled as a result of needing treatment for breast or cervical cancer and who meet the technical requirements found at 1200-13-13-.02(3)(c).

(b) Effective date of eligibility.

1. For SSI eligibles, the date determined by the Social Security Administration in approving the individual for SSI coverage.

2. For all other Medicaid eligibles, the date of the application or the date of the qualifying event (such as the date that a spend-down obligation is met), whichever is later.

3. For persons applying for Medicaid eligibility during a period when the DHS offices are not open, the date the faxed application is received at DHS.

(6) Redetermination of TennCare Medicaid eligibility.

(a) Enrollees eligible for TennCare Medicaid as a result of being eligible for SSI benefits shall follow the Redetermination requirements of the Social Security Administration.

(b) An enrollee who qualifies for TennCare Medicaid through DHS shall have his TennCare Medicaid eligibility redetermined as required by the appropriate category of medical assistance as described in Chapter 1240-03-03 of the rules of DHS - Division of Medical Services. Prior to termination of Medicaid eligibility for enrollees of the Core Medicaid Population, eligibility will be reviewed in accordance with the following process:

1. At least thirty (30) days prior to the expiration of their current eligibility period, the Bureau of TennCare will send a Request for Information to all Core Medicaid

(Rule 1200-13-13-.02, continued)

enrollees. The Request for Information will include a form to be completed with information needed to determine eligibility for open Medicaid categories.

2. Enrollees will be given thirty (30) days inclusive of mail time from the date of the Request for Information to return the completed form to DHS and to provide DHS with the necessary verifications to determine eligibility for open Medicaid categories.

3. Enrollees with a health problem, mental health problem, learning problem or a disability will be given the opportunity to request assistance in responding to the Request for Information. Enrollees with Limited English Proficiency will have the opportunity to request translation assistance for responding to the Request for Information.

4. If an enrollee provides some but not all of the necessary information to DHS to determine his eligibility for open Medicaid categories during the thirty (30) day period following the Request for Information, DHS will send the enrollee a Verification Request. The Verification Request will provide the enrollee with ten (10) days inclusive of mail time to submit any missing information as identified in the Verification Request.

5. Enrollees who respond to the Request for Information within the thirty (30) day period shall retain their eligibility for TennCare Medicaid (subject to any changes in covered services generally applicable to enrollees in their Medicaid category) while DHS reviews their eligibility for open Medicaid categories.

6. Enrollees who respond to the Request for Information or the Verification Request after the requisite time period specified in those notices but before the date of termination shall retain their eligibility for TennCare Medicaid while DHS reviews their eligibility for open Medicaid categories. If DHS determines that the enrollee remains eligible for his current Medicaid category, the enrollee will remain enrolled in such Medicaid category. If DHS makes a determination that the enrollee is eligible for a different open Medicaid category, DHS will so notify the enrollee and the enrollee will be enrolled in the new appropriate TennCare Medicaid category. When the enrollee is enrolled in the appropriate TennCare Medicaid category, his eligibility in the previous category shall be terminated without additional notice. If a child is reviewed for Medicaid eligibility and is found not to be eligible for any open Medicaid category, the child will be reviewed for eligibility for TennCare Standard under Rule 1200-13-14-.02. If DHS makes a determination that the enrollee is not eligible for any open Medicaid categories, the TennCare Bureau will send the enrollee a twenty (20) day advance Termination Notice.

7. Individuals may provide the information and verifications specified in the Request for Information after termination of eligibility. DHS shall review all such information pursuant to the rules, policies and procedures of DHS and the Bureau of TennCare applicable to new applicants for TennCare Medicaid coverage. The individual shall not be entitled to be reinstated into TennCare Medicaid pending this review. If the individual is subsequently determined to be eligible for an open Medicaid category, he shall be granted retroactive coverage to the date of application, or in the case of spend down eligibility for Medically Needy pregnant women and children, to the latter of (a) the date of the application, or (b) the date spend down eligibility is met.

(c) A woman who has been determined eligible for TennCare Medicaid under 1200-13-13-.02(3)(c) of these rules shall annually recertify her eligibility in terms of continuation of

(Rule 1200-13-13-.02, continued)

active treatment, her address, and access to health insurance. If she is found to no longer be eligible through this review, the enrollee will be reviewed using the Redetermination process set forth in 1200-13-13-.02(6)(b) of these rules.

(7) Termination of eligibility.

(a) Eligibility for TennCare Medicaid shall cease when:

1. The individual no longer qualifies for TennCare Medicaid pursuant to Chapter 1240-03-03 of the rules of DHS; or

2. A woman determined eligible under 1200-13-13-.02(3)(c) of these rules:

(i) Reaches age sixty-five (65); or

(ii) Gains access to group health insurance that provides coverage for treatment of breast or cervical cancer as defined elsewhere in these rules; or

(iii) It has been determined that she no longer needs treatment for breast or cervical cancer, including pre-cancerous conditions.

(b) The TennCare Bureau will send Termination Notices to all Core Medicaid Population enrollees being terminated pursuant to state and federal law who are not determined to be eligible for open Medicaid categories pursuant to the Request for Information processes described herein.

(c) Termination Notices will be sent twenty (20) days in advance of the date upon which the coverage will be terminated.

(d) Termination Notices will provide enrollees with forty (40) days from the date of the notice to appeal the termination and will inform enrollees how they may request a hearing. Appeals will be processed by DHS in accordance with Rule 1200-13-13-.12.

(e) Enrollees with a health problem, mental health problem, learning problem or a disability will be given the opportunity to request additional assistance for their appeal. Enrollees with Limited English Proficiency will have the opportunity to request translation assistance for their appeal.

(8) Disenrollment related to discontinued Medicaid categories.

Prior to the disenrollment of any enrollee in a discontinued Medicaid category based on coverage terminations resulting from TennCare Medicaid Eligibility Reforms, Medicaid eligibility shall be reviewed in accordance with the following:

(a) Ex Parte Review.

DHS will conduct an ex parte review for open Medicaid categories for all enrollees in eligibility groups due to be terminated as part of the TennCare Medicaid eligibility reforms. Such ex parte review shall be conducted in accordance with federal requirements as set forth by CMS in the Special Terms and Conditions of the TennCare demonstration project.

(b) Request for Information.

(Rule 1200-13-13-.02, continued)

1. At least thirty (30) days prior to the expiration of their current eligibility period, the Bureau of TennCare will send a Request for Information to enrollees in eligibility groups being terminated pursuant to TennCare Medicaid eligibility reforms. The Request for Information will include a form to be completed with information needed to determine eligibility for open Medicaid categories, as well as a list of the types of proof needed to verify certain information.

2. Enrollees will be given thirty (30) days inclusive of mail time from the date of the Request for Information to return the completed form to DHS and to provide DHS with the necessary verifications to determine eligibility for open Medicaid categories.

3. Enrollees with a health problem, mental health problem, learning problem or a disability will be given the opportunity to request assistance in responding to this Request for Information. Enrollees with Limited English Proficiency will have the opportunity to request translation assistance for responding to the Request for Information.

4. Enrollees will be given an opportunity until the date of termination to request one extension for good cause of the thirty (30) day time frame for responding to the Request for Information. The good cause extension is intended to allow a limited avenue for possible relief for certain enrollees who face significant unforeseen circumstances, or who, as a result of a health problem, mental health problem, learning problem, disability, or limited English proficiency, are unable to respond timely. The good cause exception does not confer an entitlement upon enrollees and the application of this exception will be within the discretion of DHS. Only one (1) thirty (30) day good cause extension can be granted to each enrollee. Good cause is determined by DHS eligibility staff. Good cause is not requested nor determined by filing an appeal. Requests for an extension of the thirty (30) day time frame to respond to the Request for Information must be initiated by the enrollee. However, the enrollee may receive assistance in initiating such request. DHS will not accept a request for extension of the thirty (30) day time frame submitted by a family member, advocate, provider, or CMHC, acting on the enrollee's behalf without the involvement and knowledge of the enrollee, for example, to allow time for such entity to locate the enrollee if his whereabouts are unknown. All requests for a good cause extension must be made prior to termination of Medicaid eligibility. A good cause extension will be granted if DHS determines that a health problem, mental health problem, learning problem, disability or limited English proficiency prevented an enrollee from understanding or responding timely to the Request for Information. Except in the aforementioned circumstances, a good cause extension will only be granted if such request is submitted in writing to DHS prior to termination of Medicaid eligibility and DHS determines that serious personal circumstances such as illness or death prevent an enrollee from responding to the Request for Information for an extended period of time. Proof of the serious personal circumstances is required with the submission of the written request in order for a good cause extension to be granted. Good cause extensions will be granted at the sole discretion of DHS, and, if granted, shall provide the enrollee with an additional thirty (30) days inclusive of mail time from the date of DHS's decision to grant the good cause extension. DHS will send the enrollee a letter granting or denying the request for good cause extension. DHS's decisions with respect to good cause extensions shall not be appealable.

5. If an enrollee provides some but not all of the necessary information to DHS to determine his eligibility for open Medicaid categories during the thirty (30) day period following the Request for Information, DHS will send the enrollee a

(Rule 1200-13-13-.02, continued)

Verification Request. The Verification Request will provide the enrollee with ten (10) days inclusive of mail time to submit any missing information as identified in the Verification Request. Enrollees will not have the opportunity to request an extension for good cause of the ten (10) day time frame for responding to the Verification Request.

6. Enrollees who respond to the Request for Information within the thirty (30) day period or within any extension of such period granted by DHS shall retain their eligibility for TennCare Medicaid (subject to any changes in covered services generally applicable to enrollees in their Medicaid category) while DHS reviews their eligibility for open Medicaid categories.

7. DHS shall review all information and verifications provided within the requisite time period by an enrollee pursuant to the Request for Information and/or Verification Request to determine whether the enrollee is eligible for any open Medicaid categories. If DHS makes a determination that the enrollee is eligible for an open Medicaid category, DHS will so notify the enrollee and the enrollee will be enrolled in the appropriate Medicaid category. When the enrollee is enrolled in the appropriate TennCare Medicaid category, his eligibility in the discontinued Medicaid category shall be terminated without additional notice. If DHS makes a determination that the enrollee is not eligible for any open Medicaid categories or if an enrollee does not respond to the Request for Information within the requisite thirty (30) day time period or any extension of such period granted by DHS, the TennCare Bureau will send the enrollee a twenty (20) day advance Termination Notice.

8. Enrollees who respond to the Request for Information or the Verification Request after the requisite time period specified in those notices or after any extension of such time period granted by DHS but before the date of termination shall retain their eligibility for TennCare Medicaid (subject to any changes in covered services generally applicable to enrollees in their Medicaid category) while DHS reviews their eligibility for open Medicaid categories. If DHS makes a determination that the enrollee is eligible for an open Medicaid category, DHS will so notify the enrollee, and the enrollee will be enrolled in the appropriate TennCare Medicaid category, and his eligibility in the discontinued Medicaid category shall be terminated without additional notice. If DHS makes a determination that the enrollee is not eligible for any open Medicaid categories, the TennCare Bureau will send the enrollee a twenty-(20) day advance Termination Notice.

9. Individuals may provide information and verifications specified in the Request for Information after termination of eligibility. DHS shall review all such information pursuant to the rules, policies and procedures of DHS and the Bureau of TennCare applicable to new applicants for TennCare coverage. The individual shall not be entitled to be reinstated into TennCare pending this review. If the individual is subsequently determined to be eligible for an open Medicaid category, he shall be granted retroactive coverage to the date of application, or in the case of spend down eligibility for Medically Needy pregnant women and children, to the latter of (a) the date of application, or (b) the date spend down eligibility is met.

(c) Termination Notice.

1. The TennCare Bureau will send Termination Notices to all enrollees being terminated pursuant to TennCare Medicaid eligibility reforms who are not

(Rule 1200-13-13-.02, continued)

determined to be eligible for open Medicaid categories pursuant to the Ex Parte Review or Request for Information processes described in this subparagraph.

2. Termination Notices will be sent twenty (20) days in advance of the date upon which the coverage will be terminated.

3. Termination Notices will provide enrollees with forty (40) days from the date of the notice to appeal valid factual disputes related to the disenrollment and will inform enrollees how they may request a hearing.

4. Enrollees with a health problem, mental health problem, learning problem, or a disability will be given the opportunity to request additional assistance for their appeal. Enrollees with Limited English Proficiency will have the opportunity to request translation assistance for their appeal.

5. Enrollees will not have the opportunity to request an extension for good cause of the forty (40) day time frame in which to request a hearing.

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 4-5-209, 71-5-105, and 71-5-109 and Executive Order No. 23.* ***Administrative History:*** *Public necessity rule filed July 1, 2002; effective through December 13, 2002. Original rule filed September 30, 2002; to be effective December 14, 2002; however, on December 9, 2002, the House Government Operations Committee of the General Assembly stayed Rule 1200-13-13-.02; new effective date February 12, 2003. Emergency rule filed December 13, 2002; effective through May 27, 2003. Amendment filed April 9, 2003; effective June 23, 2003. Public necessity rule filed April 29, 2005, effective through October 11, 2005. Public necessity rule filed June 3, 2005; effective through November 15, 2005. Amendment filed July 28, 2005; effective October 11, 2005. Amendments filed September 1, 2005; effective November 15, 2005. Public necessity rule filed December 9, 2005; effective through May 23, 2006. Public necessity rule filed March 3, 2006; effective through August 15, 2006. Amendment filed March 3, 2006; effective May 17, 2006. Amendment filed June 1, 2006; effective August 15, 2006. Public necessity rule filed February 8, 2008; effective through July 22, 2008. Repeal and new rule filed May 7, 2008; effective July 21, 2008. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendment filed May 27, 2010; effective August 25, 2010. Amendment filed October 26, 2010; effective January 24, 2011. Amendment filed September 26, 2013; effective December 25, 2013. Emergency rules filed July 1, 2016; effective through December 28, 2016. Amendments filed September 30, 2016; effective December 29, 2016.*

1200-13-13-.03 ENROLLMENT, REASSIGNMENT, AND DISENROLLMENT WITH MANAGED CARE CONTRACTORS (MCCS).

(1) Enrollment.

There are three (3) different types of managed care entities that provide services to TennCare enrollees. Enrollment procedures differ according to the type of managed care entity, the geographic area, and the number of managed care entities operating in each geographic area. Enrollment procedures also differ for ECF CHOICES, as described in subparagraph (c) below.

(a) TennCare Managed Care Organizations (MCOs) other than TennCare Select.

1. Except as provided in subparagraph (c), individuals or families determined eligible for TennCare shall select a health plan (Managed Care Organization/MCO) at the time of application. The health plan must be available in the Grand Division of the State in which the enrollee lives. All family members living in the same household and enrolled in TennCare must be assigned to the same MCO except children determined by the Bureau to be eligible to enroll in TennCare Select. An enrollee is given his choice of MCOs when possible. If the

requested MCO cannot accept new enrollees, the Bureau will assign each enrollee to an MCO that is accepting new enrollees. If no MCO is available to enroll new members in the enrollee's Grand Division, the enrollee will be assigned to TennCare Select until such time as another MCO becomes available. The Bureau may also assign TennCare children with special health care needs to TennCare Select.

Individuals enrolled as a result of being eligible for SSI benefits will be assigned to an MCO as they do not have the opportunity to select a health plan prior to the effective date of coverage, since they are enrolled through the Social Security Administration.

2. Except as provided in subparagraph (c), a TennCare enrollee may change MCOs one (1) time within the initial ninety (90) calendar days (inclusive of mail time) from the date of the letter informing him of his MCO assignment, if there is another MCO in the enrollee's Grand Division that is currently permitted by the Bureau to accept new enrollees. No additional changes will be allowed except as otherwise specified in these rules. An enrollee shall remain a member of the designated plan until he is given an opportunity to change once each year during an annual change period. The annual change period will occur each year in March for enrollees in West Tennessee, in May for enrollees in Middle Tennessee, and in July for enrollees in East Tennessee. Thereafter, an MCO change is permitted only during an annual change period, unless the Bureau authorizes a change as the result of the resolution of an appeal requesting a "hardship" reassignment as specified in paragraph (2)(b) below. When an enrollee changes MCOs, the enrollee's medical care will be the responsibility of the current MCO until he is enrolled in the requested MCO.

3. Each MCO shall offer its enrollees, to the extent possible, freedom of choice among participating providers. If after notification of enrollment the enrollee has not chosen a primary care provider, one will be selected for him by the MCO. The period during which an enrollee may choose his primary care provider shall not be less than fifteen (15) calendar days.

4. In the event a pregnant woman entering an MCO's plan is receiving medically necessary prenatal care the day before enrollment, the MCO shall be responsible for the costs of continuation of such medically necessary services, without any form of prior approval and without regard to whether such services are being provided within or outside the MCO's provider network until such time as the MCO can reasonably transfer the enrollee to a service and/or network provider without impeding service delivery that might be harmful to the enrollee's health.

In the event a pregnant woman entering the MCO's plan is in her second or third trimester of pregnancy and is receiving medically necessary prenatal care services the day before enrollment, the MCO shall be responsible for providing continued access to the provider (regardless of network affiliation) through the postpartum period. Reimbursement to an out-of-network provider shall be as set out in Rule 1200-13-13-.08.

(b) TennCare Select.

TennCare Select is a prepaid inpatient health plan (PIHP), as defined in 42 C.F.R. § 438.2, which operates in all areas of the State and covers the same services as the MCOs. The State's TennCare Select contractor is reimbursed on a non-risk, non-

(Rule 1200-13-13-.03, continued)

capitated basis for services rendered to covered populations, and in addition receives fees from the State to offset administrative costs.

1. The TennCare populations included in the TennCare Select delivery system are as follows:

   (i) Children under the age of twenty-one (21) years who are eligible for Supplemental Security Income.

   (ii) Children in state custody and children leaving state custody for six (6) months post-custody as long as the child remains eligible.

   (iii) Children under the age of twenty-one (21) years in an institutional eligibility category who are receiving care in a Nursing Facility or an Intermediate Care Facility for persons with Mental Retardation (or pursuant to federal law, Intermediate Care Facility for the Mentally Retarded) (ICF/MR), and children and adults in a Home and Community Based Services 1915(c) waiver for individuals with mental retardation.

   (iv) Enrollees living in areas where there is insufficient MCO capacity to serve them.

   After being assigned to TennCare Select, persons in categories (i) and (iii) above may choose to disenroll from TennCare Select and enroll in another MCO if one is available. Persons in categories (ii) and (iv) must remain in TennCare Select. TennCare Select is not open to voluntary selection by TennCare enrollees.

2. TennCare Select also provides the following functions:

   (i) It is the back-up plan should one of the MCOs leave the TennCare program unexpectedly. For TennCare enrollees previously enrolled with the MCO, TennCare Select provides medical case management and all MCO covered services.

   (ii) It is the only entity responsible for payment of the services described in 42 C.F.R. § 431.52, services provided to residents temporarily absent from the State, and provides all MCO covered services (primarily emergency services).

   (iii) It is the only entity responsible for payment of the services described in 42 C.F.R. § 440.255, limited services for certain aliens.

(c) TennCare Managed Care Organizations (MCOs) for ECF CHOICES. Individuals enrolled in ECF CHOICES may select from only the MCOs participating in ECF CHOICES.

1. If an individual enrolled in an MCO other than an ECF CHOICES participating MCO wants to enroll in the ECF CHOICES program, the individual must choose to enroll in an ECF CHOICES participating MCO in order to enroll in ECF CHOICES.

2. If an individual enrolled in the ECF CHOICES program elects to transition to an MCO that is not participating in ECF CHOICES, the individual is choosing to voluntarily disenroll from ECF CHOICES. Because this is a voluntary decision, advance notice and the right to a fair hearing shall not be provided. However, the

(Rule 1200-13-13-.03, continued)

individual may elect to transition back to an ECF CHOICES participating MCO in order to resume enrollment in ECF CHOICES

(d) TennCare Dental Benefits Manager (DBM).

TennCare children shall be assigned to the Dental Benefits Manager (DBM) under contract with the Bureau to provide dental benefits through the TennCare Program. TennCare adults age 21 and older enrolled in ECF CHOICES shall be assigned to the DBM under contract with the Bureau to provide Adult Dental Services through the ECF CHOICES program as defined in 1200-13-01-.02.

(e) TennCare Pharmacy Benefits Manager (PBM).

TennCare enrollees who are eligible to receive pharmacy services shall be assigned to the Pharmacy Benefits Manager (PBM) under contract with the Bureau to provide pharmacy benefits for both medical and behavioral health services through the TennCare Program.

(2) Reassignment.

(a) Reassignment to an MCO other than the current MCO in which the TennCare enrollee is enrolled is subject to another MCO's capacity to accept new enrollees and must be approved by the Bureau of TennCare in accordance with one of the following:

1. During the initial ninety (90) day period following notification of MCO assignment as described at Rule 1200-13-13-.03, a TennCare enrollee may request a change of MCOs.

2. A TennCare enrollee must change MCOs if he moves outside the MCO's Grand Division, and that MCO is not authorized to operate in the enrollee's new place of residence. Until the TennCare enrollee selects or is assigned to a new MCO and his enrollment is deemed complete, his medical care will remain the responsibility of the original MCO.

3. If an enrollee's MCO withdraws from participation in the TennCare Program, TennCare will assign him to a MCO operating in his Grand Division, if one is available. The enrollee will be provided notice of the change and will have ninety (90) days to select another MCO in his Grand Division. If no MCO is available to accept enrollees from an exiting plan, the enrollees will be assigned to TennCare Select until such time as another MCO becomes available.

4. An enrollee shall be given an opportunity to change MCOs once each year during an annual change period. Only one (1) MCO change is permitted every twelve (12) months, unless the Bureau authorizes a change as the result of the resolution of an appeal requesting a "hardship" reassignment. When an enrollee changes MCOs, the enrollee's medical care will be the responsibility of the current MCO until enrolled in the requested MCO. If an enrollee changes MCOs during an annual change period, all family members living in the same household and enrolled in TennCare shall also be changed except children enrolled in TennCare Select.

(b) A TennCare enrollee may change MCOs if the TennCare Bureau has granted a request for a change in MCOs or an appeal of a denial of a request for a change in MCOs has been resolved in his favor based on hardship criteria.

1. The following situations will not be determined to be "hardships":

(i) The enrollee is unhappy with the current MCO or primary care provider (PCP), but there is no hardship medical situation (as stated in Part 2. below);

(ii) The enrollee claims lack of access to services but the plan meets the state's access standard;

(iii) The enrollee is unhappy with a current PCP or other providers, and has refused alternative PCP or provider choices offered by the MCO;

(iv) The enrollee is concerned that a current provider might drop out of the plan in the future;

(v) The enrollee is a Medicare beneficiary who (with the exception of pharmacy) may utilize choice of providers, regardless of network affiliation; or

(vi) The enrollee's PCP is no longer in the MCO's network, the enrollee wants to continue to see the current PCP and has refused alternative PCP or provider choices offered by the MCO.

2. Requests for hardship MCO reassignments must meet all of the following six (6) hardship criteria for reassignment. Determinations will be made on an individual basis.

(i) A member has a medical condition that requires complex, extensive, and ongoing care; and

(ii) The member's specialist has stopped participating in the member's current MCO network and has refused continuation of care to the member in his current MCO assignment; and

(iii) The ongoing medical condition of the member is such that another physician or provider with appropriate expertise would be unable to take over his care without significant and negative impact on his care; and

(iv) The current MCO has been unable to negotiate continued care for this member with the current specialist; and

(v) The current provider of services is in the network of one or more alternative MCOs; and

(vi) An alternative MCO is available to enrolled members (i.e., has not given notice of withdrawal from the TennCare Program, is not in receivership, and is not at member capacity for the member's region).

Requests to change MCOs submitted by TennCare enrollees shall be evaluated in accordance with the hardship criteria referenced above. If an enrollee's request to change MCOs is granted due to hardship, all family members living in the same household and enrolled in TennCare will be assigned to the new MCO except children determined by the Bureau to be eligible to enroll in TennCare Select. Upon denial of a request to change MCOs, enrollees shall be provided notice and appeal rights as described in applicable provisions of Rule 1200-13-13-.11.

(c) Members receiving long-term services and supports.

(Rule 1200-13-13-.03, continued)

1. In the event that a CHOICES member is determined, based on an assessment of needs, to require a long-term care service that is not currently available under the MCO in which he is currently enrolled, but that is available through another MCO, the Bureau shall work with the current MCO to arrange for provision of the required service, which may involve providing such service out-of-network. It shall be considered to be a hardship reason to change MCO assignment only if the current MCO, after working with the Bureau, is unable to provide the required service. In such cases, the MCO that is unable to provide the required service after working with the Bureau may be subject to sanctions.

2. A CHOICES or ECF CHOICES member may request and shall have cause to change MCO assignment if all of the following are met:

(i) The member receives institutional, residential, or employment support services in the MLTSS program in which he is enrolled;

(ii) The member's institutional, residential, or employment support services provider has stopped participating in the member's MCO network and has refused continuation of care to the member in his current MCO assignment;

(iii) The member's current MCO has been unable to negotiate continued services for the member with the current provider;

(iv) The member would have to change his residential, institutional, or employment supports provider based on that provider's change in status from an in-network to an out-of-network provider with the MCO;

(v) As a result, the member would experience a disruption in his residence or employment;

(vi) The current institutional, residential, or employment support services provider is in the network of one or more alternative MCOs; and

(vii) The alternative MCO the member has selected is available to enroll members (i.e., has not given notice of withdrawal from the TennCare Program, is not in receivership, and is not at member capacity for the member's region).

(d) Enrollees who are out-of-state on a temporary basis, but maintain their status as Tennessee residents under federal and state laws, shall be reassigned to TennCare Select for the period they are out-of-state.

(e) TennCare shall only accept a request to change MCO assignment from the affected enrollee, his parent, guardian, spouse, child over age eighteen (18), or responsible party as defined in Rule 1200-13-13-.01.

(3) Disenrollment.

(a) When it has been determined that an individual no longer meets the criteria for TennCare eligibility, that individual shall be disenrolled from the TennCare Program, including the CHOICES and ECF CHOICES program, as applicable. Services provided by the TennCare MCO in which the individual has been enrolled, as well as the PBM and DBM, if applicable, shall be terminated upon disenrollment. Such disenrollment action will be accompanied by appropriate due process procedures as described

(Rule 1200-13-13-.03, continued)

elsewhere in this Chapter. Disenrollment from the CHOICES program shall proceed as described in Rule 1200-13-01-.05. Disenrollment from the ECF CHOICES program shall proceed as described in Rule 1200-13-01-.31.

(b) Coverage shall cease at 12:00 midnight, local time, on the date that an individual is disenrolled from TennCare.

(c) TennCare may reassign individuals from a designated MCO and place them in another MCO as described elsewhere in these rules. A TennCare MCO may not reassign an enrollee without the permission of TennCare. A TennCare MCO shall not request the reassignment of a TennCare enrollee for any of the following reasons:

1. Adverse changes in the enrollee's health;

2. Pre-existing medical conditions; or

3. High cost medical bills.

Coverage by a particular MCO shall cease at 12:00 midnight local time on the date that an individual has been reassigned by TennCare from one MCO and placed in another plan. Coverage by the new MCO will begin when coverage by the old MCO ends.

Authority: *T.C.A. §§ 4-5-202, 4-5-203, 4-5-208, 4-5-209, 71-5-105, and 71-5-109 and Executive Order No. 23.* ***Administrative History:*** *Public necessity rule filed July 1, 2002; effective through December 13, 2002. Original rule filed September 30, 2002; to be effective December 14, 2002; however, on December 9, 2002, the House Government Operations Committee of the General Assembly stayed Rule 1200-13-13-.03; new effective date February 12, 2003. Emergency rule filed December 13, 2002; effective through May 27, 2003. Public necessity rule filed April 29, 2005; effective through October 11, 2005. Amendments filed July 28, 2005; effective October 11, 2005. Public necessity rule filed December 29, 2005; expired June 12, 2006. On June 13, 2006, affected rules reverted to status on December 28, 2005. Amendment filed March 31, 2006; effective June 14, 2006. Amendment filed August 14, 2006; effective October 28, 2006. Public necessity rule filed February 8, 2008; effective through July 22, 2008. Repeal and new rule filed May 7, 2008; effective July 21, 2008. Amendments filed September 25, 2009; effective December 24, 2009. Amendment filed November 30, 2009; effective February 28, 2010. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendments filed May 27, 2010; effective August 25, 2010. Amendments filed October 26, 2010; effective January 24, 2011. Emergency rules filed July 1, 2016; effective through December 28, 2016. Amendments filed September 30, 2016; effective December 29, 2016. Amendments filed September 25, 2017; effective December 24, 2017. Amendments filed July 8, 2021; effective October 6, 2021.*

1200-13-13-.04 COVERED SERVICES.

(1) Benefits covered under the managed care program

(a) TennCare MCCs shall cover the following services and benefits subject to any applicable limitations described in this Chapter. TennCare MCCs shall cover TennCare CHOICES services and benefits for individuals enrolled in the TennCare CHOICES program in accordance with Rule 1200-13-01-.05 and ECF CHOICES services and benefits for individuals enrolled in the ECF CHOICES program in accordance with Rule 1200-13-01-.31.

1. Any and all medically necessary services may require prior authorization or approval by the MCC, except where prohibited by law.

2. An MCC shall not refuse to pay for a service solely because of a lack of prior authorization as follows:

(i) EPSDT services. MCCs shall provide all medically necessary, covered services regardless of whether the need for such services was identified by a provider whose services had received prior authorization from the MCC or by an in-network provider.

(ii) Emergency services. MCCs shall not require prior authorization or approval for covered services rendered in the event of an emergency, as defined in these rules. Such emergency services may be reviewed on the basis of medical necessity or other MCC administrator requirements, but cannot be denied solely because the provider did not obtain prior authorization or approval from the enrollee's MCC.

3. MCCs shall not impose any service limitations that are more restrictive than those described herein; however, this shall not limit the MCC's ability to establish procedures for the determination of medical necessity.

4. Services for which there is no federal financial participation (FFP) are not covered.

5. Non-covered services are non-covered regardless of medical necessity.

(b) The following physical health and mental health benefits are covered under the TennCare managed care program. Benefits offered under the TennCare CHOICES program are also covered under the TennCare managed care program, as described in Rule 1200-13-01-.05. Benefits offered under the ECF CHOICES program are also covered under the TennCare managed care program, as described in Rule 1200-13-01-.31. There are some exclusions to the benefits listed below. The exclusions are listed in this rule and in Rule 1200-13-13-.10.

SERVICE	**BENEFIT FOR PERSONS UNDER AGE 21**	**BENEFIT FOR PERSONS AGED 21 AND OLDER**
1. Ambulance Services.	See "Emergency Air and Ground Transportation" and "Non-Emergency Ambulance Transportation."	See "Emergency Air and Ground Transportation" and "Non-Emergency Ambulance Transportation."
2. Bariatric Surgery, defined as surgery to induce weight loss.	Covered as medically necessary.	Covered as medically necessary.
3. Chiropractic Services [defined at 42 C.F.R. § 440.60(b)].	Covered as medically necessary.	Not covered.
4. Community Health Services, [defined at 42 C.F.R. § 440.20(b) and (c) and 42 C.F.R. § 440.90].	Covered as medically necessary.	Covered as medically necessary.
5. Dental Services [defined at 42 C.F.R. § 440.100].	Preventive, diagnostic, and treatment services covered as medically necessary. Dental services under EPSDT are provided in accordance with the state's periodicity schedule as determined after consultation with recognized dental organizations	Not covered.

(Rule 1200-13-13-.04, continued)

SERVICE	BENEFIT FOR PERSONS UNDER AGE 21	BENEFIT FOR PERSONS AGED 21 AND OLDER
	and at other intervals as medically necessary. Orthodontic services must be prior authorized by the Dental Benefits Manager (DBM). Orthodontic services are only covered for individuals under age 21. Effective October 1, 2013, TennCare reimbursement for orthodontic treatment approved and begun before age 21 will end on the individual's 21st birthday. For individuals receiving treatment prior to October 1, 2013, such treatment may continue until completion as long as the enrollee remains eligible for TennCare. Orthodontic treatment is not covered unless it is medically necessary to treat a handicapping malocclusion. Cleft palate, hemifacial microsomia, or mandibulofacial dysostosis shall be considered handicapping malocclusions. A TennCare-approved Malocclusion Severity Assessment (MSA) will be conducted to measure the severity of the malocclusion. An MSA score of 28 or higher, as determined by the DBM's dentist reviewer(s), will be used for making orthodontic treatment determinations of medical necessity. However, an MSA score alone cannot be used to deny orthodontic treatment. Orthodontic treatment will not be authorized for cosmetic purposes. Orthodontic treatment will be paid for by TennCare only as long as the individual remains eligible for TennCare. The MCO is responsible for the provision of transportation to and from covered dental services, as well as the medical and	

(Rule 1200-13-13-.04, continued)

SERVICE	BENEFIT FOR PERSONS UNDER AGE 21	BENEFIT FOR PERSONS AGED 21 AND OLDER
	anesthesia services related to the covered dental services.	
6. Durable Medical Equipment [defined at 42 C.F.R. § 440.70(b)(3)].	Covered as medically necessary.	Covered as medically necessary.
7. Emergency Air and Ground Transportation [defined at 42 C.F.R. § 440.170(a)(1) and (3)].	Covered as medically necessary.	Covered as medically necessary.
8. EPSDT Services, [defined at 42 C.F.R. § 441, Subpart B].	Screening and interperiodic screening covered in accordance with federal regulations. (Interperiodic screens are screens in between regular checkups which are covered if a parent or caregiver suspects there may be a problem.) Diagnostic and follow-up treatment services covered as medically necessary and in accordance with federal regulations. The periodicity schedule for child health screens is that set forth in the latest "American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care." All components of the screens must be consistent with the latest "American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care."	Not applicable. (EPSDT is for persons under age 21.)
9. Health Home Services for Persons with Serious and Persistent Mental Illness [described at 42 U.S.C. § 1396w-4(h)(4)].	Covered as medically necessary.	Covered as medically necessary.
10. Home Health Care [defined at 42 C.F.R. § 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 (6) of this rule. All home health care must be delivered by a licensed Home Health Agency, as defined by 42 C.F.R. § 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 (6) of this rule. All home health care must be delivered by a licensed Home Health Agency, as defined by 42 C.F.R. § 440.70.

(Rule 1200-13-13-.04, continued)

SERVICE	BENEFIT FOR PERSONS UNDER AGE 21	BENEFIT FOR PERSONS AGED 21 AND OLDER
11. Hospice Care [defined at 42 C.F.R., Part 418].	Covered as medically necessary. Must be provided by an organization certified pursuant to Medicare Hospice requirements.	Covered as medically necessary. Must be provided by an organization certified pursuant to Medicare Hospice requirements.
12. Inpatient and Outpatient Substance Abuse Benefits [defined as services for the treatment of substance abuse that are provided (a) in an inpatient hospital (as defined at 42 C.F.R. § 440.10) or (b) as outpatient hospital services (see 42 C.F.R. § 440.20(a)); includes services in IMDs as provided for in 42 U.S.C. § 1396n(l)].	Covered as medically necessary.	Covered as medically necessary. Substance abuse benefits delivered in IMDs are covered up to 30 days per year.
13. Inpatient Hospital Services [defined at 42 C.F.R. § 440.10].	Covered as medically necessary. Preadmission and concurrent reviews allowed.	Covered as medically necessary. Preadmission and concurrent reviews allowed.
14. Inpatient Rehabilitation Facility Services.	See “Inpatient Hospital Services.”	Not Covered.
15. Lab and X-ray Services [defined at 42 C.F.R. § 440.30].	Covered as medically necessary.	Covered as medically necessary.
16. Medical Supplies [defined at 42 C.F.R. § 440.70(b)(3)].	Covered as medically necessary.	Covered as medically necessary.
17. Mental Health Crisis Services [defined as services rendered to alleviate a psychiatric emergency].	Covered as medically necessary.	Covered as medically necessary.
18. Methadone Clinic Services [defined as services provided by a methadone clinic].	Covered as medically necessary.	Covered as medically necessary.
19. Non-Emergency Ambulance Transportation, [defined at 42 C.F.R. § 440.170(a)(1) and (3)].	Covered as medically necessary.	Covered as medically necessary.
20. Non-Emergency Transportation [defined at 42 C.F.R. § 440.170(a)(1) and (3)].	Covered as necessary for enrollees lacking accessible transportation for covered services. Emphasis shall be placed on the utilization of fixed route and/or public transportation where appropriate and available.	Covered as necessary for enrollees lacking accessible transportation for covered services. Emphasis shall be placed on the utilization of fixed route and/or public transportation where appropriate and available. The travel to access primary care and

(Rule 1200-13-13-.04, continued)

SERVICE	BENEFIT FOR PERSONS UNDER AGE 21	BENEFIT FOR PERSONS AGED 21 AND OLDER
	The travel to access primary care and dental services must meet the requirements of the TennCare demonstration project terms and conditions. The availability of specialty services as related to travel distance should meet the usual and customary standards for the community. However, in the event the MCC is unable to negotiate such an arrangement for an enrollee, transportation must be provided regardless of whether the enrollee has access to transportation. If the enrollee is a minor child, transportation must be provided for the child and an accompanying adult. However, transportation for a minor child shall not be denied pursuant to any policy which poses a blanket restriction due to enrollee's age or lack of parental accompaniment. Any decision to deny transportation of a minor 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 appeals process. Tennessee recognizes the "mature minor exception" to permission for medical treatment. The provision of transportation to and from covered dental services is the responsibility of the MCO. For persons dually eligible for Medicare and Medicaid, non-emergency transportation to access medical services covered by Medicare is provided, as long as these services would be covered by TennCare for the enrollee if he did not have Medicare. The Medicare provider	dental services must meet the requirements of the TennCare demonstration project terms and conditions. The availability of specialty services as related to travel distance should meet the usual and customary standards for the community. However, in the event the MCC is unable to negotiate such an arrangement for an enrollee, transportation must be provided regardless of whether the enrollee has access to transportation. For persons dually eligible for Medicare and Medicaid, non-emergency transportation to access medical services covered by Medicare is provided, as long as these services would be covered by TennCare for the enrollee if he did not have Medicare. The Medicare provider of the medical service does not have to participate in TennCare. Transportation to these medical services is covered within the same access standards as those applicable for TennCare enrollees who are not also Medicare beneficiaries. One escort is allowed per enrollee if the enrollee requires assistance. Assistance is defined for purposes of this rule as help provided to the enrollee that enables the enrollee to receive a medically necessary service. Examples of assistance are: physical assistance such as holding doors or pushing wheelchairs; language assistance such as interpreter services or reading for someone who is illiterate; or decision making assistance. See Rule 1200-13-13-.01 for a definition of who may be an escort.

(Rule 1200-13-13-.04, continued)

SERVICE	BENEFIT FOR PERSONS UNDER AGE 21	BENEFIT FOR PERSONS AGED 21 AND OLDER
	of the medical services does not have to participate in TennCare. Transportation to these medical services is covered within the same access standards as those applicable for TennCare enrollees who are not also Medicare beneficiaries. One escort is allowed per enrollee if the enrollee requires assistance. Assistance is defined for purposes of this rule as help provided to the enrollee that enables the enrollee to receive a medically necessary service. Examples of assistance are: physical assistance such as holding doors or pushing wheelchairs; language assistance such as interpreter services or reading for someone who is illiterate; or decision making assistance. See Rule 1200-13-13-.01 for a definition of who may be an escort.	
21. Occupational Therapy [defined at 42 C.F.R. § 440.110(b)].	Covered as medically necessary, by a Licensed Occupational Therapist, to restore, improve, stabilize or ameliorate impaired functions.	Covered as medically necessary, by a Licensed Occupational Therapist, to restore, improve, or stabilize impaired functions.
22. Organ and Tissue Transplant Services and Donor Organ/Tissue Procurement Services [defined as the transfer of an organ or tissue from individual to a TennCare enrollee.	Covered as medically necessary. Experimental or investigational transplants are not covered.	Covered as medically necessary when coverable by Medicare. Experimental or investigational transplants are not covered.
23. Outpatient Hospital Services [defined at 42 C.F.R. § 440.20(a)].	Covered as medically necessary.	Covered as medically necessary.
24. Outpatient Mental Health Services (including Physician Services), [defined at 42 C.F.R. § 440.20(a), 42 C.F.R. § 440.50, and 42 C.F.R. § 440.90].	Covered as medically necessary.	Covered as medically necessary.
25. Pharmacy Services [defined at 42 C.F.R. § 440.120(a) and obtained directly from	Covered as medically necessary. Certain drugs (known as DESI, LTE, IRS drugs) are excluded from coverage. Persons dually	(A) Covered as medically necessary, subject to the limitations set out below. Certain drugs (known as DESI, LTE, IRS drugs) are excluded from coverage.

(Rule 1200-13-13-.04, continued)

SERVICE	BENEFIT FOR PERSONS UNDER AGE 21	BENEFIT FOR PERSONS AGED 21 AND OLDER
an ambulatory retail pharmacy setting, outpatient hospital pharmacy, mail order pharmacy, or those administered to a long-term care facility (nursing facility) resident].	eligible for Medicaid and Medicare will receive their pharmacy services through Medicare Part D. Pharmacy services are the responsibility of the PBM, except for pharmaceuticals supplied and administered in a doctor's office. For persons who are not dually eligible for Medicare and Medicaid, pharmaceuticals supplied and administered in a doctor's office are the responsibility of the MCO. For persons who are dually eligible for Medicare and Medicaid, pharmaceuticals supplied and administered in a doctor's office are the responsibility of the MCO if not covered by Medicare.	Persons dually eligible for Medicaid and Medicare will receive their pharmacy services through Medicare Part D. (B) Pharmacy services are the responsibility of the PBM, except for pharmaceuticals supplied and administered in a doctor's office. (C) Pharmacy services with no quantity limits on the number of prescriptions per month for the following non-Medicare enrollees only: adults age 21 and older enrolled in CHOICES 1 or CHOICES 2; adults age 21 and older enrolled in ECF CHOICES who meet nursing facility level of care or transitioned from a Section 1915(c) waiver into ECF CHOICES and granted an exception by TennCare based on ICF/IID level of care; non-Medicare PACE enrollees; and persons receiving TennCare-reimbursed services in an Intermediate Care Facility for Individuals with Intellectual Disabilities or a Home and Community Based Services Waiver for Individuals with Intellectual Disabilities. (D) For hospice patients, drugs used for the relief of pain and symptom control related to their terminal illness are covered as part of the hospice benefit. If the patient is not a Medicare beneficiary, pharmacy services needed for conditions unrelated to the terminal illness are covered by TennCare. There are no quantity limits on the number of prescriptions per month covered by TennCare if the hospice patient is receiving TennCare-reimbursed room and board in a Nursing Facility. If the patient is receiving hospice services at home or in a residential hospice, coverage of pharmacy services is as described in sections (C) and (E). (E) Subject to (C) and (D) above, pharmacy services for Medicaid adults age 21 and older 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. Additional drugs for individuals in (E) shall not be covered.

(Rule 1200-13-13-.04, continued)

SERVICE	BENEFIT FOR PERSONS UNDER AGE 21	BENEFIT FOR PERSONS AGED 21 AND OLDER
		(F) Prescriptions shall be counted beginning on the first day of each calendar month. Each prescription and/or refill counts as one (1). A prescription or refill can be for no more than a thirty-one (31) day supply. (G) The Bureau of TennCare shall maintain an Automatic Exception List of medications which shall not count against such limit. The Bureau of TennCare may modify the Automatic Exception List at its discretion. The most current version of the Automatic Exception List will be made available to enrollees via the internet from the TennCare website and upon request by mail through the DHS Family Assistance Service Center. Only medications that are specified on the current version of the Automatic Exception List that is available on the TennCare website located on the World Wide Web at www.tn.gov/tenncare on the date of service shall be considered exempt from applicable prescription limits. (H) The Bureau of TennCare shall also maintain a Prescriber Attestation List of medications available when the prescriber attests to an urgent need. The State may include certain drugs or categories of drugs on the list, and may maintain, and make available to physicians, providers, pharmacists, and the public, a list that shall indicate the drugs or types of drugs the State has determined to so include. The Prescriber Attestation List drugs may be approved for enrollees who have already met an applicable benefit limit only if the prescribing professional seeks and obtains a Special exemption. In order to obtain a special exemption, the prescribing provider must submit an attestation as directed by TennCare regarding the urgent need for the drug. TennCare will approve the prescribing provider's determination that the criteria for the special exemption are met, without further review, within 24 hours of receipt. Enrollees will not be entitled to a hearing regarding their eligibility for a special exemption if (i) the prescribing provider has not submitted the required attestation,

(Rule 1200-13-13-.04, continued)

SERVICE	BENEFIT FOR PERSONS UNDER AGE 21	BENEFIT FOR PERSONS AGED 21 AND OLDER
		or (ii) the requested drug is not on the Prescriber Attestation List. (I) Pharmacy services in excess of five (5) prescriptions and/or refills per enrollee per month, of which no more than two (2) are brand name drugs, are non-covered services, unless (a) each excess drug is specified on the current version of the Prescriber Attestation List and a completed Prescriber Attestation is on file for each listed drug as of the date of the pharmacy service, or (b) the excess drug is specified on the Automatic Exception List of medications which shall not count against such limit. (J) Over-the-counter (OTC) drugs for TennCare adults are not covered even if the enrollee has a prescription for such service, unless the drug is listed on the "Covered OTC Drug List" that is available on the TennCare website located at www.tn.gov/tenncare on the date of service.
26. Physical Therapy [defined at 42 C.F.R. § 440.110(a)].	Covered as medically necessary, by a Licensed Physical Therapist, to restore, improve, stabilize or ameliorate impaired functions,	Covered as medically necessary, by a Licensed Physical Therapist, to restore, improve, or stabilize impaired functions.
27. Physician Inpatient Services [defined at 42 C.F.R. § 440.50].	Covered as medically necessary.	Covered as medically necessary.
28. Physician Outpatient Services/Community Health Clinics/Other Clinic Services [defined at 42 C.F.R. § 440.20(b), 42 C.F.R. § 440.50, and 42 C.F.R. § 440.90].	Covered as medically necessary. Services provided by a Primary Care Provider when the enrollee has a primary behavioral health diagnosis (ICD-9-CM 290.xx-319.xx) are the responsibility of the MCO. Medical evaluations provided by a neurologist, as approved by the MCO, and/or an emergency room provider to establish a primary behavioral health diagnosis are the responsibility of the MCO.	Covered as medically necessary. Services provided by a Primary Care Provider when the enrollee has a primary behavioral health diagnosis (ICD-9-CM 290.xx-319.xx) are the responsibility of the MCO. Medical evaluations provided by a neurologist, as approved by the MCO, and/or an emergency room provider to establish a primary behavioral health diagnosis are the responsibility of the MCO.
29. Private Duty Nursing [defined at 42 C.F.R. § 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	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

(Rule 1200-13-13-.04, continued)

SERVICE	BENEFIT FOR PERSONS UNDER AGE 21	BENEFIT FOR PERSONS AGED 21 AND OLDER
	licensed practical nurse (L.P.N.) who is not an immediate relative. Prior authorization required, as described in Paragraph (6) of this rule.	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 required. Prior authorization required, as described in Paragraph (6) of this rule.
30. Prosthetic Devices [defined at 42 C.F.R. § 440.120(c)].	Covered as medically necessary.	Covered as medically necessary.
31. Psychiatric Inpatient Facility Services [defined at 42 C.F.R. § 441, Subparts C and D and including services for persons of all ages].	Covered as medically necessary, Preadmission and concurrent reviews by the MCC are allowed.	Covered as medically necessary, Preadmission and concurrent reviews by the MCC are allowed.
32. Psychiatric Pharmacy.	See “Pharmacy Services.”	See “Pharmacy Services.”
33. Psychiatric Rehabilitation Services [defined as psychiatric services delivered in accordance with 42 C.F.R. § 440.130(d)].	Covered as medically necessary.	Covered as medically necessary.
34. Psychiatric Physician Inpatient Services [defined at 42 C.F.R. § 440.50].	Covered as medically necessary.	Covered as medically necessary.
35. Psychiatric Physician Outpatient Services.	See “Outpatient Mental Health Services.”	See “Outpatient Mental Health Services.”
36. Psychiatric Residential Treatment Services [defined at 42 C.F.R. § 483.352] and including services for persons of all ages].	Covered as medically necessary.	Covered as medically necessary.
37. Reconstructive Breast Surgery [defined in accordance with Tenn. Code Ann. § 56-7-2507].	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	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

(Rule 1200-13-13-.04, continued)

SERVICE	BENEFIT FOR PERSONS UNDER AGE 21	BENEFIT FOR PERSONS AGED 21 AND OLDER
	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.	occurs within five (5) years of the date the reconstructive breast surgery was performed on a diseased breast.
38. Rehabilitation Services.	See "Occupational Therapy," and "Physical Therapy," and "Speech Therapy," and "Inpatient Rehabilitation Facility Services."	See "Occupational Therapy," "Physical Therapy," and "Speech Therapy."
39. Renal Dialysis Clinic Services [defined at 42 C.F.R. § 440.90].	Covered as medically necessary. Generally limited to the beginning ninety (90) day period prior to the enrollee's becoming eligible for coverage by the Medicare program.	Covered as medically necessary. Generally limited to the beginning ninety (90) day period prior to the enrollee's becoming eligible for coverage by the Medicare program.
40. Speech Therapy [defined at 42 C.F.R. § 440.110(c)].	Covered as medically necessary, by a Licensed Speech Therapist to restore, improve, stabilize or ameliorate impaired functions.	Covered as medically necessary, as long as there is continued medical progress, by a Licensed Speech Therapist to restore speech after a loss or impairment.
41. Transportation.	See "Emergency Air and Ground Transportation," "Non-Emergency Ambulance Transportation," and "Non-Emergency Transportation."	See "Emergency Air and Ground Transportation," "Non-Emergency Ambulance Transportation," and "Non-Emergency Transportation."
42. Vision Services [defined as services to treat conditions of the eyes].	Preventive, diagnostic, and treatment services (including eyeglasses) covered as medically necessary.	Medical eye care, meaning evaluation and management of abnormal conditions, diseases, and disorders of the eye (not including evaluation and treatment of the refractive state) is 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 are not covered. One pair of cataract glasses or lenses is covered for adults following cataract surgery.

(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.

(Rule 1200-13-13-.04, continued)

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

6. Nonprescription drugs.

7. 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 his designee.

8. 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.

9. Buprenorphine products for opiate addiction treatment for persons aged 21 and older are restricted as follows:

   (i) Dosage shall not exceed sixteen milligrams (16 mg) per day for a period of up to six (6) months from the initiation of therapy.

   (ii) For enrollees who are pregnant while receiving the sixteen milligrams (16 mg) per day dosage, the six-month period does not begin until the enrollee is no longer pregnant.

   (iii) At the end of the six-month period described in subparts (i) and (ii), the covered dosage amount shall not exceed eight milligrams (8 mg) per day.

10. Sedative hypnotic medications for persons aged 21 and older shall not exceed fourteen (14) pills per month for sedative hypnotic formulations in pill form such as Ambien and Lunesta, one hundred forty milliliters (140 ml) per month of chloral hydrate, or one (1) bottle every sixty (60) days of Zolpimist.

11. Allergy medications.

12. Opioid products for persons aged twenty-one (21) and older are restricted as follows:

   (i) "Chronic opioid user" means:

      (I) A TennCare enrollee whose TennCare paid claims data demonstrates that he has received at least a ninety (90) day quantity of prescribed opioids in the one hundred eighty (180) day period immediately preceding the opioid's prescription date.

      (II) For a TennCare enrollee who has not been enrolled in TennCare long enough to demonstrate that he is a chronic opioid user as

defined in Item (I), the enrollee may demonstrate that he has received at least a ninety (90) day quantity of prescribed opioids in the one hundred eighty (180) day period immediately preceding the opioid's prescription date by supplying paid claims data and medical records from his previous healthcare provider(s) or health insurer(s).

(ii) "Non-chronic opioid user" means a TennCare enrollee whose TennCare paid claims data demonstrates he has received less than a ninety (90) day quantity of prescribed opioids in the one hundred eighty (180) day period immediately preceding the opioid's prescription date.

(iii) Non-chronic opioid users shall be eligible to receive covered prescription opioid products as follows:

(I) A maximum of fifteen (15) dosage days in any six (6) month period; and

(II) Daily dosage shall not exceed sixty (60) morphine milligram equivalents (MME) per day.

(iv) The restrictions in Subpart (iii) do not apply for enrollees with severe cancer pain undergoing active or palliative cancer treatment and enrollees in hospice and palliative care.

(v) The following considerations apply for enrollees who experience more frequent or aggressive pain episodes due to these specific clinical disease states:

(I) Enrollees with Sickle Cell may receive up to forty-five (45) days of sixty (60) MME per day in any ninety (90) day period; and

(II) Severe burn victims may receive up to forty-five (45) days of sixty (60) MME per day in any ninety (90) day period.

(vi) Notwithstanding the restrictions in Subpart (iii), enrollees residing in a Medicaid-certified Nursing Facility may receive up to forty-five (45) days of sixty (60) MME per day in any ninety (90) day period.

(vii) Opioid prescriptions are subject to prior authorization following the first fill of a new opioid prescription.

(viii) For women of child-bearing age (between the ages of fifteen (15) and forty-four (44)) and ability, when prior authorization is required for an opioid prescription, the prescribing provider must submit information to the enrollee's PBM regarding the enrollee's pregnancy status and use of contraception or family planning methods, and the provision of counseling regarding the risks of becoming pregnant while receiving opioid medication. The information regarding pregnancy status and contraceptive use may, when appropriate, be based on self-reporting by the patient.

(d) The MCC shall be allowed to provide cost effective alternative services as defined in paragraph 1200-13-13-.01(30). Cost effective alternative services are not reimbursable in any circumstances other than those described in that paragraph.

(2) Use of Cost Effective Alternative Services.

(Rule 1200-13-13-.04, continued)

(a) MCCs shall be allowed, but are not required, to use cost effective alternative services if and only if:

1. These services are listed in the MCC contract and/or in Policy BEN 08-001; or

2. These services are provided under the CHOICES program for individuals enrolled in the CHOICES program in accordance with Rule 1200-13-01-.05 or the ECF CHOICES program for individuals enrolled in the ECF CHOICES program in accordance with Rule 1200-13-01-.31; and

3. They are medically appropriate and cost effective.

(b) Use of approved cost effective alternative services is made at the sole discretion of the MCC.

(3) Emergency Medical Services.

Emergency Medical Services shall be available twenty-four (24) hours per day, seven (7) days per week. Coverage of emergency medical services shall not be subject to prior authorization by the managed care organization but may include a requirement that notice be given to the MCC of use of out-of-plan emergency services. However, such notice requirements shall provide at least a 24-hour time frame after the emergency for notice to be given to the MCC.

(4) Hospital Discharges.

Hospital discharges of mothers and newborn babies following delivery shall take into consideration the following guidelines:

(a) The decision to discharge postpartum mothers and newborns less than 24-48 hours after delivery should be made based upon discharge criteria collaboratively developed and adopted by obstetricians, pediatricians, family practitioners, delivery hospitals, and health plans. The criteria must be contingent upon appropriate preparation, meeting in hospital criteria for both mother and baby, and the planning and implementation of appropriate follow-up. An individualized plan of care must include identification of a primary care provider for both mother and baby and arrangements for follow-up evaluation of the newborn.

Length of hospital stay is only one factor to consider when attempting to optimize patient outcomes for postpartum women and newborns. Excellent outcomes are possible even when length of stay is very brief (less than 24 hours) if perinatal health care is well planned, allows for continuity of care, and patients are well chosen. Some postpartum patients and/or newborns may require extended hospitalization (greater than 48-72 hours) despite meticulous care due to medical, obstetric, or neonatal complications. The decision for time of discharge must be individualized and made by the physicians caring for the mother-baby pair. The following guidelines have been developed to aid in the identification of postpartum mothers and newborns who may be candidates for discharge prior to 24-48 hours. The guidelines also provide examples where discharge is inappropriate.

Principles of patient care should be based upon data obtained by clinical research. Regarding the question of postpartum and newborn length of hospitalization, there are inadequate studies available to provide clear direction for clinical decision-making. Clinical guidelines represent an attempt to conceptualize what is, in reality, a dynamic process of health care refinement. Review of these guidelines is desirable and expected.

No provider shall be denied participation, reimbursement or reduction in reimbursement within a network solely related to his/her compliance with the "Guidelines for Discharge of Postpartum Mothers and Newborns."

(b) Guidelines for Discharge of Postpartum Mothers and Newborns.

1. Discharge Planning.

(i) Discharge planning should occur in a planned and systematic fashion for all postpartum women and newborns in order to enhance care, prevent complications and minimize the need for rehospitalization. Prior to discharge a discussion should be held between the physician or another health care provider and the mother (and father if possible) about any expected perinatal problems and ways to cope with them. Plans for future and immediate care as well as instructions to follow in the event of an emergency or complication should be discussed.

(ii) Follow-up care must be planned for both mother and baby at the time of discharge. For patients leaving the hospital prior to 24-48 hours, contact within 48-72 hours of discharge is recommended and may include appropriate follow-up within 48-72 hours as deemed necessary by the attending provider, depending upon individual patient need. This follow-up visit will be acknowledged as a provider encounter.

(I) Maternal Considerations:

I. Prior to discharge, the patient should be informed of normal postpartum events including but not limited to:

A. Lochial patterns;

B. Range of activity and exercise;

C. Breast care;

D. Bladder care;

E. Dietary needs;

F. Perineal care;

G. Emotional responses;

H. What to report to physician or other health care provider including:

(A) Elevation of temperature,

(B) Chills,

(C) Leg pains, and

(D) Increased vaginal bleeding.

I. Method of contraception;

J. Coitus resumption; and

K. Specific instructions for follow-up (routine and emergent)

(II) Neonatal Considerations:

I. Prior to discharge, the following points should be reviewed with the mother or, preferably, with both parents:

A. Condition of the neonate;

B. Immediate needs of the neonate, (e.g., feeding methods and environmental supports);

C. Instructions to follow in the event of a newborn complication or emergency;

D. Feeding techniques;

E. Skin care, including cord care and genital care;

F. Temperature assessment and measurement with the thermometer; and

G. Assessment of neonatal well-being;

H. Recognition of illness including jaundice;

I. Proper infant safety including use of car seat and sleeping position;

J. Reasonable expectations for the future; and

K. Importance of maintaining immunization begun with initial dose of hepatitis B vaccine.

2. Criteria for Maternal Discharge Less Than 24-48 Hours Following Delivery.

(i) Prior to discharge of the mother, the following should occur:

(I) The mother should have been observed after delivery for a sufficient time to ensure that her condition is stable, that she has sufficiently recovered and may be safely transferred to outpatient care.

(II) Laboratory evaluations should be obtained and include ABO blood group and Rh typing with appropriate use of Rh immune globulin; and hematocrit or hemoglobin.

(III) The mother should have received adequate preparation for and be able to assume self and immediate neonatal care.

(ii) Factors which may exclude maternal discharge prior to 24-48 hours include:

(I) Abnormal bleeding.

(II) Fever equal to or greater than 100.4 degrees.

(III) Inadequate or no prenatal care.

(IV) Cesarean section.

(V) Untreated or unstable maternal medical condition.

(VI) Uncontrolled hypertension.

(VII) Inability to void.

(VIII) Inability to tolerate solid foods.

(IX) Adolescent mother without adequate support and where appropriate follow-up has not been established. A nurse home visit within 24-48 hours of discharge would act as appropriate follow-up.

(X) All efforts should be made to keep mother and infant together to ensure simultaneous discharge.

(XI) Psychosocial problems (maternal or family) which have been identified prenatally or in hospital. Where appropriate follow-up has not been established, a nurse home visit within 24-48 hours of discharge would act as appropriate follow-up.

3. Criteria for Neonatal Discharge Less than 24-48 Hours Following Delivery.

The nursery stay is planned to allow the identification of early problems and to reinforce instruction in preparation for care of the infant at home. Complications often are not predictable by prenatal and intrapartum events. Because many neonatal problems do not become apparent until several days after birth there is an element of medical risk in early neonatal discharge. Most problems are manifest during the first 12 hours, and discharge at or prior to 24 hours is appropriate for many newborns.

(i) Prior to discharge of the newborn at 24-48 hours, the following should have occurred:

(I) The course of antepartum, intrapartum, and postpartum care for both mother and fetus should be without problems, which may lead to newborn complications.

(II) The baby is a single birth at 37 to 42 weeks' gestation and the birth weight is appropriate for gestational age according to appropriate intrauterine growth curves.

(III) The baby's vital signs are documented as being normal and stable for the 12 hours preceding discharge, including a respiratory rate below 60/minute, a heart rate of 100 to 160 beats per minute, and an axillary temperature of 36.1 degrees C in an open crib with appropriate clothing.

(IV) The baby has urinated and passed at least one stool.

(Rule 1200-13-13-.04, continued)

(V) No evidence of excessive bleeding after circumcision greater than 2 hours.

(VI) The baby has completed at least two successful feedings, with documentation that the baby is able to coordinate sucking, swallowing, and breathing while feeding.

(VII) No evidence of significant jaundice in the first 24 hours of life.

(VIII) The parent's or caretaker's knowledge, ability, and confidence to provide adequate care for her baby are documented.

(IX) Laboratory data are available and reviewed including:

I. Maternal syphilis and hepatitis B surface antigen status.

II. Cord or infant blood type and direct Coomb's test result as clinically indicated.

(X) Screening tests are performed in accordance with state regulations. If the test is performed before 24 hours of milk feeding, a system for repeating the test must be assured during the follow-up visit.

(XI) Initial hepatitis B vaccine is administered or a scheduled appointment for its administration has been made.

(XII) A physician-directed source of continuing medical care for both the mother and the baby is identified. For newborns discharged less than 24-48 hours after delivery, a definitive plan for contact within 48-72 hours after discharge has been made. A nurse home visit within 24-48 hours would be considered appropriate follow-up.

(ii) Maternal factors which may exclude discharge of the newborn prior to 24-48 hours include:

(I) Inadequate or no prenatal care,

(II) Medical conditions that pose a significant risk to the infant,

(III) Group B streptococcus colonization,

(IV) Untreated syphilis,

(V) Suspected active genital herpes,

(VI) HIV,

(VII) Adolescent without adequate support and where appropriate follow-up has not been established (a nurse home visit within 24-48 hours of discharge will act as appropriate follow-up),

(VIII) Mental retardation or psychiatric illness, and

(IX) Requirements for continued maternal hospitalization.

(Rule 1200-13-13-.04, continued)

(iii) Newborn factors which may exclude discharge of the newborn prior to 24-48 hours include:

(I) Preterm gestation (less than 37 weeks);

(II) Small for gestational age;

(III) Large for gestational age;

(IV) Abnormal physical exam, vital signs, colors, activity, feeding or stooling;

(V) Significant congenital malformations; and

(VI) Abnormal laboratory finding:

I. Hypoglycemia,

II. Hyperbilirubinemia,

III. Polycythemia,

IV. Anemia, and

V. Rapid plasma reagin positive.

(5) Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services for TennCare Medicaid Enrollees under the Age of Twenty-One (21).

The Bureau of TennCare, through its contracts with Managed Care Organizations (MCOs) and other contractors (also referred to collectively as Contractors), operates an EPSDT program to provide health care services as required by 42 C.F.R. Part 441, Subpart B and the "Omnibus Budget Reconciliation Act of 1989" to TennCare Medicaid-eligible enrollees under the age of twenty-one (21).

(a) Responsibilities of the Bureau of TennCare.

1. The Bureau will:

(i) Keep Contractors informed as to changes to the requirements for the operation of the EPSDT program;

(ii) Make changes to TennCare policy when necessary to keep the EPSDT program in compliance with federal and state requirements;

(iii) Provide policy clarification when needed; and

(iv) Oversee the activities of the Contractors to assure compliance with all aspects of the EPSDT program.

2. The Bureau, through local health departments, shall provide information on covered services to adolescent prenatal patients who enter TennCare Medicaid through presumptive eligibility. Assistance will be offered to presumptive eligibles on the day eligibility is determined in making a timely first prenatal appointment. For a woman past her first trimester, this appointment should occur within fifteen (15) days.

3. The Bureau, through the Department of Children's Services, shall inform foster parents and institutions or other residential treatment settings with a number of eligible children, annually or more often when the need arises, including when a change of administrators, social workers, or foster parents occur, of the availability of EPSDT services.

(b) Responsibilities of Contractors.

1. Contractors shall aggressively and effectively inform TennCare Medicaid enrollees of the existence of the EPSDT program, including the availability of specific EPSDT screening and treatment services. Such informing shall occur in a timely manner, generally within sixty (60) days of the MCC's receipt of notification of the child's enrollment in its plan and if no one eligible in the family has utilized EPSDT services, at least annually thereafter.

   Contractors shall document to the Bureau the contractor's outreach activities and what efforts were made to inform TennCare Medicaid enrollees and/or the enrollee's responsible party about the availability of EPSDT services and how to access such services. All children, particularly those who have not received complete screenings timely, shall be the target of outreach efforts by the MCOs which are reasonably calculated to insure the child's participation in EPSDT. Failure to timely submit the requested data may result in liquidated damages as described in the contracts between the Bureau of TennCare and the Contractors.

2. Contractors shall use clear and non-technical terms to provide a combination of written and oral information so that the program is clearly and easily understandable.

3. Contractors shall use effective methods (developed through collaboration with agencies which have established procedures for working with such individuals) to inform TennCare Medicaid individuals who are illiterate, blind, deaf, or cannot understand English, about the availability of EPSDT services.

4. Contractors shall design and conduct outreach to inform all TennCare Medicaid-eligible individuals about what services are available under EPSDT, the benefits of preventive health care, where services are available, and how to obtain them; and that necessary transportation and scheduling assistance is available.

5. Contractors shall create a system so that TennCare Medicaid families can readily access an accurate list of names and phone numbers of contract providers who are currently accepting TennCare.

6. Contractors shall make known and offer to a TennCare Medicaid-covered child and the child's responsible party of the availability for both transportation and scheduling assistance prior to the due date of the TennCare Medicaid child's periodic examination.

7. Contractors shall provide TennCare Medicaid enrollees assistance in scheduling appointments**,** and obtaining transportation prior to the date of each periodic examination as requested and necessary.

8. Contractors shall document services declined by a parent or guardian of a TennCare Medicaid-eligible child or a mature competent child, specifying the particular service declined so that outreach and education for other EPSDT services continues.

9. Contractors shall maintain records of the efforts taken to outreach TennCare Medicaid children who have missed screening appointments when scheduled or who have failed to schedule regular check-ups. These records shall be made available to the Bureau and other parties as directed.

10. Contractors shall treat a TennCare Medicaid-eligible woman's request for EPSDT services during pregnancy as a request for EPSDT services for the child at birth. If the pregnant woman is under age twenty-one (21), she may request EPSDT services for herself.

(c) Compliance.

Contractors must document and maintain records of all outreach efforts made to inform TennCare Medicaid enrollees about the availability of EPSDT services.

(6) 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 and aides delivering prior approved home health care services may accompany an enrollee outside the home in accordance with T.C.A. § 71-5-107(a)(12).

(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

(Rule 1200-13-13-.04, continued)

(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.

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 4-5-209, 71-5-105, 71-5-109, and 71-5-197; Executive Order No. 23; and Public Chapter 473, Acts of 2011.* ***Administrative History:*** *Public necessity rule filed July 1, 2002; effective through December 13, 2002. Original rule filed September 30, 2002; to be effective December 14, 2002; however, on December 9, 2002, the House Government Operations Committee of the General Assembly stayed Rule 1200-13-13-.04; new effective date February 12, 2003. Emergency rule filed December 13, 2002; effective through May 27, 2003. Public necessity rule filed July 1, 2005; effective through December 13, 2005. Public necessity rule filed September 7, 2005; effective through February 19, 2006. Amendments filed September 29, 2005; effective December 13, 2005. Public necessity rule filed December 29, 2005; expired June 12, 2006. On June 13, 2006, affected rules reverted to status on December 28, 2005. Public necessity rule filed March 13, 2006; effective through August 25, 2006. Public necessity rules filed May 3, 2006; effective through October 15, 2006. Amendments filed March 31, 2006; effective June 14, 2006. Amendment filed June 12, 2006; effective August 26, 2006. Amendment filed July 28, 2006; effective October 11, 2006. Public necessity rule filed December 1, 2006; expires May 5, 2007. Public necessity rule filed January 26, 2007; expires July 10, 2007. Public necessity rule filed February 2, 2007; effective through July 16, 2007. Amendment filed February 2, 2007; effective April 18, 2007. Amendment filed April 25, 2007; effective July 9, 2007. Amendments filed May 2, 2007; effective July 16, 2007. Public necessity rule filed October 11, 2007; effective through March 24, 2008. Amendment filed January 8, 2008; effective March 23, 2008. Public necessity rule filed September 8, 2008; effective through February 20, 2009. Amendment filed August 19, 2008; effective November 2, 2008. Amendment filed December 5, 2008; effective February 18, 2009. Public necessity rule filed July 1, 2009; effective through December 13, 2009. Amendment filed June 11, 2009; effective August 25, 2009. Amendment filed September 11, 2009; effective December 10, 2009. Amendments filed September 25, 2009; effective December 24, 2009. Amendments filed September 30, 2009; effective December 29, 2009. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendments filed May 27, 2010; effective August 25, 2010. Amendment filed October 26, 2010; effective January 24, 2011. Emergency rules filed July 1, 2011; effective through December 28, 2011. Emergency rule filed August 2, 2011; effective through January 29, 2012. Amendments filed September 23, 2011; effective December 22, 2011. Amendment filed October 28, 2011; effective January 26, 2012. Amendment filed August 10, 2011; effective January 29, 2012. Amendment filed April 25, 2012; effective September 28, 2012. Emergency rule filed September 27, 2013; effective through March 26, 2014. Amendments filed July 1, 2013; effective September 29, 2013. Amendment filed August 7, 2013; effective November 5, 2013. Amendment filed September 27, 2013; effective December 26, 2013. Amendment filed December 17, 2013; effective March 17, 2014. Emergency rule filed September 30, 2015; effective through March 28, 2016. Amendments filed December 29, 2015; effective March 28, 2016. Emergency rules filed June 24, 2016; effective through December 21, 2016. Emergency rules filed July 1, 2016; effective through December 28, 2016. Amendments filed September 13, 2016; effective December 12, 2016. Amendments*

(Rule 1200-13-13-.04, continued)
filed September 30, 2016; effective December 29, 2016. Emergency rules filed January 16, 2018; effective through July 15, 2018. Amendments filed April 9, 2018; effective July 8, 2018. Amendments filed January 3, 2019; effective April 3, 2019. Amendments filed July 8, 2021; effective October 6, 2021. Amendments filed October 26, 2021; effective January 24, 2022.

1200-13-13-.05 ENROLLEE COST SHARING.

(1) TennCare Medicaid enrollees do not have cost sharing responsibilities for TennCare coverage and covered services, except TennCare Medicaid adults (age 21 and older) who receive pharmacy services have nominal copays for the pharmacy services. The copays are $3.00 (three dollars) for each covered branded drug and $1.50 (one dollar and fifty cents) for each covered generic drug. Branded drugs which exceed the limit of two (2) prescriptions or refills per enrollee per month are not covered. Generic drugs and covered branded drugs which exceed the limit of five (5) prescriptions or refills per enrollee per month are not covered. Family planning drugs and emergency services are exempt from copay. Enrollees may not be denied a service for inability to pay a copay. There is no Out-of-Pocket Maximum on copays.

(2) The following adult groups are exempt from copay:

(a) Individuals receiving hospice services who provide verbal notification of such to the pharmacy provider at the point of service;

(b) Individuals who are pregnant who provide verbal notification of such to the pharmacy provider at the point of service; and

(c) Individuals who are receiving services in a Nursing Facility, an Intermediate Care Facility for Individuals with Intellectual Disabilities, CHOICES Group 2, or a Home and Community Based Services waiver for individuals with intellectual disabilities.

(d) Adults age 21 and older enrolled in ECF CHOICES who meet nursing facility level of care or transitioned from a Section 1915(c) waiver into ECF CHOICES and granted an exception by TennCare based on ICF/IID level of care.

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 4-5-209, 71-5-105, and 71-5-109; Acts of 2003, Public Chapter 412, §1(c); and Executive Order No. 23.* ***Administrative History:*** *Public necessity rule filed July 1, 2002; effective through December 13, 2002. Original rule filed September 30, 2002; to be effective December 14, 2002; however, on December 9, 2002, the House Government Operations Committee of the General Assembly stayed Rule 1200-13-13-.05; new effective date February 12, 2003. Emergency rule filed December 13, 2002; effective through May 27, 2003. Amendment by Acts of 2003, Public Chapter 412, §1(c) filed and effective June 25, 2003. Public necessity rule filed July 1, 2005; effective through December 13, 2005. Amendment filed September 26, 2005; effective December 10, 2005. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendment filed May 27, 2010; effective August 25, 2010. Emergency rule filed September 26, 2013; effective through March 25, 2014. Amendment filed December 17, 2013; effective March 17, 2014. Emergency rules filed July 1, 2016; effective through December 28, 2016. Amendments filed September 30, 2016; effective December 29, 2016.*

1200-13-13-.06 MANAGED CARE ORGANIZATIONS.

Managed Care Organizations participating in TennCare will be limited to Health Maintenance Organizations that are appropriately licensed to operate within the state of Tennessee to provide medical, behavioral, and long-term care services in the TennCare program. Managed Care Organizations shall have a fully executed contract with the Tennessee Department of Finance and Administration. MCOs, DBMs and PBMs shall agree to comply with all applicable rules, policies, and contract requirements as specified by the Tennessee Department of Finance and Administration as applicable. Managed Care

(Rule 1200-13-13-.06, continued)

Organizations must continually demonstrate a sufficient provider network based on the standards set by the Bureau of TennCare to remain in the program and must reasonably meet all quality of care requirements established by the Bureau of TennCare.

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 71-5-105, and 71-5-109 and Executive Order No. 23.* ***Administrative History:*** *Public necessity rule filed July 1, 2002; effective through December 13, 2002. Original rule filed September 30, 2002; to be effective December 14, 2002; however, on December 9, 2002, the House Government Operations Committee of the General Assembly stayed Rule 1200-13-13-.06; new effective date February 12, 2003. Emergency rule filed December 13, 2002; effective through May 27, 2003. Amendment filed September 25, 2009; effective December 24, 2009. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendment filed May 27, 2010; effective August 25, 2010.*

1200-13-13-.07 MANAGED CARE ORGANIZATION PAYMENT.

Managed care organizations will be paid pursuant to the contract the MCO has fully executed with the Tennessee Department of Finance and Administration.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, and 71-5-109 and Executive Order No. 23.* ***Administrative History:*** *Public necessity rule filed July 1, 2002; effective through December 13, 2002. Original rule filed September 30, 2002; to be effective December 14, 2002; however, on December 9, 2002, the House Government Operations Committee of the General Assembly stayed Rule 1200-13-13-.07; new effective date February 12, 2003. Emergency rule filed December 13, 2002; effective through May 27, 2003.*

1200-13-13-.08 PROVIDERS.

(1) Payment in full.

(a) All Participating Providers, as defined in this Chapter, must accept as payment in full for provision of covered services to TennCare enrollees, the amounts paid by the MCC plus any copayment required by the TennCare Program to be paid by the individual.

(b) Any Non-Participating Providers who provide TennCare Program covered services by authorization from an MCC must accept as payment in full for provision of covered services to TennCare enrollees, the amounts paid by the MCC plus any copayment required by the TennCare Program to be paid by the individual.

(c) Any Non-Participating Provider, as defined in this Chapter, who provides TennCare Program covered non-emergency services to TennCare enrollees without authorization from the enrollee's MCC does so at his own risk. He may not bill the patient for such services except as provided for in Rule 1200-13-13-.08(5).

(d) Any Out-of-State Emergency Provider, as defined in this Chapter, who provides covered emergency services to TennCare enrollees in accordance with this Chapter must accept as payment in full the amounts paid by the MCC plus any copayment required by the TennCare Program.

(2) Non-Participating Providers.

(a) In situations where a MCC authorizes a service to be rendered by a provider who is not a Participating Provider with the MCC, as defined in this Chapter, payment to the provider shall be no less than eighty percent (80%) of the lowest rate paid by the MCC to equivalent participating network providers for the same service.

(b) Covered medically necessary outpatient emergency services, when provided to Medicaid managed care enrollees by non-contract hospitals in accordance with Section

(Rule 1200-13-13-.08, continued)

1932(b)(2)(D) of the Social Security Act (42 U.S.C.A. § 1396u-2(b)(2)(D)), shall be reimbursed at seventy-four percent (74%) of the 2006 Medicare rates for these services. 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 Medicaid managed care enrollees by non-contract hospitals in accordance with Section 1932(b)(2)(B) of the Social Security Act (42 U.S.C.A. § 1396u-2(b)(2)(B)), shall be reimbursed at 57 percent of the 2008 Medicare Diagnostic Related Groups (DRG) rates (excluding Medical Education and Disproportionate Share components) determined in accordance with 42 C.F.R. § 412 for those services. For DRG codes that are adopted after 2008, 57 percent of the rate from the year of adoption will apply. Such an inpatient stay will continue until no longer medically necessary or until the patient can be safely transported to a contract hospital or to another contract service, whichever comes first.

(d) Non-Participating Providers who furnish covered CHOICES services are reimbursed in accordance with Rule 1200-13-01-.05.

(e) Non-Participating Providers who furnish covered ECF CHOICES services are reimbursed in accordance with Rule 1200-13-01-.31.

(3) Participation in the TennCare program will be limited to providers who:

(a) Accept, as payment in full, the amounts paid by the managed care contractor, including copays from the enrollee, or the amounts paid in lieu of the managed care contractor by a third party (Medicare, insurance, etc.);

(b) Maintain Tennessee, or the State in which they practice, medical licenses and/or certifications as required by their practice, or licensure by the TDMHDD, if appropriate;

(c) Are not under a federal Drug Enforcement Agency (DEA) restriction of their prescribing and/or dispensing certification for scheduled drugs (relative to physicians, osteopaths, dentists and pharmacists);

(d) Agree to maintain and provide access to TennCare and/or its agent all TennCare enrollee medical records for five (5) years from the date of service or upon written authorization from TennCare following an audit, whichever is shorter;

(e) Provide medical assistance at or above recognized standards of practice; and

(f) Comply with all contractual terms between the provider and the managed care contractor and TennCare policies as outlined in federal and state rules and regulations and TennCare provider manuals and bulletins.

(g) Failure to comply with any of the above provisions (a) through (f) may subject a provider to the following actions:

1. Sanctions set out in T.C.A. § 71-5-118. In addition, the provider may be subject to stringent review/audit procedures, which may include clinical evaluation of services and a prepayment requirement for documentation and justification for each claim.

2. The Bureau of TennCare may withhold or recover payments to managed care contractors in cases of provider fraud, willful misrepresentation, or flagrant non-compliance with contractual requirements and/or TennCare policies.

(Rule 1200-13-13-.08, continued)

3. The Bureau of TennCare may refuse to approve or may suspend provider participation with a provider if any person who has an ownership or controlling interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the U.S. Title XX Services Program.

4. The Bureau of TennCare may refuse to approve or may suspend provider participation if it determines that the provider did not fully and accurately make any disclosure of any person who has ownership or controlling interest in the provider, or is an agent or managing employee of the provider and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the U.S. Title XX Services Program since the inception of these programs.

5. The Bureau of TennCare shall refuse to approve or shall suspend provider participation if the appropriate State Board of Licensing or Certification fails to license or certify the provider at any time for any reason or suspends or revokes a license or certification.

6. The Bureau of TennCare shall refuse to approve or shall suspend provider participation upon notification by the U.S. Office of Inspector General Department of Health and Human Services that the provider is not eligible under Medicare or Medicaid for federal financial participation.

7. The Bureau of TennCare may recover from a managed care contractor any payments made by an enrollee and/or his family for a covered service, in total or in part, except as permitted. If a provider knowingly bills an enrollee and/or his family for a covered service, in total or in part, except as permitted, the Bureau of TennCare may terminate the provider's participation in TennCare.

(4) Solicitations and Referrals.

(a) Managed care contractors and providers shall not solicit TennCare enrollees by any method offering as enticements other goods and services (free or otherwise) for the opportunity of providing the enrollee with TennCare covered services that are not medically necessary and/or that overutilize the TennCare program.

(b) A managed care contractor may request a waiver from this restriction in writing to TennCare. TennCare shall determine the value of a waiver request based upon the medical necessity and need for the solicitation. The managed care contractor may implement the solicitation only upon receipt of a written waiver approval from TennCare. This waiver is not transferable and may be canceled by TennCare upon written notice.

(c) TennCare payments for services related to a non-waivered solicitation enticement shall be considered by TennCare as a non-covered service and recouped. Neither the managed care contractor nor the provider may bill the enrollee for non-covered services recouped under this authority.

(d) A provider shall not offer or receive remuneration in any form related to the volume or value of referrals made or received from or to another provider.

(5) Providers may seek payment from a TennCare enrollee only under the following circumstances. These circumstances apply to all TennCare providers, as defined in this Chapter, including those who are Out-of-Network Providers in a particular enrollee's MCC.

(Rule 1200-13-13-.08, continued)

These circumstances include situations where the enrollee may choose to seek an out-of-network provider for a specific covered service.

(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.

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

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

(b) The claim(s) submitted to TennCare or the enrollee's managed care contractor for payment was/were denied due to provider billing error or a TennCare claim processing error.

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

(d) The provider failed to comply with TennCare 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 managed care contractor or TennCare.

(f) The provider failed to ascertain the existence of TennCare eligibility or pending eligibility prior to providing non-emergency services. Even if the enrollee presents another form of insurance, the provider must determine whether the patient is covered under TennCare.

(g) The provider failed to inform the enrollee prior to providing a service not covered by TennCare 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. Notwithstanding this exemption, providers shall remain obligated to provide notice to enrollees who have exceeded benefit limits in accordance with Rule 1200-13-13-.11.

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

(i) The provider is a TennCare Provider, as defined in this Chapter, but is not participating with a particular enrollee's MCC and is seeking to bill the enrollee as though the provider were a Non-TennCare Provider, as defined in this Chapter.

(7) Providers may seek payment from a person whose TennCare eligibility is pending at the time services are provided if the provider informs the person that TennCare assignment will not be accepted whether or not eligibility is established retroactively.

(8) Providers may seek payment from a person whose TennCare eligibility is pending at the time services are provided. Providers may bill such persons at the provider's usual and customary rate for the services rendered. However, all monies collected for TennCare-covered services rendered during a period of TennCare eligibility must be refunded when a claim is submitted to TennCare if the provider agreed to accept TennCare assignment once retroactive TennCare eligibility was established.

(Rule 1200-13-13-.08, continued)

(9) Providers of inpatient hospital services, outpatient hospital services, skilled nursing facility services, independent laboratory and x-ray services, hospice services, and home health agencies must be approved for Title XVIII-Medicare in order to be certified as providers under the TennCare Program; in the case of hospitals, the hospital must meet state licensure requirements and be approved by TennCare as an acute care hospital as of the date of enrollment in TennCare. Children's hospitals and State mental hospitals may participate in TennCare without having been Medicare approved; however, the hospital must be approved by the Joint Commission for Accreditation of Health Care Organizations as a condition of participation.

(10) Pharmacy providers may not waive pharmacy copayments for TennCare Standard 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.

(11) Providers shall not deny services for a Medicaid enrollee's failure to make copayments.

(12) All claims must be filed in accordance with the following:

(a) Claims filed with an MCC must be submitted in accordance with the requirements and timeframes set forth in the MCC's contract.

(b) All other fee-for-service claims for services delivered outside of the TennCare managed care program must be filed with the Bureau of TennCare as follows:

1. All claims must be filed within one (1) year of the date of service except in the following circumstances:

(i) Recipient eligibility was determined retroactively to the extent that filing within one (1) year was not possible. In such situations, claims must be filed within one (1) year after final determination of eligibility.

(ii) If a claim filed with Medicare on a timely basis does not automatically cross over from the Medicare carrier to the Bureau, a TennCare claim may be filed within six (6) months of notification of payment or denial from Medicare.

2. Should an original claim be denied, any resubmission or follow-up of the initial claim must be received within six (6) months from the date the original claim was filed. The Bureau will not process submissions received after the six (6) month time limit. The one exception is those claims returned due to available third party coverage. These claims must be submitted within sixty (60) days of notice from the third party resource.

3. Should a correction document involving a suspended claim be sent to the provider, the claim will be denied if the correction document is not completed by the provider and returned to the Bureau within ninety (90) days from the date on the document.

4. If claim is not filed within the above timeframes, no reimbursement may be made.

5. Claims will be paid on a first claim approved - first claim paid basis.

6. The Bureau will not reimburse providers for services for which there is no Federal Financial Participation.

(Rule 1200-13-13-.08, continued)

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 4-5-209, 71-5-105, 71-5-109, and 71-5-134; Acts of 2003, Public Chapter 412, §1(c); and Executive Order No. 23.* ***Administrative History:*** *Public necessity rule filed July 1, 2002; effective through December 13, 2002. Original rule filed September 30, 2002; to be effective December 14, 2002; however, on December 9, 2002, the House Government Operations Committee of the General Assembly stayed Rule 1200-13-13-.08; new effective date February 12, 2003. Emergency rule filed December 13, 2002; effective through May 27, 2003. Amendment by Acts of 2003, Public Chapter 412, §1(c) filed and effective June 25, 2003. Amendment filed October 12, 2004; effective December 26, 2004. Public necessity rule filed July 29, 2005; effective through January 10, 2006. Public necessity rule filed December 29, 2005; expired June 12, 2006. On June 13, 2006, affected rules reverted to status on December 28, 2005. Amendment filed October 27, 2005; effective January 10, 2006. Amendment filed March 31, 2006; effective June 14, 2006. Public necessity rule filed September 8, 2008; effective through February 20, 2009. Amendment filed December 5, 2008; effective February 18, 2009. Amendment filed February 25, 2009; effective May 11, 2009. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendment filed May 27, 2010; effective August 25, 2010. Emergency rule filed September 3, 2010; effective through March 2, 2011. Amendment filed December 2, 2010 to have been effective March 2, 2011 was stayed by the Government Operations Committee on March 2, 2011; new effective date March 29, 2011. Emergency rules filed July 1, 2016; effective December 28, 2016. Amendments filed September 30, 2016; effective December 29, 2016.*

1200-13-13-.09 THIRD PARTY RESOURCES.

(1) Individuals applying for TennCare Medicaid or TennCare Standard coverage shall disclose the availability of any third party health care coverage to the agency responsible for determining the individual's eligibility for TennCare.

(2) An individual enrolled in TennCare Medicaid or TennCare Standard shall disclose access to third party resources to his/her specified Managed Care Contractors as soon as s/he becomes aware of the existence of any third party resources.

(3) Managed Care Contractors under contract with the Tennessee Departments of Finance and Administration or Mental Health and Developmental Disabilities shall provide all third party resource information obtained from the plan's enrollees to the Bureau of TennCare on a regular basis as required by their contracts.

(4) Managed Care Contractors shall enforce TennCare subrogation rights pursuant to T.C.A. § 71-5-117.

(5) Managed Care Contractors may pay health insurance premiums for their enrollees if such payments are determined by the Bureau to be cost effective.

(6) TennCare shall be the payor of last resort, except where contrary to federal or state law.

(7) Asset Disregards for Qualifying Long Term Care Insurance Policies:

(a) Individuals who purchase a qualified long term care insurance policy may have certain assets disregarded in the determination of eligibility for TennCare Medicaid. The Department of Human Services (DHS) shall disregard an individual's assets up to the amount of payments made by the individual's qualifying long-term care insurance policy for services covered under the policy at the time of TennCare application.

(b) The amount of the individual's assets properly disregarded under these provisions shall continue to be disregarded through the lifetime of the individual.

(c) Assets which were disregarded for purposes of Medicaid eligibility determination during the person's lifetime are also protected from estate recovery. When the amount of

(Rule 1200-13-13-.09, continued)

assets disregarded during the person's lifetime was less than total benefits paid by the qualified long term care insurance policy, additional assets may be protected in the estate recovery process up to the amount of payments made by the individual's qualifying long term care policy for services covered under the policy. If no assets were disregarded during the person's lifetime, the personal representative may designate assets to protect from estate recovery up to the lesser of the two options specified above, even if a qualified long term care policy's benefits were not completely exhausted.

(8) Upon enrollment in TennCare Medicaid or TennCare Standard an individual assigns to the Bureau any rights to third party insurance benefits to which the individual may be entitled.

(9) Upon accepting medical assistance, an enrollee in TennCare Medicaid or TennCare Standard shall be deemed to have made an assignment to the Bureau of the right to third party insurance benefits to which the enrollee may be entitled.

(10) The Bureau shall utilize direct billing when it is determined that a previously paid service may have been covered by a third party.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109, and 71-5-117 and Executive Order No. 23.* ***Administrative History:*** *Public necessity rule filed July 1, 2002; effective through December 13, 2002. Original rule filed September 30, 2002; to be effective December 14, 2002; however, on December 9, 2002, the House Government Operations Committee of the General Assembly stayed Rule 1200-13-13-.09; new effective date February 12, 2003. Emergency rule filed December 13, 2002; effective through May 27, 2003. Amendment filed February 18, 2009; effective May 4, 2009. Amendment filed January 15, 2013; effective April 15, 2013.*

1200-13-13-.10 EXCLUSIONS.

(1) General exclusions. The following items and services shall not be considered covered services by TennCare:

(a) Provision of medical assistance which is outside the scope of benefits as defined in these rules.

(b) Provision of services to persons who are not enrolled in TennCare, either on the date the services are delivered or retroactively to the date the services are delivered.

(c) Services for which there is no Federal Financial Participation (FFP).

(d) Services provided outside the United States or its territories.

(e) Services provided outside the geographic borders of Tennessee, including transportation to return to Tennessee to receive medical care except in the following circumstances:

1. Emergency medical services are needed because of an emergency medical condition;

2. Non-emergency urgent care services are requested because the recipient's health would be endangered if he were required to travel, but only upon the explicit prior authorization of the MCC;

3. The covered medical service would not be readily available within Tennessee if the enrollee was physically located in Tennessee at the time of need and the covered service is explicitly prior authorized by the enrollee's TennCare MCC; or

4. The out-of-state provider is participating in the enrollee's MCC network.

(f) Investigative or experimental services or procedures including, but not limited to:

1. Drug or device that lacks FDA approval except when medically necessary as defined by TennCare;

2. Drug or device that lacks approval of facility's Institutional Review Board;

3. Requested treatment that is the subject of Phase I or Phase II clinical trials or the investigational arm of Phase III clinical trials; or

4. A requested service about which prevailing opinion among experts is that further study is required to determine safety, efficacy, or long-term clinical outcomes of requested service.

(g) Services which are delivered in connection with, or required by, an item or service not covered by TennCare, including the transportation to receive such non-covered services, except that treatment of conditions resulting from the provision of non-covered services may be covered if medically necessary, notwithstanding the exclusions set out herein.

(h) Items or services furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury.

(i) Non-emergency services that are ordered or furnished by an out-of-network provider and that have not been approved by the enrollee's MCC. An exception exists for dually eligible enrollees. In-network care ordered by out-of-network providers is covered for dually eligible enrollees unless the MCO has informed such enrollee in advance of a request for a service that the specific service requires prior authorization and an order from an in-network provider.

(j) Services that are free to the public, with the exception of services delivered in the schools pursuant to the Individuals with Disabilities in Education Act (IDEA).

(k) Items or services ordered, prescribed, administered, supplied, or provided by an individual or entity that has been excluded from participation in the Medicaid program under the authority of the United States Department of Health and Human Services or the Bureau of TennCare.

(l) Items or services ordered, prescribed, administered, supplied, or provided by an individual or entity that is not licensed by the appropriate licensing board.

(m) Items or services outside the scope and/or authority of a provider's specialty and/or area of practice.

(n) Items or services to the extent that Medicare or a third party payer is legally responsible to pay or would have been legally responsible to pay except for the enrollee's or the treating provider's failure to comply with the requirements for coverage of such services.

(o) Medical services for inmates confined in a local, state, or federal prison, jail, or other penal or correctional facility, including a furlough from such facility.

(Rule 1200-13-13-.10, continued)

(p) Services delivered by a specific provider, even a provider who is an in-network provider with the enrollee's managed care plan, when the managed care plan has offered the enrollee the services of a qualified provider who is available to provide the needed services.

(q) Items or services that are not covered by Medicare or a third party payer for an individual enrollee because the item or service is essentially equivalent to a Medicare or third party payer service that is being covered (e.g., home health services for individuals receiving hospice care).

(2) Exception to General and Specific Exclusions: COST EFFECTIVE ALTERNATIVE. As approved by CMS and/or authorized by Policy BEN 08-001, each MCC has sole discretionary authority to provide certain cost effective alternatives when providing appropriate medically necessary care. These services are otherwise excluded and are not covered services unless the MCC has followed the procedures set forth in Policy BEN 08-001 and opts at its sole discretion to provide such requested item or service.

(3) Specific exclusions. The following services, products, and supplies are specifically excluded from coverage under the TennCare Section 1115 waiver program unless excepted by paragraph (2) herein. Some of these services may be covered under the CHOICES or ECF CHOICES programs or outside the managed care program under a Section 1915(c) Home and Community Based Services waiver when provided as part of an approved plan of care, in accordance with the appropriate approved TennCare Home and Community Based Services waiver.

(a) Services, products, and supplies that are specifically excluded from coverage except as medically necessary for children under the age of 21:

1. Audiological therapy or training

2. Beds and bedding equipment as follows:

(i) Powered air flotation beds, air fluidized beds (including Clinitron beds), water pressure mattress, or gel mattress

For persons age 21 and older: Not covered unless a member has both severely impaired mobility (i.e., unable to make independent changes in body position to alleviate pain or pressure) and any stage pressure ulcer on the trunk or pelvis combined with at least one of the following: impaired nutritional status, fecal or urinary incontinence, altered sensory perception, or compromised circulatory status.

(ii) Bead beds, or similar devices

(iii) Bed boards

(iv) Bedding and bed casings

(v) Ortho-prone beds

(vi) Oscillating beds

(vii) Springbase beds

(viii) Vail beds, or similar bed

(Rule 1200-13-13-.10, continued)

3. Biofeedback

4. Chiropractor's services

5. Cushions, pads, and mattresses as follows:

   (i) Aquamatic K Pads

   (ii) Elbow protectors

   (iii) Heat and massage foam cushion pads

   (iv) Heating pads

   (v) Heel protectors

   (vi) Lamb's wool pads

   (vii) Steam packs

6. Diagnostic tests conducted solely for the purpose of evaluating the need for a service which is excluded from coverage under these rules.

7. Ear plugs

8. Food supplements and substitutes including formulas

   For persons 21 years of age and older: Not covered, except that Parenteral Nutrition formulas, Enteral Nutrition formulas for tube feedings and phenylalanine-free formulas (not foods) used to treat PKU, as required by T.C.A. § 56-7-2505, are covered for adults. In addition, oral liquid nutrition may be covered when medically necessary for adults with swallowing or breathing disorders who are severely underweight (BMI<15 kg/m^2) and physically incapable of otherwise consuming a sufficient intake of food to meet basic nutritional requirements.

9. Hearing services, including the prescribing, fitting, or changing of hearing aids and cochlear implants

10. Humidifiers (central or room) and dehumidifiers

11. Inpatient rehabilitation facility services

12. Medical supplies, over-the-counter, as follows:

   (i) Alcohol, rubbing

   (ii) Band-aids

   (iii) Cotton balls

   (iv) Eyewash

   (v) Peroxide

   (vi) Q-tips or cotton swabs

13. Nutritional supplements and vitamins, over-the-counter, except that prenatal vitamins for pregnant women and folic acid for women of childbearing age are covered

14. Orthodontic services, except as defined in Rule 1200-13-13-.04(1)(b)5. or 1200-13-14-.04(1)(b)5.

15. Certain pharmacy items as follows:

    (i) Agents when used for anorexia or weight loss

    (ii) Agents when used to promote fertility

    (iii) Agents when used for cosmetic purposes or hair growth

    (iv) Agents when used for the symptomatic relief of cough and colds

    (v) 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

    (vi) Nonprescription drugs

    (vii) Buprenorphine-containing products used for treatment of opiate addiction in excess of the covered amounts listed below:

        (I) Dosage of sixteen milligrams (16 mg) per day for a period of up to six (6) months (183 days) from the initiation of therapy or from the conclusion of pregnancy, if the enrollee is pregnant during this initial maximum dosage therapy; and

        (II) Dosage of eight milligrams (8 mg) per day after the sixth (6th) month (183rd day) of therapy.

    (viii) Sedative hypnotic medications in dosage amounts that exceed the dosage amounts listed below:

        (I) Fourteen (14) pills per month for sedative hypnotic formulations in pill form such as Ambien and Lunesta;

        (II) One hundred forty milliliters (140 ml) per month of chloral hydrate; or

        (III) One (1) bottle every sixty (60) days of Zolpimist.

    (ix) Allergy medications

    (x) Opioid products are restricted as set out in Rule .04(1)(c)12.

16. Purchase, repair, or replacement of materials or equipment when the reason for the purchase, repair, or replacement is the result of enrollee abuse

17. Purchase, repair, or replacement of materials or equipment that has been stolen or destroyed except when the following documentation is provided:

    (i) Explanation of continuing medical necessity for the item, and

(ii) Explanation that the item was stolen or destroyed, and

(iii) Copy of police, fire department, or insurance report if applicable

18. Radial keratotomy

19. Reimbursement to a provider or enrollee for the replacement of a rented durable medical equipment (DME) item that is stolen or destroyed

20. Repair of DME items not covered by TennCare

21. Repair of DME items covered under the provider's or manufacturer's warranty

22. Repair of a rented DME item

23. Speech, language, and hearing services to address speech problems caused by mental, psychoneurotic, or personality disorders

24. Standing tables

25. Vision services for persons 21 years of age and older that are not needed to treat a systemic disease process including, but not limited to:

(i) Eyeglasses, sunglasses, and/or contact lenses for persons aged 21 and older, including eye examinations for the purpose of prescribing, fitting, or changing eyeglasses, sunglasses, and/or contact lenses; procedures performed to determine the refractive state of the eye(s); one pair of cataract glasses or lenses is covered for adults following cataract surgery

(ii) LASIK

(iii) Orthoptics

(iv) Vision perception training

(v) Vision therapy

(b) Services, products, and supplies that are specifically excluded from coverage under the TennCare program.

1. Air cleaners, purifiers, or HEPA filters

2. Alcoholic beverages

3. Animal therapy including, but not limited to:

(i) Dolphin therapy

(ii) Equine therapy

(iii) Hippo therapy

(iv) Pet therapy

4. Art therapy

(Rule 1200-13-13-.10, continued)

5. Autopsy

6. Bathtub equipment and supplies as follows:

   (i) Paraffin baths

   (ii) Sauna baths

7. Beds and bedding equipment as follows:

   (i) Adjust-a-Beds, lounge beds, or similar devices

   (ii) Pillows

   (iii) Waterbeds

8. Bioenergetic therapy

9. Body adornment and enhancement services including, but not limited to:

   (i) Body piercing

   (ii) Breast augmentation

   (iii) Breast capsulectomy

   (iv) Breast implant removal that is not medically indicated

   (v) Ear piercing

   (vi) Hair transplantation, and agents for hair growth

   (vii) Tattoos or removal of tattoos

   (viii) Tongue splitting or repair of tongue splitting

   (ix) Wigs or hairpieces

10. Breathing equipment as follows:

    (i) Intrapulmonary Percussive Ventilators (IPVs)

    (ii) Spirometers, except for peak flow meters for medical management of asthma and incentive spirometers

    (iii) Vaporizers

11. Carbon dioxide therapy

12. Care facilities or services, the primary purpose of which is non-medical, including, but not limited to:

    (i) Day care

    (ii) Evening care centers

(iii) Respite care, except as a component of Mental Health Crisis Services benefits or Hospice Care benefits as provided at Rule 1200-13-13-.04(1)(b).

(iv) Rest cures

(v) Social or diversion services related to the judicial system

13. Carotid body tumor, excision of, as treatment for asthma

14. Chelation therapy, except for the treatment of heavy metal poisoning or secondary hemochromatosis in selected settings. Chelation therapy for treatment of arteriosclerosis or autism is not covered. Chelation therapy for asymptomatic individuals is not covered. In the case of lead poisoning, the lead levels must be extremely high. For children, a minimum level of 45 ug/dl is recommended. Because chelation therapy and its after-effects must be continuously monitored for possible adverse reactions, chelation therapy is covered only in inpatient or outpatient hospital settings, renal dialysis facilities, and skilled nursing facilities. It is not covered in an office setting, an ambulatory surgical center, or a home setting.

15. Clothing, including adaptive clothing

16. Cold therapy devices

17. Comfort and convenience items including, but not limited to:

(i) Corn plasters

(ii) Garter belts

(iii) Incontinence products (diapers/liners/underpads) not needed for a medical condition; not covered for children age 3 and younger

(iv) Support stockings, when light or medium weight or prescribed for relief of tired or aching legs or treatment of spider/varicose veins. Surgical weight stockings prescribed by a doctor or other qualified licensed health care practitioner for the treatment of chronic foot/ankle swelling, venous insufficiencies, or other medical conditions and thrombo-embolic deterrent support stockings for pre- and post-surgical procedures are covered as medically necessary.

18. Computers, personal, and peripherals including, but not limited to printers, modems, monitors, scanners, and software, including their use in conjunction with an Augmentative Communication Device

19. Convalescent care.

20. Cosmetic dentistry, cosmetic oral surgery, and cosmetic orthodontic services

21. Cosmetic prosthetic devices

22. Cosmetic surgery or surgical procedures primarily for the purpose of changing the appearance of any part of the body to improve appearance or self-esteem,

(Rule 1200-13-13-.10, continued)

including scar revision. The following services are not considered cosmetic services:

(i) Reconstructive surgery to correct the results of an injury or disease

(ii) Surgery to treat congenital defects (such as cleft lip and cleft palate) to restore normal bodily function

(iii) Surgery to reconstruct a breast after mastectomy that was done to treat a disease, or as a continuation of a staged reconstructive procedure

(iv) In accordance with Tennessee law, surgery of the non-diseased breast following mastectomy and reconstruction to create symmetrical appearance

(v) Surgery for the improvement of the functioning of a malformed body member

(vi) Reduction mammoplasty, when the minimum amount of breast material to be removed is equal to or greater than the 22nd percentile of the Schnur Sliding Scale based on the individual's body surface area.

23. Dance therapy

24. Dental services for adults age 21 and older

25. Services provided solely or primarily for educational purposes, including, but not limited to:

(i) Academic performance testing

(ii) Educational tests and training programs

(iii) Habilitation

(iv) Job training

(v) Lamaze classes

(vi) Lovaas therapy

(vii) Picture illustrations

(viii) Remedial education

(ix) Sign language instruction

(x) Special education

(xi) Tutors

26. Encounter groups or workshops

27. Environmental modifications including, but not limited to:

(i) Air conditioners, central or unit

(ii) Micronaire environmentals, and similar devices

(iii) Pollen extractors

(iv) Portable room heaters

(v) Vacuum systems for dust filtering

(vi) Water purifiers

(vii) Water softeners

28. Exercise equipment including, but not limited to:

(i) Exercise equipment

(ii) Exercycles (including cardiac use)

(iii) Functional electrical stimulation

(iv) Gravitronic traction devices

(v) Gravity guidance inversion boots

(vi) Parallel bars

(vii) Pulse tachometers

(viii) Tilt tables when used for inversion

(ix) Training balls

(x) Treadmill exercisers

(xi) Weighted quad boots

29. Food and food products (distinct from food supplements or substitutes, as defined in Rule 1200-13-13-.10(3)(a)10.), including but not limited to specialty food items for use in diets such as:

(i) Low-phenylalanine or phenylalanine-free

(ii) Gluten-free

(iii) Casein-free

(iv) Ketogenic

30. Generators and auxiliary power equipment that may be used to provide power for covered medical equipment or for any purpose

31. Grooming services including, but not limited to:

(i) Barber services

(Rule 1200-13-13-.10, continued)

(ii) Beauty services

(iii) Electrolysis

(iv) Hairpieces or wigs

(v) Manicures

(vi) Pedicures

32. Hair analysis

33. Home health aide services or services from any other individual or agency that are for the primary purpose of safety monitoring

34. Home modifications and items for use in the home

(i) Decks

(ii) Enlarged doorways

(iii) Environmental accessibility modifications such as grab bars and ramps

(iv) Fences

(v) Furniture, indoor or outdoor

(vi) Handrails

(vii) Meals

(viii) Overbed tables

(ix) Patios, sidewalks, driveways, and concrete slabs

(x) Plexiglass

(xi) Plumbing repairs

(xii) Porch gliders

(xiii) Rollabout chairs

(xiv) Room additions and room expansions

(xv) Telephone alert systems

(xvi) Telephone arms

(xvii) Telephone service in home

(xviii) Televisions

(xix) Tilt tables when used for inversion

(Rule 1200-13-13-.10, continued)

(xx) Toilet trainers and potty chairs. Positioning commodes and toilet supports are covered as medically necessary.

(xxi) Utilities (gas, electric, water, etc.)

35. Homemaker services

36. Hospital inpatient items that are not directly related to the treatment of an injury or illness (such as radios, TVs, movies, telephones, massage, guest beds, haircuts, hair styling, guest trays, etc.)

37. Hotel charges, unless pre-approved in conjunction with a transplant or as part of a non-emergency transportation service

38. Hypnosis or hypnotherapy

39. Infant/child car seats, except that adaptive car seats may be covered for a person with disabilities such as severe cerebral palsy, spina bifida, muscular dystrophy, and similar disorders who meets all of the following conditions:

(i) Cannot sit upright unassisted, and

(ii) Infant/child care seats are too small or do not provide adequate support, and

(iii) Safe automobile transport is not otherwise possible.

40. Infertility or impotence services including, but not limited to:

(i) Artificial insemination services

(ii) Purchase of donor sperm and any charges for the storage of sperm

(iii) Purchase of donor eggs, and any charges associated with care of the donor required for donor egg retrievals or transfers of gestational carriers

(iv) Cryopreservation and storage of cryopreserved embryos

(v) Services associated with a gestational carrier program (surrogate parenting) for the recipient or the gestational carrier

(vi) Fertility drugs

(vii) Home ovulation prediction kits

(viii) Services for couples in which one of the partners has had a previous sterilization procedure, with or without reversal

(ix) Reversal of sterilization procedures

(x) Any other service or procedure intended to create a pregnancy

(xi) Testing and/or treatment, including therapy, supplies, and counseling, for frigidity or impotence

41. Injections for the treatment of pain such as:

(i) Facet/medial branch injections for therapeutic purposes

(ii) Medial branch injections for diagnostic purposes in excess of four (4) injections in a calendar year

(iii) Trigger point injections in excess of four (4) injections per muscle trigger point during any period of six (6) consecutive months

(iv) Epidural steroid injections in excess of three (3) injections during any period of six (6) consecutive months, except epidural injections associated with childbirth

42. Lamps such as:

(i) Heating lamps

(ii) Lava lamps

(iii) Sunlamps

(iv) Ultraviolet lamps

43. Lifts as follows:

(i) Automobile van lifts

(ii) Electric powered recliner, elevating seats, and lift chairs

(iii) Elevators

(iv) Overhead or ceiling lifts, ceiling track system lifts, or wall mounted lifts when installation would require significant structural modification and/or renovation to the dwelling (e.g., moving walls, enlarging passageways, strengthening ceilings and supports). The request for prior authorization must include a specific breakdown of equipment and installation costs, specifying all required structural modifications (however minor) and the cost associated thereto.

(v) Stairway lifts, stair glides, and platform lifts, including but not limited to Wheel-O-Vators

44. Ligation of mammary arteries, unilateral or bilateral

45. Megavitamin therapy

46. Motor vehicle parts and services including, but not limited to:

(i) Automobile controls

(ii) Automobile repairs or modifications

47. Music therapy

48. Nail analysis

(Rule 1200-13-13-.10, continued)

49. Naturopathic services

50. Necropsy

51. Organ and tissue transplants that have been determined experimental or investigational

52. Organ and tissue donor services provided in connection with organ or tissue transplants covered pursuant to Rule 1200-13-13-.04(1)(b)22., including, but not limited to:

    (i) Transplants from a donor who is a living TennCare enrollee and the transplant is to a non-TennCare enrollee

    (ii) Donor services other than the direct services related to organ procurement (such as, hospitalization, physician services, anesthesia)

    (iii) Hotels, meals, or similar items provided outside the hospital setting for the donor

    (iv) Any costs incurred by the next of kin of the donor

    (v) Any services provided outside of any “bundled rates” after the donor is discharged from the hospital

53. Oxygen, except when provided under the order of a physician and administered under the direction of a physician

54. Oxygen, preset system (flow rate not adjustable)

55. Certain pharmacy items as follows: DESI, LTE, and IRS drugs

56. Play therapy

57. Primal therapy

58. Prophylactic use of stainless steel crowns

59. Psychodrama

60. Psychogenic sexual dysfunction or transformation services

61. Purging

62. Recertification of patients in Level 1 and Level II Nursing Facilities

63. Recreational therapy

64. Religious counseling

65. Retreats for mental disorders

66. Rolfing

(Rule 1200-13-13-.10, continued)

67. Routine health services which may be required by an employer; or by a facility where an individual lives, goes to school, or works; or by the enrollee's intent to travel

    (i) Drug screenings

    (ii) Employment and pre-employment physicals

    (iii) Fitness to duty examinations

    (iv) Immunizations related to travel or work

    (v) Insurance physicals

    (vi) Job related illness or injury covered by workers' compensation

68. Sensitivity training or workshops

69. Sensory integration therapy and equipment used in sensory integration therapy including, but not limited to:

    (i) Ankle weights

    (ii) Floor mats

    (iii) Mini-trampolines

    (iv) Poof chairs

    (v) Sensory balls

    (vi) Sky chairs

    (vii) Suspension swings

    (viii) Trampolines

    (ix) Therapy balls

    (x) Weighted blankets or weighted vests

70. Sensory stimulation services

71. Services provided by immediate relatives, i.e., a spouse, parent, grandparent, stepparent, child, grandchild, brother, sister, half brother, half sister, a spouse's parents or stepparents, or members of the recipient's household

72. Sex change or transformation surgery

73. Sexual dysfunction or inadequacy services and medicine, including drugs for erectile dysfunctions and penile implant devices

74. Sitter services.

75. Speech devices as follows:

(Rule 1200-13-13-.10, continued)

(i) Phone mirror handivoice

(ii) Speech software

(iii) Speech teaching machines

76. Sphygmomanometers (blood pressure cuffs)

77. Stethoscopes

78. Supports: Cervical pillows

79. TENS (transcutaneous electrical nerve stimulation) units for the treatment of chronic lower back pain

80. Thermograms

81. Thermography

82. Time involved in completing necessary forms, claims, or reports

83. Tinnitus maskers

84. Toy equipment such as: Flash switches (for toys)

85. Transportation costs as follows:

(i) Transportation to a provider who is outside the geographical access standards that the MCC is required to meet when a network provider is available within such geographical access standards or, in the case of Medicare beneficiaries, transportation to Medicare providers who are outside the geographical access standards of the TennCare program when there are Medicare providers available within those standards

(ii) Mileage reimbursement, car rental fees, or other reimbursement for use of a private vehicle unless prior authorized by the MCC in lieu of contracted transportation services

(iii) Transportation back to Tennessee from vacation or other travel out-of-state in order to access non-emergency covered services (unless authorized by the MCC)

(iv) Any non-emergency out-of-state transportation, including airfare, that has not been prior authorized by the MCC. This includes the costs of transportation to obtain out-of-state care that has been authorized by the MCC. Out-of-state transportation must be prior authorized independently of out-of-state care.

86. Transsexual surgery

87. Urine drug testing that, within a calendar year, is in excess of twenty-four (24) presumptive urine drug tests using optical observation, and twelve (12) presumptive urine drug tests using instrument chemistry analyzers, and twelve (12) definitive drug urine tests

(Rule 1200-13-13-.10, continued)

88. Vagus nerve stimulators, except after conventional therapy has failed in treating partial onset of seizures.

89. Weight loss or weight gain and physical fitness programs including, but not limited to:

    (i) Dietary programs of weight loss programs, including, but not limited to, Optifast, Nutrisystem, and other similar programs or exercise programs. Food supplements will not be authorized for use in weight loss programs or for weight gain.

    (ii) Health clubs, membership fees (e.g., YMCA)

    (iii) Marathons, activity and entry fees

    (iv) Swimming pools

90. Wheelchairs and wheelchair accessories as follows:

    (i) Wheelchairs defined by CMS as power operated vehicles (POVs), namely, scooters and devices with three (3) or four (4) wheels that have tiller steering and limited seat modification capabilities (i.e. provide little or no back support).

    (ii) Standing wheelchairs. However a power standing system is covered as set out in the definition of Power Seating Accessories in Rule 1200-13-13-.01.

    (iii) Stair climbing wheelchairs.

    (iv) Recreational wheelchairs.

91. Whirlpools and whirlpool equipment such as:

    (i) Action bath hydro massage

    (ii) Aero massage

    (iii) Aqua whirl

    (iv) Aquasage pump, or similar devices

    (v) Hand-D-Jets, or similar devices

    (vi) Jacuzzis, or similar devices

    (vii) Turbojets

    (viii) Whirlpool bath equipment

    (ix) Whirlpool pumps

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 71-5-105, 71-5-109, and 71-5-113; 42 C.F.R. Part 431 Subpart E; 42 C.F.R. Part 438 Subpart F; Executive Order No. 23; and Public Chapter 473, Acts of 2011.* ***Administrative History:*** *Public necessity rule filed July 1, 2002; effective through December 13, 2002. Original rule filed September 30, 2002; to be effective December 14, 2002; however, on December 9, 2002, the House Government Operations Committee of the General Assembly stayed Rule 1200-13-13-*

(Rule 1200-13-13-.10, continued)

.10; new effective date February 12, 2003. Emergency rule filed December 13, 2002; effective through May 27, 2003. Repeal and new rule filed October 27, 2005; effective January 10, 2006. Public necessity rules filed May 3, 2006; effective through October 15, 2006. Public necessity rule filed May 3, 2006; effective through October 15, 2006. Amendment filed July 28, 2006; effective October 11, 2006. Public necessity rule filed February 2, 2007; effective through July 16, 2007. Amendment filed January 30, 2007; effective April 15, 2007. Amendment filed May 2, 2007; effective July 16, 2007. Amendment filed June 27, 2007; effective Sept 10, 2007. Amendment filed February 8, 2008; effective April 23, 2008. Amendment filed February 11, 2008; effective April 26, 2008. Amendment filed April 2, 2008; effective June 16, 2008. Amendments filed August 19, 2008; effective November 2, 2008. Amendment filed July 28, 2009; effective October 26, 2009. Amendment filed November 9, 2009; effective February 7, 2010. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendment filed May 27, 2010; effective August 25, 2010. Amendment filed October 26, 2010; effective January 24, 2011. Amendment filed December 14, 2010; effective May 31, 2011. Emergency rule filed July 1, 2011; effective through December 28, 2011. Emergency rule filed August 2, 2011; effective through January 29, 2012. Amendment filed September 23, 2011; effective December 22, 2011. Amendment filed October 28, 2011; effective January 26, 2012. Emergency rule filed September 27, 2013; effective through March 26, 2014. Amendment filed July 1, 2013; effective September 29, 2013. Amendment filed September 27, 2013; effective December 26, 2013. Amendment filed December 17, 2013; effective March 17, 2014. Amendments filed December 23, 2014; effective March 23, 2015. Emergency rule filed September 30, 2015; effective through March 28, 2016. Amendments filed December 29, 2015; effective March 28, 2016. Amendments filed December 30, 2015; effective March 29, 2016. Emergency rules filed June 24, 2016; effective through December 21, 2016. Emergency rules filed July 1, 2016; effective through December 28, 2016. Amendments filed September 13, 2016; effective December 12, 2016. Amendments filed September 30, 2016; effective December 29, 2016. Amendments filed September 25, 2017; effective December 24, 2017. Emergency rules filed January 16, 2018; effective through July 15, 2018. Amendments filed April 9, 2018; effective July 8, 2018. Amendments filed July 8, 2021; effective October 6, 2021.

1200-13-13-.11 APPEAL OF ADVERSE BENEFIT DETERMINATIONS.

(1) Notice Requirements.

(a) When Written Notice is Required.

1. A written notice shall be given to an enrollee by his/her MCC of any adverse benefit determination.

2. A written notice shall be given to an enrollee of any MCC-initiated reduction, termination or suspension of inpatient hospital care.

3. A written notice shall be given to an enrollee of any provider-initiated reduction, termination or suspension.

4. 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.

5. 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.

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.

(b) Timing of Written Notice.

1. Written notice of MCC-initiated reduction, termination or suspension of medical assistance must be provided to an enrollee within the time frames required by 42 C.F.R. §§ 431.210 - 431.214 (usually ten (10) days in advance). However, in instances of MCC-initiated reduction, termination or suspension of inpatient hospital treatment, the notice may be provided to an enrollee the same day of the proposed action. Where applicable and not in conflict with this rule, the exceptions set out at 42 C.F.R. §§ 431.211 - 431.214 permit or require reduction of the time frames within which advance notice must be provided.

2. An MCC must notify an enrollee of its decision in response to a request by or on behalf of an enrollee for prior authorization for medical or related services as set out in 42 C.F.R. § 438.210(d).

3. Written notice of delay of covered medical assistance must be provided to an enrollee immediately upon an MCC's receipt of information leading it to expect that such delay will occur.

4. Written notice of provider-initiated reduction, termination or suspension of services must be provided to an enrollee in compliance with 42 C.F.R. §§ 431.211, 431.213 and 431.214.

5. Written notice is deemed to be provided to an enrollee upon deposit with the U.S. Postal Service or other commercial mail carrier, or upon hand-delivery to an enrollee or his/her representative.

(c) Notice Contents.

1. Whenever this rule requires that a TennCare enrollee receive written notice of an adverse benefit determination, the notice must be readable and must comply with the requirements of 42 C.F.R. §§ 431.210 and 438.404.

2. Remedying of Notice. If a notice of adverse benefit determination provided to an enrollee does not meet the notice content requirements of Rule 1200-13-13-.11(1)(c)1., TennCare or the MCC may cure any such deficiencies by providing one corrected notice to enrollees. 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.

(2) Appeal Rights of Enrollees. Enrollees have the following rights:

(a) To appeal adverse benefit determinations.

(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 benefit determinations that have been made or are proposed to be made, may not be denied.

(c) To have the appeal rights that are prescribed by 42 C.F.R. Part 431, Subpart E and Tennessee Code Annotated §§ 4-5-301, et seq.

(d) To be allowed sixty (60) days from the date on the written notice or, if no notice is provided, from the time the enrollee becomes aware of an adverse benefit determination, to appeal any adverse benefit determination. To file a Request for Reimbursement for expenses incurred between the effective eligibility date and the date that notice of eligibility is provided, the enrollee must request reimbursement and provide complete information to TennCare, as prescribed by Rule .01, within sixty (60) days from the date of the written notification of the effective eligibility date or, if no written notice is provided, within sixty (60) days from the date the enrollee becomes aware of the effective eligibility date. For all other Requests for Reimbursement, the enrollee must request reimbursement and provide complete information, as prescribed by Rule .01, within sixty (60) days from the date the enrollee paid out of pocket for covered services.

(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.

(f) For ongoing services, have the right to continuation or reinstatement of services, pursuant to 42 C.F.R. §§ 431.230 and 431.231 as modified by this rule, pending resolution of the appeal when the enrollee submits a timely appeal and timely request for COB. When an enrollee is so entitled to continuation or reinstatement of services, this right may not be denied for any reason, including:

1. An MCC's failure to inform an enrollee of the availability of such continued services;

2. An MCC's failure to reimburse providers for delivering services pending appeal; or

3. An MCC's failure to provide such services when timely requested.

(g) To an appeals process. But for initial reconsideration by an MCC as permitted by this rule, no person who is an employee, agent or representative of an MCC may participate in deciding the outcome of a SFH. No state official who was directly involved in the initial determination of the action in question may participate in deciding the outcome of an enrollee's appeal.

(3) Special Provisions Relating to Appeals.

(a) Individualized Decisions Required. Neither the TennCare program nor its MCCs may employ utilization control guidelines or other quantitative coverage limits, whether explicit or de facto, unless supported by an individualized determination of medical necessity based upon the needs of each TennCare enrollee and his or her medical history.

(Rule 1200-13-13-.11, continued)

(b) Medical Evidence.

1. Appeal decisions must be based on an evaluation of pertinent medical evidence. TennCare and the MCCs shall elicit from enrollees and their treating providers all pertinent medical records that support an appeal; and

2. Medical opinions shall be evaluated 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 benefit determination.

(c) Record on Review. When TennCare receives an appeal from an enrollee regarding an adverse benefit determination, TennCare is responsible for obtaining from the MCC any and all records or documents pertaining to the MCC's decision to take the contested action. TennCare shall correct any violation of this rule that is evident from a review of those records.

(d) Valid Factual Disputes. When TennCare receives an appeal from an enrollee, TennCare will dismiss this appeal unless the enrollee has established a valid factual dispute relating to an adverse benefit determination.

1. Processing of Appeals. TennCare shall screen all appeals submitted by TennCare enrollees to determine if the enrollees have presented a valid factual dispute. If TennCare determines that an enrollee failed to present a valid factual dispute, TennCare will immediately provide the enrollee with a notice, informing him/her that the enrollee must provide additional information as identified in the notice. If the enrollee does not provide this information, the appeal shall be dismissed without the opportunity for a state fair hearing within ten (10) days of the date of the notice. If the enrollee adequately responds to this notice, TennCare shall inform the enrollee that the appeal will proceed to a hearing. If the enrollee responds but fails to provide adequate information, TennCare will provide a notice to the enrollee, informing him/her that the appeal is dismissed without the opportunity for a state fair hearing. If the enrollee does not respond, the appeal will be dismissed without the opportunity for a state fair hearing, without further notice to the enrollee.

2. Information Required to Establish Valid Factual Disputes. In order to establish a valid factual dispute, TennCare enrollees must provide the following information: Enrollee's name; member SSN or TennCare ID#; address and phone; identification of the service or item that is the subject of the adverse benefit determination; and the reason for the appeal, including any factual error the enrollee believes TennCare or the MCC has made. For reimbursement and billing appeals, enrollees must also provide the date the service was provided, the name of the provider, copies of receipts which prove that the enrollee paid for the services or copies of a bill for the services, whichever is applicable.

(e) Appeals When Enrollees Lack a Prescription. When a TennCare enrollee attempts to lodge an appeal for a benefit for which the enrollee lacks a prescription, TennCare may require the enrollee to exhaust the following administrative process before an appeal can proceed:

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

(Rule 1200-13-13-.11, continued)

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.

2. In order for this appeal to continue, the enrollee shall be required to contact TennCare after attending the appointment with a physician and demonstrate that he/she remains without a prescription for the service. If the enrollee fails to contact TennCare within sixty (60) days from the date of the notice described in subparagraph (e)1., TennCare will dismiss the appeal without providing an opportunity for a hearing for the enrollee.

(f) Appeals When No Adverse Benefit Determination Has Been Made. Enrollees shall not possess the right to appeal when no adverse benefit determination has been made. If enrollees request a hearing in this circumstance, their request shall be denied by the TennCare bureau without the opportunity for a hearing. Such circumstances include but are not limited to when enrollees appeal and no request for services had previously been denied.

(4) Hearing Rights of Enrollees.

(a) TennCare shall inform enrollees of their state fair hearing rights;

(b) Enrollees shall be entitled to a hearing before a hearing officer that affords each enrollee the right to:

1. Representation at the hearing by anyone of his/her choice, including a lawyer;

2. Review information and facts relied on for the decisions by the MCC and the TennCare Bureau before the hearing;

3. Cross-examine adverse witnesses;

4. Present evidence, including the right to compel attendance of witnesses at hearings;

5. Review and present information from his/her medical records;

6. Present evidence at the hearing challenging the adverse decision by his/her MCC;

7. Ask for an independent medical opinion, at no expense to the enrollee;

8. Continue or reinstate ongoing services pending a hearing decision, as specified in this rule;

9. A written decision setting out the hearing officer’s rulings on findings of fact and conclusions of law; and

10. Resolution, including a hearing before a hearing officer if the case has not been previously resolved in favor of the enrollee, pursuant to 42 C.F.R. § 431.244.

(c) TennCare shall not impair the ability of an enrollee to appeal an adverse hearing decision by requiring that the enrollee bear the expense of purchasing a hearing transcript when such purchase would be a financial hardship for the enrollee.

(Rule 1200-13-13-.11, continued)

(d) Parties to an Appeal. Under this rule, the parties to a state fair hearing are limited to the enrollee and TennCare, permitted by federal regulations as modified by CMS letter dated June 5, 2017. The purpose of the hearing is to focus on the enrollee's medical needs.

(e) Consistent with the Code of Judicial Conduct, hearing officers shall assist pro se enrollees in developing the factual record and shall have authority to order second medical opinions at no expense to the enrollee.

(f) Review of Hearing Decisions.

1. Hearing officers shall promptly issue an Order of their decision. Any Order delivered orally from the bench in an expedited hearing by a hearing officer shall be effective immediately as to the provision or denial of benefits. In accordance with 42 C.F.R. Part 431 Subpart E and 42 C.F.R. Part 438 Subpart F, the hearing officer shall enter a written order as soon as practicable and shall provide the parties with copies of such Orders. The time for appealing any oral Order shall not begin to run until entry of the written Order.

2. The TennCare Bureau shall have the opportunity to review all decisions of hearing officers, in accordance with T.C.A. §§ 4-5-314 and 4-5-315, to determine whether such decisions are contrary to applicable law, regulations or policy interpretations, which shall include but not be limited to decisions regarding the defined package of covered benefits, determinations of medical necessity and decisions based on the application of this chapter and 42 C.F.R. Part 431 Subpart E and 42 C.F.R. Part 438 Subpart F.

(i) If TennCare modifies or overturns the decision of the hearing officer, TennCare shall issue a written decision that will be provided to the enrollee and the hearing officer. TennCare's decision shall constitute final agency action.

(ii) If TennCare does not modify or overturn the decision of the hearing officer, the hearing officer's decision shall constitute final agency action without additional notice to the enrollee.

(iii) Review of final agency action shall be available to enrollees pursuant to T.C.A. § 4-5-322.

(iv) A hearing officer's decision in an enrollee's appeal shall not be deemed precedent for future appeals.

(g) Continuation or Reinstatement of TennCare Services.

1. As permitted under 42 C.F.R. §§ 431.230, 431.231 and 438.420, if required or if the enrollee requests, TennCare services shall continue or be reinstated until the earlier of dismissal of the appeal through the valid factual dispute process, enrollee's withdrawal of the appeal, or an initial hearing decision adverse to the enrollee.

2. In the case of a timely request for continuation or reinstatement of the TennCare services described in paragraph (4)(g)1. above, the services shall continue or be reinstated only if and to the extent prescribed by the enrollee's treating clinician.

(Rule 1200-13-13-.11, continued)

3. Notwithstanding the requirements of this part, TennCare enrollees are not entitled to continuation or reinstatement of services pending an appeal related to the following:

(i) When a service is denied because the enrollee has exceeded the benefit limit applicable to that service;

(ii) When a request for prior authorization is denied for a prescription drug, with the exception of:

(I) Pharmacists shall provide a single 72-hour interim supply in emergency situations for the non-authorized drug, unless such supply would exceed applicable pharmacy benefit limits; or

(II) When the drug has been prescribed on an ongoing basis or with unlimited refills and becomes subject to prior authorization requirements.

(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;

(iv) When coverage for a prescription drug is denied because the enrollee has been locked into one pharmacy and the enrollee seeks to fill a prescription at another pharmacy;

(v) When a request for reimbursement is denied and the enrollee appeals this denial;

(vi) When a physician has failed to prescribe or order the service or level of service for which continuation or reinstatement is requested; or

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

(h) Reserved.

(5) Reserved.

(6) Release of Enrollees' Medical Records.

(a) When a request is made, by or on behalf of a TennCare enrollee, for approval of a TennCare service or for an appeal of an adverse benefit determination, the enrollee is deemed to have consented to release of his/her relevant medical records to his/her MCC and the TennCare Bureau for the purposes of acting upon the enrollee's request.

(b) Providers shall promptly provide copies of an enrollee's medical records to the enrollee's MCC(s) and to the TennCare Bureau upon being informed by the MCC(s) or TennCare Bureau that the records have been requested for the purpose of acting upon an enrollee's request for approval of a TennCare service or an enrollee's appeal of an adverse benefit determination.

(c) An enrollee's consent to release of his/her medical records may be evidenced by his signature (or his provider's or authorized representative's signature) upon the enrollee's initial application for TennCare, upon his TennCare appeal form or other written request for authorization or appeal, or, in the event of an appeal by telephone,

(Rule 1200-13-13-.11, continued)

by a TennCare Bureau employee's signing of an appeal form on behalf of an enrollee with documentation of consent to do so.

(d) The medical records obtained by MCCs and the TennCare Bureau under this rule remain confidential. MCCs and the TennCare Bureau may use and disclose the records only as necessary in their consideration of the enrollee's request for approval of a TennCare service or the enrollee's appeal of an adverse benefit determination.

(7) Time Requirements.

(a) MCCs must act upon a request for prior authorization as provided in 42 C.F.R. § 438.210.

(b) MCCs must complete reconsideration of standard appeals within fourteen (14) calendar days of the request from TennCare. MCCs must complete reconsideration of expedited appeals within seventy-two (72) hours of the request for SFH.

(c) All standard and expedited appeals not previously resolved in favor of the enrollee during reconsideration, shall be set for hearing before a hearing officer, and shall be resolved pursuant to the timeframes set forth in 42 C.F.R. § 431.244. In accordance with 42 C.F.R. § 438.410(a) and 42 C.F.R. § 431.244(f)(2), SFH requests which are approved for expedited resolution and which are not resolved in the enrollee's favor during MCC's reconsideration, shall be resolved by TennCare within three (3) working days from the date of the MCC's reconsideration determination. TennCare is not charged with any delays attributable to the enrollee.

(d) In no circumstance will a directive be issued by the TennCare Bureau or a hearing officer to provide a service to an enrollee if, when the appeal is resolved, the service is no longer covered by TennCare for the enrollee. A directive also will not be issued by the TennCare Bureau if the service cannot reasonably be provided to the enrollee before the date when the service is no longer covered by TennCare for the enrollee.

(8) Reserved.

(9) Special Provisions Relating to Children in State Custody. Children in the custody of the State have the rights and protections established by 42 C.F.R. Part 431, Subpart E regarding TennCare services and benefits.

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 71-5-105, 71-5-109, and 71-5-113; 42 C.F.R. Part 431 Subpart E; 42 C.F.R. Part 438 Subpart F; and Executive Order No. 23.* ***Administrative History:*** *Public necessity rule filed July 1, 2002; effective through December 13, 2002. Original rule filed September 30, 2002; to be effective December 14, 2002; however, on December 9, 2002, the House Government Operations Committee of the General Assembly stayed Rule 1200-13-13-.11; new effective date February 12, 2003. Emergency rule filed December 13, 2002; effective through May 27, 2003. Public necessity rule filed May 5, 2005; effective through October 17, 2005. Public necessity rule filed July 29, 2005; effective through January 10, 2006. Amendments filed July 28, 2005; effective October 11, 2005. Public necessity rule filed December 29, 2005; expired June 12, 2006. On June 13, 2006, affected rules reverted to status on December 28, 2005. Amendments filed October 27, 2005; effective January 10, 2006. However, Notice of Withdrawal of permanent rule amendments (1)(d)3., (1)(d)4., (4)(g)6., (5)(a)5., (5)(e), (5)(f), and (7)(h) filed and effective January 6, 2006 (to have been effective January 10, 2006). Public necessity rule filed May 17, 2006; effective through October 29, 2006. Amendments filed March 31, 2006; effective June 14, 2006. Amendment filed August 14, 2006; effective October 28, 2006. Public necessity rule filed December 1, 2006; effective through May 15, 2007. Amendment filed March 1, 2007; effective May 15, 2007. Amendment filed August 19, 2008; effective November 2, 2008. Amendment filed September 30, 2009; effective December 29, 2009. Amendment filed October 26, 2010; effective January 24, 2011. Emergency rule filed July 1, 2011; effective through December 28, 2011. Amendment filed September 23,*

(Rule 1200-13-13-.11, continued)
2011; effective December 22, 2011. Amendments filed September 27, 2013; effective December 26, 2013. Amendments filed September 25, 2017; effective December 24, 2017. Amendments filed July 8, 2021; effective October 6, 2021.

1200-13-13-.12 OTHER APPEALS BY TENNCARE APPLICANTS AND ENROLLEES.

Notwithstanding Rule 1200-13-19-.01, or any rule to the contrary, appeals by applicants and enrollees of all non-medical eligibility matters are removed to Rule Chapter 1200-13-19, effective upon expiration of the TDHS contract to determine eligibility matters.

Authority: *T.C.A. §§ 4-5-202, 4-5-209, 71-5-105, 71-5-109, and 71-5-113; 42 C.F.R. Part 431 Subpart E; 42 C.F.R. Part 438 Subpart F; and Executive Order No. 23.* ***Administrative History:*** *Original rule filed September 30, 2002; to be effective December 14, 2002; however, on December 9, 2002, the House Government Operations Committee of the General Assembly stayed Rule 1200-13-13-.12; new effective date February 12, 2003. Emergency rule filed December 13, 2002; effective through May 27, 2003. Public necessity rule filed June 8, 2005; effective through November 20, 2005. Amendment to public necessity rule filed July 6, 2005; effective through November 20, 2005. Amendment filed September 6, 2005; effective November 20, 2005. Amendments filed September 25, 2017; effective December 24, 2017.*

1200-13-13-.13 MEMBER ABUSE OR OVERUTILIZATION OF THE TENNCARE PHARMACY PROGRAM.

(1) The Bureau is authorized to implement and maintain a pharmacy lock-in program designed to address member abuse or overutilization. Activities which may indicate abuse or overutilization justifying placement on lock-in or prior approval status include but are not limited to the following:

(a) Forging or altering a prescription for drugs.

(b) Selling TennCare paid prescription drugs.

(c) Failing to control pharmacy overutilization activity while on lock-in status.

(d) Visiting multiple prescribers or pharmacies to obtain controlled substances.

(e) Trading, swapping or selling a TennCare card.

(f) Failing to promptly report the loss or theft of a TennCare card.

(g) Forging or altering a TennCare card.

(h) Knowingly providing false, incomplete, inaccurate or erroneous information to provider(s) in order to receive covered services for which the member is ineligible.

(i) Permitting the use of a TennCare card by anyone other than the member to whom the card is assigned in order to receive or attempt to receive services.

(2) The TennCare pharmacy lock-in program shall be administered by the Bureau. Monitoring of enrollee activities listed in Paragraph (1) shall be conducted by the Bureau, the MCCs, including the PBM, and the TennCare Office of Inspector General (OIG). When an enrollee has been identified as having participated in any abuse or overutilization activities, including but not limited to the activities listed in Paragraph (1), the enrollee's name shall be referred to the Bureau as appropriate or potentially appropriate for the lock-in program as follows:

(a) Appropriate for the lock-in program:

(Rule 1200-13-13-.13, continued)

1. Any enrollee who has been identified by the OIG as having been convicted of TennCare fraud or a drug-related offense.

2. Any enrollee who has used buprenorphine-containing products for office based opioid addiction treatment within the previous six (6) months.

(b) Potentially appropriate for the lock-in program:

1. Any enrollee who has been arrested for TennCare fraud.

2. Any enrollee who has been arrested for a drug-related offense.

3. Any enrollee who has obtained multiple controlled substance prescriptions over a 90-day period that meet one of the following conditions:

(i) The prescriptions were filled at three (3) or more pharmacies and written by three (3) or more prescribers.

(ii) The prescriptions were filled at one (1) or more targeted pharmacies and written by two (2) or more prescribers.

(iii) The prescriptions were filled at two (2) or more targeted pharmacies and written by one (1) or more prescribers.

(iv) The prescriptions were filled at one (1) or more targeted pharmacies and written by one (1) or more targeted prescribers.

(v) The prescriptions were filled at two (2) or more pharmacies and written during three (3) or more emergency room visits.

(3) Pharmacy lock-in procedures shall include:

(a) A determination to place an enrollee who has been referred as appropriate or potentially appropriate for the lock-in program on lock-in status shall be made by the TennCare Pharmacy Director or designee after the enrollee's relevant pharmacy claims data has been reviewed by clinical staff.

(b) Any enrollee determined to be appropriate for the lock-in program shall be notified by the Bureau or the MCC prior to the imposition of lock-in status. The notice shall include a brief explanation of the lock-in program, the reason for the determination to place the enrollee on lock-in status, the date the lock-in will become effective, and the information necessary for the enrollee to appeal the decision of the Bureau, pursuant to Rule 1200-13-13-.11.

(c) If an enrollee fails to appeal placement in the lock-in program or an appeal is not resolved in his favor, the enrollee will be provided TennCare pharmacy services only at the lock-in provider to which the enrollee is assigned.

(4) Lock-in provider selection. A pharmacy will qualify for and may be selected by the enrollee as a lock-in provider only if it meets all the following criteria:

(a) It is enrolled in the TennCare Pharmacy Network;

(b) It is within the State of Tennessee;

(Rule 1200-13-13-.13, continued)

(c) It is a full-service pharmacy that carries all medications normally carried by pharmacies;

(d) It is not a mail order or specialty pharmacy;

(e) It is not a targeted pharmacy;

(f) It is a single pharmacy location at a specific address. A chain pharmacy may be selected but only the specific named location may be used, not multiple locations or outlets of the chain; and

(g) It is in proximity to the enrollee's residence, which must be the current address on file with the Bureau.

(5) After twelve (12) months a member may request a change of lock-in provider once each year. Additional changes are limited to the following reasons:

(a) The member has moved and his new address is at least fifteen (15) miles from the lock-in pharmacy and he has updated his address with the Bureau.

(b) The member's lock-in pharmacy has permanently closed.

(c) The member's lock-in pharmacy has voluntarily dismissed the enrollee from its practice and has notified the Bureau and the PBM.

(d) The Bureau may, at its sole discretion, determine that there is a compelling need to change the member's lock-in pharmacy.

(6) Review of lock-in status. The Bureau or the MCC shall periodically review the claims information of members on lock-in status to determine the need for continued lock-in or escalation to prior approval status.

(a) Lock-in status will be discontinued if the Bureau determines that a member has met all of the following criteria for at least six (6) consecutive months:

1. Has not paid cash for any controlled substance prescriptions covered by TennCare.

2. Has not received any narcotic medications while on buprenorphine-containing products for addiction.

3. Has received TennCare reimbursed controlled substance prescriptions from only one (1) provider.

4. Has received TennCare reimbursed prescriptions from only one (1) pharmacy.

(b) If a member is removed from lock-in status, the Bureau or the MCC will monitor the member for changes in utilization patterns and return him to lock-in status if appropriate.

(7) Prior approval status.

(a) A member against whom criminal process alleging TennCare fraud has been issued or who has been convicted of TennCare fraud shall automatically be placed on prior approval status.

(Rule 1200-13-13-.13, continued)

(b) Lock-in status shall be escalated to prior approval status if a member on lock-in status meets three (3) of the following criteria over a 90 day period:

1. Has paid cash for three (3) or more controlled substance prescriptions covered by TennCare.

2. Has filled prescriptions for controlled substances at two (2) or more pharmacies.

3. Has received controlled substance prescriptions from two (2) or more prescribers.

4. Has received a narcotic prescription while receiving buprenorphine-containing products for addiction.

(c) A member who has been treated in a hospital emergency department for an overdose of a controlled substance (as identified in the most recently available TennCare data) or an illicit substance identified by toxicology shall automatically be placed on prior approval status.

(8) Emergency pharmacy services may be obtained with a TennCare or MCC override of a member's lock-in status. The PBM has clinical staff available at all times to respond to emergency situations. The PBM must verify that a genuine emergency exists, such as documented proof from the lock-in pharmacy that it is temporarily out of stock of a needed medication. A lock-in override will not be provided simply because a pharmacy is closed for the day unless a true medical emergency exists.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109, and 71-5-146 and Executive Order No. 23.* ***Administrative History:*** *Original rule filed September 30, 2002; to be effective December 14, 2002; however, on December 9, 2002, the House Government Operations Committee of the General Assembly stayed Rule 1200-13-13-.13; new effective date February 12, 2003. Emergency rule filed December 13, 2002; effective through May 27, 2003. Public necessity rule filed December 29, 2005; expired June 12, 2006. On June 13, 2006, affected rules reverted to status on December 28, 2005. Repeal and new rule filed March 31, 2006; effective June 14, 2006. Amendment filed October 3, 2013; effective January 1, 2014. Amendments filed December 29, 2015; effective March 28, 2016.*

1200-13-13-.14 REPEALED.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, and 71-5-109 and Executive Order No. 23.* ***Administrative History:*** *Original rule filed September 30, 2002; to be effective December 14, 2002; however, on December 9, 2002, the House Government Operations Committee of the General Assembly stayed Rule 1200-13-13-.14; new effective date February 12, 2003. Emergency rule filed December 13, 2002; effective through May 27, 2003. Public necessity rule (repeal) filed August 18, 2005; effective through January 30, 2006. Repeal filed November 15, 2005; effective January 29, 2006.*

1200-13-13-.15 BESMART. This rule supersedes any other rules related to the use of buprenorphine products for treatment of opioid use disorder (OUD) in office based opioid treatment (OBOT) or an opioid treatment program (OTP) by a treating provider participating in an MCO's network of BESMART providers.

(1) BESMART treatment is a component of covered outpatient substance abuse benefits and consists of a set of coordinated medically necessary covered services which includes:

(a) Psychosocial assessment and development of a treatment plan;

(b) Individual or group counseling;

(Rule 1200-13-13-.15, continued)

(c) Peer recovery services;

(d) Care coordination;

(e) Opioid-agonist therapy consisting of buprenorphine products that have been FDA approved for OUD treatment and may be prescribed in excess of the limits described in rules .04 and .10, when determined to be medically necessary by a treating provider in an MCO's network of BESMART providers and under the participant's plan of care.

1. Except as otherwise provided for in this rule, participants may receive up to sixteen (16) mg of buprenorphine containing products daily; however, providers shall initiate and lead a discussion regarding a participant's readiness to taper down or off treatment at any time upon a participant's request, but no later than one (1) year after initiating treatment and every six (6) months thereafter.

2. Under the best practices for treatment of OUD, the BESMART provider shall utilize the lowest effective dose of Medication-Assisted Treatment (MAT).

3. The following adult populations shall be eligible to receive a maximum daily dosage of twenty-four (24) mg of buprenorphine, not to exceed one (1) year in duration:

(i) Pregnant participants confirmed by provider attestation.

(ii) Postpartum participants for a period of twelve (12) months from delivery date as shown by medical records or insurance claim.

(iii) Recent intravenous (IV) drug users confirmed by prescriber attestation and a positive urine drug screen.

(iv) Current users receiving greater than fifty (50) mg of methadone for OUD treatment transitioning to buprenorphine agonist therapy demonstrated by paid claims data from the participant's health insurer, provider attestation, or medical records.

(v) Current users of sixteen (16) mg to twenty-four (24) mg per day of buprenorphine demonstrated by paid claims data from the participant's previous health insurer.

(vi) For one (1) year from the effective date of this rule, a member who does not qualify under the criteria of this part but receives greater than sixteen (16) mg per day of buprenorphine as demonstrated by the controlled substance monitoring database shall be eligible to receive a maximum daily dose of twenty-four (24) mg.

(2) BESMART treatment requires medical office visits at least weekly for participants in the induction and stabilization phase of treatment; at least every two (2) to four (4) weeks for participants in the maintenance phase of treatment; and at least every two (2) months for participants who have been in the maintenance phase of treatment for one (1) year or longer.

(3) To be reimbursed for a BESMART covered service, treating providers must demonstrate an ability to provide all BESMART services in a coordinated, person-centric way, including the ability to facilitate access to all related treatment modalities and provider types, and must participate in at least one (1) MCO's network of BESMART providers.

(Rule 1200-13-13-.15, continued)

(4) Prescriptions of buprenorphine containing products to TennCare enrollees by nurse practitioners and physician assistants for the treatment of OUD will not be reimbursed unless the nurse practitioner or physician assistant participates in at least one (1) MCO's network of BESMART providers.

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 71-5-105, 71-5-107, and 71-5-109.* ***Administrative History:*** *Emergency rules filed April 15, 2021; effective through October 12, 2021. New rule filed June 29, 2021; effective September 27, 2021.*