

**RULES
OF
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF INSURANCE ADMINISTRATION**

**CHAPTER 0620-05-01
COVER KIDS RULES**

TABLE OF CONTENTS

0620-05-01-.01	Definitions	0620-05-01-.04	Disenrollment
0620-05-01-.02	Eligibility	0620-05-01-.05	Review of CoverKids Decisions
0620-05-01-.03	Benefits and Cost Sharing	0620-05-01-.06	Providers

0620-05-01-.01 DEFINITIONS.

- (1) Unless otherwise specifically defined in these rules, these terms will have the following meaning:
- (a) "Administrative Contractor" or "AC" is the entity responsible for determining eligibility of applicants to CoverKids. This may be a private contractor, government agency, or Departmental entity.
 - (b) "Budget Group" means for each applicant, the following family members living with the applicant: the applicant's spouse, the applicant's minor unmarried children, the siblings of children in the home when the applicant child and siblings do not have income of their own, and each of the applicant's financially responsible adults as indicated by the family including natural, adoptive, and step-parents. Children with SSI or Families First are not included in a budget group.
 - (c) "Commissioner" is the executive officer in charge of the Tennessee Department of Finance and Administration.
 - (d) "Commissioner's Designee" means a person or group of persons appointed by the Commissioner to perform a particular function under these rules.
 - (e) "CoverKids" is the program created by Tennessee Code Annotated Section 71-3-1101 et seq. and includes its authorized employees and agents as the context of the rules requires.
 - (f) "Days" means calendar days rather than business days.
 - (g) "Health insurance" shall include but not be limited to basic medical coverage (hospitalization plans), major medical insurance, comprehensive medical insurance, short-term medical policies, limited-benefit plans, mini-medical plans and high deductible health plans with health savings accounts. Health insurance shall not include the following:
 - 1. CoverTN;
 - 2. AccessTN;

(Rule 0620-05-01-.01, continued)

3. catastrophic health insurance plans that only provide medical services after satisfying a deductible in excess of \$3,000 (or the maximum allowed deductible for a health savings account plan);
4. dental-only plans;
5. vision-only plans;
6. coverage through the State of Tennessee's Children's Special Services (CSS) program; or
7. medical insurance that is available to an enrollee pursuant either to the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986 (Pub. L. No. 99-272, codified at 29 U.S.C. § 1161 *et seq.*) and which the individual declined, or to § 56-7-2312 *et seq.* and which the individual declined.

Consistent with 42 U.S.C. § 1397jj(b)(2)(B) and 42 C.F.R. 457.301 and 310(c)(1)(ii), health insurance shall also not include state-administered or other medical coverage offered by means of a family member's employment with a local education agency (LEA) if the LEA does not make more than a nominal contribution (as defined at 42 CFR 457.310(c)(1)(ii)) to the premium for the dependent who is applying (or re-applying) for coverage through CoverKids.

- (h) "Involuntary loss of coverage" means the loss of health benefits coverage arising from (but not limited to) the following circumstances:
1. a separation from employment (voluntary or involuntary);
 2. a health insurance carrier's cancellation of group or individual health benefits coverage for reasons other than premium non-payment, fraud, or misrepresentation;
 3. a health insurance carrier's decision to no longer sell small group health benefits coverage; or
 4. the loss of eligibility for TennCare Medicaid or TennCare Standard.

Involuntary loss of coverage shall not include situations in which the primary insured dropped dependent spouse and/or dependent child(ren) from the health benefits coverage policy.

- (i) "Meaningful Access" is insurance coverage that includes a network of providers within a reasonable distance from the area in which the covered individual lives.
- (j) "Parent" means a natural or appointed guardian of minor children as defined by Title 34, Part 1 of Tennessee Code Annotated subject to court orders entered or recognized by the courts of the state of Tennessee.
- (k) "Plan Administrator" or "PA" is the entity responsible for providing health care services to CoverKids enrollees. This may be a private contractor, government agency, or Departmental entity.
- (l) "SSI" means Supplemental Security Income benefits provided by the Social Security Administration.

(Rule 0620-05-01-.01, continued)

Authority: T.C.A. §§ 4-5-202, 71-3-1104, 71-3-1106, 71-3-1110. **Administrative History:** Public necessity rule filed March 13, 2007; expired August 25, 2007. Original rule filed May 30, 2007; effective August 13, 2007. Amendment filed May 22, 2008; effective August 5, 2008. Amendments filed February 25, 2009; effective June 26, 2009. Amendments filed July 20, 2016; effective October 18, 2016.

0620-05-01-.02 ELIGIBILITY.

- (1) Citizenship.
 - (a) Children must be citizens of the United States or persons designated as qualified aliens under 8 U.S.C. 1642 as applied to programs under Title XXI of the Social Security Act by federal law including 42 C.F.R. 457.320(b)(6). Notwithstanding any language to the contrary, CoverKids will grant eligibility to an unborn child whose mother is either an undocumented alien or a permanent resident alien who has not resided in the United States in that status for at least five years, to the extent that such coverage is mandated by the United States Department of Health and Human Services.
 - (b) CoverKids will comply with applicable amendments to Federal laws and regulations concerning eligibility of non-citizens.
- (2) Residency.
 - (a) The applicant must be a resident of the state of Tennessee.
- (3) Social Security Number.
 - (a) All applicants must have a Social Security Number (SSN) or proof of application for a SSN. For newborns less than 4 months of age an application for an SSN must be filed. SSN are not required for parents and children not applying for CoverKids coverage.
 - (b) Families with children under 4 months of age who were approved for CoverKids coverage without an SSN should submit the SSN to the AC as soon as received. A SSN must be received by redetermination.
- (4) Age.
 - (a) Applicants must be either a child under 19 years of age or a pregnant woman. CoverKids coverage for children ends the last day of the month in which the child turns 19.
 - (b) A female that that become pregnant at 18 years of age with a delivery date that occurs after her 19th birthday, will be allowed to retain coverage so as not to create discontinuity of care for prenatal, delivery, and post-partum care. This coverage will continue until the end of the month in which the 60th postpartum day occurs. All services rendered would be related to post-pregnancy care.
 - (c) Information of the child's age on the CoverKids application is sufficient verification of age. Any applicant for whom a date of birth is not provided will be denied CoverKids coverage.
- (5) Health Insurance.

(Rule 0620-05-01-.02, continued)

- (a) Factors in Determining Current Health Insurance.
 1. The applicant must not be currently covered by health insurance, as defined in rule 0620-05-01-.01(1)(g); and
 2. The applicant must not have had health insurance in the past three months unless the applicant experienced an involuntary loss of insurance, as defined in rule 0620-05-01-.01(1)(h).
 - (b) If the applicant is a pregnant woman with health insurance, as defined in rule 0620-05-01-.01(1)(g), she may be enrolled in CoverKids if her health insurance does not cover prenatal/maternity care. The AC will use the information on the application, the copy of the insurance card and information obtained by contacting the insurance company to determine if prenatal/maternity care is covered by her health insurance.
 - (c) Information on the CoverKids application is sufficient verification of an applicant being uninsured. The State reserves the right to investigate the insurance status of applicants. If the State determines that the applicant has other insurance or has not been without comprehensive health insurance for at least three (3) months, the State has the right to cancel coverage. The CoverKids application must be submitted with a copy of the front and back side of the insurance card for any applicants who indicate there is other insurance coverage.
- (6) Assets.
- (a) No asset test is used.
- (7) Income
- (a) To be eligible for CoverKids, children and pregnant women must have adjusted gross income above TennCare Medicaid levels but at or below 250% of the Federal Poverty Level. CoverKids may enroll persons above 250% of the Federal Poverty Level under the terms and conditions set forth in these Rules. This program will use the limited self declared information on the application to screen each applicant for potential TennCare Medicaid eligibility by aligning with the guidelines currently used in the Department of Human Services for determination of both budget groups and income calculation to the extent possible. Final determination of TennCare eligibility will be determined by the Department of Human Services or TennCare. These guidelines are subject to change with changes to the Department of Human Services guidelines. Further, these guidelines are for TennCare screening purposes only and are subject to change in accordance with any mandatory regulations issued from the federal level.
 - (b) The CoverKids application will request income information for adults who are parents (biological, adopted or step) and for caretaker relatives who are caring for children when neither parent lives in the home or in the event a parent lives in the house but the parent's current circumstances or conditions necessitate that a caretaker relative is the responsible adult assuming care of that child.
 - (c) All family income of the budget group must be reported on the application. Self-declaration of income by the responsible adult(s) of the applicant or the applicant is sufficient verification and must include the payee's name and the gross amount of monthly income.

(Rule 0620-05-01-.02, continued)

- (d) The financial eligibility for CoverKids will be calculated as follows:
 - 1. Depending on family relationships, a family may be comprised of one or multiple budget groups.
 - 2. If a child receives income and is applying for coverage, then that child and his income must be counted in the budget group.
 - 3. If a pregnant female is under the age of 19 and lives in the household with her parents, the pregnant female's budget group would consist of the pregnant minor and her parents.
 - (e) Countable Income.
 - 1. Self-declaration of income is allowed for applicants using the CoverKids application.
 - 2. Income must be reported as a monthly amount.
 - (f) Financial Factors - The AC will calculate each budget group's adjusted gross income for the month that eligibility will begin based on recent income information provided by the family on the CoverKids application. Adjusted gross income is the sum of all countable income for persons in the budget group.
- (8) Non-factors.
- (a) The following must not be a factor in determining CoverKids eligibility:
 - 1. Disability status.
 - 2. Pre-existing condition.
 - 3. Diagnosis.
- (9) Excluded Children.
- (a) Individuals who are not eligible for CoverKids include children who:
 - 1. Are eligible for TennCare Medicaid;
 - 2. Are enrolled in TennCare Medicaid or TennCare Standard;
 - 3. Have been criminally adjudicated and are in a correctional facility, including a detention home or training school;
 - 4. Are admitted to an institution for mental disease;
 - 5. Are eligible for health insurance, as defined in rule 0620-05-01-.01(1)(g), on the basis of a responsible adult's (self, parent, spouse, etc.) employment by a state agency or local education agency (unless such person has been denied enrollment due to medical underwriting); or

(Rule 0620-05-01-.02, continued)

6. Have had health insurance, as defined in rule 0620-05-01-.01(1)(g), in the past three months and voluntarily discontinued the comprehensive insurance, regardless of the cost.
- (10) Updated Federal Poverty Levels.
 - (a) Upon release by the federal government of a new calendar year's Federal Poverty Levels (usually in late winter), the AC will update the eligibility database to reflect the update.
 - (11) Changes in Family Status. If the family has applied for CoverKids and coverage was denied, applicants may reapply for CoverKids any time a change occurs that may make them eligible. This could include a change in family size, pregnancy, loss of a job, or change in family income. (A change in the child's health status does not make a child eligible for CoverKids.) If a family has a change in status that makes the children newly eligible for CoverKids, the family should reapply as soon as possible.
 - (12) Annual Redetermination of Eligibility.
 - (a) Eligibility determinations will be done annually. The AC will mail a CoverKids redetermination form to families within 60 calendar days of the beneficiary's last day of continuous eligibility. The family must review the renewal letter, note changes, attach documentation as appropriate, sign it and return it to AC. The AC will make an eligibility determination for each applicant on the redetermination form. The AC may present an option of renewal online.
 - (b) For beneficiaries at or above 250% of the FPL who continue to be otherwise eligible in this category, CoverKids eligibility will continue as long as the family continues to pay premiums timely each month.
 - (13) Pregnant women with income above 250% of the Federal poverty level will only be eligible for CoverKids enrollment if they are presently enrolled in the CoverTN program or presently enrolled in the CoverKids program.
 - (14) Enrollment Caps. CoverKids may impose enrollment caps for the program as a whole or for any category of enrollees when, in its discretion, it determines that either
 - (a) sufficient Federal funds will not be available;
 - (b) sufficient appropriations from the Tennessee General Assembly will not be available; or
 - (c) CoverKids expenditures will exceed the existing funds available for the program.

Authority: T.C.A. §§ 4-5-202, 4-5-208, 71-3-1104, 71-3-1106 and 71-3-1110. **Administrative History:** Public necessity rule filed March 13, 2007; expired August 25, 2007. Original rule filed May 30, 2007; effective August 13, 2007. Public necessity rule filed February 22, 2008; effective through August 5, 2008. Amendments filed May 22, 2008; effective August 5, 2008. Amendments filed February 25, 2009; effective June 26, 2009. Emergency rule filed October 12, 2009; effective through April 10, 2010. Amendment filed January 11, 2010; effective April 11, 2010. Amendments filed July 20, 2016; effective October 18, 2016.

0620-05-01-.03 BENEFITS AND COST SHARING.

(Rule 0620-05-01-.03, continued)

(1) The following benefits are covered by the CoverKids program as medically necessary, subject to the limitations stated.

(a) Medical benefits.

1. Ambulance services (air and ground).
2. Chiropractic care.
3. Durable medical equipment. Limited to the most basic equipment that will provide the needed care.
4. Emergency room care.
5. Home health.
6. Hospice.
7. Hospital care.
8. Inpatient mental health treatment. Pre-authorization required.
9. Inpatient substance abuse treatment. Pre-authorization required.
10. Lab and X-ray.
11. Maternity care.
12. Medical supplies. Quantities for a single prescription will be limited to a 31-day supply.
13. Outpatient mental health and substance abuse treatment.
14. Physical, speech, and occupational therapy. Limited to 52 visits per calendar year, per type of therapy.
15. Physician office visits.
16. Prescription drugs.
17. Rehabilitation hospital services.
18. Routine health assessments and immunizations.
19. Skilled nursing facility services. Limited to 100 days per calendar year following an approved hospitalization.
20. Vision benefits.
 - (i) Annual vision exam including refractive exam and glaucoma screening.
 - (ii) Prescription eyeglass lenses. Limited to one pair per calendar year. \$85 maximum benefit per pair.

(Rule 0620-05-01-.03, continued)

- (iii) Eyeglass frames. Coverage for replacement frames limited to once every two calendar years. \$100 maximum benefit per pair.
 - (iv) Prescription contact lenses in lieu of eyeglasses. Limited to one pair per calendar year. \$150 maximum benefit per pair.
- (b) Dental benefits.
- 1. Dental services. Limited to a \$1,000 annual benefit maximum per child.
 - 2. Orthodontic services. Limited to a \$1,250 lifetime benefit maximum per child. Covered only after a 12-month waiting period.
- (2) The following benefits are excluded from coverage by the CoverKids program.
- (a) Comfort or convenience items not related to an enrollee’s illness.
 - (b) Dietary guidance services.
 - (c) Homemaker or housekeeping services.
 - (d) Maintenance visits when no additional progress is apparent or expected to occur.
 - (e) Meals.
 - (f) Medical social services.
 - (g) Non-treatment services.
 - (h) Private duty nursing services.
 - (i) Routine transportation.
- (3) There are no premiums or deductibles required for participation in CoverKids.
- (4) Copays. The following copays are required, depending upon family income.

Service	Copays When Family Income is Less than 150% of Poverty	Copays When Family Income is 150%-250% of Poverty
MEDICAL BENEFITS		
Chiropractic care	\$5 per visit	\$15 per visit
Emergency room (emergency—waived if admitted)	\$5 per use	\$50 per use
Emergency room (non-emergency)	\$10 per use	\$50 per use
Home health	\$5 per visit	\$15 per visit
Hospital care	\$5 per admission; waived if readmitted within 48 hours for the same episode	\$100 per admission; waived if readmitted within 48 hours for the same episode
Inpatient mental health treatment	\$5 per admission; waived if readmitted within 48 hours for the same episode	\$100 per admission; waived if readmitted within 48 hours for the same episode

(Rule 0620-05-01-.03, continued)

Service	Copays When Family Income is Less than 150% of Poverty	Copays When Family Income is 150%-250% of Poverty
Inpatient substance abuse treatment	\$5 per admission; waived if readmitted within 48 hours for the same episode	\$100 per admission; waived if readmitted within 48 hours for the same episode
Maternity	\$5 OB or specialist, first visit only \$5 hospital admission	\$15 OB or specialist, first visit only \$20 per visit, specialist \$100 hospital admission
Medical supplies	\$5 per 31-day supply	\$5 per 31-day supply
Outpatient mental health and substance abuse treatment	\$5 per session	\$20 per session
Physical, speech, and occupational therapy	\$5 per visit	\$15 per visit
Physician office visits	\$5 per visit, primary care physician or specialist No copay for routine health assessments and immunizations rendered under the American Academy of Pediatrics guidelines	\$15 per visit, primary care physician \$20 per visit, specialist No copay for routine health assessments and immunizations rendered under the American Academy of Pediatrics guidelines
Prescription drugs	\$1, generics \$3, preferred brands \$5, non-preferred brands	\$5, generics \$20, preferred brands \$40, non-preferred brands
Rehabilitation hospital services	\$5 per admission	\$100 per admission
Vision services	\$5 for lenses; \$5 for frames (when lenses and frames are ordered at the same time, only one copay is charged)	\$15 for lenses; \$15 for frames (when lenses and frames are ordered at the same time, only one copay is charged)
DENTAL BENEFITS		
Dental	\$5 per visit No copay for routine preventive oral exam, X-rays, and fluoride application	\$15 per visit No copay for routine preventive oral exam, X-rays, and fluoride application
Orthodontic services	\$5 per visit	\$15 per visit
ANNUAL OUT-OF-POCKET MAXIMUM PER ENROLLEE		
Annual out-of-pocket maximum per enrollee	5% of the family's annual income	

- (5) Eligible children in a family that does not pay a required copay remain enrolled in the program. An individual provider may at his discretion refuse service for non-payment of a copay unless a medical emergency exists. The state does not participate in collection action or impose any benefit limitations if enrollees do not pay their copays.

Authority: T.C.A. §§ 4-5-202, 71-3-1104, 71-3-1106, and 71-3-1110. **Administrative History:** Public necessity rule filed March 13, 2007; expired August 25, 2007. Original rule filed May 30, 2007; effective August 13, 2007. Amendments filed May 22, 2008; effective August 5, 2008.

(Rule 0620-05-01-.03, continued)

Amendment filed June 17, 2014; effective September 15, 2014. Amendment filed July 27, 2015; effective October 25, 2015;

0620-05-01-.04 DISENROLLMENT.

- (1) Grounds for Disenrollment from CoverKids.
 - (a) Children enrolled in CoverKids at or below 250% of the FPL are financially eligible for 12 months, except in the following situations, which will result in disenrollment from CoverKids coverage prior to the end of the 12 month period.
 1. An enrollee, through an authorized family member, requests disenrollment.
 2. Admission of a CoverKids enrollee into a correctional facility or an institution for mental disease.
 3. A CoverKids enrollee moves from the state.
 4. Death of a CoverKids enrollee.
 5. A CoverKids enrollee is enrolled in TennCare.
 6. A CoverKids enrollee meets a TennCare Medicaid spend-down.
 7. A CoverKids enrollee turns age 19.
 8. A woman 19 or older who was enrolled because of pregnancy is no longer eligible after the last day of the month in which the sixtieth post-partum day occurs.
 9. A CoverKids enrollee gains access to health insurance, as defined in rule 0620-05-01-.01(1)(g), through a family member's employment with a state agency or local education agency.
 10. A CoverKids enrollee is enrolled into individual, group or employer-based coverage.
 11. A CoverKids enrollee is discovered not to have been eligible for CoverKids at the time of enrollment. This includes, but is not limited to, enrollees whose enrollment was obtained by fraud or misrepresentations by an enrollee, parent, guardian, or representative.
 - (b) A child above 250% of the Federal poverty level, as defined in these rules and under Federal law, may be disenrolled for nonpayment of premiums, as described more fully in regulation 0620-05-01-.03, as well as the reasons set forth in subparagraph (1)(a).
- (2) Procedures.
 - (a) Disenrollments shall be conducted under the procedures set forth in section 0620-05-01-.05 of these rules.

Authority: T.C.A. §§ 4-5-202, 71-3-1106, 71-3-1110. **Administrative History:** Public necessity rule filed March 13, 2007; expired August 25, 2007. Original rule filed May 30, 2007; effective

(Rule 0620-05-01-.04, continued)

August 13, 2007. Repeal and new rule filed May 22, 2008; effective August 5, 2008. Amendment filed February 25, 2009; effective June 26, 2009.

0620-05-01-.05 ADMINISTRATIVE REVIEW OF COVERKIDS DECISIONS.

- (1) Eligibility and Enrollment Matters. The parent of an enrollee or applicant may obtain review of a denial of eligibility, suspension or termination of enrollment (including termination for failure to pay premiums or cost sharing), or a situation in which eligibility decisions have not been made in a timely manner, through the following procedures.

(a) Informal Review.

1. A parent will be notified of a denial of eligibility or suspension or termination of enrollment in writing, and such notice will contain the reason for the denial, the procedures for seeking review of this decision, and the anticipated time by which review will be completed. Parents may also request a review for situations in which eligibility determination have not been made in a timely manner. Parents will be notified that termination or suspension of enrollment will not be effective until the completion of the review process provided in these rules.
2. Parents may request review by sending a written request to the Administrative Contractor (AC) or calling the eligibility and enrollment AC's toll-free number. This request for review must be received by the AC within 30 days of issuance of written notice of the action for which review is requested or, if notice is not provided, 30 days from the time the applicant becomes aware of the action. They may report additional information or clarify information on the applicant's account. The AC will document the call and any additional information/clarification provided. AC eligibility staff will review the matter.
3. If the AC's review does not result in the child being eligible, the parent will be notified of the reason the denial was upheld. The notification letter will inform the parent that they may submit a formal request in writing to the Division of Insurance Administration, to be reviewed by the state-level CoverKids Eligibility Appeals Committee.

(b) Formal Review.

1. The parent may request a formal review of the informal review decision with a written request to the Division of Insurance Administration. This request must be received by the Division within 30 days of issuance of the informal review decision. Receipts of requests for review will be acknowledged in writing within 10 days, including notification that a decision should be issued within one calendar month of receipt of the acknowledgment letter.
2. The Eligibility Appeals Committee, composed of five Division of Insurance Administration staff members, will review eligibility and enrollment matters. The members of this committee shall not have been directly involved in the matter under review. If the Committee disagrees with the decision of the AC, the child will be enrolled in CoverKids. If at any level of dispute, the appropriate party determines the child is eligible for enrollment in CoverKids, the enrollment will become effective

(Rule 0620-05-01-.05, continued)

retroactive to the first day of the month following the initial eligibility determination.

3. Parents may represent themselves or have a representative of their choosing in connection with formal reviews. Parents may review information relevant to the review of the decision in a timely manner and may submit supplemental information during the review process. Enrollees will remain enrolled pending completion of the review in the case of suspension or termination of enrollment.
4. The Committee is not required to conduct in-person hearings or to conduct a contested case under the requirements of the Uniform Administrative Procedures Act.
5. If the Committee agrees with the decision to deny eligibility, a letter will be sent to the parent detailing the reason for denial. The decision of the Eligibility Appeals Committee will be the final administrative recourse available.

(c) Deadlines for Review.

1. Expedited review will be provided if an applicant provides a statement from a medical professional that she or he has a medical situation that is life threatening or would seriously jeopardize the enrollee's health or ability to attain, maintain or regain maximum functioning. Expedited review should be completed within 10 days of receipt of the request.
2. All enrollment or eligibility matters not subject to expedited review shall be determined within a reasonable time.

(2) Health Services Matters. A parent of a CoverKids enrollee may request review of a Cover Kids action to delay, deny, reduce, suspend, or terminate health services, or a failure to approve, furnish, or provide payment for health services in a timely manner, according to the following provisions.

- (a) Notice. Any decision denying, or delaying a requested health service, reducing, suspending, or terminating an existing health service, or failure to approve, furnish, or provide payment for health services in a timely manner shall be in writing and must contain the reason for the determination, an explanation of review rights and procedures, the standard and expedited time frames for review, the manner of requesting a review, and the circumstances under which existing health services may continue pending review unless there is question that the existing health services are harmful.
- (b) Contractor Review. Parents commence the review process by submitting a written request to the Plan Administrator (PA) within 30 days of issuance of written notice of the action or, if no notice is provided, from the time the enrollee becomes aware of the action not to exceed six (6) months from when the action occurred. The PA will review this request and issue a written decision within 30 days of receipt of this request. Expedited reviews (within 72 hours) will be available for situations in which a benefit determination or a preauthorization denial has been made prior to services being received and the attending medical professional determines in writing (including legible handwriting) the medical situation to be life threatening or would seriously jeopardize the enrollee's health or ability to attain, maintain or regain maximum

(Rule 0620-05-01-.05, continued)

functioning. This determination should be made in legible writing with an original signature.

- (c) **State Informal Review.** After the PA's internal review is completed, the parent of an enrollee who disagrees with the decision may request further review by submitting a letter or form to the State Division of Insurance Administration which must be received within 8 days of the Administrator's decision. The Appeals Coordinator within the Division will review the matter and gather supplemental information from the family, physician, and/or insurer as needed. The Appeals Coordinator may also request review by the state's independent medical consultant. A written decision of the Appeals Coordinator should be issued within 20 days of receipt of the request for further review.
 - (d) **State Review Committee.** If the informal review does not grant the relief requested by the parent, the request will be scheduled for review by the CoverKids Review Committee. The Committee will be composed of five members, including Division of Insurance Administration staff and at least one licensed medical professional, selected by the Commissioner or his designee. The members of the Committee will not have been directly involved in the matter under review. The parent will be given the opportunity to review the file, be represented by a representative of the parent's choice, and provide supplemental information. The Committee may allow the parent to appear in person if it finds that scheduling the appearance will not cause delay in the review process. The Review Committee is not required to provide an in-person hearing or a contested case under the Uniform Administrative Procedures Act. The parent will receive written notification of the final decision stating the reasons for the decision. The decision of the CoverKids Review Committee is the final administrative recourse available to the member.
 - (e) **Time for Reviews.** Review of all non-expedited health services appeals will be completed within 90 days of receipt of the initial request for review by the PA. Reviews by both the Appeals Coordinator and the Committee may be expedited (completed within 72 hours at each the PA and State levels) for situations in which a benefit determination or a preauthorization denial has been made prior to services being received and the attending medical professional determines in writing (including legible handwriting) that the medical situation to be life threatening or would seriously jeopardize the enrollee's health or ability to attain, maintain or regain maximum functioning.
- (3) **Scope of Review.** CoverKids will not provide a review process for a change in enrollment, eligibility, or coverage under the health benefits package required by a change in the State plan or Federal and State law requiring an automatic change that affects all or a group of applicants or enrollees without regard to their individual circumstances.

Authority: T.C.A. §§ 4-5-202, 71-3-1106, 71-3-1110. **Administrative History:** Public necessity rule filed March 13, 2007; expired August 25, 2007. Original rule filed May 30, 2007; effective August 13, 2007.

0620-05-01-.06 PROVIDERS.

- (1) This rule shall be in effect from October 1, 2013.
- (2) For purposes of this rule, the following definitions shall apply:

(Rule 0620-05-01-.06, continued)

- (a) Covered services. Benefits listed in Rule 0620-05-01-.03 and authorized by the Plan Administrator ("PA").
 - (b) CoverKids network. A group of health care providers that have entered into contracts with the PA to furnish covered services to CoverKids enrollees. These contracts may take the form of general contracts or single case agreements.
 - (c) CoverKids provider. An appropriately licensed institution, facility, agency, person, corporation, partnership, or association that delivers health care services and that participates in the PA's network.
 - (d) Emergency services, including emergency mental health and substance abuse emergency treatment services. Services to treat the sudden and unexpected onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to potentially result in:
 - 1. Placing the person's (or with respect to a pregnant woman, her unborn child's) health in serious jeopardy; or
 - 2. Serious impairment to bodily functions; or
 - 3. Serious dysfunction of any bodily organ or part.
 - (e) HealthyTNBabies. The program that provides coverage of maternity care for pregnant CoverKids enrollees, including the unborn children of pregnant women with no source of coverage who meet the CoverKids eligibility requirements.
 - (f) Non-CoverKids provider. A health care provider of non-emergency services that does not participate in the PA's network.
- (3) Payment in full.
- (a) All CoverKids providers, as defined in this rule, must accept as payment in full for provision of covered services to a CoverKids enrollee, the amount paid by the PA, plus any copayment required by the CoverKids program to be paid by the individual.
 - (b) Any non-CoverKids providers who furnish CoverKids covered services by authorization from the PA must accept as payment in full for provision of covered services to CoverKids enrollees the amounts paid by the PA plus any copayment required by the CoverKids program to be paid by the individual.
 - (c) CoverKids will not pay for non-emergency services furnished by non-CoverKids providers unless these services are authorized by the PA. Any non-CoverKids provider who furnishes CoverKids Program covered non-emergency services to a CoverKids enrollee without authorization from the PA does so at his own risk. He may not bill the patient for such services except as provided for in Paragraph (5).
- (4) Non-CoverKids Providers.

(Rule 0620-05-01-.06, continued)

- (a) In situations where the PA authorizes a service to be rendered by a non-CoverKids provider, payment to the provider shall be no less than 80% of the lowest rate paid by the PA to equivalent participating CoverKids network providers for the same service, consistent with the methodology contained in Rule 1200-13-13-.08(2)(a).
 - (b) Covered medically necessary outpatient emergency services, when provided to CoverKids enrollees by non-CoverKids network hospitals, shall be reimbursed at 74% of the 2006 Medicare rates for the services, consistent with the methodology contained in Rule 1200-13-13-.08(2)(b). Emergency care to enrollees shall not require preauthorization.
 - (c) Covered medically necessary inpatient hospital admissions required as the result of emergency outpatient services, when provided to CoverKids enrollees by non-CoverKids network hospitals, shall be reimbursed at 57% of the 2008 Medicare DRG rates (excluding Medical Education and Disproportionate Share components) determined according to 42 CFR § 412 for the services, consistent with the methodology contained in Rule 1200-13-13-.08(2)(c). Such an inpatient stay will continue until no longer medically necessary or until the patient can be safely transported to a network hospital, whichever comes first.
- (5) Providers may seek payment from a CoverKids enrollee only under the following circumstances. These circumstances include situations where the enrollee may choose to seek a specific covered service from a non-CoverKids provider.
- (a) If the services are not covered by the CoverKids program and, prior to providing the services, the provider informed the enrollee that the services were not covered.
 - (b) If the services are not covered because they are in excess of an enrollee's benefit limit and one of the following circumstances applies:
 - 1. The provider has information in her own records to support the fact that the enrollee has reached his benefit limit for the particular service being requested and, prior to providing the service, informs the enrollee that the service is not covered and will not be paid for by CoverKids. This information may include:
 - (i) A previous written denial of a claim on the basis that the service was in excess of the enrollee's benefit limit for a service within the same benefit category as the service being requested, if the time period applicable to the benefit limit is still in effect; or
 - (ii) That the provider had personally provided services to the enrollee in excess of his benefit limit within the same benefit category as the service being requested, if the time period applicable to that benefit period is still in effect; or
 - (iii) The enrollee's PA has provided confirmation to the provider that the enrollee has reached his benefit limit for the applicable service.
 - 2. The provider submits a claim for service to the PA and receives a written denial of that claim on the basis that the service exceeds the enrollee's benefit limit. After informing the enrollee and within the remainder of the period applicable to that benefit limit, the provider may bill the enrollee

(Rule 0620-05-01-.06, continued)

for services within that same exhausted benefit category without having to submit claims for those subsequent services for repeated PA denial. If the provider informed the enrollee prior to providing the service for which the claim was denied that the service would exceed the enrollee's benefit limit and would not be paid for by CoverKids, the provider may bill the enrollee for that service.

3. The provider had previously taken the steps in parts 1. or 2. above and determined that the enrollee had reached his benefit limit for the particular service being requested, if the time period applicable to the benefit limit is still in effect, and informs the enrollee, prior to providing the service, that the service is not covered and will not be paid for by CoverKids.
- (c) If the services are covered only with prior authorization and prior authorization has been requested but denied, or is requested and a specified lesser level of care is approved, and the provider has given prior notice to the enrollee that the services are not covered, the enrollee may elect to receive those services for which prior authorization has been denied or which exceed the authorized level of care and be billed by the provider for such services.
- (6) Providers may not seek payment from a CoverKids enrollee under the following conditions:
 - (a) The provider knew or should have known about the patient's CoverKids enrollment prior to providing services.
 - (b) The claim submitted to the PA for payment was denied due to provider billing error or a CoverKids claim processing error.
 - (c) The provider accepted CoverKids assignment on a claim and it is determined that another payer paid an amount equal to or greater than the CoverKids allowable amount.
 - (d) The provider failed to comply with CoverKids policies and procedures or provided a service which lacks medical necessity or justification.
 - (e) The provider failed to submit or resubmit claims for payment within the time periods required by the PA or CoverKids.
 - (f) The provider failed to inform the enrollee prior to providing a service not covered by CoverKids that the service was not covered and the enrollee may be responsible for the cost of the service. Services which are non-covered by virtue of exceeding limitations are exempt from this requirement if the provider has complied with paragraph (5) above.
 - (g) The enrollee failed to keep a scheduled appointment(s).
 - (7) Pharmacy providers may not waive pharmacy copayments for CoverKids enrollees as a means of attracting business to their establishments. This does not prohibit a pharmacy from exercising professional judgment in cases where an enrollee may have a temporary or acute need for a prescribed drug, but is unable, at that moment, to pay the required copayment.

Authority: T.C.A. §§ 4-5-202, 71-3-1104, 71-3-1106 and 71-3-1110. **Administrative History:** Emergency rule filed September 26, 2013; effective through March 25, 2014. Repeal of

(Rule 0620-05-01-.06, continued)

emergency rule filed September 26, 2013 was filed on December 20, 2013. In its place, emergency rule 0620-05-01-.06 was filed December 20, 2013; effective through June 18, 2014. New rule filed March 17, 2014; effective June 15, 2014.