

**Department of State**  
**Division of Publications**  
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**For Department of State Use Only**

Sequence Number: 02-01-13  
 Rule ID(s): 5369  
 File Date: 2/1/13  
 Effective Date: 7/29/13

## Proposed Rule(s) Filing Form

*Proposed rules are submitted pursuant to T.C.A. §§ 4-5-202, 4-5-207 in lieu of a rulemaking hearing. It is the intent of the Agency to promulgate these rules without a rulemaking hearing unless a petition requesting such hearing is filed within sixty (60) days of the first day of the month subsequent to the filing of the proposed rule with the Secretary of State. To be effective, the petition must be filed with the Agency and be signed by twenty-five (25) persons who will be affected by the amendments, or submitted by a municipality which will be affected by the amendments, or an association of twenty-five (25) or more members, or any standing committee of the General Assembly. The agency shall forward such petition to the Secretary of State.*

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

**Revision Type (check all that apply):**

- Amendment  
 New  
 Repeal

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

Chapter Number	Chapter Title
1200-13-01	TennCare Long-Term Care Programs
Rule Number	Rule Title
1200-13-01-.04	Third Party Resources
1200-13-01-.11	Recipient Abuse and Overutilization of Medicaid Program
1200-13-01-.17	Statewide Home and Community Based Services Waiver for the Elderly and Disabled (Statewide E/D Waiver)
1200-13-01-.21	Provider Noncompliance or Fraud of Medicaid Program

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

Rule 1200-13-01-.04 Third Party Resources is deleted in its entirety.

Statutory Authority: T.C.A. §§ 4-5-202 and 71-5-105.

Rule 1200-13-01-.11 Recipient Abuse and Overutilization of Medicaid Program is deleted in its entirety.

Statutory Authority: T.C.A. §§ 4-5-202 and 71-5-105.

Rule 1200-13-01-.17 Statewide Home and Community Based Services Waiver for the Elderly and Disabled (Statewide E/D Waiver) is deleted in its entirety.

Statutory Authority: T.C.A. §§ 4-5-202 and 71-5-105.

Rule 1200-13-01-.21 Provider Noncompliance or fraud of Medicaid Program is deleted in its entirety.

Statutory Authority: T.C.A. §§ 4-5-202 and 71-5-105.

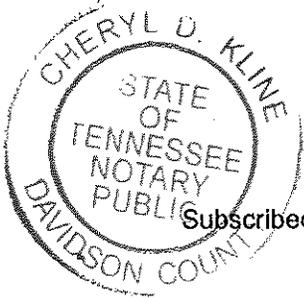
I certify that this is an accurate and complete copy of proposed rules, lawfully promulgated and adopted by the (board/commission/other authority) on 07/23/2012 (date as mm/dd/yyyy), and is in compliance with the provisions of T.C.A. § 4-5-222. The Secretary of State is hereby instructed that, in the absence of a petition for proposed rules being filed under the conditions set out herein and in the locations described, he is to treat the proposed rules as being placed on file in his office as rules at the expiration of sixty (60) days of the first day of the month subsequent to the filing of the proposed rule with the Secretary of State.

Date: 07/23/12

Signature: Patti Killingsworth

Name of Officer: Patti Killingsworth  
Chief, Long-Term Services and Supports, Bureau of TennCare

Title of Officer: Tennessee Department of Finance and Administration



Subscribed and sworn to before me on: 7/23/12

Notary Public Signature: Cheryl D Kline

My commission expires on: 9/3/2012

All proposed rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

Robert E. Cooper, Jr.  
Robert E. Cooper, Jr.  
Attorney General and Reporter  
1-29-13

Date

Department of State Use Only

Filed with the Department of State on: 2/1/13

Effective on: 7/29/13

Tre Hargett  
Tre Hargett  
Secretary of State

RECEIVED  
2012 FEB -1 AM 11:36  
SECRETARY OF STATE

### **Regulatory Flexibility Addendum**

Pursuant to T.C.A. §§ 4-5-401 through 4-5-404, prior to initiating the rule making process as described in T.C.A. § 4-5-202(a)(3) and T.C.A. § 4-5-202(a), all agencies shall conduct a review of whether a proposed rule or rule affects small businesses.

(If applicable, insert Regulatory Flexibility Addendum here)

The rules have no effect on small businesses.

### **Impact on Local Governments**

Pursuant to T.C.A. §§ 4-5-220 and 4-5-228 “any rule proposed to be promulgated shall state in a simple declarative sentence, without additional comments on the merits of the policy of the rules or regulation, whether the rule or regulation may have a projected impact on local governments.” (See Public Chapter Number 1070 (<http://state.in.us/sos/acts/106/pub/pc1070.pdf>) of the 2010 Session of the General Assembly)

(Insert statement here)

The rules are not projected to have an impact on local governments.

**Additional Information Required by Joint Government Operations Committee**

All agencies, upon filing a rule, must also submit the following pursuant to T.C.A. § 4-5-226(i)(1).

- (A) A brief summary of the rule and a description of all relevant changes in previous regulations effectuated by such rule;

The rules are being promulgated to repeal obsolete rules.

- (B) A citation to and brief description of any federal law or regulation or any state law or regulation mandating promulgation of such rule or establishing guidelines relevant thereto;

The rules are lawfully adopted by the Bureau of TennCare in accordance with Tennessee Code Annotated §§ 4-5-202 and 71-5-105.

- (C) Identification of persons, organizations, corporations or governmental entities most directly affected by this rule, and whether those persons, organizations, corporations or governmental entities urge adoption or rejection of this rule;

The persons, organizations, corporations or governmental entity most directly affected by these rules are the Bureau of TennCare, Tennessee Department of Finance and Administration.

- (D) Identification of any opinions of the attorney general and reporter or any judicial ruling that directly relates to the rule;

The rules were reviewed and approved by the Tennessee Attorney General. No additional opinion was given or requested.

- (E) An estimate of the probable increase or decrease in state and local government revenues and expenditures, if any, resulting from the promulgation of this rule, and assumptions and reasoning upon which the estimate is based. An agency shall not state that the fiscal impact is minimal if the fiscal impact is more than two percent (2%) of the agency's annual budget or five hundred thousand dollars (\$500,000), whichever is less;

The promulgation of these rules is not anticipated to have an effect on state and local government revenues and expenditures.

- (F) Identification of the appropriate agency representative or representatives, possessing substantial knowledge and understanding of the rule;

Darin J. Gordon  
Director, Bureau of TennCare

- (G) Identification of the appropriate agency representative or representatives who will explain the rule at a scheduled meeting of the committees;

Darin J. Gordon  
Director, Bureau of TennCare

- (H) Office address, telephone number, and email address of the agency representative or representatives who will explain the rule at a scheduled meeting of the committees; and

310 Great Circle Road  
Nashville, TN 37243  
(615) 507-6443  
Darin.J.Gordon@tn.gov

- (I) Any additional information relevant to the rule proposed for continuation that the committee requests.



GW1012192

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Rule 1200-13-01-.04 Third Party Resources is deleted in its entirety.

## ~~1200-13-01-.04 THIRD PARTY RESOURCES.~~

### ~~(1) Definitions~~

- ~~(a) Third party resources shall mean any individual, entity or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished to a Tennessee Medicaid recipient.~~

~~Recipient resources acquired through medical malpractice or victim compensation actions or from indemnity insurance, which compensates for loss of work or loss of limb, shall not be considered a third party resource. An indemnity insurance policy which compensates for specific medical services such as inpatient hospital confinement, is a third party resource.~~

- ~~(b) Third party payment shall mean compensation provided to a Medical provider or to Medicaid by any third party resource which eliminates or reduces Medicaid's indebtedness for medical assistance furnished to a Tennessee Medicaid recipient.~~

- ~~(c) Direct billing shall mean the process used by Medicaid to collect/recover payments for covered services from any third party resource available to a Medicaid recipient.~~

- ~~(d) Recipient assignment of rights shall mean that a recipient or responsible party shall assign rights to Medicaid for medical support or other third party payments. The recipient and/or responsible party shall cooperate with Medicaid and providers in obtaining Medical support or payments.~~

- ~~(e) Third party documentation shall mean:~~

- ~~1. an insurance company's explanation of benefits (EOB) related to the specific claim, or~~
- ~~2. a statement on the provider's letterhead indicating contact with the insurance company and the reason for denial. The statement must be signed and dated by an authorized employee of the provider and include the insurance company name, policy and group number, the date of contact, the date of service, the recipient name and Medicaid identification number.~~

- ~~(2) Claims for Medicaid covered services provided to Medicaid eligibles shall not be made against Medicaid until Medicare and other probable third party resources to the recipient have been collected, unless prohibited by federal law except where third party resources are provided by other state agencies under contract with this Department which designated the agency as payor after Medicaid.~~

- ~~(a) Medicaid may be billed following formal notification from the third party resources that the services provided are not covered or payable or when third party payment has been received. All claims submitted shall indicate the third party payment amount received, if third party resources are found to be nonexistent, copies of letter(s) or other supporting documentation shall be attached to the claim.~~

- ~~1. If third party payment is less than the Medicaid allowable, Medicaid will pay the difference between the third party payment and the Medicaid allowable. No further claim shall be allowed against the recipient and/or the recipient's responsible party(s) for Medicaid services, or~~

- ~~2. If third party payment is equal to or exceeds the Medicaid allowable no further claim shall be allowed against Medicaid or the Medicaid recipient and/or that recipient's responsible party(s) for Medicaid covered services.~~
- ~~(3) Providers receiving third party payments following Medicaid payment shall notify and refund Medicaid within 60 days of receipt of the third party payment. The refund to Medicaid shall be the lesser of the third party or Medicaid payment. The provider shall submit a check to Medicaid, or may request Medicaid to setoff the refund amount from the provider's current claim. A Medicaid Title XIX Adjustment Void Request form identifying the recipient's name and Medicaid number, date(s) of service, remittance advice, number and the name and address of the third party resource, shall be submitted with a check or request for setoff to assure the proper credit is provided to the provider and recipient accounts.~~
- ~~(4) Providers having received third party payments which should have been reported and refundable in whole or in part to Medicaid as specified in parts (2) and (3), which were held more than 60 days and not refunded, and/or which are found in an audit/review shall be subject to any resulting federal monetary assessment against the State Medicaid program.~~
- ~~(5) Medicaid shall perform audits of provider records to identify third party resources unreported and/or unrefunded to Medicaid as specified in part (3). Provider(s) to be audited shall be selected based upon the potential of the provider and/or provider category (hospitals, physicians, etc.) to receive third party resources.~~
- ~~(6) Direct Billing
  - ~~(a) Medicaid shall utilize direct billing when it is determined that a previously paid service(s) may have been covered by a third party. Additionally, notwithstanding Section (2), direct billing for some services may be more cost effective than requiring the provider to collect prior to billing Medicaid. These services shall be, but are not limited to, pharmacy claims.~~
  - ~~(b) Medicaid shall identify to the third party resource, the recipient name and address, the third party group and/or policy number (if appropriate), the name of the responsible party/policyholder, the name of the provider of service, the description of the service that was provided, the date(s) of the service, the amount billed Medicaid by the provider of service, and the amount paid by Medicaid to the provider of service.~~
  - ~~(c) The third party resources shall submit payment to Medicaid and/or notify Medicaid in writing of no coverage data such as the date the policy started and lapsed, services that are non-covered, and the identity of any other party having been paid by the third party resource for any of the identified service(s).~~
  - ~~(d) Medicaid shall notify the Tennessee Department of Human Services in the event an absent parent, court ordered to provided for medical expenses, cannot be located and/or refuses to make full restitution to Medicaid.~~~~
- ~~(7) Reserved.~~
- ~~(8) Provider Billing Requirements
  - ~~(a) Providers shall bill Medicaid for all covered services rendered under the plan and report third party collections.~~
  - ~~(b) Unless otherwise allocated on the payor's explanation of benefits (EOB), third party payment reported to Medicaid shall be prorated equally over the institutional days or professional services billed.~~~~

~~(c) Medicaid will not make payment if the provider is aware of a third party resource prior to rendering service and is denied payment from the third party resource because of provider non-compliance with policy/contract provisions.~~

~~(9) Paid claims, for which a third party resource is later identified, may be voided by Medicaid if the date of service is within one year of the resource identification. The third party resource will be identified to the provider on the remittance advice which identifies the voided claim.~~

~~(10) Provider Discrimination~~

~~A provider who furnished services and is participating under the plan may not refuse to furnish services to a recipient because of a third party potential liability for payment for the service.~~

~~(11) Assignment of Benefits~~

~~(a) A recipient assigns rights to Medicaid when the recipient uses a Medicaid card to receive medical assistance.~~

~~(b) Any document released by a provider to a Medicaid recipient concerning the provision of a covered service shall have "Benefits Assigned" printed boldly on the statement. If a provider refunds third party payments to a recipient the provider is subject to recovery from Medicaid up to the Medicaid paid amount. If a third party pays the recipient directly Medicaid shall recover from the recipient.~~

~~(c) A provider shall immediately notify Medicaid of a request for medical records from a Medicaid recipient and/or agent or attorney. If proper authorization is received from the recipient the records may be released with the statement "Benefits Assigned." The notification to Medicaid must include:~~

- ~~1. name and Medicaid number of the recipient,~~
- ~~2. dates of service in question.~~
- ~~3. provider name and provider number,~~
- ~~4. attorney name, address and telephone number, and/or~~
- ~~5. insurance company name, address and telephone number.~~

~~(12) Recipient Shall Cooperate with Provider~~

~~If the provider documents at least two attempts to obtain recipient cooperation in meeting third party resource policy/plan requirements they may contact the Medicaid TPL Unit for assistance. The provider may bill Medicaid after 180 days with copies of the documentation attached to the claim. Medicaid shall pay the provider and attempt recovery from the recipient and/or third party resource.~~

~~(13) Absent Parents~~

~~(a) An absent parent obligated by court order to provide continuing health insurance, medical support or a combination of insurance and support shall:~~

- ~~1. be billed by Medicaid for reimbursement of costs incurred for his/her child, and~~
- ~~2. reimburse Medicaid promptly or provide adequate health insurance coverage information to Medicaid.~~

~~Medicaid may bill the insurance carrier directly and request provider assistance in the recovery. Medicaid will enter into a written cooperative agreement for the enforcement of rights to, and collection of, such third party benefits as provided in 42 CFR Section 433.151, as amended.~~

- ~~(b) An absent parent obligated by court order to pay for paternity expenses only shall be billed for costs incurred for the delivery of his/her child. Failure by the absent parent to reimburse Medicaid will initiate the recovery process in Section (13)(a).~~

~~(14) Subrogation Notice~~

~~Medicaid shall notify any third party or attorney of the state's claim of subrogation, when either is suspected of representing a Medicaid recipient who has received benefits. If an unauthorized settlement is distributed to the recipient and/or a responsible party after the receipt of the subrogation notice, the person responsible for the distribution shall be financially liable to the State for Medicaid's payments.~~

~~(15) Third Party Documentation/Explanation of Benefits~~

- ~~(a) A provider shall maintain third party documentation/explanation of benefits until audited but no longer than three (3) years from date of service, unless other record requirements apply.~~
- ~~(b) A provider shall attach explicit documentation of a third party resource denial to the Medicaid claim, except in the case of UB-82 and tape billing. This documentation must provide sufficient information for Medicaid to justify payment. The information will also be used by Medicaid to update its third party resource files as appropriate.~~
- ~~(c) If a third party resource denial is based on services in excess of an annual limitation, the documentation shall only be valid on claims for the applicable year. Documentation shall be appropriate to the claim submitted or the claim will be denied.~~

~~(16) Third party is established and available on the date of service.~~

~~If provider learns of a third party resource after billing Medicaid the provider shall immediately bill the third party. If third party payment is received the provider shall adjust the previous Medicaid payment using the Medicaid Adjustment/Void Request Form. The insurance company name and policy number should be entered on the form. If no third party payment is received the explanation of benefits should be kept on file by the provider.~~

~~(17) Third party is not established or available on the date of service (example: automobile accident - party possibly at fault with liability coverage which may pay recipient medical claims.)~~

- ~~(a) A provider may elect to bill the anticipated liable third party for a covered Medicaid service, or~~
- ~~(b) If the provider elects to bill Medicaid, Medicaid will recover from the third party.~~
- ~~(c) The provider may not include charges for covered services billed to Medicaid in an independent claim to the potentially liable third party.~~
- ~~(d) The provider may void a claim previously paid by Medicaid at any time in an attempt to recover a larger payment from a potentially liable third party.~~
- ~~(e) Medicaid may not be billed for a covered service under the plan following the expiration of Medicaid's timely filing limits.~~

~~(18) A provider may keep the total third party payment even if it exceeds the Medicaid allowable amount.~~

- ~~(19) Medical assistance benefits shall be coordinated with third party resources and reimbursement shall not be made for services which would have been reimbursable by the third party except for failure to adhere to the third party's requirements.~~

Statutory Authority: T.C.A. §§ 4-5-202 and 71-5-105.

Rule 1200-13-01-.11 Recipient Abuse and Overutilization of Medicaid Program is deleted in its entirety.

~~**1200-13-01-.11 RECIPIENT ABUSE AND OVERUTILIZATION OF MEDICAID PROGRAM.**~~

~~(1) Definitions:~~

- ~~(a) Abuse: Recipient practices or recipient involvement in practices including overutilization of Medicaid Program service that result in costs to the Medicaid Program which are not medically necessary or medically justified.~~
  - ~~(b) Commencement of Services: The time at which the first covered service(s) is rendered to a Medicaid recipient for each individual medical condition.~~
  - ~~(c) Emergency: The sudden and unexpected onset of a medical condition requiring treatment immediately after onset or within 72 hours in order to prevent serious disability or death.~~
  - ~~(d) Initiating Provider: The provider who renders the first covered service to a Medicaid recipient whose current medical condition requires the services of more than one (1) provider.~~
  - ~~(e) Lock-in Provider: A provider whom a recipient on lock-in status has chosen and to whom a recipient is assigned by the Bureau for purposes of receiving medical services and referral to other providers.~~
  - ~~(f) Lock-in Status: The restriction of a recipient to a specified and limited number of health care providers.~~
  - ~~(g) Overutilization: Recipient initiated use of Medicaid services or items at a frequency or amount that is not medically necessary or medically justified.~~
  - ~~(h) Prior Approval Status: The restriction of a recipient to a procedure wherein all health care services, except in emergency situations, must be approved by the Bureau prior to the delivery of services.~~
- ~~(2) When a determination is made by the Bureau that a recipient committed, attempted to commit or aided in the commission of an abuse or overutilization of the Medicaid Program it shall:~~
- ~~(a) Restrict the recipient by placing the recipient on lock-in status for an initial period of eighteen (18) months; or~~
  - ~~(b) Restrict the recipient by placing the recipient on prior approval status for an initial period of eighteen (18) months.~~
- ~~(3) Activities or practices which may evidence overutilization of the Medicaid Program for which the commission or attempted commission justifies placement on lock-in status of all recipients involved, include but are not limited to:~~
- ~~(a) Treatment by several physicians for the same diagnosis.~~
  - ~~(b) Obtaining the same or similar controlled substances from several physicians.~~

- ~~(c) — Obtaining controlled substances in excess of the maximum recommended dose.~~
  - ~~(d) — Receiving combinations of drugs which act synergistically or belong to the same class.~~
  - ~~(e) — Frequent treatment for diagnoses which are highly susceptible to abuse.~~
  - ~~(f) — Receiving services and/or drugs from numerous providers.~~
  - ~~(g) — Obtaining the same or similar drugs on the same day or at frequent intervals.~~
  - ~~(h) — Frequent use of emergency room in non-emergency situations.~~
- ~~(4) — Activities or practices which may evidence abuse of the Medicaid Program for which the commission or attempted commission justifies placement on prior approval status of all recipients involved, include but are not limited to:~~
- ~~(a) — Trading, swapping or selling of Medicaid cards.~~
  - ~~(b) — Forging or altering drug prescriptions.~~
  - ~~(c) — Selling Medicaid paid prescription drugs.~~
  - ~~(d) — Failing to promptly report loss or theft of a Medicaid card when the recipient knew or should have known the card was lost or stolen.~~
  - ~~(e) — Inability to provide for the security and integrity of assigned Medicaid card.~~
  - ~~(f) — Altering a Medicaid card.~~
  - ~~(g) — Failure to control overutilization activity while on lock-in status.~~
  - ~~(h) — Knowingly providing incomplete, inaccurate or erroneous information during Medicaid financial eligibility determination.~~
  - ~~(i) — Knowingly providing false, incomplete, inaccurate or erroneous information to provider(s) in order to receive covered services for which the recipient is ineligible.~~
  - ~~(j) — The use of a Medicaid card by a recipient other than the recipient to which it is assigned to receive or attempt to receive covered medical services.~~
- ~~(5) — The Bureau shall conduct a review of all recipients placed on lock-in or prior approval status upon the expiration of the initial and any additional restriction period(s) and shall:~~
- ~~(a) — Remove the recipient from lock-in or prior approval status and reinstate the recipient to the normal Medicaid status, or~~
  - ~~(b) — If the recipient's activity indicates continued or attempted abuse of overutilization, regardless of the exact nature of the activity, during the initial and/or additional restriction period(s),
    - ~~1. — continue the recipient on lock-in or prior approval status for an additional eighteen (18) months; or~~
    - ~~2. — change the recipient from lock-in or prior approval status for an additional eighteen (18) months; or~~~~

- ~~3. change the recipient from Prior approval to lock-in status for an additional eighteen (18) months.~~
- ~~(c) If at any time during which a recipient is on lock-in status, the recipient's activities indicate continued abuse or attempted abuse of the Medicaid Program, the Bureau may review the recipient's status and change the recipient from lock-in status to prior approval status for the remainder of the initial or additional restriction period.~~
- ~~(d) The Bureau may reconsider the need to continue a recipient on lock-in or prior approval status upon notification and written verification from a licensed physician that the recipient is suffering from a medical condition including but not limited to:
  - ~~1. a catastrophic illness such as terminal cancer or renal dialysis; or~~
  - ~~2. a condition which necessitates admission to an inpatient facility for an extended period of time.~~~~
- ~~(6) A recipient is entitled to a fair hearing in the following circumstances:
  - ~~(a) When the Bureau makes the initial determination to place the recipient on lock-in or prior approval status; and~~
  - ~~(b) When the Bureau, after any recipient status review, makes a determination to:
    - ~~1. continue the recipient on lock-in or prior approval status; or~~
    - ~~2. change the recipient from lock-in to prior approval status; or~~
    - ~~3. change the recipient from prior approval to lock-in status.~~~~
  - ~~(c) When the Bureau, pursuant to prior approval procedures, denies a prior approval status recipient's claim to or request for the provision of a covered service.~~
  - ~~(d) When the action of the Bureau placing a recipient on a restricted status would result or has resulted in the denial of reasonable access to Medicaid services of adequate quality pursuant to subsection (13) of this section.~~~~
- ~~(7) Fair Hearing Procedures: The following procedure shall apply when a recipient becomes entitled to a fair hearing pursuant to section (6):
  - ~~(a) The Bureau shall notify the recipient in writing by certified mail, return receipt requested, of its determination. The notice shall contain:
    - ~~1. the specific and comprehensive reasons for the determination, and~~
    - ~~2. a statement of the Bureau's intended action, and~~
    - ~~3. a statement of the recipient's right to a hearing pursuant to the Uniform Administrative Procedures Act (T.C.A. Section 4-5-101 et seq.).~~~~
  - ~~(b) A recipient must request a hearing within fifteen (15) days of receipt of the notice by filing such request in writing with the Bureau. The request for hearings pursuant to subsection 6(c) must be made in writing within fifteen (15) days of the date on which the claim to or request for services is denied.~~~~

- ~~(c) If a recipient fails to request a hearing within the designated time limit the recipient shall forfeit the right to a hearing on the action specified in the notice and the Bureau shall take such action as it specified in the notice.~~
  - ~~(d) If a recipient requests a hearing within the designated time limit, the Bureau shall schedule a hearing and notify the recipient of the time and place. The recipient's then existing status will not change pending a final determination after the hearing.~~
  - ~~(e) A hearing requested pursuant to subsection (6)(c) shall be scheduled within ten (10) days of receipt of the request.~~
- ~~(8) Lock-in Status Procedures: For services rendered to any lock-in status recipient the following shall apply:~~
- ~~(a) The Bureau shall request the recipient to submit the name(s) of the provider(s) from whom the recipient wishes to receive services.~~
  - ~~(b) If the recipient's condition necessitates the services of more than one (1) physician, other physicians will be allowed to provide needed services and submit a claim to Medicaid; however, the physicians must be of different specialties and Medicaid program participants.~~
  - ~~(c) The name(s) submitted by the recipient shall become the recipient's lock in provider(s) unless the Bureau determines that the provider(s) is/are ineligible, unable or unwilling to become the lock-in provider(s) in which case additional provider names will be requested.~~
  - ~~(d) If the recipient fails to submit the requested provider name(s) within ten (10) days of the receipt of the Bureau's request, the Bureau may assign, as lock-in providers one (1) physician (non-specialist) and one (1) pharmacy from those utilized recently by the recipient, or the recipient will be placed on prior approval status until the requested provider name(s) are received and approved by the Bureau.~~
  - ~~(e) All referrals from a recipient's lock in provider to a non lock-in provider must be reported by telephone or in writing to the Bureau to avoid automatic denial of the referred providers claim.~~
  - ~~(f) A recipient who is on lock-in status may change providers by giving at least thirty (30) days written notice to the Bureau. Elective changes will only be allowed every six (6) months. Emergency changes (i.e., death of provider, discharge of recipient by provider, etc.) may be accomplished at any time by telephoning the Bureau, but must be followed by a written request within ten (10) days.~~
  - ~~(g) Upon the change of a lock-in provider pursuant to subsection (8)(f) of this section all referrals to other providers made by the previous lock-in provider shall no longer be valid.~~
  - ~~(h) All providers are responsible for ascertaining recipient Medicaid status and, except in the case of an emergency or approved referral or admission to a long term care facility, reimbursement for services rendered to a lock-in status recipient by any provider other than the recipient's lock-in provider shall be denied.~~
- ~~(9) Prior Approval Status Procedures: For services rendered to any prior approval status recipient the following shall apply:~~
- ~~(a) The provider is responsible for ascertaining the status of any Medicaid recipient.~~
  - ~~(b) The provider is responsible for securing prior approval by telephone from the Bureau in all cases, except emergencies, by calling the telephone number listed on the recipient's Medicaid care, in accordance with the following:~~

1. ~~If the commencement of services is during the normal office hours (8:00 a.m. to 4:30 p.m.) on any state working day, approval must be obtained prior to the commencement of services regardless of the number of services or the length of time services are provided.~~
  2. ~~If the commencement of services is during any time state offices are closed, approval must be obtained no later than the closing hour of the next state working day following the commencement of services regardless of the number of services or the length of time services are provided.~~
- (c) ~~In either of the circumstances listed in subsection (9)(b) of this section, if a recipient's current medical condition requires the services of more than one (1) provider the following shall apply:~~
1. ~~If the initiating provider secures prior approval in accordance with the rules, the subsequent provider(s) need not secure prior approval for any medically necessary services rendered.~~
  2. ~~If the initiating provider fails to secure prior approval in accordance with the rules, all other provider claims arising from that medical condition shall be denied except claims submitted by any subsequent provider who secures prior approval in accordance with the rules.~~
- (d) ~~The provider may not seek payment from Medicaid or the recipient for any medical services rendered without prior approval or for services rendered beyond the scope of the services contemplated by any prior approval.~~
- (e) ~~A long term care provider is not at risk of a claim denial under this rule for covered services rendered to a prior approval status recipient. Compliance with all other long term care rules is mandatory to provider reimbursement.~~
- (f) ~~A provider is not at risk of a claim denial for maintenance prescriptions filled during any time at which state offices are closed, however, prior approval procedures pursuant to subsection (9)(b) must still be followed.~~
- (g) ~~Services rendered or to be rendered shall be approved or denied based upon:~~
1. ~~The securing of prior approval;~~
  2. ~~Medical necessity;~~
  3. ~~The recipient's medical history;~~
  4. ~~The recipient's medical records;~~
  5. ~~The medical timeliness of the services; and~~
  6. ~~Review by the Medicaid Medical Director upon request by the recipient, provider or the Bureau prior to initial denial.~~
- (h) ~~A provider is not at risk of a claim denial for inpatient hospital admission and related medical services if preadmission approval has been obtained.~~
- (10) ~~Emergency Services: Any Medicaid provider may render services to a recipient on lock-in or prior approved status in the event of an emergency, provided however that reimbursement for services provided will be allowed only under the following circumstances:~~
- (a) ~~The provider notifies the Bureau by telephone no later than the end of the next state working day following the commencement of services;~~

- (b) ~~The provider presents sufficient medical evidence concerning the nature of the emergency to justify reimbursement; and~~
  - (c) ~~Review by the Medicaid Medical Director upon request by the recipient, provider or the Bureau prior to initial denial.~~
- (11) ~~Identification Verification of Medicaid Lock-In and Prior Approval Recipients. Medicaid Lock-In and Prior Approval Status Cards:~~
- (a) ~~These special cards are pink in color for ready identification and must be signed by the recipient.~~
  - (b) ~~The date of birth, eligibility period and sex designations on the card shall be utilized to assist in provider verification of card ownership as well as current eligibility status of the Card holder.~~
  - (c) ~~Each prescription dispensed shall be noted on the Medicaid card by marking through a circled number on the Medicaid card.~~
  - (d) ~~Pink cards indicating restrictions of SPECIAL PRIOR APPROVAL ONLY require that before commencement of services, the Bureau must be contacted at the telephone number specified on the card in accordance with the rules contained in subsection (9) of this section.~~
  - (e) ~~Pink cards indicating restrictions of SPECIAL LOCK IN/PHARMACY/MD limit service to the providers listed in the additional information block and in accordance with the rules contained in subsection (8) of this section.~~
- (12) ~~If reimbursement is denied based on a provider's failure to comply with any rules contained in this section the recipient or the recipient's family shall NOT be held financially responsible for payment for any covered services rendered.~~
- (13) ~~If the placement of a recipient on lock-in or prior approval status would result or has resulted in the denial of reasonable access taking into account geographic locations and reasonable travel time to Medicaid services of adequate quality, the Bureau shall:~~
- (a) ~~Prior to the placement on restricted status, take such action as is necessary to assure reasonable access to services of adequate quality; or~~
  - (b) ~~Reinstate the recipient to the normal Medicaid status until the Bureau can assure reasonable access to services of adequate quality.~~

Statutory Authority: T.C.A. §§ 4-5-202 and 71-5-105.

Rule 1200-13-01-.17 Statewide Home and Community Based Services Waiver for the Elderly and Disabled (Statewide E/D Waiver) is deleted in its entirety.

**~~1200-13-01-.17 STATEWIDE HOME AND COMMUNITY BASED COMMUNITY BASED SERVICES WAIVER FOR THE ELDERLY AND DISABLED (STATEWIDE E/D WAIVER).~~**

- (1) ~~Definitions. See Rule 1200-13-01-.02.~~
- (2) ~~Waiver Services. Covered Waiver Services shall include the following:~~
  - (a) ~~Case Management. All case management contacts shall be documented in the Enrollee's medical record and shall include one face-to-face visit per month, by a nurse or a social worker, with the Enrollee in the Enrollee's home. At least every 90 days, the home visit shall be made by a registered nurse unless otherwise directed in the waiver. Such monthly documentation shall note that the Individual Plan of Care has been reviewed and revised as appropriate.~~

~~(b) Home-delivered Meals.~~

- ~~1. The Administrative Lead Agency shall ensure that providers of home meals are properly licensed or certified by the appropriate regulatory authority and shall require that such providers comply with all laws, ordinances, and codes regarding preparation, handling, and delivery of food.~~
- ~~2. For those Enrollees who require medically prescribed diets, the Administrative Lead Agency shall ensure that such meals are planned by a registered dietitian who provides consultation to the licensed nurse supervising the Enrollee's care.~~
- ~~3. Services are limited to one (1) meal per day.~~

~~(c) Minor Home Modifications.~~

- ~~1. Minor home modifications shall not be provided unless specified in the Individual Plan of Care. The Administrative Lead Agency shall notify the Bureau of TennCare and obtain prior authorization for minor home modifications exceeding \$6,000 prior to initiating the intended modification.~~
- ~~2. The Bureau of TennCare shall be the payor of last resort for minor home modifications.~~

~~(d) Personal Care Services.~~

- ~~1. Personal care aides shall meet the standards of education and training required by the Administrative Lead Agency and approved by the Bureau of TennCare. Enrollees with a diagnosis of mental retardation shall receive personal care services only from an agency licensed as a personal support services agency or a home care organization.~~
- ~~2. The personal care aide shall report to the Case Manager any significant changes in the Enrollee's physical or mental status.~~

~~(e) Personal Emergency Response Systems. Personal Emergency Response Systems shall be provided, as specified in the Individual Plan of Care and Safety Plan, for Enrollees:~~

- ~~1. Who receive daily caregiver services but who are alone for significant parts of the day and who would otherwise require extensive routine supervision; and~~
- ~~2. Who, based on an assessment by the Administrative Lead Agency of the Enrollee's mental and physical capabilities, have the capability to effectively utilize such a system.~~
- ~~3. Installation is limited to one (1) installation per Waiver program year. A Waiver program year runs from October 1 through September 30.~~

~~(f) Homemaker Services. Homemakers shall meet TennCare standards for education and training.~~

~~(g) Respite Care.~~

- ~~1. Inpatient Respite Care services will be provided on a short term basis in a NF or ACLF, not to exceed nine (9) days per Waiver program year (October 1 through September 30).~~
- ~~2. In-Home Respite will be provided on a short term basis in the patient's residence (excluding NFs and ACLFs) not to exceed two hundred sixteen (216) hours per Waiver program year (October 1 through September 30).~~

~~(h) Adult Day Care. Services will be limited to 2080 hours per Waiver program year (October 1 through September 30).~~

- ~~(i) — ACLF Services.~~
  - ~~(j) — Assistive Technology. Services will be limited to nine (9) units of service or \$900.00 per Waiver program year (October 1 through September 30).~~
  - ~~(k) — Personal Care Assistance/Attendant. Services will be limited to 1080 hours per Waiver program year (October 1 through September 30).~~
  - ~~(l) — Pest Control Services will be limited to nine (9) occasions per Waiver program year (October 1 through September 30).~~
- ~~(3) — Documentation of Waiver Services.~~
- ~~(a) — The Administrative Lead Agency shall ensure that all services are accurately and timely documented.~~
  - ~~(b) — Documentation of Waiver services must adequately demonstrate that services are provided in accordance with the individual plan of care and the approved waiver service definitions.~~
- ~~(4) — Notification. Upon approval of a PreAdmission Evaluation for Nursing Facility care for an individual residing in Tennessee, the Bureau shall provide the individual with the following:~~
- ~~(a) — A simple explanation of the Waiver and Waiver Services;~~
  - ~~(b) — Notice of the opportunity to apply for enrollment in the Waiver and an explanation of the enrollment process; and~~
  - ~~(c) — A statement that participation in the Waiver program is voluntary.~~
- ~~(5) — Enrollment.~~
- ~~(a) — When an individual is determined to be likely to require the level of care provided by a Nursing Facility, the Administrative Lead Agency shall inform the individual or the individual's legal representative of all feasible alternatives available under the Waiver and shall offer the choice of either Nursing Facility or Waiver Services.~~
  - ~~(b) — Enrollment in the Waiver shall be voluntary and open to all Waiver Eligibles who reside in Tennessee, but shall be restricted to the maximum number of unduplicated participants specified in the Waiver for the Waiver program year, as approved by the Centers for Medicare and Medicaid Services for the State of Tennessee. Enrollment may also be restricted if sufficient funds are not appropriated by the legislature to support full enrollment.~~
  - ~~(c) — To be eligible for enrollment, an individual must meet all of the following criteria:~~
    - ~~1. — The individual must be Medicaid Eligible, must meet the Nursing Facility eligibility criteria specified in TennCare Rule 1200-13-01-.10, and must have a PreAdmission Evaluation approved by the Bureau of TennCare.~~
      - ~~(i) — The PreAdmission Evaluation shall include the physician's initial plan of care which includes, but is not limited to, diagnoses and any orders for medications, diet, activities, treatments, therapies, restorative and rehabilitative services, or other physician ordered services needed by the Enrollee.~~
      - ~~(ii) — The individual's physician must certify on the PreAdmission Evaluation that the individual requires Waiver Services.~~
    - ~~2. — The individual's medical, functional, and social needs must be such that they can be effectively and safely met through the Waiver, as determined by the Administrative Lead Agency based on a pre-enrollment screening.~~

- ~~3. The State must reasonably expect that the cost of Waiver services and TennCare HH and PDN Services the individual will need would not exceed the average cost of Level 1 NF services.~~
  - ~~4. An individual shall have one or more caregivers, as specified in (6)(a), designated to provide caregiver services each day in the Enrollee's home and, as needed, in other locations to ensure the health, safety, and welfare of the Enrollee. An individual shall have 24-hour caregiver services unless it is determined by an assessment that the needs of the individual can be met, and that the health, safety, and welfare of the individual can be assured, through the provision of daily (but less than 24-hour) caregiver services and through provision of a Personal Emergency Response System. Documentation of such assessment shall be included in an individualized Safety Plan that is developed, reviewed, and updated by the Administrative Lead Agency. If it is so determined that the health, safety, and welfare of the individual can be assured without 24-hour caregiver services, the individual shall have caregiver services provided for some portion of the day each day.~~
  - ~~5. An individual who does not have 24-hour caregiver services shall have an individualized Safety Plan that is based on an assessment of the individual's medical, functional, and social needs and capabilities and that is approved, monitored, and updated as needed, but no less frequently than annually, by the Administrative Lead Agency. The Safety Plan shall describe:
    - ~~(i) The medical, functional, and social needs and capabilities of the individual and how such can be met without jeopardizing the health, safety, and welfare of the individual;~~
    - ~~(ii) The type and schedule of caregiver services to be provided each day, specifying hours per day and number of days per week;~~
    - ~~(iii) Personal Emergency Response Systems which are designed to enable Enrollees, who meet the requirements of (2)(e), to secure help in an emergency; and~~
    - ~~(iv) Other services, devices, and supports that ensure the health, safety, and welfare of the Enrollee.~~~~
  - ~~6. All homes must provide an environment adequate to reasonably ensure the health, safety, and welfare of the Enrollee.~~
- ~~(d) An individual who is capable of living alone or independently without waiver services shall not be eligible for enrollment or continued enrollment in the Waiver.~~
- ~~(e) Enrollment of new Enrollees into the Waiver may be suspended when the average per capita fiscal year expenditure under the Waiver exceeds or is reasonably anticipated to exceed 100% of the average per capita expenditure that would have been made in the fiscal year if the care was provided in a Nursing Facility.~~

~~(6) Caregiver.~~

- ~~(a) Caregiver services shall be provided by one or more adult individuals, aged 18 or older, who sign an agreement with the Administrative Lead Agency to provide the following services to the Enrollee, as well as any additional services outlined in the Individual Plan of Care and the Safety Plan, to meet the needs of the Enrollee during the hours when Waiver Services are not being provided by the Administrative Lead Agency:
  - ~~1. Assistance with grooming, bathing, feeding, and dressing;~~
  - ~~2. Assistance with medications that are ordinarily self-administered;~~
  - ~~3. Assistance with ambulation as needed;~~~~

4. ~~Household services essential to health care and maintenance in the home;~~
5. ~~Meal preparation; and~~
6. ~~Any other assistance necessary to support the Enrollee's activities of daily living.~~

~~(b) One or more caregivers shall be available full time or part time each day in the Enrollee's home, as determined appropriate by the Administrative Lead Agency and as specified in the Individual Plan of Care and the Safety Plan, to provide care to the Enrollee. Enrollees who do not have a 24-hour caregiver shall have a Personal Emergency Response System and shall be mentally and physically capable of using it based on an assessment by the Administrative Lead Agency.~~

~~(7) PreAdmission Evaluations, Transfer Forms, and PASRR Assessments.~~

~~(a) A PreAdmission Evaluation is required when a Medicaid Eligible is admitted to the Waiver.~~

~~(b) A Transfer Form is required in the following circumstances:~~

1. ~~When an Enrollee having an approved unexpired PAE transfers from the Waiver to Level 1 care in a NF.~~
2. ~~When a Waiver Eligible with an approved unexpired PAE transfers from a NF to the Waiver.~~

~~(c) A Level I PASRR assessment for MI and MR is required in the following circumstances:~~

1. ~~When an Enrollee with an approved, unexpired PAE transfers from the Waiver to a NF.~~
2. ~~When an Enrollee with an approved, unexpired PAE requires a short-term stay in a NF.~~

~~— A Level II PASRR evaluation is required if a history of MI or MR is indicated by the Level I PASRR assessment, unless criteria for exception are met.~~

~~(d) An Administrative Lead Agency that enrolls an individual without an approved PreAdmission Evaluation or, where applicable, an approved Transfer Form does so without the assurance of reimbursement. An Administrative Lead Agency that enrolls an individual who has not been determined by the Tennessee Department of Human Services to be financially eligible to have Medicaid make reimbursement for covered services does so without the assurance of reimbursement. If an Administrative Lead Agency enrolls a Medicaid Eligible without an approved PreAdmission Evaluation, the individual must be informed by the Administrative Lead Agency that Medicaid reimbursement will not be paid until and unless the PreAdmission Evaluation is approved.~~

~~(e) The Administrative Lead Agency shall maintain in its files the original PreAdmission Evaluation and, where applicable, the original Transfer Form.~~

~~(f) An updated Safety Plan for Enrollees who do not have 24-hour caregiver services shall be required as an attachment to the PreAdmission Evaluation or Transfer Form.~~

~~(8) Individual Plan of Care.~~

~~(a) The Individual Plan of Care shall be an individualized written plan of care that specifies the services designed to meet the medical, functional, and social needs of the Enrollee and that includes, but is not limited to, the following Enrollee information:~~

1. ~~Diagnoses;~~

~~2. A description of Waiver Services and any other services regardless of payment source, including caregiver services, that the Enrollee requires to reside in the community as an alternative to care in a Nursing Facility, including the amount (specific number of hours or units per day rather than a range), frequency (number of days per week), and duration (length of time needed) of services and the type of provider to furnish each service;~~

~~3. Outcome objectives;~~

~~4. Any treatments, therapies, activities, social services, rehabilitative services, nursing related services, home health aide services, specialized equipment, medications (including dosage, frequency, and route of administration), diet, and other services needed by the Enrollee;~~

~~5. The names of each caregiver and each caregiver's schedule, including the amount (specific number of hours per day) and frequency (number of days per week) of caregiver services and provisions for alternate caregivers; and~~

~~6. A Safety Plan for Enrollees who do not have 24-hour caregiver services.~~

~~(b) Within thirty (30) working days after enrollment, the Case Management Team shall review the Physician's Plan of Care and shall develop the Individual Plan of Care. Within ten (10) working days of completion of the Individual Plan of Care, the Administrative Lead Agency shall review and approve the Individual Plan of Care.~~

~~(c) The Individual Plan of Care shall be periodically reviewed to ensure that the Waiver Services furnished are consistent with the nature and severity of the Enrollee's disability and to determine the appropriateness and adequacy of care and achievement of outcome objectives outlined in the Individual Plan of Care. The minimum schedule for reviews shall be as follows:~~

~~1. The Individual Plan of Care shall be reviewed by a registered nurse or Social Worker Case Manager as needed, but no less frequently than every ninety (90) calendar days. If a Social Worker Case Manager is utilized, an in-home visit and review of the Plan of Care must be done by a Registered Nurse at least every ninety (90) days.~~

~~2. The Individual Plan of Care shall be reviewed and signed by the Case Management Team as needed, but no less frequently than annually. The attending physician is not required to sign the Individual Plan of Care if current signed physician orders are included with the Individual Plan of Care.~~

~~(d) Waiver Services shall be provided in accordance with the Enrollee's Individual Plan of Care.~~

~~(9) Physician Services.~~

~~(a) The Enrollee's attending physician or other licensed physician shall write new orders for the Enrollee as needed and, at a minimum, every ninety (90) calendar days.~~

~~(b) The Administrative Lead Agency shall ensure that each Enrollee receives physician services as needed and, at a minimum, an annual medical examination or physician visit, and shall document such in the Enrollee's record.~~

~~(10) Reevaluation and Recertification of Need for Continued Stay.~~

~~(a) The Administrative Lead Agency shall perform reevaluations of the Enrollee's need for continued stay in the Waiver within 365 calendar days of the date of enrollment and at least annually thereafter.~~

~~(b) Recertifications, documented in a format approved by the Bureau of TennCare, shall be performed by the Enrollee's physician within 365 calendar days of the initial certification date and at least annually thereafter. The Administrative Lead Agency shall maintain in its files a copy of the recertification of need for continued stay.~~

~~(11) Voluntary Disenrollment.~~

- ~~(a) Voluntary disenrollment of an Enrollee from the Waiver may occur at any time upon written notice from the Enrollee or the Enrollee's legal representative to the Administrative Lead Agency. A Level I PASRR assessment for mental illness and mental retardation is required when an Enrollee transfers to a Nursing Facility. If the Level I PASRR assessment indicates the need for a PASRR Level II evaluation of need for specialized services for mental illness or mental retardation, the Enrollee must undergo the PASRR Level II evaluation. Prior to disenrollment, the Administrative Lead Agency shall assist the Enrollee in locating alternate services to provide the appropriate level of care and shall assist in transitioning the enrollee to the new services.~~
- ~~(b) If the Enrollee's medical condition or social environment deteriorates such that the medical, functional, and social needs cannot be met by the Waiver, the Enrollee or the Enrollee's legal representative may request disenrollment from the Waiver. The Administrative Lead Agency shall assist the individual with placement in the appropriate level of care.~~
- ~~(c) Upon voluntary disenrollment from the Waiver, the individual shall be entitled to receive Medicaid covered services only if still eligible for Medicaid.~~

~~(12) Involuntary Disenrollment.~~

- ~~(a) An Enrollee may be involuntarily disenrolled from the Waiver for any of the following reasons:
  - ~~1. The Statewide Home and Community Based Services Waiver for the Elderly and Disabled is terminated.~~
  - ~~2. An Enrollee becomes ineligible for Medicaid or is found to be erroneously enrolled in the Waiver.~~
  - ~~3. An Enrollee is no longer a resident of Tennessee.~~
  - ~~4. The condition of the Enrollee improves such that the Enrollee no longer requires the level of care provided by the Waiver.~~
  - ~~5. The condition of the Enrollee deteriorates such that the medical, functional, and social needs of the Enrollee cannot be met by the Waiver.~~
  - ~~6. The State reasonably expects that the cost of Waiver services and TennCare HH and PDN Services the individual would receive will exceed the average cost of Level 1 NF services.~~
  - ~~7. The home or home environment of the Enrollee becomes unsafe to the extent that it would reasonably be expected that Waiver Services could not be provided without significant risk of harm or injury to the Enrollee or to individuals who provide covered services to the Enrollee.~~
  - ~~8. The Enrollee no longer has a caregiver, as defined herein, or the caregiver is unwilling or unable to provide services needed by the Enrollee, and an alternate caregiver cannot be arranged.~~
  - ~~9. The Enrollee or the Enrollee's caregiver refuses to abide by the Individual Plan of Care, the Physician's Plan of Care, or related Waiver policies, resulting in the inability of the Waiver to assure quality care.~~
  - ~~10. A provider of Waiver Services is unwilling or unable to continue to provide services and an appropriate alternate service provider cannot be arranged.~~~~

11. ~~The health, safety, and welfare of the Enrollee cannot be assured due to the lack of an approved Safety Plan or an approved Individual Plan of Care, or the continuing need for Waiver Services is not recertified by the Enrollee's physician.~~
12. ~~The Enrollee does not receive Waiver services for a period exceeding 120 days if such period began prior to March 1, 2010, or a period exceeding 90 days if such period begins on or after March 1, 2010, due to the need for inpatient services in a hospital, NF, or other institutional setting.~~
- (b) ~~If the individual is involuntarily disenrolled from the Waiver, the Administrative Lead Agency shall assist the Enrollee in locating a Nursing Facility or other alternative providing the appropriate level of care and in transferring the Enrollee. Pursuant to TennCare Rules 1200-13-01-.10 and 1200-13-01-.23, a Level I PASRR screen for mental illness and mental retardation must be completed prior to admission when an Enrollee transfers to a Nursing Facility. If the Level I PASRR screen indicates the need for a PASRR Level II evaluation of need for specialized services for mental illness or mental retardation, the Enrollee must undergo the PASRR Level II evaluation prior to admission to the Nursing Facility.~~
- (c) ~~The Administrative Lead Agency shall notify the Bureau of TennCare in writing a minimum of 2 working days prior to issuing involuntary disenrollment notice to an Enrollee.~~
- (d) ~~Waiver Services shall continue until the date of discharge of the Enrollee from the Waiver.~~
- (e) ~~Notice of Disenrollment.~~
1. ~~Except under circumstances when the Statewide E/D Waiver is terminated, or an Enrollee is no longer categorically or financially eligible for Medicaid, or no longer meets medical eligibility (or NF LOC) requirements, the ALA shall provide an Enrollee written advance notice of involuntary disenrollment with an explanation of the Enrollee's right to a hearing pursuant to T.C.A. §71-5-113.~~
2. ~~When the Statewide E/D Waiver is terminated in a Grand Division upon implementation of the CHOICES program, notice of transition to the CHOICES program shall be provided in accordance with the State's approved Section 1115 Waiver amendment.~~
3. ~~If a person is involuntarily disenrolled from the Statewide E/D Waiver because his Medicaid eligibility has ended, the Medicaid eligibility termination notice, including the right to request a fair hearing regarding such eligibility decision, shall constitute notice of action for termination of all Medicaid-reimbursed (including Waiver) services. Additional notice regarding involuntary disenrollment from the Waiver shall not be provided.~~
- (13) ~~Reduction of Services. If the Enrollee's condition substantially improves, the Administrative Lead Agency and the Bureau of TennCare shall have the right to reduce Waiver Services.~~
- (14) ~~Administration of Services. The Administrative Lead Agency shall ensure the delivery of Waiver Services to Enrollees and shall ensure that related activities including, but not limited to, the following are performed:~~
- (a) ~~Pre-enrollment screening of individuals, including assessment of the individual's medical, functional, and social capabilities and needs; appropriateness for placement in the Waiver; and the ability of the caregiver to adequately care for the Enrollee in the home setting;~~
- (b) ~~Annual reevaluations of the Enrollee's need for continued stay in the Waiver;~~
- (c) ~~Enrollment of Waiver Eligibles into the Waiver after screening;~~
- (d) ~~Development, implementation, and monitoring of the Individual Plan of Care, including the Safety Plan if a Safety Plan is required;~~

- ~~(e) — Coordinating and monitoring the total range of services for Enrollees, regardless of payment source;~~
- ~~(f) — Initial certification by the Enrollee's physician of the Enrollee's need for care in a Nursing Facility and annual recertification of the medical necessity of the continuation of Waiver Services for the Enrollee;~~
- ~~(g) — Supervision of support service staff;~~
- ~~(h) — Ongoing monitoring of Enrollee and family situations and needs;~~
- ~~(i) — Maintenance of comprehensive medical records and documentation of services provided to Enrollees;~~
- ~~(j) — Expenditure and revenue reporting in accordance with state and federal requirements;~~
- ~~(k) — Any marketing activities performed for the purpose of providing information about the program to potential Enrollees;~~
- ~~(l) — Assurance of quality and accessible Waiver services which are provided in accordance with State and Federal Waiver rules, regulations, policies and definitions;~~
- ~~(m) — Contacts with Enrollees, caregivers, and service providers in accordance with state and federal requirements;~~
- ~~(n) — Assurance that each Enrollee has appropriate caregiver services provided each day in the Enrollee's home by one or more competent adult individuals who sign an agreement with the Administrative Lead Agency;~~
- ~~(o) — Assurance of the safety of the Enrollee through appropriate caregiver services, supervision, and other services and supports, as described in the Individual Plan of Care and the Safety Plan;~~
- ~~(p) — Implementation of an appeals process approved by the Bureau of TennCare;~~
- ~~(q) — Provision of expert testimony by appropriate professionals during contested case hearings; and~~
- ~~(r) — Compliance with all applicable rules of the Tennessee Medicaid Program.~~

~~(15) — Reimbursement.~~

- ~~(a) — The average per capita fiscal year expenditure under the Waiver shall not exceed 100% of the average per capita expenditure that would have been made in the fiscal year if care was provided in a Nursing Facility. The total Medicaid expenditure for Waiver Services and other Medicaid services provided to Enrollees shall not exceed 100% of the amount that would have been incurred in the fiscal year if care was provided in a Nursing Facility.~~
- ~~(b) — The provider of Waiver Services shall be reimbursed based on a rate per unit of service.~~
- ~~(c) — The Administrative Lead Agency shall ensure that a diligent effort is made to collect patient liability if it applies to the Enrollee in accordance with 42 CFR § 435.726. The Administrative Lead Agency shall complete appropriate forms showing the individual's amount of monthly income and shall submit them to the Tennessee Department of Human Services. The Tennessee Department of Human Services shall issue the appropriate forms to the Administrative Lead Agency and to the Bureau of TennCare's fiscal agent, specifying the amount of patient liability to be applied toward the cost of care for the Enrollee.~~
- ~~(d) — The Provider of waiver services shall submit bills for services to the Bureau of TennCare's fiscal agent using a claim form approved by the Bureau of TennCare. On the claim forms, the waiver service provider shall use a provider number assigned by the Bureau of TennCare.~~

- ~~(e) Reimbursement shall not be made to the provider of Waiver Services on behalf of Enrollees for therapeutic leave or fifteen-day hospital leave ("Bed holds") normally available to Level 1 NF patients pursuant to rule 1200-13-01-.03.~~
  - ~~(f) Medicaid covered services other than those specified in the Waiver's scope of services shall be reimbursed by the Bureau of TennCare as otherwise provided for by federal and state rules and regulations.~~
  - ~~(g) The Administrative Lead Agency shall ensure that the physician's initial certification and subsequent recertifications are obtained. Failure to perform recertifications in a timely manner and in the format approved by the Bureau of TennCare shall require a corrective action plan and shall result in full or partial recoupment of all amounts paid by the Bureau of TennCare during the time that recertification has lapsed.~~
- ~~(16) Subcontractors.~~
- ~~(a) The Administrative Lead Agency shall ensure that:
 
    - ~~1. Services are provided by subcontractors who have signed contracts with the Administrative Lead Agency;~~
    - ~~2. Subcontractors comply with the Quality Assurance Guidelines and other state and federal standards, rules, and regulations affecting the provision of Waiver Services; and~~
    - ~~3. Subcontractors carry appropriate professional liability insurance and other insurance (e.g., auto insurance if Enrollees are being transported).~~~~
  - ~~(b) Contracts between the Administrative Lead Agency and subcontractors for the provision of Waiver Services must be approved in writing by the Bureau of TennCare.~~
- ~~(17) Appeal Process.~~
- ~~(a) Eligibility for the Statewide E/D Waiver.
 
    - ~~1. Appeals regarding categorical and financial eligibility for the Statewide E/D Waiver will be handled by DHS.~~
    - ~~2. Appeals regarding medical (or LOC) eligibility for the Statewide E/D Waiver will be handled as set forth in Rule 1200-13-01-.10(6).~~~~
  - ~~(b) Enrollment and involuntary disenrollment.
 
    - ~~— Appeals regarding denial of enrollment into the Statewide E/D Waiver or involuntary disenrollment from the Statewide E/D Waiver for reasons other than categorical or financial eligibility or medical eligibility will be handled by the Bureau Division of Long Term Care.~~~~
  - ~~(c) Adverse actions regarding Waiver services.
 
    - ~~— Appeals regarding adverse actions pertaining to Waiver services covered under the Statewide E/D Waiver will be processed in accordance with TennCare Rule 1200-13-13-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits.~~~~

Statutory Authority: T.C.A. §§ 4-5-202 and 71-5-105.

Rule 1200-13-01-.21 Provider Noncompliance or fraud of Medicaid Program is deleted in its entirety.

~~1200-13-01-.21 PROVIDER NONCOMPLIANCE OR FRAUD OF MEDICAID PROGRAM.~~

~~(1) Definitions:~~

- ~~(a) Agent means any person who has been delegated the authority to obligate or act on behalf of a provider.~~
- ~~(b) Bureau of TennCare (herein referred to as "Bureau"). The division of the Tennessee Department of Finance and Administration (the single state Medicaid agency) that administers the TennCare Program. For the purposes of this Rule, the Bureau of TennCare shall represent the State of Tennessee.~~
- ~~(c) Convicted means that a judgment of conviction has been entered by a federal, state, or local court, regardless of whether an appeal from that judgment is pending.~~
- ~~(d) Exclusion means that period of time that a provider is suspended or terminated from participation in the Medicaid program. Any items or services furnished by an excluded provider shall not be reimbursed under Medicaid.~~
- ~~(e) Flagrant noncompliance means one or more activities identified in section (3).~~
- ~~(f) Fraud means an intentional deception or misrepresentation made by a person with the knowledge 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.~~
- ~~(g) Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of, an institution, organization, or agency.~~
- ~~(h) Noncompliance means provider practices that are inconsistent with sound fiscal or business practices or inconsistent with Medicaid rules and regulations, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.~~
- ~~(i) Person with an ownership or control interest means a person or corporation that:
  - ~~1. has an ownership interest totaling five (5) percent or more in a disclosing entity,~~
  - ~~2. has an equity in the capital, the stock or profit (indirect membership) of the disclosing entity equal to five (5) percent or more in a disclosing entity,~~
  - ~~3. has a combination of direct and indirect ownership interests equal to five (5) percent or more in a disclosing entity;~~
  - ~~4. owns an interest of five (5) percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least five (5) percent of the value of the property or assets of the disclosing entity;~~
  - ~~5. is an officer or director of a disclosing entity that is organized as a corporation; or~~
  - ~~6. is a partner in a disclosing entity that is organized as a partnership.~~~~
- ~~(j) Provider means an individual or entity which furnishes items or services for which payment is claimed under Medicaid.~~

- ~~(k) Provider responsibility means the obligation of any health care provider who furnishes or orders health care services to assure that, to the extent of his influence or control, those services are:~~
- ~~1. furnished only when, and to the extent that, they are medically necessary, and~~
  - ~~2. of a quality that meets professionally recognized standards of health care.~~
- ~~(l) Records means all paper and electronic media records which contain information relative to medical assistance provided for which payment has been made or sought under the Medicaid program, and/or which contain any other information relative to payments received or sought under the Medicaid program. It shall include records for services which are non-covered or not billed, but which initiate a covered service.~~
- ~~(m) Records access means paper and electronic media records shall be made available during normal business hours by a provider for a stringent onsite review audit and to allow Medicaid to make copies on site in order to review at a later date and/or to document audit findings. Upon written request the provider shall make copies of records (not to exceed five (5) recipients) to document services previously paid. If electronic media records are provided to Medicaid the data layout shall also be provided to Medicaid.~~
- ~~(n) Unit means the Tennessee Bureau of Investigation, Medicaid Fraud Control Unit.~~
- ~~(2) (a) In addition to the sanctions set out in T.C.A. §71-5-118, the provider may be subject to stringent review/audit procedures which may include clinical evaluation of claim services and a prepayment requirement for documentation and for justification of each claim,~~
- ~~(b) Medicaid may withhold payments to a provider in cases of fraud, willful misrepresentation, or flagrant noncompliance,~~
- ~~(c) Medicaid may refuse to enter into or may suspend a provider participation agreement 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,~~
- ~~(d) Medicaid may refuse to enter into or may suspend a provider participation agreement 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,~~
- ~~(e) Medicaid shall refuse to enter into or shall suspend a provider participation agreement 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,~~
- ~~(f) Medicaid shall refuse to enter into or shall suspend a provider participation agreement 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,~~
- ~~(g) Medicaid may refuse to enter into or may terminate a provider participation agreement if it is determined that the provider has been flagrantly noncompliant in its violation of segments of section (3) of this chapter, and~~

- ~~(h) — Medicaid may recover from a provider any payments made by a recipient and/or his family for a covered service when evidence of recipient billing by the provider is determined by Medicaid and repayment by the provider to the recipient and/or his family is not made within 30 days of receiving notification from Medicaid to make repayment. If a provider knowingly bills a recipient and/or family for a Medicaid covered service, in total or in part, except as otherwise permitted by State rules, Medicaid may terminate the provider participation agreement.~~
- ~~(3) — In addition to the grounds for actions set out in T.C.A. §71-5-118, activities or practices which justify sanctions against the contract and/or recoupment of monies incorrectly paid shall include, but not be limited to:~~
- ~~(a) — noncompliance with contractual terms,~~
  - ~~(b) — billing for a service in a quantity which is greater than the amount provided,~~
  - ~~(c) — billing for a service which is not provided or not documented,~~
  - ~~(d) — knowingly providing incomplete, inaccurate, or erroneous information to Medicaid or its agent(s),~~
  - ~~(e) — continued provision of poor record-keeping or inappropriate/inadequate medical care,~~
  - ~~(f) — medical assistance of a quality below recognized standards,~~
  - ~~(g) — provider suspension from the Medicare/Medicaid program(s) by the authorized U.S. enforcement agency,~~
  - ~~(h) — partial or total loss (voluntary or otherwise) of a providers federal Drug Enforcement Agency (DEA) dispensing or prescribing certification,~~
  - ~~(i) — restriction to and/or loss of practice by a state licensing board action,~~
  - ~~(j) — acceptance of a pretrial diversion, in state or federal court from a Medicaid or Medicare fraud charge and/or evidence from same,~~
  - ~~(k) — violation of the responsible state licensing board license and/or certification rules,~~
  - ~~(l) — convictions of a felony, conviction of any offense under state or federal drug laws, or conviction of any offense involving moral turpitude,~~
  - ~~(m) — dispensing, prescribing, or otherwise distributing any controlled substance or any other drug not in the course of professional practice, or not in good faith to relieve pain and suffering, or not to cure an ailment, physical and/or mental infirmity or disease,~~
  - ~~(n) — dispensing, prescribing, or otherwise distributing to any person a controlled substance or other drug if such person is addicted to the habit of using control substances without making a bona fide effort to cure the habit of such patient.~~
  - ~~(o) — dispensing, prescribing or otherwise distributing any controlled substance or other drug to any person in violation of any law of the state or of the United States of America,~~
  - ~~(p) — engaging in the provision of medical/dental service when mentally or physically unable to safely do so,~~
  - ~~(q) — billing Medicaid an amount that is greater than the provider's usual and customary charge to the general public for that service, and~~

- ~~(f) — falsifying or causing to be falsified dates of service, dates of certification or recertification or back dating any record which results in or could result in an inappropriate cost to Medicaid.~~
  - ~~(g) — Reserved.~~
  - ~~(t) — Fragmentation or submitting claims separately on the component parts of a procedure instead of claiming the single procedure code, (which includes the entire procedure, or all component parts) when such approach results in Medicaid paying a greater amount for the component(s) than it would for the entire procedure.~~
  - ~~(u) — Submitting claims for a separate procedure which is commonly carried out as a component part of a larger procedure, unless it is performed alone for a medically justified specific purpose.~~
- ~~(4) — Term of Provider Exclusion~~
- ~~(a) — A provider exclusion based upon either section (2)(c), (d), (e) or (f) shall continue until the excluding re-establishes the license or the Medicare/Medicaid eligibility previously denied or suspended. The provider may resubmit to Medicaid with documentation from the State Board or the U.S. Office of Inspector General Department of Health and Human Services that the provider's exclusion has been lifted or removed. The provider may then apply to Medicaid for reinstatement consideration as determined by Medicaid.~~
  - ~~(b) — A provider exclusion based upon section (2)(g) shall be eligible for reinstatement as a Medicaid provider as determined by Medicaid.~~
- ~~(5) — Access to Records — The Bureau shall in the furtherance of the administration of the Medicaid Program have access to all provider records. Such access shall include the right to make copies of those records during normal business hours.~~
- ~~(6) — Confidentiality — The Bureau shall be bound by all applicable federal and/or State statutes and regulations relative to confidentiality of records.~~
- ~~(7) — Provider Cooperation — The provider is to cooperate, with Medicaid and/or its agent(s) in the provision of records and in the timely completion of any post review audit. Failure to cooperate may subject the provider to actions identified in section (2) of this rule. Cooperation in a post review audit includes but is not limited to:~~
- ~~(a) — the provision of a private work area,~~
  - ~~(b) — the availability of provider personnel at an initial and exit conference,~~
  - ~~(c) — the furnishing of records as needed,~~
  - ~~(d) — the provision of access to provider owned copying equipment to expedite the completion of an on site segment of an audit, and~~
  - ~~(e) — the provision of records, requested in writing, for a desk review where ten (10) or less recipient records are at issue.~~
- ~~(8) — Request for Hearing — All provider hearing requests shall be received by Medicaid within fifteen (15) days of the providers receipt of notification of Medicaid action taken under this chapter.~~
- ~~(9) — For services provided prior to January 1, 1994, the rules as set out at 1200-13-01-21 (1) — (9) shall apply. Effective January 1, 1994, the rules of TennCare as set out at rule chapter 1200-13-12 shall apply except for noncompliance or fraud of Medicaid program as it relates to nursing facilities, intermediate care facilities for the mentally retarded (ICF-MR), Home and Community Based Waiver~~

~~Services, and payment of Medicare premiums, deductibles and copayments for QMBs and Special Low-Income Medicare Beneficiaries (SLIMBs) which will continue to be enforced in accordance with Medicaid rules in effect prior to January 1, 1994, and as may be amended.~~

Statutory Authority: T.C.A. §§ 4-5-202 and 71-5-105.

I certify that this is an accurate and complete copy of proposed rules, lawfully promulgated and adopted by the (board/commission/other authority) on \_\_\_\_\_ (date as mm/dd/yyyy), and is in compliance with the provisions of T.C.A. § 4-5-222. The Secretary of State is hereby instructed that, in the absence of a petition for proposed rules being filed under the conditions set out herein and in the locations described, he is to treat the proposed rules as being placed on file in his office as rules at the expiration of sixty (60) days of the first day of the month subsequent to the filing of the proposed rule with the Secretary of State.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Name of Officer: Patti Killingsworth  
Chief, Long-Term Services and Supports, Bureau of  
TennCare

Title of Officer: Tennessee Department of Finance and Administration

Subscribed and sworn to before me on: \_\_\_\_\_

Notary Public Signature: \_\_\_\_\_

My commission expires on: \_\_\_\_\_

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All proposed rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

\_\_\_\_\_  
Robert E. Cooper, Jr.  
Attorney General and Reporter

\_\_\_\_\_  
Date

**Department of State Use Only**

Filed with the Department of State on: \_\_\_\_\_

Effective on: \_\_\_\_\_

\_\_\_\_\_  
Tre Hargett  
Secretary of State

### **Regulatory Flexibility Addendum**

Pursuant to T.C.A. §§ 4-5-401 through 4-5-404, prior to initiating the rule making process as described in T.C.A. § 4-5-202(a)(3) and T.C.A. § 4-5-202(a), all agencies shall conduct a review of whether a proposed rule or rule affects small businesses.

(If applicable, insert Regulatory Flexibility Addendum here)

The rules have no effect on small businesses.

### **Impact on Local Governments**

Pursuant to T.C.A. §§ 4-5-220 and 4-5-228 "any rule proposed to be promulgated shall state in a simple declarative sentence, without additional comments on the merits of the policy of the rules or regulation, whether the rule or regulation may have a projected impact on local governments." (See Public Chapter Number 1070 (<http://state.tn.us/sos/acts/106/pub/pc1070.pdf>) of the 2010 Session of the General Assembly)

(Insert statement here)

The rules are not projected to have an impact on local governments.

All agencies, upon filing a rule, must also submit the following pursuant to T.C.A. § 4-5-226(i)(1).

- (A) A brief summary of the rule and a description of all relevant changes in previous regulations effectuated by such rule;

The rules are being promulgated to repeal obsolete rules.

- (B) A citation to and brief description of any federal law or regulation or any state law or regulation mandating promulgation of such rule or establishing guidelines relevant thereto;

The rules are lawfully adopted by the Bureau of TennCare in accordance with Tennessee Code Annotated §§ 4-5-202 and 71-5-105.

- (C) Identification of persons, organizations, corporations or governmental entities most directly affected by this rule, and whether those persons, organizations, corporations or governmental entities urge adoption or rejection of this rule;

The persons, organizations, corporations or governmental entity most directly affected by these rules are the Bureau of TennCare, Tennessee Department of Finance and Administration.

- (D) Identification of any opinions of the attorney general and reporter or any judicial ruling that directly relates to the rule;

The rules were reviewed and approved by the Tennessee Attorney General. No additional opinion was given or requested.

- (E) An estimate of the probable increase or decrease in state and local government revenues and expenditures, if any, resulting from the promulgation of this rule, and assumptions and reasoning upon which the estimate is based. An agency shall not state that the fiscal impact is minimal if the fiscal impact is more than two percent (2%) of the agency's annual budget or five hundred thousand dollars (\$500,000), whichever is less;

The promulgation of these rules is not anticipated to have an effect on state and local government revenues and expenditures.

- (F) Identification of the appropriate agency representative or representatives, possessing substantial knowledge and understanding of the rule;

Darin J. Gordon  
Director, Bureau of TennCare

- (G) Identification of the appropriate agency representative or representatives who will explain the rule at a scheduled meeting of the committees;

Darin J. Gordon  
Director, Bureau of TennCare

- (H) Office address, telephone number, and email address of the agency representative or representatives who will explain the rule at a scheduled meeting of the committees; and

310 Great Circle Road  
Nashville, TN 37243  
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- (I) Any additional information relevant to the rule proposed for continuation that the committee requests.