Notice of

Rulemaking Hearing

Tennessee Department of Finance and Administration

Bureau of TennCare

There will be a hearing before the Commissioner to consider the promulgation of amendments of rules pursuant to Tennessee Code Annotated, 71-5-105 and 71-5-109. The hearing will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, Tennessee Code Annotated, Section 4-5-204 and will take place in the Bureau of TennCare, 1st Floor East Conference Room, 310 Great Circle Road, Nashville, Tennessee 37243 at 9:00 a.m. C.D.T. on the 18th day April 2006.

Any individuals with disabilities who wish to participate in these proceedings (to review these filings) should contact the Department of Finance and Administration, Bureau of TennCare, to discuss any auxiliary aids or services needed to facilitate such participation. Such initial contact may be made no less than ten (10) days prior to the scheduled meeting date (the date the party intends to review such filings) to allow time for the Bureau of TennCare to determine how it may reasonably provide such aid or service. Initial contact may be made with the Bureau of TennCare's ADA Coordinator by mail at the Bureau of TennCare, 310 Great Circle Road, Nashville, Tennessee 37243 or by telephone at (615) 507-6474 or 1-800-342-3145.

For a copy of this notice of rulemaking hearing, contact George Woods at the Bureau of TennCare, 310 Great Circle Road, Nashville, Tennessee 37243 or call (615) 507-6446.

Substance of Proposed Rule

Rule Chapter 1200-13-1 General Rules is amended by deleting the current rule 1200-13-1-.25 Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled and by replacing it with a new rule 1200-13-1-.25 Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled which shall read as follows:

1200-13-1-.25 Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled.

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(1) Definitions: The following definitions shall apply for interpretation of this rule:

(a) Adult Dental Services - accepted dental procedures which are provided to adult Enrollees (i.e., age 21 years or older) as specified in the Plan of Care. Adult Dental Services may include fillings, root canals, extractions, the provision of dentures and other dental treatments to relieve pain and infection. Preventive dental care is not covered under Adult Dental Services.

(b) Behavioral Respite Services - services that provide Respite for an Enrollee who is experiencing a behavioral crisis that necessitates removal from the current residential setting in order to resolve the behavioral crisis.

(c) Behavior Services – assessment and amelioration of Enrollee behavior that presents a health or safety risk to the Enrollee or others or that significantly interferes with home or community activities; determination of the settings in which such behaviors occur and the events which precipitate the behaviors; development, monitoring, and revision of crisis prevention and behavior intervention strategies; and training of caregivers who are responsible for direct care of the Enrollee in prevention and intervention strategies.

(d) Bureau of TennCare - the bureau in the Tennessee Department of Finance and Administration which is the State Medicaid Agency and is responsible for administration of the Medicaid program in Tennessee.

(e) Certification - the process by which a physician, who is licensed as a doctor of medicine or doctor of osteopathy, signs and dates a Pre-Admission Evaluation signifying that the named individual requires services provided through the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled as an alternative to care in an Intermediate Care Facility for the Mentally Retarded.

(f) Covered Services or Covered Waiver Services – The services which are available through Tennessee's Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled when medically necessary and when provided in accordance with the Waiver as approved by the Centers for Medicare and Medicaid Services.

(g) Day Services - individualized services and supports that enable an Enrollee to acquire, retain, or improve skills necessary to reside in a community-based setting; to participate in community activities and utilize community resources; to acquire and maintain employment; and to participate in retirement activities.

(h) Denial - as used in regard to Waiver Services, the term shall mean the termination, suspension, or reduction in amount, scope, and duration of a Waiver Service or a refusal or failure to provide such service.

(i) Disenrollment - the voluntary or involuntary termination of enrollment of an individual receiving services through the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled.

(j) Enrollee - a Medicaid Eligible who is enrolled in the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled.

(k) Environmental Accessibility Modifications – only those interior or exterior physical modifications to the Enrollee's place of residence which are required to ensure the health,

welfare and safety of the Enrollee or which are necessary to enable the Enrollee to function with greater independence.

(l) Family Model Residential Support – a type of residential service having individualized services and supports that enable an Enrollee to acquire, retain, or improve skills necessary to reside successfully in a family environment in the home of trained caregivers other than the family of origin. The service includes direct assistance as needed with activities of daily living, household chores essential to the health and safety of the enrollee, budget management, attending appointments, and interpersonal and social skills building to enable the Enrollee to live in a home in the community. It also may include medication administration as permitted under Tennessee's Nurse Practice Act.

(m) Home (of an Enrollee) - the residence or dwelling in which the Enrollee resides, excluding hospitals, nursing facilities, Intermediate Care Facilities for the Mentally Retarded, Assisted Living Facilities and Homes for the Aged.

(n) Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled or "Waiver" - the Home and Community Based Services waiver program approved for Tennessee by the Centers for Medicare and Medicaid Services to provide services to a specified number of Medicaid-eligible individuals who have mental retardation and who meet the criteria for Medicaid reimbursement of care in an Intermediate Care Facility for the Mentally Retarded.

(o) ICF/MR Pre-Admission Evaluation (ICF/MR PAE) – the assessment form used by the State Medicaid Agency to document the current medical and habilitative needs of an individual with mental retardation and to document that the individual meets the Medicaid level of care eligibility criteria for care in an ICF/MR.

(p) Individual Support Plan – the individualized written Plan of Care.

(q) Individual Transportation Services –non-emergency transport of an Enrollee to and from approved activities specified in the Plan of Care.

(r) Intermediate Care Facility for the Mentally Retarded (ICF/MR) - a licensed facility approved for Medicaid vendor reimbursement that provides specialized services for individuals with mental retardation or related conditions and that complies with current federal standards and certification requirements for an ICF/MR.

(s) Medicaid Eligible - an individual who has been determined by the Tennessee Department of Human Services to be financially eligible to have the State Medicaid Agency make reimbursement for covered services.

(t) Medical Residential Services – a type of residential service provided in a residence where all residents require direct skilled nursing services and habilitative services and supports that enable an Enrollee to acquire, retain, or improve skills necessary to reside in a community-based setting. Medical Residential Services must be ordered by the Enrollee's physician, physician assistant, or nurse practitioner, who shall document the medical necessity of the services and specify the nature and frequency of the nursing services. The enrollee who receives Medical Residential Services shall require direct skilled nursing services on a daily basis and at a level which cannot for practical purposes be provided through two or fewer daily skilled nursing visits. The service includes direct assistance as needed with activities

of daily living, household chores essential to the health and safety of the enrollee, budget management, attending appointments, and interpersonal and social skills building to enable the enrollee to live in a home in the community. It also may include medication administration as permitted under Tennessee's Nurse Practice Act.

(u) Medicaid State Plan - the plan approved by the Centers for Medicare and Medicaid Services which specifies the covered benefits for the Medicaid program in Tennessee.

(v) Nursing Services –skilled nursing services that fall within the scope of Tennessee's Nurse Practice Act and that are directly provided to the Enrollee in accordance with a plan of care. Nursing Services shall be ordered by the Enrollee's physician, physician assistant, or nurse practitioner, who shall document the medical necessity of the services and specify the nature and frequency of the nursing services.

(w) Nutrition Services - assessment of nutritional needs, nutritional counseling, and education of the Enrollee and of caregivers responsible for food purchase, food preparation, or assisting the Enrollee to eat. Nutrition Services are intended to promote healthy eating practices and to enable the Enrollee and direct support professionals to follow special diets ordered by a physician, physician assistant, or nurse practitioner.

(x) Occupational Therapy Services – diagnostic, therapeutic, and corrective services which are within the scope of state licensure. Occupational Therapy Services provided to improve or maintain current functional abilities as well as prevent or minimize deterioration of chronic conditions leading to a further loss of function are also included within this definition.

(y) Operational Administrative Agency - the approved agency with which the State Medicaid Agency contracts for the administration of the day-to-day operations of the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled.

(z) Orientation and Mobility Training – assessment of the ability of an Enrollee who is legally blind to move independently, safely, and purposefully in the home and community environment; orientation and mobility counseling; and training and education of the Enrollee and of caregivers responsible for assisting in the mobility of the Enrollee.

(aa) Personal Assistance – the provision of direct assistance with activities of daily living (e.g., bathing, dressing, personal hygiene, eating, meal preparation excluding cost of food), household chores essential to the health and safety of the enrollee, budget management, attending appointments, and interpersonal and social skills building to enable the Enrollee to live in a home in the community. It also may include medication administration as permitted under Tennessee's Nurse Practice Act.

(bb) Personal Emergency Response System - a stationary or portable electronic device used in the Enrollee's place of residence which enables the Enrollee to secure help in an emergency. The system shall be connected to a response center staffed by trained professionals who respond upon activation of the electronic device.

(cc) Physical Therapy Services - diagnostic, therapeutic, and corrective services which are within the scope of state licensure. Physical Therapy Services provided to improve or maintain current functional abilities as well as prevent or minimize deterioration of chronic conditions leading to a further loss of function are also included within this definition.

(dd) Plan of Care – an individualized written Plan of Care which describes the medical and other services (regardless of funding source) to be furnished to the Enrollee, the Waiver Service frequency, and the type of provider who will furnish each Waiver Service and which serves as the fundamental tool by which the State ensures the health and welfare of Enrollees.

(ee) Qualified Mental Retardation Professional (QMRP) - an individual who meets current federal standards, as published in the Code of Federal Regulations, for a qualified mental retardation professional.

(ff) Re-evaluation - the annual process approved by the State Medicaid Agency by which a licensed physician or registered nurse or a Qualified Mental Retardation Professional assesses the Enrollee's need for continued Waiver Services and certifies in writing that the Enrollee continues to require Waiver Services.

(gg) Residential Habilitation - a type of residential service having individualized services and supports that enable an Enrollee to acquire, retain, or improve skills necessary to reside in a community-based setting including direct assistance with activities of daily living essential to the health and safety of the Enrollee, budget management, attending appointments, and interpersonal and social skills building to enable the Enrollee to live in a home in the community. It also may include medication administration as permitted under Tennessee's Nurse Practice Act.

(hh) Respite - services provided to an Enrollee when unpaid caregivers are absent or incapacitated due to death, hospitalization, illness or injury, or when unpaid caregivers need relief from routine caregiving responsibilities.

(ii) Safety Plan - an individualized plan by which the Operational Administrative Agency ensures the health, safety and welfare of Enrollees who do not have 24-hour direct care services.

(jj) Specialized Medical Equipment and Supplies and Assistive Technology - assistive devices, adaptive aids, controls or appliances which enable an Enrollee to increase the ability to perform activities of daily living, or to perceive, control or communicate with the environment, and supplies for the proper functioning of such items. Specialized Medical Equipment, Supplies, and Assistive Technology shall be recommended by a qualified health care professional (e.g., occupational therapist, physical therapist, speech language pathologist, physician or nurse practitioner) based on an assessment of the Enrollee's needs and capabilities and shall be furnished as specified in the Plan of Care. Specialized Medical Equipment and Supplies and Assistive Technology may also include a face-to-face consultative assessment by a physical therapist, occupational therapist, or speech therapist to assure that Specialized Medical Equipment and Assistive Technology which requires custom fitting meets the needs of the Enrollee and may include training of the Enrollee by a physical therapist, occupational therapist or speech therapist to effectively utilize such customized equipment.

(kk) Speech, Language and Hearing Services – diagnostic, therapeutic and corrective services which are within the scope of state licensure which enable an Enrollee to improve or maintain current functional abilities and to prevent or minimize deterioration of chronic conditions leading to a further loss of function.

(ll) State Medicaid Agency – the bureau in the Tennessee Department of Finance and Administration which is responsible for administration of the Title XIX Medicaid program in Tennessee.

(mm) Subcontractor - an individual, organized partnership, professional corporation, or other legal association or entity which enters into a written contract with the Operational Administrative Agency to provide Waiver Services to an Enrollee.

(nn) Support Coordination - case management services that assist the Enrollee in identifying, selecting, obtaining, coordinating and using both paid services and natural supports to enhance the Enrollee's independence, integration in the community and productivity as specified in the Enrollee's Plan of Care. Support Coordination shall be person-centered and shall include, but is not limited to, ongoing assessment of the Enrollee's strengths and needs; development, evaluation and revision of the Plan of Care; assistance with the selection of service providers; provision of general education about the Waiver program, including Enrollee rights and responsibilities; and monitoring implementation of the plan of care and initiating individualized corrective actions as necessary (e.g., reporting, referring, or appealing to appropriate entities).

(oo) Support Coordinator - the person who is responsible for developing the Individual Support Plan and participating in the development of, monitoring and assuring the implementation of the Plan of Care; who provides Support Coordination services to an Enrollee; and who meets the qualifications for a Support Coordinator as specified in the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled.

(pp) Supported Living - a type of residential service having individualized services and supports that enable an Enrollee to acquire, retain or improve skills necessary to reside in a home that is under the control and responsibility of the Enrollee. The service includes direct assistance as needed with activities of daily living, household chores essential to the health and safety of the Enrollee, budget management, attending appointments, and interpersonal and social skills building to enable the Enrollee to live in a home in the community. It also may include medication administration as permitted under Tennessee's Nurse Practice Act.

(qq) Transfer Form - the form approved by the State Medicaid Agency and used to document the transfer of an Enrollee having an approved unexpired ICF/MR Pre-Admission Evaluation from the Waiver to an ICF/MR or from an ICF/MR to the Waiver.

(rr) Vehicle Accessibility Modifications - interior or exterior physical modifications to a vehicle owned by the Enrollee or to a vehicle which is owned by the guardian or conservator of the Enrollee and which is routinely available for transport of the Enrollee. Such modifications must be intended to ensure the transport of the Enrollee in a safe manner.

(2) Covered Services and Limitations.

(a) Adult Dental Services.

1. Adult Dental Services shall not include hospital outpatient or inpatient facility services or related anesthesiology, radiology, pathology, or other medical services in such setting.

2. Adult Dental Services shall exclude orthodontic services.

3. Adult Dental Services shall be limited to adults age twenty-one (21) years or older who are enrolled in the waiver.

(b) Behavioral Respite Services.

1. Behavioral Respite Services may be provided in a Medicaid-certified ICF/MR, in a licensed respite care facility, or in a home operated by a licensed residential provider.

2. Reimbursement shall not be made for the cost of room and board except when provided as part of Behavioral Respite Services furnished in a facility approved by the State that is not a private residence.

3. Behavioral Respite Services shall be limited to a maximum of sixty (60) days per Enrollee per year.

4. Enrollees who receive Behavioral Respite Services shall be eligible to receive Individual Transportation Services only to the extent necessary during the time period when Behavioral Respite Services is being provided.

(c) Behavior Services.

1. Behavior Services shall not be billed when provided during the same time period as Physical Therapy; Occupational Therapy; Nutrition Services; Orientation and Mobility Training; or Speech, Language and Hearing Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently.

2. Behavior Services shall be provided face to face with the Enrollee except that enrollee-specific training of staff may be provided when the Enrollee is not present.

(d) Day Services.

1. Day Services may be provided in settings such as specialized facilities licensed to provide Day Services, community centers or other community sites, or job sites. Services may also be provided in the Enrollee's place of residence if there is a health, behavioral, or other medical reason or if the Enrollee has chosen retirement. This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).

2. With the exception of employment that is staff supported, Day Services shall be provided only on weekdays during the day (i.e., between the hours of 7:30 a.m. and 6:00 p.m.), as specified in the Plan of Care.

3. Day Services shall be limited to a maximum of six (6) hours per day and five (5) days per week up to a maximum of 243 days per Enrollee per year.

4. Transportation to and from the Enrollee's place of residence to Day Services and transportation that is needed during the time that the Enrollee is receiving Day Services shall be a component of Day Services and shall be included in the Day

Services reimbursement rate (i.e., it shall not be billed as a separate Waiver service) with the following exceptions:

(i) Transportation to and from medical services covered through the Medicaid State Plan, which shall not be billed as a Waiver service; or

(ii) Transportation necessary for Orientation and Mobility Training.

5. Day Services shall not replace services available under a program funded by the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act.

6. For an Enrollee receiving employment supports, reimbursement shall not be made for incentive payments, subsidies or unrelated vocational training expenses such as the following:

(i) Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

(ii) Payments that are passed through to users of supported employment programs; or

(iii) Payments for vocational training that is not directly related to an Enrollee's supported employment program.

(e) Environmental Accessibility Modifications.

1. Environmental Accessibility Modifications which are considered improvements to the home (e.g., roof or flooring repair, installing carpet, installation of central air conditioning, construction of an additional room) are excluded from coverage.

2. Any modification which is not of direct medical or remedial benefit to the Enrollee is excluded from coverage.

3. Modification of an existing room which increases the total square footage of the home is also excluded unless the modification is necessary to improve the accessibility of an Enrollee having limited mobility, in which case the modification shall be limited to the minimal amount of square footage necessary to accomplish the increased accessibility.

4. Environmental Accessibility Modifications shall be limited to a maximum of $15,000 per Enrollee per two (2) year period.

(f) Family Model Residential Support.

1. With the exception of homes that were already providing services to three (3) residents prior to January 1, 2004, a Family Model Residential Support home shall have no more than two (2) residents who receive services and supports.

2. The Family Model Residential Support provider shall be responsible for providing an appropriate level of services and supports twenty-four (24) hours per day during the hours the Enrollee is not receiving Day Services or is not at school or work.

3. Transportation shall be a component of Family Model Residential Support and shall be included in the reimbursement rate for such (i.e., it shall not be billed as a separate Waiver service) with the following exceptions:
   (i) Transportation to and from medical services covered through the Medicaid State Plan, which shall not be billed as a Waiver service;
   (ii) Transportation necessary for Behavioral Respite Services; or
   (iii) Transportation necessary for Orientation and Mobility Training.

4. This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).

5. Reimbursement for Family Model Residential Support shall not be made for room and board or for the cost of maintenance of the dwelling, and reimbursement shall not include payment made to the Enrollee's parent, step-parent, spouse, child, or sibling or to any other individual who is a conservator unless so permitted in the Order for Conservatorship.

(g) Individual Transportation Services.

1. An Enrollee receiving Orientation and Mobility Training shall be eligible to receive Individual Transportation Services to the extent necessary for participation in Orientation and Mobility Training. Enrollees who receive Respite, Behavioral Respite Services, or Personal Assistance shall be eligible to receive Individual Transportation Services only to the extent necessary during the time period when Respite, Behavioral Respite Services, or Personal Assistance is being provided.

2. Individual Transportation Services shall not be used for:

   (i) Transportation to and from Day Services;

   (ii) Transportation to and from supported or competitive employment;

   (iii) Transportation of school aged children to and from school;

   (iv) Transportation to and from medical services covered by the Medicaid State Plan; or

   (v) Transportation of an Enrollee receiving a residential service, except as described herein for Orientation and Mobility Training or Behavioral Respite Services.

(h) Medical Residential Services.

1. The Medical Residential Services provider shall be responsible for providing an appropriate level of services and supports twenty-four (24) hours per day when the Enrollee is not receiving Day Services or is not at school or work.

2. Transportation shall be a component of Medical Residential Services and shall be included in the reimbursement rate for such (i.e., it shall not be billed as a separate Waiver service) with the following exceptions:

(i) Transportation to and from medical services covered through the Medicaid State Plan, which shall not be billed as a Waiver service;
(ii) Transportation necessary for Behavioral Respite Services; or
(iii) Transportation necessary for Orientation and Mobility Training.

3. Reimbursement for Medical Residential Services shall not include the cost of maintenance of the dwelling, and reimbursement shall not include payment made to members of the Enrollee's immediate family or to the Enrollee's conservator. Reimbursement shall not be made for room and board if the home is rented, leased, or owned by the provider. If the home is rented, leased, or owned by the Enrollee, reimbursement shall not be made for room and board with the exception of a reasonable portion that is attributed to a live-in caregiver who is unrelated to the Enrollee and who provides services to the Enrollee in the Enrollee's place of residence. If an Enrollee owns or leases the place of residence, residential expenses (e.g., phone, cable TV, food, rent) shall be apportioned between the Enrollee, other residents in the home, and (as applicable) live-in or other caregivers.

4. This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).

5. Medical Residential Services providers must be licensed by the Department of Mental Health and Developmental Disabilities as a Mental Retardation Residential Habilitation Facility provider or a Supported Living Service provider and ensure that employed nurses are licensed to practice in the state of Tennessee.

(i) Nursing Services.

1. Nursing Services shall be provided face to face with the Enrollee by a licensed registered nurse or licensed practical nurse under the supervision of a registered nurse.

2. Nursing assessment and/or nursing oversight shall not be a separate billable service under this definition.

3. This service shall be provided in home and community settings, as specified in the Plan of Care, excluding inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).

4. An Enrollee who is receiving Medical Residential Services shall not be eligible to receive Nursing Services during the hours Medical Residential Services are being provided.

5. Nursing Services shall not be billed when provided during the same time period as other therapies unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently.

6. Nursing Services are not intended to replace services available through the Medicaid State Plan or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act.

(j) Nutrition Services.

1. Nutrition Services must be provided face to face with the Enrollee or, for purposes of education, with the caregivers responsible for food purchase, food preparation, or assisting the Enrollee to eat.

2. Nutrition Services shall not be billed when provided during the same time period as Physical Therapy; Occupational Therapy; Speech, Language and Hearing Services; Orientation and Mobility Training; or Behavior Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently.

3. Nutrition Services shall be limited to a maximum of 1.5 hours per Enrollee per day.

(k) Occupational Therapy Services.

1. Services must be provided by a licensed occupational therapist or by a licensed occupational therapist assistant working under the supervision of a licensed occupational therapist.

2. Occupational Therapy must be provided face to face with the Enrollee.

3. Occupational Therapy therapeutic and corrective services shall not be ordered concurrently with Occupational Therapy assessments (i.e., assess and treat orders are not accepted).

4. Occupational Therapy assessments shall not be billed on the same day with other Occupational Therapy services.

5. Occupational Therapy shall not be billed when provided during the same time period as Physical Therapy; Speech, Language and Hearing Services; Nutrition Services; Orientation and Mobility Training; or Behavior Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently. Occupational Therapy shall not be billed with Day Services if the Day Services are reimbursed on a per hour basis.

6. Occupational Therapy services are not intended to replace services available through the Medicaid State Plan or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act.

7. Occupational Therapy assessments shall be limited to a maximum of 3.0 hours per enrollee per day, and other Occupational Therapy services shall be limited to a maximum of 1.5 hours per Enrollee per day.

(l) Orientation and Mobility Training.

1. Orientation and Mobility Training shall not be billed when provided during the same time period as Physical Therapy; Occupational Therapy; Nutrition Services; Behavior Services; or Speech, Language and Hearing Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently.

2. Orientation and Mobility Training shall not replace services available under a program funded by the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act.

3. Orientation and Mobility Training shall be limited to a maximum of sixty (60) hours of services per Enrollee per year.

4. Enrollees receiving Orientation and Mobility Training shall be eligible to receive Individual Transportation Services to the extent necessary for participation in Orientation and Mobility Training.

(m) Personal Assistance.

1. Personal Assistance may be provided in the home or community; however, it shall not be provided in school settings and shall not be provided to replace personal assistance services required to be covered by schools or services available through the Medicaid State Plan.

2. An Enrollee who is receiving a residential service (i.e., Supported Living, Residential Habilitation, Medical Residential Services, or Family Model Residential Support) shall not be eligible to receive Personal Assistance. Personal Assistance shall not be provided during the same time period when the Enrollee is receiving Day Services.

3. This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).

4. Family members who provide Personal Assistance must meet the same standards as providers who are unrelated to the Enrollee. The Personal Assistance provider shall not be the spouse and shall not be the Enrollee's parent if the Enrollee is a minor. Reimbursement shall not be made to any other individual who is a conservator unless so permitted in the Order for Conservatorship.

(n) Personal Emergency Response System.

The system shall be limited to those who are alone for parts of the day and who have demonstrated mental and physical capability to utilize such a system effectively.

(o) Physical Therapy Services.

1. Services must be provided by a licensed physical therapist or by a licensed physical therapist assistant working under the supervision of a licensed physical therapist.

2. Physical Therapy must be provided face to face with the Enrollee.

3. Physical Therapy therapeutic and corrective services shall not be ordered concurrently with Physical Therapy assessments (i.e., assess and treat orders are not accepted).

4. Physical Therapy assessments shall not be billed on the same day with other Physical Therapy services.

5. Physical Therapy shall not be billed when provided during the same time period as Occupational Therapy; Speech, Language and Hearing Services; Nutrition Services; Orientation and Mobility Training; or Behavior Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently. Physical Therapy shall not be billed with Day Services if the Day Services are reimbursed on a per hour basis.

6. Physical Therapy services are not intended to replace services available through the Medicaid State Plan or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act.

7. Physical Therapy assessments shall be limited to a maximum of 3.0 hours per Enrollee per day, and other Physical Therapy services shall be limited to a maximum of 1.5 hours per Enrollee per day.

(p) Residential Habilitation.

1. A Residential Habilitation home shall have no more than 4 residents with the exception that homes which were already providing services to more than 4 residents prior to July 1, 2000, may continue to do so.

2. The Residential Habilitation provider shall be responsible for providing an appropriate level of services and supports twenty-four (24) hours per day during the hours the Enrollee is not receiving Day Services or is not at school or work.

3. Transportation shall be a component of Residential Habilitation and shall be included in the reimbursement rate for such (i.e., it shall not be billed as a separate Waiver service) with the following exceptions:
   (i) Transportation to and from medical services covered through the Medicaid State Plan, which shall not be billed as a Waiver service;
   (ii) Transportation necessary for Behavioral Respite Services; or
   (iii) Transportation necessary for Orientation and Mobility Training.

4. Reimbursement for Residential Habilitation shall not be made for room and board or for the cost of maintenance of the dwelling, and reimbursement shall not include payment made to members of the Enrollee's immediate family or to the Enrollee's conservator.

5. This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).

(q) Respite.

1. Respite may be provided in the Enrollee's place of residence, in a Family Model Residential Support home, in a Medicaid-certified ICF/MR, in a home operated by a licensed residential provider, or in the home of an approved respite provider.

2. An Enrollee receiving a residential service (i.e., Supported Living, Residential Habilitation, Medical Residential Services, or Family Model Residential Support) shall not be eligible to receive Respite as a service.

3. The cost of room and board shall be excluded from Respite reimbursement if Respite is provided in a private residence.

4. Respite shall be limited to a maximum of thirty (30) days per Enrollee per year.

5. Enrollees who receive Respite shall be eligible to receive Individual Transportation Services only to the extent necessary during the time period when Respite is being provided.

(r) Specialized Medical Equipment and Supplies and Assistive Technology.

1. Face-to-face consultative assessment by a physical therapist, occupational therapist, or speech therapist to assure that specialized medical equipment and assistive technology which requires custom fitting meets the needs of the Enrollee and training of the Enrollee by a physical therapist, occupational therapist, or speech therapist to effectively utilize such customized equipment shall be limited to a maximum of three (3) hours per Enrollee per day.

2. Items not of direct medical or remedial benefit to the Enrollee shall be excluded. Items that would be covered by the Medicaid State Plan shall be excluded from coverage. Swimming pools, hot tubs, health club memberships, and recreational equipment are excluded. Prescription and over-the-counter medications, food and food supplements, and diapers and other incontinence supplies are excluded.

3. When medically necessary and not covered by warranty, repair of equipment may be covered when it is substantially less expensive to repair the equipment rather than to replace it.

4. The purchase price for waiver-reimbursed Specialized Medical Equipment, Supplies and Assistive Technology shall be considered to include the cost of the item as well as basic training on operation and maintenance of the item.

5. Specialized Medical Equipment, Supplies and Assistive Technology shall be limited to a maximum of $10,000 per Enrollee per two (2) year period.

(s) Speech, Language and Hearing Services.

1. Services must be provided by a licensed speech language pathologist or by a licensed audiologist.

2. Speech, Language and Hearing Services must be provided face to face with the Enrollee.

3. Speech, Language and Hearing therapeutic and corrective services shall not be ordered concurrently with Speech, Language and Hearing assessments (i.e., assess and treat orders are not accepted).

4. Speech, Language and Hearing Services assessments shall not be billed on the same day with other Speech, Language and Hearing Services

5. Speech, Language and Hearing Services shall not be billed when provided during the same time period as Physical Therapy; Occupational Therapy; Nutrition Services; Orientation and Mobility Training; or Behavior Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently. Speech, Language and Hearing Services shall not be billed with Day Services if the Day Services are reimbursed on a per hour basis.

6. Speech, Language and Hearing Services assessments shall be limited to a maximum of 3.0 hours per Enrollee per day, and other Speech, Language and Hearing Services shall be limited to a maximum of 1.5 hours per Enrollee per day.

(t) Support Coordination.

There must be at least one face-to-face contact with the Enrollee per calendar month. If the Enrollee receives a residential service, the Support Coordinator shall have at least one face-to-face contact with the Enrollee in the Enrollee's place of residence each quarter.

(u) Supported Living.

1. The Supported Living provider shall not own the Enrollee's place of residence or be a co-signer of a lease on the Enrollee's place of residence unless the Supported Living provider signs a written agreement with the Enrollee that states that the Enrollee will not be required to move if the primary reason is because the Enrollee desires to change to a different Supported Living provider. A Supported Living provider shall not own, be owned by, or be affiliated with any entity that leases or rents a place of residence to an Enrollee if such entity requires, as a condition of renting or leasing, the Enrollee to move if the Supported Living provider changes.

2. The Supported Living home shall have no more than three (3) residents including the Enrollee.

3. Unless the residence is individually licensed or inspected by a public housing agency utilizing the HUD Section 8 safety checklist, the residence must have an operable smoke detector and a second means of egress.

4. The Supported Living provider shall be responsible for providing an appropriate level of services and supports twenty-four (24) hours per day during the hours the Enrollee is not receiving Day Services or is not at school or work.

5. Transportation shall be a component of Supported Living and shall be included in the reimbursement rate for such (i.e., it shall not be billed as a separate Waiver service) with the following exceptions:
   (i) Transportation to and from medical services covered through the Medicaid State Plan, which shall not be billed as a Waiver service;
   (ii) Transportation necessary for Behavioral Respite Services; or
   (iii) Transportation necessary for Orientation and Mobility Training.

6. Reimbursement for Supported Living shall not be made for room and board with the exception of a reasonable portion that is attributed to a live-in caregiver who is unrelated to the Enrollee and who provides services to the Enrollee in the Enrollee's home. Reimbursement for Supported Living shall not include the cost of maintenance of the dwelling. Residential expenses (e.g., phone, cable TV, food, rent) shall be apportioned between the Enrollee, other residents in the home, and (as applicable) live-in or other caregivers.

7. This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).

8. The Enrollee or the Enrollee's guardian or conservator shall have a voice in choosing the individuals who reside in the Supported Living residence and the staff who provide services and supports.

9. The Enrollee shall have the right to manage personal funds as specified in the Individual Support Plan.

(v) Vehicle Accessibility Modifications.

1. Replacement of tires or brakes, oil changes, and other vehicle maintenance procedures shall be excluded from coverage.

2. Vehicle Accessibility Modifications shall be limited to a maximum of $20,000 per Enrollee per five (5) year period.

(w) Out-of-State Services. A provider of Personal Assistance, Residential Habilitation, Supported Living, Medical Residential Services, and Family Model Residential Services may provide such Covered Service outside the State of Tennessee and be reimbursed only when provided in accordance with the following:

1. Covered Services provided out of state shall be for the purpose of visiting relatives or for vacations and shall be included in the Enrollee's Plan of Care. Trips to casinos or other gambling establishments shall be excluded from coverage.

2. Covered Services provided out of state shall be limited to a maximum of fourteen (14) days per Enrollee per year.

3. The waiver service provider agency must be able to assure the health and safety of the Enrollee during the period when Covered Services will be provided out of state and must be willing to assume the additional risk and liability of provision of Covered Services out of state.

4. During the period when Covered Services are being provided out of state, the waiver service provider agency shall maintain an adequate amount of staffing to meet the needs of the Enrollee and must ensure that staff meet the applicable provider qualifications.

5. The provider agency which provides Covered Services out of state shall not receive any additional reimbursement for provision of services out-of-state. The costs of travel, lodging, food, and other expenses incurred by staff during the provision of

out-of-state services shall not be reimbursed through the Waiver. The costs of travel, lodging, food, and other expenses incurred by the Enrollee while receiving out-of-state services shall be the responsibility of the Enrollee and shall not be reimbursed through the waiver.

(x) All Covered Services to be provided prior to the development of the initial Individual Support Plan must be included in the physician's plan of care section of the Pre-Admission Evaluation application.

(3) Eligibility.

(a) To be eligible for enrollment in the Waiver, an individual must meet all of the following criteria:

1. The individual must be a resident of the State of Tennessee.

2. The individual must, but for the provision of Waiver Services, require the level of care provided in an ICF/MR, and must meet the ICF/MR eligibility criteria specified in Medicaid rule 1200-13-1-.15.

3. The individual's habilitative, medical, and specialized services needs must be such that they can be effectively and safely met through the Waiver, as determined by the Operational Administrative Agency based on a pre-enrollment assessment.

4. The individual must have an unexpired ICF/MR Pre-Admission Evaluation which has been approved by the State Medicaid Agency or by its designee and which lists the Enrollee's specific Waiver Services with the amount, scope, and duration of the services.

5. The individual must have a psychological evaluation included as part of the approved Pre-Admission Evaluation and which meets the following:

(i) The psychological evaluation shall document that the individual:

(I) Has mental retardation manifested before eighteen (18) years of age and have an IQ test score of seventy (70) or below, or

(II) Is a child four (4) years of age or younger who has a developmental disability with a high probability of resulting in mental retardation (i.e., a condition of substantial developmental delay or specific congenital or acquired condition with a high probability of resulting in mental retardation).

(ii) The psychological evaluation:

(I) Shall have been made no more than three (3) calendar months before the date of admission into the Waiver; or

(II) If performed more than three (3) calendar months but no more than twelve (12) calendar months before the date of admission, shall have been signed and updated within three (3) calendar months

preceding the date of admission into the Waiver. The update must be done by the person who performed the examination or by the supervising clinical psychologist who signed the initial evaluation.

6. The individual shall have one or more designated adults who shall be present in the individual's home to observe, evaluate, and provide an adequate level of direct care services to ensure the health and safety of the individual.

   (i) An individual who does not have 24-hour-per-day direct care services shall:

      (I) Have an individualized Safety Plan that:

         I. Is based on a written assessment of the individul's functional capabilities and habilitative, medical, and specialized services needs by the Independent Support Coordinator in consultation with individuals who are knowledgeable of the individual's capability of functioning without direct care services twenty-four (24) hours per day;

         II. Addresses the individual's capability of functioning when direct care staff are not present;

         III. Addresses the ability of the individual to self-administer medications when direct care staff are not present;

         IV. Specifies whether a Personal Emergency Response System will be used by the individual to secure help in an emergency;

         V. Is updated as needed, but no less frequently than annually, by the Operational Administrative Agency to ensure the health and safety of the individual; and

         VI. Is an attachment to the ICF/MR PAE or, if applicable, to the Transfer Form.

      (II) Have one or more designated adults who shall be present in the individual's home to observe, evaluate, and provide an adequate level of direct care services to ensure the health and safety of the individual as needed but no less frequently than one day each week.

7. An individual must have a place of residence with an environment that is adequate to reasonably ensure health, safety and welfare. Any licensed facility in which the individual resides must meet all applicable fire and safety codes.

(b) A Transfer Form approved by the State Medicaid Agency:

   1. May be used to transfer an Enrollee having an approved unexpired ICF/MR PAE from the Waiver to an ICF/MR;

2. May be used to transfer an individual having an approved unexpired ICF/MR PAE from an ICF/MR to the Waiver;

3. Shall not be used to transfer an individul from one Waiver to a different Home and Community Based Services Waiver Program; and

4. Shall list the Enrollee's specific Waiver Services with the amount, scope, and duration of the services.

(4) Intake and Enrollment.

(a) When an individual is determined to be likely to require the level of care provided by an ICF/MR, the Operational Administrative Agency shall inform the individual or the individual's legal representative of any feasible alternatives available under the Waiver and shall offer the choice of available institutional services or Waiver program services. Notice to the individual shall contain:

1. A simple explanation of the Waiver and Covered Services;

2. Notification of the opportunity to apply for enrollment in the Waiver and an explanation of the procedures for enrollment; and

3. A statement that participation in the Waiver is voluntary.

(b) Enrollment in the Waiver shall be voluntary, but shall be restricted to the maximum number of individuals specified in the Waiver, as approved by the Centers for Medicare and Medicaid Services for the State of Tennessee.

(c) 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 an ICF/MR.

(5) Certification and Re-evaluation.

(a) The ICF/MR Pre-Admission Evaluation shall include a signed and dated certification by the individual's physician that the individual requires Waiver Services.

(b) The Operational Administrative Agency shall perform a re-evaluation of the Enrollee's need for continued stay in the Waiver within twelve (12) calendar months of the date of enrollment and at least every twelve (12) months thereafter. The re-evaluation shall be documented in a format approved by the State Medicaid Agency and shall be performed by a licensed physician or registered nurse or a Qualified Mental Retardation Professional.

(c) The Operational Administrative Agency shall maintain in its files for a minimum period of three (3) years a copy of the re-evaluations of need for continued stay.

(6) 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 guardian or conservator to the Operational

Administrative Agency. Prior to disenrollment the Operational Administrative Agency shall provide reasonable assistance to the Enrollee in locating appropriate alternative placement.

(b) An Enrollee may be involuntarily disenrolled from the Waiver for any of the following reasons:

1. The Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled is terminated.

2. An Enrollee becomes ineligible for Medicaid or is found to be erroneously enrolled in the Waiver.

3. An Enrollee moves out of the State 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 Enrollee's medical or behavioral needs become such that the health, safety, and welfare of the Enrollee cannot be assured through the provision of Waiver Services.

6. 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.

7. The Enrollee or the Enrollee's guardian or conservator refuses to abide by the Plan of Care or related Waiver policies, resulting in the inability of the Operational Administrative Agency to ensure quality care or the health and safety of the Enrollee.

8. The health, safety, and welfare of the Enrollee cannot be assured due to the lack of an approved Safety Plan.

9. The Enrollee was transferred to a hospital, nursing facility, Intermediate Care Facility for the Mentally Retarded, Assisted Living Facility, and/or Home for the Aged and has resided there for a continuous period exceeding 120 days.

(c) The Operational Administrative Agency shall notify the State Medicaid Agency in writing prior to involuntary disenrollment of an Enrollee and shall give advance notice to the Enrollee of the intended involuntary disenrollment and of the Enrollee's right to appeal and have a fair hearing.

(d) If an Enrollee has been involuntarily disenrolled from the Waiver, the Operational Administrative Agency shall provide reasonable assistance to the Enrollee in locating appropriate alternative placement.

(7) Plan of Care.

(a) All Waiver Services for the Enrollee shall be provided in accordance with an approved Plan of Care.

1. Prior to the development of the initial Individual Support Plan, Covered Services shall be provided in accordance with the physician's initial plan of care included in the approved ICF/MR Pre-Admission Evaluation.

2. Each Enrollee shall have an individualized written Plan of Care (the Individual Support Plan) that shall be developed for an Enrollee within ninety (90) calendar days of admission into the Waiver.

3. A Safety Plan for Enrollees who do not have 24-hour direct care services shall be maintained with the Plan of Care.

(b) To ensure that Waiver Services and other services are being appropriately provided to meet the Enrollee's needs, the Plan of Care shall be reviewed on an ongoing basis and shall be updated and signed in accordance with the following:

1. The Support Coordinator shall review the Plan of Care when needed, but no less frequently than once each calendar month, and shall document such review by a dated signature.

2. A team consisting of the Support Coordinator and other appropriate participants in the development of the Plan of Care shall review the Plan of Care when needed, but no less frequently than every twelve (12) calendar months, and shall document such review by dated signatures. Such annual review shall include, but not be limited to, reviewing outcomes and determining if progress is being made in accordance with the Plan of Care; reviewing the appropriateness of supports and services being provided and determining further needs of the Enrollee.

(8) Physician Services.

(a) The Operational Administrative Agency shall ensure that each Enrollee receives physician services as needed and that each Enrollee has a medical examination, documented in the Enrollee's record, in accordance with the following schedule:

Age	Minimum frequency of medical examinations
Up to age 21	In accordance with Medicaid EPSDT periodicity standards
21-64	Every one (1) to three (3) years, as determined by the Enrollee's physician
Over age 65	Annually

(b) All Covered Services to be provided prior to the development of the initial Individual Support Plan shall be physician ordered and shall be included in the physician's plan of care section of the Pre-Admission Evaluation application.

(c) When required by state law, Covered Services shall be ordered or reordered, by a licensed physician, licensed nurse practitioner, physician assistant, a licensed dentist, or other appropriate health care provider.

(9) Waiver Administration.

(a) The Operational Administrative Agency shall be responsible for the administration of the day-to-day operations of the Waiver under the oversight of the State Medicaid Agency and shall ensure that Covered Services are provided in accordance with state and federal laws, rules, regulations and policies established by the State Medicaid Agency. The Operational Administrative Agency shall be responsible for the following activities, whether provided directly or through subcontract:

1. Marketing of the Waiver to potential Enrollees;

2. Intake and pre-enrollment assessment of the applicant's habilitative, medical and specialized services needs; and appropriateness for enrollment in the Waiver;

3. Assisting the applicant with the submission of a properly completed ICF/MR Pre-Admission Evaluation;

4. Enrollment of eligible individuals into the Waiver;

5. Provision of a plain language explanation of appeal rights to each Enrollee upon enrollment in the Waiver;

6. Review and approval of Plans of Care (Individual Support Plans) to ensure that Waiver Services have been authorized prior to payment;

7. Ensuring that annual level of care re-evaluations have been performed to document the need for continuation of Waiver Services for the Enrollee;

8. Notification of the State Medicaid Agency in writing prior to involuntary disenrollment of any Enrollee;

9. Ensuring that Waiver providers maintain comprehensive Enrollee records and documentation of services provided to Enrollees in accordance with state and federal laws, rules, regulations and State Medicaid Agency policies;

10. Obtaining approval from the State Medicaid Agency prior to distributing policies and procedures to Waiver providers or Waiver information to Enrollees;

11. Compliance with reporting and record-keeping requirements established by the State Medicaid Agency;

12. Maintaining in its files the original ICF/MR Pre-Admission Evaluation and, where applicable, the original Transfer Form;

13. Assurance of a statewide provider network adequate to meet the needs of Enrollees;

14. Ensuring that Waiver Services providers and subcontractors meet the Waiver provider qualifications approved by the Centers for Medicare and Medicaid Services;

15. Ensuring that Waiver Services providers have a signed provider agreement which includes a requirement for compliance with the Division of Mental Retardation Services Provider Manual in the delivery of waiver services;

16. Assurance of the health and safety of Enrollees through the implementation of a comprehensive quality monitoring program;

17. Reporting instances of abuse, neglect, mistreatment or exploitation to appropriate state agencies;

18. Assurance that Covered Services are provided in accordance with the approved Waiver definitions and in accordance with the State Medicaid Agency guidelines;

19. Compliance with the appeals process specified in TennCare rule 1200-13-13-.11 to ensure that Enrollees are afforded advance notice and the right to appeal an adverse decision and have a fair hearing;

20. Ensuring that providers and subcontractors comply with the quality monitoring guidelines and requirements established by the State Medicaid Agency, by the Operational Administrative Agency, and by the Centers for Medicare and Medicaid Services, and with other state and federal laws, rules, and regulations affecting the provision of Waiver Services;

21. Collection of applicable patient liability from Enrollees;

22. Reimbursement of Waiver providers in accordance with policies established by the State Medicaid Agency;

23. Recoupment of payments made to Waiver providers when there is lack of documentation to support that services were provided or there is a lack of medical necessity of services, or when inappropriate payments have been made due to erroneous or fraudulent billing; and

24. Expenditure and revenue reporting in accordance with state and federal requirements.

(10) 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 had been provided in an ICF/MR. 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 an ICF/MR.

(b) The Operational Administrative Agency shall be reimbursed for Waiver Services at the rate per unit of service actually paid by the Operational Administrative Agency to the Waiver service provider or at the maximum rate per unit of service established by the State Medicaid Agency, whichever is lesser.

(c) In accordance with 42 CFR § 435.726, the Operational Administrative Agency shall make a diligent effort to collect patient liability if it applies to the Enrollee. The Operational

Administrative Agency or its designee 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 Operational Administrative Agency and to the State Medicaid Agency's fiscal agent that processes and pays vendor claims, specifying the amount of patient liability to be applied toward the cost of care for the Enrollee.

(d) The Operational Administrative Agency shall submit bills for services to the State Medicaid Agency's fiscal agent using a claim form approved by the State Medicaid Agency. On claim forms, the Operational Administrative Agency shall use a provider number assigned by the State Medicaid Agency.

(e) Reimbursement shall not be made to the Operational Administrative Agency for therapeutic leave or hospital leave for Enrollees in the Waiver.

(f) Medicaid benefits other than those specified in the Waiver's scope of Covered Services shall be reimbursed by the State Medicaid Agency as otherwise provided for by federal and state rules and regulations.

(g) The Operational Administrative Agency shall be responsible for obtaining the physician's initial certification and subsequent Enrollee re-evaluations. Failure to perform re-evaluations in a timely manner and in the format approved by the State Medicaid Agency shall require a corrective action plan and shall result in partial or full recoupment of all amounts paid by the State Medicaid Agency during the time period when a re-evaluation had lapsed.

(h) The State Medicaid Agency shall be responsible for defining and establishing the billing units to be used by the Operational Administrative Agency in billing for Waiver Services.

(i) An Operational Administrative Agency that enrolls an individual without an approved ICF/MR Pre-Admission Evaluation or, where applicable, an approved Transfer Form does so without the assurance of reimbursement. An Operational Administrative 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.

(11) Appeals. An Enrollee shall have the right to appeal an adverse action in accordance with TennCare rule 1200-13-13-.11.

Statutory Authority: T.C.A. 4-5-202, 4-5-203, 71-5-105, 71-5-109, Executive Order No. 23.

D1036054

I certify that this is an accurate complete representation of the intent and scope of rulemaking proposed by the Tennessee Department of Finance and Administration.

Keith Gaither
Deputy Chief Financial Officer
Tennessee Department of Finance and Administration

Subscribed and sworn to before me this the 28TH day of February, 2006.

JANICE TOMLINSON STATE OF TENNESSEE NOTARY PUBLIC DAVIDSON COUNTY

Notary Public

My Commission Expires on the 24TH day of January, 2009.

The notice of rulemaking set out herein was properly filed in the Department of State on the 28 day of Feb., 2006.

Riley C. Darnell
Secretary of State

BY:

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