

**Department of State**  
**Division of Publications**  
 312 Rosa L. Parks Avenue, 8th Floor Snodgrass/TN Tower  
 Nashville, TN 37243  
 Phone: 615-741-2650  
 Fax: 615-741-5133  
 Email: [register.information@tn.gov](mailto:register.information@tn.gov)

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**Rulemaking Hearing Rule(s) Filing Form**

*Rulemaking Hearing Rules are rules filed after and as a result of a rulemaking hearing. TCA Section 4-5-205*

<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>	Bureau of TennCare 310 Great Circle Road Nashville, Tennessee
<b>Zip:</b>	37243
<b>Phone:</b>	(615) 507-6446
<b>Email:</b>	<a href="mailto:George.woods@tn.gov">George.woods@tn.gov</a>

**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
1200-13-18	TennCare Administrative Actions and Provider Appeals
Rule Number	Rule Title
1200-13-18-.01	Scope and Authority
1200-13-18-.02	Definitions
1200-13-18-.03	Administrative Action for Recovery Under the Tennessee Medicaid False Claims Act
1200-13-18-.04	Recoupment or Withhold
1200-13-18-.05	Suspension of Payment
1200-13-18-.06	Electronic Health Record Incentive Program (EHR-IP)
1200-13-18-.07	Termination or Exclusion of a Provider from Program Participation
1200-13-18-.08	Provider Sanctions

(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.tn.us/sos/rules/1360/1360.htm>)

Emergency Rule Chapter 1200-13-18 TennCare Administrative Actions and Provider Appeals is deleted in its entirety and replaced with Rulemaking Hearing Rule Chapter 1200-13-18 which shall read as follows:

Chapter 1200-13-18  
TennCare Administrative Actions and Provider Appeals

1200-13-18-.01 Scope and Authority.

- (1) An approved provider of TennCare services may appeal the following administrative actions:
  - (a) An administrative action for recovery against a person other than an enrollee, recipient or applicant brought by the Bureau of TennCare upon written request of the Attorney General pursuant to the Tennessee Medicaid False Claims Act;
  - (b) An action proposed or taken by the Bureau of TennCare or its audit contractor to recover, recoup or withhold payment from a provider, as a result of any audit performed by or on behalf of the Centers for Medicare and Medicaid Services or the Bureau pursuant to state or federal law;
  - (c) A Bureau of TennCare determination to suspend payments to a provider due to a credible allegation of fraud for which an investigation is pending;
  - (d) A denial of eligibility for or a determination of the amount of an incentive payment pursuant to the federal Medicaid Electronic Health Record Incentive Program (EHR-IP); or,
  - (e) Termination of an approved provider's Tennessee Medicaid Provider Number by the Bureau, except when federal law mandates exclusion of the provider.
- (2) A provider of services may not appeal the following administrative actions:
  - (a) An MCC's refusal to contract with the provider;
  - (b) A decision by the Bureau to decline coverage of prescriptions not written by a provider with prescribing authority; or,
  - (c) Termination or exclusion from the Program as required by federal law.
- (3) In order to exercise the right to a hearing, a provider must submit his appeal and request for a hearing in writing to the Bureau. The notice of the Bureau action shall contain specific instructions concerning the right to appeal and the address for filing an appeal.
- (4) Any request for an appeal must be received at the address contained in the notice of action no later than 35 days following the date of the notice.
- (5) Provider appeals shall be conducted as contested case hearings by the Tennessee Department of State, Administrative Procedures Division, pursuant to the Tennessee Uniform Administrative Procedures Act (APA).
- (6) The Uniform Rules of Procedure for Hearing Contested Cases Before State Administrative Agencies, Chapter 1360-04-01, promulgated under the APA, are adopted by the Bureau and incorporated by reference herein. The Uniform Rules shall govern the conduct of a provider appeal except where a specific contrary provision is adopted by the Bureau in this Chapter.

- (7) For purposes of issuing an initial order, a contested case hearing shall be conducted by an administrative judge hearing the case alone.

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109.

1200-13-18-.02 Definitions.

- (1) **Administrative Judge.** An employee or official of the Office of the Secretary of State who is licensed to practice law and authorized by law to conduct contested case proceedings.
- (2) **Administrative Procedures Act (APA).** The Tennessee Uniform Administrative Procedures Act, as amended, codified at T.C.A. §§ 4-5-301, et seq.
- (3) **Approved Provider.** A provider of health care services who has registered with and been approved by the Bureau and has been issued a Tennessee Medicaid Provider Number.
- (4) **Audit.** The systematic process of objectively obtaining and evaluating evidence regarding assertions about economic actions and events to ascertain the degree of correspondence between those assertions and established criteria and communicating the results to interested parties. Audits are conducted in accordance with AICPA (American Institute of Certified Public Accountants) auditing or attestation engagement standards. For purposes of this chapter, audits are conducted of health care provider records, financial information, and statistical data according to principles of cost reimbursement to determine the reasonableness and allowance of costs reimbursable under the Program.
- (5) **Bureau of TennCare (Bureau).** The division of the Tennessee Department of Finance and Administration, the single state Medicaid agency, that administers the TennCare Program. For purposes of this Chapter, the Bureau shall represent the State of Tennessee.
- (6) **Civil Penalty.** A monetary penalty assessed by the Bureau against a provider in an amount of not less than \$1,000 nor more than \$5,000 for each violation of the Tennessee Medicaid False Claims Act. T.C.A. § 71-5-183(h)(3).
- (7) **Claim.** Any request or demand for money, property, or services made to any employee, officer, or agent of the state, or to any contractor, grantee, or other recipient, whether under contract or not, if any portion of the money, property, or services requested or demanded was issued from, or was provided by, the State.
- (8) **Commissioner.** The chief administrative officer of the Tennessee Department where the Bureau is administratively located.
- (9) **Commissioner's Designee.** A person authorized by the Commissioner to review appeals of initial orders and to enter final orders pursuant to T.C.A. § 4-5-315, or to review petitions for stay or reconsideration of final orders.
- (10) **Contested Case.** An administrative proceeding in which the legal rights, duties or privileges of a party are required by any statute or constitutional provision to be determined by an agency after an opportunity for a hearing.
- (11) **Credible Allegation of Fraud.** Information which has been verified by the Bureau through judicious case-by-case review and found to contain indicia of reliability. This information may be from any source, including but not limited to hotline complaints, claims data mining, patterns identified through provider audits, civil false claims cases, or law enforcement investigations.
- (12) **Department.** The Tennessee Department of Finance and Administration.
- (13) **Electronic Health Record Incentive Program (EHR-IP).** The provisions of the American Recovery and Reinvestment Act of 2009 (ARRA) that provide for incentive payments to eligible professionals (EPs) and eligible hospitals (EHs), including acute care, children's and critical access hospitals (CAHs) participating in Medicare and Medicaid programs that adopt, implement or update a certified system and successfully

demonstrate meaningful use of certified electronic health record (EHR) technology as required by federal regulations.

- (14) Enrollee. An individual eligible for and enrolled in the TennCare program.
- (15) Error Rate. The percentage of claims in a sample population that was not billed properly and is actionable. Error rates can be applied to entire populations if the sample was the result of statically valid random sampling. The use of the term "error" does not indicate the intent of the person or entity submitting the claim.
- (16) Findings of Fact. The factual findings issued by the Administrative Judge or Commissioner's Designee following an administrative hearing. The factual findings are enumerated in the initial and/or final order. An order must include a concise and explicit statement of the underlying facts of record to support the findings.
- (17) Final Agency Decision. A Final Order.
- (18) Final Order. An initial order becomes a final order without further notice if not timely appealed, or if the initial order is appealed pursuant to T.C.A. § 4-5-315, the Commissioner or Commissioner's Designee may render a final order. A statement of the procedures and time limits for seeking reconsideration or judicial review shall be included with the issuance of a final order.
- (19) Good Cause Not to Suspend Payment. The Bureau may determine not to suspend payment or not to continue suspension of payment to a provider being investigated due to a credible allegation of fraud if:
  - (a) Law enforcement officials have specifically requested that a payment suspension not be imposed because such a payment suspension may compromise or jeopardize an investigation;
  - (b) Other available remedies implemented by the State more effectively or quickly protect Program funds;
  - (c) The Bureau determines, based upon the submission of written evidence by the provider that is the subject of the payment suspension, that the suspension should be removed;
  - (d) Enrollee access to items or services would be jeopardized by a payment suspension because the provider is the sole community physician, the sole source of essential specialized services in a community, or serves a large number of enrollees within a HRSA-designated medically underserved area;
  - (e) Law enforcement declines to certify that a matter continues to be under investigation; or
  - (f) The Bureau determines that payment suspension is not in the best interests of the Program.
- (20) Good Cause to Suspend Payment Only in Part. The Bureau may determine to suspend payments in part, or to convert a payment suspension previously imposed in whole to one only in part, to a provider being investigated due to a credible allegation of fraud if:
  - (a) Enrollee access to items or services would be jeopardized by a payment suspension in whole or part because the provider is the sole community physician, the sole source of essential specialized services in a community, or serves a large number of recipients within a HRSA-designated medically underserved area;
  - (b) The Bureau determines, based upon the submission of written evidence by the provider that is the subject of a whole payment suspension, that such suspension should be imposed only in part;
  - (c) The credible allegation focuses solely and definitively on only a specific type of claim or arises from only a specific business unit of a provider, and the Bureau determines and documents in writing that a payment suspension in part would effectively ensure that potentially fraudulent claims were not continuing to be paid;

- (d) Law enforcement declines to certify that a matter continues to be under investigation; or
  - (e) The Bureau determines that payment suspension only in part is in the best interests of the Program.
- (21) Hearing. A contested case proceeding.
- (22) Indicia of Reliability. Factors which the Bureau will examine in determining whether a credible allegation of fraud exists, requiring the suspension of payments to a provider, including but not limited to:
- (a) Firsthand knowledge;
  - (b) Corroborating witness;
  - (c) Witness conflict (disgruntled employee);
  - (d) Prior bad acts;
  - (e) Pattern of bad acts;
  - (f) Documentary proof;
  - (g) Admission by provider;
  - (h) Expert opinion; or
  - (i) Indictment by a court of competent jurisdiction.
- (23) Initial Order. The decision issued by the administrative judge following a hearing. The initial order shall contain the decision, findings of fact, conclusions of law, the policy reasons for the decision and the remedy prescribed. It shall include a statement of the procedure for filing an appeal of the initial order as well as a statement of any circumstances under which the initial order may, without further notice, become a final order. A statement of the procedures and time limits for seeking reconsideration or other administrative relief and the time limits for seeking judicial review shall be included.
- (24) Notice of Action. The document or letter sent by the Bureau to a provider detailing the action the Bureau intends to take against the provider. The notice shall include a statement of the reasons and authority for the action as well as a statement of the provider's right to appeal the action, if applicable.
- (25) Notice of Hearing. The pleading filed with the Administrative Procedures Division by the Bureau upon receipt of an appeal. It shall contain a statement of the time, place, nature of the hearing, and the right to be represented by counsel; a statement of the legal authority and jurisdiction under which the hearing is to be held, referring to the particular statutes and rules involved; and, a short and plain statement of the matters asserted, in compliance with the APA.
- (26) Program. See TennCare.
- (27) Provider with Prescribing Authority. A health care professional authorized by law or regulation to order prescription medications for her patients and who:
- (a) Participates in the provider network of the MCC in which the beneficiary is enrolled; or
  - (b) Has received a referral of the beneficiary, approved by the MCC, authorizing her to treat the beneficiary; or,
  - (c) In the case of a TennCare beneficiary who is also enrolled in Medicare, is authorized to treat Medicare patients.
- (28) RAT-STATS. A widely accepted statistical software tool designed to assist the user in conducting statistically valid random sampling and evaluating audit results.

- (29) Standard of Proof. A preponderance of the evidence.
- (30) Statistically Valid Random Sampling. A method for determining error rates in healthcare billings using extrapolation. Typically used for large numbers of suspect claims or patients, a random sample of claims from a chosen population is selected using RAT-STATS or a similar program. That sample is then analyzed for errors. If the sample is the result of statistically valid random sampling, the error rate in the sample can be extrapolated to the entire population of claims.
- (31) TennCare. The program administered by the Single State Agency as designated by the State and CMS pursuant to Title XIX of the Social Security Act and the Section 1115 Research and Demonstration Waiver granted to the State of Tennessee.
- (32) Tennessee Medicaid Provider Number. The identifying number issued by the Bureau to an approved provider for the purpose of receiving payment in exchange for rendering services to TennCare enrollees.
- (33) Tennessee Medicaid False Claims Act (Act). T.C.A. §§ 71-5-181, *et seq.*
- (34) Termination. The deactivation of a provider's Tennessee Medicaid Provider Number and the cessation of the provider's TennCare billing privileges.

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109.

1200-13-18-.03 Administrative Action for Recovery Under the Tennessee Medicaid False Claims Act.

- (1) The Attorney General, following an investigation of an approved provider's claims, may determine that certain provider actions are appropriate for administrative action by the Bureau, pursuant to the Act. The Attorney General may refer any such matters to the Bureau Director, or his designee, along with the investigative file and a recommendation for action.
- (2) The Attorney General shall not refer matters originally brought under T.C.A. § 71-5-183(b) or if any person has the right to participate in or recover from the proceeding pursuant to T.C.A. § 71-5-183(c)(5).
- (3) Upon receipt of a written request from the Attorney General, the Bureau may commence a contested case proceeding on behalf of the State for recovery under the Act against any person other than an enrollee, recipient or applicant.
- (4) The Bureau may initiate the recovery process by notice of action to the provider setting out:
  - (a) The assessment of damages, civil penalties and related costs;
  - (b) The name and contact information of an individual within the Bureau with knowledge of the claim(s) and the assessment who is authorized to discuss the matter with the provider; and
  - (c) A statement of the right of the provider to appeal the assessment and the manner in which an appeal must be filed.
- (5) Any appeal of a notice of action shall be conducted according to rule .01 of this chapter.
- (6) The Bureau may recover actual damages in an amount no greater than ten thousand dollars (\$10,000). The amount of actual damages may be based upon a statistically valid random sample utilizing a software tool such as RAT-STATS.
- (7) In addition to and not limited by the amount of actual damages, the Bureau may recover:
  - (a) Civil penalties of not less than one thousand dollars (\$1,000) nor more than five thousand dollars (\$5,000) for each claim found to be in violation of the Act;
  - (b) Costs of the administrative action; and

- (c) Treble the amount of actual damages.
- (8) Any action for recovery shall not be brought:
- (a) More than six (6) years following the date on which the violation of the Act is committed; or
  - (b) More than three (3) years after the date when facts material to the right of action are known or reasonably should have been known by the state official charged with responsibility to act in the circumstances, but in no event not more than ten (10) years after the date the violation was committed, whichever occurs last.
- (9) A subpoena issued by an administrative judge pursuant to the APA requiring the attendance of a witness at a hearing may be served by certified mail at any place in the United States.
- (10) For purposes of rendering a final order pursuant to the APA, the Bureau is designated as the agency to review initial orders and issue final agency decisions. Orders issued by the Bureau shall have the effect of a final order pursuant to the APA.
- (11) Judgment. A final order issued by the Bureau under this rule may be enforced as a final judgment, as follows:
- (a) A notarized copy of the final order must be filed in the office of the Clerk of the Chancery Court of Davidson County;
  - (b) Upon filing with the Clerk, a final order shall be considered as a judgment by consent of the parties on the same terms and conditions as those recited in the order;
  - (c) The judgment shall be promptly entered by the Court;
  - (d) The judgment shall become final on the date of entry; and
  - (e) A final judgment shall have the same effect, is subject to the same procedures and may be enforced or satisfied in the same manner as any other judgment of a court of record of the State of Tennessee.

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109.

1200-13-18-.04 Recoupment or Withhold.

- (1) The Bureau is required by state and federal law to protect the integrity of the Medicaid program. This is accomplished in part by causing audits of provider claims to be conducted. Audit findings are reported to the Bureau for the purpose of recovering incorrect payments, by recoupment or withhold.
- (2) The Bureau shall notify a provider of its intent to recoup or withhold based upon audit findings by issuing a notice of action. Each notice of action sent to a provider shall contain the proposed recovery action and the following information:
  - (a) The name and contact information of an individual knowledgeable about the audit findings and who is authorized to discuss the proposed recovery action with the provider;
  - (b) The manner by which the provider may submit additional information to support his disagreement with the proposed recovery action;
  - (c) A statement that the provider has the right to appeal the proposed recovery action and the manner in which an appeal must be filed.
- (3) Any appeal of a notice of action shall be conducted according to rule .01 of this chapter.

- (4) The audit and the audit findings are not subject to appeal. (See *NHC v. Snodgrass*, 555 S.W.2d 403 (Tenn. 1977)).

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109.

#### 1200-13-18-.05 Suspension of Payment.

- (1) Pursuant to 42 C.F.R. § 447.90, the Bureau is prohibited by federal law from receiving federal financial participation (FFP) for payment to a provider of medical items or services with respect to which there is a pending investigation of a credible allegation of fraud, absent good cause not to suspend payment or good cause to suspend payment only in part.
- (2) The Bureau must provide written notice to the provider of a suspension of payments:
- (a) Five (5) days after suspending payments unless a law enforcement agency has submitted a written request to delay the notice; or
  - (b) Thirty (30) days after suspending payments when a delay was properly requested by law enforcement, except the delay may be renewed twice in writing not to exceed ninety (90) days.
- (3) Written notice of suspension of payment must contain:
- (a) A statement that payments are suspended according to this rule and federal regulation;
  - (b) The general allegations as to the nature of the suspension action, but need not disclose any specific information concerning an ongoing investigation;
  - (c) A statement that the suspension is temporary and the circumstances under which it will be terminated;
  - (d) If applicable, state the type(s) of TennCare/Medicaid claims to which suspension is effective;
  - (e) A statement that the provider has the right to submit written evidence for consideration by the Bureau; and
  - (f) A statement that the provider has the right to appeal the suspension and the manner in which an appeal must be filed.
- (4) Any appeal of a notice of suspension of payment shall be conducted according to rule .01 of this chapter.
- (5) Any suspension of payment shall be temporary and shall not continue after:
- (a) The Bureau or prosecuting authority determines there is insufficient evidence of fraud by the provider; or
  - (b) Legal proceedings related to the provider's alleged fraud are completed.
- (6) The Bureau must document in writing the termination of a suspension of payment. Such document must include any applicable appeal rights available to the provider.

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109.

#### 1200-13-18-.06 Electronic Health Record Incentive Program (EHR-IP).

- (1) An approved provider of TennCare services, upon receipt of a notice of action, may appeal the following issues related to the EHR-IP:
- (a) Denial of an incentive payment;

- (b) Incentive payment amount;
  - (c) Determination of eligibility for an incentive payment, including but not limited to measurement of patient volume;
  - (d) Determination of efforts to adopt, implement or upgrade to certified EHR technology during the first year of the EHR-IP or meaningful use of certified EHR technology in subsequent years;
  - (e) Whether the provider is hospital-based;
  - (f) Whether the provider is practicing predominantly in an FQHC or RHC;
  - (g) Whether a hospital qualifies as an acute care or children's hospital; or,
  - (h) Whether the provider is already participating in the Medicare incentive program or in the Medicaid incentive program of another state and therefore is ineligible for duplicate TennCare incentive program payments.
- (2) Each notice of action sent to a provider of a determination of any matter listed in paragraph (1) shall contain the following:
- (a) The contact information to reach an individual knowledgeable about the EHR-IP who is authorized to discuss the determination with which the provider disagrees;
  - (b) The manner by which the provider may submit additional information to support his disagreement with the determination; and
  - (c) A statement that the provider has the right to appeal the determination with which he disagrees and the manner in which an appeal must be filed.
- (3) Any appeal of a notice of action shall be conducted according to rule .01 of this chapter.

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109.

1200-13-18-.07 Termination or Exclusion of a Provider from Program Participation.

- (1) A provider may be terminated or excluded from participation in the TennCare program.
- (2) Federal Mandatory Exclusion. The Bureau is required by federal law to exclude a provider from participation in the TennCare program upon notice from HHS or CMS under the following circumstances:
  - (a) Conviction of program-related crimes;
  - (b) Conviction relating to patient abuse;
  - (c) Felony conviction relating to health care fraud; or
  - (d) Felony conviction relating to controlled substance.
- (3) Federal Permissive Exclusion. Pursuant to federal law, the Bureau may exclude a provider from participation in the TennCare program under the following circumstances:
  - (a) Conviction related to fraud;
  - (b) Conviction related to obstruction of an investigation or audit;
  - (c) Misdemeanor conviction related to controlled substance;
  - (d) License revocation or suspension;

- (e) Exclusion or suspension under federal or state health care program;
  - (f) Claims for excessive charges or unnecessary services and failure of certain organizations to furnish medically necessary services;
  - (g) Fraud, kickbacks, and other prohibited activities;
  - (h) Entities controlled by a sanctioned individual;
  - (i) Failure to disclose required information;
  - (j) Failure to supply requested information on subcontractors and suppliers;
  - (k) Failure to supply payment information;
  - (l) Failure to grant immediate access;
  - (m) Failure to take corrective action;
  - (n) Default on health education loan or scholarship obligations;
  - (o) Individuals controlling a sanctioned entity; or
  - (p) Making false statements or misrepresentation of material facts.
- (4) When a provider exclusion is mandatory, the notice of action shall state that the provider has no right to appeal the termination from program participation.
- (5) When a provider exclusion is permissive, the notice of action shall include a statement that the provider has the right to appeal the termination from program participation and the manner in which an appeal must be filed.

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109.

1200-13-18-.08 Provider Sanctions.

- (1) Pursuant to the authority granted by T.C.A. § 71-5-118 to the Commissioner to impose sanctions against providers, the Commissioner, through the Bureau, may take the following actions against a provider upon a finding that such actions will further the purpose of the Tennessee Medical Assistance Act:
- (a) Subject providers to stringent review and audit procedures which may include clinical evaluation of claim services and a prepayment requirement for documentation and for justification of each claim;
  - (b) Refuse to issue or terminate a Tennessee Medicaid Provider Number 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;
  - (c) Refuse to issue or terminate a Tennessee Medicaid Provider Number if a determination is made 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;
  - (d) Refuse to issue or terminate a Tennessee Medicaid Provider Number 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;

- (e) Refuse to issue or terminate a Tennessee Medicaid Provider Number 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;
  - (f) Suspend or withhold payments to a provider in cases of fraud, willful misrepresentation, or flagrant noncompliance; or,
  - (g) 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 the Bureau and repayment by the provider to the recipient and/or his family is not made within 30 days of receiving notification from the Bureau to make repayment. If a provider knowingly bills a recipient and/or family for a TennCare covered service, in total or in part, except as otherwise permitted by State rules, the Bureau may terminate the provider from participation in the program.
- (2) In addition to the grounds for sanctions set out in T.C.A. § 71-5-118, activities or practices which justify sanctions against a provider and may include 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 TennCare or its agent(s);
  - (e) Continued provision of poor record keeping or inappropriate or inadequate medical care;
  - (f) Medical assistance of a quality below recognized standards;
  - (g) Suspension from the Medicare or Medicaid program(s) by the authorized U.S. enforcement agency;
  - (h) Partial or total loss (voluntary or otherwise) of a provider's federal Drug Enforcement Agency (DEA) dispensing or prescribing certification;
  - (i) Restriction to 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 or evidence from such charge;
  - (k) Violation of the responsible state licensing board license or certification rules;
  - (l) Conviction of any felony, any offense under state or federal drug laws, or 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 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 controlled 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 or dental service when mentally or physically unable to safely do so;

- (q) Billing TennCare an amount that is greater than the provider's usual and customary charge to the general public for that service;
- (r) 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 TennCare;
- (s) Fragmentation or submitting claims separately on the component parts of a procedure instead of claiming a single procedure code which includes the entire procedure or all component parts, when such approach results in TennCare paying a greater amount for the components than it would for the entire procedure; or,
- (t) 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.

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109.

I certify that this is an accurate and complete copy of rulemaking hearing rules, lawfully promulgated and adopted by the Tennessee Department of Finance and Administration (board/commission/ other authority) on 5/12/11 (mm/dd/yyyy), and is in compliance with the provisions of TCA 4-5-222.

I further certify the following:

Notice of Rulemaking Hearing filed with the Department of State on: 02/14/2011

Rulemaking Hearing(s) Conducted on: (add more dates). 04/12/2011

Date: 5/12/2011

Signature: [Handwritten Signature]

Name of Officer: Darin J. Gordon  
Director, Bureau of TennCare

Title of Officer: Tennessee Department of Finance and Administration



Subscribed and sworn to before me on: 5/12/11

Notary Public Signature: [Handwritten Signature]

My commission expires on: 9/30/2012

All rulemaking hearing 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.

[Handwritten Signature]

Robert E. Cooper, Jr.

Attorney General and Reporter

5-18-11

Date

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Effective on: 8/16/11

[Handwritten Signature]

Tre Hargett  
Secretary of State

## **Public Hearing Comments**

One copy of a document containing responses to comments made at the public hearing must accompany the filing pursuant to T.C.A. §4-5-222. Agencies shall include only their responses to public hearing comments, which can be summarized. No letters of inquiry from parties questioning the rule will be accepted. When no comments are received at the public hearing, the agency need only draft a memorandum stating such and include it with the Rulemaking Hearing Rule filing. Minutes of the meeting will not be accepted. Transcripts are not acceptable.

Copies of responses to comments are included with filing.

**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 Rule Chapter is not anticipated to have an 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)

The Rule Chapter is not anticipated 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 TCA 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 Rule Chapter replaces an emergency rule chapter that provides TennCare with rules for an appeal process for providers.

- (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 Rule Chapter is lawfully adopted by the Bureau of TennCare in accordance with Tennessee Code Annotated §§ 4-5-202, 71-5-105 and 71-5-109.

- (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 or corporations most directly affected by this Rule Chapter are the TennCare providers and the managed care contractors. The governmental entities most directly affected by this Rule Chapter are the Bureau of TennCare and the 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 Rule Chapter was 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 this Rule Chapter 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.

None

GW10111124



STATE OF TENNESSEE  
BUREAU OF TENNCARE  
DEPARTMENT OF FINANCE AND ADMINISTRATION  
310 Great Circle Road  
NASHVILLE, TENNESSEE 37243

May 12, 2011

Mr. Yarnell Beatty  
Director  
Legal and Government Affairs Division  
Tennessee Medical Association  
2301 21<sup>st</sup> Avenue South  
Nashville, Tennessee 37212

RE: TennCare Rule Chapter 1200-13-18

Dear Mr. Beatty:

Thank you for sending us comments on the above-referenced rule.

The purpose of the rule is to outline a provider appeal process that providers may use when the Bureau of TennCare initiates an action that may affect them adversely. Such an action on the Bureau's part would occur primarily when the Bureau has obtained evidence of possible provider fraud or abuse.

Several of your comments address procedures that may be used in an audit, such as extrapolation. I should clarify that the rule was not intended to lay out all the details of various audit processes that may be used by TennCare or its contractors. The rule was intended simply to describe the appeal process that is available to providers when TennCare takes action against them.

With respect to your statement that the statute of limitations provision in the rule is too long, this provision is consistent with the statute of limitations for the Tennessee Medicaid False Claims Act, as codified at T.C.A. § 71-5-184(b).

Again, I appreciate your comments.

Sincerely,

Darin J. Gordon  
Director, Bureau of TennCare



April 12, 2011

George Woods  
Tennessee Department of Finance & Administration  
Bureau of TennCare  
310 Great Circle Road  
Nashville, TN 37243

**RE: Comments to New Rules 1200-13-18 Regarding TennCare Administrative Actions and Provider Appeals**

Dear Mr. Woods:

Please accept these comments on behalf of the nearly 8000 members of the Tennessee Medical Association (TMA) many of whom are participating TennCare providers. These comments address the Notice of Rulemaking regarding TennCare administrative actions and provider appeals published in the February 2011 *Tennessee Administrative Register*. Our understanding is that were promulgated as emergency rules effective on February 18, 2011.

***Extrapolation should not be allowed as evidence in a hearing***

Several provisions in the proposed rules permit the use of extrapolation, specifically in proposed rule 1200-13-18-.02(27). The TMA opposes the use of evidence in any appeal hearing that relies on extrapolation and we urge the Bureau to delete any reference to extrapolation and specifically place in the rule that extrapolation evidence may not be considered.

Extrapolation is not evidence; it is at best speculative. It can have the effect of morphing a few coding misunderstandings into a tool for prosecution without efforts to educate the provider. Extrapolation should not be used until the physician has received notice of the billing problems, the carrier has explained to the physician how to correct the problem and come into compliance, and the carrier has monitored the physician's billing practices for a period of time to determine if the errors are still occurring. The TMA objects to the use of any extrapolation for punitive purposes and failure to exclude it may result in ALJs making contrary rulings on its admissibility into evidence in hearings.

As pernicious a program as it is for health care providers, the Medicare RAC audit program actually has some extrapolation language worth adopting here. The following citations to RAC audit laws are worth considering if the Bureau must allow unfair extrapolation. First, carriers may now only use extrapolation where there is a sustained or high level of payment error or documented educational intervention has failed to correct the payment error. (42 U.S.C. §1395ddd.). There is no judicial or administrative review of determinations of sustained or high levels of payment errors. (*Id.*) Thus, extrapolation can only be used where the physician already has a track record of problems. If such sampling is even authorized, and if the statistical

methodology can be successfully attacked, (by arguing lack of documentation, inadequate sample size, etc.) no statistically valid projection can take place and the amount of the claim should be reduced substantially. Often, specific sampled cases can be eliminated from the stratified array, thus leading to an adjustment in the projected amount. If the matter ends up before an administrative law judge (ALJ) and the decision was based on a statistical sample, the ALJ must base his or her decision on a review of all claims in the sample. (42 C.F.R. §405.1064.). Therefore, extrapolation should not be authorized but if it is and an appeal gets to an ALJ, the ALJ's review/decision should be based only on the claims included in the sample.

The following proposed rules should be modified accordingly:

1200-13-18-.02(27) Statistically Valid Random Sampling. A method for ~~determining~~ predicting error rates in healthcare billings where there is a sustained or high level of payment error or documented educational intervention has failed to correct the payment error using extrapolation. Typically used for large numbers of suspect claims or patients, a random sample of claims from a chosen population is selected using RAT-STATS or a similar program. That sample is then analyzed for errors. If the sample is the result of statistically valid random sampling, the error rate in the sample can be extrapolated to the entire population of claims for purposes of making a charge of fraud against a provider. However, in a hearing on an appeal, the ALJ must base his or her decision on a review of all claims in the sample.

***Notices of Action in the proposed rule are inadequate***

Another area of concern to physicians is the notice of action provision of proposed rule 1200-13-18-.03(4). The rule should add a (d) to read:

(d) A narrative containing a detailed statement of the controversy in question or proposed action, the facts relied upon which support the violation or proposed action, and the citations of statutory or regulatory authority for the action(s) contemplated.

Similar language requiring a narrative explanation of the issues on appeal should also be inserted into proposed rules 1200-13-18-.04(2); 1200-13-18-.05(2); and 1200-13-18-.06(5).

In addition, proposed rule 1200-13-18-.04(2) should be amended to add a provision requiring a copy of the audit relied upon by the State to be sent to the provider as part of its notification of intent to recoup:

(e) A copy of the audit and findings relied upon by the Bureau for the recovery of incorrect payments.

Procedures described in the proposed rule do not allow the physician receiving notice to submit further information that might obviate the need for a hearing. TMA suggests that a provision along the lines of TCA 4-5-320(c), proceedings affecting licenses, should be included to allow the physician to demonstrate compliance. This right is afforded respondents in administrative licensure actions after investigation and before formal charges are proffered. It has the potential to reduce the State's costs of prosecuting some cases.

***The statute of limitations provision is too long***

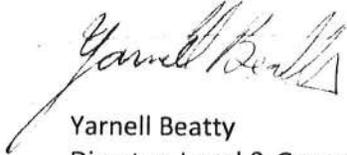
The TMA objects to the length of the statute of limitations rule found in proposed rule 1200-13-18-.03(8). Six or ten years is too far to go back for a provider to adequately and fairly defend himself/herself. Proposed subsections (a) and (b) should be deleted and the following substituted:

(8) Any action for recovery shall not be brought more than three (3) years from the date on which the violation of the Act is committed.

The State and MCOs have plenary access to claims data so the concealment provision in proposed subsection (b) is not necessary.

Thank you for your consideration of our comments.

Sincerely,

A handwritten signature in black ink, appearing to read "Yarnell Beatty". The signature is written in a cursive style with a long, sweeping underline that extends to the left.

Yarnell Beatty  
Director, Legal & Government Affairs Division



**STATE OF TENNESSEE  
BUREAU OF TENNCARE  
DEPARTMENT OF FINANCE AND ADMINISTRATION  
310 Great Circle Road  
NASHVILLE, TENNESSEE 37243**

May 12, 2011

Mr. Craig Becker  
President  
Tennessee Hospital Association  
500 Interstate Boulevard  
Nashville, TN 37210

RE: TennCare Rule Chapter 1200-13-18

Dear Mr. Becker:

We appreciate the comments you sent us with respect to the above-referenced rule.

The purpose of the rule is to outline a provider appeal process that providers may use when the Bureau of TennCare initiates an action that may affect them adversely. Such an action on the Bureau's part would occur primarily when the Bureau has obtained evidence of possible provider fraud or abuse.

A number of your comments address procedures that may be used in an audit. I should clarify that the rule was not intended to lay out all the details of various audit processes that may be used by TennCare or its contractors. The rule was also not intended to affect the independent review process that is available to providers when they have a dispute with an MCO regarding a claim. The rule was intended simply to describe the appeal process that is available to providers when TennCare takes action against them.

Again, thank you for your comments.

Sincerely,

Darin J. Gordon  
Director, Bureau of TennCare



April 11, 2011

Darin Gordon  
Deputy Commissioner  
Bureau of TennCare  
310 Great Circle Road  
Nashville, TN 37243

**Re: Notice of Rulemaking Hearing, Chapter 1200-13-18**

Dear Mr. Gordon:

The Tennessee Hospital Association (THA), on behalf of its over 200 healthcare facilities, including hospitals, home care agencies, nursing homes, and health-related agencies and businesses, and over 2,000 employees of member healthcare institutions, such as administrators, board members, nurses and many other health professionals, appreciates the opportunity to comment on these rules.

Last year the THA submitted an appeals procedure for consideration that echoed the rules CMS established for the Medicare Recovery Audit Contractor (RAC) program. That process allowed for several layers of independent appeal and gave providers a way to appeal informally and inexpensively. We still believe that process was objective, fair to both parties and preferable to these rules.

Before commenting on the substance of these proposed rules, THA will address their form. These proposed rules are difficult to read and decipher. THA believes this is because the rules address many subject matters. The rules address: 1) audits conducted on behalf of CMS and the recovery of funds, 2) recoupments generally, 3)

Provider exclusions, 4) procedures for provider administrative appeals of recoveries, exclusions and sanctions, 5) the false claims act specifically, and 6) procedures for administrative enforcement of the false claims act. THA recommends that the provisions related to the false claims act be placed in a different chapter. Administrative actions under the false claims act are distinct and different from those provided for recoveries, withholds, participation and sanctions generally. Admittedly, it is a type of provider sanction, but the standard and process is so different from the other sanctions, that its inclusion confuses the standard and process for the other matters.

#### False Claims Act, Rules .01 and .03

The rules related to the false claims act are flawed. T.C.A. § 71-5-183(h)(1) provides that the Attorney General may request the Bureau to bring an administrative action to recover funds under the false claims act. T.C.A. § 71-5-183(h)(5) provides that the administrative proceeding is to be brought in the form of a contested case hearing.

Rule .03(3) states that the Bureau may commence a contested case proceeding for recovery under the Act upon a referral from the Attorney General. Rule .03(4) states that the Bureau will provide notice of the assessment and the provider's right to appeal the assessment. The Bureau is not given the authority under the statute to provide a notice of assessment against a provider pursuant to the false claims act and to require the provider to appeal the assessment. Instead, the Bureau is required to commence a contested case hearing against the provider to seek damages and penalties under the false claims act. See T.C.A. §71-5-183(h)(2).

Similarly, Rule .02(7) provides for the Bureau to assess a monetary penalty under the false claims act. The Rule cites T.C.A. § 71-5-183(h)(3). This statute does

not authorize the Bureau to assess a penalty. It provides for the Bureau to seek damages and penalties in a contested case hearing instituted by the Bureau.

Rule .03(5) provides that the provider appeal is to be conducted according to Rule.01. Rule .01(1)(a) provides that a provider may appeal an administrative action referred by the Attorney General pursuant to the False Claims Act. This is in error. Instead of the provider appealing, the Bureau is required to commence the action. The burden is upon the Bureau to establish in a contested case hearing all of the elements necessary to establish damages and penalties under the false claims act. As previously stated, we recommend placing the proceedings for recovery under the false claims act in a separate chapter of the rules.

The definition of "Final Order", Rule .02(18) is confusing. It states that the procedures for reconsideration or judicial review shall be included with the issuance of a final order. We believe that the order should not become final for purposes of enforcement until after the opportunity for judicial review has been exhausted. Rule .03(11) provides for the final order to be entered in the court and considered a judgment by consent of the parties. The final order cannot be a judgment by consent of the parties, if one of the parties has the order on appeal to court.

#### Recoupment or Withhold, Rules .01 and .04

Providers presently have three (3) procedures available to them to challenge recoupments by MCCs. One, providers may appeal to independent reviewers. T.C.A. § 56-32-126(b)(2)(A) provides an opportunity for an independent reviewer when a "previously allowed claim is subsequently partially or totally denied by an HMO by an appropriate written or electronic notice . . . ." Two, providers may submit a complaint to

TDCI . Three, providers may follow the remedy provisions set forth in their contracts with the MCCs.

Proposed Rule .01(1)(b) provides for a contested case hearing of “an action proposed or taken by the Bureau of TennCare or its contractor to recover, recoup or withhold payment from a provider . . . .” Only the MCCs are in a position to recoup funds that have been paid to providers. The proposed rule gives providers a fourth remedy when an MCC is recouping funds. The proposed rule does not and cannot affect the other remedies presently available to providers. THA does not object to an additional remedy being made available to providers. THA would object if TennCare somehow believes that the remedy set forth in this rule becomes the exclusive remedy.

Rule .02(5) defines the audit. The definition of audit needs to be expanded to make it clear that not only are there cost report related audits that will be done in accordance with AICPA guidelines, but there may also be claims reviews that are either accomplished by complex review or automated data review. Regardless, claims audits should be conducted in accordance with Office of Inspector General (OIG) guidance and the contractor or auditor should be required to at least provide the Bureau and the provider the objective of the audit, the scope of the audit, and the methodology of conducting the audit, regardless of its type.

We have included, as an attachment, a de-identified addendum from an OIG Corporate Integrity Agreement (CIA). We believe these definitions and procedures should be incorporated into the rule. It is important that underpayments, as well as overpayments, be included in all audits.

THA opposes the use of extrapolation and we ask that it be deleted from the Rules. Extrapolation can lead to incorrect conclusions to be drawn about the impact of an error in a population; providers are not permitted to use this when dealing with provider payment errors unless both parties agree. However, if the Bureau chooses to use extrapolation, it should not be for the entire population of claims but for some defined population, i.e. looking at errors related to a particular type of claim or a category of claim. It should follow the same process as the OIG does for CIAs. It is important that there first be a discovery sample whose results are used to determine if there is a problem (i.e. if there is an Error Rate of 5% or greater). If there is, then a determination should be made as to whether it is appropriate to do extrapolation; then, if yes, create a full sample in accordance with, at a minimum, the same confidence level and precision used by the OIG.

Rule .04(2) provides for notification to the provider of the audit findings, how further information is to be submitted, and the appeal process. THA is concerned that after audit findings, it will be difficult for a provider to have meaningful discourse on the findings. THA would request that the Rules reflect that the auditors are to conduct an exit conference with the provider and that draft or preliminary audit findings are to be given to the provider with an opportunity for the provider to submit additional information. This will allow the provider to have input earlier in the process and also allow the audit to address any additional information submitted by the provider. THA believes it is in the interest of the both the Bureau and the providers to avoid the formal appeal process wherever possible.

Finally, Rule .04(4) states that audits are not subject to appeal. THA requests that this Rule be clarified to state that audit findings may be disputed in appeals where the Bureau is relying upon an audit to justify its action to recoup or withhold.

#### Provider Participation, Rule .06

Rule .06(5) provides for a notice of action with a right to appeal. The Rule does not provide an opportunity for the provider to submit further information. Many of the bases for termination of participation are subjective – such as (3)(i) failure to disclose required information; (j) Failure to supply requested information on subcontractors and suppliers; (k) Failure to supply payment information; etc. – and THA believes that there should be an opportunity for informal resolution before a formal appeal.

#### Provider Sanctions, Rule .07

This Rule addresses sanctions imposed against providers pursuant to T.C.A. § 71-5-118. The Rule does not set forth any opportunity for a hearing and it is unclear if Rule .01 is intended to provide for a hearing before the implementation of sanctions under Rule .07. T.C.A. § 71-5-118 clearly requires that the Bureau give providers an opportunity for a contested case hearing. It states:

Any action against such provider shall be treated as a contested case in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5. If a hearing is requested by the provider, it shall be held prior to the imposition of any of the sanctions of this subsection (a), except that upon a finding by the commissioner that the public health, safety, or welfare imperatively requires emergency action, these sanctions may be imposed pending an opportunity for the provider to request a prompt hearing. Furthermore, the commissioner has the right to set off any money incorrectly paid against any claim for money submitted by the provider pending an opportunity for a hearing.

T. C. A. § 71-5-118

The only opportunity for the Bureau to sanction before the contested case hearing is where the Commissioner finds that the "public health, safety, or welfare imperatively requires emergency action . . ."

THA request that the opportunity for a contested case hearing before the imposition of sanctions be added to the Rule. THA further requests that a process for informal discourse and the submittal of further information before an appeal be added to the Rule.

Finally, Rule .07(2)(a) list noncompliance with contractual terms to be a basis for sanctions. This is vague. It does not state what contract is being addressed. THA requests that this basis for sanction be limited to noncompliance with contractual terms required by the CRA.

THA appreciates this opportunity to comment on the proposed Rules. Please feel free to contact us if you need any clarification of these comments.

Sincerely,

A handwritten signature in black ink, appearing to read "Craig Becker". The signature is fluid and cursive, with the first name "Craig" and last name "Becker" clearly distinguishable.

Craig Becker  
President

Enclosure

## APPENDIX B CLAIMS REVIEW

### A. Claims Review

1. *Definitions.* For the purposes of the Claims Review, the following definitions shall be used:
  - a. Overpayment: The amount of money the provider has received in excess of the amount due and payable under any Federal health care program requirements.
  - b. Item: Any discrete unit that can be sampled (e.g., code, line item, beneficiary, patient encounter, etc.).
  - c. Paid Claim: A code or line item submitted by the provider for items or services rendered at providers department, and for which the provider has received reimbursement from the Medicare program.
  - d. Population: Except as otherwise defined in Section III.D.2 of the CIA, for the first Reporting Period, the Population shall be defined as all Items for which a code or line item has been submitted by or on behalf of the provider and for which the provider has received reimbursement from Medicare (*i.e.*, Paid Claim) during the 12-month period covered by the first Claims Review.

For the remaining Reporting Periods, the Population shall be defined as all Items for which the provider has received reimbursement from Medicare (*i.e.*, Paid claim) during the 12-month period covered by the Claims Review.

To be included in the Population, an Item must have resulted in at least one Paid claim. Any Item selected for inclusion in discovery Sample 1 shall not also be included in Discovery Sample 2, but shall be replaced by another Item for the appropriate Population.

- e. Error Rate: The Error Rate shall be the percentage of net Overpayments identified in the sample. The net Overpayments shall be calculated by subtracting all underpayments identified in the sample from all gross Overpayments identified in the sample. (Note: Any potential cost settlements or other supplemental payments should not be included in the net Overpayment calculation. Rather, only underpayments identified as part of a discovery Sample shall be included as part of the net Overpayment calculation).

The Error Rate is calculated by dividing the net Overpayment identified in the sample by the total dollar amount associated with the Items in the sample.

## 2. *Other Requirements.*

- a. Paid Claims without Supporting Documentations. For the purpose of appraising Items included in the Claims Review, any Paid Claim for which the provider cannot produce documentation sufficient to support the Paid Claim shall be considered an error and the total reimbursement received by the provider for such Paid Claim shall be deemed an Overpayment. Replacement sampling for Paid Claims with missing documentation is not permitted.
- b. Replacement Sampling. Considering the Population shall consist only of Paid Claims and that Items with missing documentation cannot be replaced, there is no need to utilize alternate or replacement sampling units.
- c. Use of First Samples Drawn. For the purposes of all samples (Discovery Sample(s) and full Sample(s) discussed in this Appendix, the Paid Claims associated with the Items selected in each first sample (or first sample for each strata, if applicable) shall be used (i.e., it is not permissible to generate more than one list of random samples and then select one for use with the discovery Samples or Full Sample), excepting only replacement samples for discovery Sample 2, as described above in Paragraph A.1.d.

B. Claims Review Report. The following information shall be included in the Claims Review Report for each discovery Sample and Full Sample (if applicable).

### 1. *Claims Review Methodology.*

- a. Sampling Unit. A description of the Item as that term is utilized for the Claims Review.
- b. Claims Review Population. A description of the Population subject to the Claims Review.
- c. Claims Review Objective. A clear statement of the objective intended to be achieved by the Claims Review.
- d. Sampling Frame. A description of the sampling frame, which is the totality of Items from which the Discovery Sample and, if any, Full Sample has been selected and an explanation of the methodology used to identify the sampling frame. In most circumstances, the sampling frame will be identical to the Population.
- e. Source of Data. A description of the specific documentation relied upon by the IRO when performing the Claims Review (e.g., medical records, physician orders,

certificates of medical necessity, requisition forms, local medical review policies (including title and policy number), CMS program memoranda (including title and issuance number), Medicare carrier or intermediary manual or bulletins (including issue and date), other policies, regulations, or directives).

- f. Review Protocol. A narrative description of how the Claims Review was conducted and what was evaluated.

2. *Statistical Sampling Documentation.*

- a. The number of Items appraised in the Discovery Sample and, if applicable, in the Full Sample.
- b. A copy of the printout of the random numbers generated by the "Random Numbers" function of the statistical sampling software used by the IRO.
- c. A copy of the statistical software printout(s) estimating how many Items are to be included in the Full Sample, if applicable.
- d. A description or identification of the statistical sampling software package used to select the sample and determine the full Sample size, if applicable.

3. *Claims Review Findings:*

a. Narrative Results.

- i. A description of the provider's billing and coding system(s), including the identification, by position description, of the personnel involved in coding and billing.
- ii. A narrative explanation of the IRO's findings and supporting rationale (including reasons for errors, patterns noted, etc.) regarding the Claims Review, including the results of the discovery Sample, and the results of the Full Sample (if any).

b. Quantitative Results.

- i. Total number and percentage of instances in which the IRO determined that the Paid Claims submitted by the provider (Claim Submitted) differed from what should have been the correct claim (Correct Claim), regardless of the effect on the payment.
- ii. Total number and percentage of instances in which the Claim Submitted differed from the Correct Claim and in which such difference resulted in an Overpayment to the District.

- iii. Total dollar amount of all Overpayments in the sample.
  - iv. Total dollar amount of paid Items included in the sample and the net Overpayment associated with the sample.
  - v. Error Rate in the sample
  - vi. A spreadsheet of the Claims Review results that includes the following information for each Paid Claim appraised: Federal health care program billed, beneficiary health insurance claim number, date of service, procedure code submitted, procedure code reimbursed, allowed amount reimbursed by payor, correct procedure code (as determined by the IRO), correct allowed amount (as determined by the IRO), dollar difference between allowed amount reimbursed by payor and the correct allowed amount. (See Attachment 1 to this Appendix).
4. **Systems Review.** Observations, findings, and recommendations on possible improvements to the system(s) and process(es) that generated the Overpayment(s).
5. **Credentials.** The names and credentials of the individuals who: (1) designed the statistical sampling procedures and review methodology utilized for the Claims Review; and (2) performed the Claims Review.

*(The remainder of this page is intentionally left blank).*

**Department of State**  
**Division of Publications**  
 312 Rosa L. Parks Avenue, 8th Floor Snodgrass/TN Tower  
 Nashville, TN 37243  
 Phone: 615-741-2650  
 Fax: 615-741-5133  
 Email: [register.information@tn.gov](mailto:register.information@tn.gov)

**For Department of State Use Only**

Sequence Number: \_\_\_\_\_  
 Rule ID(s): \_\_\_\_\_  
 File Date: \_\_\_\_\_  
 Effective Date: \_\_\_\_\_

**Rulemaking Hearing Rule(s) Filing Form**

*Rulemaking Hearing Rules are rules filed after and as a result of a rulemaking hearing. TCA Section 4-5-205*

<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>	Bureau of TennCare 310 Great Circle Road Nashville, Tennessee
<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
1200-13-18	TennCare Administrative Actions and Provider Appeals
Rule Number	Rule Title
1200-13-18-.01	Scope and Authority
1200-13-18-.02	Definitions
1200-13-18-.03	Administrative Action for Recovery Under the Tennessee Medicaid False Claims Act
1200-13-18-.04	Recoupment or Withhold
1200-13-18-.05	Suspension of Payment
1200-13-18-.06	Electronic Health Record Incentive Program (EHR-IP)
1200-13-18-.07	Termination or Exclusion of a Provider from Program Participation
1200-13-18-.08	Provider Sanctions

(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.tn.us/sos/rules/1360/1360.htm>)

Emergency Rule Chapter 1200-13-18 TennCare Administrative Actions and Provider Appeals is deleted in its entirety and replaced with Rulemaking Hearing Rule Chapter 1200-13-18 which shall read as follows:

Chapter 1200-13-18  
TennCare Administrative Actions and Provider Appeals

1200-13-18-.01 Scope and Authority.

- (1) An approved provider of TennCare services may appeal the following administrative actions:
  - (a) An administrative action for recovery against a person other than an enrollee, recipient or applicant brought by the Bureau of TennCare upon written request of the Attorney General pursuant to the Tennessee Medicaid False Claims Act;
  - (b) An action proposed or taken by the Bureau of TennCare or its audit contractor to recover, recoup or withhold payment from a provider, as a result of ~~including actions resulting from~~ any audit performed by or on behalf of the Centers for Medicare and Medicaid Services or the Bureau pursuant to state or federal law;
  - (c) A Bureau of TennCare determination to suspend payments to a provider due to a credible allegation of fraud for which an investigation is pending;
  - ~~(d)(e)~~ A denial of eligibility for or a determination of the amount of an incentive payment pursuant to the federal Medicaid Electronic Health Record Incentive Program (EHR-IP); or,
  - ~~(e)(d)~~ Termination of an approved provider's Tennessee Medicaid Provider Number by the Bureau, except when federal law mandates exclusion of the provider.
- (2) A provider of services may not appeal the following administrative actions:
  - (a) An MCC's refusal to contract with the provider;
  - (b) A decision by the Bureau to decline coverage of prescriptions not written by a provider with prescribing authority; or,
  - (c) Termination or exclusion from the Program as required by federal law.
- (3) In order to exercise the right to a hearing, a provider must submit his appeal and request for a hearing in writing to the Bureau. The notice of the Bureau action shall contain specific instructions concerning the right to appeal and the address for filing an appeal.
- (4) Any request for an appeal must be received at the address contained in the notice of action no later than 35 days following the date of the notice.
- (5) Provider appeals shall be conducted as contested case hearings by the Tennessee Department of State, Administrative Procedures Division, pursuant to the Tennessee Uniform Administrative Procedures Act (APA).
- (6) The Uniform Rules of Procedure for Hearing Contested Cases Before State Administrative Agencies, Chapter 1360-04-01, promulgated under the APA, are adopted by the Bureau and incorporated by reference herein. The Uniform Rules shall govern the conduct of a provider appeal except where a specific contrary provision is adopted by the Bureau in this Chapter.

- (7) For purposes of issuing an initial order, a contested case hearing shall be conducted by an administrative judge hearing the case alone.

Statutory Authority: T.C.A. §§ 4-5-208 ~~4-5-202~~, 71-5-105 and 71-5-109.

1200-13-18-.02 Definitions.

- (1) Administrative Judge. An employee or official of the Office of the Secretary of State who is licensed to practice law and authorized by law to conduct contested case proceedings.
- (2) Administrative Procedures Act (APA). The Tennessee Uniform Administrative Procedures Act, as amended, codified at T.C.A. §§ 4-5-301, et seq.
- ~~(3) Affordable Care Act (ACA). The amendments made to Medicaid law by the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act of 2010, dispersed throughout Title XIX of the Social Security Act, codified in Title 42 of the United States Code.~~
- ~~(3)~~(4) Approved Provider. A provider of health care services who has registered with and been approved by the Bureau and has been issued a Tennessee Medicaid Provider Number.
- ~~(4)~~(5) Audit. The systematic process of objectively obtaining and evaluating evidence regarding assertions about economic actions and events to ascertain the degree of correspondence between those assertions and established criteria and communicating the results to interested parties. Audits are conducted in accordance with AICPA (American Institute of Certified Public Accountants) auditing or attestation engagement standards. For purposes of this chapter, audits are conducted of health care provider records, financial information, and statistical data according to principles of cost reimbursement to determine the reasonableness and allowance of costs reimbursable under the Program.
- ~~(5)~~(6) Bureau of TennCare (Bureau). The division of the Tennessee Department of Finance and Administration, the single state Medicaid agency, that administers the TennCare Program. For purposes of this Chapter, the Bureau shall represent the State of Tennessee.
- ~~(6)~~(7) Civil Penalty. A monetary penalty assessed by the Bureau against a provider in an amount of not less than \$1,000 nor more than \$5,000 for each violation of the Tennessee Medicaid False Claims Act. T.C.A. § 71-5-183(h)(3).
- ~~(7)~~(8) Claim. Any request or demand for money, property, or services made to any employee, officer, or agent of the state, or to any contractor, grantee, or other recipient, whether under contract or not, if any portion of the money, property, or services requested or demanded was issued from, or was provided by, the State.
- ~~(8)~~(9) Commissioner. The chief administrative officer of the Tennessee Department where the Bureau is administratively located.
- ~~(9)~~(10) Commissioner's Designee. A person authorized by the Commissioner to review appeals of initial orders and to enter final orders pursuant to T.C.A. § 4-5-315, or to review petitions for stay or reconsideration of final orders.
- ~~(10)~~(11) Contested Case. An administrative proceeding in which the legal rights, duties or privileges of a party are required by any statute or constitutional provision to be determined by an agency after an opportunity for a hearing.
- ~~(11)~~ Credible Allegation of Fraud. Information which has been verified by the Bureau through judicious case-by-case review and found to contain indicia of reliability. This information may be from any source, including but not limited to hotline complaints, claims data mining, patterns identified through provider audits, civil false claims cases, or law enforcement investigations.
- (12) Department. The Tennessee Department of Finance and Administration.

- (13) Electronic Health Record Incentive Program (EHR-IP). The provisions of the American Recovery and Reinvestment Act of 2009 (ARRA) that provide for incentive payments to eligible professionals (EPs), and eligible hospitals (EHs), including acute care, children's and critical access hospitals (CAHs), participating in Medicare and Medicaid programs that adopt, implement or update a certified system and successfully demonstrate meaningful use of certified electronic health record (EHR) technology as required by federal regulations.
- (14) Enrollee. An individual eligible for and enrolled in the TennCare program.
- (15) Error Rate. The percentage of claims in a sample population that was not billed properly and is actionable. Error rates can be applied to entire populations if the sample was the result of statically valid random sampling. The use of the term "error" does not indicate the intent of the person or entity submitting the claim.
- (16) Findings of Fact. The factual findings issued by the Administrative Judge or Commissioner's Designee following an administrative hearing. The factual findings are enumerated in the initial and/or final order. An order must include a concise and explicit statement of the underlying facts of record to support the findings.
- (17) Final Agency Decision. A Final Order.
- (18) Final Order. An initial order becomes a final order without further notice if not timely appealed, or if the initial order is appealed pursuant to T.C.A. § 4-5-315, the Commissioner or Commissioner's Designee may render a final order. A statement of the procedures and time limits for seeking reconsideration or judicial review shall be included with the issuance of a final order.
- (19) Good Cause Not to Suspend Payment. The Bureau may determine not to suspend payment or not to continue suspension of payment to a provider being investigated due to a credible allegation of fraud if:
- (a) Law enforcement officials have specifically requested that a payment suspension not be imposed because such a payment suspension may compromise or jeopardize an investigation;
  - (b) Other available remedies implemented by the State more effectively or quickly protect Program funds;
  - (c) The Bureau determines, based upon the submission of written evidence by the provider that is the subject of the payment suspension, that the suspension should be removed;
  - (d) Enrollee access to items or services would be jeopardized by a payment suspension because the provider is the sole community physician, the sole source of essential specialized services in a community, or serves a large number of enrollees within a HRSA-designated medically underserved area;
  - (e) Law enforcement declines to certify that a matter continues to be under investigation; or
  - (f) The Bureau determines that payment suspension is not in the best interests of the Program.
- (20) Good Cause to Suspend Payment Only in Part. The Bureau may determine to suspend payments in part, or to convert a payment suspension previously imposed in whole to one only in part, to a provider being investigated due to a credible allegation of fraud if:
- (a) Enrollee access to items or services would be jeopardized by a payment suspension in whole or part because the provider is the sole community physician, the sole source of essential specialized services in a community, or serves a large number of recipients within a HRSA-designated medically underserved area;
  - (b) The Bureau determines, based upon the submission of written evidence by the provider that is the subject of a whole payment suspension, that such suspension should be imposed only in part;

(c) The credible allegation focuses solely and definitively on only a specific type of claim or arises from only a specific business unit of a provider, and the Bureau determines and documents in writing that a payment suspension in part would effectively ensure that potentially fraudulent claims were not continuing to be paid;

(d) Law enforcement declines to certify that a matter continues to be under investigation; or

(e) The Bureau determines that payment suspension only in part is in the best interests of the Program.

~~(21)(19)~~ Hearing. A contested case proceeding.

(22) Indicia of Reliability. Factors which the Bureau will examine in determining whether a credible allegation of fraud exists, requiring the suspension of payments to a provider, including but not limited to:

(a) Firsthand knowledge;

(b) Corroborating witness;

(c) Witness conflict (disgruntled employee);

(d) Prior bad acts;

(e) Pattern of bad acts;

(f) Documentary proof;

(g) Admission by provider;

(h) Expert opinion; or

(i) Indictment by a court of competent jurisdiction.

~~(23)(20)~~ Initial Order. The decision issued by the administrative judge following a hearing. The initial order shall contain the decision, findings of fact, conclusions of law, the policy reasons for the decision and the remedy prescribed. It shall include a statement of the procedure for filing an appeal of the initial order as well as a statement of any circumstances under which the initial order may, without further notice, become a final order. A statement of the procedures and time limits for seeking reconsideration or other administrative relief and the time limits for seeking judicial review shall be included.

~~(24)(24)~~ Notice of Action. The document or letter sent by the Bureau to a provider detailing the action the Bureau intends to take against the provider. The notice shall include a statement of the reasons and authority for the action as well as a statement of the provider's right to appeal the action, if applicable.

~~(25)(22)~~ Notice of Hearing. The pleading filed with the Administrative Procedures Division by the Bureau upon receipt of an appeal. It shall contain a statement of the time, place, nature of the hearing, and the right to be represented by counsel; a statement of the legal authority and jurisdiction under which the hearing is to be held, referring to the particular statutes and rules involved; and, a short and plain statement of the matters asserted, in compliance with the APA.

~~(26)(23)~~ Program. See TennCare.

~~(27)(24)~~ Provider with Prescribing Authority. A health care professional authorized by law or regulation to order prescription medications for her patients and who:

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

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

- (c) In the case of a TennCare beneficiary who is also enrolled in Medicare, is authorized to treat Medicare patients.
- ~~(28)~~(25) RAT-STATS. A widely accepted statistical software tool designed to assist the user in conducting statistically valid random sampling and evaluating audit results.
- ~~(29)~~(26) Standard of Proof. A preponderance of the evidence.
- ~~(30)~~(27) Statistically Valid Random Sampling. A method for determining error rates in healthcare billings using extrapolation. Typically used for large numbers of suspect claims or patients, a random sample of claims from a chosen population is selected using RAT-STATS or a similar program. That sample is then analyzed for errors. If the sample is the result of statistically valid random sampling, the error rate in the sample can be extrapolated to the entire population of claims.
- ~~(31)~~(28) TennCare. The program administered by the Single State Agency as designated by the State and CMS pursuant to Title XIX of the Social Security Act and the Section 1115 Research and Demonstration Waiver granted to the State of Tennessee.
- ~~(32)~~(29) Tennessee Medicaid Provider Number. The identifying number issued by the Bureau to an approved provider for the purpose of receiving payment in exchange for rendering services to TennCare enrollees.
- ~~(33)~~(30) Tennessee Medicaid False Claims Act (Act). T.C.A. §§ 71-5-181, *et seq.*
- (34) Termination. The deactivation of a provider's Tennessee Medicaid Provider Number and the cessation of the provider's TennCare billing privileges.

Statutory Authority: T.C.A. §§ ~~4-5-208~~ 4-5-202, 71-5-105 and 71-5-109.

1200-13-18-.03 Administrative Action for Recovery Under the Tennessee Medicaid False Claims Act.

- (1) The Attorney General, following an investigation of an approved provider's claims, may determine that certain provider actions are appropriate for administrative action by the Bureau, pursuant to the Act. The Attorney General may refer any such matters to the Bureau Director, or his designee, along with the investigative file and a recommendation for action.
- (2) The Attorney General shall not refer matters originally brought under T.C.A. § 71-5-183(b) or if any person has the right to participate in or recover from the proceeding pursuant to T.C.A. § 71-5-183(c)(5).
- (3) Upon receipt of a written request from the Attorney General, the Bureau may commence a contested case proceeding on behalf of the State for recovery under the Act against any person other than an enrollee, recipient or applicant.
- (4) The Bureau may initiate the recovery process by notice of action to the provider setting out:
  - (a) The assessment of damages, civil penalties and related costs;
  - (b) The name and contact information of an individual within the Bureau with knowledge of the claim(s) and the assessment who is authorized to discuss the matter with the provider; and
  - (c) A statement of the right of the provider to appeal the assessment and the manner in which an appeal must be filed.
- (5) Any appeal of a notice of action shall be conducted according to rule .01 of this chapter.
- (6) The Bureau may recover actual damages in an amount no greater than ten thousand dollars (\$10,000). The amount of actual damages may be based upon a statistically valid random sample utilizing a software tool such as RAT-STATS.
- (7) In addition to and not limited by the amount of actual damages, the Bureau may recover:

- (a) Civil penalties of not less than one thousand dollars (\$1,000) nor more than five thousand dollars (\$5,000) for each claim found to be in violation of the Act;
  - (b) Costs of the administrative action; and
  - (c) Treble the amount of actual damages.
- (8) Any action for recovery shall not be brought:
- (a) More than six (6) years following the date on which the violation of the Act is committed; or
  - (b) More than three (3) years after the date when facts material to the right of action are known or reasonably should have been known by the state official charged with responsibility to act in the circumstances, but in no event not more than ten (10) years after the date the violation was committed, whichever occurs last.
- (9) A subpoena issued by an administrative judge pursuant to the APA requiring the attendance of a witness at a hearing may be served by certified mail at any place in the United States.
- (10) For purposes of rendering a final order pursuant to the APA, the Bureau is designated as the agency to review initial orders and issue final agency decisions. Orders issued by the Bureau shall have the effect of a final order pursuant to the APA.
- (11) Judgment. A final order issued by the Bureau under this rule may be enforced as a final judgment, as follows:
- (a) A notarized copy of the final order must be filed in the office of the Clerk of the Chancery Court of Davidson County;
  - (b) Upon filing with the Clerk, a final order shall be considered as a judgment by consent of the parties on the same terms and conditions as those recited in the order;
  - (c) The judgment shall be promptly entered by the Court;
  - (d) The judgment shall become final on the date of entry; and
  - (e) A final judgment shall have the same effect, is subject to the same procedures and may be enforced or satisfied in the same manner as any other judgment of a court of record of the State of Tennessee.

Statutory Authority: T.C.A. §§ ~~4-5-208~~ 4-5-202, 71-5-105 and 71-5-109.

1200-13-18-.04 Recoupment or Withhold.

- (1) The Bureau is required by state and federal law to protect the integrity of the Medicaid program. This is accomplished in part by causing audits of provider claims to be conducted. Audit findings are reported to the Bureau for the purpose of recovering incorrect payments, by recoupment or withhold.
- (2) The Bureau shall notify a provider of its intent to recoup or withhold based upon audit findings by issuing a notice of action. Each notice of action sent to a provider shall contain the proposed recovery action and the following information:
  - (a) The name and contact information of an individual knowledgeable about the audit findings and who is authorized to discuss the proposed recovery action with the provider;
  - (b) The manner by which the provider may submit additional information to support his disagreement with the proposed recovery action;

- (c) A statement that the provider has the right to appeal the proposed recovery action and the manner in which an appeal must be filed.
- (3) Any appeal of a notice of action shall be conducted according to rule .01 of this chapter.
- (4) The audit and the audit findings are not subject to appeal. (See NHC v. Snodgrass, 555 S.W.2d 403 (Tenn. 1977)).

Statutory Authority: T.C.A. §§ ~~4-5-208~~ 4-5-202, 71-5-105 and 71-5-109.

1200-13-18-.05 Suspension of Payment.

- (1) Pursuant to 42 C.F.R. § 447.90, the Bureau is prohibited by federal law from receiving federal financial participation (FFP) for payment to a provider of medical items or services with respect to which there is a pending investigation of a credible allegation of fraud, absent good cause not to suspend payment or good cause to suspend payment only in part.
- (2) The Bureau must provide written notice to the provider of a suspension of payments:
  - (a) Five (5) days after suspending payments unless a law enforcement agency has submitted a written request to delay the notice; or
  - (b) Thirty (30) days after suspending payments when a delay was properly requested by law enforcement, except the delay may be renewed twice in writing not to exceed ninety (90) days.
- (3) Written notice of suspension of payment must contain:
  - (a) A statement that payments are suspended according to this rule and federal regulation;
  - (b) The general allegations as to the nature of the suspension action, but need not disclose any specific information concerning an ongoing investigation;
  - (c) A statement that the suspension is temporary and the circumstances under which it will be terminated;
  - (d) If applicable, state the type(s) of TennCare/Medicaid claims to which suspension is effective;
  - (e) A statement that the provider has the right to submit written evidence for consideration by the Bureau; and
  - (f) A statement that the provider has the right to appeal the suspension and the manner in which an appeal must be filed.
- (4) Any appeal of a notice of suspension of payment shall be conducted according to rule .01 of this chapter.
- (5) Any suspension of payment shall be temporary and shall not continue after:
  - (a) The Bureau or prosecuting authority determines there is insufficient evidence of fraud by the provider; or
  - (b) Legal proceedings related to the provider's alleged fraud are completed.
- (6) The Bureau must document in writing the termination of a suspension of payment. Such document must include any applicable appeal rights available to the provider.

Statutory Authority: T.C.A. §§ ~~4-5-208~~ 4-5-202, 71-5-105 and 71-5-109.

1200-13-18-.065 Electronic Health Record Incentive Program (EHR-IP).

- (1) An approved provider of TennCare provider services, upon receipt of a notice of action, may appeal the following issues related to the EHR-IP:
  - (a) Denial of an incentive payment;
  - (b) Incentive payment amount;
  - (c) Determination of eligibility for an incentive payment, including but not limited to measurement of patient volume;
  - (d) Determination of efforts to adopt, implement or upgrade to certified EHR technology during the first year of the EHR-IP or meaningful use of certified EHR technology in subsequent years;
  - ~~(d) Determination of meaningful use of certified EHR technology, including efforts to adopt, implement or upgrade to certified EHR technology;~~
  - (e) Whether the provider is hospital-based;
  - (f) Whether the provider is practicing predominantly in an FQHC or RHC;
  - (g) Whether a hospital qualifies as an acute care or children's hospital; or,
  - (h) Whether the provider is already participating in the Medicare incentive program or in the Medicaid incentive program of another state and therefore is ineligible for duplicate TennCare incentive program payments.
- (2) Each notice of action sent to a provider of a determination of any matter listed in paragraph (1) shall contain the following:
  - (a) The contact information to reach an individual knowledgeable about the EHR-IP who is authorized to discuss the determination with which the provider disagrees;
  - (b) The manner by which the provider may submit additional information to support his disagreement with the determination; and
  - (c) A statement that the provider has the right to appeal the determination with which he disagrees and the manner in which an appeal must be filed.
- (3) Any appeal of a notice of action shall be conducted according to rule .01 of this chapter.

Statutory Authority: T.C.A. §§ ~~4-5-208~~ 4-5-202, 71-5-105 and 71-5-109.

1200-13-18-.076 Termination or Exclusion of a Provider from Program Participation.

- (1) A provider may be terminated or excluded from participation in the TennCare program.
- (2) Federal Mandatory Exclusion. The Bureau is required by federal law to exclude a provider from participation in the TennCare program upon notice from HHS or CMS under the following circumstances:
  - (a) Conviction of program-related crimes;
  - (b) Conviction relating to patient abuse;
  - (c) Felony conviction relating to health care fraud; or
  - (d) Felony conviction relating to controlled substance.

- (3) Federal Permissive Exclusion. Pursuant to federal law, the Bureau may exclude a provider from participation in the TennCare program under the following circumstances:
- (a) Conviction related to fraud;
  - (b) Conviction related to obstruction of an investigation or audit;
  - (c) Misdemeanor conviction related to controlled substance;
  - (d) License revocation or suspension;
  - (e) Exclusion or suspension under federal or state health care program;
  - (f) Claims for excessive charges or unnecessary services and failure of certain organizations to furnish medically necessary services;
  - (g) Fraud, kickbacks, and other prohibited activities;
  - (h) Entities controlled by a sanctioned individual;
  - (i) Failure to disclose required information;
  - (j) Failure to supply requested information on subcontractors and suppliers;
  - (k) Failure to supply payment information;
  - (l) Failure to grant immediate access;
  - (m) Failure to take corrective action;
  - (n) Default on health education loan or scholarship obligations;
  - (o) Individuals controlling a sanctioned entity; or
  - (p) Making false statements or misrepresentation of material facts.
- (4) When a provider exclusion is mandatory, the notice of action shall state that the provider has no right to appeal the termination from program participation.
- (5) When a provider exclusion is permissive, the notice of action shall include a statement that the provider has the right to appeal the termination from program participation and the manner in which an appeal must be filed.

Statutory Authority: T.C.A. §§ ~~4-5-208~~ 4-5-202, 71-5-105 and 71-5-109.

1200-13-18-.08 7 Provider Sanctions.

- (1) Pursuant to the authority granted by T.C.A. § 71-5-118 to the Commissioner to impose sanctions against providers, the Commissioner, through the Bureau, may take the following actions against a provider upon a finding that such actions will further the purpose of the Tennessee Medical Assistance Act:
- (a) Subject providers to stringent review and audit procedures which may include clinical evaluation of claim services and a prepayment requirement for documentation and for justification of each claim;
  - (b) Refuse to issue or terminate a Tennessee Medicaid Provider Number 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;

- (c) Refuse to issue or terminate a Tennessee Medicaid Provider Number if a determination is made 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;
  - (d) Refuse to issue or terminate a Tennessee Medicaid Provider Number 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;
  - (e) Refuse to issue or terminate a Tennessee Medicaid Provider Number 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;:-
  - (f) Suspend or withhold payments to a provider in cases of fraud, willful misrepresentation, or flagrant noncompliance; or,
  - (g) 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 the Bureau and repayment by the provider to the recipient and/or his family is not made within 30 days of receiving notification from the Bureau to make repayment. If a provider knowingly bills a recipient and/or family for a TennCare covered service, in total or in part, except as otherwise permitted by State rules, the Bureau may terminate the provider from participation in the program.
- (2) In addition to the grounds for sanctions set out in T.C.A. § 71-5-118, activities or practices which justify sanctions against a provider and may include 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 TennCare or its agent(s);
  - (e) Continued provision of poor record keeping or inappropriate or inadequate medical care;
  - (f) Medical assistance of a quality below recognized standards;
  - (g) Suspension from the Medicare or Medicaid program(s) by the authorized U.S. enforcement agency;
  - (h) Partial or total loss (voluntary or otherwise) of a provider's federal Drug Enforcement Agency (DEA) dispensing or prescribing certification;
  - (i) Restriction to 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 or evidence from such charge;
  - (k) Violation of the responsible state licensing board license or certification rules;
  - (l) Conviction of any felony, any offense under state or federal drug laws, or 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 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 controlled 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 or dental service when mentally or physically unable to safely do so;
- (q) Billing TennCare an amount that is greater than the provider's usual and customary charge to the general public for that service;
- (r) 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 TennCare;
- (s) Fragmentation or submitting claims separately on the component parts of a procedure instead of claiming a single procedure code which includes the entire procedure or all component parts, when such approach results in TennCare paying a greater amount for the components than it would for the entire procedure; or,
- (t) 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.

Statutory Authority: T.C.A. §§ ~~4-5-208~~ 4-5-202, 71-5-105 and 71-5-109.

I certify that this is an accurate and complete copy of rulemaking hearing rules, lawfully promulgated and adopted by the Tennessee Department of Finance and Administration (board/commission/ other authority) on \_\_\_\_\_ (mm/dd/yyyy), and is in compliance with the provisions of TCA 4-5-222.

I further certify the following:

Notice of Rulemaking Hearing filed with the Department of State on: 02/14/2011

Rulemaking Hearing(s) Conducted on: (add more dates). 04/12/2011

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

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

Name of Officer: Darin J. Gordon

Director, 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: \_\_\_\_\_

All rulemaking hearing 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

## **Public Hearing Comments**

One copy of a document containing responses to comments made at the public hearing must accompany the filing pursuant to T.C.A. §4-5-222. Agencies shall include only their responses to public hearing comments, which can be summarized. No letters of inquiry from parties questioning the rule will be accepted. When no comments are received at the public hearing, the agency need only draft a memorandum stating such and include it with the Rulemaking Hearing Rule filing. Minutes of the meeting will not be accepted. Transcripts are not acceptable.

Copies of responses to comments are included with filing.

**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 Rule Chapter is not anticipated to have an 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)

The Rule Chapter is not anticipated 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 TCA 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 Rule Chapter replaces an emergency rule chapter that provides TennCare with rules for an appeal process for providers.

- (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 Rule Chapter is lawfully adopted by the Bureau of TennCare in accordance with Tennessee Code Annotated §§ 4-5-202, 71-5-105 and 71-5-109.

- (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 or corporations most directly affected by this Rule Chapter are the TennCare providers and the managed care contractors. The governmental entities most directly affected by this Rule Chapter are the Bureau of TennCare and the 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 Rule Chapter was 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 this Rule Chapter 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

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

None

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