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Notice of Rulemaking Hearing

Hearings will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, Tennessee Code Annotated, Section 4-5-204. For questions and copies of the notice, contact the person listed below.

Agency/Board/Commission: Tennessee Department of Finance and Administration
Division: Bureau of TennCare
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Any Individuals with disabilities who wish to participate in these proceedings (to review these filings) and may require aid to facilitate such participation should contact the following at least 10 days prior to the hearing:

ADA Contact: ADA Coordinator
Bureau of TennCare
310 Great Circle Road
Address: Nashville, Tennessee 37243
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Hearing Location(s) (for additional locations, copy and paste table)

Address 1:	Bureau of TennCare 1st Floor East Conference Room 310 Great Circle Road
Address 2:	
City:	Nashville, Tennessee
Zip:	37243
Hearing Date :	*08/17/09*
Hearing Time:	9:00a.m. X CDT ___EST

Additional Hearing Information:

Revision Type (check all that apply):
X Amendments
___ New
___ Repeal

Rule(s) (**ALL** chapters and rules contained in filing must be listed here. If needed, copy and paste additional tables)

Chapter Number	Chapter Title
1200-13-01	General Rules
Rule Number	**Rule Title**
1200-13-01-.10	Criteria for Medicaid Reimbursement of Care in Nursing Facilities
1200-13-01-.15	Criteria for Medicaid Reimbursement of Care in an Intermediate Care Facility for the Mentally Retarded (ICF/MR)
1200-13-01-.17	Statewide Home and Community Based Services Waiver for the Elderly and Disabled
1200-13-01-.23	Nursing Home Preadmission Screenings for Mental Illness and Mental Retardation
1200-13-01-.25	Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled
1200-13-01-.28	Home and Community Based Services Waiver for Persons with Mental Retardation
1200-13-01-.29	Tennessee Self-Determination Waiver Program

Substance of Proposed Rules

General Rules

Amendments

Rule 1200-13-01-.10 Criteria for Medicaid Reimbursement of Care in Nursing Facilities is deleted in its entirety and replaced with a new rule 1200-13-01-.10 which shall read as follows:

1200-13-01-.10 Criteria for Medicaid Reimbursement of Care in Nursing Facilities.

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

(a) Bureau of TennCare - the State's Medical Assistance Unit, located within the Tennessee Department of Finance and Administration, which is the Single State Medicaid Agency in Tennessee.

(b) Certification - a process by which a physician, who is licensed as a doctor of medicine or doctor of osteopathy, signs and dates a PreAdmission Evaluation signifying that the requested level of Nursing Facility care is medically necessary for the individual.

(c) Department - the Tennessee Department of Finance and Administration, which is the Single State Medicaid Agency for the State of Tennessee. The Bureau of TennCare is the State's Medical Assistance Unit, located within the Department of Finance and Administration.

(d) Designated Correspondent - a person or agency authorized by an individual to receive correspondence on his/her behalf related to a PreAdmission Evaluation.

(e) Expiration Date - a date assigned by the Bureau of TennCare at the time of approval of a PreAdmission Evaluation after which Medicaid reimbursement will not be made unless a new PreAdmission Evaluation is submitted and approved, or 365 days after the PAE Approval Date when the PAE has not been used. A PAE is "used" when the person has begun receiving long-term care services based on the level of care approved in the PAE. A PAE is "expired" when the person has not begun receiving long-term care services on or before the 365th day. The first claim for reimbursement may be submitted after the 365th day, so long as the first date of service is on or before the 365th day.

(f) Inpatient nursing care - nursing services which are available 24 hours per day by or under the supervision of a licensed practical nurse or registered nurse and which, in accordance with general medical practice, are usually and customarily provided on an inpatient basis in a Nursing Facility. Inpatient nursing care includes, but is not limited to, routine nursing services such as observation and assessment of the individual's medical condition, administration of legend drugs, and supervision of nurse aides, and other skilled nursing therapies or services that are performed by a licensed practical nurse or registered nurse.

(g) Medicaid Eligible - an individual who has been determined by the Tennessee Department of Human Services or the Social Security Administration to be financially eligible to have TennCare make reimbursement for covered services.

(h) Medically Entitled - an individual who has a PreAdmission Evaluation that has been certified by a physician and that has been approved by the Bureau of TennCare.

(i) Notice of Disposition or Change - a notice issued by the Department of Human Services of an individual's financial eligibility for Medicaid and approved Medicaid vendor date for payments to a Nursing Facility.

(j) Nursing Facility - a Medicaid-certified nursing facility licensed by the Department of Health.

(k) Nursing Facility Eligible - an individual who has attained Medicaid Eligible status and who is Medically Entitled.

(l) PAE Approval Date - the beginning date of level of care eligibility for Medicaid-reimbursed care in a Nursing Facility for which the PreAdmission Evaluation has been approved by TennCare, which cannot precede completion of the PASRR process.

(m) Patient Liability - the amount determined by the Tennessee Department of Human Services which a Medicaid Eligible is required to pay for covered services provided by a Nursing Facility.

(n) "Plain language" - any notice or explanation that requires no more than a sixth grade level of education as measured by the Flesch Index, Fog Index, or Flesch-Kincaid Index.

(o) PreAdmission Evaluation (PAE) - a process of assessment approved by the Bureau of TennCare and used to document an individual's medical condition and level of care eligibility for Medicaid-reimbursed care in a Nursing Facility.

(p) PreAdmission Screening/Resident Review (PASRR) - the process by which the State determines whether an individual who resides in or seeks admission to a Medicaid-certified Nursing Facility has, or is suspected of having, mental illness or mental retardation, and, if so, whether the individual requires specialized services and is appropriate for nursing facility placement.

(q) Skilled nursing service - a physician-ordered nursing service the complexity of which is such that it can only be safely and effectively provided directly by a registered nurse or licensed practical nurse.

(r) Skilled rehabilitative service - a physician-ordered rehabilitative service the complexity of which is such that it can only be safely and effectively provided by qualified health care personnel (e.g., registered physical therapist, licensed physical therapist assistant, registered occupational therapist, certified occupational therapist assistant, licensed respiratory therapist, licensed respiratory therapist assistant).

(s) Specialized services for individuals with Mental Illness - the implementation of an individualized plan of care developed under and supervised by a physician, provided by a physician and other qualified mental health professionals, that prescribes specific therapies and activities for the treatment of persons who are experiencing an acute episode of severe mental illness, which necessitates continuous supervision by trained mental health personnel. Services to maintain generally independent individuals who are able to function with little supervision or in the absence of a continuous specialized services program are not included.

(t) Specialized services for individuals with Mental Retardation and Related Conditions - the implementation of an individualized plan of care specifying a continuous program for each individual, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services that is directed towards the acquisition of the behaviors necessary for the individual to function with as much self-determination and independence as possible; and the prevention or deceleration of regression or loss of current optimal functional status. Services to maintain generally independent

individuals who are able to function with little supervision or in the absence of a continuous specialized services program are not included.

(u) Transfer Form - a form which is used in lieu of a new PreAdmission Evaluation to document the transfer of a Nursing Facility Eligible having an approved unexpired PreAdmission Evaluation from Medicaid Level 1 at one Nursing Facility to Medicaid Level 1 at another such facility or from Medicaid Level 2 at one Nursing Facility to Medicaid Level 2 at another.

(2) PreAdmission Evaluations and Transfer Forms

(a) A PreAdmission Evaluation is required in the following circumstances:

1. When a Medicaid Eligible is admitted to a Nursing Facility.

2. When a private-paying resident of a Nursing Facility attains Medicaid Eligible status.

3. When a Nursing Facility Eligible is changed from Medicaid Level 1 to Medicaid Level 2.

4. When a Nursing Facility Eligible is changed from Medicaid Level 2 to Medicaid Level 1, unless the individual has an approved unexpired Level 1 PreAdmission Evaluation.

5. When a Nursing Facility Eligible requires continuation of the same level of care beyond the expiration date assigned by the Department.

6. When a Nursing Facility Eligible no longer requires the specific skilled nursing or rehabilitative services for which a Level 2 PreAdmission Evaluation was approved but requires other Level 2 care in a Nursing Facility.

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

1. When a Medicaid-Eligible having an approved unexpired PreAdmission Evaluation transfers from Medicaid Level 1 at one Nursing Facility to Medicaid Level 1 at another such facility; or

2. When a Medicaid Eligible having an approved unexpired PreAdmission Evaluation transfers from Medicaid Level 2 at one Nursing Facility to Medicaid Level 2 at another. A Transfer Form may be used only if there is no change in the skilled nursing or rehabilitative service for which the PreAdmission Evaluation was approved. If the skilled nursing or rehabilitative service changes, a new PreAdmission Evaluation is required.

(c) A PreAdmission Evaluation is not required in the following circumstances:

1. When a Medicaid Eligible with an approved unexpired Level 1 PreAdmission Evaluation returns to the Nursing Facility after being hospitalized.

2. When a Medicaid Eligible with an approved unexpired Level 2 PreAdmission Evaluation returns to the Nursing Facility after being hospitalized, if there has been no change in the skilled nursing or rehabilitative service for which the PreAdmission Evaluation was approved.

3. When a Medicaid-Eligible changes from Level 2 to Level 1, if that individual was previously receiving Medicaid-reimbursed Level 1 care and still has an approved unexpired Level 1 PreAdmission Evaluation.

4. When an individual's financial status changes from Medicaid Eligible to private pay and then back to Medicaid Eligible within a 90-day time period.

5. To receive Medicaid co-payment when Medicare is the primary payer of Level 2 care.

6. When a Transfer Form is appropriate in accordance with (2)(b).

(d) If a Nursing Facility admits or allows continued stay of a Medicaid Eligible without an approved PreAdmission Evaluation, it does so at its own risk and in such event the Nursing Facility shall give the individual a plain language written notice, in a format approved by the Department, that Medicaid reimbursement will not be paid unless the PreAdmission Evaluation is approved and if it is not finally approved the individual can be held financially liable for services provided.

(e) An approved PreAdmission Evaluation is valid for ninety (90) calendar days beginning with the PAE Approval Date. An approved PreAdmission Evaluation that has not been used within ninety (90) calendar days of the PAE Approval Date can be updated within 365 calendar days of the PAE Approval Date if the physician certifies that the individual's current medical condition is consistent with that described in the approved PreAdmission Evaluation. If the individual's medical condition has significantly improved such that the previously-approved PreAdmission Evaluation does not reasonably reflect the individual's current medical condition and functional capabilities, a new PreAdmission Evaluation shall be required. A PAE that is not used within 365 days of the PAE Approval Date is expired and cannot be updated.

(f) A PreAdmission Evaluation must include a recent history and physical or current medical records which support the applicant's functional and/or skilled nursing or rehabilitative needs, as reflected in the PAE. The history and physical or medical records must be signed by a physician who is licensed as a doctor of medicine or doctor of osteopathy, or by a licensed nurse practitioner or physician's assistant. A signed history and physical performed within 365 calendar days of the PAE Request Date may be used if the patient's condition has not significantly changed. Additional medical records (progress notes, office records, discharge summaries, etc.) may be used to supplement a history and physical and provide current medical information if changes have occurred since the history and physical was performed.

(g) A PreAdmission Evaluation may be approved by the Department for a fixed period of time with an expiration date based on an assessment by the Department of the individual's medical condition and anticipated continuing need for inpatient nursing care. Notice of appeal rights shall be provided when a PreAdmission Evaluation is approved with an expiration date.

(h) All individuals who reside in or seek admission to a Medicaid-certified Nursing Facility must have a PASRR Level I screen for mental illness and mental retardation. The initial Level I screen must be completed prior to admission to the Nursing Facility and submitted to TennCare regardless of: (1) payer source; (2) whether the PASRR screening is positive or negative (including specified exemptions); and (3) the level of nursing facility reimbursement requested. If the Level I screen indicates the need for a PASRR Level II evaluation of need for specialized services for mental illness and/or mental retardation, the individual must undergo the PASRR Level II evaluation prior to admission to the Nursing Facility.

(i) Medicaid payment will not be available for any dates of Nursing Facility services rendered prior to the date the PASRR process is complete, and the individual has been determined appropriate for nursing home placement. The PASRR process is complete when either:

1. TennCare has received a negative Level I PASRR screen form and no contradictory information is subsequently received; or

2. TennCare has determined level of care eligibility (i.e., approved the PAE) and received the Level II PASRR evaluation, including determination by the Department of Mental Health and Developmental Disabilities and/or the Division of Mental Retardation Services, as applicable, that the person is appropriate for Nursing Facility placement. Determination by TennCare that a Level II PASRR evaluation must be performed may be made: (a) upon receipt of a positive PASRR screen from the NF or other submitting entity; (b) based on TennCare review of a negative PASRR screen form or history and physical submitted by a NF or other entity; or (c) upon review of any contradictory information submitted in the PAE application or supporting documentation subsequent to TennCare's review of a negative PASRR screen but prior to disposition of the PAE.

(j) A Nursing Facility that has entered into a provider agreement with the Department shall assist a resident or applicant as follows:

1. The Nursing Facility shall assist a Nursing Facility resident or an applicant for admission in applying for Medicaid eligibility and in applying for Medicaid-reimbursed Nursing Facility care. This shall include assistance in properly completing all necessary paperwork and in providing relevant Nursing Facility documentation to support the PreAdmission Evaluation. Reasonable accommodations shall be made for an individual with disabilities or, alternatively, for a Designated Correspondent with disabilities when assistance is needed with the proper completion and submission of a PreAdmission Evaluation.

2. The Nursing Facility shall request a Notice of Disposition or Change from the Department of Human Services upon learning that a resident or applicant has, or is likely to have, applied for Medicaid eligibility.

(k) The Bureau of TennCare shall process PreAdmission Evaluations independently of determinations of financial eligibility by the Tennessee Department of Human Services; however, Medicaid reimbursement shall not be available until the PASRR process has been completed, and both the PreAdmission Evaluation and financial eligibility for Medicaid vendor payment have been approved.

(3) Medicaid Reimbursement

(a) A Nursing Facility that has entered into a provider agreement with the Department is entitled to receive Medicaid reimbursement for covered services provided to a Nursing Facility Eligible if

1. The Nursing Facility has completed the PASRR process as defined in 1200-13-01-.10(2)(i) above.

2. The Department has received an approvable PreAdmission Evaluation for the individual within ten (10) calendar days of the PAE Request Date or the physician certification date, whichever is earlier. The PAE Approval Date shall not be more than ten (10) days prior to date of submission of an approvable PAE. An approvable PAE is one in which any deficiencies in the submitted application are cured prior to disposition of the PAE.

3. For the same-level transfer to nursing facility services (Level 1 to Level 1, Level 2 to Level 2, or HCBS to Level 1) of an individual having an approved unexpired PreAdmission Evaluation, the Department has received an approvable Transfer Form within ten (10) calendar days after admission into the same level of care at the admitting Nursing Facility (i.e., the Nursing Facility to which the individual is being transferred). For transfer from Level 1 nursing facility services to a Home and Community Based Services Waiver program for the Elderly and Adults with Physical Disabilities, the transfer form must be submitted and approved prior to enrollment in HCBS.

4. For a retroactive eligibility determination, the Department has received a Notice of Disposition or Change and has received an approvable request to update an approved, unexpired PreAdmission Evaluation within thirty (30) calendar days of the mailing date of the Notice of Disposition or Change. The effective date of payment for nursing facility services shall not be earlier than the PAE Approval Date of the original approved, unexpired PAE which has been updated.

(b) Any deficiencies in a submitted PAE application must be cured prior to disposition of the PAE to preserve the PAE submission date for payment purposes.

1. Deficiencies cured after the PAE is denied but within thirty (30) days of the original PAE submission date will be processed as a new application, with reconsideration of the earlier denial based on the record as a whole (including both the original denied application and the additional information submitted). If approved, the effective date of PAE approval can be no earlier than the date of receipt of the information which cured the original deficiencies in the denied PAE. Payment will not be retroactive back to the date the deficient application was received or to the date requested in the deficient application.

2. Once a PAE has been denied, the original denied PAE application must be resubmitted along with any additional information which cures the deficiencies of the original application. Failure to include the original denied application may delay the availability of Medicaid reimbursement for nursing facility services.

(c) The earliest date of Medicaid reimbursement for care provided in a Nursing Facility shall be the date that all of the following criteria are met:

1. Completion of the PASRR process, as defined in 1200-13-01-.10(2)(i) above;

2. The effective date of level of care eligibility as reflected by the PAE Approval Date;

3. The effective date of Medicaid eligibility; and

4. The date of admission to the Nursing Facility.

(d) A Nursing Facility that has entered into a provider agreement with the Department and that admits a Medicaid Eligible without completion of the PASRR process, and without an approved PreAdmission Evaluation or, where applicable, an approved Transfer Form does so without the assurance of reimbursement from the Department.

(e) Medicaid reimbursement will only be made to a Nursing Facility on behalf of the Nursing Facility Eligible and not directly to the Nursing Facility Eligible.

(f) A Nursing Facility that has entered into a provider agreement with the Department shall admit individuals on a first come, first served basis, except as otherwise permitted by state and federal laws and regulations.

(4) Criteria for Reimbursement of Medicaid Level 1 Care in a Nursing Facility

(a) The Nursing Facility must have completed the PASRR process as defined in 1200-13-01-.10(2)(i) above.

(b) The individual must be determined by the Tennessee Department of Human Services to be financially eligible for Medicaid reimbursement for Nursing Facility Care.

(c) An individual must meet both of the following criteria in order to be approved for Medicaid-reimbursed Level 1 care in a Nursing Facility:

1. Medical Necessity of Care: Care in a Nursing Facility must be expected to improve or ameliorate the individual's physical or mental condition, to prevent a deterioration in health status, or to delay progression of a disease or disability, and such care must be ordered and supervised by a physician on an ongoing basis.

2. Need for Inpatient Nursing Care: The individual must have a physical or mental condition, disability, or impairment that, as a practical matter, requires daily inpatient nursing care. The individual must be unable to self-perform needed nursing care and must meet or equal one or more of the following criteria on an ongoing basis:

(i) Transfer - The individual is incapable of transfer to and from bed, chair, or toilet unless physical assistance is provided by others on an ongoing basis (daily or multiple times per week).

(ii) Mobility - The individual requires physical assistance from another person for mobility on an ongoing basis (daily or multiple times per week). Mobility is defined as the ability to walk, using mobility aids such as a walker, crutch, or cane if required, or the ability to use a wheelchair if walking is not feasible. The need for a wheelchair, walker, crutch, cane, or other mobility aid shall not by itself be considered to meet this requirement.

(iii) Eating - The individual requires gastrostomy tube feedings or physical assistance from another person to place food/drink into the mouth. Food preparation, tray set-up, and assistance in cutting up foods shall not be considered to meet this requirement.

(iv) Toileting - The individual requires physical assistance from another person to use the toilet or to perform incontinence care, ostomy care, or indwelling catheter care on an ongoing basis (daily or multiple times per week).

(v) Expressive and Receptive Communication - The individual is incapable of reliably communicating basic needs and wants (e.g., need for assistance with toileting; presence of pain) using verbal or written language; or the individual is incapable of understanding and following very simple instructions and commands (e.g., how to perform or complete basic activities of daily living such as dressing or bathing) without continual staff intervention.

(vi) Orientation - The individual is disoriented to person (e.g., fails to remember own name, or recognize immediate family members) or is disoriented to place (e.g., does not know residence is a Nursing Facility).

(vii) Medication Administration - The individual is not mentally or physically capable of self-administering prescribed medications despite the availability of limited assistance from another person. Limited assistance includes, but is not limited to, reminding when to take medications, encouragement to take, reading medication labels, opening bottles, handing to individual, and reassurance of the correct dose.

(viii) Behavior - The individual requires persistent staff intervention due to an established and persistent pattern of dementia-related behavioral problems (e.g., aggressive physical behavior, disrobing, or repetitive elopement).

(ix) Skilled Nursing or Rehabilitative Services - The individual requires daily skilled nursing or rehabilitative services at a greater frequency, duration, or intensity than, for practical purposes, would be provided through a daily home health visit.

The intent is that the above criteria should reflect the individual's capabilities on an ongoing basis and not isolated, exceptional, or infrequent limitations of function in a generally independent individual who is able to function with minimal supervision or assistance.

(d) For continued reimbursement of Medicaid Level 1 care in a Nursing Facility, an individual must continue to be financially eligible for Medicaid reimbursement for Nursing Facility Care and must meet both of the following continued stay criteria:

1. Medical Necessity of Care: Care in a Nursing Facility must be expected to improve or ameliorate the individual's physical or mental condition, to prevent a deterioration in health status, or to delay progression of a disease or disability, and such care must be ordered and supervised by a physician on an ongoing basis.

2. Need for Inpatient Care: The individual must have a physical or mental condition, disability, or impairment that continues to require the availability of daily inpatient nursing care.

(e) A Nursing Facility Eligible admitted to a Nursing Facility before the effective date of this rule must meet continued stay criteria in effect at the time of admission.

(5) Criteria for Reimbursement of Medicaid Level 2 Care in a Nursing Facility

(a) The Nursing Facility must have completed the PASRR process as defined in 1200-13-01-.10(2)(i) above.

(b) The individual must be determined by the Tennessee Department of Human Services to be financially eligible for Medicaid reimbursement for Nursing Facility Care.

(c) An individual must meet both of the following criteria in order to be approved for Medicaid-reimbursed Level 2 care in a Nursing Facility:

1. Medical Necessity of Care: Care in a Nursing Facility must be expected to improve or ameliorate the individual's physical or mental condition, to prevent a deterioration in health status, or to delay progression of a disease or disability, and such care must be ordered and supervised by a physician on an ongoing basis.

2. Need for Inpatient Skilled Nursing or Rehabilitative Services on a Daily Basis: The individual must have a physical or mental condition, disability, or impairment that requires skilled nursing or rehabilitative services on a daily basis or skilled rehabilitative services at least five days per week when skilled rehabilitative services constitute the primary basis for the approval of the PreAdmission Evaluation. The individual must require such services at a greater frequency, duration, or intensity than, for practical purposes, would be provided through a daily home health visit. In addition, the individual must be mentally or physically unable to perform the needed skilled services or the individual must require skilled services which, in accordance with accepted medical practice, are not usually and customarily self-performed.

For interpretation of this rule, the following shall apply:

(i) Administration of oral medications, ophthalmics, otics, inhalers, subcutaneous injections (e.g., fixed-dose insulin, subtherapeutic heparin, and calcitonin), topicals, suppositories, nebulizer treatments, oxygen administration, shall not, in and of itself, be considered sufficient to meet the requirement of (5)(c)2.

(ii) Nursing observation and assessment, in and of itself, shall not be considered sufficient to meet the requirement of (5)(c)2. Examples of nursing services for which Level 2 reimbursement might be provided include, but are not limited to, the following:

(I) Gastrostomy tube feeding
(II) Sterile dressings for Stage 3 or 4 pressure sores
(III) Total parenteral nutrition
(IV) Intravenous fluid administration
(V) Nasopharyngeal and tracheostomy suctioning
(VI) Ventilator services

(iii) A skilled rehabilitative service must be expected to improve the individual's condition. Restorative and maintenance nursing procedures (e.g., routine range of motion exercises; stand-by assistance during ambulation; applications of splints/braces by nurses and nurses aides) shall not be considered sufficient to fulfill the requirement of (5)(c)2. Factors to be considered in the decision as to whether a rehabilitative service meets, or continues to meet, the requirement of (5)(c)2. shall include, but not be limited to, an assessment of the type of therapy and its frequency, the remoteness of the injury or impairment, and the reasonable potential for improvement in the individual's functional capabilities or medical condition.

(6) PreAdmission Evaluation Denials and Appeal Rights

(a) A Medicaid Eligible or the legal representative of the Medicaid Eligible has the right to appeal the denial of a PreAdmission Evaluation and to request a Commissioner's Administrative Hearing by submitting a written letter of appeal to the Bureau of TennCare, Division of Long-Term Care, within thirty (30) calendar days of receipt of the notice of denial.

(b) If the Department denies a PreAdmission Evaluation, the individual will be notified in the following manner:

1. A written notice of denial shall be sent to the individual and, where applicable, to the designated correspondent. A notice of denial shall also be mailed or faxed to the Nursing Facility. This notice shall advise the individual of the right to appeal the denial decision within thirty (30) calendar days. The notice shall also advise the individual of the right to submit within thirty (30) calendar days either the original PreAdmission Evaluation with additional information for review or a new PreAdmission Evaluation. The notice shall be mailed to the individual's address as it appears upon the PreAdmission Evaluation. If no address appears on the PreAdmission Evaluation and supporting documentation, the notice will be mailed to the Nursing Facility for forwarding to the individual.

2. If the PreAdmission Evaluation is resubmitted with additional information for review and if the Department continues to deny the PreAdmission Evaluation, another written notice of denial shall be sent as described in (6)(b)1.

(c) The individual has the right to be represented at the hearing by anyone of his/her choice. The hearing will be conducted according to the provisions of the Tennessee Uniform Administrative Procedures Act.

(d) Reasonable accommodations shall be made for individuals with disabilities who require assistance with an appeal.

(e) Any notice required pursuant to this section shall be a plain language written notice.

(f) When a PreAdmission Evaluation is approved for a fixed period of time with an expiration date determined by the Department, the individual shall be provided with a notice of appeal rights, including the opportunity to submit an appeal within thirty (30) calendar days prior to the expiration date. Nothing in this section shall preclude the right of the individual to submit a new PreAdmission Evaluation establishing medical necessity of care when the expiration date has been reached.

Rule 1200-13-01-.15 Criteria for Medicaid Reimbursement of Care in an Intermediate Care Facility for the Mentally Retarded (ICF/MR) is deleted in its entirety and replaced with a new rule 1200-13-01-.15 which shall read as follows:

1200-13-01-.15 Criteria for Medicaid Reimbursement of Care in an Intermediate Care Facility for the Mentally Retarded (ICF/MR).

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

(a) Bureau of TennCare - the State's Medical Assistance Unit, located within the Tennessee Department of Finance and Administration, which is the Single State Medicaid Agency in Tennessee.

(b) Certification - a process by which a physician, who is licensed as a doctor of medicine or doctor of osteopathy, signs and dates an ICF/MR PreAdmission Evaluation signifying that care in an Intermediate Care Facility for the Mentally Retarded is medically necessary for the individual.

(c) Designated Correspondent - an individual or agency authorized by an individual to receive correspondence on his/her behalf related to an ICF/MR PreAdmission Evaluation.

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

(e) ICF/MR Eligible - an individual who has attained Medicaid Eligible status and who is Medically Entitled.

(f) ICF/MR PAE Approval Date - the beginning date of level of care eligibility for Medicaid-reimbursed care in an ICF/MR for which the ICF/MR PreAdmission Evaluation has been approved by TennCare.

(g) ICF/MR PreAdmission Evaluation (ICF/MR PAE) - a process of assessment approved by the Bureau of TennCare and used to document an individual's medical condition and need for specialized services for mental retardation or related conditions.

(h) Medicaid Eligible - an individual who has been determined by the Tennessee Department of Human Services or the Social Security Administration to be financially eligible to have TennCare make reimbursement for covered services.

(i) Medically Entitled - an individual who has an ICF/MR PreAdmission Evaluation that has been certified by a physician and that has been approved by the Bureau of TennCare.

(j) Mental Retardation - significantly subaverage intellectual functioning manifested prior to the age of eighteen (18) with an I.Q. of 70 or below on an individually-administered I.Q. test.

(k) Notice of Disposition or Change - a notice issued by the Department of Human Services of an individual's financial eligibility for Medicaid and approved Medicaid vendor date for payments to an ICF/MR.

(l) "Plain language" - any notice or explanation that requires no more than a sixth grade level of education as measured by the Flesch Index, Fog Index, or Flesch-Kincaid Index.

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

(n) Related Conditions - a severe chronic developmental disability likely to continue indefinitely which results in impairment of intellectual functioning equivalent to that of individuals with mental retardation and which requires specialized services similar to those needed by such individuals.

(o) Specialized Services for Mental Retardation or Related Conditions - the implementation of an individualized plan of care, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services that is directed towards the acquisition of the behaviors necessary for the individual to function with as much self-determination and independence as possible; and the prevention or deceleration of regression or loss of current optimal functional status.

(p) Transfer Form - a Medicaid-approved form used to document the transfer of an ICF/MR Eligible having an approved unexpired ICF/MR PAE from one ICF/MR to another ICF/MR, from an HCBS MR Waiver Program to an ICF/MR, from an ICF/MR to an HCBS MR Waiver Program, or from one HCBS MR Waiver Program to another HCBS MR Waiver Program.

(2) ICF/MR PreAdmission Evaluations and Transfer Forms

(a) An ICF/MR PreAdmission Evaluation is required to be submitted to the Bureau of TennCare for approval when

1. A Medicaid Eligible is admitted to an ICF/MR.

2. A private-paying resident of an ICF/MR attains Medicaid Eligible status or applies for Medicaid eligibility. A new ICF/MR PreAdmission Evaluation is not required when an individual's financial status changes from Medicaid Eligible to private pay and then back to Medicaid Eligible within a 90-day time period.

(b) A Transfer Form is required to be submitted to the Bureau of TennCare for approval when an ICF/MR Eligible having an approved unexpired ICF/MR PAE transfers from one ICF/MR to another ICF/MR or from the HCBS MR Waiver Program to an ICF/MR. A Transfer Form is

required to be submitted to the Division of Mental Retardation Services for approval when an ICF/MR Eligible having an approved unexpired ICF/MR PAE transfers from an ICF/MR to the HCBS MR Waiver Program.

(c) An approved ICF/MR PreAdmission Evaluation is valid for ninety (90) calendar days from the ICF/MR PAE Approval Date. An approved ICF/MR PreAdmission Evaluation that has not been used within ninety (90) calendar days of the ICF/MR PAE Approval Date can be updated within 365 calendar days of the ICF/MR PAE Approval Date if the physician certifies that the individual's current medical condition is consistent with that described in the approved ICF/MR PreAdmission Evaluation. A PAE that is not used within 365 days of the PAE Approval Date is expired and cannot be updated.

(d) An ICF/MR PreAdmission Evaluation must include a recent medical history and physical signed by a physician who is licensed as a doctor of medicine or doctor of osteopathy, or by a licensed nurse practitioner or physician's assistant. A medical history and physical performed within 365 calendar days of the ICF/MR PAE Request Date may be used if the individual's condition has not significantly changed. Additional medical records (progress notes, office records, discharge summaries, etc.) may be used to supplement a history and physical and provide current medical information if changes have occurred since the history and physical was performed.

(e) An ICF/MR PreAdmission Evaluation must include a psychological evaluation of need for care performed no more than twelve (12) months before admission. (This does not invalidate the requirement of 42 CFR § 456.370(b) regarding psychological evaluations for individuals admitted to an ICF/MR.)

(3) Medicaid Reimbursement

(a) An ICF/MR which has entered into a provider agreement with the Bureau of TennCare is entitled to receive Medicaid reimbursement for covered services provided to an ICF/MR Eligible if

1. The Bureau of TennCare has received an approvable ICF/MR PreAdmission Evaluation for the individual within ten (10) calendar days of the ICF/MR PAE Request Date or the physician certification date, whichever is earlier. The PAE Approval Date shall not be more than ten (10) days prior to date of submission of an approvable PAE. An approvable PAE is one in which any deficiencies in the submitted application are cured prior to disposition of the PAE.

2. For the transfer to an ICF/MR of an individual having an approved unexpired ICF/MR PreAdmission Evaluation, the Bureau of TennCare has received an approvable Transfer Form within ten (10) calendar days after the date of the transfer. For transfer from ICF/MR services to an HCBS MR Waiver program, the transfer form must be submitted and approved prior to enrollment in the HCBS MR Waiver program.

3. For a retroactive eligibility determination, the Bureau of TennCare has received a Notice of Disposition or Change and has received an approvable request to update an approved, unexpired ICF/MR PreAdmission Evaluation within thirty (30) calendar days of the mailing date of the Notice of Disposition or Change. The effective date of payment for ICF/MR services shall not be earlier than the PAE Approval Date of the original approved, unexpired PAE which has been updated.

(b) Any deficiencies in a submitted PAE application must be cured prior to disposition of the PAE to preserve the PAE submission date for payment purposes.

1. Deficiencies cured after the PAE is denied but within thirty (30) days of the original PAE submission date will be processed as a new application, with reconsideration of the earlier denial based on the record as a whole (including both the original denied application and the additional information submitted). If approved, the effective date of PAE approval can be no earlier than the date of receipt of the information which cured the original deficiencies in the denied PAE. Payment will not be retroactive back to the

date the deficient application was received or to the date requested in the deficient application.

2. Once a PAE has been denied, the original denied PAE application must be resubmitted along with any additional information which cures the deficiencies of the original application. Failure to include the original denied application may delay the availability of Medicaid reimbursement for ICF/MR services.

(c) An ICF/MR that admits a Medicaid Eligible without an approved ICF/MR PreAdmission Evaluation or, where applicable, an approved Transfer Form does so without the assurance of reimbursement from the Bureau of TennCare.

(4) Criteria for Medicaid-reimbursed Care in an Intermediate Care Facility for the Mentally Retarded (ICF/MR)

(a) Medicaid Eligible Status: The individual must be determined by the Tennessee Department of Human Services to be financially eligible for Medicaid-reimbursed care in an Intermediate Care Facility for the Mentally Retarded.

(b) An individual must meet all of the following criteria in order to be approved for Medicaid-reimbursed care in an Intermediate Care Facility for the Mentally Retarded:

1. Medical Necessity of Care: Care must be expected to enhance the individual's functional ability or to prevent or delay the deterioration or loss of functional ability. Care in an Intermediate Care Facility for the Mentally Retarded must be ordered and supervised by a physician.

2. Diagnosis of Mental Retardation or Related Conditions.

3. Need for Specialized Services for Mental Retardation or Related Conditions: The individual must require a program of specialized services for mental retardation or related conditions provided under the supervision of a qualified mental retardation professional (QMRP). The individual must also have a significant deficit or impairment in adaptive functioning in one of the following areas: communication, comprehension, behavior, or activities of daily living (e.g., toileting, bathing, eating, dressing/grooming, transfer, mobility).

(c) Individuals with mental retardation or related conditions who were in an Intermediate Care Facility for the Mentally Retarded or who were in community residential placements funded by the Division of Mental Retardation on or prior to the effective date of this rule may be deemed by the Bureau of TennCare to meet the requirements of (4)(b)2. and (4)(b)3.

(d) For continued Medicaid reimbursement of care in an Intermediate Care Facility for the Mentally Retarded, an individual must continue to meet the criteria specified in (4)(a) and (4)(b), unless otherwise exempted by (4)(c).

(5) Grievance process

(a) A Medicaid Eligible or the legal representative of the Medicaid Eligible has the right to appeal the denial of an ICF/MR PreAdmission Evaluation and to request a Commissioner's Administrative Hearing by submitting a written letter of appeal to the Bureau of TennCare within thirty (30) calendar days of receipt of the notice of denial.

(b) If the Bureau of TennCare denies an ICF/MR PreAdmission Evaluation, the individual will be notified in the following manner:

1. A written notice of denial shall be sent to the individual and, where applicable, to the designated correspondent. A notice of denial shall also be mailed or faxed to the ICF/MR. This notice shall advise the individual of the right to appeal the denial decision within thirty (30) calendar days. The notice shall also advise the individual of the right to submit within thirty (30) calendar days either the original ICF/MR PreAdmission

Evaluation with additional information for review or a new ICF/MR PreAdmission Evaluation. The notice shall be mailed to the individual's address as it appears upon the ICF/MR PreAdmission Evaluation. If no address appears on the ICF/MR PreAdmission Evaluation and supporting documentation, the notice will be mailed to the ICF/MR for forwarding to the individual.

2. If an ICF/MR PreAdmission Evaluation is resubmitted with additional information for review and if the Bureau of TennCare continues to deny the ICF/MR PreAdmission Evaluation, another written notice of denial shall be sent as described in (5)(b)1.

(c) The individual has the right to be represented at the hearing by anyone of their choice. The hearing will be conducted according to the provisions of the Tennessee Uniform Administrative Procedures Act.

(d) Reasonable accommodations shall be made for individuals with disabilities who require assistance with appeals.

(e) Any notice required pursuant to this section shall be a plain language written notice.

Subparagraph (x) of paragraph (1) of rule 1200-13-01-.17 Statewide Home and Community Based Services Waiver for the Elderly and Disabled is amended by replacing the phrase "PreAdmission Screening/Annual Resident Review (PASARR)" with the phrase "PreAdmission Screening/Resident Review (PASRR)" so as amended subparagraph (x) shall read as follows:

(x) PreAdmission Screening/Resident Review (PASRR) - the process by which the State determines whether an individual who resides in or seeks admission to a Medicaid-certified Nursing Facility has, or is suspected of having, mental illness or mental retardation, and, if so, whether the individual requires specialized services.

The introductory sentence to paragraph (7) and subparagraph (c) of rule 1200-13-01-.17 is amended by replacing the letters "PASARR" with the letters "PASRR" so as amended paragraph (7) shall read as follows:

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

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

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

1. When an Enrollee having an approved unexpired PreAdmission Evaluation transfers from the Waiver to Level 1 care in a Nursing Facility.

2. When an Enrollee having an approved unexpired PreAdmission Evaluation transfers from one Home and Community Based Services Waiver for the Elderly and Disabled to a different Home and Community Based Services Waiver for the Elderly and Disabled.

3. When a Waiver Eligible with an approved unexpired PreAdmission Evaluation transfers from a Nursing Facility to the Waiver.

(c) A Level I PASRR assessment for mental illness and mental retardation is required when an Enrollee with an approved, unexpired PreAdmission Evaluation transfers from the Waiver to a Nursing Facility. A Level II PASRR evaluation is required if a history of mental illness or mental retardation is indicated by the Level I PASRR assessment, unless criteria for exception are met.

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

Agency that Medicaid reimbursement will not be paid until and unless the PreAdmission Evaluation is approved.

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

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

Subparagraph (a) of paragraph (11) of rule 1200-13-01-.17 Statewide Home and Community Based Services Waiver for the Elderly and Disabled is amended by replacing the letters "PASARR" wherever they appear with the letters "PASRR" so as amended subparagraph (a) shall read as follows:

(a) Voluntary disenrollment of an Enrollee from the Waiver may occur at any time upon written notice from the Enrollee or the Enrollee's legal representative to the Administrative Lead Agency. A Level I PASRR assessment for mental illness and mental retardation is required when an Enrollee transfers to a Nursing Facility. If the Level I PASRR assessment indicates the need for a PASRR Level II evaluation of need for specialized services for mental illness or mental retardation, the Enrollee must undergo the PASRR Level II evaluation. Prior to disenrollment, the Administrative Lead Agency shall assist the Enrollee in locating alternate services to provide the appropriate level of care and shall assist in transitioning the enrollee to the new services.

Subparagraph (b) of paragraph (12) of rule 1200-13-01-.17 Statewide Home and Community Based Services Waiver for the Elderly and Disabled is deleted in its entirety and replaced with a new subparagraph (b) which shall read as follows:

(b) If the individual is involuntarily disenrolled from the Waiver, the Administrative Lead Agency shall assist the Enrollee in locating a Nursing Facility or other alternative providing the appropriate level of care and in transferring the Enrollee. Pursuant to TennCare Rule 1200-13-01-.10 and 1200-13-01-.23, a Level I PASRR screen for mental illness and mental retardation must be completed prior to admission when an Enrollee transfers to a Nursing Facility. If the Level I PASRR screen indicates the need for a PASRR Level II evaluation of need for specialized services for mental illness or mental retardation, the Enrollee must undergo the PASRR Level II evaluation prior to admission to the Nursing Facility.

Rule 1200-13-01-.23 Nursing Home Preadmission Screening for Mental Illness and Mental Retardation is deleted in its entirety and replaced with a new rule 1200-13-01-.23 which shall read as follows:

1200-13-01-.23 Nursing Home Preadmission Screening for Mental Illness and Mental Retardation.

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

(a) Identification Screen (Level I) - The identification screen is to determine which nursing facility applicants or residents have mental illness or mental retardation and are subject to preadmission screening/resident review (PASRR). Individuals with a supportable primary diagnosis of Alzheimer's disease or dementia will also be detected through the identification screen. Nursing facilities are responsible for ensuring that all applicants receive a Level I identification screen prior to admission to the facility, and for submission of the Level I screen to TennCare.

(b) Preadmission Screening/Resident Review (Level II) - The process whereby a determination is made about whether the individual requires the level of services provided by a nursing facility or another type of facility and, if so, whether the individual requires specialized services. These reviews shall be the responsibility of the State Department of Mental Health and Developmental Disabilities and/or the Division of Mental Retardation, as applicable.

(c) Mental Illness - An individual is considered to have mental illness if he/she has a current primary or secondary diagnosis of a major mental disorder (as defined in the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition) limited to schizophrenic, paranoid, major

affective, schizoaffective disorders and atypical psychosis, and does not have a primary diagnosis of dementia (including Alzheimer's disease or a related disorder).

(d) Mental Retardation and Related Conditions - An individual is considered to be mentally retarded if he/she has a level of retardation (mild, moderate, server and profound) as described in the American Association on Mental Deficiency's Manual on Classification in Mental Retardation (1983).

Mental Retardation refers to significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period (i.e., prior to age eighteen).

The provisions of this section also apply to persons with "related conditions", as defined by 42 CFR 435.1010, which states: "Persons with related conditions" means individuals who have a severe, chronic disability that meets all of the following conditions:

1. It is attributable to:

   (i) Cerebral palsy or epilepsy, or

   (ii) Any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with mental retardation, and requires treatment or services similar to those required for these persons.

2. It is manifested before the person reaches age 22.

3. It is likely to continue indefinitely.

4. It results in substantial functional limitations in three or more of the following areas of major life activity:

   (i) Self-care;

   (ii) Understanding and use of language;

   (iii) Learning;

   (iv) Mobility;

   (v) Self-direction; and

   (vi) Capacity for independent living.

(e) Specialized Services for Individuals with Mental Retardation - A continuous program for each individual, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services that is directed towards (1) the acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (2) the prevention or deceleration of regression or loss of current optimal functional status. Specialized services does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous specialized services program.

(f) Specialized Services for Individuals with Mental Illness - Specialized services is defined as the implementation of an individualized plan of care developed under and supervised by a physician, provided by a physician and other qualified mental health professionals, that prescribes specific therapies and activities for the treatment of persons who are experiencing an acute episode of severe mental illness, which necessitates supervision by trained mental health personnel.

(2) Medicaid-certified nursing facilities may not admit individuals applying for admission unless these persons are screened to determine if they have mental illness or mental retardation regardless of

method of payment or "known diagnosis." A Medicaid-certified nursing facility is prohibited from admitting any new resident who has mental illness or mental retardation (or a related condition), unless that individual has been determined by the Tennessee Department of Mental Health and Developmental Disabilities and/or the Division of Mental Retardation Services, as applicable, not to be in need of specialized services and appropriate for placement in a nursing facility. (The individual must also meet the Bureau of TennCare's preadmission criteria for nursing facility services). The criteria to be used in making determinations will be categorized into two levels: 1) identification screens (Level I) and 2) preadmission screening/resident reviews evaluations (Level II).

(a) Criteria for Identification Screen (Level I)

1. Prior to admission of any person to a nursing facility, it must be determined if:

(i) For Mental Illness

(I) The individual has a diagnosis of mental illness. See prior definition of mental illness).

(II) The person has any recent (within the last two years) history of mental illness, or has been prescribed a major tranquilizer on a regular basis in the absence of justifiable neurological disorder.

(III) There is any presenting evidence of mental illness (except primary diagnosis of Alzheimer's disease or dementia) including possible disturbances in orientation or mood.

(ii) For Mental Retardation or Persons with Related Conditions

(I) The individual has a diagnosis of mental retardation. (See prior definition of mental retardation).

(II) There is any history of mental retardation or developmental disability in the identified individual's past.

(III) There is any presenting evidence (cognitive of behavior functions) that may indicate the person has mental retardation or developmental disability.

(IV) The person is referred by an agency that serves persons with mental retardation (or other developmental disabilities), and the person has been deemed to be eligible for that agency's services.

(V) The preceding criteria must also be applied to residents of a nursing facility who have not received an identification screen.

(VI) There must be a record of the identification screen results and interpretation in the nursing home resident's record.

(VII) Results of the identification screen must be used (unless there is other indisputable evidence that the individual is not mentally ill or mentally retarded) in determining whether an individual is (or is suspected to be) mentally ill or mentally retarded and therefore must be subjected to the PASRR process. Findings from the evaluation should be used in making determinations about whether an individual has mental illness or mental retardation.

(b) Any individual for whom there is a negative response for all of the identification evaluative criteria for mental retardation or mental illness and for whom there is no other evidence of a condition of mental illness or mental retardation may be admitted to or continue to reside in a Medicaid-certified nursing facility without being determined appropriate for nursing facility placement through the PASRR evaluation process (Level II).

(c) Any individual for whom there is a positive response for any of the identification evaluative criteria for mental retardation or mental illness may not be admitted to or continue to reside in a Medicaid-certified nursing facility without being determined appropriate for nursing facility placement through the PASRR evaluation process (Level II).

(d) Exemptions from Level II Review

An individual who has a diagnosis of mental illness or mental retardation will be exempt from the PASRR process if they meet any of the following criteria:

1. Dementia - This must be a primary diagnosis based on criteria in the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition; or it may be the secondary diagnosis (including Alzheimer's disease and related disorders) as long as the primary diagnosis is not a major mental illness. The primary or secondary diagnosis of dementia (including Alzheimer's disease and related disorders) must be based on a neurological examination. Dementia is not allowed as an exemption if the individual has, or is suspected of having, a diagnosis of mental retardation.

2. Convalescent Care - Any person with mental illness or mental retardation as long as that person is not a danger to self and/or others, may be admitted to a Medicaid-certified nursing facility after release from an acute care hospital for a period of recovery without being subjected to the PASRR process for mentally ill or mentally retarded evaluation.

3. Terminal Illness - Under Section 1861(dd)(3)(A) of the Social Security Act, a Medicare beneficiary is considered to be terminally ill if he or she has a medical prognosis that (his/her) life expectancy is six months or less. This same standard is to be applied to Medicaid recipients with mental illness, mental retardation or related conditions who are found to be suffering from a terminal illness. An individual with mental illness or mental retardation, as long as that person is not a danger to self and/or others, may be admitted to or reside in a Medicaid-certified nursing facility without being subjected to the PASRR/MI or PASRR/MR evaluative process if he or she is certified by a physician to be "terminally ill," as that term is defined in Section 1861(dd)(3)(A) of the Social Security Act, and requires continuous nursing care and/or medical supervision and treatment due to his/her physical condition.

4. Severity of Illness - Any person with mental illness or mental retardation who is comatose, ventilator dependent, functions at the brain stem level, or has a diagnosis of: Severe Parkinson's Disease, Huntingdon's Disease, Amyotrophic Lateral Sclerosis, Congestive Heart Failure, or Chronic Obstructive Pulmonary Disease, and any other diagnosis so determined by the Health Care Financing Administration.

(e) Processes upon expiration of exemption

1. If an individual is admitted to a nursing facility as a Medicare patient, with a "30-day hospital discharge exemption" on the PASRR screen form, and it is determined that the individual will need to extend the stay beyond 30 days, it is the responsibility of the nursing facility to notify TennCare and to ensure that a PASRR evaluation is completed no more than 40 days from the original date of admission (i.e., within 10 days of expiration of the 30-day exemption). If Medicaid reimbursement will be sought, this includes submission and disposition of the PAE which will be required in order to timely complete the PASRR evaluation.

2. If an individual enters the facility with an exemption of "120-day short term stay" on the PASRR screen form and it is determined that the individual will need to extend the stay beyond 120 days, it is the responsibility of the nursing facility to notify TennCare at least seven (7) working days prior to expiration of the 120 days in order to ensure that a PASRR evaluation is completed timely before the 120-day exemption expires. If Medicaid reimbursement will be sought, the PAE must also be submitted to TennCare with sufficient time for review and approval. In such case, it is the responsibility of the nursing facility to notify TennCare and to submit a completed PAE at least ten (10) working days prior to expiration of the 120 days in order to ensure that a PASRR evaluation is completed timely before the 120-day exemption expires.

(3) Right to Appeal - Each patient has the right to appeal any decision made. The appeal process will be handled in accordance with T.C.A. §7I-5-113.

Subparagraph (qq) of paragraph (1) of rule 1200-13-01-.25 Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled is deleted in its entirety and replaced with a new subparagraph (qq) which shall read as follows:

(qq) Transfer Form - the form approved by the State Medicaid Agency and used to document the transfer of an Enrollee having an approved unexpired ICF/MR Pre-Admission Evaluation from the Waiver to an ICF/MR, from an ICF/MR to the Waiver or from one MR Waiver program to another MR Waiver program. For purposes of transfer to an MR Waiver program, whether from an ICF/MR or from another MR Waiver program, such Transfer Form shall be processed by TennCare only if submitted by the Division of Mental Retardation Services (DMRS). DMRS shall submit a Transfer Form only after verifying that the person otherwise meets all applicable admission criteria for the applicable MR Waiver program, as the Transfer Form accomplishes only the transfer of the level of care eligibility.

Part 5. of subparagraph (a) of paragraph (3) of rule 1200-13-01-.25 Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled is deleted in its entirety and replaced with a new part 5. which shall read as follows:

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

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

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

(II) Is a child five (5) years of age or younger who has a developmental disability with a high probability of resulting in mental retardation (i.e., a condition of substantial developmental delay or specific congenital or acquired condition with a high probability of resulting in mental retardation); and

(ii) There is no time limit for when the psychological evaluation is conducted as long as it is completed prior to the submission of the PAE, and as long as the evaluation meets the requirements specified in 1200-13-01-.25(3)(a)(5)(i) above, and the person's current medical, social, developmental and psycho-social history continues to support the evaluation.

(iii) A new psychological evaluation performed within ninety (90) calendar days preceding the date of admission into the waiver shall be required if the person's condition has significantly changed, or the original evaluation is not otherwise consistent with the person's current medical, social, developmental and psycho-social history.

Subparagraph (b) of paragraph (3) of rule 1200-13-01-.25 Home and Community Based Services for the Mentally Retarded and Developmentally Disabled is amended by deleting parts 3. and 4. in their entirety and replacing them with new parts 3. and 4. so as amended subparagraph (b) shall read as follows:

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

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

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

3. May be used to transfer an individual from one MR Waiver to a different Home and Community Based Services MR Waiver Program as specified in 1200-13-01-.25(1)(qq) above; and

4. Shall include an initial plan of care that lists the Enrollee's specific Waiver Services with the amount, scope, and duration of the services.

Part 2. of subparagraph (a) of paragraph (7) of rule 1200-13-01-.25 Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled is deleted in its entirety and replaced by a new part 2. which shall read as follows:

2. Each Enrollee shall have a comprehensive individualized written Plan of Care (the Individual Support Plan) that shall be developed for the Enrollee within sixty (60) calendar days of admission into the Waiver.

Subparagraph (qq) of paragraph (1) of rule 1200-13-01-.28 Home and Community Based Services Waiver for Persons with Mental Retardation is deleted in its entirety and replaced with a new subparagraph (qq) which shall read as follows:

(qq) Transfer Form - the form approved by the State Medicaid Agency and used to document the transfer of an Enrollee having an approved unexpired ICF/MR Pre-Admission Evaluation from the Waiver to an ICF/MR, from an ICF/MR to the Waiver or from one MR Waiver program to another MR Waiver program. For purposes of transfer to an MR Waiver program, whether from an ICF/MR or from another MR Waiver program, such Transfer Form shall be processed by TennCare only if submitted by the Division of Mental Retardation Services (DMRS). DMRS shall submit a Transfer Form only after verifying that the person otherwise meets all applicable admission criteria for the applicable MR Waiver program, as the Transfer Form accomplishes only the transfer of the level of care eligibility.

Part 6. of subparagraph (a) of paragraph (3) of rule 1200-13-01-.28 Home and Community Based Services Waiver for Persons with Mental Retardation is deleted in its entirety and replaced with a new part 6. which shall read as follows:

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

(i) The psychological evaluation shall document that the individual has mental retardation manifested before eighteen (18) years of age and has an IQ test score of seventy (70) or below; and

(ii) There is no time limit for when the psychological evaluation is conducted as long as it is completed prior to the submission of the PAE, and as long as the evaluation meets the requirements specified in 1200-13-01-.28(3)(a)(6)(i) above, and the person's current medical, social, developmental and psycho-social history continues to support the evaluation.

(iii) A new psychological evaluation performed within ninety (90) calendar days preceding the date of admission into the waiver shall be required if the person's condition has significantly changed, or the original evaluation is not otherwise consistent with the person's current medical, social, developmental and psycho-social history.

Subparagraph (b) of paragraph (3) of rule 1200-13-01-.28 Home and Community Based Services Waiver for Persons with Mental Retardation is amended by deleting parts 3. and 4. in their entirety and replacing them with new parts 3. and 4. so as amended subparagraph (b) shall read as follows:

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

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

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

3. May be used to transfer an individual from one MR Waiver to a different Home and Community Based Services MR Waiver Program as specified in 1200-13-01-.28(1)(qq) above; and

4. Shall include an initial plan of care that lists the Enrollee's specific Waiver Services with the amount, scope, and duration of the services.

Part 2. of subparagraph (a) of paragraph (7) of rule 1200-13-01-.28 Home and Community Based Services Waiver for Persons with Mental Retardation is deleted in its entirety and replaced with a new part 2. which shall read as follows:

2. Each Enrollee shall have a comprehensive individualized written Plan of Care (the Individual Support Plan) that shall be developed for an Enrollee within sixty (60) calendar days of admission into the Waiver.

Subparagraph (ss) of paragraph (1) of rule 1200-13-01-.29 Tennessee Self-Determination Waiver Program is deleted in its entirety and replaced with a new subparagraph (ss) which shall read as follows:

(ss) Transfer Form - the form approved by the State Medicaid Agency and used to document the transfer of an Enrollee having an approved unexpired ICF/MR Pre-Admission Evaluation from the Waiver to an ICF/MR, from an ICF/MR to the Waiver or from one MR Waiver program to another MR Waiver program. For purposes of transfer to an MR Waiver program, whether from an ICF/MR or from another MR Waiver program, such Transfer Form shall be processed by TennCare only if submitted by the Division of Mental Retardation Services (DMRS). DMRS shall submit a Transfer Form only after verifying that the person otherwise meets all applicable admission criteria for the applicable MR Waiver program, as the Transfer Form accomplishes only the transfer of the level of care eligibility.

Part 7. of subparagraph (a) of paragraph (4) of rule 1200-13-01-.29 Tennessee Self-Determination Waiver Program is deleted in its entirety and replaced with a new part 7. which shall read as follows:

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

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

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

(II) Is a child five (5) years of age or younger who has a developmental disability with a high probability of resulting in mental retardation (i.e., a condition of substantial developmental delay or specific congenital or acquired condition with a high probability of resulting in mental retardation); and

(ii) There is no time limit for when the psychological evaluation is conducted as long as it is completed prior to the submission of the PAE, and as long as the evaluation meets the requirements specified in 1200-13-01-.29(4)(a)7.(i) above, and the person's current medical, social, developmental and psycho-social history continues to support the evaluation.

(iii) A new psychological evaluation performed within ninety (90) calendar days preceding the date of admission into the waiver shall be required if the person's condition has significantly changed, or the original evaluation is not otherwise consistent with the person's current medical, social, developmental and psycho-social history.

Subparagraph (b) of paragraph (4) of rule 1200-13-01-.29 Tennessee Self-Determination Waiver Program is amended by deleting parts 3. and 4. in their entirety and replacing them with new parts 3. and 4. so as amended subparagraph (b) shall read as follows:

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

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

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

3. May be used to transfer an individual from one MR Waiver to a different Home and Community Based Services MR Waiver Program as specified in 1200-13-01-.29(1)(ss) above; and

4. Shall include an initial plan of care that lists the Enrollee's specific Waiver Services with the amount, scope, and duration of the services.

Part 2. of subparagraph (a) of paragraph (8) of rule 1200-13-01-.29 Tennessee Self-Determination Waiver Program is deleted in its entirety and replaced with a new part 2. which shall read as follows:

2. Each Enrollee shall have an individualized written Plan of Care (the Individual Support Plan) that shall be developed for an Enrollee within sixty (60) calendar days of admission into the Waiver.

Statutory Authority: T.C.A. 4-5-202, 4-5-203, 71-5-105, 71-5-109.

I certify that the information included in this filing is an accurate and complete representation of the intent and scope of rulemaking proposed by the agency.

Date: 6/30/2009

Signature: [signature]

Name of Officer: Darin J. Gordon

Title of Officer: Director, Bureau of TennCare
Tennessee Department of Finance and Administration

Subscribed and sworn to before me on: 6/30/09

Notary Public Signature: Marsha Thibault

My commission expires on: 10/25/2011

MARSHA THIBAULT
STATE OF TENNESSEE NOTARY PUBLIC
WILSON COUNTY

Department of State Use Only

Filed with the Department of State on: 6/30/09

Tre Hargett by [signature] POA
Tre Hargett
Secretary of State

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