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TENNESSEE ADMINISTRATIVE REGISTER



December 15, 2005
Volume 31, Number 12

RILEY C. DARNELL
Secretary of State

Division of Publications
8th Floor, Snodgrass-Tennessee Tower
312 8th Avenue North
Nashville TN 37243 - 0310

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PREFACE

The Tennessee Administrative Register (T.A.R) is an official publication of the Tennessee Department of State. The *T.A.R.* is compiled and published monthly by the Department of State pursuant to *Tennessee Code Annotated, Title 4, Chapter 5*. The *T.A.R.* contains in their entirety or in summary form the following: (1) various announcements (e.g. the maximum effective rate of interest on home loans as set by the Department of Commerce and Insurance, formula rate of interest and notices of review cycles); (2) emergency rules; (3) proposed rules; (4) public necessity rules; (5) notices of rulemaking hearings and (6) proclamations of the Wildlife Resources Commission.

Emergency Rules are rules promulgated due to an immediate danger to the public health, safety or welfare. These rules are effective immediately on the date of filing and remain in effect thereafter for up to 165 days. Unless the rule is promulgated in some permanent form, it will expire after the 165-day period. The text or a summary of the emergency rule will be published in the next issue of the *T.A.R.* after the rule is filed. Thereafter, a list of emergency rules currently in effect will be published.

Proposed Rules are those rules the agency is promulgating in permanent form in the absence of a rulemaking hearing. Unless a rulemaking hearing is requested within 30 days of the date the proposed rule is published in the *T.A.R.*, the rule will become effective 105 days after said publication date. All rules filed in one month will be published in the *T.A.R.* of the following month.

Public Necessity Rules are promulgated to delay the effective date of another rule that is not yet effective, to satisfy constitutional requirements or court orders, or to avoid loss of federal programs or funds. Upon filing, these rules are effective for a period of 165 days. The text or summary of the public necessity rule will be published in the next issue of the *T.A.R.* Thereafter, a list of public necessity rules currently in effect will be published.

Once a rule becomes effective, it is published in its entirety in the *official compilation-Rules and Regulations of the State of Tennessee*. Replacement pages for the compilation are published on a monthly basis as new rules or changes in existing rules become effective.

Wildlife Proclamations contain seasons, creel, size and bag limits, and areas open to hunting and/or fishing. They also establish wildlife and/or public hunting areas and declare the manner and means of taking. Since Wildlife Proclamations are published in their entirety in the *T.A.R.*, they are not published in the *official compilation-Rules and Regulations of the State of Tennessee*.

Back Issues - Some back issues of the *Tennessee Administrative Register* are available. Please send \$ 1.50 per issue along with the volume, number and date you wish to order to the address in the back of this issue.

Copies of Rules from Back Issues of the *Tennessee Administrative Register* may be ordered from the Division of Publications for 25 cents per page with \$ 1.00 minimum. Back issues presently available start with the August, 1975 edition. The mailing address of the Division of Publications is shown on the order

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ANNOUNCEMENTS

DEPARTMENT OF FINANCIAL INSTITUTIONS – 0180

ANNOUNCEMENT OF FORMULA RATE OF INTEREST

Pursuant to the provisions of Chapter 464, Public Acts of 1983, the Commissioner of Financial Institutions hereby announces that the formula rate of interest is 11.00%.

This announcement is placed in the Tennessee Administrative Register for the purpose of information only and does not constitute a rule within the meaning of the Uniform Administrative Procedures Act.

Kevin P. Lavender

DEPARTMENT OF FINANCIAL INSTITUTIONS – 0180

ANNOUNCEMENT OF MAXIMUM EFFECTIVE RATE OF INTEREST

The Federal National Mortgage Association has discontinued its free market auction system for commitments to purchase conventional home mortgages. Therefore, the Commissioner of Financial Institutions hereby announces that the maximum effective rate of interest per annum for home loans as set by the General Assembly in 1987, Public Chapter 291, for the month of January 2006 is 8.91 percent per annum.

The rate as set by the said law is an amount equal to four percentage points above the index of market yields of long-term government bonds adjusted to a thirty (30) year maturity by the U. S. Department of the Treasury. For the most recent weekly average statistical data available preceding the date of this announcement, the calculated rate is 4.91 percent.

Persons affected by the maximum effective rate of interest for home loans as set forth in this notice should consult legal counsel as to the effect of the Depository Institutions Deregulation and Monetary Control Act of 1980 (P.L. 96-221 as amended by P.L. 96-399) and regulations pursuant to that Act promulgated by the Federal Home Loan Bank Board. State usury laws as they relate to certain loans made after March 31, 1980, may be preempted by this Act.

Kevin P. Lavender

ANNOUNCEMENTS

GOVERNMENT OPERATIONS COMMITTEES

ANNOUNCEMENT OF PUBLIC HEARINGS

For the date, time, and, location of this hearing of the Joint Operations committees, call 615-741-3642. The following rules were filed in the Secretary of State's office during the previous month. All persons who wish to testify at the hearings or who wish to submit written statements on information for inclusion in the staff report on the rules should promptly notify Fred Standbrook, Suite G-3, War Memorial Building, Nashville, TN 37243-0059, (615) 741-3072.

ANNOUNCEMENTS

SEQ. NO.	DATE FILED	DEPARTMENT AND DIVISION	TYPE OF FILING	DESCRIPTION	RULE NUMBER AND RULE TITLE	LEGAL CONTACT	EFFECTIVE DATE
11-01	Nov 2, 2005	1730 Veterinary Medical Examiners	Rulemaking Hearing Rules	Amendments	<p><i>Chapter 1730-1</i> <i>General Rules Governing Veterinarians</i> 1730-1-.04 Qualifications for Licensure 1730-1-.11 Retirement and Reactivation of License 1730-1-.14 Temporary License</p> <p><i>Chapter 1730-2</i> <i>General Rules Governing Veterinary Facilities</i> 1730-2-.02 Veterinary Facilities Inspections and Premises PeRule Making it 1730-2-.08 Small Animal Surgery</p> <p><i>Chapter 1730-3</i> <i>General Rules Governing Veterinary Medical Technicians</i> 1730-3-.11 Retirement and Reactivation of License</p> <p><i>Chapter 1730-4</i> <i>General Rules Governing Certified Animal Control Agencies</i> 1730-4-.07 Requirements for Inspection</p> <p><i>Chapter 1730-5</i> <i>General Rules Governing Certified Animal Euthanasia Technicians</i> 1730-5-.08 Renewal Application and Reinstatement/Reactivation of Expired or Retired Certificate</p>	Nicole Arström, Health OGC 26th Fl TN Twr 312 8th Ave N Nashville TN 37247-0120 (615) 741-1611	Jan 16, 2006
11-02	Nov 2, 2005	1200 Health Board of Alcohol and Drug Abuse Counselors	Rulemaking Hearing Rules	Amendments	<p><i>Chapter 1200-30-1</i> <i>Rules Governing Licensure of Alcohol and Drug Abuse Counselors</i> 1200-30-1-.01 Definitions 1200-30-1-.10 Supervision 1200-30-1-.12 Continuing Education</p>	Nicole Arström, Health OGC 26th Fl TN Twr 312 8th Ave N Nashville TN 37247-0120 (615) 741-1611	Jan 16, 2006
11-03	Nov 4, 2005	0540 Electrolysis Examiners	Rulemaking Hearing Rule	Amendments	<p><i>Chapter 0540-1</i> <i>General Rules Governing Electrology Electrologists and Electrology Instructors</i> 0540-1-.15 Disciplinary Actions and Civil Penalties</p> <p>Chapter 0540 3 General Rules Governing Schools of Electrology 0540-3-.15 Disciplinary Actions and Civil Penalties</p>	Ernest Sykes Jr. Health OGC 26th Fl TN Twr 312 8th Ave N Nashville TN 37247-0120 (615) 741-1611	Jan 18, 2006

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SEQ. NO.	DATE FILED	DEPARTMENT AND DIVISION	TYPE OF FILING	DESCRIPTION	RULE NUMBER AND RULE TITLE	LEGAL CONTACT	EFFECTIVE DATE
11-04	Nov 4, 2005	1000 Nursing	Rulemaking Hearing Rule	Amendments	<p><i>Chapter 1000-1</i> <i>Rules and Regulations of Registered Nurses</i> 1000-1-.13 Unprofessional Conduct and Negligence Habits or Other Cause 1000-1-.15 Scope of Practice</p> <p><i>Chapter 1000-2</i> <i>Rules and Regulations of Licensed Practical Nurses</i> 1000-2-.13 Unprofessional Conduct and Negligence Habits or Other Cause</p> <p><i>Chapter 1000-4</i> <i>Advanced Practice Nurses & Certificates of Fitness to Prescribe</i> 1000-4-.06 Fees</p>	Richard Russell Health OGC 26th Fl TN Twr 312 8th Ave N Nashville TN 37247-0120 (615) 741-1611	Jan 18, 2006

ANNOUNCEMENTS

SEQ. NO.	DATE FILED	DEPARTMENT AND DIVISION	TYPE OF FILING	DESCRIPTION	RULE NUMBER AND RULE TITLE	LEGAL CONTACT	EFFECTIVE DATE
11-05	Nov 9, 2005	1640 Student Assistance Corp	Proposed Rules	New Rules	<i>Chapter 1640-1-19</i> <i>Tennessee Education Lottery Scholarship Program</i> 1640-1-19-.01 Definitions 1640-1-19-.02 Scholarship Award Amounts and Classifications 1640-1-19-.03 Application Process 1640-1-19-.04 General Eligibility 1640-1-19-.05 Eligibility – Tennessee Hope Scholarship 1640-1-19-.06 Eligibility – Tennessee ASPIRE Award 1640-1-19-.07 Eligibility – General Assembly Merit Scholarship 1640-1-19-.08 Eligibility – Tennessee Hope Access Grant 1640-1-19-.09 Eligibility – Tennessee HOPE Foster Child Tuition Grant 1640-1-19-.10 Eligibility – Wilder-Naifeh Technical Skills Grant 1640-1-19-.11 Eligibility – Tennessee Dual Enrollment Grant 1640-1-19-.12 Retention of Awards – General Requirements 1640-1-19-.13 Retention of Awards – Tennessee Hope Access Grant 1640-1-19-.14 Retention of Awards – Tennessee Dual Enrollment Grant 1640-1-19-.15 Tennessee Education Lottery Scholarship Award Process 1640-1-19-.16 Continuation of Tennessee Education Lottery Scholarship Award 1640-1-19-.17 Award Made in Error 1640-1-19-.18 Refund Policy 1640-1-19-.19 Converting from Full-time to Part-time Enrollment 1640-1-19-.20 Personal or Medical Leave of Absence 1640-1-19-.21 Military Mobilization of Eligible Students 1640-1-19-.22 Calculation of Postsecondary Cumulative Grade Point Average 1640-1-19-.23 Transfer Students 1640-1-19-.24 Transient Students 1640-1-19-.25 Denial of Initial Eligibility – Failure to Timely Enroll 1640-1-19-.26 Appeal and Exception Process	Will Burns TN Higher Education Commission Suite 1900 Parkway Twrs 404 James Robertson Pkwy Nashville TN 37243 (615) 741-7571	Mar 30, 2006

ANNOUNCEMENTS

SEQ. NO.	DATE FILED	DEPARTMENT AND DIVISION	TYPE OF FILING	DESCRIPTION	RULE NUMBER AND RULE TITLE	LEGAL CONTACT	EFFECTIVE DATE
11-07	Nov 9 2005	0080 Agriculture Regulatory Services	Proposed Rules	New Rules	<i>Chapter 0080-6-26</i> <i>Rules and Regulations Governing Quarantine of Sudden Oak Death (Phytophthora ramorum)</i> 0080-6-26-.01 Establishment and Purpose of Quarantine 0080-6-26-.02 Definitions 0080-6-26-.03 Regulated and Restricted Articles 0080-6-26-.04 Quarantined Areas 0080-6-26-.05 Conditions Governing the Intrastate Movement of Regulated and Restricted Articles From Quarantined Areas 0080-6-26-.06 Issuance and Cancellation of Certificates 0080-6-26-.07 Compliance Agreements and Cancellation 0080-6-26-.08 Assembly and Inspection of Regulated Articles 0080-6-26-.09 Attachment and Disposition of Certificates 0080-6-26-.10 Treatments 0080-6-26-.11 Inspection and Sampling Protocol 0080-6-26-.12 Penalty	Phyllis Childs General Counsel Department of Agriculture P. O. Box 40627 Nashville, TN 37204 615-837-5280	Mar 30, 2006

ANNOUNCEMENTS

SEQ. NO.	DATE FILED	DEPARTMENT AND DIVISION	TYPE OF FILING	DESCRIPTION	RULE NUMBER AND RULE TITLE	LEGAL CONTACT	EFFECTIVE DATE
11-09	Nov 9, 2005	1180 Psychology	Rulemaking Hearing Rules	Amendments	<p><i>Chapter 1180-1</i> <i>General Rules Governing the Practice of Psychologists Senior Psychological Examiners Psychological Examiners and Certified Psychological Assistants</i></p> <p>1180-1-.01 Definitions 1180-1-.03 Fees 1180-1-.05 Renewal of License or Certification 1180-1-.07 Retirement and Reactivation of License or Certificate 1180-1-.08 Continuing Education</p> <p><i>Chapter 1180 2</i> <i>Rules Governing Psychologists</i></p> <p>1180-2-.03 Procedures for Licensure 1180-2-.04 Examinations 1180-2-.05 Temporary License 1180-2-.06 Provisional License 1180-2-.07 Free Health Clinic and Volunteer Practice Requirements</p> <p><i>Chapter 1180 3</i> <i>Rules Governing Psychological Examiners and Senior Psychological Examiners</i></p> <p>1180-3-.03 Procedures for Licensure 1180-3-.04 Examinations 1180-3-.05 Temporary License</p>	Nicole Armstrong Health OGC 26th Fl TN Twr 312 8th Ave N Nashville TN 37247-0120 (615) 741-1611	Jan 23, 2006
11-10	Nov 10, 2005	1720 UT UT Knoxville	Proposed Rules	Amendments	<p><i>Chapter 1720</i> <i>Traffic and parking Penalties</i></p> <p>1720-4-5-.07 Penalties</p>	Ronald C. Leadbetter Associate General Counsel UT Office of Vice President General Counsel and Secretary 719 Andy Holt Tower Knoxville TN 37996-0170 (865) 974-3247	Mar 30, 2006
11-11	Nov 10, 2005	1720 UT UT Knoxville	Proposed Rules	Amendments	<p><i>Chapter 1720-4-6</i> <i>Library Fines</i></p> <p>1720-4-6-.01 For Regular Loans 1720-4-6-.02 For Reserve Books Media And Equipment. 1720-4-6-.03 Lost Items And Equipment 1720-4-6-.07 Recalls</p>	Ronald C. Leadbetter Associate General Counsel UT Office of Vice President General Counsel and Secretary 719 Andy Holt Tower Knoxville TN 37996-0170 (865) 974-3247	Mar 30, 2006

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SEQ. NO.	DATE FILED	DEPARTMENT AND DIVISION	TYPE OF FILING	DESCRIPTION	RULE NUMBER AND RULE TITLE	LEGAL CONTACT	EFFECTIVE DATE
11-12	Nov 10,, 2005	1720 UT UT Martin	Proposed Rules	New Rules	<i>Chapter 1720-5-4</i> <i>Student Housing Regulations</i> 1720-5-4-.01 Housing Requirement 1720-5-4-.02 Classification (For Housing Purposes Only) 1720-5-4-.03 Types of Differentiated Housing 1720-5-4-.04 Separate Accommodations By Sex 1720-5-4-.05 Judicial Proceedings 1720-5-4-.06 Room Painting 1720-5-4-.07 Period of Occupancy 1720-5-4-.08 Residence Hall Safety Regulations 1720-5-4-.09 TeRule Making ination of Housing Contract 1720-5-4-.10 Pregnancy	Ronald C. Leadbetter Associate General Counsel UT Office of Vice President General Counsel and Secretary 719 Andy Holt Tower Knoxville TN 37996-0170 (865) 974-3247	Mar 30, 2006
11-14	Nov 15,, 2005	0620 Finance and Administration Bureau of TennCare	Rulemaking Hearing Rules	Amendment	<i>Chapter 1200-13-14</i> <i>TennCare Standard</i> 1200-13-14-.14 Tennncare Partners State-Only Program	George Woods Bureau of TennCare 310 Great Circle Road Nashville TN 37243 (615) 507-6446	Jan 29, 2006
11-15	Nov 15, 2005	0620 Finance and Administration Bureau of TennCare	Rulemaking Hearing Rules	Amendment	<i>Chapter 1200-13-13</i> <i>TennCare Medicaid</i> <i>Tennncare Partners State-Only Program</i> 1200-13-13-.14 Tennncare Partners State-Only Program	George Woods Bureau of TennCare 310 Great Circle Road Nashville TN 37243 (615) 507-6446	Jan 29, 2006
11-17	Nov 16, 2005	0080 Agriculture Regulatory Services	Proposed Rules	Amendments	<i>Chapter 0080-2-1</i> <i>Health Requirements for Admission and Transportation of Livestock and Poultry</i> 0080-2-1-.01 Definitions	Phyllis Childs General Counsel Department of Agriculture P.O. Box 40627 Nashville Tennessee 37204 615-837-5093	Mar 30, 2006
11-18	Nov 16,, 2005	0080 Agriculture Division of Regulatory Services	Proposed Rules	Amendments	<i>Chapter 0080-2-3</i> <i>Rules and Regulations Governing Movement and Handling of Livestock at Fairs and Exhibitions</i> 0080-2-3-.01 General 0080-2-3-.02 Definitions 0080-2-3-.03 Cattle 0080-2-3-.04 Swine 0080-2-3-.05 Poultry 0080-2-3-.06 Horses and Other Equidae 0080-2-3-.07 Sheep 0080-2-3-.08 Goats 0080-2-3-.09 Camelids 0080-2-3-.10 Captive Cervidae 0080-2-3-.11 Imported Livestock and Poultry 0080-2-3-.12 Enforcement	Phyllis Childs General Counsel Department of Agriculture P.O. Box 40627 Nashville Tennessee 37204 615-837-5093	Mar 30, 2006

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SEQ. NO.	DATE FILED	DEPARTMENT AND DIVISION	TYPE OF FILING	DESCRIPTION	RULE NUMBER AND RULE TITLE	LEGAL CONTACT	EFFECTIVE DATE
11-19	Nov 16, 2005	1200 Health Bureau of Health Licensure and Regulation Division of Emergency Medical Services	Rulemaking Hearing Rules	Amendments	<i>Chapter 1200-12-1 General Rules</i> 1200-12-1-.03 Emergency Medical Services Equipment and Supplies	Juanita Presley Health OGC TN Twr 26th Fl 312 8th Ave N Nashville TN 37247-0120 (615) 741-1611	Jan 30, 2006
11-20	Nov 16, 2005	1200 Health Bureau of Health Licensure and Regulation Division of Emergency Medical Services	Rulemaking Hearing Rules	Amendments	<i>Chapter 1200-12-1 General Rules</i> 1200-12-1-.16 Emergency Medical First Responders	Richard F. Russell Health OGC TN Twr 26th Fl 312 8th Ave N Nashville TN 37247-0120 (615) 741-1611	Jan 30, 2006

ANNOUNCEMENTS

SEQ. NO.	DATE FILED	DEPARTMENT AND DIVISION	TYPE OF FILING	DESCRIPTION	RULE NUMBER AND RULE TITLE	LEGAL CONTACT	EFFECTIVE DATE
11-21	Nov 16, 2005	0800 Labor and Workforce Development Workers' Compensation	Public Necessity Rules	New Rules	<p><i>Chapter 0800-2-17</i> <i>Medical Cost Containment Program</i></p> <p>0800-2-17-.01 Purpose and Scope 0880-2-17-.02 Severability and Preemption 0800-2-17-.03 Definitions 0800-2-17-.04 InfoRule Making ation Program Involving Rules 0800-2-17-.05 Procedure Codes/Adoption of CMS' Medicare Procedures Guidelines and Amounts 0800-2-17-.06 Procedures for Which Codes Are Not Listed 0800-2-17-.07 Modifier Codes 0800-2-17-.08 Total Procedures Billed Separately 0800-2-17-.09 Independent Medical Examination to Evaluate Medical Aspects of Case 0800-2-17-.10 Payment 0800-2-17-.11 Reimbursement for Employee-Paid Services 0800-2-17-.12 Recovery of Payment 0800-2-17-.13 Penalties for Violations of Fee Schedule Rules 0800-2-17-.14 Missed Appointment 0800-2-17-.15 Medical Report of Initial Visit & Progress Reports for Other than Inpatient Hospital Care 0800-2-17-.16 Additional Reports 0800-2-17-.17 Deposition/Witness Fee Limitation 0800-2-17-.18 Out-of-State Providers 0800-2-17-.19 Preauthorization 0800-2-17-.20 Process for Resolving Differences Between Carriers and Providers Regarding Bills 0800-2-17-.21 Administrative Review of Fee Schedule Disputes/Hearings 0800-2-17-.22 Utilization Review 0800-2-17-.23 Rule Review 0800-2-17-.24 Provider and Facility Fees for Copies of Medical Records 0800-2-17-.25 Penalties for Violations of Fee Schedule Rules and Medical Cost Containment Program Rules</p>	E. Blaine Sprouse Workers' Compensation Labor & Workforce Development A Johnson Twr 2nd Fl 710 James Robertson Pkwy Nashville TN 37243-0661 (615) 253-0064	Nov 16, through April 30, 2006

ANNOUNCEMENTS

SEQ. NO.	DATE FILED	DEPARTMENT AND DIVISION	TYPE OF FILING	DESCRIPTION	RULE NUMBER AND RULE TITLE	LEGAL CONTACT	EFFECTIVE DATE
11-22	Nov 16, 2005	0800 Labor and Workforce Development Division of Workers' Compensation	Public Necessity Rules	New Rules	<i>Chapter 0800-2-18 Medical Fee Schedule</i> 0800-2-18-.01 Medicare-basis for System Applicability Effective Date and Coding References 0800-2-18-.02 General Information and Instructions for Use 0800-2-18-.03 General Guidelines 0800-2-18-.04 Surgery Guidelines 0800-2-18-.05 Anesthesia Guidelines 0800-2-18-.06 Injections Guidelines 0800-2-18-.07 Ambulatory Surgical Centers and Outpatient Hospital Care (Including Emergency Room Facility Charges) 0800-2-18-.08 Chiropractic Services Guidelines 0800-2-18-.09 Physical and Occupational Therapy Guidelines 0800-2-18-.10 Durable Medical Equipment Guidelines 0800-2-18-.11 Orthotics Prosthetics and Implants Guidelines 0800-2-18-.12 Pharmacy Making Schedule Guidelines 0800-2-18-.13 Ambulance Services Guidelines 0800-2-18-.14 Clinical Psychological Service Guidelines 0800-2-18-.15 Penalties for Violations of Fee Schedules	E. Blaine Sprouse Workers' Compensation Labor & Workforce Development A Johnson Twr 2nd Fl 710 James Robertson Pkwy Nashville TN 37243-0661 (615) 253-0064	Nov 16, 2005 through April 30, 2006
11-23	Nov 16,, 2005	0800 Labor and Workforce Development Division of Workers' Compensation	Public Necessity Rules	New Rules	<i>Chapter 0800-2-19 In-Patient Hospital Fee Schedule</i> 0800-2-19-.01 General Rules 0800-2-19-.02 Definitions 0800-2-19-.03 Special Ground Rules – Inpatient Hospital Services 0800-2-19-.04. Preauthorization 0800-2-19- 05 Other Services 0800-2-19-.06 Penalties for Violations of Fee Schedules	E. Blaine Sprouse Workers' Compensation Labor & Workforce Development A Johnson Twr 2nd Fl 710 James Robertson Pkwy Nashville TN 37243-0661 (615) 253-0064	Nov 16, 2005 through April 30, 2006

ANNOUNCEMENTS

SEQ. NO.	DATE FILED	DEPARTMENT AND DIVISION	TYPE OF FILING	DESCRIPTION	RULE NUMBER AND RULE TITLE	LEGAL CONTACT	EFFECTIVE DATE
11-24	Nov 16, 2004	0800 Labor and Workforce Development Division of Workers' Compensation	Public Necessity Rules	New Rules	<p><i>Chapter 0800-2-20</i> <i>Medical Impairment Rating Registry Program</i></p> <p>0800-2-20-.01 Definitions 0800-2-20-.02 Purpose and scope 0800-2-20-.03 Severability and Preemption 0800-2-20-.05 Application Procedures for Physicians to Join the Registry 0800-2-20-.06 Requests for a MIR Registry Three-Physician List 0800-2-20-.07 Payments/Fees 0800-2-20-.08 Multiple Impairment Rating Evaluations 0800-2-20-.09 Communication with Registry Physicians 0800-2-20-.10 Requirements for the Evaluation 0800-2-20-.11 Requirements for the "MIR Impairment Rating Report" 0800-2-20-.13 Removal of a Physician from the Registry 0800-2-20-.15 Time Limits 0800-2-20-.16 Claimant Cooperation 0800-2-20-.17 Overturning a MIR Physician's Opinion</p>	E. Blaine Sprouse Workers' Compensation Labor & Workforce Development A Johnson Twr 2nd Fl 710 James Robertson Pkwy Nashville TN 37243-0661 (615) 253-0064	Nov 16, 2005 through April 30, 2006

ANNOUNCEMENTS

SEQ. NO.	DATE FILED	DEPARTMENT AND DIVISION	TYPE OF FILING	DESCRIPTION	RULE NUMBER AND RULE TITLE	LEGAL CONTACT	EFFECTIVE DATE
11-25	Nov 17, 2005	0400 Environment and Conservation Division of Radiological Health	Rule Making Hearing Rules	New Rules	<p><i>Chapter 1200-2-5</i> <i>Standards for Protection Against Radiation</i> 1200-2-5-.94 Application for Use of Higher Assigned Protection Factors</p> <p><i>Chapter 1200-2-12</i> <i>Radiation Safety Requirements for Well Logging</i> 1200-2-12-.27 Energy Compensation Source 1200-2-12-.28 Tritium Neutron Generator Target</p>	Alan Leiserson TDEC GOC L & C Twr 20th Fl 401 Church St Nashville TN 37243-1548 615-532-0131	Jan 31, 2006
			Amendments	<p><i>Chapter 1200-2-5</i> <i>Standards for Protection Against Radiation</i></p> <p><i>Chapter 1200-2-7</i> <i>Use of Sealed Radioactive Sources in the Healing Arts</i></p> <p><i>Chapter 1200-2-8</i> <i>Radiation Safety Requirements for Industrial Radiography</i></p> <p><i>Chapter 1200-2-10</i> <i>Licensing and Registration</i></p> <p><i>Chapter 1200-2-12</i> <i>Radiation Safety Requirements for Well Logging</i></p>			

ANNOUNCEMENTS

SEQ. NO.	DATE FILED	DEPARTMENT AND DIVISION	TYPE OF FILING	DESCRIPTION	RULE NUMBER AND RULE TITLE	LEGAL CONTACT	EFFECTIVE DATE
11-26	Nov 17, 2005	0400 Environment and Conservation Division of Radiological Health	Rule Making Hearing Rules	New Rule	<i>Chapter 1200-2-5 Standards for Protection Against Radiation 1200-2-5-.162 Type X Quantities and Transport Groups</i>	Alan Leiserson TDEC GOC L & C Twr 20th Fl 401 Church St Nashville TN 37243-1548 615-532-0131	Jan 31, 2006
				Amendments	<i>Chapter 1200-2-4 General Provisions</i>		
					<i>Chapter 1200-2-5 Standards for Protection Against Radiation</i>		
					<i>Chapter 1200-2-6 Use of X-Ray Apparatus</i>		
					<i>Chapter 1200-2-7 Use of Sealed Radioactive Sources in the Healing Arts</i>		
					<i>Chapter 1200-2-8 Radiation Safety Requirements for Industrial Radiography Operations</i>		
					<i>Chapter 1200-2-9 Requirements for Accelerators</i>		
					<i>Chapter 1200-2-10 Licensing and Registration</i>		
					<i>Chapter 1200-2-11 Licensing Requirements for Land Disposal of Radioactive Waste</i>		
					<i>Chapter 1200-2-12 Radiation Safety Requirements for Well Logging</i>		
				Repeals	1200-2-5-.01 through 1200-2-5-.29		

ANNOUNCEMENTS

SEQ. NO.	DATE FILED	DEPARTMENT AND DIVISION	TYPE OF FILING	DESCRIPTION	RULE NUMBER AND RULE TITLE	LEGAL CONTACT	EFFECTIVE DATE
11-27	Nov 17, 2005	0400 Environment and Conservation Division of Ground Water Protection	Rule Making Hearing Rules	Amendments	<i>Chapter 1200-1-6</i> <i>Regulations to Govern Subsurface Sewage Disposal Systems</i> 1200-1-6-.01 Definitions 1200-1-6-.02 Subdivisions 1200-1-6-.03 Additional Site Requirements and Limitations for Subdivision Approval And Issuance of Construction PeRule Making it 1200-1-6-.04 Percolation Test Procedures 1200-1-6-.05 Construction PeRule Making it 1200-1-6-.06 Design of Conventional Disposal Field 1200-1-6-.07 Septic Tank Capacity 1200-1-6-.08 Design of Septic Tanks 1200-1-6-.09 Effluent Treatment Devices/Systems 1200-1-6-.10 Location of Septic Tanks Dosing Chambers and Absorption Fields 1200-1-6-.11 Design of Dosing Systems 1200-1-6-.12 Maintenance of the Subsurface Sewage Disposal System 1200-1-6-.13 Grease Traps 1200-1-6-.14 Alternative Methods of Subsurface Sewage Disposal 1200-1-6-.15 Experimental Methods of Treatment and Disposal other Than Those in These Regulations 1200-1-6-.16 Privies and Composting Toilets 1200-1-6-.17 Approved Soil Consultants 1200-1-6-.18 Installer of Subsurface Sewage Disposal Systems 1200-1-6-.19 Septic Tank Pumping Contractor 1200-1-6-.20 Domestic Septage Disposal 1200-1-6-.21 Fees for Services 1200-1-6-.22 General Provisions	Dan E. Hoover Ground Water Protection 10th fl L&C Twr 401 Church St Nashville TN 37243-1540 615-532-0772	Jan 31, 2006
11-29	Nov 29, 2005	0400 Environment and Conservation Tennessee Petroleum Underground Storage Tank Board	Rule Making Hearing Rules	Amendments	<i>Chapter 1200-1-15</i> <i>Underground Storage Tank Program</i> 1200-1-15-.01 Program Scope and Minimum Requirements for Tanks 1200-1-15-.09 Administrative Guidelines and Procedures for the TN Petroleum Undergropund Storage Tank Fund	Alan Leiserson TDEC GOC L & C Twr 20th Fl 401 Church St Nashville TN 37243-1548 615-532-0131	Feb 12, 2006

ANNOUNCEMENTS

TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY - 0720

NOTICE OF BEGINNING OF REVIEW CYCLE

Visit the Tennessee Health Services and Development Agency web site at: <http://www.state.tn.us/hsda/> for the latest Notice of Beginning of Review Cycle.

ANNOUNCEMENTS

BOARD OF MEDICAL EXAMINERS - 0880

**PETITION FOR DECLARATORY ORDER
NOTICE OF HEARING**

There will be a hearing before the Tennessee Board of Medical Examiners to consider a petition for a declaratory order pursuant to T.C.A. §§ 4-5-223 and 4-5-224. The hearing will be conducted as a contested case and in the manner prescribed by the Uniform Administrative Procedures Act, Tennessee Code Annotated, Section 4-5-301 et seq. It will take place in the Cumberland Room on the Ground Floor of the Cordell Hull Building located at 425 5th Avenue North, Nashville, Tennessee commencing at 1:30 p.m. C.S.T. on January 24, 2006.

Petitioner's Name: Tennessee Hospital Association

Petitioner's Address: c/o William B. Hubbard
Hubbard, Berry, Doughty, Harris & Barrick, PLLC
SunTrust Bank Building
201 Fourth Avenue, North, Suite 1420
Nashville, TN 37219

Whom the Petitioner represents:

The Tennessee Hospital Association is a voluntary membership organization comprised of over 200 health-care facilities, including hospitals and hospital based ambulatory surgical treatment centers. THA represents the interests of over 80% of the hospitals, approximately 145 hospitals and health systems, located in the State of Tennessee. Inpatient and outpatient surgery is performed at 88% of our members except for very small acute care facilities and the few mental health or rehabilitation specialty hospitals. About 10% of the hospitals and health systems either own or joint venture in an ambulatory surgical treatment center.

SUMMARY OF RELIEF REQUESTED:

"The Tennessee Hospital Association (THA) submits this Petition for a Declaratory Order to have the Office Based Surgery Rules designated as 0880-2-.21 declared invalid" because the "THA does not believe that the BME has the statutory authority to promulgate these Rules."

Citation to statutes and rules which the agency will interpret and/or upon which the agency will base its decision:

The Tennessee Hospital Association contents that no statutes exist that authorize the Board to promulgate the office based surgery rules. Consequently, the entirety of Chapter 6 of Title 63 of the Tennessee Code Annotated as well as those other statutes indicative of legislative intent will be the statutes the Board will interpret and/or upon which it will base its decision as to whether statutory authority exists.

The notice of declaratory order set out herein was properly filed in the Department of State on the 22nd day of November, 2005. (11-35)

ANNOUNCEMENTS

OFFICE OF SURFACE MINING (OSM), UNITED STATES DEPARTMENT OF THE INTERIOR

NOTICE OF RECEIPT OF A LANDS UNSUITABLE FOR MINING PETITION

On November 10, 2005, the National Parks and Conservation Association and the Wariota Chapter of the National Audubon Society, etal petitioned the Office of Surface Mining (OSM), United States Department of the Interior, to designate an area located in the New River watershed and those areas identified as preferred Cerulean Warbler habitat in the New River watershed, the East Sundquist Wildlife Management Area (WMA), Frozen Head State Park and portions of the Royal Blue WMA that fall outside of the New River watershed in Anderson, Campbell, Morgan, and Scott Counties, Tennessee, as unsuitable for surface coal mining operations pursuant to the Surface Mining Control and Reclamation Act of 1977 (Public Law 95-87). The petition as accepted is more than a 90 page document with 459 pages of exhibits. The Federal Program for Tennessee, as administered by OSM, applies to all surface coal mining operations in Tennessee including the processing of lands unsuitable for mining petition (49 FR, 33874 October 1, 1984).

The petition area occupies approximately 283,834 acres of the New River watershed and adjacent WMA's preferred Cerulean Warbler habitat in Anderson, Campbell, Morgan and Scott Counties.

The major allegations of the petition can be summarized as follows:

1. Surface coal mining operations will not be reclaimed because it is not technologically or economically feasible;
2. Surface coal mining operations will affect fragile or historic lands, resulting in significant damage to important historic, cultural, scientific, and esthetic values and natural systems;
3. Surface coal mining operations would be incompatible with existing state or local land use plans or programs;
4. Surface coal mining operations would affect renewable resource lands, resulting in a substantial loss or reduction of long-range productivity of a public water supply; and
5. Surface coal mining operations would affect natural hazard lands that could substantially endanger life and property.

Copies of the petition are available upon request from the OSM's Knoxville Field Office at 710 Locust Street, 2nd Floor, Knoxville, Tennessee 37902. The public record on the petition is available for review during normal working hours at the OSM office listed above,

For further information contact: Gary Tucker at the OSM office listed above or telephone (865) 545-4103, extension 179.

EMERGENCY RULES

EMERGENCY RULES NOW IN EFFECT

FOR TEXT OF EMERGENCY RULE SEE T.A.R. CITED

- 0080 - Department of Agriculture - Division of Animal Industries - Emergency rules promulgated in response to the threat of Vesicular Stomatitis introduction into the State of Tennessee, Chapter 0080-2-1 Health Requirements for Admission and Transportation of Livestock and Poultry, 8 T.A.R., Volume 31, Number 8 (August 2005) - Filed July 25, 2005; effective through January 6, 2006. (07-25)
- 0400 - Department of Environment and Conservation - Division of Underground Storage Tanks - Emergency rules addressing nonmetallic underground piping connected to petroleum underground storage tanks, Chapter 1200-1-15 Underground Storage Tanks, 11 T.A.R., Volume 31, Number 11 (November 2005) - Filed October 28, 2005; effective through April 11, 2006. (10-37)
- 0780 - Department of Commerce and Insurance - Division of Insurance - Emergency Rules promulgated with respect to proper standards for health insurance issuers in paying insurance producers that sell contracts of health insurance coverage, Chapter 0780-1-88 TN Health Insurance Portability, Availability and Renewability Regulations, 8 T.A.R., Volume 31, Number 8 (August 2005) - Filed July 26, 2005; effective through January 7, 2006. (07-32)
- 0800 - Department of Labor - Division of Boiler and Elevator Inspection - Emergency Rule regarding the standards for the emergency keyed lock box in elevators, Chapter 0800-3-15 Fire Safety for Elevators, 11 T.A.R., Volume 31, Number 11 (November 2005) - Filed October 11, 2005; effective through March 25, 2006. (10-12)
- 1240 - Department of Human Services - Child Support Services Division - Emergency rules dealing with Income Shares Guidelines methodology, Chapter 1240-2-4 Child Support Guidelines, 11 T.A.R., Volume 31, Number 11 (November 2005) - Filed October 14, 2005; effective through March 28, 2006. (10-16)
- 1360 - Department of State - Division of Charitable Solicitations - Emergency rules regarding procedure for filing applications, amendments, and financial accounting reports for organizations exempt from federal taxation, Chapter 1360-3-2 Procedures for Operating Charitable Gaming Events, 9 T.A.R., Volume 31 Number 9 (September 2005) Filed August 11, 2005; effective through January 23, 2006. (08-14)

PROPOSED RULES

TENNESSEE DEPARTMENT OF AGRICULTURE - 0080 DIVISION OF REGULATORY SERVICES

CHAPTER 0080-2-1 HEALTH REQUIREMENTS FOR ADMISSION AND TRANSPORTATION OF LIVESTOCK AND POULTRY

Presented herein are proposed amendments of Division of Regulatory Services, Department of Agriculture submitted pursuant to T.C.A. § 4-5-202 in lieu of a rulemaking hearing. It is the intent of the Division of Regulatory Services, Department of Agriculture to promulgate these rules without a rulemaking hearing unless a petition requesting such hearing is filed within thirty (30) days of the publication date of the issue of the Tennessee Administrative Register in which the proposed amendments are published. Such petition to be effective must be filed with the Department of Agriculture, Box 40627, Nashville, Tennessee 37204, and the Department of State, 8th Floor, William R Snodgrass Tower, 312 Eighth Avenue North, Nashville, Tennessee 37243-0307, and must be signed by twenty-five (25) persons who will be affected by the amendments, or submitted by a municipality which will be affected by the amendments, or an association of twenty-five (25) or more members, or any standing committee of the General Assembly.

For copies of the entire text of the proposed amendments, contact: Dr. Ronald B. Wilson, State Veterinarian, Department of Agriculture, P. O. Box 40627, Nashville, Tennessee, 37204, 615-837-5120.

The text of the proposed amendments is as follows:

AMENDMENTS

Subparagraph (t) of Paragraph (1) of Rule 0080-2-1-.01 Definitions is amended by adding Part 4. so that, as amended, the subparagraph shall read:

- (t) Official Health Certificate
 - 1. An official health certificate is a legible record on a form adopted and approved for such use by the appropriate animal health official of the State of origin, prepared by an accredited veterinarian of the State of origin, certifying to the health of the animal(s) described thereon. Legal requirements shall not be met until an approved copy is forwarded by the appropriate animal health official of the State of origin to the Tennessee State Veterinarian.
 - 2. The health certificate shall list the name and address of the consignor and consignee and shall also reflect the origin and final destination of the animals if different. It shall include an accurate description sufficient for individual identification of the animal(s); this may include: age, sex, breed, tags, tattoos, and/or brands. It shall indicate the health status of the animals listed, including dates and results of required tests and dates of pertinent vaccinations.

PROPOSED RULES

3. Health certificates shall be void after thirty (30) days from date of issuance. No health certificate shall be issued except in compliance with all import requirements of the State of Tennessee, unless otherwise specifically authorized by the Tennessee State Veterinarian.
4. An Equine Interstate Event Permit (equine passport) is an official document, valid for 6 months, signed by the State Veterinarian, Chief Animal Health Officer, or equivalent, of the state issuing the permit. Permits must minimally include: the owner with complete address and phone number, the official Certificate of Veterinary Inspection number that was the basis for issuing the permit, a unique permit number issued by the state, the expiration date of the permit, date of issue of the official Certificate of Veterinary Inspection, a complete description of the horse including name of horse, breed, color, age, sex, date of the EIA test, laboratory performing test and laboratory accession number.

Rule 0080-2-1-.02 Paragraph (1) is amended by deleting the current language in its entirety and substituting the following language so that as amended the paragraph shall read:

- (1) All domestic animals imported into Tennessee, except poultry, or those expressly exempted herein, shall be accompanied by an official health certificate or other transportation document as recognized by the state veterinarian, which shall be in possession of the driver of the vehicle transporting such animals.

Rule 0080-2-1-.06 Paragraph (1) is amended by deleting the current language in its entirety and substituting the following language so that as amended the paragraph shall read:

- (1) Health Certificate – Horses, mules or other equidae transported into or through the State of Tennessee shall be accompanied by an official Health Certificate or Equine Interstate Event Permit (equine passport).

Authority: *T.C.A. §§ 44-2-102 and 4-3-203.*

The proposed rules set out herein were properly filed in the Department of State on the 16th day of November, 2005, and pursuant to the instructions set out above, and in the absence of the filing of a petition calling for a rulemaking hearing, will become effective on the 30th day of March, 2006. (11-17)

PROPOSED RULES

**TENNESSEE DEPARTMENT OF AGRICULTURE - 0080
DIVISION OF REGULATORY SERVICES**

**CHAPTER 0080-2-3
RULES AND REGULATIONS GOVERNING MOVEMENT AND
HANDLING OF LIVESTOCK AT FAIRS AND EXHIBITIONS**

Presented herein are proposed amendments of Division of Regulatory Services, Department of Agriculture submitted pursuant to T.C.A. § 4-5-202 in lieu of a rulemaking hearing. It is the intent of the Division of Regulatory Services, Department of Agriculture to promulgate these rules without a rulemaking hearing unless a petition requesting such hearing is filed within thirty (30) days of the publication date of the issue of the Tennessee Administrative Register in which the proposed amendments are published. Such petition to be effective must be filed with the Department of Agriculture, Box 40627, Nashville, Tennessee 37204, and the Department of State, 8th Floor, William R Snodgrass Tower, 312 Eighth Avenue North, Nashville, Tennessee 37243-0307, and must be signed by twenty-five (25) persons who will be affected by the amendments, or submitted by a municipality which will be affected by the amendments, or an association of twenty-five (25) or more members, or any standing committee of the General Assembly.

For copies of the entire text of the proposed amendments, contact: Dr. Ronald B. Wilson, State Veterinarian, Department of Agriculture, P. O. Box 40627, Nashville, Tennessee, 37204, 615-837-5120.

The text of the proposed rules and amendments is as follows:

AMENDMENTS

Chapter 0080-2-3 is amended by deleting the Chapter in its entirety and substituting the following language so that, as amended, the Chapter shall read:

**CHAPTER 0080-2-3
RULES AND REGULATIONS GOVERNING MOVEMENT AND
HANDLING OF LIVESTOCK AT FAIRS AND EXHIBITIONS**

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0080-2-3-.01	General
0080-2-3-.02	Definitions
0080-2-3-.03	Cattle
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0080-2-3-.07	Sheep
0080-2-3-.08	Goats
0080-2-3-.09	Camelids
0080-2-3-.10	Captive Cervidae
0080-2-3-.11	Imported Livestock and Poultry
0080-2-3-.12	Enforcement

PROPOSED RULES

0080-2-3-.01 GENERAL

- (1) All livestock which enter fairs and exhibitions shall be accompanied by an official veterinary health certificate with individual permanent identification or sufficient description to identify each animal. Certificates for this purpose shall be valid for ninety (90) days from date of issue.
- (2) All stalls, pens, chutes, etc., located on the grounds of fairs and exhibitions shall be thoroughly cleaned and disinfected with a disinfectant approved by USDA, APHIS between each scheduled fair or exhibition.
- (3) No animal showing clinical signs of infectious or communicable disease shall be allowed to enter or remain on premises of fair or exhibitions. It shall be the responsibility of the manager of each event to assure prompt removal of such animals.

Authority: T.C.A. §§ 4-3-203 and 44-2-102.

0080-2-3-.02 DEFINITIONS

- (1) For the purposes of these Rules, the "Definitions" outlined in Chapter 0080-2-1-.01 of the Published Rules of the Department of Agriculture shall apply unless otherwise indicated herein.

Authority: T.C.A. §§ 4-3-203 and 44-2-102

0080-2-3-.03 CATTLE

- (1) All cattle which enter fairs and exhibitions shall be accompanied by an official veterinary health certificate with individual permanent identification or sufficient description to identify each animal.

Authority: T.C.A. §§ 4-3-203 and 44-2-102.

0080-2-3-.04 SWINE

- (1) All swine which enter fairs and exhibitions shall be accompanied by an official veterinary health certificate with individual permanent identification or sufficient description to identify each animal.

Authority: T.C.A. §§ 4-3-203 and 44-2-102.

0080-2-3-.05 POULTRY

- (1) Sponsors of poultry shows or exhibitions shall notify the Tennessee Department of Agriculture at least thirty (30) days prior to such show or exhibition.

PROPOSED RULES

- (2) All poultry assembled at shows or exhibitions shall be accompanied by evidence of a negative test within ninety (90) days for Pullorum-Typhoid or shall originate directly from a flock which has been certified as Pullorum-Typhoid clean under the Tennessee Poultry Improvement Plan.
- (3) Poultry found not to be in apparent good health shall be removed immediately from any show or exhibition.

Authority: T.C.A. §§ 4-3-203 and 44-2-102.

0080-2-3-.06 HORSES AND OTHER EQUIDAE

- (1) Horses and other Equidae six (6) months of age and older which enter fairs and exhibitions must have a negative Equine Infectious Anemia test within the preceding twelve (12) months.

Authority: T.C.A. §§ 4-3-203 and 44-2-102.

0080-2-3-.07 SHEEP

- (1) Sheep which enter fairs and exhibitions must have an official veterinary health certificate as provided in Rule 0080-2-3-.01 (1) and meet the requirements of the National Scrapie Identification Program.

Authority: T.C.A. §§ 4-3-203 and 44-2-102.

0080-2-3-.08 GOATS

- (1) Goats which enter fairs and exhibitions must have an official veterinary health certificate as provided in Rule 0080-2-3-.01 (1) and meet the requirements of the National Scrapie Identification Program.

Authority: T.C.A. §§ 4-3-203 and 44-2-102.

0080-2-3-.09 CAMELIDS

- (1) Camelids which enter fairs and exhibitions must have an official veterinary health certificate as provided in Rule 0080-2-3-.01 (1).

Authority: T.C.A. §§ 4-3-203 and 44-2-102.

0080-2-3-.10 CAPTIVE CERVIDAE

- (1) Captive Cervidae which enter fairs and exhibitions must have an official veterinary health certificate as provided in Rule 0080-2-3-.01 (1).

Authority: T.C.A. §§ 4-3-203 and 44-2-102.

PROPOSED RULES

0080-2-3-.11 IMPORTED LIVESTOCK AND POULTRY

- (1) Domestic animals entering fairs and exhibitions from areas outside the State of Tennessee shall be subject to current Tennessee import requirements found in Chapter 0080-2-1 and any emergency rules in effect at the time which can be found on the Tennessee Department of Agriculture website: www.state.tn.us/agriculture.

Authority: T.C.A. §§ 4-3-203 and 44-2-102.

0080-2-3-.12 ENFORCEMENT

- (1) Fair association or exhibition management shall inform exhibitors of the rules of this chapter, and shall notify the State Veterinarian or his agent of any violation. Exhibitors shall present evidence of compliance with this chapter to the State Veterinarian or his agent upon request.
- (2) These Rules and Regulations in no way restrict fairs and exhibitions from establishing additional or more stringent health requirements.
- (3) Persons dealing with the movement and handling of domestic animals at fairs and exhibitions shall submit records for inspection and copies of documents immediately upon the request of the Commissioner or his agent.

Authority: T.C.A. §§ 4-3-203 and 44-2-102.

The proposed rules set out herein were properly filed in the Department of State on the 16th day of November, 2005, and pursuant to the instructions set out above, and in the absence of the filing of a petition calling for a rulemaking hearing, will become effective on the 30th day of March, 2006. (11-18)

PROPOSED RULES

**TENNESSEE DEPARTMENT OF AGRICULTURE - 0080
DIVISION OF REGULATORY SERVICES**

**CHAPTER 0080-6-26
RULES AND REGULATIONS GOVERNING
QUARANTINE OF SUDDEN OAK DEATH (PHYTOPHTHORA RAMORUM)**

Presented herein are proposed rules of Division of Regulatory Services, Department of Agriculture submitted pursuant to T.C.A. §4-5-202 in lieu of a rulemaking hearing. It is the intent of the Division of Regulatory Services, Department of Agriculture to promulgate these rules without a rulemaking hearing unless a petition requesting such hearing is filed within thirty (30) days of the publication date of the issue of the Tennessee Administrative Register in which the proposed amendments are published. Such petition to be effective must be filed with the Department of Agriculture, 440 Hogan Road, Nashville, Tennessee 37220, and the Department of State, 8th Floor, William R Snodgrass Tower, 312 Eighth Avenue North, Nashville, Tennessee 37243-0307, and must be signed by twenty-five (25) persons who will be affected by the amendments, or submitted by a municipality which will be affected by the amendments, or an association of twenty-five (25) or more members, or any standing committee of the General Assembly.

For copies of the entire text of the proposed rules, contact: Walker G. Haun, Plant Certification Administrator, Department of Agriculture, P. O. Box 40627, Nashville, Tennessee, 37204, 615-837-5338.

The text of the proposed rules is as follows:

NEW RULES

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0080-6-26-.01	Establishment and Purpose of Quarantine
0080-6-26-.02	Definitions
0080-6-26-.03	Regulated and Restricted Articles
0080-6-26-.04	Quarantined Areas
0080-6-26-.05	Conditions Governing the Intrastate Movement of Regulated and Restricted Articles From Quarantined Areas
0080-6-26-.06	Issuance and Cancellation of Certificates
0080-6-26-.07	Compliance Agreements and Cancellation
0080-6-26-.08	Assembly and Inspection of Regulated Articles
0080-6-26-.09	Attachment and Disposition of Certificates
0080-6-26-.10	Treatments
0080-6-26-.11	Inspection and Sampling Protocol
0080-6-26-.12	Penalty

0080-6-26-.01 ESTABLISHMENT AND PURPOSE OF QUARANTINE.

- (1) The destructive pathogen known as Sudden Oak Death, ramorum blight/dieback, *Phytophthora ramorum* has been intercepted in Tennessee and found established in other states. This pest can be extremely injurious to Tennessee forests and certain kinds of nursery stock; therefore, it would be in the best interest of man, agriculture and silviculture in Tennessee that a quarantine be established against this pest.
- (2) A quarantine against the above defined pest is hereby established to regulate the movement of certain articles capable of transporting the highly destructive pathogen known as *Phytophthora*

PROPOSED RULES

ramorum, into uninfected or unregulated areas of the state by regulating the movement of those articles that pose a significant threat of spreading *Phytophthora ramorum*.

Authority: T.C.A. § 43-6-104.

0080-6-26-.02 DEFINITIONS.

- (1) Bark chips: Bark fragments broken or shredded from a log or tree.
- (2) Commissioner: Means the Commissioner of Tennessee Department of Agriculture or the Commissioner's duly authorized agents.
- (3) Certificate: A document in which an inspector or person operating under a compliance agreement affirms that a specified regulated article meets the requirements of 0080-6-26-.06(1) of this subject and may be moved intrastate to any destination.
- (4) Compliance agreement: A written agreement between the Tennessee Department of Agriculture and a person engaged in growing, processing, handling, or moving regulated articles, wherein the person agrees to comply with this subpart.
- (5) Departmental permit: A document issued by the Commissioner in which he or she affirms that intrastate movement of the regulated article identified on the document is for scientific or experimental purposes and that the regulated article is eligible for intrastate movement in accordance with 0080-6-26-.05(1)(b) of this subpart.
- (6) Duff: Decaying plant matter that includes leaf litter, green waste, stem material, bark, and any other plant material that, upon visual inspection, does not appear to have completely decomposed into soil.
- (7) Firewood: Wood that has been cut, sawn, or chopped into a shape and size commonly used for fuel.
- (8) Forest stock: All flowers, trees, shrubs, vines, scions, buds, fruit pits, or other seeds of fruit and ornamental trees or shrubs that are wild-grown, backyard-grown, or naturally occurring and do not meet the definition of nursery stock, and that are not located on a nursery premises.
- (9) Inspector: Any employee of the Tennessee Department of Agriculture, Division of Regulatory Services, Plant Certification Section, and/or other person(s) authorized by the Commissioner to perform the duties required under this subpart.
- (10) Intrastate: Movement within the State of Tennessee
- (11) Log: The bole of a tree; trimmed timber that has not been sawn further than to form cants.
- (12) Lumber: Logs that have been sawn into boards, planks, or structural members such as beams.
- (13) Moved (move, movement): Shipped, offered for shipment, received for transportation, transported, carried, or allowed to be moved, shipped, transported or carried.

PROPOSED RULES

- (14) Mulch: Bark chips, wood chips, wood shavings, or sawdust, or a mixture thereof that could be used as a protective or decorative ground cover.
- (15) Nursery stock: All greenhouse or field-grown florist's stock, trees, shrubs, vines, cuttings, grafts, scions, buds, fruit pits, and other seeds of fruit and ornamental trees or shrubs, and other plants and plant products for propagation, except field, vegetable, and flower seeds, bedding plants, and other herbaceous plants, bulbs, and roots.
- (16) Person: Any association, company, corporation, firm, individual, joint stock company, partnership, society, or other entity.
- (17) Quarantined area: Any county, or any portion of a county in Tennessee, listed in 0080-6-26-.04 (3) of this subpart or otherwise designated as a quarantined area in accordance with 0080-6-26-.04 (2) of this subpart.
- (18) Regulated article: Any article listed in 0080-6-26-.03 (1) of this subpart.
- (19) Restricted article: Any article listed in 0080-6-26-.03 (2) of this subpart.
- (20) Soil: Any non-liquid combination of organic and/or inorganic material in which plants can grow.

Authority: T.C.A. § 43-6-104.

0080-6-26-.03 REGULATED AND RESTRICTED ARTICLES.

- (1) The following are regulated articles, and may be moved intrastate from a quarantined area only if accompanied by a certificate issued in accordance with the regulations in this subpart:
 - (a) Nursery stock (except acorns and seeds), unprocessed wood and wood products, and plant products, including firewood, logs, lumber, wreaths, garlands, and greenery of Alleghany = Willowood Viburnum (*Viburnum x rhytidophylloides*), Andrew's Clintonia Bead Lily (*Clintonia andrewsiana*), Arrowwood or Bodant Viburnum (*Viburnum x bodnantense*), Bay Laurel (*Laurus nobilis*), Bigleaf Maple (*Acer macrophyllum*), Burkwood Viburnum (*Viburnum x burkwoodii*), California Bay Laurel = Pepperwood = Oregon Myrtle (*Umbellularia californica*), California Black Oak (*Quercus kelloggii*), California Buckeye (*Aesculus californica*), California Coffeeberry (*Rhamnus californica*), California Hazelnut (*Corylus cornuta*), California Honeysuckle (*Lonicera hispidula*), California maidenhair fern (*Adiantum jordanii*), California wood fern (*Dryopteris arguta*), Camellia – all species, hybrids and cultivars (*Camellia* spp.), Canyon live oak (*Quercus chrysolepis*), Cascara (*Rhamnus purshiana*), Chinese Pieris (*Pieris Formosa* var. *forrestii*), Chinese witch-hazel (*Hamamelis mollis*), Coast Live Oak (*Quercus agrifolia*), Coast Redwood (*Sequoia sempervirens*), David Viburnum (*Viburnum davidii*), Doublefile Viburnum (*Viburnum plicatum* var. *tomentosum*), Douglas-fir (*Pseudotsuga menziesii* var. *menziesii*), Drooping leucothoe (*Leucothoe fontanesiana*), European Ash (*Fraxinus excelsior*), European beech (*Fagus sylvatica*), European cranberrybush Viburnum (*Viburnum opulus*), European Ewe (*Taxus baccata*), European Turkey Oak (*Quercus cerris*), False Solomon's Seal (*Maianthemum racemosa* = *Smilacina racemosum*), Formosa Firethorn (*Pyracantha koidzumii*), Fragrant Viburnum (*Viburnum farreri*= *V. fragans*), Goat willow (*Salix caprea*), Grand Fir (*Abies grandis*), Griselinia (*Griselinia littoralis*), Himalaya Pieris (*Pieris formosa*), Holm Oak (*Quercus ilex*),

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Horse Chestnut (*Aesculus hippocastanum*), huckleberry (*Vaccinium ovatum*), Iron tree (*Parrotia persica*), Japanese Pieris (*Pieris japonica*), Laurustinus (*Viburnum tinus*), Lilac (*Syringa vulgaris*), Loebner Magnolia (*Magnolia x loebneri*), Madrone (*Arbutus menziesii*), Manzanita (*Arctostaphylos manzanita*), Mountain laurel (*Kalmia latifolia*), Northern Red Oak (*Quercus rubra*), Pacific Yew (*Taxus brevifolia*), Pieris (*Pieris formoso* var. *forrestii* x *Pieris japonica*), Pieris "Brouwer's Beauty" (*Pieris floribunda* x *japonica*), Pieris "Forest Flame" (*Pieris Formosa* x *japonica*), Planetree Maple (*Acer pseudoplatanus*), Poison Oak (*Toxicodendron diversilobum*), Prague Viburnum (*Viburnum x pragense*), Red Tip Photinia (*Photinia fraseri*), Rhododendron (*Rhododendron* species, including *azalea*), Robel Beech (*Nothofagus obliqua*), Salmonberry (*Rubus spectabilis*), Saucer Magnolia (*Magnolia x soulangeana*), Scotch Heather (*Calluna vulgaris*), Shreve's oak (*Quercus parvula* var. *shrevei*), Southern Red Oak (*Quercus falcata*), Spicebush (*Calycanthus occidentalis*), Star Magnolia (*Magnolia stellata*), Strawberry tree (*Arbutus unedo*), Sweet Chestnut (*Castanea sativa*), Tanoak (*Lithocarpus densiflorus*), Toyon (*Heteromeles arbutifolia*), Viburnum (*Viburnum x carlcephalum* x *V. utile*), Victorian box (*Pittosporum undulatum*), Wayfaringtree Viburnum (*Viburnum lantana*), Western starflower (*Trientalis latifolia*), Winter's bark (*Drimys winteri*), Witch Hazel (*Hamamelis virginiana*), Wood Rose (*Rosa gymnocarpa*), Yew (*Taxus media*),

- (b) Soil.
 - (c) Any other product or article that an inspector determines to present a risk of spreading *Phytophthora ramorum*, if an inspector notifies the person in possession of the product or article that it is subject to the restrictions in the regulations.
- (2) The following are restricted articles, and may only be moved intrastate from a quarantined area by permit from the Tennessee Department of Agriculture for experimental or scientific purposes, and only in accordance with the regulations in 0080-6-26-.05 (1)(b) of this subpart:
- (a) Bark chips, forest stock, or mulch of Alleghany = Willowood Viburnum (*Viburnum x rhytidophylloides*), Andrew's Clintonia Bead Lily (*Clintonia andrewsiana*), Arrowwood or Bodant Viburnum (*Viburnum x bodnantense*), Bay Laurel (*Laurus nobilis*), Bigleaf Maple (*Acer macrophyllum*), Burkwood Viburnum (*Viburnum x burkwoodii*), California Bay Laurel = Pepperwood = Oregon Myrtle (*Umbellularia californica*), California Black Oak (*Quercus kelloggii*), California Buckeye (*Aesculus californica*), California Coffeeberry (*Rhamnus californica*), California Hazelnut (*Corylus cornuta*), California Honeysuckle (*Lonicera hispidula*), California maidenhair fern (*Adiantum jordanii*), California wood fern (*Dryopteris arguta*), Camellia – all species, hybrids and cultivars (*Camellia* spp.), Canyon live oak (*Quercus chrysolepis*), Cascara (*Rhamnus purshiana*), Chinese Pieris (*Pieris Formosa* var. *forrestii*), Chinese witch-hazel (*Hamamelis mollis*), Coast Live Oak (*Quercus agrifolia*), Coast Redwood (*Sequoia sempervirens*), David Viburnum (*Viburnum davidii*), Doublefile Viburnum (*Viburnum plicatum* var. *tomentosum*), Douglas-fir (*Pseudotsuga menziesii* var. *menziesii*), Drooping leucothoe (*Leucothoe fontanesiana*), European Ash (*Fraxinus excelsior*), European beech (*Fagus sylvatica*), European cranberrybush Viburnum (*Viburnum opulus*), European Ewe (*Taxus baccata*), European Turkey Oak (*Quercus cerris*), False Solomon's Seal (*Maianthemum racemosum* = *Smilacina racemosum*), Formosa Firethorn (*Pyracantha koidzumii*), Fragrant Viburnum (*Viburnum farreri* = *V. fragans*), Goat willow (*Salix caprea*), Griselinia (*Griselinia littoralis*), Grand Fir (*Abies grandis*), Himalaya Pieris (*Pieris formosa*), Holm Oak (*Quercus ilex*), Horse Chestnut (*Aesculus hippocastanum*), huckleberry (*Vaccinium ovatum*), Iron tree (*Parrotia persica*), Japanese Pieris (*Pieris japonica*), Laurustinus (*Viburnum tinus*), Lilac

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(Syringa vulgaris), Loebner Magnolia (Magnolia x loebneri) Madrone (Arbutus menziesii), Manzanita (Arctostaphylos manzanita), Mountain laurel (Kalmia latifolia), Northern Red Oak (Quercus rubra), Pacific Yew (Taxus brevifolia), Pieris (Pieris formoso var. forrestii x Pieris japonica), Pieris "Brouwer's Beauty"(Pieris floribunda x japonica), Pieris "Forest Flame" (Pieris Formosa x japonica), Planetree maple (Acer pseudoplatanus), Poison Oak (Toxicodendron diversilobum), Prague Viburnum (Viburnum x pragense), Red Tip Photinia (Photinia fraseri), Rhododendron (Rhododendron species, including azalea), Robel Beech (Nothofagus obliqua), Salmonberry (Rubus spectabilis), Saucer Magnolia (Magnolia x soulangeana), Scotch Heather (Calluna vulgaris), Shreve's oak (Quercus parvula var. shrevei), Southern Red Oak (Quercus falcata), Spicebush (Calycanthus occidentalis) Star Magnolia (Magnolia stellata), Strawberry tree (Arbutus unedo), Sweet Chestnut (Castanea sativa), Tanoak (Lithocarpus densiflorus), Toyon (Heteromeles arbutifolia), Viburnum (Viburnum x carlcephalum x V. utile), Victorian box (Pittosporum undulatum), Wayfaringtree Viburnum (Viburnum lantana), Western starflower (Trientalis latifolia), Winter's bark (Drimys winteri), Witch Hazel (Hamamelis virginiana), Wood Rose (Rosa gymnocarpa), Yew (Taxus media),

- (b) Any other product or article that an inspector determines to present a risk of spreading Phytophthora ramorum, if an inspector notifies the person in possession of the product or article that it is a restricted article.

Authority: T.C.A. §§ 43-6-104 and 43-6-106. *Administrative History.*

0080-6-26-.04 QUARANTINED AREAS.

- (1) Except as otherwise provided in paragraph (2) of this section, the Commissioner will list as a quarantined area in paragraph (3) of this section each County, or each portion of a County, in which Phytophthora ramorum has been found by an inspector, in which the Commissioner has reason to believe that Phytophthora ramorum is present, or that the Commissioner considers necessary to quarantine because of its inseparability for quarantine enforcement purposes from localities in which Phytophthora ramorum has been found. Less than an entire county will be designated as a quarantined area if the Commissioner determines that the designation of less than the entire county as a quarantined area will prevent the intrastate spread of Phytophthora ramorum.
- (2) The Commissioner may temporarily designate any non-quarantined area in the State as a quarantined area in accordance with paragraph (1) of this section. The Commissioner will give a copy of this regulation along with a written notice for the temporary designation to the owner or person in possession of regulated/restricted items that are within the temporary designated quarantined area. Thereafter, the intrastate movement of any regulated/restricted article from an area temporarily designated as a quarantined area will be subject to this subpart. As soon as practicable, this area will be added to the list in paragraph (3) of this section or the Commissioner will terminate the designation. The owner or person in possession of regulated/restricted articles for which designation is terminated will be given notice of the termination as soon as practicable.
- (3) The following areas are designated as quarantined areas: Currently, there are no quarantined areas in Tennessee.

Authority: T.C.A. §§ 43-6-104, 43-6-106.

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0080-6-26-.05 CONDITIONS GOVERNING THE INTRASTATE MOVEMENT OF REGULATED AND RESTRICTED ARTICLES FROM QUARANTINED AREAS.

Regulated articles and restricted articles may be moved intrastate from a quarantined area only if moved in accordance with this section. Requirements under all other applicable State and Federal domestic plant quarantines and regulations must also be met.

- (1) With a certificate or departmental permit.
 - (a) Any regulated articles may be moved intrastate from a quarantined area if accompanied by a certificate issued and attached in accordance with 0080-6-26-.06 and 0080-6-26-.09 of this subpart, and provided that the regulated article is moved through the quarantined area without stopping except for refueling, rest stops, emergency repairs, and for traffic conditions, such as traffic lights or stop signs.
 - (b) Any restricted article may be moved intrastate from a quarantined area for experimental or scientific purposes only if the article is moved:
 1. Pursuant to a departmental permit issued by the Commissioner for the article; and
 2. Under conditions specified on the departmental permit and found by the Commissioner to be adequate to prevent the spread of *Phytophthora ramorum*; and
 3. With a tag or label bearing the number of the departmental permit issued for the article attached to the outside of the container holding the article, or attached to the article itself if not in a container.
- (2) Without a certificate or departmental permit.
 - (a) The regulated or restricted article originated outside the quarantined area and the point of origin of the article is indicated on the waybill of the vehicle transporting the article; and
 - (b) The regulated or restricted article is moved from outside the quarantined area through the quarantined area without stopping except for refueling or for traffic conditions, such as traffic lights or stop signs, and the article is not unpacked or unloaded in the quarantined area.

Authority: *T.C. A. § 43-6-106.*

0080-6-26-.06 ISSUANCE AND CANCELLATION OF CERTIFICATES.

- (1) An inspector may issue a certificate for the intrastate movement of regulated articles if an inspector determines that:
 - (a) The regulated articles have been treated under the direction of an inspector in accordance with 0080-6-26-.10 of this subpart; or
 - (b) The regulated articles are wood products such as firewood, logs, or lumber that are free of bark; or

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- (c) The regulated article is soil that has not been in direct physical contact with any article infected with *Phytophthora ramorum*, and from which all duff has been removed.
 - (d) The regulated articles are articles of nursery stock that:
 - 1. Are shipped from a nursery or premises in a quarantined area that is inspected annually in accordance with the inspection and sampling protocol described in 0080-6-26-.11 (1) of this subpart, and that has been found free of *Phytophthora ramorum*; and
 - 2. Are part of a shipment of nursery stock that has been inspected prior to intrastate movement in accordance with 0080-6-26-.11 (2) of this subpart, and that has been found free of *Phytophthora ramorum*; and
 - 3. Have been kept separate from regulated articles not inspected between the time of the inspection and the time of intrastate movement; and
 - 4. Have not been grown in, or moved from, other areas within a quarantined area except nurseries or premises that are annually inspected for *Phytophthora ramorum* in accordance with this section, and that have been found free of *Phytophthora ramorum*.
 - (e) The regulated article is to be moved in compliance with any additional emergency conditions the Commissioner may impose under the Tennessee Plant Act to prevent the spread of *Phytophthora ramorum*; and
 - (f) The regulated article is eligible for unrestricted movement under all other State and Federal domestic plant quarantines and regulations applicable to the regulated article.
- (2) Certificates may be issued by any person engaged in the business of growing, processing, handling, or moving regulated articles provided such person has entered into and is operating under a compliance agreement. Any such person may execute and issue a certificate for the intrastate movement of regulated articles if an inspector has previously made the determination that the article is eligible for a certificate in accordance with 0080-6-26-.06 (1) of this subpart.
 - (3) Any certificate that has been issued may be withdrawn, either orally or in writing, by an inspector if he or she determines that the holder of the certificate has not complied with all conditions in this subpart for the use of the certificate. If the withdrawal is oral, the withdrawal and the reasons for the withdrawal will be confirmed in writing within 3 days. Any person whose certificate has been withdrawn may appeal the decision in writing to the Commissioner within 10 days after receiving the written notification of the withdrawal. The appeal must state all of the facts and reasons upon which the person relies to show that the certificate was wrongfully withdrawn. The Commissioner, or his designee, will hold a hearing within 30 days to resolve any conflict as to any material fact. The Commissioner or his designee, will grant or deny the appeal, in writing, stating the reasons for the decision, within 15 days of the date of the hearing.

Authority: T.C.A. § 43-6-106.

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0080-6-26-.07 COMPLIANCE AGREEMENTS AND CANCELLATION.

- (1) Any person engaged in growing, processing, handling, or moving regulated articles other than nursery stock may enter into a compliance agreement when an inspector determines that the person understands this subpart, agrees to comply with its provisions, and agrees to comply with all the provisions contained in the compliance agreement.
- (2) Any person engaged in growing, processing, handling, or moving regulated articles of nursery stock may enter into a compliance agreement when 0080-6-26-.06 (1)(d) requirements are met and a inspector determines that the person understands this subpart, agrees to comply with its provisions, and agrees to comply with all the provisions contained in the compliance agreement.
- (3) Any compliance agreement may be canceled, either orally or in writing, by an inspector whenever the inspector finds that the person who has entered into the compliance agreement has failed to comply with this subpart. If the cancellation is oral, the cancellation and the reasons for the cancellation will be confirmed in writing within 3 days. Any person whose compliance agreement has been canceled may appeal the decision, in writing, within 10 days after receiving written notification of the cancellation. The appeal must state all of the facts and reasons upon which the person relies to show that the compliance agreement was wrongfully canceled. The Commissioner, or his designee, will hold a hearing within 30 days to resolve any conflict as to any material fact. The Commissioner or his designee, will grant or deny the appeal, in writing, stating the reasons for the decision, within 15 days of the date of the hearing.

Authority: T.C.A. §§ 43-6-104, 43-6-106, 43-6-110.

0080-6-26-.08 ASSEMBLY AND INSPECTION OF REGULATED ARTICLES.

- (1) Any person (other than a person authorized to issue certificates under 0080-6-26-.06(2) of this subpart) who desires to move a regulated article intrastate accompanied by a certificate must notify an inspector as far in advance of the desired intrastate movement as possible, but no less than 14 days before the desired intrastate movement.
- (2) The regulated article must be assembled at the place and in the manner the inspector designates as necessary to comply with this subpart.

Authority: T.C.A. §§ 43-6-104, 43-6-106

0080-6-26-.09 ATTACHMENT AND DISPOSITION OF CERTIFICATES.

- (1) A certificate required for the intrastate movement of a regulated article must, at all times during the intrastate movement, be:
 - (a) Attached to the outside of the container containing the regulated article; or
 - (b) Attached to the regulated article itself if not in a container; or

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- (c) Attached to the consignee's copy of the accompanying waybill. If the certificate is attached to the consignee's copy of the waybill, the regulated article must be sufficiently described on the certificate and on the waybill to identify the regulated article.
- (2) The certificate for the intrastate movement of a regulated article must be relinquished by the carrier to the consignee listed on the certificate upon arrival at the location provided on the certificate.

Authority: T.C.A. §§ 43-6-104, 43-6-106

0080-6-26-.10 TREATMENTS.

The following methods may be used to treat the regulated articles listed for *Phytophthora ramorum*:

- (1) Soil must be heated to a temperature of at least 180° F for 30 minutes in the presence of an inspector.
- (2) Wreaths, garlands, and greenery of Alleghany = Willowood Viburnum (*Viburnum x rhytidophylloides*), Andrew's Clintonia Bead Lily (*Clintonia andrewsiana*), Arrowwood or Bodant Viburnum (*Viburnum x bodnantense*), Bay Laurel (*Laurus nobilis*), Bigleaf Maple (*Acer macrophyllum*), Burkwood Viburnum (*Viburnum x burkwoodii*), California Bay Laurel = Pepperwood = Oregon Myrtle (*Umbellularia californica*), Californina Black Oak (*Quercus kelloggii*), California Buckeye (*Aesculus californica*), California Coffeeberry (*Rhamnus californica*), California Hazelnut (*Corylus cornuta*), California Honeysuckle (*Lonicera hispidula*), California maidenhair fern (*Adiantum jordanii*), California wood fern (*Dryopteris arguta*), Camellia – all species, hybrids and cultivars (*Camellia* spp.), Canyon live oak (*Quercus chrysolepis*), Cascara (*Rhamnus purshiana*), Chinese Pieris (*Pieris Formosa* var. *forrestii*), Chinese witch-hazel (*Hamamelis mollis*), Coast Live Oak (*Quercus agrifolia*), Coast Redwood (*Sequoia sempervirens*), David Viburnum (*Viburnum davidii*), Doublefile Viburnum (*Viburnum plicatum* var. *tomentosum*), Douglas-fir (*Pseudotsuga menziesii* var. *menziesii*), Drooping leucothoe (*Leucothoe fontanesiana*), European Ash (*Fraxinus excelsior*), European beech (*Fagus sylvatica*), European cranberrybush Viburnum (*Viburnum opulus*), European Ewe (*Taxus baccata*), European Turkey Oak (*Quercus cerris*), False Solomon's Seal (*Maianthemum racemosa* = *Smilacina racemosum*), Formosa Firethorn (*Pyracantha koidzumii*), Fragrant Viburnum (*Viburnum farreri* = *V. fragans*), Goat willow (*Salix caprea*), Grand Fir (*Abies grandis*), Giselinia (*Griselinia littoralis*), Himalaya Pieris (*Pieris formosa*), Holm Oak (*Quercus ilex*), Horse Chestnut (*Aesculus hippocastanum*), huckleberry (*Vaccinium ovatum*), Irontree (*Parrotia persica*), Japanese Pieris (*Pieris japonica*), Laurustinus (*Viburnum tinus*), Lilac (*Syringa vulgaris*), Loebner Magnolia (*Magnolia x loebneri*), Madrone (*Arbutus menziesii*), Manzanita (*Arctostaphylos manzanita*), Mountain laurel (*Kalmia latifolia*), Northern Red Oak (*Quercus rubra*), Pacific Yew (*Taxus brevifolia*), Pieris (*Pieris formoso* var. *forrestii* x *Pieris japonica*), Pieris "Brouwer's Beauty" (*Pieris floribunda* x *japonica*), Pieris "Forest Flame" (*Pieris Formosa* x *japonica*), Planetree Maple (*Acer pseudoplatanus*), Poison Oak (*Toxicodendron diversilobum*), Prague Viburnum (*Viburnum x pragense*), Red Tip Photinia (*Photinia fraseri*), Rhododendron (*Rhododendron* species, including azalea), Robel Beech (*Nothofagus obliqua*), Salmonberry (*Rubus spectabilis*), Saucer Magnolia (*Magnolia x soulangeana*), Scotch Heather (*Calluna vulgaris*), Shreve's oak (*Quercus parvula* var. *shrevei*), Spicebush (*Calycanthus occidentalis*), Southern Red Oak (*Quercus falcata*), Star Magnolia (*Magnolia stellata*), Strawberry tree (*Arbutus unedo*), Sweet Chestnut (*Castanea sativa*), Tanoak (*Lithocarpus densiflorus*), Toyon (*Heteromeles arbutifolia*), Viburnum (*Viburnum x carlcephalum* x *V. utile*), Victorian box (*Pittosporum undulatum*), Wayfaringtree Viburnum (*Viburnum lantana*),

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Western starflower (*Trientalis latifolia*), Winter's bark (*Drimys winteri*), Witch Hazel (*Hamamelis virginiana*), Wood Rose (*Rosa gymnocarpa*), Yew (*Taxus media*) and must be dipped for 1 hour in water that is held at a temperature of at least 160° F.

Authority: T.C.A. §§ 43-6-104, 43-6-106.

0080-6-26-.11 INSPECTION AND SAMPLING PROTOCOL.

- (1) Annual nursery inspection and sampling. To meet the requirements of 0080-6-26.06 (1)(d) of this subpart, nurseries that ship regulated articles of nursery stock intrastate must be inspected for symptoms of *Phytophthora ramorum* annually in accordance with this section.
 - (a) If the nursery contains 100 or fewer regulated articles, an inspector will inspect each regulated article. If the nursery contains more than 100 regulated articles, an inspector will inspect 100 regulated articles and at least 2 percent of the number of regulated articles contained in the nursery that exceeds 100. The regulated articles to be inspected will be randomly selected from throughout the nursery.
 - (b) If symptomatic plants are found upon inspection, the inspector must collect at least one sample per symptomatic plant.
 - (c) If fewer than 40 symptomatic plants are found in a nursery during an annual inspection, the inspector must collect samples from non symptomatic regulated articles of nursery stock so that the total number of sampled plants is at least 40.
 - (d) Samples must be labeled and sent for testing to a laboratory approved by APHIS.
 - (e) If any regulated articles within a nursery are found to be infected with *Phytophthora ramorum*, the nursery will be prohibited from moving regulated articles intrastate until such time as an inspector can determine that the nursery is free of *Phytophthora ramorum*.
- (2) Inspection and sampling of individual shipments. To meet the requirements of 0080-6-26-.06 (1)(d) of this subpart, each shipment of regulated articles of nursery stock intended for intrastate movement must be inspected for symptoms of *Phytophthora ramorum* in accordance with this section.
 - (a) If a shipment contains 100 or fewer regulated articles, an inspector will inspect each regulated article. If a shipment contains more than 100 regulated articles, an inspector will inspect 100 regulated articles and at least 2 percent of the number of regulated articles contained in the shipment that exceeds 100. The regulated articles to be inspected will be randomly selected.
 - (b) If symptomatic plants are found upon inspection, the inspector will collect at least one sample per symptomatic plant, and one sample per regulated article of nursery stock that is in close proximity to or that has had physical contact with a symptomatic plant.
 - (c) Samples will be labeled and sent for testing to a laboratory approved by APHIS, and must be found free of *Phytophthora ramorum* prior to the intrastate movement of any regulated articles contained in the shipment.

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- (d) If any plants intended for intrastate movement are found to be infected with *Phytophthora ramorum*, the nursery from which they originate will be prohibited from moving regulated articles intrastate until such as time as an inspector can determine that the nursery is free of *Phytophthora ramorum*.

Authority: T.C.A. §§ 43-6-107, 43-6-110.

0080-6-26-.12 PENALTY.

Any person, firm, or corporation who shall violate any of the provisions of this quarantine shall be deemed guilty of a misdemeanor as provided in T.C.A. Section 43-6-112 of the Plant Pest Act, and shall be liable to the penalties as prescribed therein as well as applicable civil penalties found in chapter 0080-6-25.

The proposed rules set out herein were properly filed in the Department of State 9th day of November, 2005, and pursuant to the instructions set out above, and in the absence of the filing of an appropriate petition calling for a rulemaking hearing, will become effective on the 30 th day of March, 2006. (11-07)

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**TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT - 0800
DIVISION OF BOILER AND ELEVATOR INSPECTION
BOARD OF BOILER RULES**

**CHAPTER 0800-3-3
BOILER INSPECTIONS**

Presented herein are proposed amendments of the Department of Labor and Workforce Development, Division of Boiler and Elevator Inspection, Board of Boiler Rules, submitted pursuant to T.C.A. § 4-5-202 in lieu of a rulemaking hearing. It is the intent of the Department of Labor and Workforce Development to promulgate these amendments without a rulemaking hearing unless a petition requesting such hearing is filed within thirty (30) days of the publication date of the issue of the Tennessee Administrative Register in which the proposed amendments are published. Such petition to be effective must be filed in the Legal Division of the Department of Labor and Workforce Development, Andrew Johnson Tower, 2nd Floor, 710 James Robertson Parkway, Nashville, Tennessee 37243, and in the Administrative Procedures Division of the Department of State, William R. Snodgrass Tennessee Tower, 8th Floor, 312 8th Avenue North, Nashville, Tennessee, 37243-0310, and must be signed by twenty-five (25) persons who will be affected by the amendments, or submitted by a municipality which will be affected by the amendments, or an association of twenty-five (25) or more members, or any standing committee of the General Assembly.

For a copy of the proposed amendments, contact Mr. Gary Cookston, Director, Division of Boiler and Elevator Inspection, Tennessee Department of Labor and Workforce Development, Andrew Johnson Tower, 3rd Floor, 710 James Robertson Parkway, Nashville, Tennessee 37243-0663, telephone: (615) 532-1929.

The text of the proposed amendments is as follows:

AMENDMENTS

Rule 0800-3-3-.01 Definitions is amended by deleting the rule in its entirety and substituting the following language, so that as amended the rule shall read:

0800-3-3-.01 DEFINITIONS.

- (1) "Act" means the provisions of Tennessee Code Annotated (T.C.A.), Title 68, Chapter 122.
- (2) "Alteration" means a change in any item described on the original Manufacturer's Data Report which affects the pressure containing capability of the boiler or pressure vessel. Non-physical changes, such as an increase in the maximum allowable working pressure (internal or external), increase in design temperature, or a reduction in minimum temperature of a boiler or pressure vessel shall be considered an alteration.
- (3) "ANSI" means the American National Standards Institute.
- (4) "API" means the American Petroleum Institute.
- (5) "Approved" means approved by the Board of Boiler Rules.
- (6) "ASME Code" means the American Society of Mechanical Engineers Code.
- (7) "Authorized Inspection Agency" means:

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- (a) A jurisdiction as defined by paragraph (21) of this rule; or
 - (b) An insurance company which has been licensed or registered by the appropriate authority of a state of the United States or a province of Canada to write boiler and pressure vessel insurance and to provide all inspection services required by the Act for boilers and pressure vessels insured by such company in this State.
- (8) "Board" means the Board of Boiler Rules.
- (9) "Boiler" means and includes a closed vessel or vessels intended for use in heating water or other liquids or for generating steam or other vapors under pressure or vacuum by the direct application of heat from combustible fuels, electricity, or nuclear energy, and also includes an unfired pressure vessel, meaning a vessel in which pressure is obtained from an external source or from an indirect application of heat.
- (a) "Power boiler" means a boiler in which steam or other vapor is generated at a pressure of more than 15 psig.
 - (b) "High-temperature water boiler" means a water boiler intended for operation at pressures in excess of 160 psig or temperatures exceeding 250°F.
 - (c) "Heating boiler" means a steam or vapor boiler operating at pressures not exceeding 15 psig or a hot water boiler operating at pressures not exceeding 160 psig or temperatures not exceeding 250°F.
 - (d) "Electric boiler" means a power or heating boiler in which the source of heat is electricity.
 - (e) "Miniature boiler" means a power or high-temperature water boiler which does not exceed the following limits:
 - 1. 16 inches inside diameter of shell;
 - 2. 20 square feet of heating surface (not applicable to electric boilers);
 - 3. 5 cubic feet of gross volume exclusive of casing and insulation; and
 - 4. 100 psig maximum allowable working pressure.
 - (f) "Unfired steam boiler" means an unfired pressure vessel or system of unfired pressure vessels intended for operation at a pressure in excess of 15 psig steam for the purpose of producing and controlling an output of thermal energy.
 - (g) "Waste heat boiler" means an unfired pressure vessel or system of unfired pressure vessels intended for operation in excess of 15 psig steam for the purpose of producing and controlling an output of thermal energy.
 - (h) "Heat recovery boiler" means a vessel or system of vessels comprised of one or more heat exchanger surfaces used for the recovery of waste heat.

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- (i) "Steam heating boiler" means a steam boiler for operation at pressures not exceeding 15 psig.
 - (j) "Hot water heating boiler" means a boiler in which no steam is generated, from which hot water is circulated for heating purposes and then returned to the boiler, and which is operated at a pressure not exceeding 160 psig and/or a temperature of 250°F at or near the boiler outlet.
 - (k) "Hot water supply boiler" means a boiler completely filled with water that furnishes hot water to be used externally to itself at pressures not exceeding 160 psig and/or a temperature of 250°F at or near the boiler outlet.
 - (l) "Portable boiler" means a boiler which is primarily intended for temporary location, where the construction and usage permits it to be readily moved from one location to another.
 - (m) "Potable hot water heater" means a heater supplying potable water for commercial purposes in which the pressure does not exceed 160 psig and the temperature does not exceed 210°F.
- (10) "BTU/hr" means British Thermal Units per hour.
- (11) "Certificate inspection" means an inspection, the report of which is used by the Chief Inspector as justification for issuing, withholding, suspending or revoking a certificate of inspection. This certificate inspection shall be an internal inspection when required; otherwise, it shall be as complete an inspection as possible.
- (a) "Internal inspection" means an inspection that can reasonably be conducted on the internal and external surfaces of a boiler or pressure vessel while it is shut down and the manhole plates, handhole plates or other inspection opening closures are removed.
 - (b) "External inspection" means an inspection made when a boiler or pressure vessel is in operation, if possible.
- (12) "Certificate of competency" means a certificate issued to a person who has passed the examination prescribed by the Board pursuant to T.C.A. § 68-122-109.
- (13) "Certificate of inspection" means a certificate issued for operation of a boiler or pressure vessel as required in T.C.A. § 68-122-111.
- (14) "Commission" means the commission issued by the National Board of Boiler and Pressure Vessel Inspectors to a holder of a certificate of competency who desires to make shop or field inspections in accordance with the National Board Rules for Commissioned Inspectors, and whose employer submits the inspector's application to the National Board for such commission.
- (15) "Condemned boiler or pressure vessel" means a boiler or pressure vessel that has been inspected and declared unsafe, or disqualified by legal requirements, by an inspector qualified to take such action who has applied a stamping or marking designating its rejection.
- (16) "Department" means the Tennessee Department of Labor and Workforce Development.

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- (17) "Existing installation" means any boiler constructed, installed, placed in operation, or contracted for before July 1, 1955.
- (18) "Historic power boilers" means any steam traction engine, portable or stationary, standard or nonstandard power boiler, including free-lance and scale models, owned by publicly operated museums, non-profit organizations and individuals who preserve, maintain, exhibit and only occasionally operate these boilers on a not-for-profit basis and for the primary purpose of perpetuating the agricultural and pioneer heritage of the state of Tennessee.
- (19) "Inspector" means the Chief Inspector, Deputy Inspector, or Special Inspector.
- (a) Chief Inspector is the Chief Boiler and Pressure Vessel Inspector appointed pursuant to T.C.A. § 68-122-106.
- (b) Deputy Inspector is any inspector appointed pursuant to T.C.A. § 68-122-107.
- (c) Special Inspector is an inspector holding a Tennessee certificate of competency, and who is continuously employed by an insurance company authorized to insure against loss from explosion of boilers or pressure vessels in this State, or a company owning or operating pressure vessels (Owner-User Inspection Agency) in this State for the purposes of making inspections of pressure vessels used or to be used by such company, and provided such company complies with the requirements of T.C.A. § 68-122-108.
1. A special inspector shall receive no salary from, nor shall any of their expenses be paid by, the State, and the continuance of a special inspector's commission shall be conditioned upon the special inspector continuing in the employ of a boiler insurance company duly authorized as aforementioned or upon continuing in the employ of a company operating unfired pressure vessels in this State, and upon the special inspector's maintenance of the standards imposed by the Act.
 2. A special inspector of a company operating unfired pressure vessels shall not be authorized to inspect boilers.
 3. A special inspector shall inspect all boilers and unfired pressure vessels insured or all unfired pressure vessels operated by their respective companies and, when so inspected, the owners and users of such boilers and unfired pressure vessels shall be exempt from the payment to the State of the inspection fees as provided for in T.C.A. § 68-122-113.
 4. A special inspector shall submit inspection reports in accordance with paragraph (13) of this rule.
- (20) "Installation permit" means a permit issued by the Chief Inspector for authorization to install a boiler or pressure vessel in accordance with Rule 0800-3-3-.03(5).
- (21) "Jurisdiction" means a state, commonwealth, county or municipality of the United States or a province of Canada which has adopted one or more sections of the ASME Code, one of which is Section I, and maintains a duly constituted department, bureau or division for the purpose of enforcement of such Code.

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- (22) "Lethal service (pressure vessel)" means a pressure vessel stamped "lethal service" which contains, under pressure, poisonous gas or liquids of such a nature that a very small amount of the gas or of the vapor of the liquid mixed or unmixed with air is dangerous to life when inhaled.
- (23) "Licensed boiler and pressure vessel contractor" means a person, corporation, partnership or firm authorized to engage in the erection and/or repair of boilers and pressure vessels.
- (24) "Lined potable water heater" means a water heater with a corrosion-resistant lining used to supply potable hot water.
- (25) "National Board" means the National Board of Boiler and Pressure Vessel Inspectors (NB), 1055 Crupper Avenue, Columbus, Ohio 43229.
- (26) "National Board Inspection Code" means the code for the repair, alteration and inspection of boilers and pressure vessels published by the National Board.
- (27) "New installation" means any boiler constructed, installed, placed in operation or contracted for after July 1, 1949 and any pressure vessel constructed, installed, placed in operation or contracted for after July 1, 1955.
- (28) "NFPA" means the National Fire Protection Association, Inc.
- (29) "Non-certificate inspection" means any inspection of a boiler or pressure vessel the result of which

does not warrant the issuance of a certificate of inspection.
- (30) "Non-standard boiler or pressure vessel" means a boiler or pressure vessel that does not bear the ASME code symbol stamp, the API-ASME code symbol stamp, or the stamp of any jurisdiction which has adopted a standard of construction equivalent to that required by the Board.
- (31) "Nuclear power plant" means one or more nuclear power systems and containment systems.
- (32) "Nuclear power system" means a system that serves the purpose of producing and controlling an output of thermal energy from nuclear fuel and those associated systems essential to the functions of the power system. The components of the system include such items as pressure vessels, piping systems, pumps, valves and storage tanks.
- (33) "Owner or User" means any person, firm or corporation legally responsible for the safe installation, operation and maintenance of any boiler or pressure vessel within the jurisdiction.
- (34) "Owner-User Inspection Agency" means an owner or user of pressure vessels who maintains a regularly established inspection department, whose organization and inspection procedures generally meet the requirements of the National Board rules and are acceptable to the Board.
- (35) "Pressure vessel" means a vessel in which the pressure is obtained from an external source, or by the application of heat from an indirect source, or from a direct source other than those boilers defined in subparagraphs (a) – (m) of paragraph (9) of this rule.
- (36) "Psig" means pounds per square inch gauge.
- (37) "Reinstalled boiler or pressure vessel" means a boiler or pressure vessel removed from its

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original setting and reinstalled at the same location without change of ownership.

- (38) "Repair" means the work necessary to restore a boiler or pressure vessel to a safe and satisfactory operating condition provided there is no deviation from the original design.
- (39) "Second-hand boiler or pressure vessel" means a boiler or pressure vessel which has changed both location and ownership since last used.
- (40) "Special Inspection" means:
 - (a) Inspection of a boiler or pressure vessel (stamped lethal service) upon installation by permit, subject to the fees in accordance with Rule 0800-3-3-.09(10);
 - (b) Boilers and pressure vessels (stamped lethal service) discovered to be installed without an installation permit. The owner or user shall be assessed a fee set by the Chief Inspector in accordance with T.C.A. § 68-122-113 plus all expenses allowed therein and Rule 0800-3-3-.09(10); or
 - (c) An additional inspection deemed appropriate and necessary by the Chief Inspector, subject to a fee in accordance with T.C.A. § 68-122-113 plus all expenses allowed therein and Rule 0800-3-3-.09(10).
- (41) "Standard boiler or pressure vessel" means a boiler or pressure vessel which bears the stamp of this State, the ASME code symbol stamp, the API-ASME code symbol stamp, both the ASME and National Board stamps, or the stamp of another jurisdiction which has adopted a standard of construction equivalent to that required by the Board.
- (42) "Supplemental documentation" means additional material used in the determination of a safe and proper construction, installation, repair, use and operation of boilers and pressure vessels in this State.

Authority: T.C.A. §§ 4-5-202, 68-122-102, 68-122-106, 68-122-107, 68-122-108, 68-122-109, 68-122-111, and 68-122-113.

Rule 0800-3-3-.03 Administration is amended by deleting the rule in its entirety and substituting the following language, so that as amended the rule shall read:

- (1) Construction Standards.
 - (a) No boiler or unfired pressure vessel shall be installed for operation in the State unless it is designed, constructed, inspected, stamped, and installed for the desired pressure and temperature in accordance with the provisions of this Chapter, the applicable section of the ASME Code, and other applicable law.
 - (b) Boilers and pressure vessels shall bear the National Board stamping and the manufacturer's NB number as registered with the National Board. A copy of the Manufacturer's Data Report signed by the manufacturer's representative and the National Board commissioned inspector employed by the third party inspection agency shall be filed with the Chief Inspector when the boiler or pressure vessel is shipped into this State for installation.
 - (c) Electrically heated boilers subject to the ASME Code requirements shall bear the

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“Underwriters Laboratory” label in addition to the required ASME Code symbol stamp. This means that the boiler shall be supplied by the manufacturer as a complete unit and not converted in the field.

- (d) Piping.
 - 1. Power piping external to power boilers from the boiler to the first stop valve of a single boiler, and to the second stop valve in a battery of two or more boilers, is subject to the requirements of the ASME Code, Power Boilers, Section I. The design, fabrication, installation and testing of the valves and piping shall be in accordance with ASME B31.1.
 - 2. Welded piping is subject to the ASME Code requirements for proper code certification, including stamping in conformance with the code and furnishing of applicable ASME data report forms for the owners and the Chief Inspector.
- (2) Exemptions. Potable hot water heaters are exempt from the “Construction Standards” requirements of subparagraphs (a) and (b) of Rule 0800-3-3-.03(1) when neither of the following limitations are exceeded:
 - (a) Heat input of 199,999 BTU/hr.
 - (b) Water temperature of 210°F. However, such potable hot water heaters, with a heat input of between 100,000 and 199,999 BTU/hr., are subject to registration, inspection and inspection certificate requirements.
 - (c) These vessels are required to have an NB rated, ASME constructed, test-lever pressure-temperature activated safety relief device.
- (3) “Tennessee Special” Boilers and Pressure Vessels. If a boiler or pressure vessel is of special design, or one that cannot bear the ASME and National Board stamping, details of the proposed construction (including shop drawings) shall be submitted to the Chief Inspector. Approval for construction and installation as a “Tennessee Special” boiler or pressure vessel must be obtained from the Board before construction is started.
- (4) Tennessee Standard Pressure Vessels.
 - (a) Vessels constructed by an owner-user who is authorized by the State as an Owner-User Inspection Agency and who holds a valid certificate of authorization to use the ASME “U” Stamp shall be stamped “Tennessee Standard”, provided the vessels are:
 - 1. Inspected by an owner-user inspector holding a valid certificate of competency issued by the State; and
 - 2. To be used exclusively by the owner-user and not for resale.
 - (b) Such vessels shall meet all requirements of the ASME Code, Section VIII, Division 1, except that they are inspected by an owner-user inspector.
- (5) Permission to Install.

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- (a) All installers of boilers or pressure vessels shall be knowledgeable in the proper installation of the boiler or pressure vessel they are requesting to install.
- (b) The company or person responsible for the installation of the boiler or pressure vessel (stamped lethal service) shall obtain an installation permit for the boiler or pressure vessel prior to any work being performed. An "Application for Permission to Install a Boiler or Pressure Vessel (stamped lethal service)", boiler room layout drawings/dimensions, Manufacturer's Data Report, and a copy of any applicable local/municipal building or like permit shall be forwarded to the Tennessee Department of Labor and Workforce Development, Boiler Inspection Division. "Tennessee Special" boilers and pressure vessels are subject to the requirements of this rule.
- (c) All boiler installations between 400,000-12,500,000 BTU/hr (excluding hot water heaters) shall meet all the requirements of ASME-CSD-1. Boilers 12,500,000 BTU/hr and over shall meet any additional requirements of NFPA 85. A copy of the "Controls and Safety Devices" section of the installation application must accompany all submitted Applications for Permission to Install a Boiler or Pressure Vessel (stamped lethal service). Failure to comply with the requirements of this rule, without significant explanation, could delay the permission to install approval or warrant non-acceptance of the application.
- (d) After the application has been reviewed by the Chief Inspector, an installation permit shall be issued.
- (e) All newly installed boilers and pressure vessels (stamped lethal service) shall be inspected by a Deputy Inspector before the boiler or pressure vessel is put into service. The company or person performing the installation is responsible for notifying the Tennessee Department of Labor and Workforce Development, Boiler Inspection Division, when the boiler or pressure vessel (stamped lethal service) is ready for inspection. The inspection upon installation by permit is subject to the fees in accordance with Rule 0800-3-3-.09(10).
- (f) A revised application shall be submitted to the Chief Inspector by the installer if there is a change to the original application. A copy of the original installation permit and supplemental documentation shall accompany the revised application.
- (g) All installation permits shall be issued for a period of twelve (12) months. If the boiler or pressure vessel (stamped lethal service) is not installed during this period, the installation permit shall expire and the file shall be closed. When a file has been closed, the installer shall be required to apply for another installation permit in accordance with subparagraph (b) of this rule.
- (h) A boiler or pressure vessel may be installed prior to submission of the "Application for Permission to Install a Boiler or Pressure Vessel (stamped lethal service)" when it has been determined by the Chief Inspector that the installation is an emergency situation. Immediately thereafter, the installer shall submit an application, layout drawings/dimensions, Manufacturer's Data Report and a copy of any applicable local/municipal building or like permit in accordance with subparagraph (b) of this rule.
- (i) When it is discovered that a boiler or pressure vessel (stamped lethal service) has been installed without an approved installation permit prior to installation, the Chief Inspector shall notify the owner or user. The Chief Inspector shall take appropriate action in accordance with T.C.A. § 68-122-106. The owner or user shall be assessed a special inspection fee

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set by the Chief Inspector in accordance with T.C.A. § 68-122-113 and Rule 0800-3-3-.09(10). Any owner or user aggrieved by an order or act of the Chief Inspector may, within fifteen (15) days after notice thereof, appeal from such order or act to the Board.

- (6) Permission to Reinstall.
 - (a) Reinstallation of Boilers or Pressure Vessels (Removed from the State). When a standard boiler or pressure vessel located in this State is moved outside the State for temporary use or repair, the owner or user shall apply to the Chief Inspector for permission to reinstall the boiler or pressure vessel in this State. After the owner or user files the "Application for Permission to Reinstall" and it is approved, the Deputy Inspector shall conduct an inspection. When a non-standard boiler or pressure vessel is removed from this State, it shall not be reinstalled within this State without additional approval of the Board.
 - (b) Installation of Second-Hand Boilers or Pressure Vessels. Second-hand boilers and pressure vessels may not be installed unless the Chief Inspector approves an "Application for Permission to Reinstall". After the owner or user files the "Application for Permission to Reinstall" and it is approved, the Deputy Inspector shall conduct an inspection.
 - (c) Reinstallation of Boilers or Pressure Vessels (Not Second-Hand). The owner or user shall apply to the Chief Inspector for permission to reinstall a boiler or pressure vessel in this State. After the owner or user files the "Application for Permission to Reinstall" and it is approved, the Deputy Inspector shall conduct an inspection.
 - (d) An owner or user of the boiler and pressure vessel described in subparagraphs (a), (b) and (c) of this rule is subject to the permitting requirements in accordance with Rule 0800-3-3-.03(5), and the Special Inspection fee requirements of Rule 0800-3-3-.09(10). An "Application for Permission to Reinstall" form must accompany all permit applications for these installations.
 - (e) For reinstalled boilers and pressure vessels with a current certificate of inspection, the Deputy Inspector shall submit a reinspection report in accordance with Rule 0800-3-3-.03(13)(b). The comment that the boiler or pressure vessel is "reinstalled" shall be noted on the reinspection report. The reinspection shall be a non-certificate inspection.
- (7) Application of State Serial Numbers. Upon completion of the installation of a boiler or pressure vessel, or at the time of the initial certificate inspection of an existing installation, the inspector shall tag each boiler or pressure vessel in the vicinity of the code stamping with a Board approved and Department supplied registration tag.
- (8) Accessibility to Code Stamping. Code stamping shall not be concealed by lagging or paint. The stamping shall be exposed at all times, unless a suitable record is kept of the location of the stamping so that it may be readily uncovered when desired.
- (9) Frequency of Inspections. All boilers and pressure vessels subject to inspection under the Act shall be inspected in accordance with the requirements of T.C.A. § 68-122-110.
- (10) Notification of Inspection.

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- (a) Certificate inspections, as required, shall be carried out no more than two (2) months prior to the expiration date of the certificate or within the two (2) month period following the expiration date at a time mutually agreeable to the inspector and owner or user.
 - (b) External inspections may be performed by the inspector during reasonable hours and without prior notification.
 - (c) When, as a result of external inspection or determination by other objective means, it is the inspector's opinion that continued operation of the boiler or pressure vessel constitutes a danger to life or property, the inspector may order an internal inspection or an appropriate pressure test, or both, to evaluate conditions. In such instances, the owner or user shall prepare the boiler or pressure vessel for such inspections or tests as the inspector designates.
- (11) External Inspection Disclosure of Defective Conditions. If, upon an external inspection, there is evidence of a leak or crack, sufficient covering of the boiler or pressure vessel shall be removed to permit the inspector to determine satisfactorily the safety of the boiler or pressure vessel. If the covering cannot be removed at that time, the inspector may order the operation of the boiler or pressure vessel stopped until the covering can be removed and proper examination made. The Chief Inspector shall be notified immediately.
- (12) Notification of an Incident or Accident. The owner or user shall promptly submit to the Chief Inspector a detailed report of any incident or accident that occurs to a boiler or pressure vessel. In the event of a personal injury, incident, accident, or explosion, the owner or user shall immediately give notice to the office of the Chief Inspector. Neither the boiler or pressure vessel, nor any parts thereof, shall be removed or disturbed without the permission of the Chief Inspector, except for the purpose of saving human life or limiting consequential damage.
- (13) Inspection reports.
- (a) Deputy and Special Inspectors shall submit to the Chief Inspector on a form approved by the Board, an initial inspection report for each boiler and pressure vessel subject to inspection in this State. Complete data shall be submitted on a form approved by the Board for each non-standard boiler or pressure vessel.
 - (b) Deputy and Special Inspectors shall submit to the Chief Inspector on a form approved by the Board, reinspection reports of subsequent inspections of both standard and non-standard boilers and pressure vessels.
 - (c) Owner-User Inspection Agencies shall submit reports in accordance with subparagraphs (a) and (b) of this rule. Said reports shall be filed as provided in paragraph (20) of this rule.
 - (d) Inspection reports required by subparagraphs (a), (b), and (c) of this rule shall be submitted within thirty (30) days after the date of inspection.
- (14) Working Pressure for Existing Installations. With the approval of the Chief Inspector, any inspector may decrease the maximum working pressure on any existing installation if the condition of the boiler or pressure vessel warrants.

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(15) Repairs and Alterations.

- (a) Repairs and alterations shall not be made without the permission of an inspector employed by the Authorized Inspection Agency responsible for the in-service inspection of the subject boiler or pressure vessel. Such repairs and alterations shall be done in accordance with the National Board Inspection Code. The inspector authorizing the repair or alteration shall sign the necessary National Board "NB-R" form or forms.
- (b) The person, corporation, partnership or firm performing the repair or alteration shall have a valid license in accordance with T.C.A. §§ 68-122-201 through 68-122-209. In order to qualify for such license, the applicant shall have a valid Certificate of Authorization from the National Board for the use of a Repair Code Symbol stamp.
- (c) A copy of the signed applicable "NB-R" form or forms shall be submitted to the Chief Inspector for each repair or alteration performed.

(16) Safety Appliances.

- (a) No person shall attempt to remove, or do any work on, any safety appliance prescribed by this Chapter while the appliance is subject to pressure.
- (b) Should any such appliance be removed for repair during an outage of a boiler or pressure vessel, it shall be reinstalled and in proper working order before the object is again placed in service.
- (c) No person shall alter any safety or safety relief valve or pressure relief devices in any manner to maintain a working pressure in excess of that stated on the boiler or pressure vessel inspection certificate.
- (d) Only the holder of a valid certificate of authorization for use of the National Board "VR" stamp, or an owner-user's maintenance organization approved by the Chief Inspector, may repair safety or safety relief valves. An owner-user maintenance organization shall be limited to repairing such valves for its own use.

(17) Restamping of Boilers and Pressure Vessels.

- (a) When the Code stamping of a boiler or pressure vessel becomes indistinct, the inspector shall instruct the owner or user to have it restamped. The owner or user shall submit a request for authorization of restamping to the Chief Inspector on the appropriate "Replacement of Stamped Data Form". Proof of the original stamping shall accompany the request.
- (b) If the Chief Inspector authorized restamping, it shall be done only in the presence of an inspector, and shall be identical with the original stamping.
- (c) The ASME Code symbol may be restamped only by the original manufacturer of the boiler or pressure vessel in the presence of an inspector of the Authorized Inspection Agency who signed the Manufacturer's Data Report or a Deputy Inspector. The witnessing inspector shall file with the Chief Inspector the completed and signed "Replacement of Stamped Data Form" with a facsimile of the stamping applied.

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- (18) **Condemned Boilers and Pressure Vessels.** The Chief Inspector or a Deputy Inspector shall stamp on any boiler or pressure vessel declared unfit for further service the letters “XXX” on either side of the State number. Such stamping (XXX 00 XXX) shall designate a condemned boiler or pressure vessel.
- (19) **Insurance.**
- (a) An insurance company shall notify the Chief Inspector within thirty (30) days of all boilers or pressure vessels, on which insurance is written, cancelled, not renewed or suspended.
 - (b) An insurance company shall conduct all required inspections to boilers and pressure vessels that are covered in the insurance policy, where premiums for specific inspection requirements are specified.
 - (c) If a Special Inspector employed by the insurance company does not perform the inspection required in subparagraph (b) of this rule within ninety (90) days of the expiration date of the certificate of inspection, or required external inspection on a power boiler, a Deputy Inspector may be called upon by the Chief Inspector to perform such inspection to determine the safety compliance of such boiler or pressure vessel. In the event that a Deputy Inspector performs an inspection on an insured boiler or pressure vessel, the insurance company in question shall be assessed a special inspection fee set by the Chief Inspector in accordance with T.C.A. § 68-122-113.
- (20) **Owner-User Inspection Agency.** Each Owner-User Inspection Agency shall:
- (a) Conduct inspections of pressure vessels (not exempt under T.C.A. § 68-122-105), utilizing only qualified inspection personnel, as provided in this Chapter;
 - (b) Retain on file where the equipment is inspected a true record or copy of each of the latest inspection reports submitted by the inspector;
 - (c) Execute and deliver to the Chief Inspector and those responsible for the operation of the pressure vessel a true report of each inspection, together with appropriate requirements or recommendations that result from such inspections;
 - (d) Promptly notify the Chief Inspector of any pressure vessel which does not meet the applicable requirements; and
 - (e) Maintain inspection records, which shall be readily available for examination by the Chief Inspector or his authorized representatives during business hours. Such records shall include:
 - 1. A list of each pressure vessel covered by the Act, showing a serial number and such abbreviated descriptions as may be necessary for identification; and
 - 2. The date of the last inspection of each unit, and the approximate date for the next inspection (arrived at by applying the appropriate rules to all data available when the inspection record is complete).
- (21) **Special Inspectors - Notification of Unsafe Boilers and Pressure Vessels.**

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- (a) If a Special Inspector, upon first inspection of a new risk, finds that a boiler or pressure vessel, or any appurtenance thereof, is in such condition that his company would refuse insurance, the inspector shall immediately notify the Chief Inspector and submit a report about the defects.
 - (b) If, upon inspection, a Special Inspector finds a boiler or pressure vessel to be unsafe for further operation, he shall promptly notify the owner or user and state what repairs or other corrective measures are required to bring the boiler or pressure vessel into compliance with this Chapter. Unless the owner or user makes such repairs or adopts other corrective measures promptly, the Special Inspector shall immediately notify the Chief Inspector. Until such corrections have been made, no further operation of the boiler or pressure vessel involved shall be permitted. If a certificate of inspection is required and is in force, it shall be suspended by the Chief Inspector. When a reinspection establishes that the boiler or pressure vessel is safe to operate, the Chief Inspector shall be notified. At that time, a certificate of inspection (where applicable) may be issued.
 - (c) If a Special Inspector, while making required inspections, becomes aware of any other boiler or pressure vessel on the premises which are not registered in accordance with applicable law, he shall report this information to the owner or user of the boiler or pressure vessel and to the Chief Inspector within thirty (30) days.
- (22) Examination for Certificate of Competency.
- (a) Unless other arrangements are made, the examination for an inspector's certificate of competency shall be held in conjunction with a quarterly meeting of the Board at such location as it designates.
 - (b) An applicant for examination shall have education and experience equal to at least one of the following:
 - 1. A degree from an accredited school in mechanical engineering, plus one year of experience in design, construction, operation or inspection of high-pressure boilers and pressure vessels;
 - 2. A degree from an accredited school in a branch of engineering other than mechanical engineering, or an associate degree in mechanical technology, plus two years of experience in design, construction, operation or inspection of high-pressure boilers and pressure vessels; or
 - 3. A high school education (or the equivalent) plus three years of experience:
 - (i) In high-pressure boiler and pressure vessel construction or repair; or
 - (ii) As an operating engineer in charge of high-pressure boiler operation; or
 - (iii) As an inspector of high-pressure boilers and pressure boiler operation.
 - (c) An application for examination shall be submitted on the form prescribed by the Chief Inspector at least forty-five (45) days prior to the date of examination. Each application shall be accompanied by a nonrefundable fee of one hundred dollars (\$100.00).

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- (d) The Board may reject any application containing a willfully false or misleading statement.
 - (e) The Board shall administer to qualified applicants a written examination dealing with the construction, maintenance, and repair of boilers and pressure vessels and their appurtenances.
 - (f) The Board may waive examination of an applicant who holds a valid commission or certificate of competency from a state that has a standard of examination substantially equal to that of this State, and a valid commission and current commission card issued by the National Board.
- (23) Certificate of Competency and Identification Card.
- (a) In order to be eligible to receive a certificate of competency, the applicant shall be in the regular employment of, and exclusively engaged by, an Authorized Inspection Agency or Owner-User Inspection Agency.
 - (b) A request for a certificate of competency and identification card shall be submitted by the employer on the form prescribed by the Chief Inspector. The request shall be accompanied by a nonrefundable fee of fifty dollars (\$50.00).
 - (c) When the holder of a certificate of competency ceases to be employed by the organization which requested the certificate, that organization shall return the certificate of competency and valid identification card to the Chief Inspector.
 - (d) Identification cards shall be renewable annually by application of the employer. The application shall be submitted not later than December 31 of each year, and shall be accompanied by a nonrefundable fee of twenty-five dollars (\$25.00) for each card.
- (24) Conflict of Interest. An inspector shall not engage in the sale of any service, article or device relating to boilers, pressure vessels, or their appurtenances.

Authority: T.C.A. §§ 4-5-202, 4-5-202(a)(3), 68-122-102(a), 68-122-102(b), 68-122-103 through 68-122-113, and 68-122-116.

Subparagraphs (b) and (c) of Paragraph (10) of Rule 0800-3-3-.04 General Requirements are amended by deleting that language entirely and substituting the following language, so that as amended the rule shall read:

- (b) Repairs shall be made by an organization holding a current National Board Repair Certificate of Authorization and the license required by Rule 0800-3-3-.03(15)(b).
- (c) Alterations shall be made by an organization holding a current National Board Repair Certificate of Authorization and the license required by Rule 0800-3-3-.03(15)(b).

Authority: T.C.A. §§ 4-5-202, 4-5-202(a)(3), 68-122-102, 68-122-202 through 68-122-209.

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Subparagraph (a) of Paragraph (5) of Rule 0800-3-3-.06 Existing Heating Boilers is amended by deleting that language entirely and substituting the following language, so that as amended the rule shall read:

- (a) Each steam boiler shall have one or more ASME/National Board stamped safety valves of the spring pop-type adjusted and sealed to discharge at a pressure not to exceed 15 psig. Seals shall be attached in a manner to prevent the valves from being taken apart without breaking the seal. The safety valves shall be arranged so that they cannot be reset to relieve at a higher pressure than the maximum allowable working pressure of the boiler. A body drain connection below seat level shall be provided by the manufacturer and this drain shall not be plugged during or after field installation. For valves exceeding two and one half (2½) inches pipe size, the drain holes or holes shall be tapped not less than three eighths (¾) inch pipe size. For valves less than two and one half (2½) inches, the drain hole shall not be less than one fourth (¼) inch in diameter.

Authority: T.C.A. §§ 4-5-202, 4-5- 202(a)(3), 68-122-102 through 68-122-104, 68-122-110.

Paragraph (1) of Rule 0800-3-3-.08 Historic Boilers is amended by deleting that language entirely and substituting the following language, so that as amended the rule shall read:

- (1) These rules apply to “historic power boilers” as defined in Rule 0800-3-3-.01(18).

Authority: T.C.A. §§ 4-5- 202(a)(3), 68-122-102, and 68-122-104.

Rule 0800-3-3-.09 Fees is amended by deleting the rule in its entirety and substituting the following language, so that as amended the rule shall read:

0800-3-3-.09 FEES.

- (1) For shop inspections, quality control system reviews and surveys of manufacturers and contractors of boilers and pressure vessels, and owner-user inspection agencies:
 - (a) For one-half (½) day minimum \$250.00
 - (b) For one (1) full day maximum \$500.00
- (2) For special boiler and pressure vessel inspections and second-hand inspections:
 - (a) For one-half (½) day minimum \$250.00
 - (b) For one (1) full day maximum \$500.00
- (3) Boilers inspection fees (fired vessels):
 - (a) Boilers of 5 horsepower (H.P.) or less, or fifty (50) square feet or less of heating surface \$30.00
 - (b) Boilers over 5 H.P. or over fifty (50) square feet of heating surface \$30.00
 - (c) External inspections \$20.00

PROPOSED RULES

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| (d) Inspection of heating boilers | \$15.00 |
| (4) Boiler inspection fees (unfired vessels): | |
| (a) Internal and/or external inspection of each unfired pressure vessel subject to inspection having a cross-sectional area of fifty (50) square feet or less is | \$15.00 |
| (b) For each additional one hundred (100) square feet or fraction thereof, of area in excess of fifty (50) square feet is | \$6.00 |
| Not more than seventy-five dollars (\$75.00) shall be paid per day for the actual inspection time of each inspector on any one (1) vessel. | |
| (5) Examination fee (nonrefundable) | \$100.00 |
| (6) Certificate of competency fee (nonrefundable) | \$50.00 |
| (7) Identification card fee (nonrefundable) annual renewal | \$25.00 |
| (8) Inspection certificates fees: | |
| (a) For power boilers | \$25.00 |
| (b) For low pressure heating boilers and unfired pressure vessels | \$40.00 |
| (9) License fee: | |
| (a) Original license (first year) | \$50.00 |
| (b) Annual renewal license | \$30.00 |
| (10) For special inspection fee based on the number of working days notice of inspection: | |
| (a) 1 – 10 Working Days: For one-half (1/2) day minimum | \$250.00 |
| For one (1) day maximum | \$500.00 |
| (b) 11 – 20 Workings Days: For one-half (1/2) day minimum | \$100.00 |
| For one (1) day maximum | \$200.00 |
| (c) 21 – 30 Working Days: For one-half (1/2) day minimum | \$50.00 |
| For one (1) day maximum | \$100.00 |
| (d) More than 30 Working Days: For one-half (1/2) day minimum | \$30.00 |

□

Authority: T.C.A. §§ 4-5-202(a)(3), 68-122-102 through 68-122-104, 68-122-106, 68-122-111, 68-122-113, and 68-122-116.

The proposed rules set out herein were properly filed in the Department of State on the 21st day of November, 2005, and pursuant to the instructions set out above, and in the absence of the filing of an appropriate petition calling for a rulemaking hearing, will become effective on the 30th day of March, 2006. (11-30)

PROPOSED RULES

TENNESSEE STUDENT ASSISTANCE CORPORATION - 1640

CHAPTER 1640-1-19

TENNESSEE EDUCATION LOTTERY SCHOLARSHIP PROGRAM

Presented herein are amended rules of the Tennessee Student Assistance Corporation submitted pursuant to Tenn. Code Ann. § 4-5-202 in lieu of a rulemaking hearing. It is the intent of the Tennessee Student Assistance Corporation to promulgate these rules without a rulemaking hearing unless a petition requesting such hearing is filed within thirty (30) days of the publication date of the issue to the Tennessee Administrative Register in which the proposed amendments are published. Such petition to be effective must be filed in Suite 1950 of Parkway Towers located at 404 James Robertson Parkway, Nashville, Tennessee 37243 and in the Department of State, Administrative Procedures Division, Eighth Floor, William R. Snodgrass Tower, 312 Eighth Avenue North, Nashville, Tennessee 37243 and must be signed by twenty-five (25) persons who will be affected by the rule, or submitted by a municipality which will be affected by the rule, or an association of twenty-five (25) or more members, or any standing committee of the General Assembly.

For a copy of these proposed rules, contact Lora Daniels, Tennessee Student Assistance Corporation, Suite 1950, Parkway Towers, 404 James Robertson Parkway, Nashville, Tennessee 37243, telephone 615-741-1346.

The text of the revised rules is as follows:

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1640-1-19-.01 DEFINITIONS

- (1) Academic Year: Three consecutive semesters that begins with the fall semester and ends with the summer semester.
- (2) ACT: The ACT Assessment administered by ACT, Inc., exclusive of the essay and optional subject area battery tests.
- (3) Adjusted Gross Income Attributable to the Student or Student's Adjusted Gross Income:
 - (a) The adjusted gross income of the student's parent or parents as reported on the student's Free Application for Federal Student Aid (FAFSA) and used by the Corporation in determinations of eligibility for federal or state financial aid, if the student is a dependent of a parent or parents as defined by FAFSA; or
 - (b) The adjusted gross income of the student and, if applicable, the student's spouse as reported on the student's FAFSA and used by the Corporation in determinations of eligibility for federal or state financial aid, if the student is independent of parents as defined by FAFSA.
- (4) Alternative Study Program: Program of study including, but not limited to student exchange programs, practicum, co-op programs and internships, that includes travel outside the State of Tennessee that is sponsored or offered by:
 - (a) an eligible postsecondary institution; or
 - (b) an eligible postsecondary institution in conjunction with either another eligible postsecondary institution or a postsecondary institution that is accredited by a regional accrediting association.
- (5) ASPIRE Award: An award to a student for study in pursuit of an associate or baccalaureate degree at an eligible postsecondary institution who qualifies for a Tennessee HOPE scholarship and whose adjusted gross income attributable to the student does not exceed thirty-six thousand dollars (\$36,000).
- (6) Award Year: Three consecutive semesters that begins with the fall semester and ends with the summer semester.
- (7) Board of Regents: The Board of Regents of the State University and Community College System of Tennessee.
- (8) Certificate or Diploma: A credential, other than a degree, the receipt of which indicates satisfactory completion of training in a program of study offered by a Tennessee Technology Center operated by the Board of Regents.
- (9) Continuing Education: Courses and programs that do not lead to a certificate, diploma or degree that are designed for personal development and are an extension of the traditional on-campus learning process.
- (10) Continuous Enrollment: A student is enrolled in the fall and spring semesters of a single academic year. Enrollment in summer semester or inter-session terms is not required.

PROPOSED RULES

- (11) Corporation: Tennessee Student Assistance Corporation.
- (12) Cost of Attendance: The expenses, both direct and indirect, incurred by a student and the student's family to finance the cost of receiving a postsecondary education as determined in accordance with the standards and practices used for Title IV programs by the institution at which the student is enrolled.
- (13) Credit Hours Attempted: The number of semester hours for which a degree-seeking or diploma/certificate-seeking student attending a postsecondary institution is enrolled as of the institutionally defined census date shall be considered credit hours attempted, regardless of whether a grade has been assigned. This standard shall apply to any change to a non-credit status, notwithstanding anything in Rule 1640-1-19-.22.
- (14) Degree: A two-year associate degree or four-year bachelor's degree conferred on students by a postsecondary educational institution upon completion of a unified program of study at the undergraduate level.
- (15) Distance Learning: An educational process that is characterized by the separation, in time or place, between instructor and student. It may include credit hours offered principally through the use of television, audio, or computer transmission, such as open broadcast, closed circuit, cable, or satellite transmission; audio or computer conferencing; video cassettes or discs, or correspondence.
- (16) Dual Enrollment: An arrangement between a high school and a postsecondary institution wherein a high school student enrolls in postsecondary classes and earns units of credit that count toward high school graduation requirements and hours or units of postsecondary credit.
- (17) Eligible High School:
 - (a) Tennessee public secondary school; or
 - (b) Any private secondary school that is located in Tennessee and:
 - 1. is approved by the State Board of Education as a category 1, 2, or 3 secondary school; or
 - 2. is a candidate for full accreditation status by an accrediting agency approved by the State Board of Education by June 8, 2004 for the purpose of application for Tennessee Hope scholarships for the 2004-05 academic year by students who graduated after January 1, 2003 and prior to December 1, 2004.
 - (c) A secondary school operated by the United State Department of Defense on a military base that is located in whole or in part in Tennessee;
 - (d) An out-of-state public secondary school located in a county bordering Tennessee that Tennessee residents are authorized to attend under T.C.A. § 49-6-3108; or
 - (e) An out-of-state boarding school accredited by a regional accrediting association that is attended by a bona fide Tennessee resident.

PROPOSED RULES

- (18) Eligible Postsecondary Institution: An eligible independent postsecondary institution or an eligible public postsecondary institution.
- (19) Eligible Independent Postsecondary Institution:
- (a) An institution created by testamentary trust for which the state acts by statute as trustee and for which the governor is authorized to appoint commissioners with the advice and consent of the senate and that offers courses leading to undergraduate degrees; or
 - (b) A Southern Association of Colleges and Schools accredited private postsecondary institution whose main campus is located in Tennessee; or
 - (c) A private, four-year postsecondary institution that:
 - 1. Has been chartered in Tennessee as a not-for-profit entity for at least thirty (30) consecutive years;
 - 2. Has had its primary campus domiciled in Tennessee for at least thirty (30) consecutive years;
 - 3. Is accredited by an accrediting agency that is recognized by the United States Department of Education and the Council on Higher Education Accreditation;
 - 4. Awards associate or baccalaureate degrees; and
 - 5. As of May 1, 2005, has an articulation agreement with an institution of the state university and community college system or the University of Tennessee system.
- (20) Eligible Public Postsecondary Institution:
- (a) An institution operated by the Board of Regents; or
 - (b) An institution in the University of Tennessee system.
- (21) Entering Freshman: A student entering a postsecondary institution who has not attempted any semester hours at any postsecondary institution after graduating from high school, completing high school in a home school program, or obtaining a GED.
- (22) FAFSA: Free Application for Federal Student Aid or the Renewal FAFSA as authorized by the U. S. Department of Education to indicate eligibility for federal and state financial aid programs.
- (23) Foster Child: A child who was in the custody of the Tennessee Department of Children's Services:
- (a) For at least one (1) year after reaching fourteen (14) years of age;
 - (b) For at least one (1) year after reaching fourteen (14) years of age and placed for adoption by the Department of Children's Services or one of its adoption contract agencies and the adoption was finalized; or
 - (c) For at least one (1) year and placed in permanent guardianship by the Department of Children's Services after reaching fourteen (14) years of age.
- (24) Full-Time Student: A student attending a postsecondary educational institution and enrolled for at least twelve (12) semester hours during a semester of attendance.

PROPOSED RULES

- (25) General Assembly Merit Scholarship: An award to a student for study in pursuit of an associate or baccalaureate degree at an eligible postsecondary institution awarded for academic excellence to supplement the Tennessee HOPE scholarship.
- (26) GED: A general educational development credential awarded by a state-approved institution or organization.
- (27) Grade Point Average: The numbered grade average calculated using a 4.0 scale, calculated to the hundredth decimal.
- (28) Home School Student: A student who completed high school in a Tennessee home school program meeting the requirements of §49-6-3050. For two (2) years immediately preceding completion of high school as a home school student, such student shall have been a student in a home school associated with a church-related school as defined by §49-50-801 and registered with the Tennessee local school district which the student would otherwise attend as required by §49-6-3050(a)(2)(C)(i) or an independent home school student whose parent or guardian has given notice to the local director of a Tennessee school district under § 49-6-3050(b)(1) of intent to conduct a home school.
- (29) Home Institution: The eligible postsecondary institution in which the student is enrolled and is in a matriculating status working toward a degree, diploma, or certificate.
- (30) Host Institution: The eligible postsecondary institution the student is temporarily attending as a transient student.
- (31) Immediate Family Member: Spouse, parents, children or siblings.
- (32) Incarcerated: Currently confined to a local, state, or federal correctional institution, as well as work release or educational release facilities.
- (33) Joint Enrollment: An arrangement between a high school and a postsecondary institution wherein a student enrolls in postsecondary classes while attending high school, but for which the student will receive credit from only one of the two institutions.
- (34) Junior: A student who has attempted at least forty-eight (48) semester hours, but less than seventy-two (72) semester hours.
- (35) Matriculated Status: The student is a recognized candidate for an appropriate degree, diploma, or certificate at an eligible postsecondary educational institution.
- (36) Non-Traditional student: A student who is at least twenty-five (25) years of age as of the first day of class upon enrolling in an eligible postsecondary institution as an entering freshman.
- (37) Parent: A parent or guardian.
- (38) Part-time Student: A student attending a postsecondary educational institution and enrolled for at least six (6) semester hours, but less than twelve (12) semester hours, during a semester of attendance.
- (39) Regional Accrediting Association: Approved accrediting agencies are as follows:

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- (a) The Southern Association of Colleges and Schools;
 - (b) The New England Association of Schools and Colleges;
 - (c) The Middle States Association of Colleges and Schools;
 - (d) The North Central Association of Colleges and Schools;
 - (e) The Northwestern Association of Schools and Colleges; and
 - (f) The Western Association of Schools and Colleges.
- (40) SAT: The SAT I administered by the College Board., exclusive of the essay and optional subject area battery tests.
- (41) Satisfactory Academic Progress: Progress in a course of study in accordance with the standards and practices used for Title IV programs by the postsecondary institution at which the student is currently enrolled.
- (42) Semester: Fall, spring, or summer semester at a postsecondary institution, if the institution is on a semester system, or the equivalent, if the institution is on a system other than a semester system.
- (43) Semester Hour: The credit hour used by a postsecondary institution, if the institution is on a semester system, or its equivalent, if the institution is on a system other than a semester system. Semester hour includes each semester hour attempted, whether remedial, developmental or for credit toward a degree, but shall not include any semester hour attempted before graduating from high school or earning a GED.
- (44) Study Abroad Program: Programs of study for which college credit is earned that include travel outside the United States.
- (45) TELS (Tennessee Education Lottery Scholarship) Award: Any scholarship and/or grant provided for by these rules that a student is eligible to receive, excluding the Tennessee Dual Enrollment Grant.
- (46) Tennessee Dual Enrollment Grant: A grant for study at an eligible postsecondary institution that is funded from net proceeds of the state lottery and awarded to students who are attending high school and who are also enrolled in courses at eligible postsecondary institutions that count toward high school graduation requirements and hours or units of postsecondary credit.
- (47) Tennessee HOPE Access Grant: A grant to freshman students for study in pursuit of an associate or baccalaureate degree at an eligible postsecondary institution that is one-half the amount of a Tennessee HOPE Scholarship and the need based supplemental award, which is funded from net proceeds of the state lottery.
- (48) Tennessee HOPE Foster Child Tuition Grant: A grant in addition to the Tennessee HOPE Scholarship to a foster child to only be used towards the costs of tuition, maintenance fees, student activity fees and required registration or matriculation fees at the eligible public postsecondary institution the student attends.

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- (49) Tennessee HOPE Scholarship: A scholarship for study in pursuit of an associate or baccalaureate degree at an eligible postsecondary institution that is funded from net proceeds of the state lottery.
- (50) Test Date: Date designated by the ACT, Inc., or the College Board for administration of the ACT or SAT at national test centers designated by the respective testing entities. This shall also include the administration of either test on other dates as approved by the respective testing entities to accommodate an individual student's documented disability or other hardship.
- (51) Title IV: Title IV of the Higher Education Act of 1965, as amended, 20 U.S.C.A. § 1070, et seq.
- (52) Transient Student: A visiting student enrolled in another institution who is granted temporary admission for the purpose of completing work to transfer back to the home institution and who expects to return to the institution in which he or she was previously enrolled.
- (53) Undergraduate Student: A student attending an eligible postsecondary institution and enrolled in a program leading to a diploma/certificate, an associate degree, or a bachelor's degree.
- (54) Unweighted Grade Point Average: Grade point average on a 4.0 scale calculated without additional points awarded for advanced placement, honors, or other similar courses.
- (55) Weighted Grade Point Average: Grade point average on a 4.0 scale calculated with additional quality points added to the unweighted grade point average for advanced placement, honors, and dual enrollment courses as those courses are defined by the high school. The corporation shall calculate the weighted grade point average by adding 0.5 quality point to the grade of any honors or dual-enrollment course and by adding 1.0 quality point to the grade of any advanced placement, international baccalaureate or advance honors course.
- (56) Wilder-Naifeh Technical Skills Grant: A grant for study in pursuit of a certificate or diploma at a Tennessee Technology Center operated by the Tennessee Board of Regents that is funded from net proceeds of the state lottery.

Authority: T.C.A. §§ 49-4-902, 49-4-924, and Public Chapter 481, Acts of 2005.

1640-1-19-.02 SCHOLARSHIP AWARD AMOUNTS AND CLASSIFICATIONS

- (1) The Tennessee Education Lottery Scholarship program is intended to provide financial awards to offset costs associated with pursuing postsecondary education.
- (2) Award levels for a full-time student in the 2005-2006 academic year are as follows:
 - (a) Tennessee HOPE Scholarship:
 - 1. One thousand six hundred fifty dollars (\$1,650) per semester, maximum three thousand three hundred dollars (\$3,300) at four year institutions; and
 - 2. Eight hundred twenty-five dollars (\$825) per semester, maximum one thousand six hundred fifty dollars (\$1,650) at two year institutions.

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- (b) Tennessee ASPIRE Award:
 - 1. Seven hundred fifty dollars (\$750) supplement to base award per semester, maximum one thousand five hundred dollars (\$1,500).
- (c) General Assembly Merit Scholarship:
 - 1. Five hundred dollars (\$500) supplement to base award per semester, maximum one thousand dollars (\$1,000).
- (a) Tennessee HOPE Access Grant (one half each of the Tennessee HOPE scholarship and ASPIRE award):
 - 1. One thousand two hundred dollars (\$1,200) per semester, maximum two thousand four hundred dollars (\$2,400) at four year institutions; and
 - 2. Seven hundred eighty-eight dollars (\$788) per semester, maximum one thousand five hundred seventy-five dollars (\$1,575) at two year institutions.
- (e) Wilder-Naifeh Technical Skills Grant:
 - 1. One thousand three hundred dollars (\$1,300) maximum at Tennessee Technology Centers.
- (f) Tennessee Dual Enrollment Grant:
 - 1. One hundred dollars (\$100) per semester hour (or equivalent contact hours at technology centers) for a maximum award of three hundred dollars (\$300) per semester and six hundred dollars \$600 per academic year.
- (3) Award amounts for subsequent years shall be determined in accordance with §4-51-111 and shall be set in the general appropriations act.
- (4) Recipients of any TELS award as provided by these rules may enroll as a full-time or part-time student at any eligible postsecondary institution. The amount of the award for part-time students shall be based on the hours attempted. Students enrolled in six, seven or eight hours will receive half of the award of full-time students. Students enrolled in nine, ten or eleven hours will receive three quarters of the award of a full-time student.
- (5) Except for approved medical or personal leaves of absence as provided in Rule 1640-1-19-.20 or emergency military duty as provided in Rule 1640-1-19-.21, award recipients must be continuously enrolled in an eligible postsecondary institution.
- (6) In the event that net lottery proceeds are insufficient to fully fund the TELS award program, the Corporation shall determine the appropriate manner in which the various awards shall be reduced.
- (7) Receipt of student financial aid from sources other than TELS that are applied to educational expenses will not operate to reduce the student's TELS award as long as the student's total aid does not exceed the total cost of attendance. In the event that a student's total aid exceeds

PROPOSED RULES

the cost of attendance, the eligible postsecondary institution shall, to the extent it does not violate applicable federal regulations, use its institutional policy in reducing the student's total aid package.

- (8) The receipt of a Tennessee HOPE scholarship, Tennessee HOPE Access grant, Tennessee ASPIRE award, Tennessee HOPE Foster Child Grant, General Assembly Merit Scholarship or Tennessee Dual Enrollment grant is contingent upon admission to an eligible postsecondary institution. Academically qualifying for any of these awards program does not guarantee admission to an eligible postsecondary institution.

Authority: T.C.A. §§ 49-4-903, 49-4-912, 49-4-914, 49-4-915, 49-4-916, 49-4-919, 49-4-920, 49-4-921, 49-4-922, 49-4-924, and Public Chapter 481, Acts of 2005.

1640-1-19-.03 APPLICATION PROCESS

- (1) The FAFSA shall be the application for all first year TELS awards and the FAFSA, or Renewal FAFSA, shall be the means by which eligible students reapply for TELS awards after their initial year of eligibility. The FAFSA must be submitted by mail or electronically as directed in the FAFSA instructions. Regardless of the adjusted gross income attributable to the student, he or she is required to complete the FAFSA for each academic year in order to apply for and receive a TELS award.
- (2) Students must have a FAFSA received by the U.S. Department of Education on or before September 1 for fall enrollment and February 1 for spring and summer enrollment in determining awards for that academic year. Students enrolling in a Tennessee Technology Center shall have a FAFSA received by the U. S. Department of Education on or before July 1 for the summer trimester, November 1 for the fall trimester and March 1 for the spring trimester. It shall be the responsibility of the student to ensure that the FAFSA is timely submitted to ensure it is received by the above deadlines.
- (3) Students shall apply for the Tennessee Dual Enrollment during their junior and senior years prior to high school graduation by submitting the Dual Enrollment Grant Fee Waiver Application to the postsecondary institution to which the student is seeking admission. The student must renew the Dual Enrollment Grant application each postsecondary academic term.
 - (a) The application deadline shall be set by the high school and postsecondary institution participating in the Dual Enrollment Grant program, but shall be no later than the eligible postsecondary institution's census date for that semester.

Authority: T.C.A. § 49-4-924 and Public Chapter 481, Acts of 2005.

1640-1-19-.04 GENERAL ELIGIBILITY

- (1) To be eligible for a TELS award a student shall:
 - (a) Be a Tennessee resident, as defined by Chapter 0240-2-2, Classifying Students In-State and Out-of-State, as promulgated by the Board of Regents, for one year as of September 1 of the academic year of enrollment in an eligible postsecondary institution; students

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enrolling in a Tennessee Technology Center must be a Tennessee resident one year prior to date of term enrollment;

- (b) Make application for a TELS award by submitting the FAFSA or Renewal FAFSA as required by Rule 1640-1-19-.03;
- (c) Be admitted to an eligible postsecondary institution;
- (d) Comply with United States Selective Service System requirements for registration, if such requirements are applicable to the student;
- (e) Be in compliance with federal drug-free rules and laws for receiving financial assistance;
- (f) Meet each qualification relating to the relevant TELS award and applicable to the student;
- (g) Not be in default on a federal Title IV educational loan or Tennessee educational loan;
- (h) Not owe a refund on a federal Title IV student financial aid program or a Tennessee student financial aid program; and
- (i) Not be incarcerated.

Authority: T.C.A. §§ 49-4-904, 49-4-905, and 49-4-924.

1640-1-19-.05 ELIGIBILITY – TENNESSEE HOPE SCHOLARSHIP

- (1) In addition to the general eligibility requirements of Rule 1640-1-19-.04, to be eligible for a Tennessee HOPE scholarship as an entering freshman, students graduating from an eligible high school, graduating from another high school located in Tennessee, completing of a Tennessee home school program, obtaining a GED, or choosing to seek enrollment in a postsecondary institution in lieu of completing high school requirements after December 1, 2004, shall, no later than 16 months following completion of the respective high school requirements be required to:
 - (a) Apply for a Tennessee HOPE scholarship as provided by Rule 1640-1-19-.03 and enroll in an eligible postsecondary institution; and
 - 1. Achieve a final overall unweighted high school grade point average of at least 3.0; or
 - 2. Attain a composite ACT score of at least 21 on any single ACT test date or a combined SAT score of at least 980 on any single SAT test date taken prior to enrolling in a postsecondary institution; or
 - 3. Pass the GED tests with an average score of at least 525, and attain a composite ACT score of at least 21 on any single ACT test date, or a combined SAT score of at least 980 on any single SAT test date taken prior to enrolling in a post secondary institution.

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- (2) In addition to the general eligibility requirements of Rule 1640-1-19-.04, to be eligible for a Tennessee HOPE scholarship as an entering freshman, students graduating from an eligible high school after December 1, 2003, but prior to December 1, 2004, must also meet the applicable additional requirements outlined below:
- (a) Apply for a Tennessee HOPE scholarship as provided in Rule 1640-1-19-.03 and enroll in an eligible postsecondary institution; and
1. Achieve a final overall unweighted high school grade point average of at least 3.0; or
 2. Attain a composite ACT score of at least 19 on any single ACT test date, or a combined SAT score of at least 890 on any single SAT test date taken prior to enrolling in a post secondary institution.
- (3) In addition to the general eligibility requirements of Rule 1640-1-19-.04, to be eligible for a Tennessee HOPE scholarship as an entering freshman, students completing a Tennessee home school program, obtaining a GED, graduating from a Tennessee high school that is not an eligible high school or choosing to seek enrollment in a postsecondary institution in lieu of completing high school requirements after December 1, 2003, but prior to December 1, 2004, shall, no later than 16 months following the completion of the home school program, graduation, or the last class taken toward high school requirements shall be required to:
- (a) Apply for a Tennessee HOPE scholarship as provided in Rule 1640-1-19-.03 and enroll in an eligible postsecondary institution; and
1. Attain a composite ACT score of at least 21 on any single ACT test date, or a combined SAT score of at least 980 on any single SAT test date taken prior to enrolling in a post secondary institution, if such student completed high school in a Tennessee home school program or graduated from a high school located in Tennessee that is not an eligible high school; or
 2. Pass the GED tests with an average score of at least 525, and attain a composite ACT score of at least 19 on any single ACT test date, or a combined SAT score of at least 890 on any single SAT test date taken prior to enrolling in a post secondary institution.
- (4) In addition to the general eligibility requirements of Rule 1640-1-19-.04, to be eligible for a Tennessee HOPE scholarship, students completing high school requirements after January 1, 2003, but prior to December 1, 2003, must also meet the applicable additional requirements outlined below:
- (a) Students graduating from an eligible high school shall, no later than the fall semester immediately following graduation, be required to:
1. Apply for a Tennessee HOPE scholarship as provided by Rule 1640-1-19-.03 and enroll in an eligible postsecondary institution; and
 - (i) Achieve a final overall unweighted high school grade point average of at least 3.0; or

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- (ii) Attain a composite ACT score of at least 19 on any single ACT test date or a combined SAT score of at least 890 on any single SAT test date taken prior to enrolling in a postsecondary institution.
- (b) Students completing high school in a Tennessee home school program, or graduating from a high school located in Tennessee that is not an eligible high school, or choosing to seek enrollment in a postsecondary institution in lieu of completing high school requirements shall, no later than the fall semester immediately following graduation, completion of the home school program, or the last class taken toward high school requirements shall be required to:
 - 1. Apply for a Tennessee HOPE scholarship as provided by Rule 1640-1-19-.03 and enroll in an eligible postsecondary institution; and
 - (i) Attain a composite ACT score of at least 21 on any single ACT test date or a combined SAT score of at least 980 on any single SAT test date taken prior to enrolling in a postsecondary institution.
- (c) Student obtaining a GED shall pass the GED tests with an average score of at least 525 and shall, no later than the fall semester immediately following obtaining a GED, be required to :
 - 1. Apply for a Tennessee HOPE scholarship as provided by Rule 1640-1-19-.03 and enrolling in an eligible postsecondary institution; and
 - (i) Attain a composite ACT score of at least 19 on any single ACT test date or a combined SAT score of at least 890 on any single SAT test date taken prior to enrolling in a postsecondary institution.
- (d) All students meeting the requirements of subparagraph (4)(a), (b), or (c) of this rule, shall also meet each of the following criteria:
 - 1. Attend an eligible postsecondary institution or a postsecondary institution located outside of Tennessee that is accredited by a regional accrediting association during the 2003-2004 academic year without a Tennessee HOPE scholarship and complete at least twenty-four (24) semester hours at such institution with a cumulative grade point average of 2.75; and
 - 2. Maintain satisfactory progress in a course of study in accordance with the standards and practices used for federal Title IV programs by the postsecondary institution in which the student enrolled.
- (5) Students entering active duty in the United States Armed Services within two years after graduating from an eligible high school, graduating from a high school located in Tennessee that is not an eligible high school, completing high school in a Tennessee home school program or obtaining a GED, and otherwise meets the criteria outlined in this rule may apply for a TELS award if the student:
 - (A) Applies within seven years of the student's date of entry into military service, or within one year of the student's honorable discharge from military service, whichever comes first; and

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- (b) After graduation from high school, did not attend a postsecondary institution prior to entering military service.
- (6) Students who are a Tennessee citizen and a dependent child of a member of the U. S. armed forces or the Tennessee National Guard whose home of record is Tennessee and who is engaged in active military service, or Department of Defense employee shall be eligible for a Tennessee Hope Scholarship as an entering freshman, if such students meet all eligibility requirements except that the students;
- (a) Did not reside in Tennessee for one (1) year immediately preceding the date of application for the Tennessee HOPE scholarship; and
 - (b) Are a natural, adoptive, or stepchild, under 21, and claimed as a dependent on the federal income tax return of military parent; and
 - (c) Did not graduate from an eligible high school as defined in 1640-1-19-.01(17), an ineligible high school, home school, or obtain a GED; and
 - (d) Graduated from a high school located outside Tennessee. Such high school shall be considered eligible if the school was;
 - 1. Operated by the United States; or
 - 2. Accredited by the appropriate regional accrediting association for the state in which the school is located; or
 - 3. Accredited by an accrediting association recognized by the foreign nation in which the school is located.
- (7) Beginning with the Fall 2005 semester a non-traditional student who is an entering freshman, as those terms are defined in these rules, may become eligible for a Tennessee HOPE scholarship. In addition to the general eligibility requirements of Rule 1640-1-19-.04, the non-traditional student must have an adjusted gross income attributable to the student that does not exceed thirty-six thousand dollars (\$36,000) and attend an eligible postsecondary institution as a full- or part-time student, as those terms are defined in these rules, and attempt at least twenty-four (24) semester hours. If the student achieves a 2.75 grade point average at the end of the semester in which twenty-four (24) hours are attempted, the student shall be eligible for a Tennessee HOPE scholarship in subsequent semesters if the following additional requirements are met:
- (a) Applies for the Tennessee HOPE scholarship as provided in Rule 1649-1-19-.03;
 - (b) Has an adjusted gross income attributable to the student that does not exceed thirty-six thousand dollars (\$36,000);
 - (c) Is continuously enrolled in an eligible postsecondary institution as a full- or part-time student, as those terms are defined in these rules;
 - (d) Meets the applicable retention requirements of Rule 1640-1-19-.12; and
 - (e) Maintains satisfactory progress in a course of study in accordance with the standards and practices used for federal Title IV programs at the postsecondary institution attended.

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- (8) A non-traditional student who does not meet the grade point average requirement of paragraph (7) of this rule, shall be eligible for a Tennessee HOPE scholarship if the student achieves a cumulative grade point average of at least 3.0 at the end of any semester in which eligibility is reviewed under Rule 1640-1-19-.12, provided the student continues to meet the provisions of paragraph (7)(a), (b), (c), and (e) of this rule.
- (9) A non-traditional student shall not be eligible for either the ASPIRE award or the General Assembly Merit Scholarship award.

Authority: T.C.A. §§ 49-4-905, 49-4-907, 49-4-908, 49-4-909, 49-4-910, 49-4-918, 49-4-924, and Public Chapter 481, Acts of 2005.

1640-1-19-.06 ELIGIBILITY – TENNESSEE ASPIRE AWARD

Except as provided in 1640-1-19-.05(9), any student eligible for the Tennessee HOPE scholarship with an adjusted gross income attributable to the student that does not exceed thirty-six thousand dollars (\$36,000) will receive ASPIRE award in addition to the base award. The adjusted gross income attributable to the student shall be reviewed each academic year to determine continuing eligibility for the ASPIRE award. Notwithstanding the provisions of Rule 1640-1-19-.12 to the contrary, a student otherwise eligible for the Tennessee HOPE scholarship and meeting the requirements of this rule shall receive the ASPIRE award regardless of the student's eligibility for this grant in any prior year. A student eligible for both the ASPIRE award and the General Assembly Merit Scholarship shall be awarded the ASPIRE award, but shall not simultaneously receive both awards.

Authority: T.C.A. §§ 49-4-915, 49-4-917, 49-4-924, and Public Chapter 481, Acts of 2005.

1640-1-19-.07 ELIGIBILITY – GENERAL ASSEMBLY MERIT SCHOLARSHIP

- (1) Any student eligible for the Tennessee HOPE scholarship and enrolled in a program leading to an associate or baccalaureate degree will also receive a General Assembly Merit Scholarship if the following criteria are met:
 - (a) Students graduating from an eligible high school after December 1, 2003, shall:
 - 1. Apply for the General Assembly Merit scholarship as provided in Rule 1640-1-19-.03;
 - 2. Attain a composite ACT score of at least 29 on any single ACT test date or a combined SAT score of at least 1280 on any single SAT test date taken prior to enrolling in a postsecondary institution; and
 - 3. Achieve a final overall weighted high school grade point average of at least 3.75;
 - (b) Students completing high school in a Tennessee home school program after December 1, 2003, or graduating from a high school located in Tennessee that is not an eligible high school after December 1, 2003, shall:

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1. Attain a composite ACT score of at least 29 on any single ACT test date or a combined SAT score of at least 1280 on any single SAT test date taken prior to enrolling in a postsecondary institution;
 2. During the course of a home school program or while attending high school, enroll in at least four (4) courses totaling at least twelve (12) semester hours at an eligible postsecondary institution. Such courses shall meet or be equivalent to courses meeting the minimum degree requirements of the Board of Regents, other than the minimum degree requirements pertaining to physical education; and
 3. Achieve a cumulative grade point average of at least 3.0 for all courses attempted at any eligible postsecondary institution during the course of a home school program or while attending high school.
- (c) Students graduating from an eligible high school after January 1, 2003, but prior to December 1, 2003, and seeking an associate or baccalaureate degree shall have:
1. Achieved a final overall unweighted high school grade point average of at least 3.75; and
 2. Attained a composite ACT score of at least 29 on any single ACT test date or a combined SAT score of at least 1280 on any single SAT test date;
 3. Enrolled in either an eligible postsecondary institution or a postsecondary institution located outside of Tennessee that is accredited by a regional accrediting association during the 2003-2004 academic year and attempt at least twenty-four (24) semester hours at such institution with a cumulative grade point average of 2.75;
 4. Maintained satisfactory progress in a course of study in accordance with the standards and practices used for federal Title IV programs by the eligible postsecondary institution in which the student enrolled; and
- (2) Students eligible for both the ASPIRE award and the General Assembly Merit Scholarship shall be awarded the ASPIRE award, but shall not simultaneously be awarded both.
- (3) Failure to retain the General Assembly Merit Scholarship for any reason shall result in the permanent loss of the award. Additionally, if a student loses the General Assembly Merit Scholarship for any reason other than failure to maintain the required cumulative grade point average, then the student shall not be able to regain either the Tennessee HOPE scholarship or the General Assembly Merit Scholarship.

Authority: T.C.A. §§ 49-4-916, 49-4-917, 49-4-924, and Public Chapter 481, Acts of 2005.

1640-1-10-.08 ELIGIBILITY – TENNESSEE HOPE ACCESS GRANT

- (1) In addition to the general eligibility requirements in Rule 1640-1-19-.04, to be eligible for a Tennessee HOPE access grant a student shall:
 - (a) Have an adjusted gross income attributable to the student that does not exceed thirty-six thousand dollars (\$36,000);

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- (b) Apply for a Tennessee HOPE access grant as provided in Rule 1640-1-19-.03;
- (c) Graduate from an eligible high school after December 1, 2003, upon having completed curriculum requirements of the high school for graduation;
- (d) Achieve a final overall unweighted high school grade point average of at least 2.75; and
- (e) Attain a composite ACT score of at least 18 on any single ACT test date or a combined SAT score of at least 860 on any single SAT test date taken prior to enrolling in a postsecondary institution.

Authority: §§ 49-4-920 and 49-4-924.

1640-1-19-.09 ELIGIBILITY – TENNESSEE HOPE FOSTER CHILD GRANT

- (1) In addition to the general eligibility requirements in Rule 1640-1-19-.04 and the applicable requirements of Rule 1640-1-19-.05(1), to be eligible for a Tennessee HOPE Foster Child Grant, a student shall present the Corporation with official certification from the Department of Children's Services that the student meets the eligibility requirement for the tuition grant.
- (2) The Tennessee HOPE foster child tuition grant shall be awarded in addition to any other TELS award that a student is eligible to receive. The Tennessee HOPE foster child tuition grant shall be applied only toward the costs of tuition, maintenance fees, student activity fees and required registration or matriculation fees at the eligible public postsecondary institution the student attends.
- (3) Any student eligible for the Tennessee HOPE foster child tuition grant shall apply for all available financial aid, including, but not limited to, the Tennessee HOPE scholarship or Tennessee HOPE access grant, if eligible, and funds provided through the Federal Foster Care Independence Act of 1999, if applicable. Any of the additional sources of financial aid for which the student is eligible shall first be applied to the student's room and board, which shall not exceed the maximum cost of room and board provided through the facilities of the eligible public postsecondary institution that the student is attending, then to additional items making up the institution's cost of attendance not covered by the Tennessee HOPE foster child tuition grant.
- (4) Subject to meeting retention standards provided by these rules for a TELS award, the student shall be eligible for the Tennessee HOPE foster child tuition grant:
 - (a) For a period of no more than four (4) years after the date of graduation from high school or equivalent; and
 - (b) For a period of six (6) years after admittance to an eligible public postsecondary institution, if, except as provided by Rule 1640-1-19-.20 or 1640-1-19-.21, the student maintains satisfactory progress in a course of study in accordance with the standards and practices used for Title IV programs by the postsecondary institution in which the student is currently enrolled.
- (5) Nothing in these rules shall be construed to limit the participation of a youth in or formerly in the custody of the state in any other program of financial assistance for postsecondary education.

Authority: Public Chapter 481, Acts of 2005.

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1640-1-19-.10 ELIGIBILITY – WILDER-NAIFEH TECHNICAL SKILLS GRANT

- (1) In addition to the general eligibility requirements in Rule 1640-1-19-.04, to be eligible for a Wilder-Naifeh technical skills grant a student seeking a diploma or certificate at a Tennessee Technology Center operated by the Board of Regents shall:
 - (a) Be admitted to the institution in a program of study leading to a certificate or diploma; and
 - (b) Have not, at any time, been the recipient of a Tennessee HOPE scholarship or completed a certificate or diploma with a Wilder-Naifeh Technical Skills Grant.
- (2) No minimum number of hours of enrollment is required for eligibility for a Wilder-Naifeh technical skills grant.
- (3) An eligible student may receive a Wilder-Naifeh technical skills grant for all course work required by the institution for a program of study leading to a certificate or diploma. Wilder-Naifeh technical skills grants may not be used for continuing education courses.

Authority: *T.C.A. §§ 49-4-921 and 49-4-924.*

1640-1-19-.11 ELIGIBILITY – TENNESSEE DUAL ENROLLMENT GRANT

- (1) In addition to the general eligibility requirements of Rule 1640-1-19-.04, to be eligible for a Tennessee Dual Enrollment grant a student shall be enrolled in a Tennessee high school or home school program, admitted to, and concurrently enrolled in, an eligible postsecondary institution and make application to the eligible postsecondary institution on the application form developed by the Corporation.
- (2) The student must have completed all of the academic requirements of the 10th grade (high school sophomore) and be classified as an 11th grader (high school junior) or 12th grader (high school senior) by the student's high school or home school program.
- (3) The student must not have already received a high school diploma or General Education Development (GED) diploma.
- (4) A student's participation in the Tennessee Dual Enrollment Grant program is limited to the remaining amount of time normally required to complete the high school diploma, from the time of initial participation in the program. The grant is available for the regular Fall and Spring semesters, and for Summer semesters prior to graduation from high school for those students who did not exceed the maximum award during the regular school year.

Authority: *Public Chapter 481, Acts of 2005.*

1640-1-19-.12 RETENTION OF AWARDS – GENERAL REQUIREMENTS

- (1) To retain a TELS award authorized by this chapter, a student at an eligible postsecondary institution shall continue to meet all applicable requirements for the scholarship and shall reapply by completing the FAFSA or Renewal FAFSA pursuant to Rule 1640-1-19-.03 for the applicable award for each academic year.

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- (2) Eligibility shall also be reviewed at the end of the semester in which the student has attempted a total of twenty-four (24), forty-eight (48), seventy-two (72), or ninety-six (96) semester hours. At the end of the semester in which the student has attempted a total of twenty-four (24) semester hours, the student shall have achieved a cumulative grade point average of at least 2.75 to continue to receive the TELS award. At the end of the semester in which the student has attempted a total of forty-eight (48), seventy-two (72), or ninety-six (96) semester hours, the student shall achieve a cumulative grade point average of at least 3.0 to continue to receive the TELS award.
- (3) Except as provided in paragraph (4) of this rule and Rules 1640-1-19-.20 and 1640-1-19-.21 which outline appropriate justification for medical and personal leaves of absence, a student may receive a Tennessee HOPE scholarship until the first of the following events:
 - (a) The student has earned a baccalaureate degree;
 - (b) The student has attempted at any postsecondary institution a total of one hundred twenty (120) semester hours;
 - (c) Five years have passed from the date of the student's initial enrollment at any postsecondary institution.
- (4) The attempted credit hour limitation includes remedial and developmental studies and all regular college credit courses attempted after high school graduation. If a student enters the semester with less than one hundred twenty (120) semester hours attempted and will surpass the one hundred twenty (120) semester hours limit, he or she is eligible for payment for the full number of hours enrolled for that semester. If the student is enrolled in a specific undergraduate degree program that is designed to be more than one hundred twenty (120) semester hours in length, the student is eligible for a total of one hundred thirty-six (136) semester hours attempted, or the number of hours required for graduation, whichever is less. The student shall achieve a cumulative grade point average of 3.0 at the end of the semester in which the student has attempted one hundred twenty (120) semester hours to continue to receive the scholarship. The student is eligible for payment for the full number of hours enrolled in the final semester. Regardless of the number of hours attempted, once the student has earned a bachelor's degree, he or she is ineligible for additional TELS awards.
- (5) A student who meets all other requirements for fourth or fifth year eligibility except that he or she is classified at the professional level rather than as an undergraduate, and has not been awarded a baccalaureate degree, is eligible if he or she was accepted into the professional level program of study that is an extension of the student's bachelor's degree program. Such student is eligible for a total of one hundred thirty-six (136) semester hours, or the number of hours required for the degree, whichever is less.
- (6) If a student ceases to be eligible for any TELS award, except the General Assembly Merit Scholarship, due to failure to achieve the cumulative grade point average required at the end of the semester in which the student has attempted twenty-four (24), forty-eight (48), seventy-two (72), ninety-six (96), or one hundred twenty (120) semester hours, the student may regain the applicable award or awards by:
 - (a) Continuing to meet all applicable non-academic requirements for the applicable award or awards,

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- (b) Maintaining continuous enrollment at an eligible postsecondary institution without the applicable award or awards,
 - (c) Achieving a cumulative grade point average of at least 3.0 at the end of any semester in which eligibility would have been reviewed, had the student not lost the award or awards,
 - (d) Reapplying for the scholarship as provided in Rule 1640-1-19-.03.
- (7) The provisions of paragraph (6) of this rule shall also apply to any student who:
- (a) Completed high school requirements after December 1, 2003, who, for whatever reason, did not receive a TELS award, notwithstanding the fact that the student met the applicable initial eligibility requirements of Rule 1640-1-19-.05(1), (2) or (3); or
 - (b) Completed high school requirements after January 1, 2003 and prior to December 1, 2003, who completed at least twenty-four (24) semester hours during the 2003-2004 academic year with a cumulative grade point average under 2.75, but met all other applicable initial eligibility requirements of Rule 1640-1-19-.05(4), and is otherwise eligible for the award.
- (8) No retroactive awards shall be made for semester hours attempted in order to regain the scholarship.
- (9) A student can utilize the option outlined in paragraph (6) of this rule only one time. A student who, after regaining the award or awards pursuant to paragraph (6) of this rule, subsequently fails to retain any TELS award due to failure to achieve the cumulative grade point average at a regular credit hour checkpoint shall not be eligible to regain the TELS award or become eligible for another TELS award.
- (10) Except as provided by Rule 1640-1-19-.20 or 1640-1-19-.21, a student receiving a TELS award provided by this chapter shall maintain continuous enrollment at an eligible postsecondary institution and maintain satisfactory progress in a course of study in accordance with the standards and practices used for Title IV programs by the postsecondary institution in which the student is currently enrolled.

Authority: T.C.A. §§ 49-4-909, 49-4-911, 49-4-912, 49-4-913, 49-4-920, 49-4-921, 49-9-924, and Public Chapter 481, Acts of 2005.

1640-1-19-.13 RETENTION OF AWARDS – TENNESSEE HOPE ACCESS GRANT

- (1) In addition to the general requirements for retention of award in Rule 1640-1-19-.12:
- (a) A Tennessee HOPE access grant shall be awarded to an eligible student only until the end of the semester in which the student has attempted a total of twenty-four (24) semester hours. A student who is eligible for a Tennessee HOPE scholarship shall be ineligible for a Tennessee HOPE access grant.
 - (b) If a student receiving a Tennessee HOPE access grant has achieved a cumulative grade point average of at least 2.75 at the end of the semester in which the student has attempted twenty-four (24) semester hours, the student shall be eligible for a Tennessee

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HOPE scholarship. The student will also receive the ASPIRE award referenced in Rule 1640-1-19-.06, if the adjusted gross income attributable to the student at the time of review does not exceed thirty-six thousand dollars (\$36,000).

- (c) If a student ceases to be eligible due to failure to achieve the cumulative grade point average required at the end of the semester in which the student has attempted twenty-four (24) semester hours, the student may be eligible to regain the HOPE Scholarship by following the procedure outlined in Rule 1640-1-19-.12(6).
- (d) A student may receive a Tennessee HOPE scholarship after having received a Tennessee HOPE access grant until the first of the following events:
 - 1. The student has earned a baccalaureate degree;
 - 2. The student has attempted at any postsecondary institution a total of one hundred twenty (120) semester hours, or if the student is enrolled in an undergraduate degree program required to be more than one hundred twenty (120) semester hours in length, that student is eligible for a total of one hundred thirty-six (136) semester hours attempted, or the number of hours required for graduation, whichever is less; or
 - 3. Five years from the date of the student's initial enrollment at any postsecondary institution have passed.

Authority: T.C.A. §§ 49-4-920, 49-4-924, and Public Chapter 481, Acts of 2005.

1640-1-19-.14 RETENTION OF AWARDS – TENNESSEE DUAL ENROLLMENT GRANT

- (1) To be eligible for a dual enrollment grant for a semester beyond the first semester of receipt, the student shall continue to meet all eligibility requirements for the grant and shall achieve a cumulative grade point average of 2.75 for all postsecondary courses attempted under a dual enrollment grant.
- (2) The dual enrollment cumulative grade point average used to determine eligibility for a renewal of a dual enrollment grant must be calculated by the institution the student is attending, utilizing its institutional grading policy and must be based on all dual enrollment credit hours attempted, except as otherwise provided in this rule.
- (3) Remedial and developmental studies, distance education courses and independent studies courses are eligible for payment with a Tennessee dual enrollment grant and shall be included in the calculation of the postsecondary cumulative grade point average.
- (4) Courses in which a student enrolls as an audit student for which no college credit will be received cannot be paid with a dual enrollment grant.
- (5) Students who obtain a grade change shall notify the financial aid office within thirty (30) calendar days of the grade change and request reinstatement of his/her award on a form developed by the institution for this purpose. If the grade change makes the student eligible for a dual enrollment grant, the student can be awarded retroactively in the current award year. If the grade change affects the student's eligibility from the previous award year, the award may be adjusted in the current award year.

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- (6) A student enrolled in a matriculating status at an eligible postsecondary institution shall qualify for award payment for distance learning courses if all other eligibility requirements are met.
- (7) The grant will pay only for lower division (courses numbered 100-200 or 1000-2000) postsecondary credit for general education courses and courses in the disciplines. The grant will not pay for upper division courses (numbered 300-400 or 3000-4000).

Authority: *Public Chapter 481, Acts of 2005.*

1640-1-19-.15 TENNESSEE EDUCATION LOTTERY SCHOLARSHIP AWARD PROCESS

- (1) On or before June 15 of each year, all Tennessee high schools and home school programs shall utilize available services provided by the corporation or other partnering agencies to submit the name, social security number, grade point averages, and highest composite ACT/SAT scores for academically eligible students, cumulative at least through the seventh semester.
- (2) On or before September 1 of each year, all Tennessee high schools shall revise and submit to the Corporation the information required of each in the paragraph 1 of this rule, cumulative through the eighth semester.
- (3) Eligible postsecondary institutions that enroll students receiving scholarships or grants shall assist in providing and certifying student information necessary for administering, receiving, and evaluating such programs.

Authority: *T.C.A. §§ 49-4-903 and 49-4-924.*

1640-1-19-.16 CONTINUATION OF TENNESSEE EDUCATION LOTTERY SCHOLARSHIP AWARD

- (1) All students receiving a TELS award shall reapply for the award by filing a FAFSA or Renewal FAFSA as provided in Rule 1640-1-19-.03 for each subsequent year.
- (2) During the certification process, all eligible postsecondary institutions shall certify the number of credit hours attempted and the cumulative grade point average of all students receiving a TELS award at the end of the semester at which the student has attempted twenty-four (24), forty-eight (48), seventy-two (72), ninety-six (96), or one hundred twenty (120) semester hours.

Authority: *§§ 49-4-903, 49-4-911, and 49-4-924.*

1640-1-19-.17 AWARD MADE IN ERROR

If a student receives a TELS award and it is later determined that all or a portion of the award was made in error, the student shall be required to reimburse the eligible postsecondary institution for the amount of the award made in error. The eligible postsecondary institution shall provide the student with a notice indicating the amount to be refunded. Additionally, the eligible postsecondary institution shall notify the Corporation of the charge back, which shall be noted on the student's record. The eligible postsecondary institution shall also be responsible for obtaining repayment from the student. The student will be ineligible for student aid from the Corporation until the refund is paid.

Authority: *T.C.A. § 49-4-924.*

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1640-1-19-.18 REFUND POLICY

If a recipient of a TELS award or a Tennessee dual enrollment grant fails to complete a semester for any reason, the eligible postsecondary institution shall apply its refund policy to determine whether a refund may be required and/or funds returned to the Corporation. The eligible postsecondary institution shall provide the student with a notice indicating the amount to be returned to the student or the amount to be refunded to the Corporation. Additionally, the eligible postsecondary institution shall notify the Corporation of the charge back, which shall be noted on the student's record. The eligible postsecondary institution shall also be responsible for obtaining repayment from the student. The student shall be ineligible for student aid from the Corporation until the refund is paid.

Authority: *T.C.A. § 49-4-924*

1640-1-19-.19 CONVERTING FROM FULL-TIME TO PART-TIME ENROLLMENT

- (1) Students enrolled in a full-time status, as of institutionally defined census date, may not convert to part-time status within the same semester and receive a scholarship award for the succeeding semesters unless the student requests and the institution approves the change to part-time status.
- (2) An institution may allow a change from full-time to part-time status within the same semester only when there are documented medical or personal grounds. Such medical or personal grounds shall include, but not be limited to, illness of the student, illness or death of an immediate family member, extreme financial hardship of the student or student's immediate family, or other extraordinary circumstances beyond the student's control where continued full-time attendance by the student creates a substantial hardship.
- (3) Each eligible postsecondary institution shall adopt procedures for considering student requests for change from full-time to part-time status within the semester. In the event an institution denies a student's request to change from full-time status to part-time status within a semester, the student may appeal the decision pursuant to Rule 1640-1-19-.26.
- (4) In the event that the decision to deny the change of status is upheld through the appeals process, the student shall be ineligible to regain the TELS award or become eligible for another TELS award.
- (5) In the event the change to part-time status is approved, the eligible postsecondary institution shall apply its refund policy to determine whether a refund may be required and/or funds returned to the Corporation. The eligible postsecondary institution shall provide the student with a notice indicating the amount to be returned to the Corporation. Additionally, the eligible postsecondary institution shall notify the Corporation of the charge back, which shall be noted on the student's record.
- (6) For the purposes of this rule, only courses that are included in the calculation of the grade point average pursuant to Rule 1640-1-19-.22 are to be considered in determining full-time status.

Authority: *T.C.A. §§ 49-4-911, 49-4-912, and 49-4-924.*

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1640-1-19-.20 PERSONAL OR MEDICAL LEAVE OF ABSENCE

- (1) A student may be granted medical or personal leaves of absence from attendance at an eligible postsecondary institution and resume receiving an award(s) upon resumption of the student's attendance at an eligible postsecondary institution so long as all other applicable eligibility criteria are met. Each eligible postsecondary institution shall adopt procedures for considering student requests for leaves of absence. An eligible postsecondary institution may grant leaves of absence only for medical or personal reasons. In addition to the reasons outlined in Rule 1640-1-.18, allowable medical or personal reasons shall include, but not be limited to, illness of the student, illness or death of an immediate family member, extreme financial hardship of the student or student's immediate family, to fulfill a religious commitment expected of all students of that faith, or other extraordinary circumstances beyond the student's control where continued attendance by the student creates a substantial hardship. Acceptable reasons shall also include a student's participation in an internship or co-op program that is required or encouraged as part the academic program in which he/she is enrolled. In the event an institution denies a student's request for a medical or personal leave of absence, the student may appeal the decision in accordance with Rule 1640-1-19-.26.
- (2) A student granted a medical or personal leave of absence who resumes their education at an eligible postsecondary institution shall retain TELS award eligibility until the first of the following events:
 - (a) The student has earned a baccalaureate degree;
 - (b) The student has attempted at any postsecondary institution a total of one hundred twenty (120) semester hours, or if the student is enrolled in an undergraduate degree program required to be more than one hundred twenty (120) semester hours in length, that student is eligible for a total of one hundred thirty-six (136) semester hours attempted, or the number of hours required for graduation, whichever is less; or
 - (c) The sum of the number of calendar years the student attended a postsecondary institution prior to the leave of absence and the number of calendar years of attendance after the leave of absence equals five calendar years.

Authority: T.C.A. §§ 49-4-903, 49-4-919, and 49-4-924.

1640-1-19-.21 MILITARY MOBILIZATION OF ELIGIBLE STUDENTS

- (1) Members of the United States Armed Services, National Guard, or Armed Forces Reserves receiving a TELS award who are mobilized for active duty during a semester that is already in progress shall be granted a personal leave of absence by the eligible postsecondary institution the student is attending and shall not have their TELS award eligibility negatively impacted.
- (2) If, as a result of being mobilized, a student elects to completely withdraw from an eligible postsecondary institution, then the hours attempted during the semester will not be taken into consideration for purposes of determining future TELS award eligibility.
- (3) If due to a military mobilization the student elects to receive an "incomplete" in any or all courses, the provisions of Rule 1640-1-19-.22(13) shall apply.

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- (4) Upon re-enrollment within one year following mobilization, the student's TELS award eligibility will resume as if no break in enrollment had occurred and shall retain TELS award eligibility until the first of the following events:
 - (a) The student has earned a baccalaureate degree;
 - (b) The student has attempted at any postsecondary institution a total of one hundred twenty (120) semester hours, or if the student is enrolled in an undergraduate degree program required to be more than one hundred twenty (120) semester hours in length, that student is eligible for a total of one hundred thirty-six (136) semester hours attempted, or the number of hours required for graduation, whichever is less; or
 - (c) The sum of the number of calendar years the student attended a postsecondary institution prior to the leave of absence and the number of calendar years of attendance after the leave of absence equals five calendar years.
- (5) An eligible postsecondary institution shall be authorized to consider a request for a leave of absence from a student whose spouse, child, father or mother is mobilized for active duty as a valid basis for a personal leave of absence. This request shall be made in accordance with the provisions of this rule. If the request is granted the student shall receive the same accommodations described above.

Authority: *T.C.A. §§ 49-4-903, 49-4-919, and 49-4-924.*

1640-1-19-.22 CALCULATION OF POSTSECONDARY CUMULATIVE GRADE POINT AVERAGE

- (1) The postsecondary cumulative grade point average used to determine eligibility for a renewal of a TELS award, must be calculated by the institution the student is attending, utilizing its institutional grading policy and must be based on all credit hours attempted after high school graduation, except as otherwise provided in this rule.
- (2) All credit hours attempted at all postsecondary institutions the student has attended after graduating from high school and their corresponding grades must be included in the calculation of the postsecondary cumulative grade point average, regardless of whether the receiving institution will apply the credit hours toward the student's degree requirements. Except as provided in subparagraph (a) of this paragraph, credit hours that were repeated shall be included in the postsecondary cumulative grade point average calculation, and are counted towards the limitation on credit hours.
 - (a) A student shall have a one time option to repeat one course and utilize only the higher of the two grades in the calculation of their postsecondary grade point average for purposes of determining continued eligibility for a TELS award. The semester hours for both attempted courses, however, will be included in the one hundred twenty (120) limitation of semester hours.
 - (b) It shall be the responsibility of the student to advise the appropriate official of the eligible postsecondary institution when this option is being exercised.
- (3) Credit hours attempted prior to high school graduation, completion of a home school program in Tennessee or achieve a GED, including those attempted with the Tennessee dual enrollment

PROPOSED RULES

grant, do not count toward the limitation on semester hours provided in Rule 1640-1-19-.12(3), nor are the grades for those classes included in the postsecondary cumulative grade point average.

- (4) Credit hours earned by examination are not eligible for payment with TELS awards and shall not be included in the postsecondary cumulative grade point average or counted towards the limitation on credit hours provided in Rule 1640-1-19-.12(3).
- (5) Credit hours attempted as part of a diploma or certificate program of study are not considered to be college credit hours and therefore shall not be included in the postsecondary cumulative grade point average or counted towards the limitation on credit hours provided in Rule 1640-1-19-.12(3), unless those hours are accepted toward a degree.
- (6) Remedial and developmental studies and independent studies courses are eligible for payment with TELS awards and shall be included in the calculation of the postsecondary cumulative grade point average and shall be counted towards the limitation on credit hours provided in Rule 1640-1-19-.12(3).
- (7) Courses in which a student enrolls as an audit student for which no college credit will be received cannot be paid with a TELS award nor will the semester hours be included in the calculation of the postsecondary cumulative grade point average or in the credit hour limitation provided in Rule 1640-1-19-.12(3).
- (8) Continuing education courses are not eligible for payment with TELS awards and shall not be included in the postsecondary cumulative grade point average or counted towards the limitation on semester hours provided in Rule 1640-1-19-.12(3).
- (9) Students who obtain a grade change shall notify the financial aid office within thirty (30) calendar days of the grade change and request reinstatement of his/her award on a form developed by the institution for this purpose. If the grade change makes the student eligible for a TELS award, the student can be awarded retroactively in the current award year. If the grade change affects the student's eligibility from the previous award year, the TELS award may be adjusted in the current award year. The eligible postsecondary institution shall make necessary reductions in the student's financial aid package if the reinstatement of a TELS award results in either an over award of need based aid or exceeds the institution's cost of attendance for any semester. If the student's application for reinstatement is denied, he/she may appeal the decision in accordance with Rule 1640-1-19-.26.
- (10) A student enrolled in a matriculating status at an eligible postsecondary institution shall qualify for TELS award payment for distance learning courses if all other eligibility requirements are met. Students may take courses through more than one eligible postsecondary institution during the same semester. Payment for the distance learning courses shall be made in the same manner as transient students as provided in Rule 1640-1-19-.24.
- (11) A student enrolled in a matriculating status at an eligible postsecondary institution may qualify for TELS award payment while participating in an internship or co-op program if the student receives college credit from the internship or co-op experience and must pay tuition and fees. The semester hours shall be included in the postsecondary cumulative grade point average and count toward the limitation on credit hours as provided in Rule 1640-1-19-.12(3).

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- (12) A student enrolled in a matriculating status at an eligible postsecondary institution may qualify for TELS award payment while participating in an alternative study or study abroad program if all other eligibility requirements are met. The eligible postsecondary institution which is the student's home institution must approve the alternative study or study abroad program for credit toward the student's degree and the number of hours that will be applied toward the degree prior to the student's departure.
- (13) Courses that appear on a student's transcript as an "incomplete" shall be considered credit hours attempted. The student's TELS award eligibility, however, shall be determined by excluding the credit hours attributable to the course for which an "incomplete" has been assigned from the cumulative grade point average calculation.
- (a) If the student fails to retain eligibility for a TELS award as a result of the calculation, but later becomes eligible when the grade for the "incomplete" course is reported, the student is eligible to receive a TELS award retroactively within the award year and shall retain eligibility. Retroactive TELS awards for previous award years shall be added to the current award year. The eligible postsecondary institution shall, however, make necessary reductions in the student's financial aid package if the reinstatement of a TELS award results in either an over award of need based aid or exceeds the institution's cost of attendance for any semester. It shall be the responsibility of the student to notify the financial aid office at the eligible postsecondary institution that a grade has been awarded and request that the TELS award be reinstated. Each eligible postsecondary institution shall develop a standard form for use by students to comply with this provision. If the student's application for reinstatement is denied, he/she may appeal the decision in accordance with Rule 1640-1-19-.26.
- (b) If the student retains eligibility for a TELS award as a result of the calculation, but later becomes ineligible when the grade for the "incomplete" course is reported, then the student shall be ineligible for all TELS awards. Additionally, the student shall reimburse the institution for TELS awards received in the interim.
- (14) If the student is otherwise eligible to receive a TELS award, but does not receive TELS funding, or TELS funding is reduced because his or her cost of attendance is covered by other aid, all credit hours attempted that semester shall still apply to the credit hour limitation provided in Rule 1640-1-19-.12(3).

Authority: *T.C.A. §§ 49-4-903, 49-4-924, and Public Chapter 481, Acts of 2005.*

1640-1-19-.23 TRANSFER STUDENTS

- (1) A TELS recipient transferring from an eligible postsecondary institution to another is eligible for a TELS award if all eligibility requirements continue to be met at the postsecondary institution at which the student is currently enrolled.
- (2) Any student who was otherwise eligible for a TELS award upon completion of high school requirements based on the applicable provisions of these rules, but who enrolled in a regionally accredited out-of-state postsecondary institution upon completing high school requirements, may transfer to an eligible Tennessee postsecondary institution and receive a TELS awards. The student must from that point be continuously enrolled in an eligible postsecondary institution and meet all eligibility and retention requirements, as provided in these rules.

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Authority: T.C.A. §§ 49-4-910, 49-4-924, and Public Chapter 481, Acts of 2005.

1640-1-19-.24 TRANSIENT STUDENTS

A transient student is eligible to receive a TELS award if all other eligibility requirements are met and if both the home and host institutions are eligible postsecondary institutions. The home institution shall award the TELS funds to the transient student based on certification of eligibility from the host institution. The home institution shall certify to the Corporation that the student is eligible for a TELS award. Each eligible postsecondary institution shall develop a process to effectuate each provision of this rule and shall notify its students of the process and the availability of the necessary forms to comply with the requirements. At the end of the semester the host institution shall provide the student's home institution with all information necessary for the home institution to determine continued TELS award eligibility.

Authority: T.C.A. §§ 49-4-903 and 49-4-924.

1640-1-19-.25 DENIAL OF INITIAL ELIGIBILITY – FAILURE TO TIMELY ENROLL

A student who fails to timely enroll in an eligible postsecondary institution as required by Rule 1640-1-19-.05 may be granted an exception if the student failed to meet the requirement for any reason provided for in this rule. An exception shall be granted only for medical or personal reasons. Acceptable medical or personal reasons shall include, but not be limited to, illness of the student, illness or death of an immediate family member, extreme financial hardship of the student or student's immediate family, to fulfill a religious commitment expected of all students of that faith, or other extraordinary circumstances beyond the student's control where timely enrollment by the student would create a substantial hardship. In the event a student's request for an exemption for failing to timely enroll is denied, the student may appeal the decision pursuant to Rule 1640-1-19-.26.

Authority: T.C.A. §§ 49-4-903 and 49-4-924.

1640-1-19-.26 APPEAL AND EXCEPTION PROCESS

- (1) Each eligible postsecondary institution shall establish an Institutional Review Panel (IRP) for the purposes of hearing appeals from decisions denying or revoking applicants' TELS award. Each eligible postsecondary institution shall establish written procedures for an applicant or recipient to appeal a decision of an eligible postsecondary institution to deny or revoke a TELS award. These procedures shall include, but not be limited to, the establishment and composition of the IRP and the process and timelines for appeals to the IRP. Each eligible postsecondary institution shall also establish a process to ensure students applying for or receiving a TELS award are notified of the procedures to appeal the denial or revocation of a TELS award including the timeframe within which an appeal must be filed with the TELS Award Appeals Panel. No eligible postsecondary institution official rendering a decision to deny or revoke a TELS award shall participate in the appeal process for the same applicant or recipient. The IRP may award or reinstate the student's TELS award without a hearing and shall make such determination no later than fourteen (14) calendar days after an applicant or recipient properly files an appeal. If the IRP determines that a hearing is required the IRP shall hear the appeal no later than fourteen (14) calendar days after an applicant or recipient properly files an appeal. Except where exigent circumstances exist, the IRP shall render a decision no later than seven calendar days after hearing an appeal. Such decision shall be reduced to writing and shall include a summary of

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the pertinent facts and issues and the panel's decision. The IRP shall provide a copy of the written decision to the appellant as soon as practicable. For the purposes of this rule, it will be presumed that the decision was delivered to the appellant two calendar days after the decision was placed in the U.S. Postal Service addressed to the appellant's official mailing address according to the eligible postsecondary institution's records.

- (2) The Appeals Panel shall be appointed by the Corporation's Executive Director for purpose of hearing appeals from decisions rendered by the IRPs. No official of an eligible postsecondary institution shall sit as a member of the Appeals Panel where the denial or revocation being appealed involves such official's eligible postsecondary institution. A student seeking an appeal of a decision rendered by an IRP shall request an appeal, to include a written statement outlining the basis for the appeal as well as all pertinent information related to the appeal, with the Corporation within fourteen (14) calendar days from the date that the decision was delivered to the student. A complete record of the institutional IRP hearing shall be provided to the Corporation by the student. The Appeals Panel may award or reinstate the student's TELS award without a hearing. This decision shall be made no later than 30 calendar days after an appeal is properly filed and the record from the IRP hearing is received. If the Appeals Panel determines that a hearing is required, it shall provide the appellant with notice of the hearing date, such notice shall include the time and location of the hearing. The Appeals Panel shall hear the appeal no later than forty-five (45) calendar days after the appeal is properly filed, unless an extension is requested by the appellant and granted by the Appeals Panel. Except where exigent circumstances exist, the Appeals Panel shall render a decision no later than fourteen (14) calendar days after hearing an appeal. Such decision shall be reduced to writing and shall include a summary of the pertinent facts and issues and the panel's decision. The Appeals Panel shall provide a copy of the written decision to the appellant and the appellant's home institution as soon as practicable. The Appeals Panel is the final administrative appeal.
- (3) The authority of the IRPs and the TELS Award Appeals Panel shall be strictly limited to consideration of appeals arising from eligibility determinations made by an eligible postsecondary institution or the Corporation. Neither appeals panel shall have the authority to rule on the validity of any information provided to the eligible postsecondary institution or Corporation by another entity on which its decision to deny or revoke a TELS award was based, including, but not limited to high school grade point average, ACT or SAT scores, or grades from another eligible postsecondary institution. Additionally, neither appeals panel shall have the authority to consider requests for exceptions to the high school or collegiate grade point average.

Authority: T.C.A. § 49-4-924.

The proposed rules set out herein were properly filed in the Department of State on the 9th day of November, 2005, and pursuant to the instructions set out above, and in the absence of the filing of an appropriate petition calling for a rulemaking hearing, will become effective on the 30th day of March, 2006. (11-05)

PROPOSED RULES

**THE UNIVERSITY OF TENNESSEE - 1720
THE UNIVERSITY OF TENNESSEE, KNOXVILLE**

**CHAPTER 1720-4-5
TRAFFIC AND PARKING REGULATIONS**

Presented herein are proposed amendments of The University of Tennessee submitted pursuant to Tennessee Code Annotated, Section 4-5-202, in lieu of a rulemaking hearing. It is the intent of The University of Tennessee to promulgate these amendments without a rulemaking hearing unless a petition requesting such hearing is filed within thirty (30) days of the publication date of the issue of the Tennessee Administrative Register in which the proposed amendments are published. Such petition to be effective must be filed in Room 719, Andy Holt Tower, The University of Tennessee, Knoxville, Tennessee 37996-0170, and in the Department of State, 8th Floor, William R. Snodgrass Tennessee Tower, 312 8th Avenue North, Nashville, Tennessee 37243, and must be signed by twenty-five (25) persons who will be affected by the amendments, or submitted by a municipality which will be affected by the amendments, or an association of twenty-five (25) or more members, or any standing committee of the General Assembly.

For a copy of the proposed amendments, contact Ronald C. Leadbetter, Associate General Counsel, The University of Tennessee, Office of General Counsel, 719 Andy Holt Tower, Knoxville, TN 37996-0170, telephone number (865) 974-3247.

The text of the proposed amendments is as follows:

AMENDMENTS

Rule 1720-4-5-.07(1)(a) is amended by deleting \$27.00 and substituting \$32.00, so that, as amended, the subparagraph shall read:

- (a) Registration violation \$32.00 (except an altered or mutilated registration tag or parking permit violation, an unauthorized possession of registration tag or parking permit violation, and a falsification of registration information violation, the penalty for each of which is \$250.00).

Authority: *T.C.A. § 49-9-209(e).*

Rule 1720-4-5-.07(1)(b) is amended by deleting \$12.00 and substituting \$24.00, so that, as amended, the subparagraph shall read:

- (b) Parking violation \$24.00 (Except a FIRE LANE violation, which is \$42.00, and a handicapped or ramp violation and an unauthorized use of a handicapped plate or placard violation, each of which is \$100.00).

Authority: *T.C.A. § 49-9-209(e).*

The proposed rules set out herein were properly filed in the Department of State on the 10th day of November, 2005, and pursuant to the instructions set out above, and in the absence of the filing of an appropriate petition calling for a rulemaking hearing, will become effective on the 30th day of March, 2006. (11-10).

PROPOSED RULES

THE UNIVERSITY OF TENNESSEE - 1720 THE UNIVERSITY OF TENNESSEE, KNOXVILLE

CHAPTER 1720-4-6 LIBRARY FINES

Presented herein are proposed amendments of The University of Tennessee submitted pursuant to Tennessee Code Annotated, Section 4-5-202, in lieu of a rulemaking hearing. It is the intent of The University of Tennessee to promulgate these amendments without a rulemaking hearing unless a petition requesting such hearing is filed within thirty (30) days of the publication date of the issue of the Tennessee Administrative Register in which the proposed amendments are published. Such petition to be effective must be filed in Room 719, Andy Holt Tower, The University of Tennessee, Knoxville, Tennessee 37996-0170, and in the Department of State, 8th Floor, William R. Snodgrass Tennessee Tower, 312 8th Avenue North, Nashville, Tennessee 37243, and must be signed by twenty-five (25) persons who will be affected by the amendments, or submitted by a municipality which will be affected by the amendments, or an association of twenty-five (25) or more members, or any standing committee of the General Assembly.

For a copy of the proposed amendments, contact Ronald C. Leadbetter, Associate General Counsel, The University of Tennessee, Office of General Counsel, 719 Andy Holt Tower, Knoxville, TN 37996-0170, telephone number (865) 974-3247.

The text of the proposed amendments is as follows:

AMENDMENTS

Rule 1720-4-6-.01 is amended by deleting the current language of the rule and substituting new language so that, as amended, the rule shall read:

1720-4-6-.01 FOR REGULAR LOANS.

No regular overdue fines for books, monographs, serials, periodicals, or other items not specified below.

- (1) A notice is sent 1 to 8 days after your book is due. If you do not respond a final bill for replacement will be sent about 21 days later. Failure to receive notices does not relieve the borrower of his/her responsibility.

Authority: T.C.A. §49-9-209(e).

Rule 1720-4-6-.02 is amended by deleting the current language of the rule and substituting new language so that, as amended, the rule shall read:

1720-4-6-.02 FOR RESERVE BOOKS, MEDIA, AND EQUIPMENT.

- (1) 2-hour reserve/overnight - \$.25 per hour per item to a maximum of \$20.00 per item.
- (2) 1-day, 3-day/7-day reserve and equipment - \$1.00 per day per item to a maximum of \$20.00 per item.
- (3) 3-hour or 24-hour Equipment Loans, \$.25 per hour per item overdue up to a maximum of \$20.00 per item.

PROPOSED RULES

- (4) 3-day Media (e.g. video, DVD) loans - \$.25 per hour per item overdue up to a maximum of \$20.00 per item.

Authority: T.C.A. §49-9-209(e).

Rule 1720-4-6-.03 is amended by deleting the current language of the rule and substituting new language so that, as amended, the rule shall read:

1720-4-6-.03 LOST ITEMS AND EQUIPMENT. Resolution of lost items and equipment transactions require payment of accumulated fines plus library cost recoveries (Item or equipment replacement cost plus \$20.00 processing fee).

Authority: T.C.A. §49-9-209(e).

Rule 1720-4-6-.07 is amended by deleting \$.25 and substituting \$.50 so that, as amended, the rule reads:

1720-4-6-.07 RECALLS. All books on loan are subject to recall. When a recall is requested, a new due date is set for ten days from the date of the request. If the recalled item is not returned within that ten-day period, your borrowing privileges will be blocked and fines of \$.50 per day will be assessed from the new due date forward to a maximum of \$20.00.

Authority: T.C.A. §49-9-209(e).

The proposed rules set out herein were properly filed in the Department of State on the 10th day of November, 2005, and pursuant to the instructions set out above, and in the absence of the filing of an appropriate petition calling for a rulemaking hearing, will become effective on the 30th day of March, 2006. (11-11)

PROPOSED RULES

THE UNIVERSITY OF TENNESSEE - 1720

The University of Tennessee at Martin

CHAPTER 1720-5-4

STUDENT HOUSING REGULATIONS

Presented herein are proposed amendments of The University of Tennessee submitted pursuant to Tennessee Code Annotated, Section 4-5-202, in lieu of a rulemaking hearing. It is the intent of The University of Tennessee to promulgate these amendments without a rulemaking hearing unless a petition requesting such hearing is filed within thirty (30) days of the publication date of the issue of the Tennessee Administrative Register in which the proposed amendments are published. Such petition to be effective must be filed in Room 719, Andy Holt Tower, The University of Tennessee, Knoxville, Tennessee 37996-0170, and in the Department of State, 8th Floor, William R. Snodgrass Tennessee Tower, 312 8th Avenue North, Nashville, Tennessee 37243, and must be signed by twenty-five (25) persons who will be affected by the amendments, or submitted by a municipality which will be affected by the amendments, or an association of twenty-five (25) or more members, or any standing committee of the General Assembly.

For a copy of the proposed amendments, contact Ronald C. Leadbetter, Associate General Counsel, The University of Tennessee, Office of General Counsel, 719 Andy Holt Tower, Knoxville, TN 37996-0170, telephone number (865) 974-3247.

The text of the proposed amendments is as follows:

AMENDMENTS

Chapter 1720-5-4 is amended by deleting the current language and substituting new language so that, as amended, the chapter shall read:

CHAPTER 1720-5-4 STUDENT HOUSING REGULATIONS

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1720-5-4-.01 HOUSING REQUIREMENT. In view of the educational advantages and academic needs on campus and the desire to provide campus housing at a minimum cost to students, The University of Tennessee at Martin requires all single freshmen and sophomores, except those living with their parents, to live on campus.

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1720-5-4-.02 CLASSIFICATION (FOR HOUSING PURPOSES ONLY). For housing policy purposes (but not for academic classification purposes), a freshman is defined as a student with less than two completed semesters of work (fewer than 30 hours), a sophomore as one with two but less than four semesters (fewer than 60 hours), a junior as one with four but less than six semesters, and a senior as one with six or more semesters completed. A graduate student is a student taking course work beyond the bachelor degree level. Summer semester work may be counted in computing the number of semesters.

1720-5-4-.03 TYPES OF DIFFERENTIATED HOUSING.

- (1) Three types of on campus housing are available for single students.
 - (a) Type I: No Visitation. Available to all single students, with preference to freshmen, followed by sophomores, juniors, and seniors. Quiet hours are enforced between 8:00 p.m. and 8:00 a.m. Sunday through Thursday and from 12:00 a.m. until 8:00 a.m. Friday and Saturday. During examination week, quiet hours are in effect 24 hours daily. Hall clerks are on duty 24 hours daily. Resident Assistants on each floor provide counseling and aid in maintaining order. Emergency message service is available at the central desk.
 - (b) TYPE II: Limited Visitation. Available to all single students, with preference to freshmen, followed by sophomores, juniors and seniors. Quiet hours are enforced between 8:00 p.m. and 8:00 a.m. Sunday through Thursday and from 12:00 a.m. until 8:00 a.m. Friday and Saturday. During examination weeks, quiet hours are in effect 24 hours daily. Sunday through Thursday, visitation is permitted between 12:00 p.m. and 12:00 a.m. Friday and Saturday visitation is between 12:00 p.m. and 2:00 a.m. Hall clerks are on duty 24 hours daily. Resident Assistants on each floor provide counseling and aid in maintaining order. Emergency message service is available at the central desk.
 - (c) Type III: Available to all single students living in apartments. Open visitation 24 hours daily. Minimal supervision and regulations. Students must conform to all Student Handbook policies.

1720-5-4-.04 SEPARATE ACCOMMODATIONS BY SEX. Co-educational housing of single students in the same suites, rooms or apartments is not permitted at UTM.

1720-5-4-.05. JUDICIAL PROCEEDINGS. Standards of conduct expected of students are published in the Student Handbook, and specific regulations pertaining to residence halls are posted on bulletin boards or announced in hall meetings. Students who are accused of violations may have their cases handled in either of two ways:

- (1) Administratively by the Hall Director or Student Affairs staff; or
- (2) By the student court.

After hearing a case, a judgment of guilt or innocence is made and a penalty is assessed where appropriate. The penalties that may be assessed are loss of privilege, disciplinary warning, disciplinary probation, and

PROPOSED RULES

suspension. In addition, these penalties may include dismissal from the residence hall or apartment. The student has the option to appeal to the Disciplinary Hearing Board or the University Council.

1720-5-4-.06 ROOM PAINTING. Interested residents should visit the Housing Facilities Office and discuss room painting with the Paint Supervisor.

1720-5-4-.07 PERIOD OF OCCUPANCY. Students having assignments may occupy their rooms on the date specified by the Office of Housing. Normally the dates begin the day preceding registration period and end on the last day of the final examination period, except for certain university holidays such as Thanksgiving and Easter. If a student fails to occupy the assigned room by the date specified without giving the Office of Housing prior notification of delayed arrival, the room may be reassigned to another student. Delayed arrival does not relieve the student of the responsibility for accepting available accommodation.

- (1) Soliciting: Soliciting is not permitted in the non-public areas of the residence halls. It may be permitted in the public areas by registered student organizations depending on space, circumstances and provisions of the Student Handbook.
- (2) Windows and Screens: Window screens must not be unfastened or removed. In addition, the following rules also apply.
 - (a) Food may not be stored between windows and screens or outside of the windows at anytime.
 - (b) Displays in windows which are deemed inappropriate by the hall head staff and not removed by the resident(s), will be removed by the staff and the resident(s) billed for this service.
 - (c) Under no circumstances will the throwing of objects from any windows in the residence halls be tolerated. Such conduct poses a danger to the health and safety of other residents. Residents assigned to a room from which an object is thrown will be subject to administrative eviction from the university residence halls in accordance with the terms and conditions of the Housing Contract.
- (3) Business from Residents' Rooms: Residents are not permitted to carry on any organized business for remunerative purposes from their apartments or rooms, inscribe or affix any sign, object, advertisement, or notice on any part of the inside or outside of the building or premises, or use their room phone numbers for business purposes.
- (4) Open House and Visitation: At no time may a member of the opposite sex be in a non-public area unless the guest is in compliance with the open house or visitation policies of that unit. Resident Assistants are able to define these areas specifically for the hall, including but not limited to corridor of a living unit, resident's room etc.
- (5) Guests: Residents may have overnight guests of the same sex only; it is the host's responsibility to arrange for sleeping facilities, including linens, permission from another roommate for use of his/her bed, etc. Unless extraordinary arrangements have been made with the Hall Director or Assistant Hall Director, no keys will be issued to guests, and no resident may have a guest in the hall when the resident will not be present to act as his/her host.

PROPOSED RULES

- (a) Guests are discouraged during weekday nights and during the last week of each semester when final exams are being given. The maximum length of any visit is 3 days and 3 nights, with extensions granted only by the Hall Director or Assistant Hall Director.
 - (b) University officials can require guests to produce proof that they are legitimate guests. Guests must complete a Guest Registration Card available at the main desk of each hall. The information on this card may aid in contacting the guest and/or his/her designee should the need arise. The guest's copy of the card will also serve as an identification card during his/her stay on campus.
 - (c) All guests are governed by university and residence hall rules and regulations. For a violation of rules by an off-campus guest, the host is responsible for any damages caused by the guest.
 - (d) No individual will be permitted to sleep in the main or floor lounges of university residence halls. Night clerks and hall staff will ask such persons to leave the hall or to return to their assigned rooms. If a non-resident does not comply with the request to leave, Campus Security will be called to remove them.
- (6) Pets: For health reasons, pets are not permitted in the halls. Cats, dogs and other pets present a multitude of problems in a residence hall and are not permitted on the premises. (The only exceptions to this policy are (1) guide dogs accompanying blind persons and (2) fish which live completely submerged in water.)
- (7) Attachments: Residents should not install any of the following in their rooms:
- (a) Locks;
 - (b) Decals or transfer pictures;
 - (c) Outside antenna for radio or television;
 - (d) Additional electrical wiring;
 - (e) Attachments to the telephone;
 - (f) Shades, blinds, awnings or window guards;
 - (g) Air-conditioning or heating units.
- (8) Noise Level: Residents are expected to show consideration for others at all times and should avoid excessive noise. They are requested to refrain from: unnecessary noise; congregating in the hall, bath, or elevator areas; loud talking or laughing; and loud playing of electronic equipment. For obvious (audible) reasons, musical instruments may be played only in areas provided for this purpose. Abuse of these standards may result in the instrument or appliance being stored until it can be removed from the campus. Radios, stereos or other electronic equipment should not be placed in or near windows, as the noise may distract others whose windows may be open.

Beyond this, residence hall associations may establish specific quiet hours within their respective halls.

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- (9) Furniture: All university property is inventoried according to location and is not to be moved or dismantled except with written permission of the Hall Director. Removal of furniture from its assigned location, except with permission, is grounds for disciplinary action. Residents will also be charged for any furniture or facilities assigned to their rooms and found missing at the time of checkout.
- (10) Water Furniture: Water furniture, including beds and chairs, are not permitted in residents' rooms.
- (11) Bicycles: Racks are provided for bikes in front of each hall. Off-street parking is provided for motorized bikes in designated areas. Motorized bikes are not allowed inside residence halls. Although non-motorized bikes may be kept in residents' rooms, they are not to be left unattended, ridden, or chained in common areas of the halls such as hallways, stairwells, lobbies, study rooms, etc. Bikes found in such areas will be removed at the owner's expense, stored for a short time, and then disposed of. (Bikes may not be stored in luggage or other storage rooms due to lack of space.)
- (12) Stairwells: Under no circumstances will the dropping of objects or fireworks down stairwells be tolerated. Such conduct poses obvious danger to the health and safety of other residents. Persons involved in such actions will be subject to eviction from university residence halls, in accordance with the terms and conditions of the Housing contract.
- (13) The University Of Tennessee Reserves The Right To Make Other Policies From Time To Time Deemed Necessary And Appropriate For The Safety And Cleanliness Of The Premises, And For Securing The Comfort And Convenience Of All Residents.

1720-5-5-.08 RESIDENCE HALL SAFETY REGULATIONS.

- (1) Flammable Items: Items which are flammable, such as fuel, etc., may not be stored in residents' rooms.
- (2) Open Flames: Items which require an open flame to operate or which produce heat (i.e., Bunsen burners, lighted candles, alcohol burners) are not allowed in residents' rooms. Candles must have the wicks removed and may be used for decorative purposes.
- (3) Decorations: Decorative items, such as fishnets, parachutes, and other such items which are flammable are not permitted in residents' rooms, unless they have been fireproofed. Only Underwriters' Laboratory (U.L.) approved lights may be used to decorate rooms.
- (4) Cooking: Hall kitchens and other facilities are provided for residents to use for cooking. Cooking with open coil appliances is not permitted in student rooms.
- (5) Electrical Appliances: In residence halls, U.L. approved microwaves, George Forman type grills, closed coil only popcorn poppers and coffee makers may be in student rooms.
- (6) Fires And Fire Drills: Fire evacuation plans are posted in each resident's room. A resident will be subject to disciplinary action for tampering with or activating fire alarm or control equipment except in case of a fire or for failure to evacuate the building during an evacuation and safety drill. A safety exit drill will be conducted in each residence hall once per month

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in compliance with state law. A resident who sees or suspects a fire should immediately notify a staff member who will activate the fire alarm system if necessary.

- (7) Fire Lanes: Several halls have nearby emergency lanes which are strictly reserved for use by emergency vehicles only. Unauthorized vehicles parked in these areas will be towed away by Public Safety at the owner's risk and expense.
- (8) Safety Equipment: The University of Tennessee at Martin, through the Office of Housing, hereby advises all students that the University will not tolerate the irresponsible behavior of persons whose actions jeopardize the safety and welfare of others. Tampering with, vandalizing, or otherwise abusing elevator, fire, or safety equipment in the university residence halls will constitute reason for eviction from the residence halls and possible suspension from The University of Tennessee at Martin.

1720-5-4-.09 TERMINATION OF HOUSING CONTRACT. When considered in the best interest of the university, a resident can be asked to move from the hall. An appeal can be made by the student through the established administrative and judicial procedures.

1720-5-4-.10 PREGNANCY. UTM Housing Office policies do not permit assignment of single-student rooms to pregnant students during the third trimester of pregnancy. This policy does not prevent a pregnant woman from enrolling in the university provided off-campus housing and medical arrangements can be made by the enrolling student and her family. The primary concern of this university policy is that the prospective mother be in an environment where the necessary service and care be provided for her and her baby. Alternative housing will be offered. Refund of the customary portion of rent paid would be made.

Authority: *T.C.A. § 49-9-209(e).*

The proposed rules set out herein were properly filed in the Department of State on the 10th day of November, 2005, and pursuant to the instructions set out above, and in the absence of the filing of an appropriate petition calling for a rulemaking hearing, will become effective on the 30th day of March, 2006. (11-12)

PUBLIC NECESSITY RULES

PUBLIC NECESSITY RULES NOW IN EFFECT

FOR TEXT OF PUBLIC NECESSITY RULE, SEE T.A.R.

- 0400 - Department of Environment and Conservation - Petroleum Underground Storage Tank Division - Public Necessity rules dealing with incentives for tank owners, Chapter 1200-1-15 Underground Storage Tank Program, 9 T.A.R. (September 2005) Filed August 29, 2005; effective through February 10, 2006, (08-57)
- 0620 - Department of Finance and Administration - Bureau of TennCare - Public Necessity Rules concerning TennCare Demonstration Project, chapter 1200-13-1 General Rules, 10 T.A.R. (October 2005) - Filed September 26, 2005; effective through March 10, 2006. (09-29)
- 0620 - Department of Finance and Administration - Bureau of TennCare - Public Necessity Rules concerning TennCare Demonstration Project, chapter 1200-13-13 TennCare Medicaid, 8 T.A.R. (August 2005) - Filed July 26, 2005; effective through January 10, 2006. (07-43)
- 0620 - Department of Finance and Administration - Bureau of TennCare - Public Necessity Rules concerning TennCare Demonstration Project, chapter 1200-13-13 TennCare Medicaid, 8 T.A.R. (August 2005) - Filed July 29, 2005; effective through January 10, 2006. (07-44)
- 0620 - Department of Finance and Administration - Bureau of TennCare - Public Necessity Rules deleting sections relating to the TennCare Partners State-Only Program, chapter 1200-13-13 TennCare Medicaid, 9 T.A.R. (September 2005) - Filed August 18, 2005; effective through January 30, 2005. (08-33)
- 0620 - Department of Finance and Administration - Bureau of TennCare - Public Necessity Rules concerning changes resulting from the amendment of the TennCare waiver, chapter 1200-13-13 TennCare Medicaid, 10 T.A.R. (October 2005) - Filed September 7, 2005; effective through February 19, 2006. (09-12)
- 0620 - Department of Finance and Administration - Bureau of TennCare - Public Necessity Rules concerning TennCare Demonstration Project, chapter 1200-13-14 TennCare Standard, 8 T.A.R. (August 2005) - Filed July 29, 2005; effective through January 10, 2006. (07-45)
- 0620 - Department of Finance and Administration - Bureau of TennCare - Public Necessity Rules concerning TennCare Demonstration Project, chapter 1200-13-14 TennCare Standard, 8 T.A.R. (August 2005) - Filed July 29, 2005; effective through January 10, 2006. (07-46)
- 0620 - Department of Finance and Administration - Bureau of TennCare - Public Necessity Rules concerning TennCare Partners State-Only Program, chapter 1200-13-14 TennCare Standard, 9 T.A.R. (September 2005) - Filed August 18, 2005; effective through January 30, 2006. (08-34)
- 0780 - Department of Commerce and Insurance - Division of Insurance - Public necessity rules concerning MMA and state Medigap, chapter 0780 Medicare Supplement Insurance Minimum Standards, 10 T.A.R. (October 2005) - Filed September 1, 2005; effective through February 13, 2006. (09-03)

PUBLIC NECESSITY RULES

- 1240 - Department of Human Services - Medical Services Division - Public Necessity Rules promulgated to avoid loss of federal funds, chapter 1240-3-3 Technical and Financial Eligibility Requirements for Medicaid, 10 T.A.R. (October 2005) - Filed September 30, 2005; effective through March 14, 2006. (09-41)
- 1540 - TN Higher Education Commission - Public Necessity Rules adding eligible employees, chapter 1540-1-5 Public Higher Education Fee Discounts for Children of Licensed Public School Teachers and State Employees, 10 T.A.R. (October 2005) - Filed September 1, 2005, 2005; effective through February 13, 2006. (09-01)
- 1640 - TN Student Assistance Corporation - Public Necessity rule dealing with lottery scholarships, Chapter 1640-1-19 TN Educational Lottery Scholarship Program, Volume 31, Number 11 (November 2005) - Filed October 4, 2005; effective through March 18, 2006. (10-02)

PUBLIC NECESSITY RULES

**THE TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT - 0800
DIVISION OF WORKERS' COMPENSATION**

**CHAPTER 0800-2-17
MEDICAL COST CONTAINMENT PROGRAM**

STATEMENT OF NECESSITY FOR READOPTING PUBLIC NECESSITY RULES

Pursuant to Tenn. Code Ann. §§ 4-5-209(a)(4) and (b) and 50-6-204(i)(5), the Commissioner submits the In-patient Hospital Fee Schedule Rules ("Rules") for readoption as public necessity rules as part of the comprehensive medical fee schedule and related system applicable to all medical treatment under the Workers' Compensation Law as administered by the Workers' Compensation Division of the Tennessee Department of Labor and Workforce Development. Readoption of these as public necessity rules is necessary for the reasons set forth below and because Tenn. Code Ann. § 50-6-204(i) requires the comprehensive medical fee schedule and related system be in place and effective on and after July 1, 2005. Tenn. Code Ann. § 50-6-204(i)(5).

These Rules were initially adopted as public necessity rules and filed with the secretary of state's office on June 15, 2005, when proposed rules were also filed. Those public necessity rules will expire on November 27, 2005, and unless these rules are readopted as public necessity rules now, there will be a period of time when no effective Rules will be in place. In response to a petition on the proposed rules, a rulemaking public hearing was held on these Rules on September 23, 2005. The Department is currently analyzing all of the numerous oral and written comments received during the rulemaking public hearing and must respond to each in writing as required pursuant to Tenn. Code Ann. § 4-5-222. Given that the rulemaking hearing rules may not be effective until at least 75 days after filing with the secretary of state's office, it would be impossible to avoid a lapse in these Rules without the readoption of these Rules as public necessity rules. The Department could not have reasonably foreseen during the initial one hundred sixty-five day period that the original need for the public necessity rules would continue to the present time.

Medical providers, employees, employers and insurers are statutorily mandated to comply with the medical fee schedule rules, of which these Rules are an integral part, on and after July 1, 2005, in providing all workers' compensation medical benefits. These rules are necessary to comply with the mandate enacted by the General Assembly in Public Chapter 962 (Tenn. Code Ann. § 50-6-204, (2005 Supp.)) to provide the required medical fee schedule with guidelines and procedures to medical providers, employees, employers and insurers. Thus, these public necessity rules are being readopted to protect the public welfare. Due to the length of time necessary to complete the rulemaking process under the Uniform Administrative Procedures Act, these public necessity rules should be readopted immediately to provide applicable medical fees, guidelines and procedures so as not to jeopardize injured employees' ability to receive prompt and adequate medical care. Further, Tenn. Code Ann. § 50-6-204(i)(5) specifically authorizes adoption of these rules as public necessity rules.

James Neeley, Commissioner
Tennessee Department of Labor &
Workforce Development

For copies of this public necessity rule, contact: Vickie Gregory, Administrative Assistant, Tennessee Department of Labor and Workforce Development, Division of Workers' Compensation, Andrew Johnson Tower, Second Floor, 710 James Robertson Parkway, Nashville, TN 37243-0661, (615) 253-1613.

PUBLIC NECESSITY RULES

**RULES
OF
TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
DIVISION OF WORKERS' COMPENSATION**

**CHAPTER 0800-2-17
MEDICAL COST CONTAINMENT PROGRAM**

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0800-2-17-.01 PURPOSE AND SCOPE.

- (1) Purpose. Pursuant to Tenn. Code Ann. § 50-6-204 (Supp. 2004), the following Medical Cost Containment Program Rules, together with the Medical Fee Schedule Rules, Chapter 0800-2-18-.01 et seq., and the In-patient Hospital Fee Schedule Rules, Chapter 0800-2-19.01 et seq., are hereby adopted by the Commissioner in order to establish a comprehensive medical fee schedule and a related system which includes, but is not limited to, procedures for review of charges, enforcement procedures and appeal hearings, to implement a medical fee schedule. The Commissioner promulgates these Medical Cost Containment Program Rules together with the Medical Fee Schedule and In-patient Hospital Fee Schedule rules to establish the maximum allowable fees for health care services falling within the purview of the Tennessee Workers' Compensation Act ("Act"). These Medical Cost Containment Program Rules must be used in conjunction with the Medical Fee Schedule Rules and In-patient Hospital Fee Schedule Rules. The Medical Cost Containment Program Rules, Medical Fee Schedule Rules and In-patient Hospital Fee Schedule Rules (collectively herein "Rules") establish maximum allowable fees. Employers, carriers and providers may negotiate and contract lesser fees as are agreeable between them, but in no event shall reimbursement be in excess of the Rules, subject to the civil

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penalties prescribed in the Rules, as assessed by, and in the discretion of, the Commissioner, the Commissioner's designee, or an agency member appointed by the Commissioner.

- (2) Scope. These rules do all of the following:
- (a) Establish procedures by which the employer shall furnish, or cause to be furnished to an employee who receives a personal injury, or suffers an occupational disease, arising out of and in the course of employment, reasonable and necessary medical, surgical, and hospital services and medicines, or other attendance or treatment recognized by the laws of the state as legal, when needed. The employer shall also supply to the injured employee dental services, crutches, artificial limbs, eyes, teeth, eyeglasses, hearing apparatus, and other appliances necessary to cure, so far as reasonably and necessarily possible, and relieve from the effects of the injury or occupational disease.
 - (b) Establish schedules of maximum fees by a health facility or health care provider for such treatment or attendance, service, device, apparatus, or medicine.
 - (c) Establish procedures by which a health care provider shall be paid the lesser of: (1) the provider's usual charge, (2) the maximum fee established under these Rules, or (3) the MCO/PPO or any other negotiated and contracted price, where applicable. In no event shall reimbursement be in excess of these Rules. Reimbursement in excess of these Rules may, at the Commissioner's discretion, result in civil penalties of ten thousand dollars (\$10,000.00) per violation each assessed severally against the provider accepting such fee and the carrier or employer paying the excessive fee, if a pattern or practice of such activity is found. At the Commissioner's discretion, such provider may also be reported to the appropriate certifying board, and may be subject to exclusion from participating in providing care under the Act.
 - (d) Identify utilization of health care and health services which is above the usual range of utilization for such services, based on medically accepted standards. Also to provide the ability by a carrier and the Division to obtain necessary records, medical bills, and other information concerning any health care or health service under review.
 - (e) Establish a system for the evaluation by a carrier of the appropriateness in terms of both the level of and the quality of health care and health services provided to injured employees, based upon medically accepted standards.
 - (f) Authorize carriers to withhold payment from, or recover payment from, health facilities or health care providers which have made excessive charges or which have required unjustified and/or unnecessary treatment, hospitalization, or visits.
 - (g) Permit review by the Division of the records and medical bills of any health facility or health care provider which has been determined not to be in compliance with these Rules, or to be requiring unjustified and/or unnecessary treatment, hospitalization or office visits.
 - (h) Establish that when a health care facility or health care provider provides health care or health care service that is not usually associated with, is longer in duration than, is more frequent than, or extends over a greater number of days than the health care or service usually does with a diagnosis or condition for which the patient is being treated, the health care provider may be required by the carrier to explain the necessity in writing.
 - (i) Implement the Division's review and decision responsibility. These Rules and definitions are not intended to modify the workers' compensation laws, other administrative rules of the Division, or court decisions interpreting the laws or the Division's administrative rules.
 - (j) Establish maximum fees for depositions/witnesses.

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- (k) Establish maximum fees for medical reports.
- (l) Provide for uniformity of billing for provider services.
- (m) Establish the effective date for implementation of these Rules.
- (n) Adopt by reference as part of this rule the American Medical Association's CPT, Medical Fee Schedule, the In-patient Hospital Fee Schedule and any amendments to the fee schedule.
- (o) Establish procedures for reporting of medical claims.
- (p) Establish procedures for preauthorization of non-emergency hospitalizations, transfers between facilities, and outpatient services.
- (q) Establish procedures for imposing and collecting civil penalties for violations of these Rules.
- (r) The Rules shall be effective July 1, 2005.

Authority: T.C.A. §§ 50-6-118, 50-6-125, 50-6-128, 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

0800-2-17-.02 SEVERABILITY AND PREEMPTION.

If any provision of these Medical Cost Containment Program Rules, the Medical Fee Schedule Rules or the In-patient Hospital Fee Schedule Rules (collectively hereinafter "Rules") or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the Rules and the application of the provisions to other persons or circumstances shall not be affected in any respect whatsoever. Whenever a conflict arises between these Rules and any other rule or regulation, these Rules shall prevail.

Authority: T.C.A. §§ 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

0800-2-17-.03 DEFINITIONS.

The following definitions are for the purposes of these Medical Cost Containment Program Rules, the Medical Fee Schedule Rules and the In-patient Hospital Fee Schedule Rules:

- (1) "Act" means Tennessee's Workers' Compensation Act, Tenn. Code Ann. §§ 50-6-101 et seq., as amended.
- (2) "Adjust" means that a carrier or a carrier's agent reduces a health care provider's request for payment such as:
 - (a) Applies the Division's maximum fee;
 - (b) Applies an agreed upon discount to the provider's usual charge;
 - (c) Adjusts to a reasonable amount when the maximum fee is by report;
 - (d) Recodes a procedure;
 - (e) Reduces payment as a result of utilization review.

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- (3) "Administrator" means the chief administrative officer of the Workers' Compensation Division of the Tennessee Department of Labor and Workforce Development.
- (4) "Appropriate care" means health care that is suitable for a particular person, condition, occasion, or place as determined by the Commissioner or the Commissioner's designee after consultation with the Medical Director.
- (5) "Bill" means a request by a provider submitted to a carrier for payment for health care services provided in connection with a compensable injury, illness or occupational disease.
- (6) "Bill adjustment" means a reduction of a fee on a provider's bill.
- (7) "BR" (By Report) means that the procedure is not assigned a maximum fee and requires a written description. The description shall be included on the bill or attached to the bill and shall include the following information, as appropriate:
 - (a) Copies of operative reports.
 - (b) Consultation reports.
 - (c) Progress notes.
 - (d) Office notes or other applicable documentation.
 - (e) Description of equipment or supply (when that is the charge).
- (8) "Carrier" means any stock company, mutual company, or reciprocal or inter-insurance exchange or self-insured employer authorized to write or carry on the business of workers' compensation insurance in this state; whenever required by the context, the term 'carrier' shall be deemed to include duly qualified self-insureds or self-insured groups.
- (9) "Case" means a compensable injury, illness or occupational disease identified by the worker's name and date of injury, illness or occupational disease.
- (10) "Case record" means the complete health care record maintained by the carrier pertaining to a compensable injury, illness or occupational disease and includes the circumstances or reasons for seeking health care; the supporting facts and justification for initial and continual receipt of health care; all bills filed by a health care service provider; and actions of the carrier which relate to the payment of bills filed in connection with a compensable injury, illness or occupational disease.
- (11) "CMS" means the U.S. Centers for Medicare & Medicaid Services (formerly HCFA).
- (12) "Commissioner" means the Commissioner of the Tennessee Department of Labor and Workforce Development, the Commissioner's designee, or an agency member appointed by the Commissioner.
- (13) "Complete procedure" means a procedure containing a series of steps which are not to be billed separately.
- (14) "Consultant service" means; in regard to the health care of a covered injury and illness; an examination, evaluation, and opinion rendered by a health care specialist when requested by the authorized treating practitioner or by the employee; and which includes a history, examination, evaluation of treatment, and a written report. If the consulting practitioner assumes responsibility for the continuing care of the patient, subsequent service(s) cease(s) to be a consultant service.

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- (15) "Compensable injury, illness or occupational disease" means an injury, illness or occupational disease for which health care treatment is mandated under Tennessee Workers' Compensation Act.
- (16) "CPT" means the most current edition of the American Medical Association's Current Procedural Terminology.
- (17) "Critical care" has the same meaning as that in the most current version of the CPT.
- (18) "Day" means a calendar day, unless otherwise designated in these Rules.
- (19) "Department" means the Tennessee Department of Labor and Workforce Development.
- (20) "Diagnostic procedure" means a service which aids in determining the nature and cause of an occupational disease or injury.
- (21) "Division" means the Workers' Compensation Division of the Tennessee Department of Labor and Workforce Development.
- (22) "Dispute" means a disagreement between a carrier or a carrier's agent and a health care provider on the application of these Rules.
- (23) "DRG" (Diagnosis Related Group) means one of the classifications of diagnoses in which patients demonstrate similar resource consumption and length of stay patterns as for Medicare purposes by CMS (see "HCFA").
- (24) "Durable medical equipment" or "DME" is equipment which (1) can withstand repeated use, (2) is primarily and customarily used to serve a medical purpose, (3) generally is not useful to a person in the absence of illness, injury or occupational disease, and (4) is appropriate for use in the home.
- (25) "Established patient" has the same meaning as in the most current version of the CPT.
- (26) "Expendable medical supply" means a disposable article which is needed in quantity on a daily or monthly basis.
- (27) "Focused review" means the evaluation of a specific health care service or provider to establish patterns of use and dollar expenditures.
- (28) "Follow-up care" means the care which is related to the recovery from a specific procedure and which is considered part of the procedure's maximum allowable payment, but does not include care for complications.
- (29) "Follow-up days" means the days of care following a surgical procedure which are included in the procedure's maximum allowable payment, but does not include care for complications.
- (30) "Follow-up visits" means the number of office visits following a surgical procedure which is included in the procedure's maximum allowable payment, but does not include care for complications.
- (31) "HCFA" (now the "CMS") means the U.S. Centers for Medicare & Medicaid Services, formerly known as the Health Care Financing Administration of the U.S. Department of Health and Human Services.
- (32) "Health care organization" means a group of practitioners or individuals joined together to provide health care services and includes, but is not limited to, a freestanding surgical outpatient facility, health maintenance organization, an industrial or other clinic, an occupational health care center, a home health agency, a visiting nurse association, a laboratory, a medical supply company, or a community mental health center.

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- (33) "Health care review" means the review of a health care case or bill, or both, by a carrier, or the carrier's agent.
- (34) "Health Care Specialist" means a board-certified practitioner, board-eligible practitioner, or a practitioner otherwise considered an expert in a particular field of health care service by virtue of education, training, and experience generally accepted by practitioners in that particular field of health care service.
- (35) "Health Care Specialist service" means, in regard to the health care of a compensable injury, illness or occupational disease, the treatment by a health care specialist, when requested by the treating practitioner, carrier, or by the employee, and includes a history, an examination, evaluation of medical data, treatment, and a written report.
- (36) "Inappropriate health care" means health care that is not suitable for a particular person, condition, occasion, or place as determined by the Commissioner or the Commissioner's designee after consultation with the Division's Medical Director.
- (37) "Incidental surgery" means a surgery performed through the same incision, on the same day, by the same doctor, and not related to the diagnosis.
- (38) "Independent medical examination" means an examination and evaluation conducted by a practitioner different from the practitioner providing care, other than one conducted under the Division's Medical Impairment Rating Registry (MIRR) Program.
- (39) "Independent procedure" means a procedure which may be carried out by itself, separate and apart from the total service that usually accompanies it.
- (40) "Inpatient services" mean services rendered to a person who is formally admitted to a hospital and whose length of stay exceeds 23 hours.
- (41) "Institutional services" mean all non-physician services rendered within the institution by an agent of the institution.
- (42) "Maximum allowable payment" means the maximum fee for a procedure established by these Rules or the usual and customary charge, whichever is less, except as otherwise might be specified. In no event shall reimbursement be in excess of the Division's Medical Fee Schedule. Charges in excess of the Division's Medical Fee Schedule shall, at the Commissioner's discretion, result in civil penalties of ten thousand dollars (\$10,000.00) per violation for each violation assessed severally against the provider accepting such fee and the carrier or employer paying the excessive fee, whenever a pattern or practice of such activity is found. At the Commissioner's discretion, such provider may also be reported to the appropriate certifying board, and may be subject to exclusion from participating in providing care under the Act.
- (43) "Maximum fee" means the maximum allowable fee for a procedure established by this rule, the Medical Fee Schedule and the In-patient Hospital Fee Schedule.
- (44) "Medical admission" means any hospital admission where the primary services rendered are not surgical, psychiatric, or rehabilitative in nature.
- (45) "Medically accepted standard" means a measure which is set by a competent authority as the rule for evaluating quantity or quality of health care or health care services and which may be defined in relation to any of the following:
 - (a) Professional performance.
 - (b) Professional credentials.
 - (c) The actual or predicted effects of care.

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- (d) The range of variation from the norm.
- (46) "Medically appropriate care" means health care that is suitable for a particular person, condition, occasion, or place.
- (47) "Medical Director" means the Division's Medical Director appointed by the Commissioner pursuant to T.C.A. § 50-6-126 (Repl. 1999)
- (48) "Medical only case" means a case which does not involve lost work time.
- (49) "Medical supply" means either a piece of durable medical equipment or an expendable medical supply.
- (50) "Modifier code" means a 2-digit number used in conjunction with the procedure code to describe unusual circumstances which arise in the treatment of an injured or ill employee.
- (51) "New patient" means a patient who is new to the provider for a particular compensable injury, illness or occupational disease and who needs to have medical and administrative records established.
- (52) "Operative report" means the practitioner's written description of the surgery and includes all of the following:
 - (a) A preoperative diagnosis.
 - (b) A postoperative diagnosis.
 - (c) A step-by-step description of the surgery.
 - (d) An identification of problems which occurred during surgery.
 - (e) The condition of the patient, when leaving the operating room, the practitioner's office, or the health care organization.
- (53) "Ophthalmologist" shall be defined according to T.C.A. § 71-4-102(3).
- (54) "Optician" shall mean a licensed dispensing optician as set forth in T.C.A. § 63-14-103.
- (55) "Optometrist" means an individual licensed to practice optometry.
- (56) "Optometry" shall be defined according to T.C.A. § 63-8-102.
- (57) "Orthotic equipment" means an orthopedic apparatus designed to support, align, prevent, correct deformities, or improve the function of a movable body part.
- (58) "Orthotist" means a person skilled in the construction and application of orthotic equipment.
- (59) "Outpatient service" means a service provided by the following, but not limited to, types of facilities: physicians' offices and clinics, hospital emergency rooms, hospital outpatient facilities, community mental health centers, outpatient psychiatric hospitals, outpatient psychiatric units, and freestanding surgical outpatient facilities also known as ambulatory surgical centers.
- (60) "Package" means a surgical procedure that includes but is not limited to all of the following components:
 - (a) The operation itself.
 - (b) Local infiltration.

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- (c) Topical anesthesia when used.
- (d) The normal, uncomplicated follow-up care/visits. This includes a standard postoperative period of 30 days.
- (61) "Pharmacy" means the place where the science, art, and practice of preparing, preserving, compounding, dispensing, and giving appropriate instruction in the use of drugs is practiced.
- (62) "Practitioner" means a person licensed, registered, or certified as an audiologist, doctor of chiropractic, doctor of dental surgery, doctor of medicine, doctor of osteopathy, doctor of podiatry, doctor of optometry, nurse, nurse anesthetist, nurse practitioner, occupational therapist, orthotist, pharmacist, physical therapist, physician's assistant, prosthetist, psychologist, or other person licensed, registered, or certified as a health care professional.
- (63) Prevailing Charge: The charge at the 80th percentile in any array of weighted customary charges made for the same geographical location.
- (64) "Primary procedure" means the therapeutic procedure most closely related to the principle diagnosis.
- (65) "Procedure" means a unit of health service.
- (66) "Procedure code" means a 5-digit numerical sequence or a sequence containing an alpha or alphas and followed by three or four digits, which identifies the service performed and billed.
- (67) "Properly submitted bill" means a request by a provider for payment of health care services submitted to a carrier on the appropriate forms which are completed pursuant to this rule. Properly submitted bills shall include appropriate documentation as required by this rule.
- (68) "Prosthesis" means an artificial substitute for a missing body part.
- (69) "Prosthetist" means a person skilled in the construction and application of prosthesis.
- (70) "Provider" means a facility, health care organization, or a practitioner.
- (71) "Reasonable amount" means a payment based upon the amount generally paid in the state for a particular procedure code using data available from but not limited to the provider, the carrier, or the Tennessee Workers' Compensation Division.
- (72) "Reject" means that a carrier or a carrier's agent denies payment to a provider or denies a provider's request for reconsideration.
- (73) "Secondary procedure" means a surgical procedure which is performed to ameliorate conditions that are found to exist during the performance of a primary surgery and which is considered an independent procedure that may not be performed as a part of the primary surgery or for the existing condition.
- (74) "Stop-Loss Payment" or "SLP" means an independent method of payment for an unusually costly or lengthy stay.
- (75) "Stop-Loss Reimbursement Factor" or "SLRF" means a factor established by the Commissioner to be used as a multiplier to establish a reimbursement amount when total hospital charges have exceeded specific stop-loss thresholds.
- (76) "Stop-Loss Threshold" or "SLT" means a threshold of charges established by the Commissioner, beyond which reimbursement is calculated by multiplying the applicable SLRF times the total charges identifying that particular threshold.

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- (77) "Surgical admission" means any hospital admission where there is an operating room charge, the patient with has a surgical procedure code, or the patient has a surgical DRG as defined by the CMS.
- (78) "Transfer between facilities" means to move or remove a patient from one facility to another for a purpose related to obtaining or continuing medical care. The transfer may or may not involve a change in the admittance status of the patient, i.e., patient transported from one facility to another to obtain specific care, diagnostic testing, or other medical services not available in the facility in which the patient has been admitted. The transfer between facilities shall include costs related to transportation of patient to obtain medical care.
- (79) "Usual and customary charge" means eighty percent (80%) of a specific provider's average charges to all payers for the same procedure.
- (80) "UB-92, HCFA-1450, 1500 or CMS-1450" means the health insurance claim form maintained by HCFA/CMS for use by institutional care providers. Currently this form is known as the UB-92.
- (81) "Wage loss case" means a case that involves the payment of wage loss compensation.
- (82) "Workers' Compensation Standard Per Diem Amount" or "SPDA" means a standardized per diem amount established for the reimbursement of hospitals for services rendered.

Authority: T.C.A. §§ 50-6-102, 50-6-204 (Supp. 2004).

0800-2-17-.04 INFORMATION PROGRAM INVOLVING RULES.

The Division may institute an ongoing information program regarding these Rules for providers, carriers, employees and employers. The program may include, at a minimum, informational sessions throughout the state, as well as the distribution of appropriate information materials.

Authority: T.C.A. §§ 50-6-102, 50-6-204 (Supp. 2004).

0800-2-17-.05 PROCEDURE CODES/ADOPTION OF THE CMS' MEDICARE PROCEDURES, GUIDELINES AND AMOUNTS.

- (1) Services and medical supplies must be coded with valid procedure or supply codes of the Health Care Financing Administration Common Procedure Coding System ("HCPCS"). Procedure codes used in these rules were developed and copyrighted by the American Medical Association ("AMA").
- (2) The most current editions of the American Medical Association's Current Procedural Terminology ("CPT") and Medicare RBRVS: The Physicians' Guide shall be used with these Rules.
- (3) Unless otherwise explicitly stated in these Rules, the most current effective Medicare procedures and guidelines are hereby adopted and incorporated as part of these Rules as if fully set out herein and are effective upon adoption and implementation by the CMS. Whenever there is no specific fee or methodology for reimbursement set forth in these Rules, then the maximum amount of reimbursement shall be at 100% of the 2005 CMS' Medicare allowable amount. The most current effective Medicare guidelines and procedures shall be followed in arriving at the correct amount. The Medicare base amount may, upon review by the Commissioner, be adjusted upward annually based upon the annual Medicare Economic Index adjustment, but this amount shall never fall below the effective 2005 Medicare amount. Whenever there is no applicable Medicare code or methodology, the service, equipment, diagnostic procedure, etc. shall be reimbursed at the usual and customary amount as defined in these Rules.

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Authority: T.C.A. §§ 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

0800-2-17-.06 PROCEDURES FOR WHICH CODES ARE NOT LISTED.

- (1) If a procedure is performed which is not listed in the Medicare Resource Based Relative Value Scale ("RBRVS"), the health care provider must use an appropriate CPT procedure code. The provider must submit an explanation, such as copies of operative reports, consultation reports, progress notes, office notes or other applicable documentation, or description of equipment or supply (when that is the charge).
- (2) The CPT contains procedure codes for unlisted procedures. These codes should only be used when there is no procedure code which accurately describes the service rendered. A special report is required as these services are reimbursed BR.
- (3) Reimbursement by the carrier for BR procedures should be based upon the carrier's review of the submitted documentation, the recommendations from the carrier's medical consultant, and the carrier's review of the prevailing charges for similar services as identified by the carrier based on data which is representative of Tennessee charges.

Authority: T.C.A. §§ 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

0800-2-17-.07 MODIFIER CODES.

- (1) Modifiers listed in the most current CPT shall be added to the procedure code when the service or procedure has been altered from the basic procedure described by the descriptor.
- (2) The use of modifiers does not imply or guarantee that a provider will receive reimbursement as billed. Reimbursement for modified services or procedures must be based on documentation of reasonableness and necessity and must be determined on a case-by-case basis.
- (3) When Modifier 21, 22, or 25 is used, a report explaining the medical necessity of the situation must be submitted to the carrier. It is not appropriate to use Modifier 21, 22, or 25 for routine billing.

Authority: T.C.A. §§ 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

0800-2-17-.08 TOTAL PROCEDURES BILLED SEPARATELY.

Certain diagnostic procedures (neurological testing, radiology and pathology procedures, etc.) may be performed by two separate entities that also bill separately for the professional and technical components. When this occurs, the total reimbursement must not exceed the maximum medical fee schedule allowable for the 5-digit procedure code listed.

- (1) When billing for the professional component only, Modifier 26 must be added to the appropriate 5-digit procedure code.
- (2) When billing for the technical component only, Modifier TC (Technical Component) must be added to the appropriate 5-digit code.

Authority: T.C.A. §§ 50-6-128, 50-6-204, 50-6-205 (Supp. 2004).

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0800-2-17-.09 INDEPENDENT MEDICAL EXAMINATION TO EVALUATE MEDICAL ASPECTS OF CASE.

- (1) An independent medical examination, other than one conducted under the Division's Medical Impairment Rating Registry ("MIRR") Program, shall include a study of previous history and medical care information, diagnostic studies, diagnostic x-rays, and laboratory studies, as well as an examination and evaluation. This service may be necessary in order to make a judgment regarding the current status of the injured or ill worker, or to determine the need for further health care.
- (2) An independent medical examination, performed to evaluate the medical aspects of a case (other than one conducted under the Division's MIRR Program), shall be billed using the independent medical examination procedure code 99455 or 99456, and shall include the practitioner's time only. Time spent shall include face-to-face time with the patient, time spent reviewing records, reports and studies, and time spent preparing reports. The office visit charge is included with the code 99455 or 99456 and shall not be billed separately. The total amount for an IME under this Rule shall not exceed \$500.00 per hour, and shall be pro-rated per quarter hour, i.e. two and one-half hours may not exceed \$1,250.00.
- (3) Any laboratory procedure, x-ray procedure, and any other test which is needed to establish the worker's ability to return to work shall be identified by the appropriate procedure code established by this Rule and reimbursed accordingly.

Authority: T.C.A. §§ 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

0800-2-17-.10 PAYMENT.

- (1) Reimbursement for all health care services and supplies shall be the lesser of (a) the provider's usual charge, (b) the maximum fee calculated according to these Rules (and/or any amendments to these Rules) or (c) the MCO/PPO or any other contracted price, wherever applicable. A licensed provider shall receive no more than the maximum allowable payment, in accordance with these Rules, for appropriate health care services rendered to a person who is entitled to health care services under the Act.
- (2) The most current edition of the Medicare RBRVS: The Physicians' Guide is adopted by reference as part of these Rules. The Medicare RBRVS is distributed by the American Medical Association and by the Office of the Federal Register and is also available on the Internet at www.cms.hhs.gov/medicare. Whenever a different guideline or procedure is not set forth in these Rules, the most current effective Medicare guidelines and procedures shall be followed.
- (3) When extraordinary services resulting from severe head injuries, major burns, and severe neurological injuries or any injury requiring an extended period of intensive care are required, a greater fee may be allowed up to 150% of the professional service fees normally allowed under these Rules. Such cases shall be billed with modifier 21 or 22 (for CPT coded procedures) and shall contain a detailed written description of the extraordinary service rendered and the need therefore. This provision does not apply to In-patient Hospital Care facility fees which are specifically addressed in the In-patient Hospital Fee Schedule Rules, 0800-2-19-.01 et seq.
- (4) Billing for provider services shall be submitted on the forms approved by the Division: UB-92 and HFCA-1500, or their official replacement forms.
- (5) A carrier shall not make a payment for a service unless all required review activities pertaining to that service are completed.
- (6) A carrier's payment shall reflect any adjustments in the bill made through the carrier's utilization review program.

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- (a) A carrier must provide an explanation of medical benefits to a health care provider whenever the carrier's reimbursement differs from the amount billed by the provider.
 - (b) A provider shall not attempt to collect from the injured employee, employer, or carrier any amounts properly reduced by the carrier pursuant to this rule.
- (7) A carrier shall date stamp medical bills and reports upon receipt and shall pay an undisputed and properly submitted bill within thirty-one (31) calendar days of receipt. Any carrier that fails to pay an undisputed and properly submitted bill within thirty-one (31) calendar days of receipt shall be assessed a civil penalty of 2.08% monthly (25% annual percentage rate ("APR")). The 2.08% monthly civil penalty (25% APR) shall be compounded monthly and shall be payable to the provider at the time of reimbursement.
 - (8) When a carrier disputes a bill or portion thereof, the carrier shall pay the undisputed portion of the bill within thirty-one (31) calendar days of receipt of a properly submitted bill. Any carrier not paying an undisputed portion of the bill within thirty-one (31) calendar days of receipt shall be assessed a civil penalty of 2.08% monthly (25% APR) on the undisputed portion of the bill. The 2.08% monthly civil penalty (25% APR) shall be compounded monthly and shall be payable to the provider at the time of reimbursement.
 - (9) Any provider not receiving timely payment of the undisputed portion of the provider's bill may institute a collection action in a court having proper jurisdiction over such matters to obtain payment of the bill, together with the interest civil penalty of 25% APR. Such providers, if they prevail, shall also be entitled to reasonable costs and attorney fees incurred in such collection actions to be paid by the carrier or self-insured employer.
 - (10) Billings not submitted on the proper form, as prescribed in these Rules, the In-patient Hospital Fee Schedule Rules, and the Medical Fee Schedule Rules, may be returned to the provider for correction and resubmission. If a carrier returns such billings, it must do so within 20 calendar days of receipt of the bill. The number of days between the date the carrier returns the billing to the provider and the date the carrier receives the corrected billing, shall not apply toward the thirty-one (31) calendar days within which the carrier is required to make payment.
 - (11) Payments to providers for initial examinations and treatment authorized by the carrier or a self-insured employer shall be paid by that carrier or self-insured employer and shall not later be subject to reimbursement by the employee or another medical insurance program, even if the injury or condition for which the employee was sent to the provider is later determined non-compensable under the Act.

Authority: T.C.A. §§ 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

0800-2-17-.11 REIMBURSEMENT FOR EMPLOYEE-PAID SERVICES.

Notwithstanding any other provision of this rule, if an employee has personally paid for a health care service and at a later date a carrier is determined to be responsible for the payment, then the employee shall be fully reimbursed by the carrier.

Authority: T.C.A. §§ 50-6-128, 50-6-204, 50-6-205 (Supp. 2004).

0800-2-17-.12 RECOVERY OF PAYMENT.

- (1) Nothing in these Rules shall preclude the recovery of payment already made for services and bills which may later be found to have been medically paid at an amount which exceeds the maximum allowable payment. Likewise, nothing in these Rules shall preclude any provider from

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receiving additional payment for services or supplies if it is properly due that provider and does not exceed the Medical Fee Schedule Rules amount.

- (2) A carrier may recover a payment to a provider, whether by an employee or a carrier, if the carrier requests the provider for the recovery of the payment, with a statement of reasons for the request, within one year of the date of payment. A provider may likewise recover additional payment from any carrier with a statement of reasons for the request, within one year of the date of service.
- (3) Within thirty-one (31) calendar days of receipt of the carrier's or provider's request for recovery of the payment, the provider or carrier shall do either of the following:
 - (a) If in agreement with the request, the provider shall refund payment to the carrier, or in the case of a provider requesting additional payment, the carrier shall submit payment to the provider;
 - (b) If not in agreement with the request, supply the carrier or provider with a written detailed statement of the reasons for the disagreement, along with a refund of the portion, if any, of the payment that the provider agrees should be refunded, or payment of the amount the carrier agrees should be paid to the provider.
- (4) If the carrier or provider does not accept the reason for disagreement supplied by the adverse party, the carrier or provider may file a request for Administrative Review, within thirty-one (31) calendar days of receipt of the provider's statement of disagreement. The request for review shall be filed with the Medical Director for a recommendation by the Medical Care and Cost Containment Committee (MCCCC). The complaining party shall supply a copy to the opposing party.
- (5) If, within 62 calendar days of the provider or carrier's request for recovery of a payment, the carrier or provider does not receive either a full refund of the payment (or full payment in the case of providers) or a statement of disagreement, then, at the option of the carrier or provider, the carrier or provider may do the following:
 - (a) File a request for Administrative Review as outlined above, of which the complaining party shall supply a copy to the opposing party.
 - (b) If a carrier, then reduce the payable amount on the provider's subsequent bills (in the case in question or any other case) to the extent of the request for recovery of payment.
- (6) If, within thirty-one (31) calendar days of a recommendation from the MCCCC, the amount recommended is not paid, the carrier may reduce the payable amount on the provider's subsequent bills to the extent of the request for recovery of payment, plus an additional 25% per annum. A provider may also add the additional 25% per annum to the amount recommended to be paid by the MCCC. The provider or carrier may, at its discretion, pursue recovery of the refund or, in the case of providers, additional payment, in a court of law with proper jurisdiction pursuant to Tenn. Code Ann. § 50-6-226.

Authority: *T.C.A. §§ 50-6-204, 50-6-205, 50-6-226 (Supp. 2004), 50-6-233 (Repl. 1999).*

0800-2-17-.13 PENALTIES FOR VIOLATIONS OF FEE SCHEDULE RULES.

- (1) Providers shall not accept and employers or carriers shall not pay any amount for health care services provided for the treatment of a covered injury or illness or for any other services encompassed within the Medical Cost Containment Program Rules, Medical Fee Schedule Rules or the In-patient Hospital Fee Schedule Rules, when that amount exceeds the maximum allowable payment established by these Rules. Any provider accepting and any employer or

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carrier paying an amount in excess of the Division's Medical Cost Containment Program Rules, Medical Fee Schedule Rules or the In-patient Hospital Fee Schedule Rules, shall be in violation of these Rules and may, at the Commissioner's discretion, be subject to civil penalties of ten thousand dollars (\$10,000.00) per violation for each violation, which may be assessed severally against the provider accepting such fee and the carrier or employer paying the excessive fee whenever a pattern or practice of such activity is found. At the discretion of the Commissioner, the Commissioner's Designee, or an agency member appointed by the Commissioner, such provider may also be reported to the appropriate certifying board, and may be subject to exclusion from participating in providing care under the Act. Any other violation of the Medical Cost Containment Program Rules, Medical Fee Schedule Rules, or the In-patient Hospital Fee Schedule Rules shall subject the violator(s) to a civil penalty of not less than one hundred dollars (\$100.00) nor more than ten thousand dollars (\$10,000.00) per violation, at the discretion of the Commissioner, Commissioner's Designee, or an agency member appointed by the Commissioner.

- (2) A provider, employer or carrier found to be in violation of these Rules, whether a civil penalty is assessed or not, may request a contested case hearing by requesting the hearing in writing within fifteen (15) calendar days of issuance of a Notice of Violation and, if applicable, notice of the assessment of civil penalties. If a request for hearing is not received by the Division within the fifteen (15) calendar days of issuance of the Notice of Violation, the determination of such violation shall be deemed a final order of the Department and not subject to further review.
- (3) A request for hearing shall be made to the Division in writing by an employer, carrier or provider notified of violation of these Rules.
- (4) Any request for a hearing shall be filed with the Division within fifteen (15) calendar days of the date of issuance of the Notice of Violation and, if applicable, of civil penalty. Failure to file a request for a hearing within fifteen (15) calendar days of the date of issuance of the Notice of Violation shall result in the decision of the Commissioner, Commissioner's Designee, or an agency member appointed by the Commissioner becoming a final order and not subject to further review.
- (5) The Commissioner, Commissioner's Designee, or an agency member appointed by the Commissioner shall have the authority to hear the matter as a contested case and determine if any civil penalty assessed should have been assessed.
- (6) Upon receipt of a timely filed request for a hearing, the Commissioner shall issue a Notice of Hearing to all interested parties.

Authority: T.C.A. §§ 50-6-118, 50-6-125, 50-6-128, 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

0800-2-17-.14 MISSED APPOINTMENT.

A provider shall not receive payment for a missed appointment unless the appointment was arranged by the Division, the carrier or the employer. If the carrier or employer fails to cancel the appointment not less than one (1) business day prior to the time of the appointment, the provider may bill the carrier for the missed appointment using procedure code 99199 with a maximum fee of the amount which would have been allowed for the office visit only, had the patient not missed the appointment.

Authority: T.C.A. §§ 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

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0800-2-17-.15 MEDICAL REPORT OF INITIAL VISIT AND PROGRESS REPORTS FOR OTHER THAN INPATIENT HOSPITAL CARE.

- (1) Except for inpatient hospital care, a provider shall furnish the carrier with a narrative medical report for the initial visit, all information pertinent to the compensable injury, illness, or occupational disease if requested within thirty (30) days after examination or treatment of the injured employee, and a progress report for every 60 days of continuous treatment for the same compensable injury, illness or occupational disease.
- (2) If the provider continues to treat an injured or ill employee for the same compensable injury, illness or occupational disease at intervals which exceed 60 calendar days, then the provider shall provide a progress report following each treatment that is at intervals exceeding 60 calendar days.
- (3) The narrative medical report of the initial visit and the progress report shall include all of the following information:
 - (a) Subjective complaints and objective findings, including interpretation of diagnostic tests.
 - (b) For the narrative medical report of the initial visit, the history of the injury, and for the progress report(s), significant history since the last submission of a progress report.
 - (c) The diagnosis.
 - (d) As of the date of the narrative medical report or progress report, the projected treatment plan, including the type, frequency, and estimated length of treatment.
 - (e) Physical limitations.
 - (f) Expected work restrictions and length of time if applicable.
- (4) Cost of these narrative medical reports required by 0800-2-17-.15(1) and (2) shall be reimbursed at the following rate: Initial and Subsequent Reports – Not to exceed \$10.00 for reports twenty (20) pages or less in length, and twenty-five (25) cents per page after the first twenty pages. Under no circumstances shall a provider bill for more than one report per visit. Initial reports shall be billed using procedure code WC101, subsequent reports shall be billed using procedure code WC102, and all final reports shall be billed using procedure code WC103. No charge is allowed for routine office notes as these are not considered narrative reports under this Rule.
- (5) A medical provider shall not charge any fee for completing a medical report form required by the Division.

Authority: T.C.A. §§ 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

0800-2-17-.16 ADDITIONAL REPORTS.

Nothing in this rule shall preclude a carrier or an employee from requesting reports from a provider in addition to those specified in Rule 0800-2-17-.15.

Authority: T.C.A. §§ 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

0800-2-17-.17 DEPOSITION/WITNESS FEE LIMITATION.

- (1) Any provider who gives a deposition shall be allowed a witness fee.

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- (2) Procedure Code 99075 must be used to bill for a deposition.
- (3) Licensed physicians shall be reimbursed for depositions at the same rate established in Rule 0800-2-16-.01

Authority: T.C.A. §§ 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

0800-2-17-.18 OUT-OF-STATE PROVIDERS.

All services and requests for change-of-physician to out-of-state providers must be made to providers who agree to abide by the Division's Medical Fee Schedule Rules, In-patient Hospital Fee Schedule Rules and Medical Cost Containment Program Rules.

Authority: T.C.A. §§ 50-6-204, 50-6-205 (Supp. 2004).

0800-2-17-.19 PREAUTHORIZATION.

Preauthorization shall be required for all non-emergency hospitalizations, non-emergency transfers between facilities, and non-emergency outpatient services. Decisions regarding authorization must be communicated to the requesting provider within seven (7) business days. Failure to provide a timely decision within seven (7) business days shall result in the authorization being deemed approved. Any decision of denial for payment for any type of health care service and/or treatment resulting from a utilization review, as opposed to a determination of whether such service or treatment is related to a compensable injury or occupational disease, shall only be made by an agent of a Utilization Review Company properly approved by the Tennessee Department of Commerce and Insurance as prescribed in Rule 0800-2-6-.02. Upon emergency admission, notice must be given to the carrier within 24 hours or the next business day.

Authority: T.C.A. §§ 50-6-118, 50-6-125, 50-6-128, 50-6-204, 50-6-205 (Supp. 2004).

0800-2-17-.20 PROCESS FOR RESOLVING DIFFERENCES BETWEEN CARRIERS AND PROVIDERS REGARDING BILLS.

- (1) Carrier's Dispute of a Bill
 - (a) When a carrier adjusts and/or disputes a bill or portion thereof, the carrier shall notify the provider within thirty-one (31) calendar days of the receipt of the bill of the specific reasons for adjusting and/or disputing the bill or portion thereof, and shall notify the provider of its right to provide additional information and to request reconsideration of the carrier's action.
 - (b) If the provider sends a bill to a carrier and the carrier does not respond in thirty-one (31) calendar days, and if a provider sends a second bill and receives no response within 62 days from the date the provider supplied the first bill, the provider may then proceed with whatever collection actions it deems appropriate in a court of law with proper jurisdiction.
 - (c) The carrier shall notify the employer, employee and the provider that the rules prohibit a provider from billing an employee, employer, or carrier for any amount for health care services provided for the treatment of a compensable work-related injury, illness or occupational disease when that amount is disputed by the carrier pursuant to its utilization review program, or when the amount exceeds the maximum allowable payment established

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by the Fee Schedule Rules (Medical and In-patient Hospital). The carrier shall request the employee to notify the carrier if the provider so bills the employee, or employer.

(2) Provider's Request for Reconsideration of Bill

A provider may request reconsideration of its adjusted and/or disputed bill by a carrier within thirty-one (31) days of receipt of a notice of an adjusted and/or disputed bill or portion thereof. The provider's request to the carrier for reconsideration of the adjusted and/or disputed bill shall include a statement in detail of the reasons for disagreement with the carrier's adjustment and/or dispute of a bill or portion thereof.

(3) Carrier's Response to Provider's Request for Reconsideration of Bill; Provider's Right to Appeal

- (a) Within thirty-one (31) calendar days of receipt of a provider's request for reconsideration, the carrier shall notify the provider of the actions taken and a detailed statement of the reasons. The carrier's notification shall include an explanation of the appeal process provided under this rule.
- (b) If a provider is disagrees with the action taken by the carrier on its request for reconsideration, the provider may file a request for Administrative Review within thirty-one (31) calendar days from the date of receipt of a carrier's denial of the provider's request for reconsideration, and the provider shall supply a copy to the carrier.
- (c) If within sixty-two (62) calendar days of the provider's request for reconsideration, the provider does not receive payment for the adjusted and/or disputed bill or portion thereof, or a written detailed statement of the reasons for the actions taken by the carrier, then the provider may make application for Administrative Review by the Medical MCCCC.

(4) Disputes

- (a) Unresolved disputes between a carrier and provider concerning charges and/or due to conflicting interpretation of these Rules and/or the Medical Fee Schedule Rules and/or the In-patient Hospital Fee Schedule Rules may be presented to the Medical Care and Cost Containment Committee. A request for Administrative Review may be submitted to:

Medical Director of the Workers' Compensation Division,
Tennessee Department of Labor and Workforce Development
710 James Robertson Parkway, Andrew Johnson Tower, 2nd Floor
Nashville, Tennessee 37243.

- (b) Valid requests for Administrative Review do not require a particular form but must be legible and contain copies of the following:
 - 1. Copies of the original and resubmitted bills in dispute which include dates of service, procedure codes, charges for services rendered and any payment received, and an explanation of unusual services or circumstances.
 - 2. Copies of the specific reimbursement.
 - 3. Supporting documentation and correspondence, if any.
 - 4. Specific information regarding contact with the carriers.
 - 5. A verified or declared written medical report signed by the physician.
 - 6. A specific written request for Administrative Review.

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- (c) The party requesting Administrative Review must send a copy of the request and all documentation accompanying the request to the opposing party as well.

Authority: T.C.A. §§ 50-6-126, 50-6-204, 50-6-205 (Supp. 2004), 50-6-226, 50-6-233 (Repl. 1999).

0800-2-17-.21 ADMINISTRATIVE REVIEW OF FEE SCHEDULE DISPUTES/HEARINGS.

(1) Administrative Review Procedure

- (a) When a request for Administrative Review by the MCCCC is received by the Division's Medical Director, the parties will be notified when the MCCCC will consider the dispute.
- (b) The MCCCC shall consider the dispute and issue its recommendation as to the proper resolution of the dispute.
- (c) If the parties to the dispute do not follow the recommendation of the MCCCC, then either party may proceed in any court of law with proper jurisdiction to decide the dispute.

(2) Computation of Time Periods

In computing a period of time prescribed or allowed by the Medical Fee Schedule Rules, Medical Cost Containment Program Rules and In-Patient Hospital Fee Schedule Rules, the day of the act, event or default from which the designated period of time begins to run shall not be included. The last day on which compliance therewith is required shall be included. If the last day within which an act shall be performed or an appeal filed is a Saturday, Sunday, or a legal holiday, the day shall be excluded, and the period shall run until the end of the next day which is not a Saturday, Sunday, or legal holiday. ["Legal holiday" means those days designated as a holiday by the President or Congress of the United States or so designated by the laws of this State.]

Authority: T.C.A. §§ 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

0800-2-17-.22 UTILIZATION REVIEW.

(1) Scope of this part:

Requirements contained in this part shall pertain to utilization review activity as defined by Tenn. Code Ann. § 50-6-124 (Repl. 1999) with respect to services by a provider for health care or health related services furnished as a result of a compensable injury, illness or occupational disease arising out of and in the course of employment. These Rules are intended to supplement and do not in any way displace the Division's Utilization Review Rules, Chapter 0800-2-6.

(2) Carrier's Utilization Review Program

- (a) The carrier shall have a utilization review program.
- (b) Utilization review shall be conducted in a reasonable manner and in accordance with this rule.
- (c) Under the utilization review program, the carrier shall do all of the following:
 - 1. Perform ongoing utilization review of medical bills to identify over-utilization of services and improper billing;
 - 2. Determine the accuracy of the procedure coding. If the carrier determines, based upon review of the bill and any related material which describes the procedure

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performed, that the procedure is incorrectly or incompletely coded, the carrier may recode the procedure, but shall notify the provider of the reasons for the recoding within 30 days of receipt of the bill;

3. Reduce the bill to the maximum allowable payment for that procedure;
 4. Refer to the Division's Medical Director all providers whose billing practices indicate over-utilization.
 5. A carrier may have another certified entity perform utilization review activities on its behalf.
- (d) The utilization review program, whether operated by the carrier or an entity on behalf of the carrier, shall be certified by the Tennessee Department of Commerce and Insurance as prescribed in the Division's Rule 0800-2-6-.02.
- (e) The carrier shall provide the Division with the name, address, and license number (and a copy of the contract agreement between the carrier and other entity if applicable) of the entity responsible for conducting the carrier's utilization review program.
- (f) The carrier is responsible for notifying the Division when changing reviewing entities.
- (g) For purposes of this rule, a carrier which has another entity perform utilization review activities on its behalf maintains full responsibility for compliance with this rule.
- (h) Under the carrier's utilization review program, the carrier shall make determinations concerning a compensable injury, illness or occupational disease through one of the following approaches:
1. Review by licensed, registered, or certified health care professionals.
 2. The application of criteria developed by licensed, registered, or certified health care professionals.
 3. A combination of approaches in subdivisions (1) and (2) of this Subsection according to the type of covered injury or illness.
- (i) Licensed, registered, or certified health care professionals shall be involved in determining the carrier's response to a request by a provider for reconsideration of its bill.
- (j) These licensed, registered, or certified health care professionals shall have suitable occupational injury or disease expertise, or both, to render an informed clinical judgment on the medical appropriateness of the services provided.

Authority: T.C.A. § 50-6-124, 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

0800-2-17-.23 RULE REVIEW.

The Division encourages participation in the development of and changes to the Medical Cost Containment Program Rules, the Medical Fee Schedule Rules and the In-patient Hospital Fee Schedule Rules by all groups, associations, and the public. Any such group, association or other party desiring input into or changes made to these Rules and associated schedules must make their recommendations, in writing, to the Commissioner. After analysis, the Division may incorporate such recommended changes into Rules after appropriate consideration and public comment. The Medical Fee Schedule Rules, Medical Cost Containment Program Rules and In-Patient Hospital Fee Schedule Rules shall be reviewed by the Commissioner, in consultation with the Medical Care and Cost Containment Committee and the Advisory Council on Workers'

PUBLIC NECESSITY RULES

Compensation July 2006 and on an annual basis thereafter. When appropriate, the Commissioner may revise the Fee Schedule Rules as necessary and appropriate.

Authority: *T.C.A. § 50-6-204 (Supp. 2004).*

0800-2-17-.24 PROVIDER AND FACILITY FEES FOR COPIES OF MEDICAL RECORDS.

- (1) Health care providers and facilities are entitled to recover a reasonable amount to cover the cost of copying documents requested by the carrier, self-insured employer, employee, attorneys, etc. Documentation which is submitted by the provider and/or facility, but was not specifically requested by the carrier, shall not be allowed a copy charge.
- (2) Health care providers and facilities must furnish an injured employee or the employee's attorney and carriers/self-insureds or their legal representatives copies of records and reports upon request. The maximum charge allowed shall be the same as that set out in T.C.A. § 50-6-204, as amended.
- (3) Health care providers and facilities may charge the actual direct cost of copying x-rays, microfilm or other non-paper records.
- (4) The copying charge shall be paid by the party who requests the records.
- (5) An itemized invoice shall accompany the copy.

Authority: *T.C.A. §§ 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).*

0800-2-17-.25 PENALTIES FOR VIOLATIONS OF FEE SCHEDULE RULES AND MEDICAL COST CONTAINMENT PROGRAM RULES.

The Commissioner, Commissioner's Designee, or an agency member appointed by the Commissioner, shall have the authority to assess civil penalties up to and including \$10,000.00 per violation, as set forth more fully in Rule 0800-2-17-.13, for violations of the Medical Fee Schedule Rules, In-patient Hospital Fee Schedule Rules or the Medical Cost Containment Program Rules.

Authority: *T.C.A. §§ 50-6-118, 50-6-125, 50-6-128, 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).*

The public necessity rules set out herein were properly filed in the Department of State on the 16th day of November, 2005, and will be effective from the day of filing for a period of 165 days. These public necessity rules will remain in effect through the 30th day of April, 2006. (11-21)

PUBLIC NECESSITY RULES

**THE TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT - 0800
DIVISION OF WORKERS' COMPENSATION**

**CHAPTER 0800-2-18
MEDICAL FEE SCHEDULE**

STATEMENT OF NECESSITY FOR READOPTING PUBLIC NECESSITY RULES

Pursuant to Tenn. Code Ann. §§ 4-5-209(a)(4) and (b) and 50-6-204(i)(5), the Commissioner submits the In-patient Hospital Fee Schedule Rules ("Rules") for readoption as public necessity rules as part of the comprehensive medical fee schedule and related system applicable to all medical treatment under the Workers' Compensation Law as administered by the Workers' Compensation Division of the Tennessee Department of Labor and Workforce Development. Readoption of these as public necessity rules is necessary for the reasons set forth below and because Tenn. Code Ann. § 50-6-204(i) requires the comprehensive medical fee schedule and related system be in place and effective on and after July 1, 2005. Tenn. Code Ann. § 50-6-204(i)(5).

These Rules were initially adopted as public necessity rules and filed with the secretary of state's office on June 15, 2005, when proposed rules were also filed. Those public necessity rules will expire on November 27, 2005, and unless these rules are readopted as public necessity rules now, there will be a period of time when no effective Rules will be in place. In response to a petition on the proposed rules, a rulemaking public hearing was held on these Rules on September 23, 2005. The Department is currently analyzing all of the numerous oral and written comments received during the rulemaking public hearing and must respond to each in writing as required pursuant to Tenn. Code Ann. § 4-5-222. Given that the rulemaking hearing rules may not be effective until at least 75 days after filing with the secretary of state's office, it would be impossible to avoid a lapse in these Rules without the readoption of these Rules as public necessity rules. The Department could not have reasonably foreseen during the initial one hundred sixty-five day period that the original need for the public necessity rules would continue to the present time.

Medical providers, employees, employers and insurers are statutorily mandated to comply with the medical fee schedule rules, of which these Rules are an integral part, on and after July 1, 2005, in providing all workers' compensation medical benefits. These rules are necessary to comply with the mandate enacted by the General Assembly in Public Chapter 962 (Tenn. Code Ann. § 50-6-204, (2005 Supp.)) to provide the required medical fee schedule with guidelines and procedures to medical providers, employees, employers and insurers. Thus, these public necessity rules are being readopted to protect the public welfare. Due to the length of time necessary to complete the rulemaking process under the Uniform Administrative Procedures Act, these public necessity rules should be readopted immediately to provide applicable medical fees, guidelines and procedures so as not to jeopardize injured employees' ability to receive prompt and adequate medical care. Further, Tenn. Code Ann. § 50-6-204(i)(5) specifically authorizes adoption of these rules as public necessity rules.

James Neeley, Commissioner
Tennessee Department of Labor &
Workforce Development

For copies of this public necessity rule contact: Vickie Gregory, Administrative Assistant, Tennessee Department of Labor and Workforce Development, Division of Workers' Compensation, Andrew Johnson Tower, Second Floor, 710 James Robertson Parkway, Nashville, TN 37243-0661, (615) 253-1613.

PUBLIC NECESSITY RULES

**RULES
OF
TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
DIVISION OF WORKERS' COMPENSATION**

**CHAPTER 0800-2-18
MEDICAL FEE SCHEDULE**

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0800-2-18-.01 MEDICARE-BASIS FOR SYSTEM, APPLICABILITY, EFFECTIVE DATE AND CODING REFERENCES.

- (1) The Medical Fee Schedule of the Tennessee Division of Workers' Compensation ("TDWC") is a Medicare-based system, but with multiple conversion factors. These Medical Fee Schedule rates apply state-wide. The Medical Fee Schedule is based upon the Centers for Medicare and Medicaid Services ("CMS") (formerly the Health Care Financing Administration's ("HCFA") Medicare Resource Based Relative Value Scale ("RBRVS") system, utilizing the CMS' national relative value units and Tennessee specific conversion factors adopted by the Tennessee Division of Workers' Compensation in these Fee Schedule Rules. Anyone using this schedule must consult and be familiar with the Division's Medical Cost Containment Program rules, 0800-2-17-.01 et seq., the In-patient Hospital Fee Schedule rules, 0800-2-19.01 et seq., the most current American Medical Association ("AMA") CPT Codes, the Health Care Financing Administration Common Procedure Coding System ("HCPCS"), the AMA's Medicare RBRVS: The Physicians' Guide, the American Society of Anesthesiologists ("ASA") Relative Value Guide, and the most current effective Medicare procedures and guidelines.
- (2) These Medical Fee Schedule Rules must be used in conjunction with Medical Cost Containment Program Rules and the In-patient Hospital Fee Schedule Rules. The definitions set out in those rules, as well as the other general provisions, including but not limited to those regarding prompt payment of provider's bills, are adopted by reference as if set forth fully herein and those Rules must be used in conjunction with these Medical Fee Schedule Rules.

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- (3) The Medical Fee Schedule Rules are effective July 1, 2005 and apply to all services provided on or after July 1, 2005. The most current versions of the American Medical Association's CPT and the Medicare RBRVS shall automatically be applicable and are adopted by these Rules by reference upon their effective dates. Fees shall be calculated using the edition of the CPT and RBRVS effective on the date of service.

Authority: T.C.A. §§ 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

0800-2-18-.02 GENERAL INFORMATION AND INSTRUCTIONS FOR USE.

- (1) Format

This schedule consists of the following sections: General Medicine (including Evaluation and Management), General Surgery, Neuro- and Orthopedic Surgery, Radiology, Pathology, Anesthesiology, Injections, Durable Medical Equipment, Implants and Orthotics, Pharmacy, Physical and Occupational Therapy, Ambulatory Surgical Centers and Outpatient Hospital Care, Chiropractic, Ambulance Services and Clinical Psychological Services. Providers should use the section(s) containing the procedure(s) they perform, or the service(s) they render.

- (2) Reimbursement

- (a) Unless otherwise indicated herein, the most current Medicare procedures and guidelines are hereby adopted and incorporated as part of these Rules as if fully set out herein and effective upon adoption and implementation by the CMS. Whenever there is no specific fee or methodology for reimbursement set forth in these Rules for a service, diagnostic procedure, equipment, etc., then the amount of reimbursement shall be capped at 100% of the most current effective CMS' Medicare allowable amount. The most current effective Medicare guidelines and procedures shall be followed in arriving at the correct amount. For purposes of these Rules, the Medicare amount may be adjusted upward annually based upon the annual Medicare Economic Index adjustment, but this amount shall never fall below the effective 2005 Medicare amount. Whenever there is no applicable Medicare code or method of reimbursement, the service, equipment, diagnostic procedure, etc. shall be reimbursed at the usual and customary amount as defined in the Medical Cost Containment Program Rules.

- (b) Reimbursement to all providers shall be the lesser of the following:

1. The provider's usual charge;
2. The fee calculated according to the TDWC Fee Schedule Rules (includes 100% of Medicare if no other specific fee or methodology is set forth in these Rules);
3. The MCO/PPO or any other contracted price;
4. In no event shall reimbursement be in excess of these TDWC Fee Schedules, unless otherwise provided in the Division's rules. Reimbursement in excess of the TDWC Medical Fee Schedule may result in civil penalties, at the Commissioner's discretion, of \$10,000.00 per violation for each violation assessed severally against the provider accepting such fee and the carrier or employer paying the excessive fee, should a pattern or practice of such activity be found. It is recognized that providers must bill all payers at the same amount and simply billing an amount which exceeds the Fee Schedule does not constitute a violation. It is acceptance and retention of an amount in excess of this Fee Schedule that constitutes a violation by a provider. At the Commissioner's discretion, such provider may also be reported to the appropriate certifying board or other appropriate authority, and may be subject to exclusion from participating further in providing care under the Tennessee Workers' Compensation Act ("Act").

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(3) Fee Schedule Calculations

The Medical Fee Schedule maximum reimbursement amount is calculated for any specific CPT code by multiplying the national total relative value units (“RVUs”) by the appropriate conversion factor. Whether one uses the facility or nonfacility total RVU amount must be determined using Medicare guidelines and is dependent upon where the service is provided. Certain areas listed below do not have a conversion factor and the maximum reimbursement amount allowed is the usual and customary amount, as indicated. For areas not listed, such as dentistry, the maximum is 100% of the Medicare allowable amount calculated in accordance with Medicare guidelines and methodology.

(4) Conversion Factors are based on the CMS’ 2005 unit amount of \$37.8975.

(a) The conversion factors applicable under this Medical Fee Schedule are:

	<u>Conversion Factor</u>	<u>Percent of Medicare</u>
Anesthesiology.....	Usual and Customary Amount	
Chiropractic Care	\$49.27	130%
General Surgery.....	\$75.80	200%
Home Health Care	100% of LUPA*	
Home Infusion	Usual and Customary Amount	
Gen. Medicine (includes unlisted specialties, Evaluation & Management, etc.) Office visits, E&M, etc. CPT codes	\$ 60.64	160%
Emergency care CPT codes	\$ 75.80	200%
Neurosurgery (board-eligible or certified physicians) 275% (Non-board eligible physicians paid general surgery rate)		\$104.14
Orthopedic Surg. (board-eligible or cert. physicians) 275% (Non-board eligible physicians paid general surgery rate)		\$104.14
Pathology	Usual and Customary Amount	
Physical and Occupational Therapy		
Independently-owned Facilities-For First 6 visits ...	\$ 56.85	150%
Visits 7-12	\$ 49.27	130%
Visits over 12	\$ 37.90	100%
Physician-affiliated Facilities-For First 6 visits	\$ 49.27	130%
Visits 7-12	\$ 39.79	105%
Visits over 12	\$ 37.90	100%
Radiology	\$ 75.80	200%

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- (b) The appropriate conversion factor should be determined by the type of CPT code for the procedure performed in all cases except those involving orthopedic and neurosurgery. The appropriate conversion factor for all surgical CPT codes for surgical procedures by any physician other than certified and board-eligible neurosurgeons and orthopedic surgeons is \$75.80, (200% of Tennessee Medicare rates). Board-eligible and certified neurosurgeons and orthopedic surgeons shall use the neurosurgery and orthopedic surgery conversion factors for all surgery CPT codes. Evaluation and management CPT codes require the use of the associated conversion factor of \$60.64 (160% of Tennessee Medicare rates) by all physicians, including neurosurgeons and orthopedic surgeons.

*“LUPA” refers to the Medicare rates for Low Utilization Payment Adjustment.

- (5) Forms
 - (a) The following forms (or their official replacements) should be used for provider billing: HCFA 1500 and UB 92
 - (b) Bills for reimbursement shall be sent directly to the party responsible for reimbursement. In most instances, this is the Insurance Carrier or the Self-Insured Employer. Insurance Carriers and/or Employers shall furnish this information to the Providers.
- (6) Violations of Fee Schedules and Medical Cost Containment Rules

The Commissioner, Commissioner’s Designee, or an agency member appointed by the Commissioner, shall have the authority to issue civil penalties up to and including \$10,000.00 per violation for violations of the Medical Fee Schedule, In-patient Hospital Fee Schedule or the Medical Cost Containment Program Rules (“Rules”) as prescribed in the Rules. Any party notified of an alleged violation, whether or not they are assessed civil penalties hereunder, shall be entitled to a contested case hearing before the Commissioner, Commissioner’s Designee, or an agency member appointed by the Commissioner pursuant to the Uniform Administrative Procedures Act, Tenn. Code Ann. § 4-5-101 et seq., if a written request is submitted to the Division by the party within fifteen (15) calendar days of issuance of notice of such violations and of any civil penalty. Failure to make a timely request will result in the violation and penalty decision becoming a final order and not subject to further review.

Authority: T.C.A. §§ 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

0800-2-18-.03 GENERAL GUIDELINES.

- (1) Guidelines define items that are necessary to appropriately interpret and report the procedures and services contained in a particular section and provide explanations regarding terms that apply only to a particular section.
- (2) The Guidelines found in the most current edition of the AMA’s CPT and Medicare RBRVS: The Physicians’ Guide apply to the following: General Medicine (includes Evaluation and Management), General Surgery, Neuro-surgery, Orthopedic Surgery, Chiropractic, Physical and Occupational Therapy, Home Health Care, Home Infusion, Ambulatory Surgical Centers and Outpatient Hospital Services, Radiology, Clinical Psychological, and Pathology. CDT-3 Codes of current dental terminology prescribed by the American Dental Association, including the terminology updates and revision issued in the future by the American Dental Association shall be used for all Dentistry services.
- (3) In addition to the Guidelines found in the AMA’s CPT and the Medicare RBRVS: The Physicians’ Guide, the following Division’s Guidelines also apply. Whenever a conflict exists between these Medical Fee Schedule Rules and any other fee schedule, rule or regulation, these Medical Fee Schedule Rules shall govern.

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Authority: T.C.A. §§ 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

0800-2-18-.04 SURGERY GUIDELINES.

- (1) Multiple Procedures: Reimbursement shall be based on 100% of the physician's usual charge for the major procedure (not to exceed 100% of the TDWC Medical Fee Schedule amount allowable) plus 50% of the physician's usual charge for the lesser or secondary procedure (s) (not to exceed 50% of the TDWC Medical Fee Schedule allowable).
- (2) Services Rendered by More Than One Physician:
 - (a) Concurrent Care: One attending physician shall be in charge of the care of the injured employee. However, if the nature of the injury requires the concurrent services of two or more specialists for treatment, then each physician shall be entitled to the listed fee for services rendered.
 - (b) Surgical Assistant: A physician who assists at surgery may be reimbursed as a surgical assistant. To identify surgical assistant services provided by physicians, Modifier 80 or 81 shall be added to the surgical procedure code which is billed. A physician serving as a surgical assistant must submit a copy of the operative report to substantiate the services rendered. Reimbursement is limited to the lesser of the surgical assistant's usual charge or 20% of the maximum allowable Medical Fee Schedule amount. Duly licensed physician assistants may serve as surgical assistants as deemed appropriate by the physician, and if so, that assistants' reimbursement shall not exceed 100% of the physician assistant fee that would be due under Medicare guidelines, without regard for conversion factors contained in the workers' compensation Medical Fee Schedule.
 - (c) Two Surgeons: For reporting see the most current CPT. Each surgeon must submit an operative report documenting the specific surgical procedure(s) provided. Each surgeon must submit an individual bill for the services rendered. Reimbursement must not be made to either surgeon until the carrier has received each surgeon's individual operative report and bill. Reimbursement to both surgeons shall not exceed 150% of the maximum allowable Fee Schedule amount of the first surgeon and shall be allocated between the surgeons as agreed by them.
- (3) When a surgical fee is chargeable, no office visit charge shall be allowed for the day on which this surgical fee is earned, except if surgery is performed on the same day as the physician's first examination. All exceptions require use of the appropriate modifiers.
- (4) Certain of the listed procedures in the Medical Fee Schedule are commonly carried out as an integral part of a total service and, as such, do not warrant a separate charge.
- (5) Lacerations ordinarily require no aftercare except removal of sutures. The removal is considered a routine part of an office or hospital visit and shall not be billed separately unless such sutures are removed by a provider different from the provider administering the sutures.

Authority: T.C.A. §§ 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

0800-2-18-.05 ANESTHESIA GUIDELINES.

- (1) General Information and Instructions.
 - (a) The current ASA Relative Value Guide, by the American Society of Anesthesiologists will be used to determine reimbursement for anesthesia codes that do not appear in the

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RBRVS. These values are to be used only when the anesthesia is personally administered by an Anesthesiologist or Certified Registered Nurse Anesthetist ("CRNA") who remains in constant attendance during the procedure, for the sole purpose of rendering such anesthesia service. To order the Relative Value Guide, write to the American Society of Anesthesiologists, 520 N Northwest Highway; Park Ridge, IL 60068-2573, or call (847) 825-5586.

- (b) When anesthesia is administered by a CRNA not under the medical direction of an anesthesiologist, reimbursement shall be 90% of the provider's usual and customary charge. No payment will be made to the surgeon supervising the CRNA.
- (c) When anesthesia is administered personally by an anesthesiologist or administered by a care team involving an anesthesiologist and CRNA, reimbursement shall not exceed 100% of the provider's usual and customary charge.

(2) Anesthesia Values

- (a) Each anesthesia service contains two value components which make up the charge and determine reimbursement: a Basic Value and a Time Value.
- (b) **Basic Value:** This relates to the complexity of the service and includes the value of all usual anesthesia services except the time actually spent in anesthesia care and any modifiers. The Basic Value includes usual preoperative and postoperative visits, the anesthesia care during the procedure, the administration of fluids and/or blood products incidental to the anesthesia or surgery and interpretation of non-invasive monitoring (ECG, temperature, blood pressure, oximetry, capnography, and mass spectrometry). When multiple surgical procedures are performed during an operative session, the Basic Value for anesthesia is the Basic Value for the procedure with the highest unit value. The Basic Values in units for each anesthesia procedure code are listed in the current ASA Relative Value Guide.
- (c) **Time Value:** Anesthesia time starts when the anesthesiologist or CRNA begins to prepare the patient for induction of anesthesia and ends when the personal attendance of the anesthesiologist or CRNA is no longer required and the patient can be safely placed under customary, postoperative supervision. Anesthesia time must be reported on the claim form as the total number of minutes of anesthesia. For example, one hour and eleven minutes equals 71 minutes of anesthesia. The Time Value is converted into units for reimbursement as follows:
 - 1. Each 15 minutes or any fraction thereof equals one (1) time unit. For example, 71 minutes of anesthesia time would have the following time units: $71/15 = 5$ Time Units.
 - 2. No additional time units are allowed for recovery room observation monitoring after the patient can be safely placed under customary post-operative supervision.

(3) Total Anesthesia Value

The total anesthesia value ("TAV") for an anesthesia service is the sum of the Basic Value (units) plus the Time Value which has been converted into units. The TAV is calculated for the purpose of determining reimbursement.

(4) Billing

Anesthesia services must be reported by entering the appropriate anesthesia procedure code and descriptor into Element 24 D of the HCFA 1500 Form. The provider's usual total charge for the anesthesia service must be entered in Element 24 F on the HCFA 1500 Form. The total time in minutes must be entered in Element 24 G of the HCFA 1500 Form.

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(5) Reimbursement

Reimbursement for anesthesia services must be no more than the provider's usual and customary charge.

(6) Medical Direction Provided by Anesthesiologists

When an anesthesiologist is not personally administering the anesthesia but is providing medical direction for the services of a nurse anesthetist who is not employed by the anesthesiologist, the anesthesiologist may bill for the medical direction. Medical direction includes the pre and post-operative evaluation of the patient. The anesthesiologist must remain within the operating suite, including the pre-anesthesia and post-anesthesia recovery areas, except in extreme emergency situations. Reimbursement shall not exceed 100% of the provider's usual and customary charge.

(7) Anesthesia by Surgeon

(a) Local Anesthesia

When infiltration, digital block or topical anesthesia is administered by the operating surgeon or surgeon's assistant, reimbursement for the procedure and anesthesia are included in the global reimbursement for the procedure.

(b) Regional or General Anesthesia

1. When regional or general anesthesia is provided by the operating surgeon or surgeon's assistant, the surgeon may be reimbursed for the anesthesia service in addition to the surgical procedure.

(i) To identify the anesthesia service, list the CPT surgical procedure code and add Modifier 47.

(ii) Reimbursement shall not exceed the provider's usual and customary charge.

(iii) The operating surgeon must not use the diagnostic or therapeutic nerve block codes to bill for administering regional anesthesia for a surgical procedure.

(8) Unlisted Service, Procedure or Unit Value. When an unlisted service or procedure is provided or without specified unit values, the values used shall be substantiated BR.

(9) Procedures Listed In The ASA Relative Value Guide Without Specified Unit Values. For any procedure or service that is unlisted or without specified unit value, the physician or anesthetist shall establish a unit value consistent in relativity with other unit values shown in the current ASA Relative Value Guide. Pertinent information concerning the nature, extent and need for the procedure or service, the time, the skill and equipment necessary, etc., shall be furnished. Sufficient information shall be furnished to identify the problem and the service(s).

(10) Actual time of beginning and duration of anesthesia time may require documentation, such as a copy of the anesthesia record in the hospital file.

(11) Special Supplies. Supplies and materials provided by the physician over and above those usually included with the office visit or other services rendered may be listed separately. Drugs, materials provided, and tray supplies shall be listed separately. Supplies and materials provided in a hospital or other facility must not be billed separately by the physician or CRNA. These charges must be billed by the hospital.

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- (12) Separate or Multiple Procedures. It is appropriate to designate multiple procedures that are rendered on the same date by separate entries.

Authority: T.C.A. §§ 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

0800-2-18-.06 INJECTIONS GUIDELINES.

Reimbursement for injection(s) (such as J codes) includes allowance for CPT code 90782 in addition to average wholesale price of each drug. In cases where multiple drugs are given as one injection, only one administration fee is owed. Surgery procedure codes defined as injections include the administration portion of payment for the medications billed. J Codes are found in the Health Care Financing Administration Common Procedure Coding System ("HCPCS").

Authority: T.C.A. §§ 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

0800-2-18-.07 AMBULATORY SURGICAL CENTERS AND OUTPATIENT HOSPITAL CARE (INCLUDING EMERGENCY ROOM FACILITY CHARGES).

When medically appropriate, surgical procedures may be performed on an outpatient basis to reduce unnecessary hospitalization and to shift care to a less costly setting.

- (1) For the purpose of the TDWC Medical Fee Schedule, "ambulatory surgical center" means an establishment with an organized medical staff of physicians; with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures, with continuous physicians and registered nurses on site or on call; which provides services and accommodations for patients to recover for a period not to exceed twenty-three (23) hours after surgery. An ambulatory surgical center may be a free standing facility or may be attached to a hospital facility. For purposes of workers' compensation reimbursement to ASCs, the facility must be an approved Medicare ASC.
- (2) The CMS has implemented a prospective payment system ("PPS") under Medicare for hospital outpatient services. All services paid under the new PPS are classified into groups called Ambulatory Payment Classifications ("APC"). Services in each APC are similar clinically and in terms of the resources they require. The CMS has established a payment rate for each APC. Current APC Medicare allowable payment amounts and guidelines are available online at: www.cms.hhs.gov/providers/hopps.
- (3) The most current Medicare APC rates shall be used as the basis for facility fees charged for services provided in an ambulatory surgical center ("ASC") and shall be reimbursed at a maximum of 150% of current value for such services at ASCs. Depending on the services provided, ASCs may be paid for more than one APC for an encounter. When multiple procedures are performed during the same surgical session, the reimbursement shall be made at 100% of the appropriate rate for the highest charge procedure and 50% of the appropriate rate for all additional procedures. Only separate and distinct surgical procedures shall be billed. When applicable, the Medicare Guidelines shall be used in determining separate and distinct surgical procedures.
- (4) All other outpatient hospital care, including but not limited to observation and emergency room facility fees, shall be calculated in accordance with the most current Medicare rules and procedures applicable to such services and shall be reimbursed at a maximum rate of 150% of the current value of Medicare reimbursement for outpatient hospital care.
- (5) Facility services do not include (the following services may be billed separately from the facility fees if allowed under Medicare guidelines):

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- (a) Physician services
 - (b) Laboratory services
 - (c) X-rays
 - (d) Diagnostic procedures not related to the surgical procedure
 - (e) Prosthetic devices
 - (f) Ambulance services
 - (g) Orthotics
 - (h) Implantables
 - (i) DME for use in the patient's home
 - (j) CRNA or Anesthesia Physician Services (supervision of CRNA is included in the facility fee)
 - (k) Take home medications
 - (l) Take home supplies
- (6) The above list of services and supplies shall be reimbursed according to the TDWC Fee Schedule Rules, or at the usual and customary amount as defined in these Rules (for items/services not listed in the fee schedule rules).
- (7) There may be occasions in which the patient was scheduled for out patient surgery and it becomes necessary to admit the patient. All ambulatory patients who are admitted to the hospital and stay longer than 23 hours past ambulatory surgery will be paid according to the Inpatient Hospital Fee Schedule Rules, 0800-2-19.01 et seq.
- (8) Pre-admission lab and x-ray may be billed separately from the Ambulatory Surgery bill when performed 24 hours or more prior to admission, and will be reimbursed the lesser of billed charges or the payment limit of the fee schedule. Pre-admission lab and radiology are not included in the facility fee.
- (9) Facility fees for surgical procedures not listed shall be reimbursed BR at the usual and customary rate.

Authority: T.C.A. §§ 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

0800-2-18-.08 CHIROPRACTIC SERVICES GUIDELINES.

- (1) Charges for chiropractic services shall not exceed 130% of the participating fees prescribed in the Medicare RBRVS System fee schedule. The number of approved visits shall be limited pursuant to any restrictions in T.C.A. § 50-6-204. The same procedures for certification applicable to physical therapy and occupational therapy services under Rule 0800-2-18-.09(5) below apply to chiropractic services (such as UR review after 12 visits), except that the thirty (30) day time period therein shall not apply to chiropractic services.
- (2) For chiropractic services, an office visit shall not be billed on the same day as a manipulation is billed.

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- (3) If allowable payment for chiropractic services is not paid by employers or insurers for chiropractic services provided to employees who have suffered a compensable work-related injury under the Workers' Compensation Law within thirty-one (31) days from the date of receipt by the employer or insurer of the bill for chiropractic services provided to such an employee, interest at the rate of 25% per annum of the payment allowed pursuant to these rules, compounded monthly, may be charged and paid as set forth in Rule 0800-2-11-.10 of the Medical Cost Containment Program Rules.
- (4) There shall be no fee allowable for any modalities performed in excess of four (4) modalities per day per employee. The Medicare definition of modality is applicable.
- (5) There shall be no charge for either hot packs or cold packs provided to an employee who has suffered a compensable work-related injury under the Workers' Compensation Law.

Authority: T.C.A. §§ 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

0800-2-18-.09 PHYSICAL AND OCCUPATIONAL THERAPY GUIDELINES.

- (1) Charges for physical and/or occupational therapy services shall be reimbursed on a bifurcated sliding scale based upon physician interest in the facility providing services. For the purpose of this Medical Fee Schedule, a "physician-affiliated" facility is one in which the referring physician has any type of financial interest, which includes, but is not limited to, any type of ownership, interest, debt, loan, lease, compensation, remuneration, discount, rebate, refund, dividend, distribution, subsidy, or other form of direct or indirect benefit of any kind, whether in money or otherwise, between the facility to whom the physician refers a person for services and that physician. Any hospital-based PT or OT facility shall also be deemed "physician-affiliated" if the referring physician is an employee of such hospital, or if he or she receives a benefit of any kind from the referral.
 - (a) Independently-owned and operated facilities' reimbursement shall not exceed one hundred fifty percent (150%) of the participating fees prescribed in the Medicare RBRVS System fee schedule (Medicare Fee Schedule) for the first six (6) visits, and shall not exceed one hundred thirty percent (130%) for visits 7 through 12. For all visits after visit 12, reimbursement shall not exceed one hundred percent (100%).
 - (b) Physician-affiliated facilities' reimbursement shall not exceed one hundred thirty percent (130%) of the participating fees prescribed in the Medicare RBRVS System fee schedule for the first six (6) visits, and shall not exceed one hundred five percent (105%) for visits 7 through 12. For all visits after visit 12, reimbursement shall not exceed one hundred percent (100%).
- (2) For physical therapy and/or occupational therapy, there shall be no charge for either hot packs or cold packs provided to an employee who has suffered a compensable work-related injury under the Workers' Compensation Law.
- (3) For physical therapy and/or occupational therapy, there shall be no fee allowable for any modalities performed in excess of four (4) modalities per day per employee. The Medicare definition of modality is applicable.
- (4) Any procedure for which an appropriate Medicare code is not available, such as a Functional Capacity Evaluation or work hardening. The usual and customary charge shall be the maximum amount reimbursable for such services.
- (5) Whenever physical therapy and/or occupational therapy services exceed twelve (12) sessions/visits or a period over thirty (30) days, whichever comes first, then such treatment shall be

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reviewed pursuant to the carrier's utilization review program in accordance with the procedures set forth in 0800-2-6 of the Division's Utilization Review rules before further physical therapy and/or occupational therapy services may be certified for payment by the carrier. Such certification shall be completed within two (2) business days of any request for certification to assure no interruption in delivery of needed services. Failure to properly certify such services as prescribed herein shall result in the forfeiture of any payment for uncertified services. The initial utilization review of physical therapy and/or occupational therapy services shall, if necessary and appropriate, certify an appropriate number of sessions/visits. If necessary, further subsequent utilization review shall be conducted to certify additional physical therapy and/or occupational therapy services as is appropriate.

Authority: T.C.A. §§ 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

0800-2-18-.10 DURABLE MEDICAL EQUIPMENT GUIDELINES.

All durable medical equipment shall be reimbursed at a maximum of the invoice amount plus the lesser of 15% of invoice or \$1,000.00, and coded using the HCPCS codes. Charges for durable medical equipment are in addition to, and shall be billed separately from, all facility and professional service fees. Supplies and equipment not addressed in this fee guideline shall be reimbursed at a reasonable amount, as defined in these Rules and coded 99070 if appropriate codes are not available in the HCPCS. All billing must contain the brand name, model number, and catalog number. Codes to be used are found in the HCPCS. Charges should be submitted on a HCFA 1500 form.

- (1) **Quality.** The reimbursement for supplies/equipment in this fee guideline is based on a presumption that the injured worker is being provided the highest quality of supplies/equipment. All billing must contain the brand name, model number, and catalog number.
- (2) **Rental/Purchase.** Rental fees are applicable in instances of short-term utilization (30-60 days). If it is more cost effective to purchase an item rather than rent it, this must be stressed and brought to the attention of the insurance carrier. The first month's rent should apply to the purchase price. However, if the decision to purchase an item is delayed by the insurance carrier, subsequent rental fees cannot be applied to the purchase price. When billing for rental, identify with modifier "RR".
- (3) **TENs Units.** All bills submitted to the carrier for Tens and Cranial Electrical Stimulator (CES) units should be accompanied by a copy of the invoice, if available.
 - (a) **Rentals**
 1. Include the following supplies:
 - (i) lead wires;
 - (ii) two (2) rechargeable batteries;
 - (iii) battery charger;
 - (iv) electrodes; and
 - (v) instruction manual and/or audio tape.
 2. Supplies submitted for reimbursement must be itemized. In unusual circumstances where additional supplies are necessary, use modifier 22 and "BR"
 3. Limited to 30 days trial period.

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(b) Purchase:

1. Prior to the completion of the 30-day trial period, the prescribing doctor must submit a report documenting the medical justification for the continued use of the unit. The report should identify the following:
 - (i) Describe the condition and diagnosis that necessitates the use of a TENS unit.
 - (ii) Does the patient have any other implants which would affect the performance of the TENS unit or the implanted unit?
 - (iii) Was the TENS unit effective for pain control during the trial period?
 - (iv) Was the patient instructed on the proper use of the TENS unit during the trial period?
 - (v) How often does the patient use the TENS unit?
2. The purchase price should include the items below if not already included with the rental:
 - (i) lead wires;
 - (ii) two (2) rechargeable batteries; and
 - (iii) a battery charger.
3. Only the first month's rental price shall be credited to purchase price.
4. Provider shall indicate TENS manufacturer, model name, and serial number.

(4) Continuous and Passive Motion (Use Code D0540)

Use of this unit in excess of 30 days requires documentation of medical necessity by the doctor. Only one (1) set of soft goods will be allowed for purchase.

Authority: T.C.A. §§ 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

0800-2-18-.11 ORTHOTICS, PROSTHETICS AND IMPLANTS GUIDELINES.

Implants, orthotics and prosthetics should be coded according to the HCFA Common Procedures Coding System (HCPCS). Copies may be obtained from the American Orthotic and Prosthetic Association, 1650 King Street, Suite 500, Alexandria, VA 22314, (703) 836-7116. Implants, orthotics and prosthetics shall be reimbursed at the supplier's invoice amount, plus 15% of the invoice amount or \$1,000.00, whichever is less, and coded using the HCPCS code. Charges for these items are in addition to, and shall be billed separately from, all facility and professional service fees. Supplies and equipment should be coded 99070 if appropriate codes are not available in the HCPCS. All billing must contain the brand name, model number, and catalog number. Charges should be submitted on a HCFA 1500 form.

Authority: T.C.A. §§ 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

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0800-2-18-.12 PHARMACY SCHEDULE GUIDELINES.

The Pharmaceutical Fee Guideline Amount for prescribed drugs (medicines by pharmacists and dispensing practitioners) under the Tennessee workers' compensation laws is the lesser of:

- (1) The provider's usual charge;
- (2) A negotiated contract amount; or
- (3) The fees established by the formula for brand-name and generic pharmaceuticals as described in subsection (5) of this section.
- (4) Prescribed Medication Services
 - (a) "Drug" has the meaning set out in T. C. A. § 63-10-204.
 - (b) Medicine or drugs may only be dispensed by a currently licensed pharmacist or a dispensing practitioner.
 - (c) Carriers may contract with pharmacy benefit managers to process and administer claims for reimbursement of pharmacy services and review the relatedness and appropriateness of prescribed services. Carriers and pharmacists may also negotiate alternative reimbursement schedules and amounts, so long as the reimbursement amount does not exceed the fee schedule amount set out in these Rules.
 - (d) For the purposes of these TWCD Medical Fee Schedule Rules, medicines are defined as drugs prescribed by an authorized health care provider and include only generic drugs or single-source patented drugs for which there is no generic equivalent, unless the authorized health care provider writes that the brand name is medically necessary and includes on the prescription "dispense as written."
- (5) Reimbursement
 - (a) The pharmaceutical reimbursement formula for prescribed drugs (medicines by pharmacists and dispensing practitioners) is the lesser of:

Average Wholesale Price* ("AWP") + \$5.10 filling fee, the provider's usual charge, or a negotiated contractual amount.

* The Commissioner may at any time adopt and implement a different base price other than AWP (such as average sales price), should medical reimbursement standards and/or local or other practices warrant, at the Commissioner's discretion.
 - (b) Reimbursement to pharmacists must not exceed the amount calculated by the pharmaceutical reimbursement formula for prescribed drugs. A generic drug must be substituted for any brand name drug unless: 1) there is no pharmaceutical and bioequivalent drug available, or 2) the prescribing physician indicates that substitutions are prohibited by including the words "Dispense as Written", or "No Substitution Allowed" in the prescriber's own handwriting, along with a statement that the brand name drug is medically necessary. A prescribing physician may also prohibit substitution of generic drugs by oral or electronic communication to the pharmacist so long as the same content is conveyed that is required in a written prescription.
 1. A bill or receipt for a prescription drug shall include all of the following:
 - (i) When a brand name drug with a generic equivalent is dispensed, the brand name and the generic name shall be included unless the prescriber indicates "do not label."

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- (ii) If the drug has no brand name, the generic name, and the manufacturer's name or the supplier's name, shall be included, unless the prescriber indicates "do not label."
 - (iii) The strength, unless the prescriber indicates "do not label."
 - (iv) The quantity dispensed.
 - (v) The dosage.
 - (vi) The name, address, and federal tax ID# of the pharmacy.
 - (vii) The prescription number, if available.
 - (viii) The date dispensed.
 - (ix) The name of the prescriber.
 - (x) The name of the patient.
 - (xi) The price for which the drug was sold to the purchaser.
 - (xii) The National Drug Code Number ("NDC Number").
2. The AWP shall be determined from the appropriate monthly publication. The monthly publication that shall be used for calculation shall be the same as the date of service. When an AWP is changed during the month, the provider shall still use the AWP from the monthly publication. The publications to be used are:
- a. Primary reference: Price Alert from Medi-Span , available at: www.medi-span.com/Products/index.aspx?id=27 .
 - b. Secondary reference: (for drugs NOT found in PriceAlert).
Red Book from Medical Economics.
3. Dietary supplements such as minerals and vitamins shall not be reimbursable unless a specific compensable dietary deficiency has been clinically established in the injured employee as a result of the work-related injury.
4. A compounding fee not to exceed Twenty-five Dollars (\$25.00) per compound prescription may be charged if two (2) or more prescriptive drugs require compound preparation when sold by a hospital, pharmacy, or provider of service other than a physician.
5. If allowable payment for prescriptive drugs is not paid by employers or carriers for prescriptions provided to employees who have suffered a compensable work-related injury under the Workers' Compensation Law within thirty-one (31) days from the date of receipt by the employer or insurer of the bill for prescriptive drugs provided to such an employee, interest at the rate of 2.08% /month of the payment allowed pursuant to these rules may be charged by a hospital, pharmacy, or provider of such service as set forth in Rule 0800-2-11-.10 of the Medical Cost Containment Program Rules.
6. If a workers' compensation claimant chooses a brand-name medicine when a generic medicine is available and allowed by the prescriber, the claimant shall pay the difference in price between the brand-name and generic medicine and shall not be eligible to subsequently recover this difference in cost from the employer or carrier.

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- (6) "Patent" or "Proprietary Preparations"
 - (a) "Patent" or "Proprietary preparations," frequently called "over-the-counter drugs," are sometimes prescribed for a work-related injury or illness instead of a legend drug.
 - (b) Generic substitution as discussed in (4)(b) above applies also to "over-the-counter" preparations.
 - (c) Pharmacists must bill and be reimbursed their usual and customary charge for the "over-the-counter" drug(s).
 - (d) The reimbursement formula does not apply to the "over-the-counter" drugs and no filling fee may be reimbursed.
- (7) Dispensing Practitioner
 - (a) Dispensing practitioners shall be reimbursed the same as pharmacists for prescribed drugs (medicines), except such practitioners shall not receive a filling fee.
 - (b) "Patent" or "proprietary preparations" frequently called "over-the-counter drugs," dispensed by a physician(s) from their office(s) to a patient during an office visit should be billed as follows:
 - 1. Procedure Code 99070 must be used to bill for the "proprietary preparation" and the name of the preparation, dosage and package size must be listed as the descriptor.
 - 2. An invoice indicating the cost of the "proprietary preparation" must be submitted to the carrier with the HCFA 1500 Form.
 - 3. Reimbursement is limited to the lesser of the provider's charge or 20 percent above the actual cost of the item.

Authority: T.C.A. §§ 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

0800-2-18-.13 AMBULANCE SERVICES GUIDELINES.

- (1) All non-emergency ground and air ambulance service provided to workers' compensation claimants shall be pre-certified. Emergency ground and air ambulance services shall be retro-certified within 24 hours of the service or on the next business day.
- (2) All ground and air ambulance services shall be medically necessary and appropriate. Documentation, trip sheets, shall be submitted with the bill that states the condition that indicates the necessity of the ground and air ambulance service provided. It should readily indicate the need for transport via this mode rather than another less expensive form of transportation. The service billed shall be supported by the documentation submitted for review.
- (3) Billing shall be submitted to the employer or carrier on a properly completed HCFA 1500 claim form by HCPCS code. Hospital based or owned providers must submit charges on a HCFA 1500 form by HCPCS code.
- (4) Reimbursement shall be:

Based upon the lesser of the submitted charge or the prevailing reimbursement rate for ambulances within the geographic locality. These charges shall not exceed the prevailing charges in that locality for comparable services under comparable circumstances and commensurate with

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the services actually performed. Ambulance services shall be paid on a two (2) part basis, the first level being the level of care, the second being a mileage allowance. The services rendered are independent of the type of call received.

Authority: T.C.A. §§ 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

0800-2-18-.14 CLINICAL PSYCHOLOGICAL SERVICE GUIDELINES.

- (1) Reimbursement for psychological treatment services by any clinician other than a licensed psychiatrist shall be based on reasonableness and necessity and shall be reimbursed at 100% of the participating fees prescribed in the Medicare RBRVS System fee schedule (Medicare Fee Schedule). Treatment by a licensed psychiatrist shall be reimbursed as any other evaluation and management medical treatment under this Medical Fee Schedule.
- (2) Whenever such psychological treatment services exceed fifteen (15) sessions/visits, then such treatment shall be reviewed pursuant to the carrier's utilization review program in accordance with the procedures set forth in 0800-2-6 of the Division's Utilization Review rules before further psychological treatment services may be certified for payment by the carrier. Failure to properly certify such services as prescribed herein shall result in the forfeiture of any payment for uncertified services. The initial utilization review of psychological treatment services after the first fifteen (15) sessions/visits shall, if necessary and appropriate, certify an appropriate number of sessions/visits. If necessary, further subsequent utilization review shall be conducted to certify additional psychological treatment services as is appropriate.

Authority: T.C.A. §§ 50-6-118, 50-6-125, 50-6-128, 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

0800-2-18-.15 PENALTIES FOR VIOLATIONS OF FEE SCHEDULES.

- (1) Providers shall not accept and employers or carriers shall not pay any amount for health care services provided for the treatment of a covered injury or illness or for any other services encompassed within the Medical Cost Containment Program Rules, Medical Fee Schedule Rules or the In-patient Hospital Fee Schedule Rules, when that amount exceeds the maximum allowable payment established by these Rules. Any provider accepting and any employer or carrier paying an amount in excess of the TDWC Medical Cost Containment Program Rules, Medical Fee Schedule Rules or the In-patient Hospital Fee Schedule Rules shall be in violation of these Rules and may, at the Commissioner's discretion, be subject to civil penalties of ten thousand dollars (\$10,000.00) per violation for each violation, which may be assessed severally against the provider accepting such fee and the carrier or employer paying the excessive fee whenever a pattern or practice of such activity is found. At the discretion of the Commissioner, the Commissioner's Designee, or an agency member appointed by the Commissioner, such provider may also be reported to the appropriate certifying board, and may be subject to exclusion from participating in providing care under the Act. Any other violation of the Medical Cost Containment Program Rules, Medical Fee Schedule Rules, or the In-patient Hospital Fee Schedule Rules shall subject the violator(s) to a civil penalty of not less than one hundred dollars (\$100.00) nor more than ten thousand dollars (\$10,000.00) per violation, at the discretion of the Commissioner, Commissioner's Designee, or an agency member appointed by the Commissioner.
- (2) A provider, employer or carrier found in violation of these Rules, whether a civil penalty is assessed or not, may request a contested case hearing by requesting such hearing in writing within fifteen (15) calendar days of issuance of a Notice of Violation and, if applicable, notice of assessment of civil penalties.

PUBLIC NECESSITY RULES

- (3) The request for a hearing shall be made to the Division in writing by an employer, carrier or provider which has been notified of its violation of these Rules, and if applicable, assessed a civil penalty.
- (4) Any request for a hearing shall be filed with the Division within fifteen (15) calendar days of the date of issuance of the Notice of Violation and, if applicable, of civil penalty by the Commissioner. Failure to file a request for a hearing within fifteen (15) calendar days of the date of issuance of a Notice of Violation shall result in the decision of the Commissioner, Commissioner's Designee, or an agency member appointed by the Commissioner being deemed a final order and not subject to further review.
- (5) The Commissioner, Commissioner's Designee, or an agency member appointed by the Commissioner shall have the authority to hear any matter as a contested case and determine if any civil penalty assessed should have been assessed.
- (6) Upon receipt of a timely filed request for a hearing, the Commissioner shall issue a Notice of Hearing to all interested parties.

Authority: *T.C.A. §§ 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).*

The public necessity rules set out herein were properly filed in the Department of State on the 16th day of November, 2005, and will be effective from the day of filing for a period of 165 days. These public necessity rules will remain in effect through the 30th day of April, 2006. (11-22)

PUBLIC NECESSITY RULES

**THE TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT - 0800
DIVISION OF WORKERS' COMPENSATION**

**CHAPTER 0800-2-19
IN-PATIENT HOSPITAL FEE SCHEDULE**

STATEMENT OF NECESSITY FOR READOPTING PUBLIC NECESSITY RULES

Pursuant to Tenn. Code Ann. §§ 4-5-209(a)(4) and (b) and 50-6-204(i)(5), the Commissioner submits the In-patient Hospital Fee Schedule Rules ("Rules") for re-adoption as public necessity rules as part of the comprehensive medical fee schedule and related system applicable to all medical treatment under the Workers' Compensation Law as administered by the Workers' Compensation Division of the Tennessee Department of Labor and Workforce Development. Re-adoption of these as public necessity rules is necessary for the reasons set forth below and because Tenn. Code Ann. § 50-6-204(i) requires the comprehensive medical fee schedule and related system be in place and effective on and after July 1, 2005. Tenn. Code Ann. § 50-6-204(i)(5).

These Rules were initially adopted as public necessity rules and filed with the secretary of state's office on June 15, 2005, when proposed rules were also filed. Those public necessity rules will expire on November 27, 2005, and unless these rules are re-adopted as public necessity rules now, there will be a period of time when no effective Rules will be in place. In response to a petition on the proposed rules, a rulemaking public hearing was held on these Rules on September 23, 2005. The Department is currently analyzing all of the numerous oral and written comments received during the rulemaking public hearing and must respond to each in writing as required pursuant to Tenn. Code Ann. § 4-5-222. Given that the rulemaking hearing rules may not be effective until at least 75 days after filing with the secretary of state's office, it would be impossible to avoid a lapse in these Rules without the re-adoption of these Rules as public necessity rules. The Department could not have reasonably foreseen during the initial one hundred sixty-five day period that the original need for the public necessity rules would continue to the present time.

Medical providers, employees, employers and insurers are statutorily mandated to comply with the medical fee schedule rules, of which these Rules are an integral part, on and after July 1, 2005, in providing all workers' compensation medical benefits. These rules are necessary to comply with the mandate enacted by the General Assembly in Public Chapter 962 (Tenn. Code Ann. § 50-6-204, (2005 Supp.)) to provide the required medical fee schedule with guidelines and procedures to medical providers, employees, employers and insurers. Thus, these public necessity rules are being re-adopted to protect the public welfare. Due to the length of time necessary to complete the rulemaking process under the Uniform Administrative Procedures Act, these public necessity rules should be re-adopted immediately to provide applicable medical fees, guidelines and procedures so as not to jeopardize injured employees' ability to receive prompt and adequate medical care. Further, Tenn. Code Ann. § 50-6-204(i)(5) specifically authorizes adoption of these rules as public necessity rules.

James Neeley, Commissioner
Tennessee Department of Labor &
Workforce Development

For copies of this public necessity rule, contact: Vickie Gregory, Administrative Assistant, Tennessee Department of Labor and Workforce Development, Division of Workers' Compensation, Andrew Johnson Tower, Second Floor, 710 James Robertson Parkway, Nashville, TN 37243-0661, (615) 253-1613.

PUBLIC NECESSITY RULES

**RULES
OF
TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
DIVISION OF WORKERS' COMPENSATION**

**CHAPTER 0800-2-19
IN-PATIENT HOSPITAL FEE SCHEDULE**

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0800-2-19-.01 GENERAL RULES.

- (1) This In-patient Hospital Fee Schedule shall be effective July 1, 2005 and is applicable for all inpatient services as defined herein, and includes medical, surgical, rehabilitation, and/or psychiatric services rendered in a hospital to injured workers under the Tennessee Workers' Compensation Act. Maximum fees for outpatient hospital services are not addressed in this In-patient Hospital Fee Schedule, but are contained in the Medical Fee Schedule Rules, 0800-2-18-.01 et seq. This In-patient Hospital Fee Schedule is established pursuant to Tenn. Code Ann. § 50-6-204 (Supp. 2004) is effective July 1, 2005, and must be used in conjunction with the Medical Cost Containment Program Rules, 0800-2-17-.01 et seq. and the Medical Fee Schedule Rules, 0800-2-18-.01 et seq. as the definitions and general provisions set forth in those rules are incorporated as if set forth fully herein.
- (2) General Information
 - (a) Reimbursements shall be determined for services rendered in accordance with this fee schedule and shall be considered to be inclusive unless otherwise noted.
 - (b) The most current Medicare procedures and guidelines are hereby adopted and incorporated as part of these Rules as if fully set out herein and shall be effective upon adoption and implementation by the CMS. Whenever there is no specific fee or methodology for reimbursement set forth in these Rules for a service, diagnostic procedure, equipment, etc., then the amount of reimbursement shall be at 100% of the 2005 CMS' Medicare amount and the most current effective Medicare guidelines and procedures shall be followed in arriving at the correct amount. The Medicare amount may, at the Commissioner's discretion, be adjusted upward annually based upon CMS' annual Medicare Economic Index adjustment, but this amount shall never fall below the effective 2005 Medicare amount. Whenever there is no applicable Medicare code, the service, equipment, diagnostic procedure, etc. shall be reimbursed at the usual and customary amount and be billed By Report.
 - (c) Reimbursement for a compensable workers' compensation claim shall be the lesser of the hospital's usual and customary charges or the maximum amount allowed under this Inpatient Hospital Fee Schedule.
 - (d) Inpatient hospitals shall be grouped into the following separate peer groupings:

Peer Group	1	Hospitals
Peer Group	2	Rehabilitation Hospitals
Peer Group	3	Psychiatric Hospitals

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- (e) For each inpatient claim submitted, the provider shall assign a Medicare Diagnosis Related Group ("DRG") code which appropriately reflects the patient's primary cause of hospitalization.
- (f) The inpatient hospital fee schedule shall become effective July 1, 2005 and shall be reviewed annually and may be updated annually.
- (g) Ongoing analysis will be conducted as to the projected savings of this schedule, as well as any impact on patient services.
- (h) Preauthorization is required for specific inpatient services.

Authority: *T.C.A. §§ 50-6-125, 50-6-128, 50-6-204, 50-6-205 (Supp. 2004).*

0800-2-19-.02 DEFINITIONS.

- (1) "Administrator" means the chief administrative officer of the Division of Workers' Compensation of the Tennessee Department of Labor and Workforce Development.
- (2) "Allowed Charges" or "Allowable Charges" shall mean charges reviewed and approved under an appropriate audit and utilization review by the carrier as prescribed in the Division's Rules, or as determined by the Commissioner or the Commissioner's designee after consultation with the Division's Medical Director.
- (3) "Commissioner" means the Commissioner of the Tennessee Department of Labor and Workforce Development.
- (4) "Division" means the Division of Workers' Compensation of the Tennessee Department of Labor and Workforce Development.
- (5) DRG – Medicare classifications of diagnosis in which patients demonstrate similar resource consumption and length of stay patterns.
- (6) In-patient Services - Services rendered to a person who is formally admitted to a hospital and whose length of stay exceeds 23 hours.
- (7) Institutional Services - All non-physician services rendered within the institution by an agent of the institution.
- (8) Length of Stay ("LOS") - Number of days of admission where patient appears on midnight census. Last day of stay shall count as an admission day if it is medically necessary for the patient to remain in the hospital beyond 12:00 noon.
- (9) Medical Admission - Any hospital admission where the primary services rendered are not surgical, psychiatric, or rehabilitative in nature.
- (10) Stop-Loss Payment ("SLP") - An independent method of payment for an unusually costly or lengthy stay.
- (11) Stop-Loss Reimbursement Factor ("SLRF") - A factor established by the Division to be used as a multiplier to establish a reimbursement amount when total hospital charges have exceeded specific stop-loss thresholds.
- (12) Stop-Loss Threshold ("SLT") - Threshold of total charges established by the Division, beyond which reimbursement is calculated by multiplying the applicable Stop-Loss Reimbursement Factor times the total charges identifying that particular threshold.

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- (13) Surgical Admission - Any hospital admission where there is an operating room charge, the patient has a surgical procedure code, or the patient has a surgical DRG as defined by the CMS.
- (14) Transfers Between Facilities - To move or remove a patient from one facility to another for a purpose related to obtaining or continuing medical care. May or may not involve a change in the admittance status of the patient, i.e. patient transported from one facility to another to obtain specific care, diagnostic testing, or other medical services not available in facility in which patient has been admitted. Includes costs related to transportation of patient to obtain medical care.
- (15) "Trauma Admission" - means any hospital admission in which the patient has a diagnosis code of 800 to 959.99.
- (16) "Usual and customary charge" means a particular provider's average charge for a procedure to all payment sources, and includes itemized charges previously billed separately which are included in the package for that procedure as defined by this rule.
- (17) Workers' Compensation Standard Per Diem Amount ("SPDA") - A standardized per diem amount established for the reimbursement of hospitals for services rendered.

Authority: T.C.A. §§ 50-6-125, 50-6-128, 50-6-204, 50-6-205 (Supp. 2004).

0800-2-19-.03 SPECIAL GROUND RULES – INPATIENT HOSPITAL SERVICES.

- (1) This section defines the reimbursement procedures and calculations for inpatient health care services by all hospitals. Hospital reimbursement is divided into two (2) groups based on type of admission (surgical or non-surgical (medical)) and length of stay (less than eight (8) days/over seven (7) days). Rehabilitation and Psychiatric hospitals are grouped separately.
- (2) General Information
 - (a) For each inpatient claim submitted, the provider shall assign a Diagnosis Related Group (DRG) code which appropriately reflects the patient's primary cause for hospitalization to determine average length of stay and for tracking purposes. Hospitals within each peer group are subject to a maximum amount per inpatient day.
 - (b) The maximum per diem rates to be used in calculating the reimbursement rate is as follows:
 - 1. Peer Group 1 \$1,800.00 Surgical adm for the first seven (7) days;
1,500.00 per day thereafter (surgical adm.)
Includes Intensive Care (ICU) & Critical Care (CCU)

1,500.00 Medical adm. for first seven (7) days;
1,250.00 per day thereafter (medical adm.)
 - 2. Peer Group 2 1,000.00 For the first seven (7) days;
(Rehabilitation) 800.00 per day thereafter
 - 3. Peer Group 3 700.00 Psychiatric Hospitals (applicable to chemical
dependency as well.)
 - (c) All trauma care at any licensed Level 1 Trauma Center shall be reimbursed at a maximum rate of \$3,000.00 per day for each day of patient stay.
 - (d) Surgical implants shall be reimbursed separately and in addition to the per diem hospital charges.

PUBLIC NECESSITY RULES

1. Reimbursement for trauma inpatient hospital services shall be limited to the lesser of the maximum allowable as calculated by the appropriate per diem rate, or the hospital's billed charges minus any non-covered charges.
 2. Non-covered charges are: convenience items, charges for services not related to the work injury/illness services that were not certified by the payer or their representative as medically necessary.
 3. Additional reimbursement may be made in addition to the per diem for implantables (i.e. rods, pins, plates and joint replacements, etc.). The reimbursement for the implantables is limited to hospital's cost plus fifteen percent (15%) of invoice, up to a maximum of invoice plus \$1,000.00. Implantables shall be billed using the appropriate HCPCS codes, when available. Billing for implantables must be accompanied by an invoice when requested by the payer.
 4. The following items are not included in the per diem reimbursement to the facility and may be reimbursed separately. All of these items must be listed with the HCPCS code.
 - (i) Durable Medical Equipment
 - (ii) Orthotics and Prosthetics
 - (iii) Implantables
 - (iv) Ambulance Services
 - (v) Take home medications and supplies
- (e) The above listed items will be reimbursed according to the Medical Cost Containment Program Rules and Medical Fee Schedule Rules payment limits. Items not listed in the fee schedule Rules will be reimbursed at the usual and customary rate, unless otherwise indicated herein.
- (f) Per diem rates are all inclusive (with the exception of those items listed in 4 above). The services must be medically necessary and delivered at the appropriate level/site of service.
- (g) The In-patient Hospital Fee Schedule allows for independent reimbursement on a case-by-case basis if the particular care exceeds the Stop-Loss Threshold.
- (3) Reimbursement Calculations
- (a) Explanation
 1. Each admission is assigned an appropriate DRG.
 2. The applicable Standard Per Diem Amount ("SPDA") is multiplied by the length of stay ("LOS") for that admission.
 3. The Workers' Compensation Reimbursement Amount ("WCRA") is the total amount of reimbursement to be made for that particular admission.
 - (b) Formula: $LOS \times SPDA = WCRA$
 - (c) Example: DRG 222: Knee Procedures W/O CC
Hospital Peer Group: 1-Surgical admission:
Maximum rate per day: \$1,800 first seven (7) days/\$1,500 per day each day thereafter
Number billed days: 9
Billed charges: \$15,600

PUBLIC NECESSITY RULES

Maximum Allowable Payment: \$15,600

(4) Stop-Loss Method

(a) Stop-loss is an independent reimbursement factor established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker.

(b) Explanation

1. To be eligible for stop loss payment, the total Allowed Charges for a hospital admission must exceed the hospital maximum payment, as determined by the hospital maximum payment rate per day, by at least \$15,000. Amounts for items set forth in rule 0800-2-19-.03(d)(4), such as implantables, DME, etc., shall not be included in determining the total Allowed Charges for stop-loss calculations.
2. This stop-loss threshold is established to ensure compensation for unusually extensive services required during an admission.
3. Once the allowed charges reach the stop-loss threshold, reimbursement for all additional charges shall be made based on a stop-loss payment factor of 80%.
4. The additional charges are multiplied by the Stop-Loss Reimbursement Factor (SLRF) and added to the maximum allowable payment.

(c) Formula: (Additional Charges x SLRF) + Maximum Allowable Payment = WCRA

(d) Example: DRG 222: Knee Procedures W/O CC

Hospital Peer Group: 1 –Surgical admission
 Maximum rate per day:\$1,800 for first 7 days; 1,500 for 2 additional days
 Number Billed Days: 9
 Total Billed Charges: \$37,600.00

Maximum allowable payment for
 Normal DRG stay \$15,600

Versus: billed charges \$37,600

Amount Payable Before Stop-Loss,
 Lower of Charge vs. Maximum Allowable \$15,600

Total difference, charges over and above maximum payments \$22,000

Difference over and above \$15,000 Stop-loss is \$7,000.00
 Payable under Stop-loss (80% of 7,000.00) \$5,600.00

Total payment
 due hospital: \$21,200.00 (15,600+5,600)

(5) Billing for Inpatient Admissions

All bills for inpatient institutional services should be submitted on the standard UB-82 (HCFA 1450) form or any revision to that form approved for use by the CMS.

Authority: T.C.A. §§ 50-6-125, 50-6-128, 50-6-204, 50-6-205 (Supp. 2004).

PUBLIC NECESSITY RULES

0800-2-19-.04 PREAUTHORIZATION.

- (1) Procedures For Requesting Preauthorization
 - (a) The insurance carrier shall be liable for the reasonable and necessary medical costs relating to the health care treatments and services listed in subparagraph (g) of this Rule required to treat a compensable injury, when any of the following situations occur:
 1. the treating doctor, his/her designated representative, or injured employee has received preauthorization from the carrier prior to the health care treatments or services;
 2. the carrier has failed to communicate approval or denial of preauthorization within seven (7) business days of a provider's request for preauthorization; or
 3. when ordered by the Division.
 - (b) The insurance carrier shall designate an accessible direct telephone number, and may also designate a facsimile number for use by the provider or the provider's designated representative or the injured employee to request preauthorization during normal business hours. The direct number shall be answered or the facsimile responded to, by the carrier's agent who is delegated to approve or deny requests for preauthorization, within the time limits established in subsection (d) of this section.
 - (c) Prior to the date of proposed treatment or services, the provider or the provider's designated representative, shall notify the insurance carrier's delegated agent, by telephone or transmission of a facsimile, of the recommended treatment or service listed in subparagraph (g) of this Rule. Notification shall include the medical information to substantiate the need for the treatment or service recommended. If requested to do so by the carrier, the treating doctor shall also notify the insurance carrier of the location and estimated date of the recommended treatment or service, and the name of the health care provider performing the treatment or service, if other than the provider. Designated representative includes, but is not limited to, office staff, hospitals, etc.
 - (d) Within seven (7) business days of the provider's request for preauthorization, the insurance carrier's delegated agent shall notify the provider or the provider's designated representative, by telephone or transmission of a facsimile, of the insurance carrier's decision to grant or deny preauthorization. Failure of the carrier to communicate its approval or denial of authorization within seven (7) business days of a provider's request for preauthorization shall automatically be deemed an approval of the preauthorization request. When the insurance carrier approves preauthorization, the insurance carrier shall send written approval, or if denying preauthorization, shall send documentation identifying the reasons for denial. Notification shall be sent to the injured employee, the injured employee's representative if known, and the provider or the provider's designated representative, within 24 hours after notification of denial or approval.
 - (e) The insurance carrier shall maintain accurate records to reflect information regarding the preauthorization request and approval/denial process.
 - (f) If a dispute arises over denial of preauthorization by the insurance carrier, the doctor or the injured employee may file a Request for Assistance with a Benefit Review Specialist.
 - (g) The health care treatments and services requiring preauthorization are: all nonemergency hospitalizations and non-emergency transfers between facilities.

Authority: T.C.A. §§ 50-6-125, 50-6-128, 50-6-204, 50-6-205 (Supp. 2004).

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0800-2-19-.05 OTHER SERVICES.

- (1) Pharmacy Services
 - (a) Pharmaceutical services rendered as part of inpatient care are considered inclusive within the inpatient fee schedule and shall not be reimbursed separately.
 - (b) All retail pharmaceutical services rendered shall be reimbursed in accordance with the Pharmacy Schedule Guidelines.
- (2) Professional Services
 - (a) All non-institutional professional services will be reimbursed in accordance with the Division's Medical Cost Containment Program Rules and Medical Fee Schedule Rules which must be used in conjunction with these Rules.

Authority: T.C.A. §§ 50-6-118, 50-6-125, 50-6-128, 50-6-204, 50-6-205 (Supp. 2004).

0800-2-19-.06 PENALTIES FOR VIOLATIONS OF FEE SCHEDULES.

- (1) Providers shall not accept and employers or carriers shall not pay any amount for health care services provided for the treatment of a covered injury or illness or for any other services encompassed within the Medical Cost Containment Program Rules, Medical Fee Schedule Rules or the In-patient Hospital Fee Schedule Rules, when that amount exceeds the maximum allowable payment established by these Rules. Any provider accepting and any employer or carrier paying an amount in excess of the Division's Medical Cost Containment Program Rules, Medical Fee Schedule Rules or the In-patient Hospital Fee Schedule Rules shall be in violation of these Rules and may, at the Commissioner's discretion, be subject to civil penalties of ten thousand dollars (\$10,000.00) per violation for each violation, which may be assessed severally against the provider accepting such fee and the carrier or employer paying the excessive fee, whenever a pattern or practice of such activity is found. At the discretion of the Commissioner, the Commissioner's Designee, or an agency member appointed by the Commissioner, such provider may also be reported to the appropriate certifying board, and may be subject to exclusion from participating in providing care under the Act. Any other violation of the Medical Cost Containment Program Rules, Medical Fee Schedule Rules, or the In-patient Hospital Fee Schedule Rules shall subject the alleged violator(s) to a civil penalty of not less than one hundred dollars (\$100.00) nor more than ten thousand dollars (\$10,000.00) per violation, at the discretion of the Commissioner, Commissioner's Designee, or an agency member appointed by the Commissioner.
- (2) A provider, employer or carrier found to be in violation of these Rules, whether a civil penalty is assessed or not, may request a contested case hearing by requesting such hearing in writing within fifteen (15) days of issuance of a Notice of Violation and, if applicable, the notice of assessment of civil penalties.
- (3) The request for a hearing shall be made to the Division in writing by an employer, carrier or provider which has been notified of its violation of these Rules, and if applicable, assessed a civil penalty.
- (4) Any request for a hearing shall be filed with the Division within fifteen (15) calendar days of the date of issuance of the Notice of Violation and, if applicable, of civil penalty. Failure to file a request for a hearing within fifteen (15) calendar days of the date of issuance of a Notice of Violation shall result in the decision of the Commissioner, Commissioner's Designee, or an agency member appointed by the Commissioner becoming a final order and not subject to further review.

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- (5) The Commissioner, Commissioner's Designee, or an agency member appointed by the Commissioner shall have the authority to hear the matter as a contested case and determine if any civil penalty assessed should have been assessed.
- (6) Upon receipt of a timely filed request for a hearing, the Commissioner shall issue a Notice of Hearing to all interested parties.

Authority: T.C.A. §§ 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

The public necessity rules set out herein were properly filed in the Department of State on the 16th day of November, 2005, and will be effective from the day of filing for a period of 165 days. These public necessity rules will remain in effect through the 30th day of April, 2006. (11-23)

PUBLIC NECESSITY RULES

**THE TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT - 0800
DIVISION OF WORKERS' COMPENSATION**

**CHAPTER 0800-2-20
MEDICAL IMPAIRMENT RATING REGISTRY PROGRAM**

STATEMENT OF NECESSITY FOR READOPTING PUBLIC NECESSITY RULES

Pursuant to Tenn. Code Ann. §§ 4-5-209(a)(4) and (b), and 50-6-204(d)(8), the Commissioner submits the Medical Impairment Rating Registry Program Rules ("MIRR Rules") for re-adoption as public necessity rules under the Workers' Compensation Law as administered by the Workers' Compensation Division of the Tennessee Department of Labor and Workforce Development. Re-adoption of these MIRR Rules as public necessity rules is necessary for the reasons set forth below and because Tenn. Code Ann. § 50-6-204(d)(8) requires the MIRR Rules be in place and effective on and after July 1, 2005. Tenn. Code Ann. § 50-6-204(d)(8).

These MIRR Rules were initially adopted as public necessity rules and filed with the secretary of state's office on June 15, 2005, when proposed rules were also filed. Those public necessity rules will expire on November 27, 2005, and unless these rules are re-adopted as public necessity rules now, there will be a period of time when no effective Rules will be in place. In response to a petition on the proposed rules, a rulemaking public hearing was held on these MIRR Rules on October 25, 2005. The Department is currently analyzing all of the numerous oral and written comments received during the rulemaking public hearing and must respond to each in writing as required pursuant to Tenn. Code Ann. § 4-5-222. Given that the rulemaking hearing rules may not be effective until at least 75 days after filing with the secretary of state's office, it would be impossible to avoid a lapse in these Rules without the re-adoption of these MIRR Rules as public necessity rules. The Department could not have reasonably foreseen during the initial one hundred sixty-five day period that the original need for the public necessity rules would continue to the present time.

Medical providers, employees, employers and insurers are statutorily mandated to comply with the MIRR Rules on and after July 1, 2005, in resolving all cases in which there are disputes about medical impairment ratings in workers' compensations cases. These rules are necessary to comply with the mandate enacted by the General Assembly in Public Chapter 962 (Tenn. Code Ann. § 50-6-204(d)(8), (2005 Supp.)). Thus, these public necessity rules are being re-adopted to protect the public welfare. Due to the length of time necessary to complete the rulemaking process under the Uniform Administrative Procedures Act, these public necessity rules should be re-adopted immediately to provide applicable medical fees, guidelines and procedures so as not to jeopardize injured employees' ability to receive prompt and adequate medical care. Further, Tenn. Code Ann. § 50-6-204(d)(8) specifically authorizes adoption of these rules as public necessity rules.

James Neeley, Commissioner
Tennessee Department of Labor &
Workforce Development

For copies of this public necessity rule, contact: Vickie Gregory, Administrative Assistant, Tennessee Department of Labor and Workforce Development, Division of Workers' Compensation, Andrew Johnson Tower, Second Floor, 710 James Robertson Parkway, Nashville, TN 37243-0661, (615) 253-1613.

PUBLIC NECESSITY RULES

**RULES
OF
TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
DIVISION OF WORKERS' COMPENSATION**

**CHAPTER 0800-2-20
MEDICAL IMPAIRMENT RATING REGISTRY PROGRAM**

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0800-2-20-.01 DEFINITIONS. The following definitions are for the purposes of this chapter only:

- (1) "Act" means the Tennessee Workers' Compensation Act, T.C.A. 50-6-101 et seq., as amended.
- (2) "Administrator" means the chief administrative officer of the Workers' Compensation Division of the Tennessee Department of Labor and Workforce Development.
- (3) "Commissioner" means the Commissioner of the Tennessee Department of Labor and Workforce Development or the Commissioner's designee.
- (4) "Department" means the Tennessee Department of Labor and Workforce Development.
- (5) "Division" means the Workers' Compensation Division of the Tennessee Department of Labor and Workforce Development.
- (6) "Medical Director" means the Division's Medical Director, appointed by the Commissioner pursuant to T.C.A. § 50-6-126 (Repl. 1999).
- (7) "Medical Impairment Rating Registry" or "MIR Registry" means the registry or listing of physicians established by the Commissioner pursuant to Public Chapter 962, § 24 (2004) to perform independent medical impairment ratings when a dispute arises about the degree of medical impairment.

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- (8) "Program Coordinator" means the chief administrative officer of the MIR Registry Program, appointed by the Administrator, or the Program Coordinator's Designee.

Authority: *Public Chapter 962, § 24 (2004).*

0800-2-20-.02 PURPOSE AND SCOPE.

- (1) Purpose. The purpose of the Medical Impairment Rating Registry Program is to establish a resource to resolve conflicting opinions regarding permanent impairment ratings given for on-the-job injuries. In order to ensure high-quality independent medical impairment evaluations, the Department establishes these Rules for parties and physicians participating under the Act's independent medical examiner evaluation process. MIR Registry physicians shall agree to provide evaluations in a manner consistent with the standard of care in their community and in compliance with these Rules, as well as to issue opinions based upon the applicable edition of the AMA Guides to the Evaluation of Permanent Impairment or other appropriate method pursuant to the Act. These Rules are effective July 1, 2005 and are established pursuant Public Chapter 962, § 24 (2004).
- (2) Scope. The MIR Registry is available to any party who disputes an impairment rating of a physician in a Workers' Compensation claim for injuries that occur on or after July 1, 2005. Other potential issues such as causation, apportionment, appropriateness of treatment, work restrictions, and job modifications shall not be considered or addressed under this MIR Registry Program. Requests for evaluations shall be submitted by paper or electronic application to the Program Coordinator pursuant to the Rules.

Authority: *Public Chapter 962, § 24 (2004).*

0800-2-20-.03 SEVERABILITY AND PREEMPTION.

- (1) If any provision of these Rules or the application thereof to any person or circumstance is, for any reason held to be invalid, the remainder of the Rules and the application of the provisions to other persons or circumstances shall not be affected in any respect whatsoever. Whenever a conflict arises between these Rules and any other rule or regulation, these Rules shall prevail.

Authority: *Public Chapter 962, § 24 (2004).*

0800-2-20.04 REQUISITE PHYSICIAN QUALIFICATIONS FOR INCLUSION ON MEDICAL IMPAIRMENT RATING REGISTRY.

- (1) A physician seeking appointment to the MIR Registry shall make application and must satisfy the following qualifications:
- (a) Possess a license to practice medicine or osteopathy in Tennessee which is current, active, and unrestricted;
 - (b) Be board-certified in his/her medical specialty by a board recognized by the American Board of Medical Specialties, the American Osteopathic Association or another organization acceptable to the Program Coordinator;
 - (c) Have successfully completed a training course, accepted by the Program Coordinator, dedicated to the proper application of the applicable edition of the American Medical Association Guides to the Evaluation of Permanent Impairment (hereafter the "AMA Guides") in impairment evaluations and furnish satisfactory evidence thereof; and

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- (d) Have at least the minimum medical malpractice insurance coverage required by the Program Coordinator and furnish satisfactory proof thereof.

Authority: *Public Chapter 962, § 24 (2004).*

0800-2-20-.05 APPLICATION PROCEDURES FOR PHYSICIANS TO JOIN THE REGISTRY.

- (1) Appointment to the MIR Registry shall be for a two (2) year term, except as otherwise set forth in these Rules. Physicians may seek renewal appointments by the same process as the initial application described herein. The Division reserves the right to charge physicians a non-refundable application fee upon appointment, renewal, or reinstatement to the MIR Registry. The Commissioner or the Commissioner's designee, upon the advice of the Medical Director shall have the sole and exclusive authority to approve or reject applications for inclusion in the MIR Registry.
- (2) Physicians seeking appointment to the MIR Registry shall complete an "Application for Appointment to the MIR Registry," available upon request from the Program Coordinator or on-line at www.state.tn.us/labor-wfd/mainforms.html, certify to and, upon approval of the application, comply with the following conditions:
 - (a) Unless otherwise approved by the Program Coordinator, conduct all MIR evaluations based on the guidelines in the applicable edition of the AMA Guides and submit the original "MIR Impairment Rating Report" with all attachments to the Program Coordinator. In cases not covered by the applicable AMA Guides, any impairment rating allowed under the Act shall be appropriate;
 - (b) Decline the Program Coordinator's request to conduct an evaluation only on the basis of good cause shown, as determined by the Program Coordinator. Consideration will be given to a physician's schedule and other previously arranged or emergency obligations;
 - (c) Comply with the MIR Registry's Rules;
 - (d) While on the MIR Registry, agree to maintain an active and unrestricted license to practice medicine or osteopathy in Tennessee and to immediately notify the Program Coordinator of any change in the status of the license, including any restrictions placed upon the license;
 - (e) While on the MIR Registry, agree to maintain all board certifications listed on the application and to immediately notify the Program Coordinator of any change in their status;
 - (f) Conduct MIR evaluations in an objective and impartial manner, and shall:
 - 1. Conduct these evaluations only in a professional medical office suitable for medical or psychiatric evaluations where the primary use of the site is for medical services; not residential, commercial, educational, legal, or retail in nature. Exceptions will be made only on the basis of good cause shown, as determined by the Program Coordinator.
 - 2. Comply with all local, state and federal laws, regulations, and other requirements with regard to business operations, including specific requirements for the provision of medical services.
 - 3. Not conduct a physical examination on a claimant of the opposite sex without a witness of the same sex as the claimant present.
 - (g) Not refer any MIR Registry claimant to another physician for any treatment or testing nor suggest referral or treatment;

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- (h) Not become the treating physician for the claimant regarding the work-related injury;
 - (i) Not evaluate an MIR Registry claimant without prior consent of the Program Coordinator if a conflict of interest exists. A conflict of interest includes, but is not limited to, instances where the physician has treated or evaluated the claimant for the subject injury or has appeared on a panel of doctors made available to the claimant at the time of injury or subsequent to the injury in the course of medical treatment. If an employer provides a claimant with the name of a group of physicians rather than individual physician names, the entire group of physicians shall be considered to have a conflict of interest for purposes of the MIR Registry Program;
 - (j) Not employ invasive diagnostic procedures, except venipuncture for obtaining a blood sample, without prior approval of the Program Coordinator;
 - (k) Not substitute, or allow to be substituted, anyone else, including any other physician, physician assistant, nurse practitioner, physical therapist or staff member, as the physician to conduct the evaluation without prior written permission from the Program Coordinator;
 - (l) No later than thirty (30) calendar days after the cancellation of an evaluation, refund to the paying party part or all of the fee paid by that party, as may be required by the Rules, the Commissioner or the Commissioner's designee; and
 - (m) For each MIR Registry case assigned, address only the issue of permanent impairment rating and make appropriate findings.
- (3) Physicians denied appointment to the MIR Registry on their initial application may seek reconsideration of their application by submitting a request for reconsideration stating the grounds for such reconsideration to the Program Coordinator within fifteen (15) calendar days of the issuance of the Notice of Denial of their application. The Commissioner or the Commissioner's designee may affirm or reverse the initial determination upon reconsideration of the initial decision. The Commissioner or the Commissioner's designee shall issue a Notice of Final Determination which shall be the final decision.

Authority: *Public Chapter 962, § 24 (2004).*

0800-2-20-.06 REQUESTS FOR A MIR REGISTRY THREE-PHYSICIAN LIST.

- (1) Prior to Division participation, the parties may attempt to negotiate selection of any physician to conduct a medical impairment rating evaluation. Physicians whose names appear on the MIR Registry but are selected in a manner other than through the Division pursuant to these Rules shall have no greater legal presumption of correctness given to their opinion than any other provider's impairment rating when the physician was not selected pursuant to these procedures.
- (2) Application process: If there is no agreed upon selection of a physician, or if an agreement that was reached fails, either party may request the Division participate in selecting the three-physician list. A written opinion as to the permanent impairment rating given by the MIR Registry physician selected pursuant to the Division's procedures in these Rules shall be presumed to be the accurate impairment rating. However, this presumption may be rebutted by clear and convincing evidence to the contrary.
- (3) Form Required: The "Application for a Medical Impairment Rating" available upon request from the Program Coordinator or online at www.state.tn.us/labor-wfd/mainforms.html, or a materially substantial equivalent duplication approved by the Program Coordinator, shall be used in all cases to request an MIR three-physician listing. The Commissioner requires the request designate:

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- (a) All body part(s) or medical condition(s) to be evaluated, including whether mental impairment shall be evaluated;
 - (b) The names of all physicians that have previously evaluated, treated, or are currently evaluating or treating the claimant for the work-related injury at employer and/or employee expense;
 - (c) The names of all physicians made available to the claimant at the time of the injury (Form C-42). If an employer provides the claimant with the name of a group of physicians rather than with individual physician names, the same information shall be included on the request form;
 - (d) The state file number assigned to the claims.
- (4) The submitting party shall certify that all parties, as well as the Program Coordinator, have been sent the completed application form at the same time. The application will not be processed by the Program Coordinator until all required information has been provided.
- (5) Generating the three-physician listing.
- (a) Within five (5) business days of receipt of the completed "Application for a Medical Impairment Rating," the Program Coordinator will produce a listing of three qualified physicians drawn from the Division's MIR Registry, from which one physician shall be designated to perform the evaluation. The three-physician listing created will be comprised of physicians qualified, based on the information provided by the physician and on their accreditation by the Program Coordinator, to perform evaluations of the body part(s) and/or medical condition(s) designated on the application for an evaluation, excluding those who have a conflict of interest as described in the Rules. Psychiatric or psychological evaluations regarding mental and/or behavioral impairment shall be performed by a psychiatrist.
 - (b) If an evaluation is requested for a particular area of expertise not represented in the MIR Registry, the Program Coordinator shall provide a three-physician listing upon the recommendation of the Medical Director. The Program Coordinator will verify qualifications prior to assigning a listing of Temporary MIR physicians. Approval to serve as a Temporary MIR physician shall be limited to the specific case for which services are requested.
 - (c) To guarantee randomness, all three-physician listings shall be derived from the computer-generated pool of qualified physicians. The pool of physician names will be kept confidential. The Program Coordinator will notify the parties in writing only the names and the medical specialties of the physicians on the listing.
- (6) MIR Registry physician selection process.
- (a) Within three (3) business days of the issuance of the three-physician listing by the Program Coordinator, the employer shall strike one name and inform the other party and the Program Coordinator of that name. Within three (3) business days of the date of receipt of that name from the employer, the claimant shall strike one of the two remaining names and inform the Program Coordinator and the employer of the name of the remaining physician, who will perform the evaluation.
 - (b) If the Program Coordinator is not notified of the selected physician within ten (10) calendar days of the date the Program Coordinator issued the three-physician listing, the Program Coordinator may randomly select one name from the three-physician listing to perform the evaluation. If one party fails to timely strike a name from the listing, the other party shall notify the Program Coordinator, within these ten (10) calendar days, and at the same time provide to the Program Coordinator the name that it wishes to strike. In that situation, the Program Coordinator will randomly select one physician from the remaining two, and that

PUBLIC NECESSITY RULES

physician shall perform the evaluation. The Program Coordinator shall inform the parties of the name of the selected physician in writing.

- (c) If a selected physician is unable to perform the evaluation, the Program Coordinator shall provide one replacement name to the original listing using the same criteria and process set forth above, and present that revised listing to the parties and each shall again strike one name according to the above procedures. Additionally, if a physician is removed from the three-physician listing for any reason other than having been struck by one of the parties, the Program Coordinator will issue one replacement physician name.
- (7) Appointment date.
- (a) Within three (3) business days of providing or receiving notice of the physician selection, the Program Coordinator shall call the MIR Registry physician to schedule the evaluation, and shall immediately notify both parties, and the Workers' Compensation Specialist if currently assigned, of the date and time of the evaluation. Only after this notification should the employer or insurance carrier contact the MIR Registry physician and only to arrange for payment and for medical records submission required by these Rules.
- (8) Submission of Medical Records.
- (a) The employer's representative shall concurrently provide to the MIR registry physician and the claimant a complete copy of all pertinent medical records pertaining to the subject injury, postmarked or hand-delivered at least ten (10) calendar days prior to the evaluation or as otherwise arranged by the Program Coordinator with the MIR physician. If deemed necessary by the Program Coordinator, the claimant shall promptly sign a "MIR Waiver and Consent" permitting the release of information to the MIR physician. The form shall include the release of all existing medical reports relevant to the subject injury including all previous impairment rating reports, the actual images of all pertinent imaging studies, the reports of all imaging studies and diagnostic tests, all hospital admission "history and physical examination" documents, all hospital discharge summaries, and all operation reports.
 - (b) The employer's representative shall be responsible for promptly sending a copy of the consent form to all treating and evaluating physicians or other healthcare providers, diagnostic centers, and hospitals involved in the care of the claimant requiring the form to ensure that this information will be forwarded to the MIR physician prior to the date of the scheduled evaluation. If the employer's representative fails to adhere to these time limits, the claimant may submit all medical records he/she has in his/her possession no later than five (5) calendar days prior to the evaluation or as otherwise arranged by the Program Coordinator with the MIR registry physician.
 - (c) In cases involving untimely medical record submission by either party, the Program Coordinator at his/her sole discretion, may elect to reschedule the evaluation to allow the physician adequate time for record review. Otherwise, the physician shall perform the evaluation and shall produce an "MIR Impairment Rating Report" utilizing the information properly made available to the physician.
- (9) Form/Content of Medical Records Package.
- (a) The medical file shall include a dated cover sheet listing the claimant's name, MIR Registry physician's name, MIR Registry case number, date and time of the appointment, and the state file number. The medical file shall be in chronological order, by provider, and tabbed by year. It shall include a written summary by the treating physician with the range of dates of treatment. Medical records not meeting these requirements shall be resubmitted in the correct format within three (3) calendar days of notification by the Program Coordinator.

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- (b) Medical bills, adjustor notes, surveillance tapes, denials, vocational rehabilitation reports, non-treating case manager records or commentaries to the MIR Registry physician shall not be submitted without prior permission of the Program Coordinator. Medical depositions may be submitted as part of the medical records package only by written agreement of the parties.
- (10) Supplemental medical records shall be prepared in the same manner described above, and shall be mailed or hand-delivered by any party concurrently to the MIR Registry physician and the other party no later than five (5) calendar days prior to the date of the evaluation, or as otherwise arranged by the Program Coordinator.
- (11) Claimants can bring an adult friend or family member to the evaluation to provide comfort and reassurance. However, the accompanying person cannot be the claimant's attorney, paralegal, or other legal representative or any other personnel employed by the claimant's attorney or legal representative. The guest may be asked to leave the evaluation at the discretion of the MIR Registry physician. Any forms that the MIR physician requests to be completed should be completed by the claimant only. If the claimant needs assistance in completing these forms for any reason, the claimant should notify the MIR Registry physician prior to the evaluation so that assistance can be provided by the MIR Registry physician's staff.
- (12) The claimant shall notify the Program Coordinator of the necessity for a language interpreter concurrently with his/her notification of the chosen physician's name. The employer shall be responsible for arranging for the services of and paying for such language interpreter. The language interpreter shall be impartial and independent, and have no professional or personal affiliation with any party to the claim or to the MIR Registry physician.
- (13) When a claimant is required to travel outside a radius of fifteen (15) miles from the claimant's residence or workplace, then such claimant shall be reimbursed by the employer for reasonable travel expenses as defined in the Act.

Authority: *Public Chapter 962, § 24 (2004).*

0800-2-20-.07 PAYMENTS/FEES.

- (1) A physician performing evaluations under these Rules shall be prepaid by the employer a total evaluation fee for each evaluation performed, as outlined below:
 - (a) Completed reports received and accepted by the Program Coordinator within thirty (30) calendar days of scheduling the appointment..... \$1,000.00
 - (b) Completed reports received and accepted by the Program Coordinator between thirty-one (31) and forty-five (45) calendar days of the scheduling the appointment \$850.00
 - (c) Completed reports received and accepted by the Program Coordinator between forty-six (46) and sixty (60) calendar days of the scheduling of the appointment..... \$500.00
 - (d) Completed reports received and accepted by the Program Coordinator later than sixty (60) calendar days of scheduling the appointmentNo fee paid
- (2) The evaluation fee includes normal record review, the evaluation, and production of a standard "MIR Impairment Rating Report." If the record review is unusually extensive and requires substantially longer than an hour for review, the physician may contact the Program Coordinator to request additional payment. This request should be made no later than three (3) calendar days prior to the scheduled date of the evaluation. The Program Coordinator, in consultation with the Medical Director, will determine if additional time and fees are appropriate. If denied,

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the MIR registry physician shall complete the evaluation to the best of his/her ability. If additional evaluation charges are approved, the Program Coordinator shall notify the employer of the approved review charges. The physician shall bill for the additional time at the pro-rata rate of \$500.00 per hour. All non-routine test(s) for an impairment rating essential under the applicable edition of the AMA Guides to the Evaluation of Permanent Impairment shall have been performed prior to the evaluation. Routine tests necessary for a complete evaluation, such as range of motion or spirometry tests, should be performed by the MIR Registry physician as part of the evaluation at no additional cost. The MIR Registry physician shall notify the Program Coordinator prior to performing any essential test that is non-routine or requires special facilities or equipment, and such test was not previously performed, or was previously performed but the findings are not usable at the time of the evaluation. The Program Coordinator, upon the advice of the Medical Director, will determine whether the test will be approved. If approved, the employer shall be responsible for paying for the essential test.

- (3) Late fees and penalties. Failure of the employer to timely submit the evaluation fee, as determined by the Program Coordinator, shall allow the physician to charge the employer an additional \$100.00 late fee for the evaluation. If the evaluation fee and/or late fee remains unpaid fifteen (15) calendar days following the date of the evaluation, an additional \$250.00 penalty is authorized. If any portion of a fee or penalty remains unpaid after an additional thirty (30) calendar day period, an additional \$500.00 penalty is authorized, and again for each additional thirty (30) calendar day period, or portion thereof, that it remains unpaid until all fees and/or penalties are fully paid. At the request of a MIR Registry physician, the Division may assist the MIR Registry physician in collecting monies due under this Rule.
- (4) Cancellations. To be considered timely, notice of a party's desire to cancel an evaluation appointment shall be given to the Program Coordinator at least three (3) business days prior to the date of the evaluation. An evaluation may be canceled or rescheduled only after obtaining the consent of the Program Coordinator. The Program Coordinator shall decide whether an evaluation may be rescheduled within ten (10) calendar days of a request to cancel.
 - (a) If the request to cancel is not timely, the MIR registry physician shall be entitled to collect/retain a \$300.00 cancellation penalty fee. If the evaluation is rescheduled, the MIR Registry physician is entitled to the entire evaluation fee (for the rescheduled evaluation) in addition to this fee. The employer may be entitled to offset the cancellation fee(s) against any future settlement if the claimant cancels untimely or without good cause as determined by the Program Coordinator.
 1. If the claimant fails to appear for the evaluation with good cause as determined by the Program Coordinator the employer will not be entitled to offset the cancellation penalty fee against any future settlement.
 2. If the claimant fails to appear for the evaluation without good cause as determined by the Program Coordinator, the MIR Registry physician will perform a "paper only" evaluation by reviewing the existing medical record file and shall establish an impairment rating based upon the physician's opinion of the evidence presented. The physician shall be entitled to the entire fee.
 - (b) If the request to cancel is timely and the evaluation is not rescheduled, the MIR Registry physician shall be entitled to collect and/or retain a \$250.00 cancellation penalty fee.
 - (c) If the request to cancel is timely and the evaluation is rescheduled, the MIR Registry physician shall be entitled to collect and/or retain a \$150.00 cancellation penalty fee in addition to the rescheduled MIR fee.

Authority: Public Chapter 962, § 24 (2004).

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0800-2-20-.08 MULTIPLE IMPAIRMENT RATING EVALUATIONS.

- (1) In instances of more than one impairment rating being disputed in more than one medical specialty, and there is an insufficient number of physicians on the Registry who are qualified to perform all aspects of the evaluation, separate evaluations may be required, each being separate application and physician-selection processes and fees.

Authority: *Public Chapter 962, § 24 (2004).*

0800-2-20-.09 COMMUNICATION WITH REGISTRY PHYSICIANS.

- (1) Prior to the creation of the three-physician listing, MIR Registry physicians who have rendered an opinion as to the impairment relating to the subject injury to a party to the case or a party's representative prior to the creation of a three-physician listing must disclose the nature and extent of those discussions to the Program Coordinator immediately upon their selection or appointment as the MIR registry physician. The Program Coordinator, in his or her sole authority, will determine whether or not a conflict of interest exists. Failure to disclose a potential conflict of interest may result in a physician's removal from the MIR Registry. While removed from the Registry, physicians shall not be eligible to perform MIR evaluations.
- (2) During the MIR physician selection process, registry physicians cannot render opinions as to the impairment relating to the subject injury to a party to the case or a party's representative in cases in which the physician's name appears on the three-physician listing. If selected as the MIR physician, there shall be no communication with the parties or their representatives prior to the evaluation, unless allowed by the Rules or approved by the Program Coordinator. Any approved communication, other than arranging for payment and the submission of medical records and the evaluation itself, shall be in writing with copies to all parties including the Program Coordinator. Failure by a Registry physician to disclose such communications will subject the physician to penalties under the Rules.
- (3) A party who seeks the presence of the MIR physician as a witness at a proceeding for any purpose, by subpoena, deposition or otherwise, shall be responsible for payment for those services to the MIR physician. Deposition fees shall be in accordance with applicable state rules and laws.

Authority: *Public Chapter 962, § 24 (2004).*

0800-2-20-.10 REQUIREMENTS FOR THE EVALUATION.

- (1) The MIR Registry physician's responsibilities prior to the evaluation are to:
 - (a) Review all materials provided by the parties subject to these Rules; and,
 - (b) Review the purpose of the evaluation and the impairment questions to be answered in the evaluation report.
- (2) The MIR Registry physician's responsibilities following the evaluation are to:
 - (a) Consider all medical evidence obtained in the evaluation and provided by the parties subject to the Rules;
 - (b) Complete an "MIR Impairment Rating Report";
 - (c) Notify the Program Coordinator when the report has been completed;

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- (d) Send that complete report with all required attachments to the Program Coordinator only, via overnight delivery. The Program Coordinator will acknowledge, to the physician, receipt of the report.
- (3) No physician-patient relationship is created between the MIR physician and the claimant through the MIR Registry evaluation. The sole purpose of the evaluation is to establish an impairment rating and not to recommend future treatment or to provide a diagnosis or other medical advice.

Authority: Public Chapter 962, § 24 (2004).

0800-2-20-.11 REQUIREMENTS FOR THE “MIR IMPAIRMENT RATING REPORT.”

- (1) After conducting the evaluation, the MIR physician shall produce the “MIR Impairment Rating Report”. The format, available by using the Program’s electronic access, available upon request from the Program Coordinator or available online at www.state.tn.us/labor-wfd/mainforms.html, or a materially substantial equivalent approved by the Program Coordinator shall be used in all cases to detail the evaluation’s results. The MIR physician shall first review the determination by the attending physician that the claimant has reached Maximum Medical Improvement (MMI).
- (2) If, after reviewing the records, taking a history from the claimant and performing the evaluation, the MIR Registry physician concurs with the attending doctor’s determination of MMI, the report shall, at a minimum, contain the following:
 - (a) A brief description and overview of the claimant’s medical history as it relates to the subject injury, including reviewing and recapping all previous treatments.
 - (b) A statement of concurrence with the attending doctor’s determination of MMI;
 - (c) Pertinent details of the physical or psychiatric evaluation performed (both positive and negative findings);
 - (d) Results of any pertinent diagnostic tests performed (both positive and negative findings). Include copies of these tests with the report;
 - (e) An impairment rating consistent with the findings and utilizing a standard method as outlined in the applicable AMA Guides, calculated as a total to the whole person if appropriate. In cases not covered by the AMA Guides, an impairment rating by any appropriate method used and accepted by the medical community is allowed, however, a statement that the AMA Guides fails to cover the case as well as a statement of the system on which the rating was based shall be included;
 - (f) The rationale for the rating based on reasonable medical certainty, supported by specific references to the clinical findings, especially objective findings and supporting documentation including the specific rating system, sections, tables, figures, and AMA Guides page numbers, when appropriate, to clearly show how the rating was derived; and
 - (g) A true or electronic signature and date by the MIR physician performing the evaluation certifying to the following:
 - 1. “It is my opinion, both within and to a reasonable degree of medical certainty that, based upon all information available to me at the time of the MIR impairment evaluation and by utilizing the relevant AMA Guides or other appropriate method as noted above, that the claimant has the permanent impairment so described in this report. I certify that the opinion furnished is my own, that this document accurately reflects my opinion, and that I am aware that my signature attests to its truthfulness.

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I further certify that my statement of qualifications to serve on the MIR Registry is both current and completely accurate.”

- (3) If, after reviewing the records, taking a history from the claimant and performing the evaluation, the MIR physician does not concur with the attending doctor’s determination of MMI, a report shall be completed similar to the one outlined above which documents and certifies to, in sufficient detail, the rationale for disagreeing and, if possible to determine, the expected date of full or partial recovery. The physician is still entitled to collect/retain the appropriate MIR fee.
- (4) Services rendered by an MIR Registry physician shall conclude upon the Program Coordinator’s acceptance of the final “MIR Impairment Rating Report.” An MIR report is final and accepted for the purpose of these Rules when it includes the requested determination regarding final medical impairment rating and any necessary worksheets, as determined by the Program Coordinator. Once the report has been accepted the Program Coordinator will distribute copies of the report to the other parties and the Workers’ Compensation Specialist, if one is currently assigned. After acceptance of the “MIR Impairment Rating Report” the medical records file, including the final “MIR Impairment Rating Report,” shall be stored and/or disposed of by the MIR registry physician in a manner used for similar health records containing private information and within a time frame consistent with the Tennessee Board of Medical Examiners’ rules.

Authority: Public Chapter 962, § 24 (2004).

0800-2-20-.12 PEER REVIEW.

- (1) All MIR Impairment Rating Reports are subject to review for appropriateness and accuracy by an individual or organization designated by the Program Coordinator at any time. Repeated failure to properly apply the AMA Guides in determining an impairment rating, as determined solely and exclusively by the Medical Director, will result in penalties up to and including removal from the MIR Registry.

Authority: Public Chapter 962, § 24 (2004).

0800-2-20-.13 REMOVAL OF A PHYSICIAN FROM THE REGISTRY.

- (1) Written complaints regarding any MIR Registry physician shall be submitted to the Program Coordinator. The Commissioner or the Commissioner’s designee, upon the advice of the Medical Director, may remove a physician from the MIR Registry permanently or temporarily by placing a physician on inactive status based upon any of the following grounds:
 - (a) Misrepresentation on the “Application for Appointment to the MIR Registry” as determined by the Program Coordinator;
 - (b) Failure to timely report a conflict of interest in a case assignment, as determined by the Program Coordinator;
 - (c) Refusal or substantial failure to comply with the provisions of these Rules, including, but not limited to, repeated failure to determine impairment ratings correctly using the AMA Guides, as determined by the Medical Director;
 - (d) Failure to maintain the requirements of the Rules, as determined by the Program Coordinator; or
 - (e) Any other reason for the good of the Registry as determined solely and exclusively by the Commissioner or the Commissioner’s designee.

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- (2) Upon receipt of a complaint regarding a MIR Registry physician, the Program Coordinator shall send written notice of the complaint to such physician, stating the grounds of the complaint, and notifying the physician that he or she is at risk of being removed from the MIR Registry.
 - (a) The physician shall have thirty (30) calendar days from the date the Notice of Complaint is issued to the physician in which to respond in writing to the complaint(s), and may submit any responsive supporting documentation to the Program Coordinator for consideration. Failure of the physician to submit a timely response to the Notice of Complaint may result in removal of the physician from the MIR Registry without further notice or recourse.
 - (b) The Commissioner or the Commissioner's designee, in consultation with the Medical Director, shall consider the complaint(s) and any response(s) from the physician in reaching a decision as to whether the physician shall be removed from the MIR Registry, and if removed, whether the removal will be permanent or temporary.
 - (c) Upon reaching a determination on the complaint(s), the Commissioner or the Commissioner's designee shall issue a written Notice of Determination and set forth the basis for the decision in such Notice. The determination set forth shall become final fifteen (15) days after issuance of the Notice of Determination, unless a timely request for reconsideration is received.
 - (d) A MIR Registry physician may seek reconsideration of an adverse decision from the Commissioner or the Commissioner's designee by submitting a request for reconsideration stating the grounds for such reconsideration to the Program Coordinator within fifteen (15) calendar days of the issuance of the Notice of Determination. The Commissioner or the Commissioner's designee may affirm, modify or reverse the initial determination upon reconsideration of the initial decision. The Commissioner or the Commissioner's designee shall issue a Notice of Determination upon Reconsideration which shall be the final decision.
 - (e) MIR Registry physicians shall remain active on the MIR Registry pending a final decision on any complaint(s).
- (3) A physician who has been removed from the MIR Registry by the Commissioner or the Commissioner's designee may apply for reinstatement six (6) months after the date of removal by submitting a written request to the Program Coordinator.

Authority: *Public Chapter 962, § 24 (2004).*

0800-2-20-.14 OTHER PENALTIES.

- (1) Failure by any party to comply with any of these Rules for which no penalty has specifically been set forth herein shall subject that party to the appropriate civil penalties pursuant to the Act and as determined by the Commissioner or Commissioner's designee.

Authority: *Public Chapter 962, § 24 (2004).*

0800-2-20-.15 TIME LIMITS.

- (1) All time limits referenced in these Rules may be extended by the Program Coordinator in his or her sole and exclusive discretion.

Authority: *Public Chapter 962, § 24 (2004).*

PUBLIC NECESSITY RULES

0800-2-20-.16 CLAIMANT COOPERATION.

- (1) Injured workers are expected to cooperate in good faith with the Program Coordinator in scheduling evaluations. Injured workers shall also cooperate in good faith with all reasonable requests made by MIR Registry physicians during their evaluation so that the physicians can make accurate findings.

Authority: *Public Chapter 962, § 24 (2004).*

0800-2-20-.17 OVERTURNING A MIR PHYSICIAN'S OPINION.

- (1) Parties are prohibited from seeking a second MIR Registry impairment rating for the same injury if an impairment rating was issued after the first MIR Registry evaluation. Permanent impairment ratings given by MIR Registry physicians after the their assignment of cases involving the issuance of a MIR Registry three-physician listing from the MIR Registry shall be the only opinions presumed to be accurate, as set forth in the Act. This presumption may be rebutted only by clear and convincing evidence to the contrary. Opinions reached by any physicians utilized after mutually agreed upon selections not involving the issuance of an MIR Registry three-physician listing are not legally presumed to be accurate and shall carry no additional evidentiary weight in any proceedings, even in cases where the physician selected may also serve on the MIR Registry.

Authority: *Public Chapter 962, § 24 (2004).*

The public necessity rules set out herein were properly filed in the Department of State on the 16th day of November, 2005, and will be effective from the day of filing for a period of 165 days. These public necessity rules will remain in effect through the 30th day of April, 2006. (11-24)

RULEMAKING HEARINGS

BOARD OF CHIROPRACTIC EXAMINERS - 0260

There will be a hearing before the Tennessee Board of Chiropractic Examiners to consider the promulgation of an amendment to a rule and a new rule pursuant to T.C.A. §§ 4-5-202, 4-5-204, 63-2-101, 63-2-102, 63-4-101, 63-4-106, 63-4-112, and 63-4-114. The hearing will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, Tennessee Code Annotated, Section 4-5-204 and will take place in the Tennessee Room of the Cordell Hull Building located at 425 Fifth Avenue North, Nashville, TN at 3:30 p.m. (CST) on the 2nd day of February, 2006.

Any individuals with disabilities who wish to participate in these proceedings (review these filings) should contact the Department of Health, Division of Health Related Boards to discuss any auxiliary aids or services needed to facilitate such participation or review. Such initial contact may be made no less than ten (10) days prior to the scheduled meeting date (the date such party intends to review such filings), to allow time for the Division to determine how it may reasonably provide such aid or service. Initial contact may be made with the ADA Coordinator at the Division of Health Related Boards, First Floor, Cordell Hull Building, 425 Fifth Avenue North, Nashville, TN 37247-1010, (615) 532-4397.

For a copy of the entire text of this notice of rulemaking hearing contact:

Jerry Kosten, Regulations Manager, Division of Health Related Boards, 425 Fifth Avenue North, First Floor, Cordell Hull Building, Nashville, TN 37247-1010, (615) 532-4397.

SUBSTANCE OF PROPOSED RULES

AMENDMENTS

Rule 0260-2-.12 Continuing Education, is amended adding the following language as new subparagraph (6) (d):

- (6) (d) Courses that pertain to the promotion and growth, and the business management of a chiropractic practice.

Authority: T.C.A. §§ 4-5-202, 4-5-204, 63-4-106, and 63-4-112.

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NEW RULE

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0260-2-.25 Chiropractic Records

0260-2-.25 CHIROPRACTIC RECORDS.

- (1) Purposes – The purposes of these rules are:
 - (a) To recognize that chiropractic records are an integral part of the practice of chiropractic as defined in T.C.A. § 63-4-101.
 - (b) To give chiropractic physicians, their professional and non-professional staff, and the public direction about the content, transfer, retention, and destruction of those records.
 - (c) To recognize that a distinction exists between a chiropractic physician's records for a patient receiving services in the chiropractic physician's office and those records created by the chiropractic physician for that patient for purposes of services provided in a hospital as defined by T.C.A. § 68-11-302 (4).
- (2) Conflicts – As to chiropractic records, these rules should be read in conjunction with the provisions of T.C.A. §§ 63-2-101 and 102, and are not intended to conflict with those statutes in any way. Those statutes, along with these rules, govern the subjects that they cover in the absence of other controlling state or federal statutes or rules to the contrary.
- (3) Applicability – These rules regarding chiropractic records shall apply only to those records, the information for which was obtained by chiropractic physicians or their professionally licensed employees, or those over whom they exercise supervision, for purposes of services provided in any clinical setting other than those provided in a hospital as defined by T.C.A. § 68-11-302 (4), a hospital emergency room or hospital outpatient facility.
- (4) Chiropractic Records
 - (a) Duty to Create and Maintain Chiropractic Records – As a component of the standard of care and of minimal competency a chiropractic physician must cause to be created and cause to be maintained a chiropractic record for every patient for whom he or she, and/or any of his or her professionally licensed supervisees, performs services or provides professional consultation.
 - (b) Notice – Anywhere in these rules where notice is required to be given to patients of any chiropractic physician that notice shall be required to be issued within thirty (30) days of the date of the event that triggers the notice requirement, and may be accomplished by public notice.
 - (c) Distinguished from Hospital Records - The chiropractic records covered by these rules are separate and distinct from those records generated for the patient by the chiropractic physician during the course of providing chiropractic services for the patient in a hospital as defined by T.C.A. § 68-11-302 (4).

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1. The provisions of T.C.A. Title 68, Part 11, Chapter 3 govern records generated in a hospital as defined by T.C.A. § 68-11-302 (4).
 2. The chiropractic records covered by these rules are those:
 - (i) That are created prior to the time of the patient's admission to or confinement and/or receipt of services in a hospital as defined by T.C.A. § 68-11-302 (4), hospital emergency room and/or hospital outpatient facility, and/or
 - (ii) That are created after the patient's discharge from a hospital as defined by T.C.A. § 68-11-302 (4), hospital emergency room or hospital outpatient facility.
 - (iii) That are created during the practice of chiropractic as defined by T.C.A. § 63-4-101 outside of a hospital as defined by T.C.A. § 68-11-302 (4), hospital emergency room or hospital outpatient facility.
 3. Even though the records covered by these rules may, of necessity, reference provision of services in the hospital setting and the necessary initial work-up and/or follow-up to those services, that does not make them "hospital records" that are regulated by or obtainable pursuant to T.C.A. Title 68, Part 11, Chapter 3.
- (d) Content – All chiropractic records, or summaries thereof, produced in the course of the practice of chiropractic for all patients shall include all information and documentation listed in T.C.A. § 63-2-101 (c) (2) and such additional information that is necessary to insure that a subsequent reviewing or treating chiropractic physician can both ascertain the basis for the diagnosis, treatment plan and outcomes, and provide continuity of care for the patient.
- (e) Transfer
1. Records of Chiropractic Physicians upon Death or Retirement - When a chiropractic physician retires or dies while in practice, patients seen by the chiropractic physician in his/her office during the immediately preceding thirty-six (36) months shall be notified by the chiropractic physician, or his/her authorized representative and urged to find a new chiropractic physician and be informed that upon authorization, copies of the records will be sent to the new chiropractic physician. This notification requirement shall not apply to a patient when there have been fewer than two (2) office patient encounters within the immediately preceding eighteen (18) months.
 2. Records of Chiropractic Physicians upon Departure from a Group - The responsibility for notifying patients of a chiropractic physician who leaves a group practice whether by death, retirement or departure shall be governed by the chiropractic physician's employment contract.
 - (i) Whomever is responsible for that notification must notify patients seen by the chiropractic physician in his/her office during the immediately preceding thirty-six (36) months of his/her departure, except that this notification requirement shall not apply to a patient when there have been fewer than two (2) office patient encounters within the immediately preceding eighteen (18) months.
 - (ii) Except where otherwise governed by provisions of the chiropractic physician's contract, those patients shall also be notified of the chiropractic physician's new address and offered the opportunity to have copies of their chiropractic records

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forwarded to the departing chiropractic physician at his or her new practice. Provided however, a group shall not withhold the chiropractic records of any patient who has authorized their transfer to the departing chiropractic physician or any other chiropractic physician.

- (iii) The choice of chiropractic physicians in every case should be left to the patient, and the patient should be informed that upon authorization his/her records will be sent to the chiropractic physician of the patient's choice.
3. Sale of a Chiropractic Practice - A chiropractic physician or the estate of a deceased chiropractic physician may sell the elements that comprise his/her practice, one of which is its goodwill, i.e., the opportunity to take over the patients of the seller by purchasing the chiropractic physician's records. Therefore, the transfer of records of patients is subject to the following:
- (i) The chiropractic physician (or the estate) must ensure that all chiropractic records are transferred to another chiropractic physician or entity that is held to the same standards of confidentiality as provided in these rules.
 - (ii) Patients seen by the chiropractic physician in his/her office during the immediately preceding thirty-six (36) months shall be notified that the chiropractic physician (or the estate) is transferring the practice to another chiropractic physician or entity who will retain custody of their records and that at their written request the copies of their records will be sent to another chiropractic physician or entity of their choice. This notification requirement shall not apply to a patient when there have been fewer than two (2) office patient encounters within the immediately preceding eighteen (18) months.
4. Abandonment of Records – For purposes of this section of the rules death of a chiropractic physician shall not be considered as abandonment.
- (i) It shall be a prima facie violation of T.C.A. § 63-4-114 for a chiropractic physician to abandon his practice without making provision for the security, or transfer, or otherwise establish a secure method of patient access to their records.
 - (ii) Upon notification that a chiropractic physician in a practice has abandoned his practice and not made provision for the security, or transfer, or otherwise established a secure method of patient access to their records patients should take all reasonable steps to obtain their chiropractic records by whatever lawful means available and should immediately seek the services of another chiropractic physician.
- (f) Retention of Chiropractic Records – Chiropractic records, including x-rays, radiographs, and other imaging products shall be retained for a period of not less than ten (10) years from the date of the chiropractic physician's or his supervisees' last professional contact with the patient except for the following:
- 1. Chiropractic records for incompetent patients shall be retained indefinitely.
 - 2. Chiropractic records of minors shall be retained for a period of not less than one (1) year after the minor reaches the age of majority or ten (10) years from the date of the chiropractic physician's or his supervisees' last professional contact with the patient, whichever is longer.

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3. X-rays, radiographs and other imaging products may be destroyed if there exists separate interpretive records.
4. Notwithstanding the foregoing, no chiropractic record involving services which are currently under dispute shall be destroyed until the dispute is resolved.

(g) Destruction of Chiropractic Records

1. No chiropractic record shall be singled out for destruction other than in accordance with established office operating procedures.
2. Records shall be destroyed only in the ordinary course of business according to established office operating procedures that are consistent with these rules.
3. Records may be destroyed by burning, shredding, or other effective methods in keeping with the confidential nature of the records.
4. When records are destroyed, the time, date and circumstances of the destruction shall be recorded and maintained for future reference. The record of destruction need not list the individual patient chiropractic records that were destroyed but shall be sufficient to identify which group of destroyed records contained a particular patient's chiropractic records.

- (5) Violations – Violation of any provision of these rules is grounds for disciplinary action pursuant to T.C.A. §§ 63-4-114 (1) and/or (12).

Authority: T.C.A. §§ 4-5-202, 4-5-204, 63-2-101, 63-2-102, 63-4-101, 63-4-106, and 63-4-114.

The notice of rulemaking set out herein was properly filed in the Department of State on the 10th day of November, 2005. (11-13)

RULEMAKING HEARINGS

BOARD FOR PROFESSIONAL COUNSELORS, MARITAL AND FAMILY THERAPISTS, AND CLINICAL PASTORAL THERAPISTS - 0450

There will be a hearing before the Tennessee Board for Professional Counselors, Marital and Family Therapists, and Clinical Pastoral Therapists to consider the promulgation of an amendment to a rule pursuant to T.C.A. §§ 4-5-202, 4-5-204, 63-22-102, 63-22-203, and 63-22-205. The hearing will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, Tennessee Code Annotated, Section 4-5-204 and will take place in the Cumberland Room of the Cordell Hull Building located at 425 Fifth Avenue North, Nashville, TN at 3:30 p.m. (CST) on the 6th day of February, 2006.

Any individuals with disabilities who wish to participate in these proceedings (review these filings) should contact the Department of Health, Division of Health Related Boards to discuss any auxiliary aids or services needed to facilitate such participation or review. Such initial contact may be made no less than ten (10) days prior to the scheduled meeting date (the date such party intends to review such filings), to allow time for the Division to determine how it may reasonably provide such aid or service. Initial contact may be made with the ADA Coordinator at the Division of Health Related Boards, First Floor, Cordell Hull Building, 425 Fifth Avenue North, Nashville, TN 37247-1010, (615) 532-4397.

For a copy of the entire text of this notice of rulemaking hearing contact:

Jerry Kosten, Regulations Manager, Division of Health Related Boards, 425 Fifth Avenue North, First Floor, Cordell Hull Building, Nashville, TN 37247-1010, (615) 532-4397.

SUBSTANCE OF PROPOSED RULE

AMENDMENT

Rule 0450-3-.08 Examinations, is amended by deleting the introductory sentence and paragraph (1) in its entirety and substituting instead the following language, so that as amended, the new introductory sentence and the new paragraph (1) shall read:

0450-3-.08 EXAMINATIONS. In addition to having filed an application, individuals seeking licensure as a Clinical Pastoral Therapist are required to pass an examination consisting of written and oral sections.

(1) Written section

- (a) The written section of the examination shall be passed by all applicants, except certain persons who are licensed by professional experience.
- (b) The Board adopts the following examinations or their successor examinations as the written section of the examination:
 - 1. The Marital and Family Therapy Examination, published by the Professional Examination Service (PES), as developed by the Association of Marital and Family Therapy Regulatory Boards and with a passing score determined by PES.
 - 2. The National Counselor Examination and the National Clinical Mental Health Counseling Examination given by the National Board for Certified Counselors (NBCC) and with a passing score determined by NBCC.

RULEMAKING HEARINGS

3. The Examination for Professional Practice in Psychology (EPPP) provided by PES and with a passing score as determined by the Association of State and Provincial Psychology Boards.
 4. The written examination adopted by the Association of Social Work Boards (ASWB) and with a passing score as determined by ASWB.
- (c) Even though the Board adopts the above listed examinations as its written section, an applicant must successfully complete only one (1) of these examinations. The choice of which examination to successfully complete is entirely up to the applicant.
- (d) The testing agencies govern the examination dates.
- (e) A passing score on the written section will qualify the applicant for the oral section if the Board determines all other requirements pursuant to Rule 0450-3-.05 have been successfully completed.

Authority: T.C.A. §§ 4-5-202, 4-5-204, 63-22-102, 63-22-203, and 63-22-205.

The notice of rulemaking set out herein was properly filed in the Department of State on the 22nd day of November, 2005. (11-33)

RULEMAKING HEARINGS

BOARD OF DIETITIAN / NUTRITIONIST EXAMINERS - 0470

There will be a hearing before the Tennessee Board of Dietitian / Nutritionist Examiners to consider the promulgation of an amendment to a rule and a new rule pursuant to T.C.A. §§ 4-5-202, 4-5-204, and 63-25-107. The hearing will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, Tennessee Code Annotated, Section 4-5-204 and will take place in the Cumberland Room of the Cordell Hull Building located at 425 Fifth Avenue North, Nashville, TN at 3:30 p.m. (CST) on the 18th day of January, 2006.

Any individuals with disabilities who wish to participate in these proceedings (review these filings) should contact the Department of Health, Division of Health Related Boards to discuss any auxiliary aids or services needed to facilitate such participation or review. Such initial contact may be made no less than ten (10) days prior to the scheduled meeting date (the date such party intends to review such filings), to allow time for the Division to determine how it may reasonably provide such aid or service. Initial contact may be made with the ADA Coordinator at the Division of Health Related Boards, First Floor, Cordell Hull Building, 425 Fifth Avenue North, Nashville, TN 37247-1010, (615) 532-4397.

For a copy of the entire text of this notice of rulemaking hearing contact:

Jerry Kosten, Regulations Manager, Division of Health Related Boards, 425 Fifth Avenue North, First Floor, Cordell Hull Building, Nashville, TN 37247-1010, (615) 532-4397.

SUBSTANCE OF PROPOSED RULES

AMENDMENT

Rule 0470-1-.19 Board Meetings, Officers, Consultants, Records, and Declaratory Orders, is amended by deleting the catchline in its entirety and substituting instead the following language, and is further amended by adding the following language as new paragraph (7), so that as amended, the new catchline and the new paragraph (7) shall read:

0470-1-.19 BOARD MEETINGS, OFFICERS, CONSULTANTS, RECORDS, DECLARATORY ORDERS, AND SCREENING PANELS.

- (7) Screening Panels - The Board adopts, as if fully set out herein, rule 1200-10-1-.13, of the Division of Health Related Boards and as it may from time to time be amended, as its rule governing the screening panel process.

Authority: T.C.A. §§ 4-5-202, 4-5-204, 63-1-138, 63-25-107, 63-25-110, and Public Chapter 234 of the Public Acts of 2005.

NEW RULE

TABLE OF CONTENTS

0470-1-.14 Advertising

0470-1-.14 ADVERTISING.

RULEMAKING HEARINGS

- (1) All advertisements shall adhere to the professional responsibilities specifically set out in Rule 0470-1-.13 governing professional ethics.
- (2) Advertising Records and Responsibility
 - (a) Each licensee who is a principal partner, or officer of a firm or entity identified in any advertisement, is jointly and severally responsible for the form and content of any advertisement. This provision shall also include any licensed professional employees acting as an agent of such firm or entity.
 - (b) Any and all advertisements are presumed to have been approved by the licensee named therein.
 - (c) A recording of every advertisement communicated by electronic media, and a copy of every advertisement communicated by print media, and a copy of any other form of advertisement shall be retained by the licensee for a period of one (1) year from the last date of broadcast or publication and be made available for review upon request by the Board or its designee.
 - (d) At the time any type of advertisement is placed, the licensee must possess and rely upon information which, when produced, would substantiate the truthfulness of any assertion, omission or representation of material fact set forth in the advertisement or public information.

Authority: T.C.A. §§ 4-5-202, 4-5-204, 63-25-107, and Public Chapter 467 of the Public Acts of 2005.

The notice of rulemaking set out herein was properly filed in the Department of State on the 22nd day of November, 2005. (11-34)

RULEMAKING HEARINGS

**THE TENNESSEE DEPARTMENT OF ENVIRONMENT AND CONSERVATION - 0400
DIVISION OF AIR POLLUTION CONTROL**

There will be a public hearing before the Technical Secretary of the Tennessee Air Pollution Control Board to consider the promulgation of an amendment to the Tennessee Air Pollution Control Regulations and the State Implementation Plan pursuant to Tennessee Code Annotated, Section 68-201-105. The comments received at this hearing will be presented to the Tennessee Air Pollution Control Board for their consideration in regards to the proposed regulatory amendment. The hearing will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, Tennessee Code Annotated, Section 4-5-201 et. seq. and will take place in the 9th Floor Conference Room of the L & C Annex, located at 401 Church Street, Nashville, Tennessee 37243-1531 at 9:30 a.m. on the 19th day of January, 2006.

Written comments will be included in the hearing records if received by the close of business January 19, 2006, at the office of the Technical Secretary, Tennessee Air Pollution Control Board, 9th Floor, L & C Annex, 401 Church Street, Nashville, TN 37243-1531.

Any individuals with disabilities who wish to participate in these proceedings (or to review these filings) should contact the Tennessee Department of Environment and Conservation to discuss any auxiliary aids or services needed to facilitate such participation. Such initial contact may be in person, by writing, telephone, or other means, and should be made no less than ten (10) days prior to (January 19, 2006) or the date such party intends to review such filings, to allow time to provide such aid or service. Contact the Tennessee Department of Environment and Conservation ADA Coordinator, 21st Floor, 401 Church Street, Nashville TN 37243, (615) 532-0207. Hearing impaired callers may use the Tennessee Relay Service (1-800-848-0298).

If you have any questions about the origination of this rule change, you may contact Mr. Malcolm Butler at 615-532-0600. For complete copies of the text of the notice, please contact Mr. Malcolm Butler, Department of Environment and Conservation, 9th Floor, L & C Tower, 401 Church Street, Nashville, TN 37243, telephone 615-532-0600.

SUBSTANCE OF PROPOSED RULE

**CHAPTER 1200-3-26
ADMINISTRATIVE FEES SCHEDULE**

AMENDMENT

Part 12. of Subparagraph (i) of paragraph (2) of rule 1200-3-26-.02 CONSTRUCTION AND ANNUAL EMISSION FEES is amended by deleting the chemical Ethylene Glycol Monobutyl Ether from the list of chemical compounds, and adding the redefinition of the chemical compound Glycol Ethers so that as amended, the part shall read:

12. Each hazardous air pollutant listed below actually emitted or allowed to be emitted from a major source.

<u>CAS No.</u>	<u>Chemical name</u>
75070	Acetaldehyde
60355	Acetamide
75058	Acetonitrile
98862	Acetophenone

RULEMAKING HEARINGS

53963	2-Acetylaminofluorene
107028	Acrolein
79061	Acrylamide
79107	Acrylic acid
107131	Acrylonitrile
107051	Allyl chloride
92671	4-Aminobiphenyl
62533	Aniline
90040	o-Anisidine
1332214	Asbestos
71432	Benzene (including benzene from gasoline)
92875	Benzidine
98077	Benzotrichloride
100447	Benzyl chloride
92524	Biphenyl
117817	Bis(2-ethylhexyl)phthalate(DEHP)
542881	Bis(chloromethyl) ether
75252	Bromoform
106990	1,3-Butadiene
156627	Calcium cyanamide
133062	Captan
63252	Carbaryl
75150	Carbon disulfide
56235	Carbon tetrachloride
463581	Carbonyl sulfide
120809	Catechol
133904	Chloramben
57749	Chlordane
7782505	Chlorine
79118	Chloroacetic acid
532274	2-Chloroacetophenone
108907	Chlorobenzene
510156	Chlorobenzilate
67663	Chloroform
107302	Chloromethyl methyl ether
126998	Chloroprene
1319773	Cresols/Cresylic acid (isomers and mixture)
95487	o-Cresol
108394	m-Cresol
106445	p-Cresol
98828	Cumene
94757	2,4-D, salts and esters
3547044	DDE
334883	Diazomethane
132649	Dibenzofurans
96128	1,2-Dibromo-3-chloropropane
84742	Dibutylphthalate
106467	1,4-Dichlorobenzene(p)
91941	3,3-Dichlorobenzidene
111444	Dichloroethyl ether (Bis(2-chloroethyl)ether)
542756	1,3-Dichloropropene
62737	Dichlorvos

RULEMAKING HEARINGS

111422	Diethanolamine
121697	N,N-Diethyl aniline (N,N-Dimethylaniline)
64675	Diethyl sulfate
119904	3,3-Dimethoxybenzidine
60117	Dimethyl aminoazobenzene
119937	3,3'-Dimethylbenzidine
79447	Dimethyl carbamoyl chloride
68122	Dimethyl formamide
57147	1,1-Dimethyl hydrazine
131113	Dimethyl phthalate
77781	Dimethyl sulfate
534521	4,6-Dinitro-o-cresol, and salts
51285	2,4-Dinitrophenol
121142	2,4-Dinitrotoluene
123911	1,4-Dioxane (1,4-Diethyleneoxide)
122667	1,2-Diphenylhydrazine
106898	Epichlorohydrin (1-Chloro-2,3-epoxypropane)
106887	1,2-Epoxybutane
140885	acrylate
100414	Ethyl benzene
51796	Ethyl carbamate (Urethane)
75003	Ethyl Chloride (Chloroethane)
106934	Ethylene dibromide (Dibromoethane)
107062	Ethylene dichloride (1,2-Dichloroethane)
107211	Ethylene glycol
151564	Ethylene imine (Aziridine)
75218	Ethylene oxide
96457	Ethylene thiourea
75343	Ethylidene dichloride (1,1-Dichloroethane)
50000	Formaldehyde
76448	Hepotachlor
118741	Hexachlorobenzene
87683	Hexachlorobutadiene
77474	Hexachlorocyclopentadiene
67721	Hexachloroethane
822060	Hexamethylene-1,6-diisocyanate
680319	Hexamethylphosphoramide
110543	Hexane
302012	Hydrazine
7647010	Hydrochloric acid
7664393	Hydrogen fluoride (Hydrofluoric acid)
123319	Hydroquinone
78591	Isophorone
58899	Lindane (all isomers)
108316	Maleic anhydride
67561	Methanol
72435	Methoxychlor
74839	Methyl bromide (Bromomethane)
74873	Methyl chloride (Chloromethane)
71556	Methyl chloroform (1,1,1-Trichloroethane)
78933	Methyl ethyl ketone (2-Butanone)
60344	Methyl hydrazine

RULEMAKING HEARINGS

74884	Methyl iodide (Iodomethane)
108101	Methyl isobutyl ketone (Hexone)
624839	Methyl isocyanate
80626	Methyl methacrylate
1634044	Methyl tert butyl ether
101144	4,4-Methylene bis(2-chloroniline)
75092	Methylene chloride (Dichloromethane)
101688	Methylene diphenyl diisocyanate (MDI)
101779	4,4-Methylenedianiline
91203	Naphthalene
98953	Nitrobenzene
92933	4-Nitrobiphenyl
100027	4-Nitrophenol
79469	2-Nitropropane
684935	N-Nitroso-N-methylurea
62759	N-Nitrosodimethylamine
59892	N-Nitrosomorpholine
56382	Parathion
82688	Pentachloronitrobenzene (Quintobenzene)
87865	Pentachlorophenol
108952	Phenol
106503	p-Phenylenediamine
75445	Phosgene
7803512	Phosphine
7723140	Phosphorus
85449	Phthalic anhydride
1336363	Polychlorinated biphenyls (Arochlors)
1120714	1,3-Propane sultone
57578	beta-Propiolactone
123386	Propionaldehyde
114261	Propoxur (Baygon)
78875	Propylene dichloride (1,2-Dichloropropane)
75569	Propylene oxide
75558	1,2-Propylenimine (2-Methyl aziridine)
91225	Quinoline
106514	Quinone
100425	Styrene
96093	Styrene oxide
1746016	2,3,7,8-Tetrachlorodibenzo-p-dioxin
79345	1,1,2,2-Tetrachloroethane
127184	Tetrachoroethylene (Perchloroethylene)
7550450	Titanium tetrachloride
108883	Toluene
95807	2,4-Toluene diamine
584849	2,4-Toluene diisocyanate
95534	o-Toluidine
8001352	Toxaphene (chlorinated camphene)
120821	1,2,4-Trichlorobenzene
79005	1,1,2-Trichloroethane
79016	Trichloroethylene
95954	2,4,5-Trichlorophenol
88062	2,4,6-Trichlorophenol

RULEMAKING HEARINGS

121448	Triethylamine
1582098	Trifluralin
540841	2,2,4-Trimethylpentane
108054	Vinyl acetate
593602	Vinyl bromide
75014	Vinyl chloride
75354	Vinylidene chloride (1,1-Dichloroethylene)
1330207	Xylenes (isomers and mixture)
95476	o-Xylenes
108383	m-Xylenes
106423	p-Xylenes
0	Antimony Compounds
0	Arsenic Compounds (inorganic including arsine)
0	Beryllium Compounds
0	Cadmium Compounds
0	Chromium Compounds
0	Cobalt Compounds
0	Coke Oven Emissions
0	Cyanide compounds ¹
0	Glycol ethers ^{2, 6, 7}
0	Lead Compounds
0	Manganese Compounds
0	Mercury Compounds
0	Fine mineral fibers ³
0	Nickel Compounds
0	Polycyclic Organic Matter ⁴
0	Radionuclides (including radon) ⁵
0	Selenium Compounds

1 X'CN where X = H' or any other group where a formal dissociation may occur. For example KCN or Ca(CN)₂

2 Include mono- and di-ethers of ethylene glycol, diethylene glycol, and triethylene glycol R-(OCH₂CH₂)_n-OR'.

Where:

n = 1, 2, or 3:

R = alkyl C7 or less; or

R = phenyl or alkyl substituted phenyl;

R' = H or alkyl C7 or less; or

OR' consisting of carboxylic acid ester, sulfate, phosphate, nitrate, or sulfonate.

This action deletes each individual compound in a group called the surfactant alcohol ethoxylates and their derivatives (SAED) from the glycol ethers category in the list of hazardous air pollutants (HAP) established by section 112(b)(1) of the Clean Air Act (CAA).

3 Includes mineral fiber emissions from facilities manufacturing or processing glass, rock, or slag fibers (or other mineral derived fibers) of average diameter 1 micrometer or less.

4 Includes organic compounds with more than or equal to 1000C which have a boiling point greater than or equal to 100oC

RULEMAKING HEARINGS

- 5 A type of atom which spontaneously undergoes radioactive decay.
- 6 The substance ethylene glycol monobutyl ether (EGBE, 2-Butoxyethanol) (Chemical Abstract Service (CAS) Number 111-76-2) is deleted from the list of hazardous air pollutants established by 42 U.S.C. 7412(b)(1).

Authority: *T.C.A. §68-201-105 and, 4-5-202 et. seq.*

This notice of rulemaking set out herein was properly filed in the Department of State on the 23rd day of November, 2005. (11-38)

RULEMAKING HEARINGS

**THE TENNESSEE DEPARTMENT OF ENVIRONMENT AND CONSERVATION- 0400
DIVISION OF AIR POLLUTION CONTROL**

There will be a public hearing before the Technical Secretary of the Tennessee Air Pollution Control Board to consider the promulgation of an amendment to the Tennessee Air Pollution Control Regulations and the State Implementation Plan pursuant to Tennessee Code Annotated, Section 68-201-105. The comments received at this hearing will be presented to the Tennessee Air Pollution Control Board for their consideration in regards to the proposed regulatory amendment. The hearing will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, Tennessee Code Annotated, Section 4-5-201 et. seq. and will take place in the 9th Floor Conference Room of the L & C Annex, located at 401 Church Street, Nashville, Tennessee 37243-1531 at 9:30 a.m. on the 19th day of January, 2006.

Written comments will be included in the hearing records if received by the close of business January 19, 2006, at the office of the Technical Secretary, Tennessee Air Pollution Control Board, 9th Floor, L & C Annex, 401 Church Street, Nashville, TN 37243-1531.

Any individuals with disabilities who wish to participate in these proceedings (or to review these filings) should contact the Tennessee Department of Environment and Conservation to discuss any auxiliary aids or services needed to facilitate such participation. Such initial contact may be in person, by writing, telephone, or other means, and should be made no less than ten (10) days prior to (January 19, 2006) or the date such party intends to review such filings, to allow time to provide such aid or service. Contact the Tennessee Department of Environment and Conservation ADA Coordinator, 21st Floor, 401 Church Street, Nashville TN 37243, (615) 532-0207. Hearing impaired callers may use the Tennessee Relay Service (1-800-848-0298).

If you have any questions about the origination of this rule change, you may contact Mr. Malcolm Butler at 615-532-0600. For complete copies of the text of the notice, please contact Mr. Malcolm Butler, Department of Environment and Conservation, 9th Floor, L & C Tower, 401 Church Street, Nashville, TN 37243, telephone 615-532-0600.

SUBSTANCE OF PROPOSED RULE

**CHAPTER 1200-3-31
CASE BY CASE DETERMINATIONS
OF HAZARDOUS AIR POLLUTANT CONTROL REQUIREMENTS**

AMENDMENT

Paragraph (6) of rule 1200-3-31-.02 DEFINITIONS is amended by deleting the chemical Ethylene Glycol Monobutyl Ether from the list of chemical compounds, and adding the redefinition of the chemical compound Glycol Ethers, so that as amended the paragraph shall read:

- (6) "Hazardous Air Pollutant" - means any of the following air contaminants:

CAS No.	Chemical name
75070	Acetaldehyde
60355	Acetamide
75058	Acetonitrile
98862	Acetophenone
53963	2-Acetylaminofluorene
107028	Acrolein
79061	Acrylamide

RULEMAKING HEARINGS

79107	Acrylic acid
107131	Acrylonitrile
107051	Allyl chloride
92671	4-Aminobiphenyl
62533	Aniline
90040	o-Anisidine
1332214	Asbestos
71432	Benzene (including benzene from gasoline)
92875	Benzidine
98077	Benzotrichloride
100447	Benzyl chloride
92524	Biphenyl
117817	Bis(2-ethylhexyl)phthalate(DEHP)
542881	Bis(chloromethyl) ether
75252	Bromoform
106990	1,3-Butadiene
156627	Calcium cyanamide
133062	Captan
63252	Carbaryl
75150	Carbon disulfide
56235	Carbon tetrachloride
463581	Carbonyl sulfide
120809	Catechol
133904	Chloramben
57749	Chlordane
7782505	Chlorine
79118	Chloroacetic acid
532274	2-Chloroacetophenone
108907	Chlorobenzene
510156	Chlorobenzilate
67663	Chloroform
107302	Chloromethyl methyl ether
126998	Chloroprene
1319773	Cresols/Cresylic acid (isomers and mixture)
95487	o-Cresol
108394	m-Cresol
106445	p-Cresol
98828	Cumene
94757	2,4-D, salts and esters
3547044	DDE
334883	Diazomethane
132649	Dibenzofurans
96128	1,2-Dibromo-3-chloropropane
84742	Dibutylphthalate
106467	1,4-Dichlorobenzene(p)
91941	3,3-Dichloro benzidene
111444	Dichloroethyl ether (Bis(2-chloroethyl)ether)
542756	1,3-Dichloropropene
62737	Dichlorvos
111422	Diethanolamine
121697	N,N-Diethyl aniline (N,N-Dimethylaniline)
64675	Diethyl sulfate

RULEMAKING HEARINGS

119904	3,3-Dimethoxybenzidine
60117	Dimethyl aminoazobenzene
119937	3,3'-Dimethyl benzidine
79447	Dimethyl carbamoyl chloride
68122	Dimethyl formamide
57147	1,1-Dimethyl hydrazine
131113	Dimethyl phthalate
77781	Dimethyl sulfate
534521	4,6-Dinitro-o-cresol, and salts
51285	2,4-Dinitrophenol
121142	2,4-Dinitrotoluene
123911	1,4-Dioxane (1,4-Diethyleneoxide)
122667	1,2-Diphenylhydrazine
106898	Epichlorohydrin (1-Chloro-2,3-epoxypropane)
106887	1,2-Epoxybutane
140885	Ethyl acrylate
100414	Ethyl benzene
51796	Ethyl carbamate (Urethane)
75003	Ethyl Chloride (Chloroethane)
106934	Ethylene dibromide (Dibromoethane)
107062	Ethylene dichloride (1,2-Dichloroethane)
107211	Ethylene glycol
151564	Ethylene imine (Aziridine)
75218	Ethylene oxide
96457	Ethylene thiourea
75343	Ethylidene dichloride (1,1-Dichloroethane)
50000	Formaldehyde
76448	Heptachlor
118741	Hexachlorobenzene
87683	Hexachlorobutadiene
77474	Hexachlorocyclopentadiene
67721	Hexachloroethane
822060	Hexamethylene-1,6-diisocyanate
680319	Hexamethylphosphoramide
110543	Hexane
302012	Hydrazine
7647010	Hydrochloric acid
7664393	Hydrogen fluoride (Hydrofluoric acid)
123319	Hydroquinone
78591	Isophorone
58899	Lindane (all isomers)
108316	Maleic anhydride
67561	Methanol
72435	Methoxychlor
74839	Methyl bromide (Bromomethane)
74873	Methyl chloride (Chloromethane)
71556	Methyl chloroform (1,1,1-Trichloroethane)
78933	Methyl ethyl ketone (2-Butanone)
60344	Methyl hydrazine
74884	Methyl iodide (Iodomethane)
108101	Methyl isobutyl ketone (Hexone)
624839	Methyl isocyanate

RULEMAKING HEARINGS

80626	Methyl methacrylate
1634044	Methyl tert butyl ether
101144	4,4-Methylene bis(2-chloroniline)
75092	Methylene chloride (Dichloromethane)
101688	Methylene diphenyl diisocyanate (MDI)
101779	4,4'-Methylenedianiline
91203	Naphthalene
98953	Nitrobenzene
92933	4-Nitrobiphenyl
100027	4-Nitrophenol
79469	2-Nitropropane
684935	N-Nitroso-N-methylurea
62759	N-Nitrosodimethylamine
59892	N-Nitrosomorpholine
56382	Parathion
82688	Pentachloronitrobenzene (Quintobenzene)
87865	Pentachlorophenol
108952	Phenol
106503	p-Phenylenediamine
75445	Phosgene
7803512	Phosphine
7723140	Phosphorus
85449	Phthalic anhydride
1336363	Polychlorinated biphenyls (Arochlors)
1120714	1,3-Propane sultone
57578	beta-Propiolactone
123386	Propionaldehyde
114261	Propoxur (Baygon)
78875	Propylene dichloride (1,2-Dichloropropane)
75569	Propylene oxide
75558	1,2-Propylenimine (2-Methyl aziridine)
91225	Quinoline
106514	Quinone
100425	Styrene
96093	Styrene oxide
1746016	2,3,7,8-Tetrachlorodibenzo-p-dioxin
79345	1,1,2,2-Tetrachloroethane
127184	Tetrachoroethylene (Perchloroethylene)
7550450	Titanium tetrachloride
108883	Toluene
95807	2,4-Toluene diamine
584849	2,4-Toluene diisocyanate
95534	o-Toluidine
8001352	Toxaphene (chlorinated camphene)
120821	1,2,4-Trichlorobenzene
79005	1,1,2-Trichloroethane
79016	Trichloroethylene
95954	2,4,5-Trichlorophenol
88062	2,4,6-Trichlorophenol
121448	Triethylamine
1582098	Trifluralin
540841	2,2,4-Trimethylpentane

RULEMAKING HEARINGS

108054	Vinyl acetate
593602	Vinyl bromide
75014	Vinyl chloride
75354	Vinylidene chloride (1,1-Dichloroethylene)
1330207	Xylenes (isomers and mixture)
95476	o-Xylenes
108383	m-Xylenes
106423	p-Xylenes
0	Antimony Compounds
0	Arsenic Compounds (inorganic including arsine)
0	Beryllium Compounds
0	Cadmium Compounds
0	Chromium Compounds
0	Cobalt Compounds
0	Coke Oven Emissions
0	Cyanide compounds
0	Glycol ethers ^{6,7}
0	Lead Compounds
0	Manganese Compounds
0	Mercury Compounds
0	Fine mineral fibers ³
0	Nickel Compounds
0	Polycyclic Organic Matter ⁴
0	Radionuclides (including radon) ⁵
0	Selenium Compounds

¹ X'CN where X = H' or any other group where a formal dissociation may occur. For example KCN or Ca(CN)₂

² Include mono- and di-ethers of ethylene glycol, diethylene glycol, and triethylene glycol R-(OCH₂CH₂)_n-OR'.

Where:

n = 1, 2, or 3:

R = alkyl C7 or less; or

R = phenyl or alkyl substituted phenyl;

R' = H or alkyl C7 or less; or

OR' consisting of carboxylic acid ester, sulfate, phosphate, nitrate, or sulfonate.

This action deletes each individual compound in a group called the surfactant alcohol ethoxylates and their derivatives (SAED) from the glycol ethers category in the list of hazardous air pollutants (HAP) established by section 112(b)(1) of the Clean Air Act (CAA).

³ Includes mineral fiber emissions from facilities manufacturing or processing glass, rock, or slag fibers (or other mineral derived fibers) of average diameter 1 micrometer or less.

⁴ Includes organic compounds with than one benzene ring, and which have a boiling point greater than or equal to 1000 C.

⁵ a type of atom which spontaneously undergoes radioactive decay.

RULEMAKING HEARINGS

- ⁶ The substance ethylene glycol monobutyl ether (EGBE, 2-Butoxyethanol) (Chemical Abstract Service (CAS) Number 111-76-2) is deleted from the list of hazardous air pollutants established by 42 U.S.C. 7412(b)(1).

Authority: *T.C.A. §§68-201-105 and 4-5-201 et. seq.*

This notice of rulemaking set out herein was properly filed in the Department of State on the 23rd of November, 2005. (11-37)

RULEMAKING HEARINGS

TENNESSEE STATE BOARD OF EQUALIZATION - 0600

There will be a hearing before the Tennessee State Board of Equalization to consider the amendment of rules pursuant to Tenn. Code Ann. §§67-1-305. The hearing will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, Tenn. Code Ann. §4-5-204 and will take place in the 17th floor conference room, James K. Polk State Office Bldg., 505 Deaderick Street, Nashville, Tennessee, at 10:30 a.m. on the 23d day of January, 2006.

Any individuals with disabilities who wish to participate in these proceedings should contact the Board to discuss any auxiliary aids or services needed to facilitate such participation. Such initial contact should be made no less than ten (10) days prior to the scheduled meeting date, to allow time for the Board to determine how it may reasonably provide such aid or service. Initial contact may be made with the Board's ADA Coordinator, Elaine Driver, at Ste. 1400, 505 Deaderick St., Nashville, TN 37243-0261 and tele. no. 615/401-7738.

For a copy of this notice of rulemaking hearing, contact: Kelsie Jones, Ste. 1700, 505 Deaderick St., Nashville, TN 37243-0280, and tele. no. 615/747-5379.

SUBSTANCE OF PROPOSED AMENDMENT

CHAPTER 0600-5

ASSESSMENT OF COMMERCIAL AND INDUSTRIAL TANGIBLE PERSONAL PROPERTY

0600-5-.01 DEFINITIONS.

Rule 0600-5-.01 Definitions is amended by deleting item (6), substituting the following new items:

- (6) "Original cost" shall be defined as all costs incurred by the original owner to place the item in service, and any additional costs incurred by the original or subsequent owners and against which may be asserted a claim of depreciation.
- (7) "Leased tangible personal property" shall mean tangible personal property leased or rented within the meaning of Tenn. Code Ann. Section 67-4-701 et seq., except that property a consumer of services must obtain from the service provider or an affiliate, shall be considered property of the service provider whether or not it is leased or rented.

Rule 0600-5-.01 Definitions is further amended by adding the following sentence at the end of item (14):

RULEMAKING HEARINGS

"Tangible personal property includes computer software."

Rule 0600-5-.01 Definitions is further amended by appropriately renumbering the remaining items, so that the rule as amended reads as follows:

- (8) "Personal property", as defined by T.C.A. §67-5-501(7), includes every species and character of property which is not classified as real property.
- (9) "Raw material" shall be defined as items of tangible personal property, crude or processed, which are held or maintained by a manufacturer for use through refining, combining, or any other process in the production or fabrication of another item or product.
- (10) "Regular assessment" shall be defined as an assessment made on personal property when the taxpayer has filed a personal property schedule with the assessor for the current year and the assessment is based on the information reported by the taxpayer.
- (11) "Residual value" shall be defined as the minimum standard value of property in use or capable of use.
- (12) "Scrap value" shall be defined as the value of personal property no longer capable of use and for which there is no expectation of repair.
- (13) "Straight line depreciation" for tangible personal property shall be defined as depreciation allocated in equal percentages over the economic life of the property and shall be calculated by dividing 100% by the economic life to achieve a yearly depreciation percentage. Percent good factors, also termed depreciation factors, derived from these yearly depreciation percentages shall be rounded to the nearest whole percent.
- (14) "Supplies" shall be defined as expendable items of tangible personal property which are used or held for use in support of a business activity, including but not limited to office supply stocks, stocks of spare parts for maintenance of machinery and equipment, accessories used in manufacturing processes, printing supplies, and cleaning and maintenance supplies.
- (15) "Tangible personal property", as defined by T.C.A. §67-5-501(12), includes personal property such as goods, chattels, and other articles of value which are capable of manual or physical possession, and certain machinery and equipment, separate and apart from any real property, and whose value is intrinsic to the article itself. Tangible personal property includes computer software.

Rule 0600-5-.05 Audit is amended by adding the following new subsections:

- (3) Audits shall be conducted in accordance with a plan submitted by the assessor of property and approved by the State Board of Equalization.
- (4) Assessors shall maintain confidentiality of taxpayer information as required by Tenn. Code Ann. Section 67-5-402, and disclose this information only pursuant to a written request identifying a basis for disclosure consistent with Section 67-5-402.

RULEMAKING HEARINGS

Rule 0600-5-.06 Standard Valuation is amended by adding the following sentence at the end of subsection (5): "The assessor shall not fix or increase a forced assessment by use of an arbitrary percentage."

Rule 0600-5-.09 Miscellaneous is amended by changing the title to "Classification and situs" and by substituting the following for the first sentence of subsection (1) (c):

The intent of the owner and, where appropriate, the intent of other parties to a transaction involving the owner. Intent shall be determined objectively, considering business custom and usage as well as the stated intent of the owner or parties.

so that the subsection as amended reads as follows:

- (c) The intent of the owner and, where appropriate, the intent of other parties to a transaction involving the owner. Intent shall be determined objectively, considering business custom and usage as well as the stated intent of the owner or parties. This element will come into focus most frequently where leased premises are involved, although it must occasionally be considered where premises are owner-occupied. If the intent of the owner is to move the item upon relocation of the business, the item is more likely to be considered personal property, provided that such a move would be probable, practical, and cost-effective.

Rule 0600-5-.09 Miscellaneous is further amended by adding the following new item:

- (d) The following property shall be presumed to be tangible personal property in the absence of proof to the contrary: i) above ground tanks less than five hundred thousand (500,000) gallon capacity; and ii) billboards not embedded in the ground with concrete and steel.

Rule 0600-5-.11 Reporting Schedule is amended by deleting the rule in its entirety and substituting instead the following: "The form to be used by taxpayers reporting commercial and industrial tangible personal property shall be Comptroller of the Treasury form 0025-9957 (Rev. 1998). A substantially equivalent form may be used with prior approval of the director of the state Division of Property Assessments."

Authority: T.C.A. §67-1-305.

The notice of rulemaking set out herein was properly filed in the Department of State on the 30th day of November, 2005. (11-41)

RULEMAKING HEARINGS

THE TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION - 0620 BUREAU OF TENNCARE

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

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

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

SUBSTANCE OF PROPOSED RULE

Subparagraph (d) of paragraph (2) of rule 1200-13-1-.10 Criteria for Medicaid Reimbursement of Care in Nursing Facilities is deleted in its entirety and replaced with a new subparagraph (d) which shall read as follows:

- (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 if the PAE is not finally approved the individual can not be held financially liable for services provided.

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

The notice of rulemaking set out herein was properly filed in the Department of State on the 30th day of November, 2005. (11-43)

RULEMAKING HEARINGS

TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION - 0620 BUREAU OF TENNCARE

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

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

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

SUBSTANCE OF PROPOSED RULES

Paragraph (103) of rule 1200-13-13-.01 Definitions is deleted in its entirety and replaced with a new paragraph (103) which shall read as follows:

(103) TENNCARE MEDICAID ELIGIBILITY REFORMS shall mean the amendments to the TennCare demonstration project approved by CMS on March 24, 2005, to close enrollment into TennCare Medicaid for non-pregnant adults age twenty-one (21) or older who qualify as Medically Needy under Tennessee's Title XIX State Plan for Medical Assistance and to disenroll non-pregnant adults age twenty-one (21) or older who qualify as Medically Needy under Tennessee's Title XIX State Plan for Medical Assistance after completion of their twelve (12) months of eligibility.

Subparagraph (c) of paragraph (4) of rule 1200-13-13-.02 Eligibility is deleted in its entirety and replaced with a new subparagraph (c) which shall read as follows:

- (c) In implementing TennCare Medicaid Eligibility Reforms, an individual who is eligible as a non-pregnant Medically Needy adult in accordance with Rule 1240-3-2-.03 of the Tennessee Department of Human Services is found to meet all the following criteria:
1. S/he is aged twenty-one (21) or older,
 2. S/he has completed his/her twelve (12) months of eligibility for TennCare,
 3. S/he is eligible for Medicare,
 4. S/he is not receiving TennCare-reimbursed services in either a Nursing Facility, Intermediate Care Facility for the Mentally Retarded or Home and Community Based Services waiver as of December 31, 2005, and
 5. S/he has not been determined eligible in an open Medicaid category.

RULEMAKING HEARINGS

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

The notice of rulemaking set out herein was properly filed in the Department of State on the 30th day of November, 2005. (11-44)

RULEMAKING HEARINGS

**DEPARTMENT OF HEALTH - 1200
BOARD FOR LICENSING HEALTH CARE FACILITIES
DIVISION OF HEALTH CARE FACILITIES**

There will be a hearing before the Board for Licensing Health Care Facilities to consider the promulgation of amendment of rules pursuant to T.C.A. §§ 4-5-202, 4-5-204, 68-11-202 and 68-11-209. The hearing will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, Tennessee Code Annotated, Section 4-5-204 and will take place in the Tennessee Room on the Ground floor of the Cordell Hull Building located at 425 Fifth Avenue North, Nashville, TN at 9:00 a.m. (CST) on the 17th day of January, 2006.

Any individuals with disabilities who wish to participate in these proceedings (review these filings) should contact the Department of Health, Division of Health Care Facilities to discuss any auxiliary aids or services needed to facilitate such participation or review. Such initial contact may be made no less than ten (10) days prior to the scheduled meeting date (the date such party intends to review such filings), to allow time for the Division to determine how it may reasonably provide such aid or service. Initial contact may be made with the ADA Coordinator at the Division of Health Care Facilities, First Floor, Cordell Hull Building, 425 Fifth Avenue North, Nashville, TN 37247-0508, (615) 741-7598.

For a copy of the entire text of this notice of rulemaking hearing visit the Department of Health's web page on the Internet at www.state.tn.us/health and click on "rulemaking hearings" or contact: Steve Goodwin, Health Facility Survey Manager, Division of Health Care Facilities, 425 Fifth Avenue North, First Floor, Cordell Hull Building, Nashville, TN 37247-0508, (615) 741-7598.

SUBSTANCE OF PROPOSED RULES

**CHAPTER 1200-8-1
STANDARDS FOR HOSPITALS**

**CHAPTER 1200-8-6
STANDARDS FOR NURSING HOMES**

**CHAPTER 1200-8-10
STANDARDS FOR AMBULATORY SURGICAL TREATMENT CENTERS**

**CHAPTER 1200-8-11
STANDARDS FOR HOMES FOR THE AGED**

**CHAPTER 1200-8-15
STANDARDS FOR RESIDENTIAL HOSPICES**

**CHAPTER 1200-8-18
ALCOHOL AND OTHER DRUGS OF ABUSE NON-RESIDENTIAL TREATMENT FACILITIES**

**CHAPTER 1200-8-19
ALCOHOL AND OTHER DRUGS OF ABUSE DUI SCHOOL FACILITIES**

**CHAPTER 1200-8-20
ALCOHOL AND OTHER DRUGS OF ABUSE PREVENTION PROGRAM FACILITIES**

RULEMAKING HEARINGS

**CHAPTER 1200-8-25
STANDARDS FOR ASSISTED-CARE LIVING FACILITIES**

**CHAPTER 1200-8-26
STANDARDS FOR HOME CARE ORGANIZATIONS PROVIDING HOME HEALTH SERVICES**

**CHAPTER 1200-8-27
STANDARDS FOR HOME CARE ORGANIZATIONS PROVIDING HOSPICE SERVICES**

**CHAPTER 1200-8-28
STANDARDS FOR HIV SUPPORTIVE LIVING FACILITIES**

**CHAPTER 1200-8-29
STANDARDS FOR HOME CARE ORGANIZATIONS PROVIDING HOME MEDICAL EQUIPMENT**

**CHAPTER 1200-8-35
STANDARDS FOR OUTPATIENT DIAGNOSTIC CENTERS**

AMENDMENTS

Rule 1200-8-1-.04, Administration, is amended by adding the following language as new paragraph (11), so that as amended, the new paragraph (11) shall read:

- (11) Hospice services may be provided in an area designated by a hospital for exclusive use by a home care organization certified as a hospice provider to provide care at the hospice inpatient or respite level of care in accordance with the hospice's Medicare certification. Admission to the hospital is not required in order for a patient to receive such hospice services, regardless of the patient's length of stay. The designation by a hospital of a portion of its facility for exclusive use by a home care organization to provide hospice services to its patients shall not:
- (a) alter the license to bed complement of such hospital, or
 - (b) result in the establishment of a residential hospice.

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-216.

Rule 1200-8-1-.07, Optional Hospital Services, is amended by deleting subparagraphs (1)(i) and (1)(k) in their entirety and substituting instead the following language, so that as amended, the new subparagraphs (1)(i) and (1)(k) shall read:

- (1) (i) A hospital can petition the director of health care facilities of the department for a waiver from the provisions of 1200-8-1-.07(1)(h) if they are unable to employ a sufficient number of surgical technologists who meet the requirements. The facility shall demonstrate to the director that a diligent and thorough effort has been made to employ surgical technologist who meet the requirements. The director shall refuse to grant a waiver upon finding that a diligent and thorough effort has not been made. A waiver shall exempt a facility from meeting the requirements for not more than nine (9) months. Additional waivers may be granted, but all exemptions greater than twelve (12) months shall be approved by the Board for Licensing Health Care Facilities.

RULEMAKING HEARINGS

- (1) (k) Properly executed informed consent, advance directive, and organ donation forms, when applicable, must be in the patient's chart before surgery, except in emergencies.

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-209 and 68-57-102.

Rule 1200-8-1-.07, Optional Hospital Services, is amended by adding the following language as new subparagraph (1)(j) and re-numbering the remaining subparagraphs appropriately, so that as amended, the new subparagraph (1)(j) shall read:

- (1) (j) Surgical technologist shall demonstrate continued competence in order to perform their professional duties in surgical technology. The employer will maintain evidence of the continued competence of such individuals. Continued competence activities may include but are not limited to continuing education, in-service training, or certification renewal.

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-209 and 68-57-102.

Rule 1200-8-1-.08, Building Standards, is amended by adding the following language as new paragraph (26), so that as amended, the new paragraph (26) shall read:

- (26) Each hospital shall ensure that an emergency keyed lock box is installed next to each bank of functioning elevators located on the main level. Such lock boxes shall be permanently mounted seventy-two inches (72") from the floor to the center of the box, be operable by a universal key no matter where such box is located, and shall contain only fire service keys and drop keys to the appropriate elevators.

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-216 and 68-11-259.

Rule 1200-8-1-.11, Records and Reports, is amended by deleting paragraph (5) in its entirety and substituting instead the following language, so that as amended, the new paragraph (5) shall read:

- (5) Hospitals shall submit their Joint Annual Report data within one hundred and fifty (150) days after the end of each hospital's fiscal year and within one hundred and fifty (150) days after closure or a change in ownership. Hospitals shall also submit to the department, at the same time the hospital sends the signed paper copy of the report, a notarized statement from the hospital's financial auditor stating that the financial data reported on the Joint Annual Report is consistent with the audited financials for the hospital for that reporting year. The notarized statement shall also be attested to by the chief executive officer of the submitting hospital.

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-207, 68-11-209, 68-11-210, 68-11-211, 68-11-213, 68-11-216, and 68-11-310.

Rule 1200-8-6-.04, Administration, is amended by adding the following language as new paragraph (16) and re-numbering the remaining paragraphs appropriately, so that as amended, the new paragraph (16) shall read:

- (16) Each nursing home shall post whether they have liability insurance, the identity of their primary insurance carrier, and if self-insured, the corporate entity responsible for payment of any claims. It shall be posted on a sign no smaller than eleven inches (11") in width and seventeen inches (17") in height and displayed at the main public entrance.

RULEMAKING HEARINGS

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-225, 68-11-256, 68-11-257, and 68-11-906.

Rule 1200-8-6-.05, Admissions, Discharges, and Transfers, is amended by adding the following language as new paragraph (3) and re-numbering the remaining paragraphs appropriately, so that as amended, the new paragraph (3) shall read:

- (3) Each nursing home shall disclose in writing to the resident or to the resident's guardian, conservator or representative, if any, whether the facility has liability insurance and the identity of the primary insurance carrier. If the facility is self-insured, their statement shall reflect that fact and indicate the corporate entity responsible for payment of any claims.

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-257.

Rule 1200-8-6-.08, Building Standards, is amended by adding the following language as new paragraph (24), so that as amended, the new paragraph (24) shall read:

- (24) Each nursing home shall ensure that an emergency keyed lock box is installed next to each bank of functioning elevators located on the main level. Such lock boxes shall be permanently mounted seventy-two inches (72") from the floor to the center of the box, be operable by a universal key no matter where such box is located, and shall contain only fire service keys and drop keys to the appropriate elevators.

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-259.

Rule 1200-8-10-.06, Basic Services, is amended by deleting subparagraph (1)(k) in its entirety and substituting instead the following language, so that as amended, the new subparagraph (1)(k) shall read:

- (1) (k) An ASTC can petition the director of health care facilities of the department for a waiver from the provisions of 1200-8-10-.06(1)(j) if they are unable to employ a sufficient number of surgical technologists who meet the requirements. The facility shall demonstrate to the director that a diligent and thorough effort has been made to employ surgical technologist who meet the requirements. The director shall refuse to grant a waiver upon finding that a diligent and thorough effort has not been made. A waiver shall exempt a facility from meeting the requirements for not more than nine (9) months. Additional waivers may be granted, but all exemptions greater than twelve (12) months shall be approved by the Board for Licensing Health Care Facilities.

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-216, and 68-57-102.

Rule 1200-8-10-.06, Basic Services, is amended by adding the following language as new subparagraph (1)(l) and re-numbering the remaining subparagraphs appropriately, so that as amended, the new subparagraph (1)(l) shall read:

- (1) (l) Surgical technologist shall demonstrate continued competence in order to perform their professional duties in surgical technology. The employer will maintain evidence of the continued competence of such individuals. Continued competence activities may include but are not limited to continuing education, in-service training, or certification renewal.

RULEMAKING HEARINGS

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-216, and 68-57-102.

Rule 1200-8-10-.08, Building Standards, is amended by adding the following language as new paragraph (25), so that as amended, the new paragraph (25) shall read:

- (25) Each ambulatory surgical treatment center shall ensure that an emergency keyed lock box is installed next to each bank of functioning elevators located on the main level. Such lock boxes shall be permanently mounted seventy-two inches (72") from the floor to the center of the box, be operable by a universal key no matter where such box is located, and shall contain only fire service keys and drop keys to the appropriate elevators.

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-216, and 68-11-259.

Rule 1200-8-11-.01, Definitions, is amended by deleting paragraph (26) in its entirety and substituting instead the following language, so that as amended, the new paragraph (26) shall read:

- (26) Home for the Aged. A home represented and held out to the general public as a home which primarily accepts aged persons for relatively permanent, domiciliary care with primarily being defined as 51% or more of the population of the home for the aged. It provides room, board and personal services to four (4) or more nonrelated persons. The term home includes any building or part thereof which provides services as defined in these rules.

Authority: T.C.A. §§4-5-202, 4-5-204, 39-11-106, 68-11-202, 68-11-204, 68-11-206, 68-11-207, 68-11-209, 68-11-210, 68-11-211, 68-11-213, 68-11-216, 68-11-224, and 68-11-1802.

Rule 1200-8-11-.04, Administration, is amended by adding the following language as new subparagraph (5)(e) and re-numbering the remaining subparagraphs appropriately, so that as amended, the new subparagraph (5)(e) shall read:

- (5) (e) Post whether they have liability insurance, the identity of their primary insurance carrier, and if self-insured, the corporate entity responsible for payment of any claims. It shall be posted on a sign no smaller than eleven inches (11") in width and seventeen inches (17") in height and displayed at the main public entrance.

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-257.

Rule 1200-8-11-.05, Admissions, Discharges, and Transfers, is amended by adding the following language as new paragraph (2) and re-numbering the remaining paragraphs appropriately, so that as amended, the new paragraph (2) shall read:

- (2) Each home for the aged shall disclose in writing to the resident or to the resident's guardian, conservator or representative, if any, whether the facility has liability insurance and the identity of the primary insurance carrier. If the facility is self-insured, their statement shall reflect that fact and indicate the corporate entity responsible for payment of any claims.

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-257.

RULEMAKING HEARINGS

Rule 1200-8-11-.07, Building Standards, is amended by adding the following language as new paragraph (28), so that as amended, the new paragraph (28) shall read:

- (28) Each home for the aged shall ensure that an emergency keyed lock box is installed next to each bank of functioning elevators located on the main level. Such lock boxes shall be permanently mounted seventy-two inches (72") from the floor to the center of the box, be operable by a universal key no matter where such box is located, and shall contain only fire service keys and drop keys to the appropriate elevators.

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-259.

Rule 1200-8-15-.08, Building Standards, is amended by adding the following language as new paragraph (24), so that as amended, the new paragraph (24) shall read:

- (24) Each residential hospice shall ensure that an emergency keyed lock box is installed next to each bank of functioning elevators located on the main level. Such lock boxes shall be permanently mounted seventy-two inches (72") from the floor to the center of the box, be operable by a universal key no matter where such box is located, and shall contain only fire service keys and drop keys to the appropriate elevators.

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-259.

Rule 1200-8-18-.01, Definitions, is amended by adding the following language as new paragraph (10) and re-numbering the remaining paragraphs appropriately, so that as amended, the new paragraph (10) shall read:

- (10) Branch Office. A location where alcohol and drug prevention and treatment services are actually delivered and is located sufficiently close (within 100 miles from a parent office) to share administrative services with the parent office and must maintain the same corporate name of the parent.

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-201, 68-11-202, 68-11-204, 68-11-207, 68-11-209, 68-22-210, 68-11-211, and 68-11-213.

Rule 1200-8-18-.02, Licensing Procedures, is amended by deleting subparagraph (2)(b) in its entirety and substituting instead the following language, so that as amended, the new subparagraph (2)(b) shall read:

- (b) Each initial and renewal application for licensure shall be submitted with the appropriate fee or fees. All fees submitted are nonrefundable. The fee rate is based on the number of distinct facility categories to be operated at each residential and non-residential site. Offices providing alcohol and drug prevention and treatment services shall be classified as either a parent office or as a branch office of the facility and only one (1) license shall be required for the parent and its related branch offices. Any applicant who files an application during the fiscal year must pay the full license fee.

<u>Non-Residential</u>	Fees Per Site:
One (1) Distinct Facility Category.....	\$ 600.00

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-216.

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Rule 1200-8-18-.02, Licensing Procedures, is amended by deleting paragraph (4) in its entirety and re-numbering the remaining paragraphs appropriately.

Authority: *T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-216.*

Rule 1200-8-18-.04, Administration, is amended by adding the following language as new paragraphs (2), (3), (4), and (5) and re-numbering the remaining paragraphs appropriately, so that as amended, the new paragraphs (2), (3), (4), and (5) shall read:

- (2) A parent office shall develop and maintain administrative controls of the branch office and house the administrative functions and administrative records of the facility. The parent office shall be ultimately responsible for human resource activities and all financial and contractual agreements for the facility, including both parent and branch offices. The administrative records of the facility shall be viewed by the inspectors and auditors at the parent office.
- (3) A branch office is a location where alcohol and drug prevention and treatment services are actually delivered. A branch office must be sufficiently close to share administrative services with the parent office and must maintain the same corporate name of the parent. The parent office shall make on-site supervisory visits to each branch office and shall maintain regular administrative contact with its branch offices. Documentation of this contact shall be maintained by the parent office. The parent office shall receive at least quarterly written staffing reports from its branch offices, including information regarding staffing needs, staffing patterns and staff productivity. A branch office shall be deemed to be sufficiently close if it is within 100 miles of the parent office; provided that the remaining criteria set forth in this subsection are also applicable. A branch office that is greater than 100 miles from a parent office may be considered a branch office by the board if it otherwise meets the criteria set forth in this subdivision. Locations other than the parent office where merely administrative services take place, such as filling out paper work or conducting staff meetings, shall not be considered a branch office or part of the license and shall not be subject to inspection or audit.
- (4) The parent office of a facility shall have a clearly defined process to ensure that effective interchange occurs between the parent and branch regarding various functions including branch staffing requirements, branch office patient census, total visits provided by the branch, complaints, incident reports and referrals.
- (5) The branch office of a facility shall maintain the same standards of practice for the services delivered by the branch office, as the parent office of the facility, including forms, policies, procedures and service delivery standards. The parent office of a facility shall maintain documentation of integration between the parent office and its branch offices.

Authority: *T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-222.*

Rule 1200-8-19-.01, Definitions, is amended by adding the following language as new paragraph (10) and re-numbering the remaining paragraphs appropriately, so that as amended, the new paragraph (10) shall read:

- (10) Branch Office. A location where alcohol and drug prevention and treatment services are provided and is located sufficiently close (within 100 miles from a parent office) to share administrative services with the parent office and must maintain the same corporate name of the parent.

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Authority: T.C.A. §§4-5-202 through 4-5-206, 68-11-201, 68-11-202, 68-11-207, 68-11-209, 68-22-210, 68-11-211, and 68-11-213.

Rule 1200-8-19-.02, Licensing Procedures, is amended by deleting subparagraph (2)(b) in its entirety and substituting instead the following language, so that as amended, the new subparagraph (2)(b) shall read:

- (b) Each initial and renewal application for licensure shall be submitted with the appropriate fee or fees. All fees submitted are nonrefundable. The fee rate is based on the number of distinct facility categories to be operated at each residential and non-residential site. Offices providing alcohol and drug prevention and treatment services shall be classified as either a parent office or as a branch office of the facility and only one (1) license shall be required for the parent and its related branch offices. Any applicant who files an application during the fiscal year must pay the full license fee.

<u>Non-Residential</u>	Fees Per Site:
One (1) Distinct Facility Category.....	\$ 600.00

Authority: T.C.A. §§4-5-202 through 4-5-206, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-22-210, 68-11-213, and 68-11-216.

Rule 1200-8-19-.02, Licensing Procedures, is amended by deleting paragraph (4) in its entirety and re-numbering the remaining paragraphs appropriately.

Authority: T.C.A. §§4-5-202 through 4-5-206, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-22-210, 68-11-213, and 68-11-216.

Rule 1200-8-19-.04, Administration, is amended by adding the following language as new paragraphs (2), (3), (4), and (5) and re-numbering the remaining paragraphs appropriately, so that as amended, the new paragraphs (2), (3), (4), and (5) shall read:

- (2) A parent office shall develop and maintain administrative controls of the branch office and house the administrative functions and administrative records of the facility. The parent office shall be ultimately responsible for human resource activities and all financial and contractual agreements for the facility, including both parent and branch offices. The administrative records of the facility shall be viewed by the inspectors and auditors at the parent office.
- (3) A branch office is a location where alcohol and drug prevention and treatment services are actually delivered. A branch office must be sufficiently close to share administrative services with the parent office and must maintain the same corporate name of the parent. The parent office shall make on-site supervisory visits to each branch office and shall maintain regular administrative contact with its branch offices. Documentation of this contact shall be maintained by the parent office. The parent office shall receive at least quarterly written staffing reports from its branch offices, including information regarding staffing needs, staffing patterns and staff productivity. A branch office shall be deemed to be sufficiently close if it is within 100 miles of the parent office; provided that the remaining criteria set forth in this subsection are also applicable. A branch office that is greater than 100 miles from a parent office may be considered a branch office by the board if it otherwise meets the criteria set forth in this subdivision. Locations other than the parent office where merely administrative services take place, such as filling out paper work or

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conducting staff meetings, shall not be considered a branch office or part of the license and shall not be subject to inspection or audit.

- (4) The parent office of a facility shall have a clearly defined process to ensure that effective inter-change occurs between the parent and branch regarding various functions including branch staff-ing requirements, branch office patient census, total visits provided by the branch, complaints, incident reports and referrals.
- (5) The branch office of a facility shall maintain the same standards of practice for the services deliv-ered by the branch office, as the parent office of the facility, including forms, policies, procedures and service delivery standards. The parent office of a facility shall maintain documentation of integration between the parent office and its branch offices.

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-222.

Rule 1200-8-20-.01, Definitions, is amended by adding the following language as new paragraph (12) and re-numbering the remaining paragraphs appropriately, so that as amended, the new paragraph (12) shall read:

- (12) Branch Office. A location where alcohol and drug prevention and treatment services are provided and is located sufficiently close (within 100 miles from a parent office) to share administrative services with the parent office and must maintain the same corporate name of the parent.

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-201, 68-11-202, 68-11-204, 68-11-207, 68-11-209, 68-22-210, 68-11-211, and 68-11-213.

Rule 1200-8-20-.02, Licensing Procedures, is amended by deleting subparagraph (2)(b) in its entirety and substituting instead the following language, so that as amended, the new subparagraph (2)(b) shall read:

- (b) Each initial and renewal application for licensure shall be submitted with the appropriate fee or fees. All fees submitted are nonrefundable. The fee rate is based on the number of distinct facility categories to be operated at each residential and non-residential site. Offices providing alcohol and drug prevention and treatment services shall be classified as either a parent office or as a branch office of the facility and only one (1) license shall be required for the parent and its related branch offices. Any applicant who files an application during the fiscal year must pay the full license fee.

<u>Non-Residential</u>	Fees Per Site:
One (1) Distinct Facility Category.....	\$ 600.00

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-216.

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Rule 1200-8-20-.02, Licensing Procedures, is amended by deleting paragraph (4) in its entirety and re-numbering the remaining paragraphs appropriately.

Authority: *T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-216.*

Rule 1200-8-20-.04, Administration, is amended by adding the following language as new paragraphs (2), (3), (4), and (5) and re-numbering the remaining paragraphs appropriately, so that as amended, the new paragraphs (2), (3), (4), and (5) shall read:

- (2) A parent office shall develop and maintain administrative controls of the branch office and house the administrative functions and administrative records of the facility. The parent office shall be ultimately responsible for human resource activities and all financial and contractual agreements for the facility, including both parent and branch offices. The administrative records of the facility shall be viewed by the inspectors and auditors at the parent office.
- (3) A branch office is a location where alcohol and drug prevention and treatment services are actually delivered. A branch office must be sufficiently close to share administrative services with the parent office and must maintain the same corporate name of the parent. The parent office shall make on-site supervisory visits to each branch office and shall maintain regular administrative contact with its branch offices. Documentation of this contact shall be maintained by the parent office. The parent office shall receive at least quarterly written staffing reports from its branch offices, including information regarding staffing needs, staffing patterns and staff productivity. A branch office shall be deemed to be sufficiently close if it is within 100 miles of the parent office; provided that the remaining criteria set forth in this subsection are also applicable. A branch office that is greater than 100 miles from a parent office may be considered a branch office by the board if it otherwise meets the criteria set forth in this subdivision. Locations other than the parent office where merely administrative services take place, such as filling out paper work or conducting staff meetings, shall not be considered a branch office or part of the license and shall not be subject to inspection or audit.
- (4) The parent office of a facility shall have a clearly defined process to ensure that effective interchange occurs between the parent and branch regarding various functions including branch staffing requirements, branch office patient census, total visits provided by the branch, complaints, incident reports and referrals.
- (5) The branch office of a facility shall maintain the same standards of practice for the services delivered by the branch office, as the parent office of the facility, including forms, policies, procedures and service delivery standards. The parent office of a facility shall maintain documentation of integration between the parent office and its branch offices.

Authority: *T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-222.*

Rule 1200-8-25-.02, Licensing Procedures, is amended by deleting paragraph (6) in its entirety and re-numbering the remaining paragraphs appropriately.

Authority: *T.C.A. §§4-5-202, 4-5-204, 39-11-106, 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-207, 68-11-209, 68-11-210, 68-11-211, 68-11-213, 68-11-224, and 68-11-1802.*

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Rule 1200-8-25-.04, Administration, is amended by adding the following language as new subparagraph (5)(e) and re-numbering the remaining subparagraphs appropriately, so that as amended, the new subparagraph (5)(e) shall read:

- (5) (e) Post whether they have liability insurance, the identity of their primary insurance carrier, and if self-insured, the corporate entity responsible for payment of any claims. It shall be posted on a sign no smaller than eleven inches (11") in width and seventeen inches (17") in height and displayed at the main public entrance.

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-257.

Rule 1200-8-25-.04, Administration, is amended by adding the following language as new subparagraph (5)(c) and re-numbering the remaining subparagraphs appropriately, so that as amended, the new subparagraph (5)(c) shall read:

- (c) A registered nurse may make the actual determination and pronouncement of death under the following circumstances:
 - 1. The deceased was a resident of an assisted-care living facility;
 - 2. Death was anticipated, and the attending physician has agreed in writing to sign the death certificate. Such agreement by the attending physician must be present and with the deceased at the place of death;
 - 3. The nurse is licensed by the state; and
 - 4. The nurse is employed by the assisted-care living facility in which the deceased resided.

Authority: T.C.A. §§4-5-202, 4-5-204, 68-3-511, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-257.

Rule 1200-8-25-.05, Admissions, Discharges, and Transfers, is amended by adding the following language as new paragraph (2) and re-numbering the remaining paragraphs appropriately, so that as amended, the new paragraph (2) shall read:

- (2) Each assisted-care living facility shall disclose in writing to the resident or to the resident's guardian, conservator or representative, if any, whether the facility has liability insurance and the identity of the primary insurance carrier. If the facility is self-insured, their statement shall reflect that fact and indicate the corporate entity responsible for payment of any claims.

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-216, and 68-11-257.

Rule 1200-8-25-.07, Building Standards, is amended by adding the following language as new paragraph (28), so that as amended, the new paragraph (28) shall read:

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- (28) Each assisted-care living facility shall ensure that an emergency keyed lock box is installed next to each bank of functioning elevators located on the main level. Such lock boxes shall be permanently mounted seventy-two inches (72") from the floor to the center of the box, be operable by a universal key no matter where such box is located, and shall contain only fire service keys and drop keys to the appropriate elevators.

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-259.

Rule 1200-8-26-.06, Basic Agency Functions, is amended by adding the following language as new subparagraph (11)(b), and re-numbering the remaining subparagraphs appropriately, so that as amended, the new subparagraph (11)(b) shall read:

- (11) (b) A home health agency is authorized to receive and appropriately act on a written order for a plan of care for a patient concerning a home health service signed by a physician that is transmitted to the home health agency by electronically signed mail. Such order that is transmitted by electronic mail shall be deemed to meet any requirement for written documentation imposed by this regulation.

Authority: T.C.A. §§4-5-202, 4-5-204, 68-3-511, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-259, and 68-11-304.

Rule 1200-8-27-.04, Administration, is amended by adding the following language as new paragraph (9) and re-numbering the remaining paragraphs appropriately, so that as amended, the new paragraph (9) shall read:

- (9) Hospice services may be provided in an area designated by a hospital for exclusive use by a home care organization certified as a hospice provider to provide care at the hospice inpatient or respite level of care in accordance with the hospice's Medicare certification. Admission to the hospital is not required in order for a patient to receive such hospice services, regardless of the patient's length of stay. The designation by a hospital of a portion of its facility for exclusive use by a home care organization to provide hospice services to its patients shall not:
- (a) alter the license to bed complement of such hospital, or
 - (b) result in the establishment of a residential hospice.

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-222.

Rule 1200-8-27-.06, Basic Agency Functions, is amended by adding the following language as new subparagraph (14)(b), and re-numbering the remaining subparagraphs appropriately, so that as amended, the new subparagraph (14)(b) shall read:

- (14) (b) A Hospice agency is authorized to receive and appropriately act on a written order for a plan of care for a patient concerning a home health service signed by a physician that is transmitted to the hospice agency by electronically signed mail. Such order that is transmitted by electronic mail shall be deemed to meet any requirement for written documentation imposed by this regulation.

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Authority: T.C.A. §§4-5-202, 4-5-204, 68-3-511, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-259, and 68-11-304.

Rule 1200-8-28-.08, Building Standards, is amended by adding the following language as new paragraph (28), so that as amended, the new paragraph (28) shall read:

- (28) Each HIV supportive living facility shall ensure that an emergency keyed lock box is installed next to each bank of functioning elevators located on the main level. Such lock boxes shall be permanently mounted seventy-two inches (72") from the floor to the center of the box, be operable by a universal key no matter where such box is located, and shall contain only fire service keys and drop keys to the appropriate elevators.

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-216, 68-11-259, and 68-11-804.

Rule 1200-8-29-.11, Records and Reports, is amended by adding the following language as new item (2)(b)1, so that as amended, the new item (2)(b)1 shall read:

- (2) (b) 1. A home medical equipment agency is authorized to receive and appropriately act on a written order for a plan of care for a patient concerning a home health service signed by a physician that is transmitted to the home medical equipment agency by electronically signed mail. Such order that is transmitted by electronic mail shall be deemed to meet any requirement for written documentation imposed by this regulation.

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-209, and 68-11-259.

Rule 1200-8-35-.01, Definitions, is amended by deleting paragraph (50) in its entirety and substituting instead the following language, so that as amended, the new paragraph (50) shall read:

- (50) Outpatient Diagnostic Center. Any facility providing outpatient diagnostic services (computerized tomography, magnetic resonance imaging, positron emission tomography, or other imaging technology developed after the effective date of this rule which provides substantially the same functionality), unless the outpatient diagnostic services are provided as the services of another licensed healthcare institution that reports such outpatient diagnostic services on its joint annual report, or the facility is otherwise excluded from this definition. Outpatient diagnostic center does not include a physician or dental practice that is conducted at a location occupied and controlled by one or more physicians or dentists licensed under Title 63, if the outpatient diagnostic services are ancillary to the specialties of the physicians' practice or are provided primarily for persons who are patients of the physicians or dentists in the practice for purposes other than outpatient diagnostic services. Outpatient diagnostic centers in existence prior to the effective date of this rule will be required to obtain licensure by the department of health and comply with relevant reporting requirements.

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-216.

The notice of rulemaking set out herein was properly filed in the Department of State on the 16th day of November, 2006. (11-08)

RULEMAKING HEARINGS

**THE TENNESSEE DEPARTMENT OF HUMAN SERVICES - 1240
CHILD SUPPORT SERVICES DIVISION**

There will be hearings before the Tennessee Department of Human Services to consider the promulgation of amendments to rules pursuant to Tennessee Code Annotated §§ 4-5-201 et seq. and 71-1-105(12). The hearings will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, Tennessee Code Annotated § 4-5-204, and will take place in the following locations:

Washington County Department of Human Services Conference Room, 103 East Walnut Street, Johnson City, Tennessee, at 6:30 PM Eastern Time on January 17, 2006;

Knoxville State Office Building, 7th Floor Conference Room A, 531 Henley Street, Knoxville, Tennessee, at 6:30 PM Eastern Time on January 18, 2006;

Chattanooga State Office Building 1st Floor Auditorium, 540 McCallie Avenue, Chattanooga, Tennessee, at 6:30 PM Eastern Time on January 19, 2006;

Putnam County Department of Human Services Conference Room, 269-E South Willow Avenue, Cookeville, Tennessee, at 6:30 PM Central Time on January 23, 2006;

Citizens Plaza State Office Building, Second Floor Boardroom, 400 Deaderick Street, Nashville, Tennessee, at 6:30 PM Central Time on January 24, 2006;

Maury County Department of Human Services Conference Room, 1400 College Park Drive, Suite B, Columbia, Tennessee, at 6:30 PM Central Time on January 25, 2006;

Obion County Department of Human Services' Conference Room at 1416 Stad Avenue Union City, TN 38261 at 6:30 PM Central Time on January 26, 2006;

Lowell Thomas State Office Building, Suite 210, Conference Room, 225 Martin Luther King Jr. Drive, Jackson, Tennessee, at 6:30 PM Central Time on January 30, 2006;

Donnelley J. Hill State Office Building, Second Floor Auditorium, 170 North Main Street, Memphis, Tennessee, at 6:30 PM Central Time on January 31, 2006.

Any individuals with disabilities who wish to participate in these proceedings or to review these filings should contact the Department of Human Services to discuss any auxiliary aids or services needed to facilitate such participation. Such initial contact may be made no less than ten (10) days prior to the scheduled meeting date or the date the party intends to review such filings, to allow time for the Department of Human Services to determine how it may reasonably provide such aid or service. Initial contact may be made with the Department of Human Services ADA Coordinator, Fran McKinney, Citizens Plaza Building, 400 Deaderick Street, 3rd Floor, Nashville, Tennessee 37248, telephone number (615) 313-5563, (TTY)- (800) 270-1349.

For a copy of this notice of rulemaking hearing, contact: Kim Beals, Assistant General Counsel, Citizen's Plaza Building, 400 Deaderick Street, Nashville, Tennessee, 37248-0006 and (615) 313-4731.

RULEMAKING HEARINGS

SUBSTANCE OF PROPOSED RULES

THE TENNESSEE DEPARTMENT OF HUMAN SERVICES
CHILD SUPPORT SERVICES DIVISION

1240-2-4
CHILD SUPPORT GUIDELINES

REPEALS

Chapters 1240-2-4-.01, 1240-2-4-.02, 1240-2-4-.03, 1240-2-4-.04, 1240-2-4-.05, 1240-2-4-.06, 1240-2-4-.07, and 1240-2-4-.08, Child Support Guidelines, are repealed.

Authority: T.C.A. §§ 4-5-202; 71-3-132; 36-5-101(e); 71-1-105(16); 42 United States Code § 667; 45 Code of Federal Regulations 302.56.

AMENDMENTS

- 1240-2-4-.01 Legal Basis, Scope, and Purpose.
- 1240-2-4-.02 Definitions.
- 1240-2-4-.03 The Income Shares Model.
- 1240-2-4-.04 Determination of Child Support.
- 1240-2-4-.05 Modification of Child Support Orders.
- 1240-2-4-.06 Retroactive Support.
- 1240-2-4-.07 Deviations from the Child Support Guidelines.
- 1240-2-4-.08 Worksheets and Instructions.

1240-2-4-.01 LEGAL BASIS, SCOPE, AND PURPOSE.

- (1) Federal and State Legal Requirements for the Establishment and Application of Child Support Guidelines.
 - (a) Title IV-D of the Social Security Act (42 U.S.C. §§ 651-669), specifically 42 U.S.C. § 667 and 45 C.F.R. § 302.56, requires that States establish guidelines for setting and modifying child support award amounts in each State. Tennessee Code Annotated §§ 36-5-101(e), 71-1-105(16), and 71-1-132 implement these requirements and direct the Tennessee Department of Human Services to establish those guidelines to enforce the provisions of federal law.
 - (b) The Tennessee Department of Human Services is the authorized state agency for the enforcement of the child support program in the State of Tennessee under Title IV-D of the Social Security Act. The Department of Human Services will comply with federal and state requirements to promulgate Child Support Guidelines to be used in setting awards of child support.
 - (c) Pursuant to 42 U.S.C. § 667 and 45 C.F.R. § 302.56, the Child Support Guidelines must be made available to all persons in the State whose duty it is to set or modify child support award amounts in all child support cases.
 - (d) Pursuant to federal laws and regulations, the Child Support Guidelines established by a State must, at a minimum:

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1. Be applied by all judicial or administrative tribunals and other officials of the State who have power to determine child support awards in the State as a rebuttable presumption as to the amount of child support to be awarded in child support cases and result in a presumptively correct child support award;
 2. Take into consideration all earnings and income of the alternate residential parent;
 3. Be based on specific descriptive and numeric criteria and result in the computation of the child support obligation; and
 4. Provide for the child's health care needs through health insurance coverage or other means.
- (e) Federal law and regulations further provide that the amount of child support mandated by the Guidelines may be rebutted if the tribunal setting or modifying support includes, in writing, in the order:
1. The reasons the tribunal deviated from the presumptive amount of child support that would have been paid pursuant to the Guidelines;
 2. The amount of child support that would have been required under the Guidelines if the presumptive amount had not been rebutted; and
 3. A finding by the tribunal that states how, in its determination,
 - (i) Application of the Guidelines would be unjust or inappropriate in the particular case before the tribunal; and
 - (ii) The best interests of the child or children who are subject to the support award determination are served by deviation from the presumptive guideline amount.
- (2) Effective Date and Applicability.
- (a) The Child Support Guidelines established by this Chapter shall be applicable in every judicial or administrative action to establish, modify, or enforce child support, whether temporary or permanent, whether the action is filed before or after the effective date of these rules, where an order establishing, modifying, or enforcing support is entered after the effective date of these rules.
 - (b) The Child Support Guidelines shall be applied to all of the following cases involving the establishment, modification, or enforcement of child support:
 1. Divorce or separate maintenance actions of married persons who are living separately, who have children of the marriage, including those actions in which a marital dissolution agreement or parenting plan is executed.
 - (i) If the parties stipulate to the child support to be paid for the support of the parties' children, the stipulations, whether in a marital dissolution agreement, parenting plan, or in any other document establishing the amounts to be paid for the support of the parties' children, shall be reviewed by the tribunal before approval.

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- (ii) No hearing shall be required as to the amount of child support awarded in such cases. However, the tribunal shall use the Guidelines in reviewing the adequacy of child support obligations negotiated by the parties, including provisions for medical care, and, if the negotiated agreement does not comply with the Guidelines or contain the findings of fact necessary to support a deviation, the tribunal shall reject the agreement.
 - (iii) In such stipulations, the order approving the agreement or parenting plan or other document:
 - (I) Shall establish a specific numerical dollar figure for support to be paid at specified intervals (weekly, bi-weekly, semi-monthly, monthly). The final child support order shall not be expressed as a percentage of the parent's income.
 - (II) If the agreement does not state the amount of support calculated under the Guidelines, the order of the tribunal approving the agreement shall state the amount of support proposed in the agreement and the guideline amount and shall provide in writing:
 - I. The reasons the tribunal deviated from the presumptive amount of child support that would have been paid pursuant to the Guidelines;
 - II. The amount of child support that would have been required under the Guidelines if the presumptive amount had not been rebutted; and
 - III. A finding by the tribunal that states how, in its determination,
 - A. Application of the Guidelines would be unjust or inappropriate in the particular case before the tribunal; and
 - B. The best interests of the child or children who are subject to the support award determination are served by deviation from the presumptive guideline amount.
- 2. Paternity determinations;
 - 3. Actions involving orders for custody of a child, whether in state trial or juvenile tribunals, including actions where the State is seeking, or is given, custody of a child due to abuse, dependency, delinquency or unruliness of the child, or in any case in which legal or physical custody of the child is transferred to a private or public agency or entity for any other reason;
 - 4. Domestic violence orders of protection;
 - 5. Any other actions in which the provision of support for children is established by law; and
 - 6. Actions seeking interstate enforcement of support orders for any of the reasons in parts 1-5 above.

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- (c) Pursuant to 42 U.S.C. § 654(6)(A) and 45 C.F.R § 302.56(f), these Child Support Guidelines apply whether the order sought to be established, modified or enforced is for a period preceding October 13, 1989, which was the effective date of the mandatory Child Support Guidelines initially established by federal and state law, or subsequent to such date.
 - 1. The order of the judicial or administrative tribunal must comply with the criteria established by these rules.
 - 2. The order must state a specific dollar amount of support that is to be paid by the responsible party on a weekly, bi-weekly, semi-monthly or monthly basis. The final child support order shall not be expressed as a percentage of the parent's income.
- (3) The major goals in the development and application of these Guidelines are, to the extent possible, to:
 - (a) Decrease the number of impoverished children living in single parent families;
 - (b) Make child support awards more equitable by ensuring more consistent treatment of persons in similar circumstances while ensuring that the best interests of the child in the case before the tribunal are taken into consideration;
 - (c) Improve the efficiency of the tribunal process by promoting settlements and by giving tribunals and parties guidance in establishing appropriate levels of support awards;
 - (d) Encourage parents paying support to maintain contact with their child;
 - (e) Ensure that, when parents live separately, the economic impact on the child is minimized, and, to the extent that either parent enjoys a higher standard of living, the child shares in that higher standard;
 - (f) Ensure that a minimum amount of child support is set for parents with a low income in order to maintain a bond between the parent and the child, to establish patterns of regular payment, and to enable the child support enforcement agency and party receiving support to maintain contact with the parent paying support; and
 - (g) Allocate a parent's financial child support responsibility from the parent's income among all of the parent's children for whom the parent is legally responsible in a manner that gives equitable consideration, as defined by the Department's Guidelines, to children for whom support is being set in the case before the tribunal and to other children for whom the parent is legally responsible and supporting.
- (4) These Guidelines are a minimum base for determining child support obligations. The presumptive child support order may be increased according to the best interest of the child for whom support is being considered, the circumstances of the parties, and the rules of this chapter.

Authority: T.C.A. §§ 4-5-202; 36-5-101(e); 37-1-151; 71-1-105(12), (16); 71-1-132; 42 U.S.C. §§ 654, 667; 45 C.F.R. § 302.56.

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1240-2-4-.02 DEFINITIONS.

- (1) “Adjusted Gross Income” — The Adjusted Gross Income (AGI) is the net determination of a parent’s income, calculated by deducting from that parent’s gross income the following amounts:
 - (a) Any applicable self-employment taxes being paid by the parent; and
 - (b) Credits for the individual parent’s other children for whom the parent is legally responsible and actually supporting.
- (2) “Adjusted Support Obligation” — The adjusted support obligation (ASO) is the Basic Child Support Obligation (BCSO) from the Child Support Schedule (CS Schedule), adjusted for parenting time as set forth in these Rules, health care insurance, work-related childcare expenses, and uninsured medical expenses.
- (3) “Adjustments for Additional Expenses” — The additional expenses associated with the cost of health care insurance for the child, work-related childcare, and uninsured medical expenses are not included in the Basic Child Support Obligation (BCSO) and must be added to the BCSO to determine the Adjusted Support Obligation (ASO).
- (4) “Alternate Residential Parent (ARP)” — The “alternate residential parent” (ARP) is the parent with whom the child resides less than fifty percent (50%) of the time.
- (5) “Basic Child Support Obligation” — The Basic Child Support Obligation (BCSO) is the amount of support displayed on the Child Support Schedule (CS Schedule) which corresponds to the combined Adjusted Gross Income (AGI) of both parents and the number of children for whom support is being determined. This amount is rebuttably presumed to be the appropriate amount of basic child support to be provided by both parents in the case immediately under consideration, prior to consideration of any adjustments for parenting time and/or additional expenses.
- (6) “Caretaker” — The person or entity providing care and supervision of a child more than fifty percent of the time. The caretaker is the child’s Primary Residential Parent. The caretaker may be a parent of the child, a non-parent relative of the child who voluntarily or, pursuant to tribunal order or other legal arrangement, is providing care and supervision of the child (for example, the child’s grandparent). A caretaker may also be a private or public agency providing custodial care and supervision for the child through voluntary placement by the child’s parent, non-parent relative, or other designated caretaker, or by court order or other legal arrangement (for example, a foster parent).
- (7) “Child” — “Child” includes the plural “children,” and “children” includes the singular “child,” where the context requires. For purposes of this chapter, “child” means:
 - (a) A person, not otherwise emancipated, who is less than eighteen (18) years of age or a person who reaches eighteen (18) years while in high school until the person graduates from high school or until the class of which the person is a member when the person attains eighteen (18) years of age graduates, whichever occurs last; or
 - (b) A person who is disabled pursuant to T.C.A. § 36-5-101(p).
- (8) “Child Support Schedule” — The Child Support Schedule (CS Schedule or Schedule) is a chart which displays the dollar amount of the basic child support obligation (BCSO) corresponding to

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various levels of combined Adjusted Gross Income of the children's parents and the number of children for whom a child support order is being established or modified. The Schedule shall be used to calculate the basic child support obligation (BCSO), according to the rules in this chapter. Deviations from the Schedule shall comply with the requirements of 1240-2-4-.07.

- (9) "Combined Adjusted Gross Income" — The amount of Adjusted Gross Income calculated by adding together the AGI of both parents. This amount is then used to determine the BCSO for both parents for the number of children for whom support is being calculated in the case immediately under consideration.
- (10) "Days" — For purposes of this chapter, a "day" of parenting time occurs when the child spends more than twelve (12) consecutive hours in a twenty-four (24) hour period under the care, control or direct supervision of one parent or caretaker. The twenty-four (24) hour period need not be the same as a twenty-four (24) hour calendar day. Accordingly, a "day" of parenting time may encompass either an overnight period or a daytime period, or a combination thereof.
- (11) "Department" — The Tennessee Department of Human Services.
- (12) "Fifty-Fifty Parenting" — For purposes of this chapter, parenting is fifty-fifty (50-50) when the parents of the child each have fifty percent (50%) of the parenting time for that child. On the Child Support Worksheet, each parent will be designated as having one hundred eighty-two point five (182.5) days with the child. Fifty-fifty parenting is a form of standard parenting.
- (13) "Final Child Support Order" — The presumptive child support order (PCSO) adjusted by any deviations ordered by the tribunal.
- (14) "Legally Responsible for a Child" — For purposes of this chapter, a person is "legally responsible for a child" or legally obligated for a child or children when the child is or has been:
 - (a) Born of the parent's body;
 - (b) Born of the parents' marriage if the child is born during the marriage or within three hundred (300) days after termination of the marriage by death, annulment, declaration of invalidity, or divorce;
 - (c) The legally adopted child of the parent;
 - (d) Voluntarily acknowledged by the parent as the parent's child pursuant to T.C.A. § 24-7-113 or pursuant to the voluntary acknowledgement procedure of any other state or territory that comports with Title IV-D of the Social Security Act; or
 - (e) Determined to be the child of the parent by any tribunal of this State, any other state or territory, or a foreign country pursuant to a reciprocal agreement or treaty.
- (15) "Parent" — For purposes of this chapter, "parent" means a person who:
 - (a) Gave birth to the child;
 - (b) Was married to the mother of the child at the time of the birth of the child or within three hundred (300) days after termination of the marriage by death, annulment, declaration of invalidity, or divorce;
 - (c) Legally adopted the child;

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- (d) Voluntarily acknowledged the child pursuant to T.C.A. § 24-7-113 or pursuant to the voluntary acknowledgement procedure of any other state or territory of the United States that comports with Title IV-D of the Social Security Act; or
 - (e) Has been determined to be a parent of the child by any tribunal of this State, any other state or territory, or a foreign country pursuant to a reciprocal agreement or treaty.
- (16) “Parenting Time Adjustment” — Adjustment to the ARP’s portion of the BCSO based upon the ARP’s days with the child.
- (17) “Percentage of Income” — The Percentage of Income (PI) for each parent is obtained by dividing each parent’s Adjusted Gross Income [see paragraph (1) above] by the combined total of both parents’ AGI. The PI is used to determine each parent’s pro rata share of the Basic Child Support Obligation (BCSO), as well as each parent’s share of the amount of additional expense for health insurance, work-related childcare, and uninsured medical expenses.
- (18) “Presumptive Child Support Order.”
- (a) The “Presumptive Child Support Order” (PCSO) is the amount of support to be paid for the child derived from the parent’s proportional share of the basic child support obligation, adjusted for parenting time, plus the parent’s proportional share of any additional expenses.
 - (b) This amount is rebuttably presumed to be the appropriate child support order.
- (19) “Primary Residential Parent (PRP).”
- (a) The “primary residential parent” (PRP) is the parent with whom the child resides more than fifty percent (50%) of the time. The PRP also refers to the parent designated as such by T.C.A. § 36-6-402 and, if not determined by these rules, the parent designated as such by the tribunal.
 - (b) A non-parent caretaker that has been given physical custody of the child is the child’s PRP for the purposes of these rules.
 - (c) If each parent spends exactly fifty percent (50%) of the time with the child, then the tribunal shall designate the parent with the child support obligation as the ARP and the other parent as the PRP.
 - (d) If a primary residential parent has not been designated, the caretaker with whom the child resides more than fifty percent (50%) of the time will be the primary residential parent.
- (20) “Pro rata.”
- (a) For the purposes of this chapter, “pro rata” refers to the proportion of one parent’s Adjusted Gross Income to both parents’ combined Adjusted Gross Income, or to the proportion of one parent’s support obligation to the whole support obligation.
 - (b) A parent’s pro rata share of income is calculated by combining both parents’ Adjusted Gross Income and dividing each parent’s separate Adjusted Gross Income by the combined Adjusted Gross Income.

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- (c) A parent's pro rata share of the basic support obligation is calculated by multiplying the basic child support obligation obtained from the Child Support Schedule by each parent's pro rata percentage of the combined Adjusted Gross Income.

- (21) "Split Parenting"— For purposes of this chapter, the term "split parenting" can only occur in a child support case if there are two (2) or more children of the same parents, where one (1) parent is PRP for at least one (1) child of the parents, and the other parent is PRP for at least one (1) other child of the parents. In a split parenting case, each parent is the PRP of any child spending more than fifty percent (50%) of the time with that parent and is the ARP of any child spending more than fifty percent (50%) of the time with the other parent. A split parenting situation will have two (2) PRPs and two (2) ARPs, but no child will have more than one (1) PRP or ARP.

- (22) "Standard Parenting" — For purposes of this chapter, "standard parenting" refers to a child support case in which all of the children supported under the order spend more than fifty percent (50%) of the time with the same PRP. There is only one (1) PRP and one (1) ARP in a standard parenting case. Standard parenting also includes situations in which the child spends equal amounts of time with each parent.

- (23) "Theoretical Support Order" or "Theoretical Order" — A theoretical support order is a hypothetical order which allows the finder of fact to determine the amount of a child support obligation if an order existed. In these rules, a theoretical order is used to determine the amount of credit allowed as a deduction from a parent's gross income for a parent's qualified other children who are receiving support from that parent, whether or not the support is provided pursuant to a child support order.

- (24) "Tribunal" — A judicial or administrative body or agency granted legal authority to determine disputed issues within its jurisdiction including, but not limited to, the establishment, modification, or enforcement of child support and paternity issues.

- (25) "Uninsured Medical Expenses" — For the purposes of this chapter, the child's uninsured medical expenses include, but are not limited to, health insurance co-payments, deductibles, and such other costs as are reasonably necessary for orthodontia, dental treatment, asthma treatments, physical therapy, vision care, and any acute or chronic medical/health problem, or mental health illness, including counseling and other medical or mental health expenses, that are not covered by insurance.

- (26) "Work-Related Childcare Costs."
 - (a) For the purposes of this chapter, work-related childcare costs mean expenses for the care of the child for whom support is being determined which are due to employment of either parent.

 - (b) In an appropriate case, the tribunal may consider the childcare costs associated with a parent's job search or the training or education of either parent necessary to obtain a job or enhance earning potential, not to exceed a reasonable time as determined by the tribunal, if the parent proves by a preponderance of the evidence that the job search, job training, or education will benefit the children being supported.

 - (c) Childcare costs shall be projected for the next consecutive twelve (12) months and averaged to obtain a monthly amount.

Authority: T.C.A. §§ 4-5-202; 36-5-101(e); 71-1-105(12), (16); 71-1-132; 42 U.S.C. § 667; 45 C.F.R. § 302.56.

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1240-2-4-.03 THE INCOME SHARES MODEL.

- (1) General Basis.
 - (a) The Tennessee Child Support Guidelines are based on an Income Shares Model. This model presumes that both parents contribute to the financial support of the child in pro rata proportion to the actual income available to each parent.
 - (b) The Income Shares model differs from the Department's prior Flat Percentage model, established in 1989, which calculated the amount of the child support award based upon the net income of the non-custodial or alternate residential parent and which assumed an equivalent amount of financial or in-kind support was being supplied to the child by the custodial or primary residential parent. Although federal law requires consideration of only the income of the alternate residential parent, under the Income Shares model, both parents' actual income and actual additional expenses of rearing the child are considered and made part of the support order.
- (2) The Income Shares model for determining the amount of child support is predicated on the concept that the child should receive support at the same level that the child would receive if the parents were living together. While expenditures of two-household divorced, separated, or single parent families are different from intact family households, it is very important that the children of this State, to the extent possible, not be forced to live in poverty because of family disruption, and that they be afforded the same opportunities available to children in intact families consisting of parents with similar financial means to those of their own parents.
- (3) A number of authoritative economic studies measuring average child-rearing expenditures among families indicate that, although the average dollar amount devoted to child-rearing expenditures increases as the parents' incomes increase, the average percentage of parents' income devoted to child-rearing expenditures decreases as the parents' incomes increase. These studies also indicate that child-rearing expenditures in families are generally greater than what is minimally necessary to provide for the child's basic survival needs but, instead, are made in proportion to household income. These studies measure total, average child-rearing expenditures while also recognizing that household spending on behalf of children is intertwined with spending on adults for most large expenditure categories (e.g., housing, transportation) and that these expenditures cannot be disentangled, even with exhaustive financial affidavits from the parties.
- (4) The Income Shares model, which is used by over thirty (30) other states, is generally based on economic studies of child-rearing costs, including those of David Betson, Erwin Rothbarth, and Ernst Engel, and studies conducted by the United States Department of Agriculture and the United States Department of Labor's Bureau of Labor Statistics involving expenditures for the care of children.
- (5) The Child Support Guidelines established by this chapter were developed based upon:
 - (a) Studies of child-rearing costs conducted by David Betson, Erwin Rothbarth, and Ernst Engel which utilized information on child-rearing costs conducted by the United States Department of Agriculture and the United States Department of Labor's Bureau of Labor Statistics;
 - (b) Comments on these Guidelines by advocacy groups, judges, child support referees, attorneys, legislators, Title IV-D child support contractors and staff of the Tennessee

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Department of Human Services, and oral and written comments resulting from public hearings;

- (c) The work and input of the Tennessee Department of Human Services' Child Support Guidelines Task Force established in 2002. The Task Force was established to assist the Department in reviewing and considering changes to the existing Child Support Guidelines that were originally adopted in 1989 and based upon the Flat Percentage Model;
 - (d) Review of the child support guidelines of other states; and
 - (e) Recommendations made to states generally by the United States Office of Child Support Enforcement regarding measurements of child-rearing costs and their use in establishing child support guidelines.
- (6) Assumptions and Methodology Used in the Income Shares Model.
- (a) Determination of the Basic Child Support Obligation.
 - 1. The Income Shares Model incorporates a numerical schedule, designated in these Guidelines as the Child Support Schedule (CS Schedule or Schedule), found in Rule 1240-2-4-.09, that establishes the dollar amount of child support obligations corresponding to various levels of parents' combined Adjusted Gross Income and the number of children for whom the child support order is being established or modified.
 - 2. The Schedule is used to determine the basic child support obligation (BCSO), according to the rules in this chapter.
 - 3. Each parent's share of the BCSO is determined by prorating the child support obligation between the parents in the same ratios as each parent's individual Adjusted Gross Income is to the combined Adjusted Gross Income.
 - 4. The minimum BCSO upon which a child support obligation may be established is one hundred dollars (\$100) per month. The tribunal may deviate below this minimum BCSO in appropriate situations. See Rule 1240-2-4-.07(2)(f)6.
 - 5. If custody or guardianship of a child is awarded to a person or entity other than a parent of the child as defined in 1240-2-4-.02(14), the child support obligation shall be calculated on the Worksheet according to the rules for standard parenting, and each parent will be responsible for paying his/her share of the final obligation to the non-parent caretaker of the child. If only one parent is available, then that parent's income alone is considered in establishing the child support award. The income of a non-parent caretaker is not considered. If the tribunal is able to order both parents to pay support for the children, the tribunal may assign each parent a pro rata share of the additional expenses.
 - (b) Child Support Schedule Assumptions.
 - 1. The Child Support Schedule is based on the combined Adjusted Gross Income of both parties.
 - 2. Taxation Assumptions.

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- (i) All income is earned income subject to federal withholding and the Federal Insurance Contributions Act (FICA/Social Security).
 - (ii) The alternate residential parent will file as a single wage earner claiming one withholding allowance, and the primary residential parent claims the tax exemptions for the child.
 - (iii) The Schedule's combined obligation includes the tax adjustments for federal withholding and the Federal Insurance Contributions Act (FICA/Social Security).
3. The Schedule is based upon the 1996-1999 Consumer Expenditures Survey, conducted by the U.S. Bureau of Labor Statistics, and updated to 2003 levels by adjusting for the rise in the Consumer Price Index since 1996.
4. Basic Expenses.
- (i) The Schedule assumes that all families incur certain child-rearing expenses and includes in the basic child support obligation (BCSO) an average amount to cover these expenses for various levels of the parents' combined income and number of children. The bulk of these child-rearing expenses is comprised of housing, food, and transportation. The share of total expenditures devoted to clothing and entertainment are also included in the BCSO, but are relatively small compared to the other three items.
 - (ii) Basic educational expenses associated with the academic curriculum for a public school education, such as fees, books, and local field trips, are also included in the BCSO as determined by the CS Schedule.
 - (iii) The BCSO does not include the child's health insurance premium, work-related childcare costs, the child's uninsured medical expenses, special expenses, or extraordinary educational expenses because of the highly variable nature of these expenses among different families.
5. Extraordinary Education Expenses.
- (i) Extraordinary education expenses including, but not limited to, tuition, room and board, fees, books, and other reasonable and necessary expenses associated with special needs education or private elementary and secondary schooling are not included in the basic child support schedule.
 - (ii) Extraordinary educational expenses may be added to the presumptive child support order as a deviation.
6. Special Expenses.
- (i) Special expenses include, but are not limited to, summer camp, music or art lessons, travel, school-sponsored extra-curricular activities, such as band, clubs, and athletics, and other activities intended to enhance the athletic, social or cultural development of a child that do not otherwise qualify as mandated expenses like health insurance premiums and work-related childcare costs.

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- (ii) Special expenses incurred for child rearing which are quantified shall be considered and may be added by the tribunal to the PCSO as a deviation when this category of expenses exceeds seven percent (7%) of the monthly Basic Child Support Obligation (BCSO).
- (c) In the Income Shares model, it is presumed that the primary residential parent (PRP) spends his or her share of the child support obligation directly on the child and that the alternate residential parent's (ARP) share is only one component of the total child support obligation. This presumption is rebutted in some cases where the parenting time of the ARP is very high, and the percentage of income of the ARP is very low.
- (d) Adjustments for Required Expenses.
 - 1. In addition to basic support set forth in the Schedule, the child support award shall include adjustments that account for each parent's pro rata share of the child's health insurance premium costs, uninsured medical expenses, and work-related childcare costs, as provided in 1240-2-4-.04(7).
 - 2. These costs are not included in the Child Support Schedule because they are highly variable among cases.
- (e) Parenting Time Adjustment.
 - 1. These Guidelines presume that, in Tennessee, when parents live separately, the children will typically reside primarily with one parent, the PRP, and stay with the other parent, the ARP, a minimum of every other weekend from Friday to Sunday, two (2) weeks in the summer, and two (2) weeks during holidays throughout the year, for a total of eighty (80) days per year. The Guidelines also recognize that some families may have different parenting situations and, thus, allow for an adjustment in the child support obligation, as appropriate, in compliance with the criteria specified below. The calculations made for each parenting situation are based on specific factual information regarding the amount of time the ARP spends with the child.
 - 2. In cases of split parenting, both parents are eligible for a parenting time adjustment for the child(ren) for whom the parent is the ARP.
 - 3. The automated child support worksheet provided by the Department will automatically calculate all parenting time adjustments when the user enters the requested information. No manual calculation is required, however, instructions for manual calculation are provided in these rules.
 - 4. The adjustment is based upon each parent's PI as well as the ARP's number of days of parenting time. No more than one (1) day of credit for parenting time can be taken in any twenty-four (24) hour period, i.e., only one parent can take credit for parenting time in one twenty-four (24) hour period. Except in extraordinary circumstances, as determined by the tribunal, partial days of parenting time that are not consistent with this definition shall not be considered a "day" under these Guidelines. An example of extraordinary circumstances would include a parenting situation where the ARP is scheduled to pick up the child after school three (3) or more days a week and keep the child until eight (8) o'clock p.m. This three (3) day period of routinely incurred parenting time of shorter duration may be cumulated as a single day for parenting time purposes.

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5. If there are multiple children for whom support is being calculated and the ARP is spending a different amount of time with each child, then an average of the ARP's annual parenting time with all of the children in the case under consideration is used for determining the parenting time adjustment. For example, if ARP has sixty-seven (67) days of parenting time per year with Child A, eighty-four (84) days of parenting time per year with Child B, and one hundred thirty-two (132) days of parenting time per year with Child C, then the parenting time adjustment would be calculated based upon ninety-four (94) days of parenting time $[67 + 84 + 132 = 283 / 3 = 94]$. For this purpose, standard rounding rules apply.
6. Parenting Time Adjustments are not mandatory, but presumptive. The presumption may be rebutted in a case where the circumstances indicate the adjustment is not in the best interest of the child. Due to the manner of calculation of the adjustment, it is anticipated in a case where the PRP has greater income than the ARP and the ARP has a high level of parenting time with the child that support may be due from the PRP to the ARP to assist with the expenses of the children during the times spent with the ARP.
7. Reduction in Child Support Obligation for Additional Parenting Time.
 - (i) If the ARP spends ninety-two (92) or more days per calendar year with a child, or an average of ninety-two (92) days with all the children supported by this order, but less than fifty percent (50%) of the time, an assumption is made that the alternate residential parent (ARP) is making greater expenditures on the child during his/her parenting time for transferred costs such as food and/or is making greater expenditures for child-rearing expenses for items that are duplicated between the two (2) households (e.g., housing or clothing). A reduction to the ARP's child support obligation may be made to account for these transferred and duplicated expenses, as set forth in this chapter.
 - (ii) Upon reaching the threshold of ninety-two (92) days, a variable multiplier shall be applied to the BCSO, which will increase the amount of the BCSO in relation to the ARP's parenting time, in order to account for the child-rearing expenses incurred by the ARP during parenting time. These additional expenses are divided between the parents according to each parent's PI. The PRP's share of these additional expenses represents an amount owed by the PRP to the ARP and is applied as a credit against the ARP's obligation to the PRP.
 - (iii) The presumption that more parenting time by the ARP results in greater expenditures which should result in a reduction to the ARP's support obligation may be rebutted by evidence.
 - (iv) Calculation of the Parenting Time Credit

The child-rearing expenses incurred by the parents are presumed to increase as the amount of the ARP's parenting time increases. The amount of these expenses is calculated using a variable multiplier.

 - (I) First, the variable multiplier is determined by multiplying .0109589 $[2 / 182.5]$ by the ARP's parenting time determined pursuant to part (e)4 above. For example, the 94 days of parenting

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time calculated in the example from part (e)4 is multiplied by .0109589, resulting in a variable multiplier of 1.0301366 [$94 \times .0109589$].

- (II) Second, the variable multiplier calculated in item (I) above is applied to the amount of the parties' combined BCSO, which results in an adjusted BCSO. For example, application of the variable multiplier determined above for ninety-four (94) days of parenting time to a BCSO of one thousand dollars (\$1000) would result in an adjusted BCSO of one thousand thirty dollars and fourteen cents (\$1030.14).
- (III) Third, the amount of the BCSO is subtracted from the adjusted BCSO. The difference is the child-rearing expenses associated with the ARP's additional parenting time. In the example above, the additional child-rearing expenses associated with the ninety-four (94) days of parenting time would be thirty dollars and fourteen cents (\$30.14) [$\$1030.14 - \1000].
- (IV) The additional child-rearing expenses determined in item (III) above are pro-rated between the parents according to each parent's percentage of income (PI). The PRP's share of these additional expenses is applied as an adjustment against the ARP's share of the BCSO. For instance, if the PRP's PI is forty percent (40%), the PRP's share of the additional expenses in the example above would be twelve dollars and six cents (\$12.06) [$\$30.14 \times 40\%$]. The twelve dollars and six cents (\$12.06) is applied as a credit against the ARP's share of the BCSO, resulting in a child support obligation for the ARP of five hundred eighty-seven dollars and ninety-four cents (\$587.94) [$\$1000 \times 60\% = \$600 - \12.06].

8. Increase in Child Support Obligation for Less Parenting Time.

- (i) If the ARP spends sixty-eight (68) or fewer days per calendar year with the child(ren) in the case, the ARP's child support obligation may be increased for the lack of parenting time. The first step in calculating the increase is to determine the number of days fewer than sixty-nine (69) the ARP spends with the child and then divide this number of days by three hundred sixty-five (365). For example, if the ARP has sixty-eight (68) days of parenting time, the multiplier is 0.002739726 [$69 - 68 = 1; 1/365$].
- (iii) The second step is to multiply the percentage of days by the ARP's share of the BCSO. For example, if the ARP's share of the BCSO is one thousand two hundred dollars (\$1,200), and the parenting time is sixty-eight (68) days, the increased share of support is three dollars and twenty-nine cents (\$3.29) [$0.002739726 \times \$1,200 = \3.29].
- (iv) The increased share of support is added to the ARP's share of the BCSO resulting in the adjusted BCSO. Continuing the example, the ARP's increased BCSO is one thousand two hundred three dollars and twenty-nine cents (\$1,203.29). [$\$1,200 + \3.29]
- (iv) The presumption that less parenting time by the ARP should result in an increase to the ARP's support obligation may be rebutted by evidence.

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7. In an action to modify an existing child support order to reflect a change in parenting time, the parent seeking the credit must also prove a significant variance pursuant to 1240-2-4-.05 when comparing the current order to the proposed order with application of the parenting time adjustment.

(7) Revisions to the Child Support Schedule.

- (a) The CS Schedule will be reviewed every four (4) years by the Department, as required by Federal law, and revised, if necessary, to account for changes in the Basic Support Obligation due to tax changes and/or to account for changes in child rearing costs as reported by the Consumer Expenditures Survey conducted by the U.S. Bureau of Labor Statistics and to reflect authoritative economic studies of child rearing costs. If significant changes in tax laws and child rearing costs warrant, the Department may review and revise the CS Schedule prior to the regular four (4) year review.
- (b) Any revised CS Schedule published subsequent to the first Schedule appearing in Rule 1240-2-4-.09 will be incorporated by rule amendment, provided to the Administrative Office of the Courts for distribution to all Tennessee judicial tribunals, distributed by the Department to its Title IV-D Offices, and posted for use by the public on the Department's website at <http://www.state.tn.us/humanserv/> in the Department's Child Support Division link.

Authority: T.C.A. §§ 4-5-202; 36-5-101(e); 71-1-105(12),(16); 71-1-132; 42 U.S.C. § 667; 45 C.F.R. § 302.56.

1240-2-4-.04 DETERMINATION OF CHILD SUPPORT.

(1) Required Forms.

- (a) These rules contain a Child Support Worksheet, a Credit Worksheet, Instructions for both Worksheets, and the Child Support Schedule which shall be required to implement the child support order determination.
- (b) The use of the Worksheets promulgated by the Department is mandatory in order to ensure uniformity in the calculation of child support awards pursuant to the rules.
- (c) In the event that the language contained in the Worksheets, Instructions, or Schedule conflicts in any way with the language of subchapters 1240-2-4-.01 – .07, the language of those subchapters is controlling.
- (d) The Credit Worksheet shall be used for listing information regarding a parent's qualified other children and/or for calculating the appropriate credit for support provided to a parent's other qualified children.
- (e) The completed Worksheets must be maintained as part of the official record either by filing them as exhibits in the tribunal's file or as attachments to the order.
- (f) Any child support obligation determined by calculations made using the Department Worksheets shall also be reflected in the tribunal's order, together with a description of any additional expenses the parent is to pay as part of the child's support as well as any deviations from the presumptive child support order.

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- (g) Worksheets, Instructions, and the Child Support Schedule, as promulgated by the Department, may be produced by the Department with different formatting and additional highlights for use by the courts, the bar, the public, Department personnel, and the Department's contractors.
- (2) In all cases, the top of the Child Support Worksheet shall be completed with the applicable case identifying information, including the names and dates of birth of the child for whom support is being determined in the case.
- (3) Gross income.
 - (a) Determination of Gross Income.
 - 1. Gross income of each parent shall be determined in the process of setting the presumptive child support order and shall include all income from any source (before deductions for taxes and other deductions such as credits for other qualified children), whether earned or unearned, and includes, but is not limited to, the following:
 - (i) Wages;
 - (ii) Salaries;
 - (iii) Commissions, fees, and tips;
 - (iv) Income from self employment;
 - (v) Bonuses;
 - (vi) Overtime payments;
 - (vii) Severance pay;
 - (viii) Pensions or retirement plans including, but not limited to, Social Security, Veteran's Administration, Railroad Retirement Board, Keoughs, and Individual Retirement Accounts (IRAs);
 - (ix) Interest income;
 - (x) Dividend income;
 - (xi) Trust income;
 - (xii) Annuities;
 - (xiii) Capital gains;
 - (xiv) Disability or retirement benefits that are received from the Social Security Administration pursuant to Title II of the Social Security Act, whether paid to the parent or to the child based upon the parent's account;
 - (xv) Workers compensation benefits, whether temporary or permanent;
 - (xvi) Unemployment insurance benefits;

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- (xvii) Judgments recovered for personal injuries and awards from other civil actions;
- (xviii) Gifts that consist of cash or other liquid instruments, or which can be converted to cash;
- (xix) Prizes;
- (xx) Lottery winnings; and
- (xxi) Alimony or maintenance received from persons other than parties to the proceeding before the tribunal.

2. Imputed Income.

- (i) Imputing additional gross income to a parent is appropriate in the following situations:
 - (I) If a parent has been determined by a tribunal to be willfully and/or voluntarily underemployed or unemployed; or
 - (II) When there is no reliable evidence of income; or
 - (III) When the parent owns substantial non-income producing assets, the court may impute income based upon a reasonable rate of return upon the assets.
- (ii) Determination of Willful and/or Voluntary Underemployment or Unemployment.

The Guidelines do not presume that any parent is willfully and/or voluntarily under or unemployed. The purpose of the determination is to ascertain the reasons for the parent's occupational choices, and to assess the reasonableness of these choices in light of the parent's obligation to support his or her child(ren) and to determine whether such choices benefit the children.

- (I) A determination of willful and/or voluntary under or unemployment is not limited to occupational choices motivated only by an intent to avoid or reduce the payment of child support. The determination may be based on any intentional choice or act that affects a parent's income.
- (II) Once a parent that has been found to be willfully and/or voluntarily under or unemployed, additional income can be allocated to that parent to increase the parent's amount of gross income to an amount which reflects the parent's income potential or earning capacity, and the increased amount shall be used for child support calculation purposes. The additional income allocated to the parent shall be determined using the following criteria:
 - I. The parent's past and present employment; and
 - II. The parent's education and training.

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(III) A determination of willful and voluntary unemployment or underemployment shall not be made when an individual enlists, is drafted, or is activated from a Reserve or National Guard unit, for full-time service in the Armed Forces of the United States.

(iii) Factors to be Considered When Determining Willful and Voluntary Unemployment or Underemployment.

The following factors may be considered by a tribunal when making a determination of willful and voluntary under or unemployment:

(I) The parent's past and present employment;

(II) The parent's education, training, and ability to work;

(III) The state of Tennessee recognizes the role of a stay-at-home parent as an important and valuable factor in a child's life. In considering whether there should be any imputation of income to a stay at home parent, the tribunal shall consider:

I. Whether the parent acted in the role of full-time caretaker while the parents were living in the same household;

II. The length of time the parent staying at home has remained out of the workforce for this purpose; and

III. The age of the minor children.

(IV) A parent's extravagant lifestyle, including ownership of valuable assets and resources (such as an expensive home or automobile), that appears inappropriate or unreasonable for the income claimed by the parent;

(V) The parent's role as caretaker of a handicapped or seriously ill child of that parent, or any other handicapped or seriously ill relative for whom that parent has assumed the role of caretaker which eliminates or substantially reduces the parent's ability to work outside the home, and the need of that parent to continue in that role in the future;

(VI) Whether unemployment or underemployment for the purpose of pursuing additional training or education is reasonable in light of the parent's obligation to support his/her children and, to this end, whether the training or education will ultimately benefit the child in the case immediately under consideration by increasing the parent's level of support for that child in the future;

(VII) Any additional factors deemed relevant to the particular circumstances of the case.

(iv) Imputing Income When There is No Reliable Evidence of Income.

(I) When Establishing an Initial Order.

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- I. If a parent fails to produce reliable evidence of income (such as tax returns for prior years, check stubs, or other information for determining current ability to support or ability to support in prior years for calculating retroactive support); and
- II. The tribunal has no reliable evidence of the parent's income or income potential;
- III. Then, in such cases, gross income for the current and prior years shall be determined by imputing annual gross income of thirty-six thousand three hundred sixty-nine dollars (\$36,369) for male parents and twenty-six thousand nine hundred eighty-nine dollars (\$26,989) for female parents. These figures represent the full time, year round workers' median gross income, for the Tennessee population only, from the American Community Survey of 2004 from the U.S. Census Bureau.

(II) When Modifying an Existing Order

- I. If a parent fails to produce reliable evidence of income (such as tax returns for prior years, check stubs, or other information for determining current ability to support); and
- II. The tribunal has no reliable evidence of that parent's income or income potential;
- III. Then the tribunal shall calculate the basic child support obligation after increasing the gross income of the parent failing or refusing to produce evidence of income by an increment not to exceed ten percent (10%) per year for each year since the support order was entered or last modified.
- IV. If the order to be modified is not an income shares order, and the parent who fails or refuses to provide reliable evidence of income was not required to produce evidence of income under the prior order, the tribunal shall determine that parent's income under the directions of subpart (iv)(I) above.

(III) In either circumstance in subpart (iv)(I) or (II) above, upon motion to the tribunal served upon all interested parties pursuant to the Tennessee Rules of Civil Procedure, the parent may provide the reliable evidence necessary to determine the appropriate amount of support based upon this reliable evidence. Under this circumstance, the parent is not required to demonstrate the existence of a significant variance otherwise required for modification of an order under 1240-2-4-.05. In ruling on a proper motion, the tribunal may modify the amount of current support prospectively.

(IV) Arrearages accrued or retroactive amounts due under an order based upon imputed income shall not be forgiven or modified under this section.

3. Self-Employment Income.

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- (i) Income from self employment includes income from, but not limited to, business operations, work as an independent contractor or consultant, sales of goods or services, and rental properties, etc., less ordinary and reasonable expenses necessary to produce such income.
 - (ii) Ordinary and Reasonable Expenses of Self Employment Necessary to Produce Income.
 - (I) Excessive promotional, excessive travel, excessive car expenses or excessive personal expenses, or depreciation on equipment, the cost of operation of home offices, etc., shall not be considered reasonable expenses.
 - (II) Amounts allowed by the Internal Revenue Service for accelerated depreciation or investment tax credits shall not be considered reasonable expenses.
4. Fringe Benefits.
- (i) Fringe benefits for inclusion as income or “in-kind” remuneration received by a parent in the course of employment, or operation of a trade or business, shall be counted as income if they reduce personal living expenses.
 - (ii) Such fringe benefits might include, but are not limited to, company car, housing, or room and board.
 - (iii) Basic Allowance for Housing (BAH), Basic Allowance for Subsistence (BAS), and Variable Housing Allowances (VHA) for service members are considered income for the purposes of determining child support.
 - (iv) Fringe benefits do not include employee benefits that are typically added to the salary, wage, or other compensation that a parent may receive as a standard added benefit (e.g., employer-paid portions of health insurance premiums or employer contributions to a retirement or pension plan).
5. Social Security Title II Benefits.
- (i) Social Security Title II benefits received by a child on the parent’s account shall be included as income to that parent and counted as child support payments due from that parent upon whose account the child’s benefit is drawn, to be applied against the support obligation ordered to be paid by that parent. The child’s benefit is only considered when it springs from the parent’s account. For example, if a child is drawing benefits from the Mother’s Social Security account, the amount of the child’s benefit is added to the Mother’s income, and the amount of the child’s benefit is subtracted from the Mother’s child support obligation. If the child’s benefit is drawn from the child’s own disability, the child’s benefit is not added to either parent’s income and not deducted from either parent’s obligation.
 - (ii) Child Support Greater Than Social Security Benefit.

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If after calculating the parent's gross income as defined in 1240-2-4-.04(3), including the countable Social Security benefits in subpart 5(i) above, and after calculating the amount of the child support obligation using the Child Support Worksheet, the amount of the child support award due from the parent whose benefits are supplying the support is greater than the Social Security benefits paid on behalf of the child on that parent's account, then that parent shall be required to pay the amount exceeding the Social Security benefit as part of the child support award in the case.

- (iii) Child Support Equal to or Less Than Social Security Benefits.
 - (I) If after calculating the parent's gross income as defined in 1240-2-4-.04(3), including the countable Social Security benefits paid for the child, referred to in subpart 5(i) above, and after calculating the amount of the child support obligation using the Child Support Worksheet, the amount of the child support award due from the parent whose benefits are supplying the support is equal to or less than the Social Security benefits paid to the caretaker on behalf of the child on that parent's account, the child support obligation of that parent is met and no additional child support amount must be paid by that parent.
 - (II) Any Social Security Title II benefit amounts as determined by the Social Security Administration and sent to the caretaker by the Social Security Administration for the child's benefit which are greater than the support ordered by the tribunal shall be retained by the caretaker for the child's benefit and shall not be used as a reason for decreasing the child support order or reducing arrearages.
 - (iv) The tribunal shall make a written finding in the support order regarding the use of the Social Security benefits in the calculation of the child support obligation.
- (b) Variable income such as commissions, bonuses, overtime pay, dividends, etc. shall be averaged over a reasonable period of time consistent with the circumstances of the case and added to a parent's fixed salary or wages to determine gross income.
 - (c) Excluded from gross income are the following:
 - 1. Child support payments received by either parent for the benefit of children of another relationship; or
 - 2. Benefits received from means-tested public assistance programs such as, but not limited to:
 - (i) Families First, Temporary Assistance for Needy Families (TANF), or similar programs in other states or territories under Title IV-A of the Social Security Act;
 - (ii) Food Stamps or the value of food assistance provided by way of electronic benefits transfer procedures by the Food Stamp agency;
 - (iii) Supplemental Security Income (SSI) received under Title XVI of the Social Security Act;

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- (iv) Benefits received under Section 402(d) of the Social Security Act for disabled adult children of deceased disabled workers; and
 - (v) Low Income Heating and Energy Assistance Program (LIHEAP) payments.
3. The child's income from any source, including, but not limited to, trust income and Social Security benefits drawn on the child's disability.
 4. Adoption Assistance subsidy under Tennessee's Interstate Compact on Adoption Assistance, found at T.C.A. § 36-1-201 et seq. or another state's adoption assistance subsidy which is based on the Adoption Assistance and Child Welfare Act (42 USC 670 et seq.).
- (4) Adjustments to Gross Income for Self-Employed Parents.
- (a) The Child Support Schedule includes deductions from a parent's gross income for the employee's share of the contributions for the first six and two-tenths percent (6.2%) in Federal Insurance Contributions Act (FICA) and one and forty-five hundredths (1.45%) in Medicare taxes. The full tax rate, 15.3%, is a total of 12.4% for social security (old-age, survivors, and disability insurance) and 2.9% for Medicare (hospital insurance). All net earnings of at least \$400 are subject to the Medicare part. Employers pay one-half of an employee's FICA and Medicare taxes.
 - (b) For a self-employed parent who is paying self-employment tax, an amount for FICA — six and two-tenths percent (6.2%) Social Security + one and forty-five hundredths (1.45%) Medicare as of 1991, or any amount subsequently set by federal law as FICA tax — shall be deducted from that parent's gross income earned from self-employment, up to the amounts allowed under federal law, and actually paid by the parent.
 - (c) Social Security tax withholding (FICA) for high-income persons may vary during the year. Six and two-tenths percent (6.2%) is withheld on the first ninety thousand dollars (\$90,000) of gross earnings (for wage earners in 2005). After the maximum five thousand five hundred eighty dollars (\$5,580) is withheld, no additional FICA taxes are withheld.
 - (d) Self-employed persons are required by law to pay the full FICA tax of twelve and four tenths percent (12.4%) up to the ninety thousand dollars (\$90,000) gross earnings limit and the full Medicare tax rate of two and nine tenths percent (2.9%) on all earned income. One half of each amount is already accounted for in the BCSO amounts on the Schedule.
 - (e) Any self-employment tax paid up to the maximum amounts due in a year shall be deducted from gross income as part of the calculation of a parent's Adjusted Gross Income, as indicated in Part II of the CS Worksheet.
 - (f) When calculating credits for other qualified children under paragraph (5) below, any self-employment tax paid shall also be deducted on the Credit Worksheet from a parent's gross income for the purposes of calculating a theoretical child support order.
 - (g) The percentages and dollar amounts established or referenced in this paragraph (4) with respect to the payment of self-employment taxes shall be adjusted by the Department or by the tribunal, as necessary, as relevant changes occur in the federal tax laws.
- (5) Adjustments to Gross Income for Qualified Other Children.

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- (a) In addition to the adjustments to gross income for self-employment tax provided in 1240-2-4-.04(4) above, credits for either parent's other children, who are qualified under this subparagraph, shall be considered by the tribunal for the purpose of reducing the parent's gross income. Adjustments are available for a child:
 - 1. For whom the parent is legally responsible; and
 - 2. The parent is actually supporting; and
 - 3. Who is not before the tribunal to set, modify, or enforce support in the case immediately under consideration.
- (b) Children for whom support is being determined in the case under consideration, step-children, and other minors in the home that the parent has no legal obligation to support shall not be considered in the calculation of this credit.
- (c) To consider a parent's qualified other children for credit, a parent must present documentary evidence of the parent-child relationship to the tribunal. By way of example, and not by limitation, documentary evidence could include a birth certificate showing the child's name and the parent's name, or a court order establishing the parent-child relationship.
- (d) Use of Credits.
 - 1. Credits against income are available for all of the parent's other children who meet the qualifications in subparagraph (a) above including, but not limited to: a child being supported in the parent's home; a child being supported by the parent under a child support order in another case; and/or a child who does not live in the parent's home and is receiving support from the parent, but not pursuant to a court order.
 - 2. Credits against income for other qualified children are calculated and recorded on the Credit Worksheet and then entered on the Child Support Worksheet for the purpose of reducing the parent's gross income on the Child Support Worksheet. However, the credit amounts are not subtracted from the parent's gross income on the Credit Worksheet when calculating a theoretical child support under this paragraph (5).
- (e) Calculation of Credit for Qualified Other Children.
 - 1. "In-Home" Children.
 - (i) To receive a credit against gross income for qualified other children whose primary residence is with the parent seeking credit, but who are not part of the case being determined, the parent must establish a legal duty of support and that the child resides with the parent fifty percent (50%) or more of the time.
 - (l) By way of example, and not by limitation, documents that may be used to establish that the parent and child share the same residence include the child's school or medical records showing the child's address and the parent's utility bills mailed to the same address, court orders reflecting the parent is the primary residential parent or that the parent shares the parenting time of the child 50% of the time.

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- (II) Children may be deemed to be living in the parent's household though living away from the parent to attend private school [Kindergarten through grade 12].
 - (ii) The available credit against gross income for either parent's qualified "in-home" children is seventy-five percent (75%) of a theoretical support order calculated according to these Guidelines, using the Credit Worksheet, the parent's gross income less any self-employment taxes paid, the total number of qualified other children living in the parent's home, and the Schedule.
2. "Not-In-Home" Children.
- (i) To receive a credit against gross income for child support provided for qualified other children whose primary residence is not in the home of the parent seeking credit, that is, the child resides with this parent less than fifty percent (50%) of the time, the parent must establish the legal duty of support and provide documented proof of support paid for the other child consistently over a reasonable and extended period of time prior to the initiation of the proceeding that is immediately under consideration by the tribunal, but in any event, such time period shall not be less than twelve (12) months.
 - (ii) "Documented proof of support" includes:
 - (I) Physical evidence of monetary payments to the child's caretaker, such as canceled checks or money orders.
 - (II) Evidence of payment of child support under another child support order, such as a payment history from a tribunal clerk or child support office or from the Department's internet child support payment history.
 - (III) Evidence of "in kind" remuneration such as food, clothing, diapers or formula which has been reduced to a monetary amount approved by the court in the qualified other child's case or affirmed by the receiving parent in the other case.
 - (iii) The available credit against gross income for either parent's qualified "not-in-home" children is the actual documented monetary support of the qualified other children, averaged to a monthly amount of support paid over the most recent twelve (12) month period up to a maximum of seventy-five percent (75%) of a theoretical support order calculated according to these Guidelines, using the Credit Worksheet, the parent's gross income less any self-employment taxes paid, the total number of qualified other children living less than 50% of the time in the parent's home, and the Schedule.
3. The credits allowed pursuant to this subparagraph shall be calculated according to the instructions in this chapter alone, using the Credit Worksheet.
4. The amount of a theoretical order allowed as a credit against gross income under part 1 or 2 above is subject to the limitation of 1240-2-4-.07(2)(g).
5. An order may be modified to reflect a change in the number of children for whom a parent is legally responsible only upon compliance with the significant variance requirement of 1240-2-4-.05.

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(6) The Schedule of Basic Child Support Obligations.

(a) Rule 1240-2-4-.09 contains the Schedule of Basic Child Support Obligations (BCSO). The Schedule of Basic Child Support Obligations (the “Child Support Schedule” or “CS Schedule”) shall be used to determine the combined obligation of both parents for the support of their children based upon their monthly combined Adjusted Gross Income and the number of children who are the subject of the child support determination. The CS Schedule, in chart form, displays the amount of the BCSO prior to adjustments for parenting time and additional expenses and is presumed correct for the combined income of the parents and the number of children for whom support is being determined.

(b) Rounding Rule for Determination of BCSO.

When the combined Adjusted Gross Income falls between amounts shown in the Schedule, round up to the next amount of combined Adjusted Gross Income. The rounded-up number shall be used to determine the BCSO from the CS Schedule for the number of children for whom support is being determined.

(7) Adjustments for Additional Expenses.

(a) The CS Schedule does not include the cost of the child’s health insurance premium, uninsured medical expenses, or work-related childcare costs.

1. The additional expenses for the child’s health/dental insurance premium, uninsured medical expenses, and work-related childcare shall be included in the calculations to determine child support.
2. The amount of the cost for the child’s health insurance premium, uninsured medical expenses, and work-related childcare shall be determined as indicated below in subparagraphs (b), (c), and (d) and added to the BCSO as “Additional Expenses” or “add-ons,” whether paid directly by the parent or through a payroll deduction.
3. The total amount of the cost for the child’s health insurance premium, uninsured medical expenses, and work-related childcare shall be divided between the parents pro rata based upon the PI of each parent to determine the total Presumptive Child Support Order and shall be included in the written order of the tribunal together with the amount of the BCSO.

(b) Health Insurance Premiums.

1. If health and/or dental insurance that provides for the health care needs of the child can be obtained by a parent at reasonable cost, then an amount to cover the cost of the premium shall be added to the BCSO as indicated above in subparagraph (a). A health insurance premium paid by a non-parent caretaker shall be included when determining the amount of this expense. A health insurance premium paid by a step-parent shall not be included.
2. In determining the amount to be added to the order for this cost, only the amount of the insurance cost attributable to the children who are the subject of the support order shall be included.
3. If coverage is applicable to other persons and the amount of the health insurance premium attributable to the child who is the subject of the current action for support

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is not available to be verified, the total cost to the parent paying the premium shall be pro rated by the number of persons covered so that only the cost attributable to the children who are the subject of the order under consideration is included. Enter the monthly cost on the Child Support Worksheet in the Column of the parent paying the premium. If health insurance coverage is provided for the children at issue at no additional cost to the parent, no amount for this expense should be included on the Worksheet.

4. Eligibility for or enrollment of the child in TennCare shall not satisfy the requirement that the child support order provide for the child's health care needs.

(c) Work-Related Childcare Expenses.

1. Childcare expenses necessary for either parent's employment, education, or vocational training that are determined by the tribunal to be appropriate, and that are appropriate to the parents' financial abilities and to the lifestyle of the child if the parents and child were living together, shall be averaged for a monthly amount and entered on the Worksheet in the column of the parent initially paying the expense. Work-related childcare expenses of a non-parent caretaker shall be considered when determining the amount of this expense.
2. If a childcare subsidy is being provided pursuant to a means-tested public assistance program, only the amount of the childcare expense actually paid by either parent shall be included in the calculation.
3. If either parent is the provider of childcare services to the child for whom support is being determined, the value of those services shall not be added to the basic child support obligation when calculating the support award.

(d) Uninsured Medical Expenses.

1. The child's uninsured medical expenses including, but not limited to, deductibles, co-pays, dental, orthodontic, counseling, psychiatric, vision, hearing and other medical needs not covered by insurance are not included in the basic child support schedule and shall be the financial responsibility of both parents.
2. If uninsured medical expenses are routinely incurred so that a specific monthly amount can be reasonably established, a specific dollar amount shall be added to the basic child support obligation to cover those established expenses. These expenses shall be pro-rated between the parents according to each parent's percentage of income.
3. If uninsured medical expenses are not routinely incurred so that a specific monthly amount cannot be reasonably established, a specific dollar amount shall not be added to the basic child support obligation but the court order shall specify that these expenses shall be paid by the parents as incurred according to each parent's percentage of income unless some other division is specifically ordered by the tribunal.
4. If a parent fails to pay his/her pro rata share of the child's uninsured medical expenses, as specified in the child support order, within a reasonable time after receipt of evidence documenting the uninsured portion of the expense, the other

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parent, the non-parent caretaker, the State, or its IV-D contractors may enforce payment of the expense by any legal action permitted by law.

5. Every child support order shall specify how the parents are to pay both known and unknown medical expenses as they are incurred.

(e) Calculations for Additional Expenses.

1. The amounts paid by each parent, whether directly or through payroll deduction, for the child's health insurance premium, uninsured medical expenses, and/or work-related childcare costs shall be entered on the Child Support Worksheet to be used in calculating total additional expenses and each parent's ASO.
2. Each parent's pro rata share of the additional expenses shall be determined by multiplying the PI of each parent by the combined total additional expenses.
3. Adjusted Support Obligation (ASO).
 - (i) In standard parenting situations, the ASO is the parent's share of the BCSO plus the parent's share of any additional expense for the child's health insurance premium and/or work-related childcare; or
 - (ii) In split parenting situations, the ASO is each parent's BCSO for the children in the other parent's primary care plus each parent's share of any additional expense for the children's health insurance premium and/or work-related childcare.
 - (iii) If a parenting time adjustment has been calculated in any case, that parent's share of the BCSO is adjusted as specified in subparagraph 1240-2-4-.03(6)(e), then each parent's ASO is calculated as indicated above in either subpart (i) or (ii).
4. Adjustment to ASO for Payment of Additional Expenses.
 - (i) Standard Parenting.
 - (I) In cases where a parent is paying directly or through payroll deduction the child's health insurance premium or paying through payroll deduction work-related child care costs, the parent is entitled to an adjustment in the child support obligation to account for the payment of these expenses, as specified in 1240-2-4-.08(2)(e)9(i).
 - (II) If the health insurance premium is being paid by the ARP and/or the work-related child care is being paid by the ARP through payroll deduction, the payment shall be reflected in the child support order to identify the amount and nature of the obligation, but shall not be included in the ARP's income assignment. The order shall require that these expenses continue to be paid in the same manner as they were being paid prior to the instant action.

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- (III) To the extent that work-related childcare expenses are not paid by the ARP through payroll deduction, the expense shall be accounted for in the ARP's income assignment as part of the child support order. The PRP is then expected to pay this expense in full out of his/her income and the child support award since the ARP's pro rata share of the expense will be included in the income assignment resulting from the child support order.
- (ii) Split Parenting
 - (I) Each parent is entitled to an adjustment in the child support obligation, as specified in 1240-2-4-.08(2)(e)9(ii), to account for payment of the child's health insurance premium, uninsured medical expenses, or work-related child care costs, either direct or through payroll deduction.
 - (II) Each parent is expected to pay his or her own work related childcare expenses to the provider. The other parent's pro rata share of those expenses shall be reflected in the support obligation.
- (8) No adjustment to gross income shall be made in the calculation of a child support obligation which seriously impairs the ability of the PRP in the case under consideration to maintain minimally adequate housing, food, and clothing for the children being supported by the order and/or to provide other basic necessities, as determined by the court.
- (9) Presumptive Child Support Order.
 - (a) The Presumptive Child Support Order (PCSO) is the result of the calculations under these Guidelines, rounded to the nearest whole dollar, and is the amount of support for which the ARP is responsible prior to consideration of any deviations.
 - (b) Deviations from this amount must be supported by written findings in the support order, as required by 1240-2-4-.07(1).
 - (c) The completed Worksheet(s) with the calculations must be maintained as part of the official record either by filing them as exhibits in the tribunal's file or as attachments to the order.
 - (d) Payments of child support shall be ordered to be paid in a specific dollar amount on a weekly, biweekly (every two weeks), semi-monthly, or monthly basis.

Authority: T.C.A. §§ 4-5-202; 36-5-101(a); 36-5-101(e); 71-1-105(12),(16); 71-1-132; 42 U.S.C. §§ 652; 667; 45 C.F.R. §§ 302.56; 303.31.

1240-2-4-.05 MODIFICATION OF CHILD SUPPORT ORDERS.

- (1) Beginning on the effective date of these rules, all modifications shall be calculated under the Income Shares Guidelines, whether the action was pending before the effective date or filed after the effective date.
- (2) Significant Variance Required for Modification of Order.

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- (a) Unless a significant variance exists, as defined in this section, a child support order is not eligible for modification; provided, however, the necessity of providing for the child's health care needs shall be a basis for modification regardless of whether a modification in the amount of child support is warranted by other criteria.
- (b) For all orders that were established or modified before January 18, 2005, under the flat percentage guidelines, and are being modified under the income shares provisions for the first time, a significant variance is defined as:
1. At least a fifteen percent (15%) change in the gross income of the ARP; and/or
 2. A change in the number of children for whom the ARP is legally responsible and actually supporting; and/or
 3. A child supported by this order becoming disabled; and/or
 4. The parties voluntarily entering into an agreed order to modify support in compliance with these Rules, and submitting completed worksheets with the agreed order; and
 5. At least a fifteen percent (15%) change between the amount of the current support order and the amount of the proposed adjusted basic child support obligation if the current support is one hundred dollars (\$100) or greater per month and at least fifteen dollars (\$15) if the current support is less than one hundred dollars (\$100) per month; or
 6. At least a seven and one-half percent (7.5% or 0.075) change between the amount of the current support order and the amount of the proposed adjusted basic child support obligation if the tribunal determines that the Adjusted Gross Income of the parent seeking modification qualifies that parent as a low-income provider.
- For purposes of modification of orders, a low income provider is a person who:
- (i) Is not willfully and voluntarily unemployed or underemployed when working at his/her full capacity according to his/her education and experience; and
 - (ii) Has an Adjusted Gross Income at or below the federal poverty level for a single adult.
 - (I) As of the effective date of the rules, the federal poverty level for a single adult is nine thousand six hundred forty-five dollars (\$9645) annual gross income, which shall remain in effect until updated by the Department.
 - (II) Updated information regarding the federal poverty standards will be available on the Department's website at www.state.tn.us/humanserv.
- (c) For all orders that were established or modified January 18, 2005 or after, under the income shares guidelines, a significant variance is defined as at least a fifteen

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percent (15%) change between the amount of the current support order (not including any deviation amount) and the amount of the proposed presumptive support order or, if the tribunal determines that the Adjusted Gross Income of the parent seeking modification qualifies that parent as a low-income provider, at least a seven and one-half percent (7.5% or 0.075) change between the amount of the current support order (not including any deviation amount) and the amount of the proposed presumptive support order.

- (3) To determine if a modification is possible, a child support order shall first be calculated on the Child Support Worksheet using current evidence of the parties' circumstances. If the current child support order was calculated using the flat percentage guidelines, compare the existing ordered amount of current child support to the proposed amount of the ARP's adjusted basic child support obligation. If the current child support order was calculated using the income shares guidelines, compare the presumptive child support order amounts in the current and proposed orders. Do not include the amount of any previously ordered deviations or proposed deviations in the comparison. If a significant variance exists between the two amounts, such a variance would justify the modification of a child support order unless, in situations where a downward modification is sought, the obligor is willfully and voluntarily unemployed or underemployed, or except as otherwise restricted by paragraph (5) below.
- (4) The tribunal shall not refuse to consider modification of a current support order relating to the payment of prospective support on the basis that the party requesting modification has accumulated an arrears balance, unless the arrearage is the result of the intentional actions by the party.
- (5) Upon a demonstration of a significant variance, the tribunal shall increase or decrease the support order as appropriate in accordance with these Guidelines unless the significant variance only exists due to a previous decision of the tribunal to deviate from the Guidelines and the circumstances that caused the deviation have not changed. If the circumstances that resulted in the deviation have not changed, but there exist other circumstances, such as an increase or decrease in income, that would lead to a significant variance between the amount of the current order, excluding the deviation, and the amount of the proposed order, then the order may be modified.
- (6) An order may be modified to reflect a change in the number of children for whom a parent is legally responsible, a parenting time adjustment, and work-related childcare only upon compliance with the significant variance requirement specified in subchapter .05.
- (7) Modification of Orders in Split Parenting Cases and Cases Where Parenting Time is Divided on a 50/50 Basis.
 - (a) If an order was established or modified under the Income Shares guidelines between January 18, 2005 and April 1, 2005 in a case with split parenting or a case in which parenting time is divided on a 50/50 basis, the order may be modified without compliance with the significant variance requirement only for the purpose of correcting a calculation error resulting from application of the rules implemented on January 18, 2005.
 - (b) Any arrears which may have accumulated under any such order as originally established or modified under the Income Shares guidelines may be recalculated consistent with the amount of the child support obligation as modified pursuant to this subpart.

Authority: T.C.A. §§ 4-5-202; 36-5-101(a)(1) and (e); 36-5-103(f); 71-1-105(12),(16); 71-1-132; 42 U.S.C. § 667; 45 C.F.R. §§ 302.56, 303.8.

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1240-2-4-.06 RETROACTIVE SUPPORT.

- (1) Unless the rebuttal provisions of T.C.A. § 36-2-311(a)(11), or T.C.A. § 36-5-101(e)(1)(C) have been established by clear and convincing evidence provided to the tribunal, then, in cases in which initial support is being set, a judgment must be entered to include an amount of monthly support due up to the date that an order for current support is entered:
 - (a) From the date of the child's birth:
 1. In paternity cases; or,
 2. Where the child has been voluntarily acknowledged by the child's putative father as provided in T.C.A. § 24-7-113, or pursuant to the voluntary acknowledgement procedure of any other state or territory of the United States that comports with Title IV-D of the Social Security Act, or, as applicable;
 - (b) From the date:
 1. Of separation of the parties in a divorce or in an annulment; or,
 2. Of abandonment of the child and the remaining spouse by the other parent in such cases.
- (2) Deviations from the presumption that a judgment for retroactive support shall be awarded back to the date of birth of the child, the date of the separation of the parties, or the date of abandonment of the child shall be supported by written findings in the tribunal's order that include:
 - (a) The reasons the tribunal, pursuant to T.C.A. §§ 36-2-311(a)(11)(A) or 36-5-101(e)(1)(C), deviated from the presumptive amount of child support that would have been paid pursuant to the Guidelines;
 - (b) The amount of child support that would have been required under the Guidelines if the presumptive amount had not been rebutted; and
 - (c) A written finding by the tribunal that states how, in its determination,
 1. Application of the Guidelines would be unjust or inappropriate in the particular case before the tribunal; and
 2. The best interests of the child or children who are subject to the support award determination are served by deviation from the presumptive guideline amount.
- (3) The retroactive support amount shall be calculated as follows:
 - (a) For the monthly BCSO, apply the Guidelines in effect at the time of the order, using the Child Support Worksheet. Use the average monthly income of both parents over the past two (2) years as the amount to be entered for "monthly gross income," unless the tribunal finds that there is adequate evidence to support a different period of time for use in the calculation and makes such a finding in its order. Do not include any current additional expenses on the retroactive worksheet. Complete the worksheet for the retroactive monthly amount, and multiply the amount shown on the worksheet as the "Final Child Support Order" times the number of months the tribunal has determined to be the appropriate period for retroactive support.

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- (b) An additional amount may be added onto the judgment for retroactive support calculated above in subparagraph (a) to account for the ARP's share of amounts paid by the primary residential parent for childcare, the child's health insurance premium, and uninsured medical expenses over the retroactive period under consideration, and other expenses allowed under T.C.A. § 36-2-311.
 - (c) Add the total amount from subparagraph (a) above to the amount from subparagraph (b) for the total retroactive support due. The retroactive support amount as calculated in subparagraphs (a) and (b) above is presumed to be correct unless rebutted by either party.
- (4) A periodic payment amount shall be included in the support order, in addition to any prospective amount of current support, to eliminate the retroactive judgment for support within a reasonable time. Payment of the monthly amount as ordered shall be considered compliance with the retroactive order, however, the department may seek additional payments by any means allowed by rule or statute for the collection of support and past due support.

Authority: T.C.A. §§ 4-5-202; 36-2-311; 36-5-101(a); 36-5-101(e); 71-1-105(12),(16); 71-1-132; 42 U.S.C. § 667; 45 C.F.R. § 302.56.

1240-2-4-.07 DEVIATIONS FROM THE CHILD SUPPORT GUIDELINES.

- (1) Consideration of the Child's Best Interests; Written Findings to Support the Deviation.
 - (a) The amounts of support established by these Guidelines are rebuttable.
 - (b) The tribunal may order as a deviation an amount of support different from the amount of the presumptive child support order if the deviation complies with the requirements of this paragraph (1) and with this chapter. The amount or method of such deviation is within the discretion of the tribunal provided, however, the tribunal must state in its order the basis for the deviation and the amount the child support order would have been without the deviation. In deviating from the Guidelines, primary consideration must be given to the best interest of the child for whom support under these Guidelines is being determined.
 - (c) When ordering a deviation from the presumptive amount of child support established by the Guidelines, the tribunal's order shall contain written findings of fact stating:
 - 1. The reasons for the change or deviation from the presumptive amount of child support that would have been paid pursuant to the Guidelines;
 - 2. The amount of child support that would have been required under the Guidelines if the presumptive amount had not been rebutted; and
 - 3. How, in its determination,
 - (i) Application of the Guidelines would be unjust or inappropriate in the particular case before the tribunal; and
 - (ii) The best interests of the child for whom support is being determined will be served by deviation from the presumptive guideline amount.

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- (d) No deviation in the amount of the child support obligation shall be made which seriously impairs the ability of the PRP in the case under consideration to maintain minimally adequate housing, food, and clothing for the children being supported by the order and/or to provide other basic necessities, as determined by the court.
- (2) Deviation from the Guidelines may be appropriate for reasons in addition to those previously established in subchapters 1240-2-4-.01 – .06 when the tribunal finds it is in the best interest of the child, in accordance with the requirements of paragraph (1) above and the following procedures:
- (a) Consideration of Needs of the Children and Income and Expenses of the Parents for Purposes of Deviation.
 - 1. In making its determination regarding a request for deviation pursuant to this chapter, the tribunal shall consider all available income of the parents as defined by this chapter and shall make a written finding that an amount of child support other than the amount calculated under the Guidelines is reasonably necessary to provide for the needs of the minor child or children for whom support is being determined in the case immediately under consideration.
 - 2. If the circumstances that supported the deviation cease to exist, the child support order may be modified to eliminate the deviation irrespective of compliance with the significant variance requirement of 1240-2-4-.05.
 - (b) In cases where the child is in the legal custody of the Department of Children's Services, the child protection or foster care agency of another state or territory, or any other child-caring entity, public or private, the tribunal may consider a deviation from the presumptive child support order if the deviation will assist in accomplishing a permanency plan or foster care plan for the child that has a goal of returning the child to the parent(s), and the parent's need to establish an adequate household or to otherwise adequately prepare herself or himself for the return of the child clearly justifies a deviation for this purpose.
 - (c) If parenting time-related travel expenses are substantial due to the distance between the parents, the tribunal may order the allocation of such costs by deviation from the BCSO, taking into consideration the circumstances of the respective parties as well as which parent moved and the reason that the move was made.
 - (d) Extraordinary Expenses.

The Schedule includes average child rearing expenditures for families based upon the parents' monthly combined income and number of children. Extraordinary expenses are in excess of these average amounts and are highly variable among families. For these reasons, extraordinary expenses are considered on a case-by-case basis in the calculation of support and are added to the basic support award as a deviation so that the actual amount of the expense is considered in the calculation of the final child support order for only those families actually incurring the expense. These expenses may, but are not required to be, divided between the parents according to each parent's PI.

- 1. Extraordinary Educational Expenses.
 - (i) Extraordinary educational expenses may be added to the basic child support as a deviation. Extraordinary educational expenses include, but are not limited

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to, tuition, room and board, lab fees, books, fees, and other reasonable and necessary expenses associated with special needs education or private elementary and/or secondary schooling that are appropriate to the parents' financial abilities and to the lifestyle of the child if the parents and child were living together.

- (ii) In determining the amount of deviation for extraordinary educational expenses, scholarships, grants, stipends, and other cost-reducing programs received by or on behalf of the child shall be considered.
- (iii) If a deviation is allowed for extraordinary educational expenses, a monthly average of these expenses shall be based on evidence of prior or anticipated expenses and entered on the Worksheet in the deviation section.

2. Special Expenses.

- (i) Special expenses incurred for child rearing which can be quantified may be added to the child support obligation as a deviation from the PCSO. Such expenses include, but are not limited to, summer camp, music or art lessons, travel, school-sponsored extra-curricular activities, such as band, clubs, and athletics, and other activities intended to enhance the athletic, social or cultural development of a child, but that are not otherwise required to be used in calculating the child support order as are health insurance premiums and work-related childcare costs.
 - (ii) A portion of the basic child support obligation is intended to cover average amounts of these special expenses incurred in the rearing of a child. When this category of expenses exceeds seven percent (7%) of the monthly BCSO, then the tribunal shall consider additional amounts of support as a deviation to cover the full amount of these special expenses.
- (e) In instances of extreme economic hardship, such as in cases involving extraordinary medical needs not covered by insurance or other extraordinary special needs for the child of a parent's current family [child living in the home with the parent for whom the parent is legally responsible], deviation from the Guidelines may be considered when the tribunal finds the deviation supported by the criteria of 1240-2-4-.07(1). In such cases, the tribunal must consider all resources available for meeting such needs, including those available from agencies and other adults.
- (f) Deviation From Guidelines Amount For Low-Income Persons.
- 1. The tribunal may consider the low income of the primary residential parent or the alternate residential parent as a basis for deviation from the guideline amounts.
 - 2. The tribunal shall consider all non-exempt sources of income available to each party and all expenses actually paid by each party.
 - 3. The party seeking a low-income deviation must present to the tribunal documentation of all his/her income and expenses or provide sworn statements of all his/her income and expenses in support of the requested deviation.
 - 4. The tribunal shall make a written finding in its order that the deviation from the Guidelines based upon the low income and reasonable expenses of a party is clearly

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justified and shall make the necessary written findings pursuant to paragraph (1) above.

5. For purposes of this subparagraph, a parent is considered to be a low-income person if his/her annual gross income is at or below the federal poverty level for a single person as established in 1240-2-4-.05(2)(b)6(ii)(I).
6. Under no circumstance shall the tribunal fail to order a basic support obligation if the parent has non-exempt gross income. See Rule 1240-2-4-.03(6)(a)4

(g) Statutory Limitation on the Child Support Obligation – Rebuttal and Deviation.

1. When the presumptive child support order exceeds the amount found by multiplying a net income of ten thousand dollars (\$10,000) by the percentages set out below, pursuant to T.C.A. § 36-5-101(e)(1)(B), a PRP seeking support in excess of the amount provided by the applicable percentage must prove by a preponderance of the evidence that more than this amount is reasonably necessary to provide for the needs of the child.

The percentages are:

- (i) One child = Twenty-one percent (21%), [or two thousand one hundred dollars (\$2100)];
 - (ii) Two children = Thirty-two percent (32%), [or three thousand two hundred dollars (\$3200)];
 - (iii) Three children = Forty-one percent (41%), [or four thousand one hundred dollars (\$4100)];
 - (iv) Four children = Forty-six percent (46%), [or four thousand six hundred dollars (\$4600)]; and
 - (v) Five or more children = Fifty percent (50%), [or five thousand dollars (\$5000)]
2. Application of Statutory Threshold to Child Support Determination.
 - (i) If the PCSO calculated under these rules exceeds the amount specified above for the number of children for whom support is being calculated, then the amount of the PCSO shall be limited to the amount specified above for the number of children for whom support is being calculated, absent the rebuttal provided for in part 1.
 - (ii) If the PRP proves the need for support in excess of the amount provided for in part 1, the tribunal shall add an appropriate amount to the PCSO of the ARP as a deviation.
 - (iii) The court may require that sums paid pursuant to this subparagraph be placed in an educational or other trust fund for the benefit of the child.

(h) Hardship Provisions Due to Modification of Order.

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1. Any time following the effective date of these Rules when a tribunal is considering modification of an order established under Tennessee's previous child support guidelines, and the tribunal finds a significant variance between the amount of the existing child support order and the amount of the proposed child support order calculated under this chapter, which change results from the application of the guidelines rather than from the change in the income and/or circumstances of the parties, then the tribunal may modify the current child support order up to the full amount of the variance or may apply a hardship deviation as described below in parts 2-4.
2. For orders being modified as described in part 1 immediately above, the tribunal may deviate from the amount of child support required by the Income Shares Model and limit the amount of the upward or downward modification if:
 - (i) A deviation is supported in writing in the order by the criteria in 1240-2-4-.07(1); and
 - (ii) The tribunal finds that the change in the amount of child support caused by the transition to Income Shares will create a hardship either to:
 - (I) The recipient of the support who will have a substantial decrease of previously ordered support; or
 - (II) The payor who will have a substantial increase of previously ordered support.
3. The tribunal shall consider the following factors in determining whether a hardship will be created by the application of the guidelines:
 - (i) Whether the significant variance is created solely by the application of the income shares guidelines or whether it also includes a significant change in the income of either or both of the parents. It is not the intent or purpose of these guidelines to reduce the lifestyle the child(ren) enjoyed under the previous guidelines merely by the application of the income shares guidelines. Rather, the intent is to appropriately allocate the financial responsibilities of the parties with regard to the child(ren) while considering the status quo of the parties.
 - (ii) Whether the parent has incurred fixed expenses based on the amount of support previously ordered, including but not limited to mortgage payments, automobile payments, and other long-term financial obligations;
 - (iii) The standard of living the child(ren) enjoyed as a result of receiving the current level of support. In making this determination the tribunal shall consider the amount actually incurred by the PRP for basic expenses comparing the actual basic expenses incurred with the BCSO set forth by the guidelines. If the tribunal finds that the actual amount incurred for basic expenses exceeds the presumed BCSO and that the actual amount incurred is reasonable considering the relative incomes of the parents the tribunal may use the actual expenses as the BCSO.
 - (iv) If the child(ren) incurred Extraordinary Educational Expenses or Special Expenses that were previously included in the support amount determined

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under the prior guidelines, the tribunal may consider those expenses if the application of the guidelines does not adequately take said expenses into account. The tribunal may also make an equitable division of these expenses so as to maintain the status quo with regard to the financial obligations of each party.

- (v) If the current order for support includes provisions for allocating the cost of medical and / or dental insurance and uninsured medical expenses, the tribunal may compare the allocation of said expenses under the application of the guidelines with the allocation under the order.
- 4. The hardship deviation, if allowed, cannot be utilized in a later action to create a significant variance.
- 5. No modification under this hardship provision shall be made to the extent that it would seriously impair the ability of the PRP in the case under consideration to maintain minimally adequate housing, food, and clothing for the children being supported by the order and/or to provide other basic necessities, as determined by the court.

Authority: T.C.A. §§ 4-5-202; 36-5-101(e); 71-1-105(12),(16); 71-1-132; 42 U.S.C. § 667; 45 C.F.R. § 302.56.

1240-2-4-.08 WORKSHEETS AND INSTRUCTIONS.

- (1) General Instructions.
 - (a) The Child Support Worksheet and Credit Worksheet provided by the Department are mandatory for use in calculating the appropriate child support obligation under these Guidelines. The completed Worksheet(s) must be maintained as part of the official record either by filing them as exhibits in the tribunal's file or as attachments to the order.
 - (b) The Child Support Worksheet, Credit Worksheet, Instructions for Worksheets, and Child Support Schedule are part of the Tennessee Child Support Guidelines. In the event that the language contained in the Worksheets, Instructions or CS Schedule conflicts in any way with the language of subchapters 1240-2-4-.01 – .07, the language of those subchapters is controlling.
 - (c) The designations in the Instructions correspond to the designations on the Worksheet, including parts and line numbers, to allow simple correlation of the Instructions to the Worksheets. The headings for each part are only for ease of identification of the various parts on the Worksheet.
 - (d) Use of Columns on the Worksheets.
 - 1. Column A shall be used for the Mother's information, and Column B shall be used for the Father's information.
 - 2. Column C shall be used to enter a total of Column A and B where instructed.
- (2) Instructions for Child Support Worksheet.
 - (a) Part I – Identification. [Rule 1240-2-4-.04]

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In Part I of the Child Support Worksheet, enter the case specific information on the top section of the form: name of mother and father (and/or non-parent caretaker where applicable), each parent designated as either PRP, ARP, or split (if split, both parents shall be designated as such), the docket number, court name, and TCSES case number (if applicable), name and date of birth of each child for whom support is being determined, and the number of days each child spends with each parent and/or non-parent caretaker. If the parents spend an equal amount of time with the child, enter one hundred eighty-two point five (182.5) days for each parent.

(b) Part II – Basic Obligation.

1. Monthly Gross Income. [Rule 1240-2-4-.04(3)]

(i) Line 1 – Enter each parent’s monthly gross income in the appropriate column. Do not include child support payments received on behalf of other children or benefits received from means-tested public assistance programs.

(ii) Line 1a – Self-Employment Tax. [Rule 1240-2-4-.04(4)]

Enter on Line 1a of this Worksheet the average monthly amount of any self-employment tax paid by the parent.

2. Adjustments Against Gross Income for Qualified Other Children.

A parent seeking credit for qualified other children must enter all pertinent information on the Credit Worksheet in order to calculate the correct amount of the credit. Instructions for the Credit Worksheet are below in Rule 1240-2-4-.08(3).

Line 1b / 1c – Qualified Other Children Receiving Support.
[Rule 1240-2-4-.04(6)]

Adjustments shall be considered for either parent for qualified other children who are receiving support from the parent.

(i) Line 1b - For qualified other children living in the home of the parent fifty percent (50%) or more of the time, enter in the appropriate column on Line 1b the amount of the credit from Line 6 of the Credit Worksheet.

(ii) Line 1c - For qualified other children living in the home of the parent less than fifty percent (50%) of the time, enter in the appropriate column on Line 1c the amount of the credit from Line 11b of the Credit Worksheet.

3. Line 2 – Adjusted Gross Income (AGI). [Rule 1240-2-4-.02(1)].

Subtract the amounts, if any, on Lines 1a, 1b, and 1c, from Line 1. Enter the remainder as each individual parent’s AGI in the appropriate column of Line 2. Add Line 2, Columns A and B together to arrive at the combined AGI and enter this amount on Line 2, Column C.

4. Line 3 – Percentage Share of Income (PI). [Rule 1240-2-4-.02(16) and .04]

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Calculate the individual parent's percentage share (PI) of the combined Adjusted Gross Income by dividing each parent's Line 2 by the combined figure on Line 2, Column C. Enter the resulting percentages on Line 3 in Column A and B as appropriate. The sum of Line 3, Column A and Column B must equal one hundred percent (100%).

5. Line 4 – Basic Child Support Obligation (BCSO). [Rule 1240-2-4-.02(5), .04(7) and .09]

(i) For standard parenting situations, determine the “Basic Child Support Obligation” from the CS Schedule based upon the combined Adjusted Gross Income of the parents from Line 2, Column C and the number of children for whom support is being determined. Enter the amount on Line 4, Column C. For split parenting situations, Lines 6a and 6b will be used instead of Lines 4 and 5.

(ii) When the combined Adjusted Gross Income falls between two amounts on the Schedule, round up to the next higher amount. Use the rounded-up number to determine the BCSO on the CS Schedule for the number of children for whom support is being determined. [Rule 1240-2-4-.04(7)(b)]

(c) Part III – Each Parent's Share of the Child Support Obligation.

1. Line 5 – Each Parent's Share of BCSO from Line 4 – Standard Parenting. [Rule 1240-2-4-.02(16), (20) and .04]

For standard parenting situations, calculate each parent's share of the BCSO by multiplying the parent's PI from Line 3 times the BCSO from Line 4 and enter results on Line 5. [Line 3, Column A, times Line 4, Column C, enter result on Line 5, Column A for the PRP's share; Line 3, Column B, times Line 4, Column C, enter result on Line 5, Column B for the ARP's share.]

2. Lines 6a and 6b – Each Parent's Share of BCSO – Split Parenting. [Rule 1240-2-4-.02(16), (20) and (21) and .04]

For split parenting situations, Lines 4 and 5 will not be used. Instead, each parent's support obligation will be calculated as indicated below and entered on either Line 6a or 6b. Split parenting will only occur if there are at least two (2) children who are the subject of the support order and each parent is the PRP of at least one (1) child for whom support is being calculated.

- (i) Line 6a – Mother's Obligation.

Mother's child support obligation for the children for whom the Father is the PRP is calculated by using the combined AGI on Line 2, Column C and the number of children for whom the Father is the PRP to determine the BCSO for these children. This BCSO is multiplied by Mother's PI from Line 3, Column A. The result is placed on Line 6a, Column A.

- (ii) Line 6b – Father's Obligation.

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Father's child support obligation for the children for whom the Mother is the PRP is calculated by using the combined AGI on Line 2, Column C and the number of children for whom the Mother is the PRP to determine the BCSO for these children. This BCSO is multiplied by the Father's PI from Line 3, Column B. The result is placed on Line 6b, Column B.

(d) Part IV – Parenting Time Adjustment. [Rule 1240-2-4-.02(15) and .03(6)(e)]

1. General Instructions.

- (i) Parenting time adjustments may be used to reduce or to increase the obligation of a parent who spends less than fifty percent (50%) of the days in a calendar year with the child. In split parenting situations, the adjustment is applicable to either parent as an ARP, since each parent will be the ARP of at least one (1) child.
- (ii) If the adjustment is not applicable to either parent, skip Part IV in its entirety.

2. Calculations.

(i) Determination of Applicable Parenting Time.

- (I) Whether there is only one child for whom support is being calculated or multiple children spending different amounts of parenting time with the ARP, this parenting time application is used for calculating the parenting time adjustment.
- (II) The adjustment is based upon the parenting time of the ARP. If there are multiple children in the case under consideration and each child has a different amount of parenting time with the ARP, then an average amount of parenting time for all children is used for calculating the parenting time adjustment. For example, if ARP has sixty-seven (67) days of parenting time per year with Child A, eighty-four (84) days of parenting time per year with Child B, and one hundred thirty-two (132) days of parenting time per year with Child C, then the parenting time adjustment would be calculated based upon ninety-four (94) days of parenting time $[67 + 84 + 132 = 283 / 3 = 94]$.
- (III) On Line 7a, enter the parenting time, or average parenting time, that the ARP spends per calendar year with the children supported under this order. Use this line for the ARP's days whether the resulting adjustment is a credit against the obligation or an addition to the obligation.

(ii) Calculation of the Parenting Time Credit

- (I) First, the variable multiplier is determined by multiplying .0109589 $[2 / 182.5]$ by the ARP's parenting time determined pursuant to item (II) above. For example, the 94 days of parenting time calculated in the example from item (II) is multiplied by .0109589, resulting in a variable multiplier of 1.0301366 $[94 \times .0109589]$.

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- (II) Second, the variable multiplier calculated in item (I) above is applied to the amount of the parties' combined BCSO, which results in an adjusted BCSO. For example, application of the variable multiplier determined above for ninety-four (94) days of parenting time to a BCSO of one thousand dollars (\$1000) would result in an adjusted BCSO of one thousand thirty dollars and fourteen cents (\$1030.14).
 - (III) Third, the amount of the BCSO is subtracted from the adjusted BCSO. The difference is the child-rearing expenses associated with the ARP's additional parenting time. In the example above, the additional child-rearing expenses associated with the ninety-four (94) days of parenting time would be thirty dollars and fourteen cents (\$30.14) [$\$1030.14 - \1000].
 - (IV) The additional child-rearing expenses determined in item (III) above are pro-rated between the parents according to each parent's percentage of income (PI). The PRP's share of these additional expenses is applied as an adjustment against the ARP's share of the BCSO. For instance, if the PRP's PI is forty percent (40%), the PRP's share of the additional expenses in the example above would be twelve dollars and six cents (\$12.06) [$\$30.14 \times 40\%$]. The twelve dollars and six cents (\$12.06) is applied as a credit against the ARP's share of the BCSO, resulting in a child support obligation for the ARP of five hundred eighty-seven dollars and ninety-four cents (\$587.94) [$\$1000 \times 60\% = \$600 - \12.06].
 - (V) If application of this parenting time credit results in a negative obligation for the ARP, the amount of the negative obligation should be entered on the Worksheet as a positive obligation for the PRP.
- (iii) Calculating Increase for lack of Parenting Time.
- (I) The ARP's child support obligation may be increased for the lack of the ARP's parenting time. The first step in calculating the increase is to determine the number of days fewer than sixty-nine the ARP spends with the child, then divide the number of days of parenting time by three hundred sixty-five. For example, if the ARP has (68) days of parenting time, the multiplier is 0.002739726. [$69 - 68 = 1; 1/365$]
 - (II) The second step is to multiply the percentage of days by the ARP's share of the BCSO. For example, if the ARP's share of the BCSO is one thousand two hundred dollars (\$1,200), and the parenting time is sixty-eight (68) days, the increased share of support is three dollars twenty-nine cents (\$3.29). [$0.002739726 \times \$1,200 = 3.29$]
 - (III) The increased share of support is added to the ARP's share of the BCSO to find the adjusted BCSO. Continuing the example, the ARP's increased BCSO is one thousand two hundred three dollars twenty-nine cents (\$1,203.29). [$\$1,200 + \3.29]
- (iv) On Line 7b, enter the amount of the credit or increase calculated above which represents the parenting time adjustment.
 - (v) On Line 8, enter each parent's adjusted BCSO.

RULEMAKING HEARINGS

(e) Part V – Adjustments for Additional Expenses. [Rule 1240-2-4-.04(8)]

1. General Instructions.

- (i) This Part includes only health insurance premiums, uninsured medical expenses, and work-related childcare expenses.
- (ii) If expenses are not incurred regularly, a monthly amount shall be calculated by averaging the expense over a twelve (12) month period.
- (iii) Only amounts actually paid are included in the calculation. Payments that are made by a parent’s employer, but not deducted from the parent’s wages, shall not be included.
- (iv) Only the portion of the health insurance premium actually attributable to the children for whom support is being determined and actually paid by the parent is included. If the actual amount of the health insurance premium that is attributable to the child who is the subject of the current action for support is not available or cannot be verified, the total cost of the premium shall be divided by the number of persons covered by the policy to determine a per person cost. This amount is then multiplied by the number of children who are the subject of this action and are covered by the policy.

$$\frac{\$ \text{Total Premium}}{\text{No. of Persons Covered by Policy}} = \$ \text{Per Person Cost} \times \frac{\text{No. of Children Subject to Order}}{\text{Child's Portion of Premium}}$$

- (v) Additional expenses of a non-parent caretaker shall be included in calculating the amount of these expenses.

2. Line 9a – Children’s Portion of Health Insurance Premium. [Rule 1240-2-4-.04(8)(b)]

Enter on Line 9a in the column of the parent responsible for payment the amount that is, or will be, paid by a parent either directly or through payroll deduction for health insurance for the children for whom support is being determined.

3. Line 9b - Uninsured Medical Expenses. [Rule 1240-2-4-.03(6)(b)7]

- (i) If uninsured medical expenses are routinely incurred so that a specific monthly amount can be reasonably established, enter that amount on Line 9b in the column of the parent responsible for payment. These known expenses shall be divided between the parents pro rata.
- (ii) If uninsured medical expenses are not routinely incurred so that a specific monthly amount cannot be reasonably established, no amount should be entered on Line 9b. Every child support order shall specify that these unknown expenses shall be paid by the parents as they are incurred, to be divided pro-rata unless otherwise ordered by the tribunal.

4. Line 9c – Work-related Childcare Expenses – Payroll Deducted. [Rule 1240-2-4-.04(8)(c)]

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On Line 9c enter in the column of the parent responsible for payment the amount of any work-related childcare expense paid by the parent through payroll deduction for the child for whom support is being determined.

5. Line 9d – Work-related Childcare Expenses – Non-Payroll Deducted. [Rule 1240-2-4-.04(8)(c)]

On Line 9d, enter in Column A and Column B the monthly amount of any work related childcare expense paid directly, but not any amounts paid by payroll deduction, by either parent for the child for whom support is being determined. In Column C of Line 11d, enter the total amount of any work-related childcare expense paid directly by both parents for the child for whom support is being determined.

6. Line 10 – Total Additional Expenses. [Rule 1240-2-4-.04(8)]

Total the amounts on Lines 9a, 9b, 9c and 9d, Columns A and B, and enter the totals on Line 10. Add together the totals in Columns A and B from Line 10 to calculate the total amount of additional expenses and enter this total on Line 10, Column C.

7. Line 11 – Each Parent’s Share of Additional Expenses. [Rule 1240-2-4-.04(8)]

Calculate each parent’s share of the additional expenses (both directly paid and paid by payroll deduction) by multiplying each parent’s percentage of income (PI) from Line 3 times the total additional expenses from Line 10, Column C and enter amounts in the appropriate columns on Line 11. [Line 3, Column A, times Line 10, Column C for the Mother’s share; Line 3, Column B times Line 10, Column C for the Father’s share.]

8. Line 12 – Adjusted Support Obligation – BCSO plus parent’s share of additional expenses. [Rule 1240-2-4-.02(2) & .04(8)(d)]

Using one of the methods specified below, calculate the “Adjusted Support Obligation” by totaling each parent’s share of the “Basic Child Support Obligation” and each parent’s share of the “Additional Expenses” and enter the amount in the appropriate column on Line 12.

- (i) Cases With No Parenting Time Adjustment.

(I) In standard parenting cases, add together Line 5 (the BCSO for each parent) and Line 11 (each parent’s share of the additional expenses) for each parent. Enter the result for each parent in the appropriate column on Line 12 as the ASO for each parent.

(II) In split parenting situations, add Line 6a and Line 11, Column A for the Mother (Mother’s share of obligation and additional expenses); add Line 6b and Line 11, Column B for the Father (Father’s share of the obligation and additional expenses). Enter the result for each parent in the appropriate column on Line 12 as the ASO for each parent.

- (ii) Cases With a Parenting Time Adjustment.

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If a parenting time adjustment has been calculated in any case, add together Line 8 and Line 11 for each parent (each parent's adjusted BCSO and share of expenses). Enter the result for each parent in the appropriate column on Line 12.

9. Adjustment to the ASO for Payment of Additional Expenses. [Rule 1240-2-4-.04(8)(d)]

(i) Standard Parenting.

(I) Line 13 - Adjustments to the ASO for Payment of Additional Expenses.

For standard parenting situations, enter in the parent's column on Line 13 (Adjustments to ASO for payment of additional expenses) the total amount of any health insurance premium either directly paid or paid automatically through payroll deduction, and the amount of any work-related childcare expense paid automatically by the parent through payroll deduction.

(II) Line 14.

I. Subtract Line 13 from Line 12 (the Adjusted Support Obligation) in Column A and in Column B and enter the remainder on Line 14, Columns A and B in order to credit the parent for the amount of any health insurance premium paid or for the amount of any work-related childcare paid automatically through payroll deduction. The child support order must include the amount of the deduction for these expenses and identify the nature of the obligation. The order shall require that these expenses continue to be paid. (For example, deduction of \$100 monthly for ARP's payment to XYZ Insurance Company for the child's health insurance. ARP shall continue to pay XYZ Insurance Company, or the subsequent health insurance company, for the child's health insurance.)

II. If the childcare expense is not paid through payroll deduction, the ARP's portion of the expense shall be included in the income assignment resulting from the child support order, and the full amount of the expense shall be paid by the PRP through his/her income and the child support award.

(ii) Split Parenting.

(I) Line 13 - Adjustments to the ASO for Payment of Additional Expenses.

Enter in the parent's column on Line 13 (Adjustments to ASO for payment of additional expenses) the parent's pro-rata share of any additional expenses on Lines 9a and 9b paid by the parent, and, if the parent has childcare expenses for the child for whom the parent is the PRP, the parent's pro-rata share of that expense, whether paid directly or through payroll deduction.

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(II) Line 14.

- I. Subtract Line 13 from Line 12 in Column A and in Column B and enter the remainder on Line 14, Columns A and B, to credit each parent's ASO for his/her pro-rata share of additional expenses paid by the parent to third parties. The child support order must reflect these payments by identifying the amount and nature of the obligation. The order shall require that these expenses continue to be paid, whether directly or through payroll deduction.
- II. The PRP shall pay the provider for child care expenses incurred on behalf of the child residing primarily with that parent.

(f) Part VI – Presumptive Child Support Order / Modification of Current Support.

1. Line 15 – Presumptive Child Support Order. [Rule 1240-2-4-.02(18) & .04(11)]

(i) The Presumptive Child Support Order (PCSO) is the amount of child support for which the ARP is responsible.

(ii) Standard Parenting.

(I) Enter on Line 15 the amount of the ARP's child support obligation from Line 14.

(II) If the amount of the ARP's obligation from Line 14 exceeds the amount specified in 1240-2-4-.07(2)(g)1 for the number of children for whom support is being calculated, then the amount entered on Line 15 shall be limited to the amount specified in 1240-2-4-.07(2)(g)1 for the number of children for whom support is being calculated. An opportunity to rebut this limitation is provided under part (g)2 below.

(iii) Split Parenting.

(I) Subtract the lesser obligation on Line 14 from the greater and enter the difference on Line 15. The parent with the larger obligation pays the other parent the difference between the two amounts.

(II) If the amount on Line 15 for either parent exceeds the amount specified in 1240-2-4-.07(2)(g)1 for the number of children for whom support is being calculated, then that amount shall be limited to the amount specified in 1240-2-4-.07(2)(g)1 for the number of children for whom support is being calculated prior to making the calculation required in item (I) above. An opportunity to rebut this limitation is provided under part (g)2 below.

2. Line 16 – Social Security Benefits.

If a child to be supported under the order receives social security benefits on the account of the parent who will pay support under this order, and such benefit was added to that parent's gross income according to rule 1240-2-4-.04(3)(a)5, then enter the amount of that child's benefit and subtract that amount from that parent's obligation.

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3. Line 17a – For Modification of Current Child Support Order. [Rule 1240-2-4-.05]
 - (i) To determine if a modification is possible, first calculate an order on Lines 1-15 of the Child Support Worksheet using current evidence of the parties' circumstances. If a child support order already exists for the children at issue, the order cannot be modified to the amount calculated above on Line 15 of this Worksheet unless there is a significant variance between the current order and the presumptive amount of support calculated on this Worksheet and entered on Line 15.
 - (ii) Enter on Line 17a the amount of the current child support order in the case under consideration. If the order is calculated under the flat percentage guidelines, use the current support amount. If the order is calculated under income shares, use the presumptive child support amount (PCSO).
 4. Line 17b – Significant Variance Percentage. [Rule 1240-2-4-.05]

Indicate whether the significant variance percentage is fifteen percent (15% or .15) (for most cases) or seven and one-half percent (7.5% or .075) (for low income cases).
 5. Line 17c – Amount Required for Variance to Exist.

To determine the amount needed to comply with the significant variance requirement, multiply the amount from Line 17a by the percentage indicated on Line 17b – (15% or 7.5% for low-income cases). Enter the result on Line 17c.
 6. Line 17d – Significant Variance Amount. [Rule 1240-2-4-.05]

Subtract the lesser of Lines 15 and 17a from the greater and enter result on Line 17d. If Line 17d is equal to or greater than Line 17c, the significant variance requirement has been met and the child support obligation may be modified to the presumptive amount entered on Line 15.
- (g) Part VII – Deviations and Final Child Support Obligation.
1. Line 18 – Deviations. [Rule 1240-2-4-.07]
 - (i) Specify the reason for the deviation and enter the amount that will be added to or subtracted from the Presumptive Support Order from Line 15.
 - (ii) The order must include written findings supporting the deviation as outlined in 1240-2-4-.07(1).
 3. Line 19 – Final Child Support Order. [Rule 1240-2-4-.02(12)]
 - (i) To the Presumptive Support Order on Line 15, add/subtract as appropriate any amount on Line 18 and enter the result on Line 19 as the Final Child Support Order.
 - (ii) The completed Worksheets must be maintained as part of the official record

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either by filing them as exhibits in the tribunal's file or as attachments to the order. Payments of child support shall be ordered to be paid in a specific dollar amount on a weekly, biweekly (every two weeks), semi-monthly (twice a month), or monthly basis.

(3) Instructions for Credit Worksheet.

(a) The Credit Worksheet is to be utilized to calculate the available credit against the parent's gross income for qualified other children. The amount of any credit calculated on the Credit Worksheet shall be transferred to the appropriate line on the Child Support Worksheet.

(b) Part I – Identification.

In Part I of the Credit Worksheet, enter the case specific information: name of mother and father (and/or non-parent caretaker where applicable), each parent designated as either PRP, ARP, or split (if split, both parents shall be designated as such), the docket number, court name, and TCSES case number (if applicable).

(c) Part II – Calculation of Credit for Qualified Other Children.

1. A child is qualified for the credit available in this Part II if the parent is legally responsible for the child's support, the parent is actually supporting the child, and the child is not before the tribunal to set, modify, or enforce support in the case immediately under consideration.

2. Line 1 – Gross Income. [Rule 1240-2-4-.04(3)]

Enter the monthly gross income of the parent seeking credit. Do not include child support payments received for the benefit of other children or benefits received from means-tested public assistance programs.

3. Line 2a – Self-employment Tax. [Rule 1240-2-4-.04(4)]

If appropriate, enter on Line 2a the amount of any self-employment tax paid by that parent.

4. Line 2b – Adjustment to Gross Income for Self-employment Tax.

Deduct the amount on Line 2a from gross income on Line 1 and enter the result on Line 2b.

5. Line 3 – Identify Qualified Other Children Living in The Home of The Parent Seeking The Credit. [Rule 1240-2-4-.04(6)]

In the spaces provided, enter the names and dates of birth of the qualified other children living fifty percent (50%) or more of the time in the home of the parent seeking the credit. Do not consider children for whom support is being calculated in the case for which credit is being considered, step-children, or other minors in the home that the parent has no legal obligation to support. If more space is needed, use the Additional Credit Worksheet promulgated by the Department.

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6. Line 4 – Number of Qualified Other Children in the Parent's Home.

Enter on Line 4 of the Credit Worksheet the number of qualified other children from Line 3 living fifty percent (50%) or more of the time in the parent's home. If there are not any qualified other children living in the parent's home, skip to Line 7.

7. Line 5 – Calculate Theoretical Order.

(i) Using the gross income of the parent from Line 1 (or Line 2b, if appropriate) and the number of qualified other children living from Line 4, find the amount of child support on the CS Schedule that the parent would pay for the qualified other children living fifty percent (50%) or more of the time in the parent's home if a theoretical order were issued for those children. Enter this amount on Line 5 of the Credit Worksheet.

(ii) If the amount of the theoretical order exceeds the amount specified in 1240-2-4-.07(2)(g)1 for the number of children for whom support is being calculated, then the amount of the theoretical order entered on Line 5 shall be limited to the amount specified in 1240-2-4-.07(2)(g)1 for the number of children for whom support is being calculated.

8. Line 6 – Calculate Credit Amount.

Multiply the theoretical order amount from Line 5 by seventy-five percent (75% or 0.75). Enter the result on Line 6 of the Credit Worksheet and on Line 1c of the Child Support Worksheet.

9. Line 7 – Identify Qualified Other Children Living Less Than 50% of the Time in The Home of The Parent Seeking The Adjustment. [Rule 1240-2-4-.04(6)]

In the spaces provided, enter the names and dates of birth of the qualified other children living in the parent's home less than fifty percent (50%) of the time. Do not consider children for whom support is being calculated in the case for which credit is being considered, step-children or other minors for whom the parent has no legal obligation. If more space is needed, attach an additional sheet to this Worksheet.

10. Line 8 – Number of Qualified Other Children Living in the Parent's Home Less Than 50% of the Time.

Enter on Line 8 the number of qualified other children from Line 7 who reside less than fifty percent (50%) of the time in the home of the parent claiming the credit.

11. Line 9 – Determine Actual Support.

Determine the dollar amount of documented monetary support actually provided by the parent to the caretaker, such as canceled checks or money orders, over the most recent twelve (12) month period, expressed as a monthly average. Documented monetary support can include evidence of payment of child support under another child support order. Determine the monthly average by dividing the annual amount of support provided by twelve (12). Enter the result on Line 9 of the Credit Worksheet.

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12. Line 10 – Calculate Theoretical Order.
 - (i) Using the income for this parent from Line 1 (or Line 2b, if applicable) and the number of qualified other children from Line 8, use the CS Schedule to find the amount of child support the parent would pay for the qualified other children living in the parent's home less than fifty percent (50%) of the time if a theoretical order were issued for those children. Enter the amount on Line 10.
 - (ii) If the amount of the theoretical order exceeds the amount specified in 1240-2-4-.07(2)(g)1 for the number of children for whom support is being calculated, then the amount of the theoretical order entered on Line 10 shall be limited to the amount specified in 1240-2-4-.07(2)(g)1 for the number of children for whom support is being calculated.
 13. Lines 11a and 11b – Calculate Maximum Amount.
 - (i) Line 11a – Multiply the theoretical order amount from Step 10 by seventy-five percent (75% or 0.75) and enter the result on Line 11a.
 - (ii) Line 11b – Compare the results from Line 9 and Line 11a and enter the lesser amount for the credit on Line 11b of the Credit Worksheet and on Line 1d of the Child Support Worksheet. Do not exceed the lesser of the actual support or seventy-five percent (75%) of the theoretical order.
- (d) Part III - Calculator for Pro-Rata Division of Additional Expenses with Non-Parent Caretaker and Both Parents.
1. In cases where a Non-Parent Caretaker is PRP and a parent is ARP, the child support obligation shall be calculated on the Worksheet according to the rules for standard parenting. If the tribunal has jurisdiction of and is able to order support for both parents, the tribunal may assign each parent a pro rata share of the additional expenses. In that case the automated calculator in Part III of the Credit Worksheet may be used to pro-rate the additional expenses between the Mother and Father in the two cases.
 2. To use the automated calculator provided by the department to pro-rate the parent's share of the additional expenses, enter the information for the Non-parent Caretaker in Column 1, for the parent ARP in the case for which the worksheet is being prepared in Column 2, and the information for the Other Parent in Column 4. Enter each parent's adjusted gross income from Line 2 of the individual parent's worksheet on Line 12 in that parent's column. The total of the parent's AGI will be in Column 6 of Line 12, and the parent's percentage share will be in Columns 3 and 5 on Line 13. (If a manual calculation is being done, combine the parents AGI and enter the total in Column 6 of Line 12. Pro-rate the parent's share by dividing the combined AGI by the individual parent's AGI. Enter the parent's percentage of income on Line 13.)
 3. In the column of the person who pays the expense, enter the amount of the expense for:
 - (i) the child's health insurance on Line 14; and
 - (ii) the child's ascertainable recurring uninsured medical expenses on Line 15; and

RULEMAKING HEARINGS

- (iii) the child’s work-related childcare paid by payroll deduction; and
 - (iv) the child’s work-related childcare that is not payroll deducted.
4. The total additional expenses will be on Line 18 and Column 6. Each parent’s percentage share for each expense will be in Columns 3 and 5. (For a manual calculation, add each line of expenses and enter the total in Column 6 and Line 18. Apply each parent’s PI from Line 13 to each expense and enter the result in Column 3 for the ARP in the case being considered, and in Column 5 for the other parent.)
 5. Line 18, Columns 2 and 4 is the total amount of any health insurance premium either directly paid or paid automatically through payroll deduction, and the amount of any work-related childcare expense paid automatically by the parent through payroll deduction. Line 19 will show the adjustment for these expenses in Columns 3 and 5. (For a manual calculation, subtract Line 19 from Line 18 in each parent’s Column and enter the remainder on Line 20 of each parent’s Column in order to credit the parent for the amount of any health insurance premium paid or for the amount of any work-related childcare paid automatically through payroll deduction.)
 6. The calculator will enter the correct share of the expenses and any adjustment on the child support worksheet. (For a manual calculation, enter the ARP’s share of expenses from Lines 14, 15, 16, and 17 on the corresponding Lines 9a – 9d, in the PRP Column of the child support worksheet. Enter any ARP adjustment from Line 19, Column 3 on Line 13, ARP Column of the child support worksheet.)

(4) Child Support Worksheet.

State of Tennessee – Child Support Worksheet

Part I. Identification

Indicate the status of each parent or caretaker by placing an “X” in the appropriate column

Name of Mother:
 Name of Father:
 Name of non-parent Caretaker:
 TCSES case #:
 Docket #:
 Court name:

	PRP	ARP	SPLIT

Name(s) of Child(ren)

Date of Birth	Days with Mother	Days with Father	Days with Caretaker

RULEMAKING HEARINGS

Part II. Basic Support Obligation

- Use Column A for Mother's information and Column B for Father's information
- Use Credit Worksheet to calculate line items 1b and 1c.
- 1 Monthly Gross Income
 - 1a Self-employment tax paid
 - 1b Credit for In Home Children
 - 1c Credit for Not In Home Children
 - 2 Adjusted Gross Income (AGI)
 - 3 Percentage Share of Income (PI)
 - 4 Basic Child Support Obligation (BCSO)

Column A	Column B	Column C
-\$	-\$	
-	-	
-	-	
\$	\$	\$
%	%	%
		\$

Part III. Parents' Share of Support Obligation

- Standard Parenting
- 5 Each parent's share of the BCSO
- Split Parenting
- 6a Mother's obligation for children for whom father is the PRP
 - 6b Father's obligation for children for whom mother is the PRP

\$	\$	
\$		
	\$	

Part IV. Parenting Time Adjustment

- 7a Average number of days per calendar year ARP spends with children supported by this order
- 7b Parenting time adjustment
- 8 Each parent's share of the adjusted BCSO

\$	\$	
\$	\$	

State of Tennessee – Child Support Worksheet

Part V. Additional Expenses

- Re-number
- 9a Children's portion of health insurance premium
 - 9b Uninsured Medical Expenses
 - 9c Work-related childcare (payroll-deducted)
 - 9d Work-related childcare (non-payroll-deducted)
 - 10 Total expenses
 - 11 Each parent's share of Additional Expenses
 - 12 Adjusted Support Obligation (ASO)
 - 13 Adjustment to ASO for payment of Additional Expenses
 - 14 Subtract line 14 from line 13. Enter remainder.

Column A	Column B	Column C
\$	\$	
\$	\$	
\$	\$	
\$	\$	\$
\$	\$	\$
\$	\$	
\$	\$	
-	-	
\$	\$	

RULEMAKING HEARINGS

Part VI. Presumptive Child Support / Modification of Current Support

		Obligation Column	
	15	Presumptive Child Support Order (PCSO) The obligor parent's amount from Line 15* * For split parenting, enter the difference between the greater and smaller numbers from Line 15	\$
Modification of Current Child Support Order	16	SS benefit to child from obligor parent	
	17a	Current child support order amount for the obligor parent	\$
	17b	Designate 15% or 7.5% for significant variance multiplier	
	17c	Amount required for significant variance to exist	\$
	17d	Actual variance between current and presumptive child support orders	\$

Part VII. Deviations and Final Child Support Order

Deviations must be substantiated by written findings in the Child Support Order	18	Deviations (Specify):	\$
	192	Final Child Support Order	\$

Comments, Calculations, or Rebuttals to Schedule

Place an "X" in the appropriate blank

Has the tribunal identified a parent as a low-income provider?	Yes	No
--	-----	----

Preparer's Use Only

Name: _____ Date: _____

Title: _____

IV-D Use Only

20a	Child Support Obligation	\$	
20b	Medical Support Obligation	\$	

RULEMAKING HEARINGS

(5) Credit Worksheet.

State of Tennessee – Credit Worksheet

Part I. Identification			PRP	ARP	SPLIT
Indicate the status of each parent or caretaker by placing an "X" in the appropriate column	Name of Mother: _____ Name of Father: _____ Name of non-parent: _____ Caretaker: _____ TOSSES case #: _____ Docket #: _____ Court name: _____				

Part II. Other Children			Column A	Column B																
Parent Income Information	1 Monthly gross income of parent claiming credit 2a Self-employment tax paid 2b Applicable gross income for credit worksheet		\$	\$																
In-Home Children	3 Below, list qualified children living in the parent's home (if none, skip to line 7): <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%; text-align: left;">Name(s) of Child(ren) for PRP</th> <th style="width: 15%; text-align: left;">Date of Birth</th> <th style="width: 30%; text-align: left;">Name(s) of Child(ren) for ARP</th> <th style="width: 15%; text-align: left;">Date of Birth</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>	Name(s) of Child(ren) for PRP	Date of Birth	Name(s) of Child(ren) for ARP	Date of Birth															
Name(s) of Child(ren) for PRP	Date of Birth	Name(s) of Child(ren) for ARP	Date of Birth																	
	4 Number of qualified children living in the parent's home 5 Theoretical child support order (this parent's income on 6 CS Schedule for number of children from line 4), 75% of theoretical child support order from line 5		#	#																
Not-In-Home Children	7 Below, list qualified children not living in the parent's home (if none, skip to Part III): <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%; text-align: left;">Name(s) of Child(ren) for PRP</th> <th style="width: 15%; text-align: left;">Date of Birth</th> <th style="width: 30%; text-align: left;">Name(s) of Child(ren) for ARP</th> <th style="width: 15%; text-align: left;">Date of Birth</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>	Name(s) of Child(ren) for PRP	Date of Birth	Name(s) of Child(ren) for ARP	Date of Birth															
Name(s) of Child(ren) for PRP	Date of Birth	Name(s) of Child(ren) for ARP	Date of Birth																	
	8 Number of qualified children not living in the parent's home 9 Average monthly amount of documented monetary 10 support Theoretical child support order (this parent's income on 11a CS Schedule for number of children from line 8), 75% of theoretical child support order from line 10 11b Allowable credit for not-in-home children		#	#																

PART III		Column 1	Column 2	Column 3	Column 4	Column 5	Column 6
Calculator for pro-rata division of expenses –			ARP in this case	ARP's Share	Other Parent	Other Parent's Share	Totals
12	Non-parent Caretaker PRP AGI						
13	Parent's PI						
14	Health Insurance	Non-parent Caretaker					
15	Uninsured Medical						
16	Childcare – payroll deducted						
17	Childcare – not payroll deducted						
18	Total						
19	Adjustment						

RULEMAKING HEARINGS

Authority: T.C.A. §§ 4-5-202; 36-5-101(e); 71-1-105(12),(16); 71-1-132; 42 U.S.C. § 667; 45 C.F.R. § 302.56.

The notice of rulemaking set out herein was properly filed in the Department of State on the 30th day of November, 2005. (11-40)

RULEMAKING HEARINGS

BOARD OF MEDICAL EXAMINERS - 0880 COMMITTEE FOR CLINICAL PERFUSIONISTS

There will be a hearing before the Tennessee Board of Examiners' Committee for Clinical Perfusionists to consider the promulgation of amendments to rules pursuant to T.C.A. §§ 4-5-202, 4-5-204, 63-6-101, 63-28-108, 63-28-114, 63-28-117, and 63-28-118. The hearing will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, Tennessee Code Annotated, Section 4-5-204 and will take place in the Cumberland Room of the Cordell Hull Building located at 425 Fifth Avenue North, Nashville, TN at 3:30 p.m. (CST) on the 31st day of January, 2006.

Any individuals with disabilities who wish to participate in these proceedings (review these filings) should contact the Department of Health, Division of Health Related Boards to discuss any auxiliary aids or services needed to facilitate such participation or review. Such initial contact may be made no less than ten (10) days prior to the scheduled meeting date (the date such party intends to review such filings), to allow time for the Division to determine how it may reasonably provide such aid or service. Initial contact may be made with the ADA Coordinator at the Division of Health Related Boards, 1st Flr., Cordell Hull Building, 425 5th Ave. N., Nashville, TN 37247-1010, (615) 532-4397.

For a copy of the entire text of this notice of rulemaking hearing contact: Jerry Kosten, Regulations Manager, Division of Health Related Boards, 425 Fifth Avenue North, First Floor, Cordell Hull Building, Nashville, TN 37247-1010, (615) 532-4397.

SUBSTANCE OF PROPOSED RULES

AMENDMENTS

Rule 0880-11-.05 Licensure Process, is amended by adding the following language as new subparagraph (2) (g) and renumbering the remaining subparagraphs accordingly, and is further amended by deleting parts (3) (a) 1., (3) (a) 3., and (3) (b) 1. in their entirety and substituting instead the following language, so that as amended, the new subparagraph (2) (g) and the new parts (3) (a) 1., (3) (a) 3., and (3) (b) 1. shall read:

- (2) (g) Cause to be submitted to the Committees administrative office directly from the vendor identified in the Committee's licensure application materials, the result of a criminal background check.
- (3) (a) 1. Comply with all the requirements of paragraph (2) of this rule except subparagraphs (d) and (j); and
- (3) (a) 3. Cause the certification issued pursuant to subparagraph (2) (h) to show that the licensure or certification in another state is current, active and is in good standing without any restriction or encumbrance.
- (3) (b) 1. Comply with all requirements of paragraph (2) of this rule except subparagraphs (d) and (j); and

Authority: T.C.A. §§ 4-5-202, 4-5-204, 63-6-101, 63-28-114, 63-28-117, and 63-28-118.

RULEMAKING HEARINGS

Rule 0880-11-.14 Provisional Licenses, is amended by deleting paragraph (1) in its entirety and substituting instead the following language, so that as amended, the new paragraph (1) shall read:

- (1) A provisional license may be issued to an applicant who has applied for but has yet to take the licensure examination upon compliance with all provisions of rule 0880-11-.05 (2) except subparagraph (j), and submission of proof of having applied to take the examination.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 63-6-101, 63-28-108, 63-28-114, 63-28-117, and 63-28-118.*

The notice of rulemaking set out herein was properly filed in the Department of State on the 22nd day of November, 2005. (11-32(

RULEMAKING HEARINGS

BOARD OF MEDICAL EXAMINERS - 0880

There will be a hearing before the Tennessee Board of Medical Examiners to consider the promulgation of amendments to rules pursuant to T.C.A. §§ 4-5-202, 4-5-204, 63-6-101, 63-6-201, 63-6-204, 63-6-207, 63-6-214, 63-6-215, and 63-8-502. The hearing will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, Tennessee Code Annotated, Section 4-5-204 and will take place in the Cumberland Room of the Cordell Hull Building located at 425 Fifth Avenue North, Nashville, TN at 3:30 p.m. (CST) on the 19th day of January, 2006.

Any individuals with disabilities who wish to participate in these proceedings (review these filings) should contact the Department of Health, Division of Health Related Boards to discuss any auxiliary aids or services needed to facilitate such participation or review. Such initial contact may be made no less than ten (10) days prior to the scheduled meeting date (the date such party intends to review such filings), to allow time for the Division to determine how it may reasonably provide such aid or service. Initial contact may be made with the ADA Coordinator at the Division of Health Related Boards, First Floor, Cordell Hull Building, 425 Fifth Avenue North, Nashville, TN 37247-1010, (615) 532-4397.

For a copy of the entire text of this notice of rulemaking hearing contact:

Jerry Kosten, Regulations Manager, Division of Health Related Boards, 425 Fifth Avenue North, First Floor, Cordell Hull Building, Nashville, TN 37247-1010, (615) 532-4397.

SUBSTANCE OF PROPOSED RULES

AMENDMENTS

Rule 0880-2-.13 Advertising, is amended by adding the following language as new subparagraph (3) (f):

- (3) (f) Remote Services. Any physician who, pursuant to T.C.A. § 63-6-204 (b), is required to have control over and responsibility for medical services being provided at any location other than the primary location or office at which he or she practices medicine a majority of the time must have the following included in any advertisement or on any sign for that location:
1. The physician's name; and
 2. An indication of what, if any, specialty or board certification is held by the physician; and
 3. An indication of whether the physician is available on-site or remotely.

Authority: T.C.A. §§ 4-5-202, 4-5-204, 63-6-101, 63-6-204, 63-6-214 and 63-6-215.

Rule 0880-2-.14 Specifically Regulated Areas and Aspects of Medical Practice, is amended by adding the following language as new paragraphs (12) and (13):

- (12) Any physician who, pursuant to T.C.A. § 63-6-204 (b), is required to have control over and responsibility for medical services being provided by any allied health professional regardless of where those services are being provided must have an unencumbered license just as is currently required for physicians who supervise physician assistants pursuant to rule 0880-2-.18 (1) and certified nurse practitioner prescription writers pursuant to rule 0880-6-.02 (1).
- (13) Medical certification on death certificates - Any physician who is required to and refuses to or consistently fails to comply with the provisions of T.C.A. § 68-3-502 regarding medical certification on death certificates shall be subject to disciplinary action pursuant to T.C.A. § 63-6-214(b)(1).

Authority: T.C.A. §§ 4-5-202, 4-5-204, 63-6-101, 63-6-204, 63-6-214, and 68-3-502.

Rule 0880-2-.21 Office Based Surgery is amended by adding the following language as new subparagraph (2) (c):

RULEMAKING HEARINGS

- (2) (c) Any operating room established to perform Level II and/or Level III surgeries pursuant to this rule may be utilized only by the physician who established it or the group of physicians in whose practice the room is established. The room may not be used by any other physicians except in the case of unanticipated emergency consultation and/or assistance.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 63-6-101, and 63-6-204.*

The notice of rulemaking set out herein was properly filed in the Department of State on the 16th day of November, 2005. (11-16)

RULEMAKING HEARINGS

BOARD OF OPTOMETRY - 1045

There will be a hearing before the Tennessee Board of Optometry to consider the promulgation of amendments to rules pursuant to T.C.A. §§ 4-5-202, 4-5-204, and 63-8-112. The hearing will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, Tennessee Code Annotated, Section 4-5-204 and will take place in the Cumberland Room of the Cordell Hull Building located at 425 Fifth Avenue North, Nashville, TN at 3:30 p.m. (CST) on the 9th day of February, 2006.

Any individuals with disabilities who wish to participate in these proceedings (review these filings) should contact the Department of Health, Division of Health Related Boards to discuss any auxiliary aids or services needed to facilitate such participation or review. Such initial contact may be made no less than ten (10) days prior to the scheduled meeting date (the date such party intends to review such filings), to allow time for the Division to determine how it may reasonably provide such aid or service. Initial contact may be made with the ADA Coordinator at the Division of Health Related Boards, First Floor, Cordell Hull Building, 425 Fifth Avenue North, Nashville, TN 37247-1010, (615) 532-4397.

For a copy of the entire text of this notice of rulemaking hearing contact:

Jerry Kosten, Regulations Manager, Division of Health Related Boards, 425 Fifth Avenue North, First Floor, Cordell Hull Building, Nashville, TN 37247-1010, (615) 532-4397.

SUBSTANCE OF PROPOSED RULES

AMENDMENTS

Rule 1045-2-.02, Licensure Process, is amended by deleting paragraph (3) in its entirety and substituting instead the following language, so that as amended, the new paragraph (3) shall read:

- (3) An applicant shall cause to be submitted directly to the Board administrative office a certified transcript mailed by an accredited college or school of optometry which clearly shows the degree and the date received. The college or school of optometry must be accredited by one (1) of the following:
 - (a) Accreditation Council on Optometric Education (ACOE)
 - (b) National Commission on Accrediting
 - (c) United States secretary of education

Authority: T.C.A. § 4-5-202, 4-5-204, 63-8-112, and 63-8-115.

Rule 1045-2-.07, Diagnostic and Therapeutic Certification, is amended by deleting paragraph (1) in its entirety and substituting instead the following language, so that as amended, the new paragraph (1) shall read:

- (1) It is the intent of the Board that all applicants for licensure as optometrists attain the highest level of licensure available under the law including diagnostic and therapeutic certification as provided in T.C.A. §§63-8-102(12)(E) and 63-8-112(4). Attaining therapeutic certification must include attaining certification to use pharmaceutical agents by injection.

Authority: T.C.A. § 4-5-202, 4-5-204, 63-8-102, 63-8-112, and 63-8-115.

RULEMAKING HEARINGS

Rule 1045-2-.13 Optometric Professional Corporations and Optometric Professional Limited Liability Companies, is amended by deleting paragraphs (1), (2), and (3) in their entirety and substituting instead the following language, and is further amended by adding the following language as new paragraph (5), so that as amended, the new paragraphs (1), (2), (3), and (5) shall read:

- (1) Optometric Professional Corporations (OPC) - Except as provided in this rule Optometric Professional Corporations shall be governed by the provisions of Tennessee Code Annotated, Title 48, Chapter 101, Part 6.
 - (a) Filings – An OPC need not file its Charter or its Annual Statement of Qualifications with the Board.
 - (b) Ownership of Stock - With the exception of the health care professional combinations specifically enumerated in Tennessee Code Annotated, Section 48-101-610 only the following may form and own shares of stock in a foreign or domestic OPC doing business in Tennessee:
 1. Optometrists licensed pursuant to Tennessee Code Annotated Title 63, Chapter 8 or licensed in another state; and/or
 2. A foreign or domestic general partnership, OPC or OPLLC in which all partners, shareholders, members or holders of financial rights are either:
 - (i) Optometrists licensed pursuant to Tennessee Code Annotated, Title 63, Chapter 8 to practice optometry in Tennessee or optometrists licensed by other states, or composed of entities which are directly or indirectly owned by such licensed optometrists; and/or
 - (ii) Professionals authorized by Tennessee Code Annotated §§ 48-101-610, 48-248-401, or 48-249-1109 to either own shares of stock in an OPC or be a member or holder of financial rights in an OPLLC; and/or
 - (iii) A combination of professionals authorized by subparts (i) and (ii).
 - (c) Officers and Directors of Optometric Professional Corporations -
 1. All, except the following officers, must be persons who are eligible to form or own shares of stock in an optometric professional corporation as limited by T.C.A. § 48-101-610 (d) and subparagraph (1) (b) of this rule:
 - (i) Secretary;
 - (ii) Assistant Secretary;
 - (iii) Treasurer; and
 - (iv) Assistant Treasurer.
 2. With respect to members of the Board of Directors, only persons who are eligible to form or own shares of stock in an optometric professional corporation as limited by T.C.A. Section 48- 101-610 (d) and subparagraph (1) (b) of this rule shall be directors of an OPC.

RULEMAKING HEARINGS

- (d) Practice Limitations
1. Engaging in, or allowing another optometrist incorporator, shareholder, officer, or director, while acting on behalf of the OPC, to engage in, optometric practice in any area of practice or specialty beyond that which is specifically set forth in the charter may be a violation of Tennessee Code Annotated, Section 63-8-120 (2).
 2. Nothing in these rules shall be construed as prohibiting any health care professional licensed pursuant to Tennessee Code Annotated, Title 63 from being an employee of or a contractor to an OPC.
 3. Nothing in these rules shall be construed as prohibiting an OPC from electing to incorporate for the purposes of rendering professional services within two (2) or more professions or for any lawful business authorized by the Tennessee Business Corporations Act so long as those purposes do not interfere with the exercise of independent optometric judgment by the optometrist incorporators, directors, officers, shareholders, employees or contractors of the OPC who are practicing optometry as defined by Tennessee Code Annotated, Section 63-8-102 (12).
 4. Nothing in these rules shall be construed as prohibiting an optometrist from owning shares of stock in any type of professional corporation other than an OPC so long as such ownership interests do not interfere with the exercise of independent optometric judgment by the optometrist while practicing optometry as defined by Tennessee Code Annotated, Section 63-8-102 (12).
- (2) Optometric Professional Limited Liability Companies (OPLLC) - Except as provided in this rule Optometric Professional Limited Liability Companies shall be governed by either the provisions of Tennessee Code Annotated, Title 48, Chapters 248 or 249.
- (a) Filings - Articles filed with the Secretary of State shall be deemed to be filed with the Board and no Annual Statement of Qualifications need be filed with the Board.
- (b) Membership - With the exception of the health care professional combinations specifically enumerated in Tennessee Code Annotated, Sections 48-248-401 or 48-249-1109 only the following may be members or holders of financial rights of a foreign or domestic OPLLC doing business in Tennessee:
1. Optometrists licensed pursuant to Tennessee Code Annotated Title 63, Chapter 8 or licensed in other states; and/or
 2. A foreign or domestic general partnership, OPC or OPLLC in which all partners, shareholders, members or holders of financial rights are either:
 - (i) Optometrists licensed pursuant to Tennessee Code Annotated Title 63, Chapter 8 to practice optometry in Tennessee or optometrists licensed by other states or composed of entities which are directly or indirectly owned by such licensed optometrists; and/or
 - (ii) Professionals authorized by Tennessee Code Annotated, Sections 48-101-610, 48-248-401, or 48-249-1109 to either own shares of stock in an OPC or be a member or holder of financial rights in an OPLLC; and/or

RULEMAKING HEARINGS

(iii) A combination of professionals authorized by subparts (i) and (ii).

(c) Managers, Directors or Governors of an OPLLC

1. All, except the following managers, must be persons who are eligible to form or become members or holders of financial rights of an optometric professional limited liability company as limited by T.C.A. § 48-248-401 and subparagraph (2) (b) of this rule:
 - (i) Secretary
 - (ii) Treasurer
2. Only persons who are eligible to form or become members or holders of financial rights of an optometric professional limited liability company as limited by T.C.A. § 48-248-401 and subparagraph (2) (b) of this rule shall be allowed to serve as a director, or serve on the Board of Governors of an OPLLC.

(d) Practice Limitations

1. Engaging in, or allowing another optometrist member, officer, manager, director, or governor, while acting on behalf of the OPLLC, to engage in, optometric practice in any area of practice or specialty beyond that which is specifically set forth in the articles of organization may be a violation of Tennessee Code Annotated, Sections 63-8-120 (2).
 2. Nothing in these rules shall be construed as prohibiting any health care professional licensed pursuant to Tennessee Code Annotated, Title 63 from being an employee of or a contractor to an OPLLC.
 3. Nothing in these rules shall be construed as prohibiting an OPLLC from electing to form for the purposes of rendering professional services within two (2) or more professions or for any lawful business authorized by the Tennessee Business Corporations Act so long as those purposes do not interfere with the exercise of independent optometric judgment by the optometrist members or holders of financial rights, governors, officers, managers, employees or contractors of the OPLLC who are practicing optometry as defined by Tennessee Code Annotated, Section 63-8-102 (12).
 4. Nothing in these rules shall be construed as prohibiting An optometrist from being a member of any type of professional limited liability company other than an OPLLC so long as such membership interests do not interfere with the exercise of independent optometric judgment by the optometrist while practicing optometry as defined by Tennessee Code Annotated, Section § 63-8-102 (12).
 5. All OPLLCs formed in Tennessee pursuant to Tennessee Code Annotated, Sections 48-248-104 or 48-249-101, et seq., to provide services only in states other than Tennessee shall annually file with the Board a notarized statement that they are not providing services in Tennessee.
- (3) Dissolution - The procedure that the Board shall follow to notify the attorney general that an OPC or a OPLLC has violated or is violating any provision of Title 48, Chapters 101, 248 or 249, shall be as follows but shall not terminate or interfere with the secretary of state's authority regarding dissolution pursuant to Tennessee Code Annotated, Sections 48-101-624 or 48-248-409.
- (a) Service of a written notice of violation by the Board on the registered agent of the OPC

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and/or OPLLC or the secretary of state if a violation of the provisions of Tennessee Code Annotated, Title 48, Chapters 101, 248 or 249 occurs.

- (b) The notice of violation shall state with reasonable specificity the nature of the alleged violation(s).
 - (c) The notice of violation shall state that the OPC and/or OPLLC must, within sixty (60) days after service of the notice of violation, correct each alleged violation or show to the Board's satisfaction that the alleged violation(s) did not occur.
 - (d) The notice of violation shall state that, if the Board finds that the OPC and/or OPLLC is in violation, the attorney general will be notified and judicial dissolution proceedings may be instituted pursuant to Tennessee Code Annotated, Title 48.
 - (e) The notice of violation shall state that proceedings pursuant to this section shall not be conducted in accordance with the contested case provisions of the Uniform Administrative Procedures Act, compiled in Title 4, Chapter 5 but that the OPC and/or OPLLC, through its agent(s), shall appear before the Board at the time, date, and place as set by the Board and show cause why the Board should not notify the attorney general and reporter that the organization is in violation of the Act or these rules. The Board shall enter an order that states with reasonable particularity the facts describing each violation and the statutory or rule reference of each violation. These proceedings shall constitute the conduct of administrative rather than disciplinary business.
 - (f) If, after the proceeding the Board finds that an OPC and/or OPLLC did violate any provision of Title 48, Chapters 101, 248, and/or 249 or these rules, and failed to correct said violation or demonstrate to the Board's satisfaction that the violation did not occur, the Board shall certify to the attorney general and reporter that it has met all requirements of either Tennessee Code Annotated, Sections 48-101-624 (1) - (3) and/or 48-248-409 (1)-(3) and/or 48-249-101, et seq.
- (5) The authority to own shares of stock or be members or holders of financial rights in an OPC or an OPLLC granted by statute or these rules to professionals not licensed in this state shall in no way be construed as authorizing the practice of any profession in this state by such unlicensed professionals.

Authority: T.C.A. §§4-5-202, 4-5-204, 48-101-605, 48-101-608, 48-101-610, 48-101-618, 48-101-624, 48-101-628, 48-101-629, 48-101-630, 48-248-104, 48-248-202, 48-248-401, 48-248-404, 48-248-409, 48-248-501, 48-248-601, 48-248-602, 48-248-603, 48-249-101, et seq., 63-8-102, 63-8-112, 63-8-115, and 63-8-120.

The notice of rulemaking set out herein was properly filed in the Department of State on the 30th day of November, 2005. (11-42)

RULEMAKING HEARINGS

BOARD OF OCCUPATIONAL AND PHYSICAL THERAPY EXAMINERS - 1150 COMMITTEE OF PHYSICAL THERAPY

There will be a hearing before the Tennessee Board of Occupational and Physical Therapy Examiners' Committee of Physical Therapy to consider the promulgation of an amendment to a rule and a new rule pursuant to T.C.A. §§ 4-5-202, 4-5-204, 63-13-108, and 63-13-304. The hearing will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, Tennessee Code Annotated, Section 4-5-204 and will take place in the Cumberland Room of the Cordell Hull Building located at 425 Fifth Avenue North, Nashville, TN at 3:30 p.m. (CST) on the 17th day of January, 2006.

Any individuals with disabilities who wish to participate in these proceedings (review these filings) should contact the Department of Health, Division of Health Related Boards to discuss any auxiliary aids or services needed to facilitate such participation or review. Such initial contact may be made no less than ten (10) days prior to the scheduled meeting date (the date such party intends to review such filings), to allow time for the Division to determine how it may reasonably provide such aid or service. Initial contact may be made with the ADA Coordinator at the Division of Health Related Boards, First Floor, Cordell Hull Building, 425 Fifth Avenue North, Nashville, TN 37247-1010, (615) 532-4397.

For a copy of the entire text of this notice of rulemaking hearing contact:

Jerry Kosten, Regulations Manager, Division of Health Related Boards, 425 Fifth Avenue North, First Floor, Cordell Hull Building, Nashville, TN 37247-1010, (615) 532-4397.

SUBSTANCE OF PROPOSED RULES

AMENDMENT

Rule 1150-1-.12, Continuing Competence, is amended by deleting paragraph (2) in its entirety and substituting instead the following language, and is further amended by deleting paragraph (3) but not its subparagraphs and substituting instead the following language, and is further amended by deleting paragraph (4) in its entirety and substituting instead the following language, so that as amended, the new paragraph (2), the new paragraph (3) but not its subparagraphs, and the new paragraph (4) shall read:

- (2) For applicants approved for initial licensure by examination, successfully completing the requirements of Rules 1150-1-.04, .05, and .08, as applicable, shall be considered proof of sufficient competence to constitute compliance with all aspects of this rule for the initial period of licensure except for the ethics and jurisprudence education requirements of paragraph (4). Applicants approved for initial licensure by examination must successfully complete four (4) hours of ethics and jurisprudence education during their initial period of licensure.
- (3) Two (2) Year Requirement (January 1-December 31) - Continuing competence credit is awarded for the clock hours spent in an activity as provided in paragraphs (5) and (6). Except as provided in paragraph (4), all required hours may be met through Class I activities. Except as provided in paragraph (4), any Class I activity without a stated maximum number of hours may be used to accrue all required hours.
- (4) Four (4) of the hours in parts (3) (a) 1. and (3) (b) 1. must be ethics and jurisprudence education courses and is required every other two (2) calendar year period.
 - (a) Jurisprudence – This course shall be a minimum of two (2) hours, shall be Class I continuing competence as provided in paragraph (5), and shall as a minimum include education in:

RULEMAKING HEARINGS

1. The Occupational and Physical Therapy Practice Act (Tennessee Code Annotated, Title 63, Chapter 13, Parts 1 and 3);
 2. General Rules Governing the Practice of Physical Therapy (Official Compilation, Rules and Regulations, Chapter 1150-1);
 3. Committee of Physical Therapy Policy Statements;
 4. Licensure process;
 5. Scope of practice;
 6. Licensure renewal;
 7. Disclosures to patients;
 8. Offenses that may lead to disciplinary action;
 9. Supervision of Physical Therapy Assistants;
 10. Supervision of Physical Therapy assistive personnel; and
 11. Supervision of others (students, volunteers).
- (b) Ethics – This course shall be a minimum of two (2) hours, shall be Class I continuing competence as provided in paragraph (5), and shall as a minimum include education in:
1. APTA Code of Ethics;
 2. APTA Guide for Professional Conduct;
 3. APTA Standards of Ethical Conduct for the Physical Therapist Assistant;
 4. APTA Guide for Conduct of the Physical Therapist Assistant;
 5. Model for ethical decision making; and
 6. Case analysis.
- (c) Course approval – The Committee does not pre-approve Class I and Class II continuing competence courses, programs, and activities required by paragraph (5) and (6). It is the licensee's responsibility, using his/her professional judgment, to determine if the ethics and jurisprudence courses being taken are applicable, appropriate, and meet the requirements of this paragraph. However, an ethics and jurisprudence course provider must seek the Committee's course approval by submitting the following information to the Committee's administrative office at least thirty (30) days prior to a regularly scheduled meeting of the Committee that precedes the course:
1. Course description or outline;
 2. Names of all lecturers;
 3. Brief resume of all lecturers;

RULEMAKING HEARINGS

4. Date of course; and
5. How certification of attendance is to be documented.

Authority: T.C.A. §§ 4-5-202, 4-5-204, 63-13-108, and 63-13-304.

NEW RULE

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1150-1-.13 Advertising

1150-1-.13 ADVERTISING.

- (1) Policy Statement. The lack of sophistication on the part of many of the public concerning physical therapy services, the importance of the interests affected by the choice of a physical therapist and the foreseeable consequences of unrestricted advertising by physical therapists which is recognized to pose special possibilities for deception, require that special care be taken by physical therapists to avoid misleading the public. The physical therapist must be mindful that the benefits of advertising depend upon its reliability and accuracy. Since advertising by physical therapists is calculated and not spontaneous, reasonable regulation designed to foster compliance with appropriate standards serves the public interest without impeding the flow of useful, meaningful, and relevant information to the public.
- (2) Definitions
 - (a) Advertisement. Informational communication to the public in any manner designed to attract public attention to the practice of a physical therapist who is licensed to practice in Tennessee.
 - (b) Licensee - Any person holding a license to practice physical therapy in the State of Tennessee. Where applicable this shall include partnerships and/or corporations.
 - (c) Material Fact - Any fact which an ordinary reasonable and prudent person would need to know or rely upon in order to make an informed decision concerning the choice of physical therapists to serve his or her particular needs.
 - (d) Bait and Switch Advertising - An alluring but insincere offer to sell a product or service which the advertiser in truth does not intend or want to sell. Its purpose is to switch consumers from buying the advertised service or merchandise, in order to sell something else, usually for a higher fee or on a basis more advantageous to the advertiser.
 - (e) Discounted Fee - Shall mean a fee offered or charged by a person or product or service that is less than the fee the person or organization usually offers or charges for the product or service. Products or services expressly offered free of charge shall not be deemed to be offered at a "discounted fee".
- (3) Advertising Fees and Services

RULEMAKING HEARINGS

- (a) Fixed Fees. Fixed fees may be advertised for any service. It is presumed unless otherwise stated in the advertisement that a fixed fee for a service shall include the cost of all professional recognized components within generally accepted standards that are required to complete the service.
 - (b) Range of Fees. A range of fees may be advertised for services and the advertisement must disclose the factors used in determining the actual fee, necessary to prevent deception of the public.
 - (c) Discount Fees. Discount fees may be advertised if:
 - 1. The discount fee is in fact lower than the licensee's customary or usual fee charged for the service; and
 - 2. The licensee provides the same quality and components of service and material at the discounted fee that are normally provided at the regular, non-discounted fee for that service.
 - (d) Related Services and Additional Fees. Related services which may be required in conjunction with the advertised services for which additional fees will be charged must be identified as such in any advertisement.
 - (e) Time Period of Advertised Fees.
 - 1. Advertised fees shall be honored for those seeking the advertised services during the entire time period stated in the advertisement whether or not the services are actually rendered or completed within that time.
 - 2. If no time period is stated in the advertisement of fees, the advertised fee shall be honored for thirty (30) days from the last date of publication or until the next scheduled publication whichever is later whether or not the services are actually rendered or completed within that time.
- (4) Advertising Content. The following acts or omissions in the context of advertisement by any licensee shall constitute unethical conduct, and subject the licensee to disciplinary action pursuant to T.C.A. §63-13-313.
- (a) Claims that the services performed, personnel employed, materials or office equipment used are professionally superior to that which is ordinarily performed, employed, or used, or that convey the message that one licensee is better than another when superiority of services, personnel, materials or equipment cannot be substantiated.
 - (b) The misleading use of an unearned or non-health degree in any advertisement.
 - (c) Promotion of professional services which the licensee knows or should know is beyond the licensee's ability to perform.
 - (d) Techniques of communication which intimidate, exert undue pressure or undue influence over a prospective client.
 - (e) Any appeals to an individual's anxiety in an excessive or unfair manner.

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- (f) The use of any personal testimonial attesting to a quality of competency of a service or treatment offered by a licensee that is not reasonably verifiable.
- (g) Utilization of any statistical data or other information based on past performances for prediction of future services, which creates an unjustified expectation about results that the licensee can achieve.
- (h) The communication of personal identifiable facts, data, or information about a patient without first obtaining patient consent.
 - (i) Any misrepresentation of a material fact.
- (j) The knowing suppression, omission or concealment of any material fact or law without which the advertisement would be deceptive or misleading.
- (k) Statements concerning the benefits or other attributes of therapeutic procedures or products that involve significant risks without including:
 - 1. A realistic assessment of the safety and efficiency of those procedures or products; and
 - 2. The availability of alternatives; and
 - 3. Where necessary to avoid deception, descriptions or assessment of the benefits or other attributes of those alternatives.
- (l) Any communication which creates an unjustified expectation concerning the potential results of any treatment.
- (m) Failure to comply with the rules governing advertisement of fees and services, or advertising records.
- (n) The use of "bait and switch" advertisements. Where the circumstances indicate "bait and switch" advertising, the Committee may require the licensee to furnish data or other evidence pertaining to those sales at the advertised fee as well as other sales.
- (o) Misrepresentation of a licensee's credentials, training, experience, or ability.
- (p) Failure to include the corporation, partnership or individual licensee's name, address, and telephone number in any advertisement. Any corporation, partnership or association which advertises by use of a trade name or otherwise fails to list all licensees practicing at a particular location shall:
 - 1. Upon request provide a list of all licensees practicing at that location; and
 - 2. Maintain and conspicuously display at the licensee's office, a directory listing all licensees practicing at that location.
- (q) Failure to disclose the fact of giving compensation or anything of value to representative of the press, radio, television or other communicative medium in anticipation of or in return for any advertisement (for example, newspaper article) unless the nature, format or medium of such advertisement make the fact of compensation apparent.

RULEMAKING HEARINGS

- (r) After thirty (30) days of the licensee's departure, the use of the name of any licensee formerly practicing at or associated with any advertised location or on office signs or buildings. This rule shall not apply in the case of a retired or deceased former associate who practiced in association with one or more of the present occupants if the status of the former associate is disclosed in any advertisement or sign.
 - (s) Stating or implying that a certain licensee provides all services when any such services are performed by another licensee.
 - (t) Directly or indirectly offering, giving, receiving, or agreeing to receive any fee or other consideration to or from a third party for the referral of a patient in connection with the performance of professional services.
- (5) Advertising Records and Responsibility
- (a) Each licensee who is a principal partner, or officer of a firm or entity identified in any advertisement, is jointly and severally responsible for the form and content of any advertisement. This provision shall also include any licensed professional employees acting as an agent of such firm or entity.
 - (b) Any and all advertisements are presumed to have been approved by the licensee named therein.
 - (c) A recording of every advertisement communicated by electronic media, and a copy of every advertisement communicated by print media, and a copy of any other form of advertisement shall be retained by the licensee for a period of two (2) years from the last date of broadcast or publication and be made available for review upon request by the Committee or its designee.
 - (d) At the time any type of advertisement is placed, the licensee must possess and rely upon information which, when produced, would substantiate the truthfulness of any assertion, omission or representation of material fact set forth in the advertisement or public information.
- (6) Severability. It is hereby declared that the sections, clauses, sentences and part of these rules are severable, are not matters of mutual essential inducement, and any of them shall be rescinded if these rules would otherwise be unconstitutional or ineffective. If any one or more sections, clauses, sentences or parts shall for any reason be questioned in court, and shall be adjudged unconstitutional or invalid, such judgment shall not affect, impair or invalidate the remaining provisions thereof, but shall be confined in its operation to the specific provision or provisions so held unconstitutional or invalid, and the inapplicability or invalidity of any section, clause, sentence or part in any one or more instance shall not be taken to affect or prejudice in any way its applicability or validity in any other instance.

Authority: T.C.A. §§ 4-5-202, 4-5-204, 63-13-108, 63-13-304, 63-13-310, 63-13-312, 63-13-313, and Public Chapter 467 of the Public Acts of 2005.

The notice of rulemaking set out herein was properly filed in the Department of State on the 21st day of November, 2005. (11-31)



CERTIFICATE OF APPROVAL

As provided by T.C.A., Title 4, Chapter 5, I hereby certify that to the best of my knowledge, this issue of the Tennessee Administrative Register contains all documents required to be published that were filed with the Department of State in the period beginning November 1, 2005 and ending November 30, 2005.

A handwritten signature in black ink, reading 'Riley C. Darvell'.

Secretary of State