

# TAR

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**RILEY C. DARNELL**  
*Secretary of State*

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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*.

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**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 form in the back of each issue.

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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 11.50%.

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.

Greg Gonzales

### **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 April 2006 is 8.71 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 4.71 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.

Greg Gonzales

## 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
02-01	Feb 1 2006	<b>0260</b> <b>Chiropractic Examiners</b>	Rulemaking Hearing Rules	Amendment	<i>Chapter 0260-2</i> <i>General Rules Governing Chiropractic Examiners</i> 0260-2-.15 Disciplinary Actions Civil Penalties Screening Panels Subpoenas and Assessment of Costs	Robert J. Kraemer Jr. Office of General Counsel 26th Fl TN Twr 312 8th Ave N Nashville TN 37247-0120 (615) 741-1611	April 17, 2006
02-02	Feb 3 2006	<b>0800</b> <b>Labor and Workforce Development</b> Division of Workers' Compensation	Rulemaking Hearing Rules	New Rules	<i>Chapter 0800-2-17</i> <i>Medical Cost Containment Program</i> 0800-2-17-.01 Purpose and Scope 0800-2-17-.02 Severability and Preemption 0800-2-17-.03 Definitions 0800-2-17-.04 Information 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 Utilization Review 0800-2-17-.21 Process for Resolving Differences Between Carriers and Providers Regarding Bills 0800-2-17-.22 Administrative Review of Fee Schedule Disputes/Hearings 0800-2-17-.23 Rule Review 0800-2-17-.24 Provider and Facility Fees for Copies of Medical Records 0800-2-17-.01 Purpose and Scope	E. Blaine Sprouse Workers' Compensation Labor & Workforce Development Andrew Johnson Twr 2nd Fl 710 James Robertson Pkwy Nashville TN 37243-0661 (615) 253-0064	April 19, 2006

ANNOUNCEMENTS

SEQ. NO.	DATE FILED	DEPARTMENT AND DIVISION	TYPE OF FILING	DESCRIPTION	RULE NUMBER AND RULE TITLE	LEGAL CONTACT	EFFECTIVE DATE
02-03	Feb 3 2006	<b>0800 Labor and Workforce Development</b> Division of Workers' Compensation	Rulemaking Hearing Rules	New Rules	<i>Chapter 0800-2-18</i> <i>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 and Implant Guidelines 0800-2-18-.11 Orthotics and Prosthetics Guidelines 0800-2-18-.12 Pharmacy 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 Andrew Johnson Twr 2nd Fl 710 James Robertson Pkwy Nashville TN 37243-0661 (615) 253-0064	April 19, 2006
02-04	Feb 3 2006	<b>0800 Labor and Workforce Development</b> Division of Workers' Compensation	Rulemaking Hearing Rules	New Rules	<i>Chapter 0800-2-19</i> <i>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 Pre-admission Utilization Review 0800-2-19-.05 Other Services 0800-2-19-.06 Penalties for Violations of Fee Schedules	E. Blaine Sprouse Workers' Compensation Labor & Workforce Development Andrew Johnson Twr 2nd Fl 710 James Robertson Pkwy Nashville TN 37243-0661 (615) 253-0064	April 19, 2006
02-05	Feb 3 2006	<b>0800 Labor and Workforce Development</b> Division of Workers' Compensation	Rulemaking Hearing Rule	Amendments	<i>Chapter 0800-2-16</i> <i>Deposition Fees</i> 0800-2-16-.01 Deposition Fees	Mark Finks Labor and Workforce Development Andrew Johnson Twr 2nd Fl 710 James Robertson Pkwy Nashville TN 37243-0661 (615) 253-6267	April 19, 2006

ANNOUNCEMENTS

SEQ. NO.	DATE FILED	DEPARTMENT AND DIVISION	TYPE OF FILING	DESCRIPTION	RULE NUMBER AND RULE TITLE	LEGAL CONTACT	EFFECTIVE DATE
02-06	Feb 6 2006	<b>0800 Labor and Workforce Development</b> Boiler and Elevator Inspection Board of Boiler Rules	Proposed Rules	Amendments	<i>Chapter 0800-3-3 Boiler Inspections</i> 0800-3-3-.01 Definitions 0800-3-3-.05 Existing Power Boilers 0800-3-3-.08 Historic Boilers	Martin Toth Labor and Workforce Development Andrew Johnson Twr 2nd Fl 710 James Robertson Pkwy Nashville TN 37243-0661 (615) 741-2123	June 28, 2006
02-08	Feb 9 2006	<b>0400 Environment and Conservation</b> Tennessee Petroleum Underground Storage Tank Board	Rulemaking Hearing Rule	Amendments  New Rule	<i>Chapter 1200-1-15 Underground Storage Tank Program</i> 1200-1-15-.02 UST Systems: Installation and Operation  1200-1-15-.13 Voluntary Registry	Alan M. Leiserson Environment and Conservation L & C Twr 20th Fl 401 Church St Nashville TN 37243 615-532-0125	April 25, 2006
02-13	Feb 14 2006	<b>0400 Environment and Conservation</b> Bureau of Environment Division of Air Pollution Control	Rulemaking Hearing Rules	Amendment	<i>Chapter 1200-3-18 Volatile Organic Compounds</i> 1200-3-18-.24 Gasoline Dispensing Facilities – Stage I and Stage II Vapor Recovery		May 1, 2006
02-15	Feb 15 2006	1050 Osteopathic Examination's Council of Certified Professional Midwifery	Rulemaking Hearing Rules	Amendment	<i>Chapter 1050-5 General Rules Governing Certified Professional Midwives</i> 1050-5-.06 Fees	Robert J. Kraemer Health OGC 26th Fl TN Twr 312 8th Ave N Nashville TN 37247-0120 615-741-1611	May 1, 2006
02-16	Feb 15 2006	<b>1200 Health</b> TN Medical Laboratory Board Health Related Boards	Rulemaking Hearing Rules	Amendments	<i>Chapter 1200-6-1 General Rules Governing Medical Laboratory Personnel</i> 1200-6-1-.20 Qualifications and Duties of the Medical Laboratory Director 1200-6-1-.21 Qualifications and Duties of the Medical Laboratory Supervisor  <i>Chapter 1200 6 3 General Rules Governing Medical Laboratories</i> 1200-6-3-.09 Quality Control 1200-6-3-.12 Referrals of Cultures to the Department of Health 1200-6-3-.16 Alternate Site Testing	Robert J. Kraemer Health OGC 26th Fl TN Twr 312 8th Ave N Nashville TN 37247-0120 615-741-1611	May 1, 2006

ANNOUNCEMENTS

SEQ. NO.	DATE FILED	DEPARTMENT AND DIVISION	TYPE OF FILING	DESCRIPTION	RULE NUMBER AND RULE TITLE	LEGAL CONTACT	EFFECTIVE DATE
02-16, cont.					<p><i>Chapter 1200-8-26</i>  <i>Standards for Homecare Organizations Providing Home Health Services</i>                      1200-8-26-.02 Licensing Procedures</p> <p><i>Chapter 1200-8-27</i>  <i>Standards for Homecare Organizations Providing Hospice Services</i>                      1200-8-27-.02 Licensing Procedures</p> <p><i>Chapter 1200-8-28</i>  <i>Standards for HIV Supportive Living Facilities</i>                      1200-8-28-.02 Licensing Procedures</p> <p><i>Chapter 1200-8-29</i>  <i>Standards for Homecare Organizations Providing Home Medical Equipment</i>                      1200-8-29-.02 Licensing Procedures</p> <p><i>Chapter 1200-8-32</i>  <i>Standards for End Stage Renal Dialysis Clinics</i>                      1200-8-32-.02 Licensing Procedures</p> <p><i>Chapter 1200-8-34</i>  <i>Standards for Homecare Organizations Providing Professional Support Services</i>                      1200-8-34-.02 Licensing Procedures</p> <p><i>Chapter 1200-8-35</i>  <i>Standards for Outpatient Diagnostic Centers</i>                      1200-8-35-.02 Licensing Procedures</p>		
02-23	Feb 23 2006	<b>1200 Health</b> Board for Licensing Health Care Facilities	Rulemaking Hearing Rules	Amendments	<p><i>Chapter 1200-8-1</i>  <i>Standards for Hospitals</i>                      1200-8-1-.01 Definitions                      1200-8-1-.07 Optional Hospital Services</p> <p><i>Chapter 1200-8-10</i>  <i>Standards for Ambulatory Surgical Treatment Centers</i>                      1200-8-10-.01 Definitions                      1200-8-10-.06 Basic Services</p>	Richard Russell Health OGC 26th Fl TN Twr 312 8th Ave N Nashville TN 37247-0120 615-741-1611	May 9, 2006

ANNOUNCEMENTS

SEQ. NO.	DATE FILED	DEPARTMENT AND DIVISION	TYPE OF FILING	DESCRIPTION	RULE NUMBER AND RULE TITLE	LEGAL CONTACT	EFFECTIVE DATE
02-25	Feb 27 2006	<b>1200 Health</b> Board for Licensing Health Care Facilities	Rulemaking Hearing Rules	Amendments  New Rule	<i>Chapter 1200-8-22 Alcohol and other Drugs of Abuse Halfway House Treatment Facilities</i> 1200-8-22-.01 Definitions 1200-8-22-.07 Building Standards 1200-8-22-.08 Life Safety  1200-8-22-.12 Policies and Procedures for Health Care Decision-Making	Ernest Sykes Jr. Health OGC 26th Fl TN Twr 212 8th Ave N Nashville TN 37247-0120 615-532-7156	May 13, 2006
02-36	Feb 28, 2006	<b>0030 Aging and Disability</b>	Proposed Rules	Amendments	<i>Chapter 0030-1-10 Intrastate Funding Formula</i> 0030-1-10-.01 Intrastate Funding Formula	Nancy C. Peace Executive Director 500 Deaderick Street Suite 825 Nashville, TN 37243 (615) 741-2056	June 28, 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.

## **EMERGENCY RULES**

### **EMERGENCY RULES NOW IN EFFECT**

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

- 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)
- 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)

## **PROPOSED RULES**

### **THE TENNESSEE COMMISSION ON AGING AND DISABILITY - 0030**

#### **CHAPTER 0030-1-10-.01 INTRASTATE FUNDING FORMULA**

Presented herein are proposed amendments of the Tennessee Commission on Aging and Disability submitted pursuant to T.C.A. §4-5-202 in lieu of a rulemaking hearing. It is the intent of the Tennessee Commission on Aging and Disability 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 Tennessee Commission on Aging and Disability, 8<sup>th</sup> Floor, Andrew Jackson Building, 500 Deaderick Street, Suite 825, Nashville, TN 37243-0860, and in the Department of State, 8<sup>th</sup> Floor, Snodgrass Tower, 312 8<sup>th</sup> Avenue North, Nashville, TN 37242, 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: Nancy C. Brode, Supervisor of Planning, Tennessee Commission on Aging and Disability, 8<sup>th</sup> Floor, Andrew Jackson Building, 500 Deaderick Street, Suite 825, Nashville, TN 37243-0860, 615-741-2056.

The text of the proposed amendments as follows:

#### **AMENDMENTS**

Rule 0030-1-10-.01 Intrastate Funding Formula is amended by deleting sub-paragraph (1)(b) in its entirety and substituting instead the following language, so that as amended, the new sub-paragraph (1)(b) shall read:

- (b) Ninety percent of the Title III funds for area agencies is allocated for services. This amount shall be distributed as follows:
  - 1. Thirty-five percent of the services allocation shall be distributed among the area agencies in proportion to each planning and service area's share of the total number of elderly persons (aged 60 and over) in the state.
  - 2. Thirty percent of the services allocation shall be distributed among the area agencies in proportion to each planning and service area's share of the total number of elderly persons with income below 100% of the poverty level established by the Office of Management and Budget.

## PROPOSED RULES

3. Ten percent of the services allocation shall be distributed among the area agencies in proportion to each planning and service area's share of the total number of minority elderly persons with income at or below 100% of the poverty level established by the Office of Management and Budget.
4. Fifteen percent of the services allocation shall be distributed among the area agencies in proportion to each planning and service area's share of the total number of elderly living in rural areas (as defined by the Census Bureau).
5. Ten percent of the services allocation shall be distributed among the area agencies in proportion to each planning and service area's share of the total number of elderly persons who are age 80 and above.

Sub-paragraph (1)(d) of rule 0030-1-10-.01 is amended by deleting it in its entirety and substituting instead the following language, so that as amended, the new sub-paragraph (1)(d) shall read:

- (d) The source of data for all formula factors listed in sub-paragraph (1)(b) above shall be the most recent decennial federal census of population.

Authority: T.C.A. §§71-2-105 and 71-2-104(a).

The proposed rules set out herein were properly filed in the Department of State on the 28th day of February, 2006, 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 28th day of June, 2006. (02-36)

PROPOSED RULES

**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 W. 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**

Paragraph (18) of Rule 0800-3-3-.01 Definitions is amended by deleting that language entirely and substituting the following language, so that as amended the rule shall read:

(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 Tennessee.

(a) This definition shall be interpreted to include the following two types of historic boilers:

1. Traditional: Any steam traction engine, portable or stationary, standard or nonstandard power boiler that was constructed prior to July 1, 1949.
2. Nontraditional: Any free-lance and scale models, standard or nonstandard power boiler that was constructed after July 1, 1949.
  - (i) Free-lance is any nontraditional historic power boiler built without original drawings, calculations or blueprints.
  - (ii) Scale model is any nontraditional historic power boiler built as an exact or scale replica of a traditional historic power boiler.

## PROPOSED RULES

**Authority:** T.C.A. §§ 68-122-101, 68-122-102 and 68-122-104.

Parts 1 and 2 of Subparagraph (a) of Paragraph (1) and Subparagraph (b) of Paragraph (1) of Rule 0800-3-3-.05 Existing Power Boilers are amended by deleting that language entirely and substituting the following language, so that as amended the rule shall read:

- (1) Age Limits.
  - (a) There shall be an age limit of 30 years for any nonstandard existing power boiler, except for the following:
    1. Any such boiler not having a lap-riveted longitudinal joint may be continued in operation for so long as no distress or leakage develops during a pressure test with water temperature between 60° to 120° F, of no more than 90% of the set pressure of the lowest setting pressure relief device on the boiler, held for a period of at least thirty (30) minutes.
    2. Any such boiler having lap-riveted longitudinal joints and operating at a pressure in excess of 50 psig shall have an age limit of 20 years. When removed from an existing setting, this type of boiler shall not be reinstated for a pressure in excess of 15 psig.
    3. "Historic power boilers" as defined in T.C.A. § 68-122-104(c)(1) and Rule 0800-3-3-.01(18).
  - (b) The age limit for a standard existing power boiler shall be dependent upon the results of a thorough internal and external inspection and, where required by the inspector, a pressure test with water temperature between 60° to 120° F, of no more than 90% of the set pressure of the lowest setting pressure relief device on the boiler, held for a period of at least thirty (30) minutes.

**Authority:** T.C.A. §§ 68-122-101, 68-122-102 and 68-122-104(c)(1).

Rule 0800-3-3-.08 Historic Boilers is amended by deleting the rule in its entirety 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).
- (2) Historic power boilers shall receive prior authorization from the Chief Inspector before entry and operation of the boiler in the state of Tennessee. Prior to entering the State with the boiler, the owner or user shall submit the proper Board approved application for operation of a historic power boiler.
  - (a) For historic power boilers located in the State, the owner or user shall be required to submit the initial application as long as he possesses a current Tennessee certificate of inspection. If the Tennessee certificate of inspection expires, the owner or user shall reapply to the Chief Inspector for permission to operate.

## PROPOSED RULES

- (b) For historic power boilers located outside of the State, with a valid Tennessee certificate of inspection, the owner or user is allowed to freely operate their boiler at events within the State. As long as the boiler has a valid Tennessee certificate of inspection, there is no need to reapply for permission to operate. If the Tennessee certificate of inspection remains expired for more than sixty (60) days without an inspection, or if the owner chooses to no longer operate the boiler or retain a Tennessee certificate of inspection, the boiler shall be placed in dormant status. If at any time the boiler is placed in dormant status, the owner or user shall reapply with the Chief Inspector for permission to operate.
- (3) Design and Testing.
  - (a) For all traditional historic power boilers, both standard and nonstandard, and nontraditional nonstandard historic power boilers, the owner or user shall supply the Chief Inspector with reports of the maximum allowable working pressure calculations and ultrasonic testing at the time of application to operate.

The calculations and ultrasonic testing shall be completed by a knowledgeable individual familiar with the practice. All report results are subject to the acceptance of the Chief Inspector at time of application.
  - (b) A copy of the manufacturer's data report shall accompany all applications to operate nontraditional standard historic power boilers in the State.
  - (c) The Chief Inspector or Deputy Inspector may at anytime during the application and inspection process request additional information, such as, but not limited to, design, material, inspection or testing.
- (4) Traditional Historic Power Boilers.
  - (a) The maximum allowable working pressure shall be calculated with a minimum safety factor of 5 for standard, and 5.5 for traditional nonstandard historic power boilers, using the formula for historic power boilers in paragraph (14) of this rule, not to exceed 125 psig.
  - (b) The minimum safety factor shall be 6.5 for traditional historic power boilers having lap-riveted longitudinal joints. The maximum allowable working pressure should not exceed 100 psig. Seal welding of a lap-riveted longitudinal joint is not permitted.
- (5) Nontraditional Historic Power Boilers.
  - (a) All nontraditional historic power boilers constructed after the effective date of this rule shall be constructed in accordance to Rule 0800-3-3-03(1). Nontraditional nonstandard historic power boilers, free-lance or scale models, constructed after the effective date of this rule shall not be allowed to operate in the State.
  - (b) The maximum allowable working pressure for nontraditional standard historic power boilers shall be determined in accordance with the applicable provisions of the edition of the ASME Code under which they were constructed.

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- (c) The maximum allowable working pressure shall be calculated with a minimum safety factor of 5.5 for nontraditional nonstandard historic power boilers, using the formula for historic power boilers in paragraph (14) of this rule, not to exceed 125 psig.
  - (d) Nontraditional nonstandard historic power boilers having lap-riveted longitudinal joints shall not be allowed to operate in the State.
- (6) An annual inspection of all historic power boilers shall be conducted by a Deputy Inspector. The issuance of the annual Tennessee certificate of inspection shall be based on the results of the annual inspection.
- (7) Operational Log.
- (a) The owner of a historic power boiler operating in the State shall possess a bound operational log. After successful completion of the initial inspection by a Deputy Inspector, the owner shall be provided with a registered operational log book by the Chief Inspector. The operational log shall contain, but is not limited to, the following:
    1. The operation date of the historic power boiler;
    2. The length of time the historic power boiler was operated;
    3. Location where operated (city and state);
    4. Jurisdictional inspection dates with the signature and commission number of inspector;
    5. Description of repairs and alterations, including the dates, with signature and commission number of inspector;
    6. Testing performed and by whom (e.g., pressure test, ultrasonic test, radiographic test, etc.);
    7. Change of ownership, including the date the historic power boiler changed hands and to whom; and
    8. The front page of the operational log shall include a page number index of all inspections, inspector instructions, and repairs or incidents involved with the historic power boiler.
  - (b) Operational logs shall be available to the inspector at all times the historic power boiler is to be operated in the State. Operational logs that are lost or misplaced shall be reported to the Chief Inspector immediately. The owner or user of the historic power boiler shall be responsible for the cost of the operational log replacement. Failure to possess or report a lost or misplaced operational log, may prevent the historic power boiler from operating in the State or revoking of the Tennessee certificate of inspection.
  - (c) Whenever the pages of an operational log have been completely filled, the owner shall request a supplemental operational log from the Chief Inspector at no cost to the owner. The owner is responsible for retaining all operational logs, initial and supplemental, for the life of the historic boiler. In the event that the historic power boiler changes hands,

## PROPOSED RULES

the new owner shall receive all original operational logs, initial and supplemental, from the previous owner. The previous owner may make a copy of the operational logs for his records.

- (8) A pressure test with water temperature between 60° to 120° F, and not to exceed 90% of the set pressure of the lowest setting pressure relief device on the boiler, held for a period of at least thirty (30) minutes may be conducted at the discretion of the Deputy Inspector.
- (9) All historic power boilers shall be equipped with an ASME-stamped National Board-rated safety valve of adequate capacity, together with a water level indicator, calibrated pressure gauge and two suitable means of introducing water into the boiler.
- (10) The historic power boilers, traditional and nontraditional, shall be equipped with a fusible plug. All fusible plugs shall be constructed to meet the requirements of the ASME Code.
  - (a) Fusible plugs shall be located at the lowest permissible water level as determined by the boiler manufacturer or the Chief Inspector when this information is not available.
  - (b) Fireside fusible plugs shall protrude at a minimum of one inch into the water.
  - (c) Waterside fusible plugs shall not protrude into the fire area more than one inch.
  - (d) Fusible plugs shall not be refilled.
  - (e) All fusible plugs shall be removed for inspection once every two years.
  - (f) All fusible plugs shall be replaced after 300 hours of service with a new fusible plug constructed to meet the requirements of the ASME Code.
  - (g) The date when the fusible plug is removed for inspection or replaced shall be documented in the owner's operational log.
- (11) All historic power boilers shall be equipped with operational tri-cocks, a gauge glass and pressure gauge. A siphon, or water seal, shall be installed between the pressure gauge and boiler. All pressure gauges shall be proven accurate at the time of the annual inspection by testing or documentation of calibration.
- (12) Repairs and Alterations.
  - (a) Any welded code repair or any alteration shall be performed by organizations holding a valid National Board "R" stamp. If the repair or alteration is performed in this State, the "R" stamp-holder shall have a current State of Tennessee Boiler Repair and Erection Contractor's license.
  - (b) Mechanical code repairs to historic power boilers such as, but not limited to, tube, rivet and stay replacement may be completed by the owner, or his designee, who is knowledgeable about the repair to be performed with prior approval of the Chief Inspector.
  - (c) All repairs and alterations, welded and mechanical, shall be inspected by an inspector and documented on the applicable National Board "NB-R" form. The "NB-R" form shall be submitted and kept on file in the Chief Inspector's office.

## PROPOSED RULES

1. For those repairs and alterations performed in the State, a Deputy Inspector shall perform the inspection.
2. For repairs and alterations performed outside of the State, the inspection shall be performed by a National Board commissioned boiler inspector.
3. All repairs and alterations shall be documented in the owner's operational log and signed by the inspector who performed the inspection.

(13) All standard historic power boilers shall have legible stamping clearly visible to the inspector.

(14) Maximum Allowable Working Pressure for Nonstandard Historic Power Boilers.

- (a) The maximum allowable working pressure of a historic power boiler shall be determined in accordance with the following formula:

$$\frac{TS t E}{RFS} = \text{maximum allowable working pressure (psig)}$$

Where:

TS = ultimate tensile strength of shell plate, pounds per square inch (psi)

t = minimum thickness of shell plate, in weakest course (inches)

E = efficiency of longitudinal joint (For tube ligaments and pitch, determine E by the rules provided in Section I of the ASME Code. For riveted construction, refer to the National Board Inspection Code, 1973 edition. For seamless construction, consider E to be 100%)

R = inside radius of weakest course of shell (inches)

FS = factor of safety [See subparagraph (a) of paragraph (4) and subparagraph (c) of paragraph (5) of this rule]

- (b) Tensile Strength - When the tensile strength of steel or wrought iron shell plates is not known, it shall be taken as 55,000 psi for steel and 45,000 psi for wrought iron.
- (c) Crushing Strength of Mild Steel - The resistance to crushing of mild steel shall be taken as 95,000 psi.
- (d) Strength of Rivets in Shear - When computing the ultimate strength of rivets in shear, the following values in psi of the cross-sectional area of the rivet shank shall be used:

	PSI
Iron rivets in single shear	38,000
Iron rivets in double shear	76,000
Steel rivets in single shear	44,000
Steel rivets in double shear	88,000

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When the diameter of the rivet holes in the longitudinal joints of a boiler is not known, the diameter and cross-sectional area of rivets, after driving, may be selected from Table 1, or as ascertained by cutting out one rivet in the body of the joint.

TABLE 1  
SIZES OF RIVETS BASED ON PLATE THICKNESS

Thickness of plate (inches)	1/4	9/32	5/16	11/32	3/8	13/32
Diameter of rivet after driving (inches)	11/16	11/16	3/4	3/4	13/16	13/16
Thickness of plate (inches)	7/16	15/32	1/2	9/16	5/8	
Diameter of rivet after driving (inches)	15/16	15/16	15/16	1-1/16	1-1/16	

- (e) The working pressure may be decreased by the inspector, with authorization of the Chief Inspector, if the condition and safety of the boiler warrant.

**Authority:** T.C.A. §§ 68-122-101, 68-122-102 and 68-122-104.

The proposed rules set out herein were properly filed in the Department of State on the 6th day of February, 2006, 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 28th day of June 2006. (02-06)

## **PUBLIC NECESSITY RULES**

### **PUBLIC NECESSITY RULES NOW IN EFFECT**

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

- 0620 - Department of Finance and Administration - Bureau of TennCare - Public Necessity Rules allowing for the disenrollment of Medically Needy dual eligibles on or after January 1, 2006, chapter 1200-13-13 TennCare Medicaid, 1 T.A.R. (January 2006) - Filed December 9, 2005; effective through May 23, 2006. (12-09)
- 0620 - Department of Finance and Administration - Bureau of TennCare - Public Necessity Rules required to conform the current TennCare Medicaid rules to reflect changes resulting from court orders and a state plan amendment., chapter 1200-13-13 TennCare Medicaid, 1 T.A.R. (January 2006) - Filed December 29, 2005; effective through June 12, 2006. (12-38)
- 0620 - Department of Finance and Administration - Bureau of TennCare - Public Necessity Rules required to conform the current TennCare Medicaid rules to reflect changes resulting from court orders and a state plan amendment., chapter 1200-13-13 TennCare Medicaid, 1 T.A.R. (January 2006) - Filed December 29, 2005; effective through June 12, 2006. (12-39)
- 0620 - Department of Finance and Administration - Bureau of TennCare - Public Necessity Rules required to conform the current TennCare Standard rules to reflect changes resulting from court orders and a state plan amendment, chapter 1200-13-14 TennCare Standard, 1 T.A.R. (January 2006) - Filed December 29, 2005; effective through June 12, 2006. (12-40)
- 0620 - Department of Finance and Administration - Bureau of TennCare - Public Necessity Rules required to conform the current TennCare Medicaid rules to reflect changes resulting from the amendment of the TennCare waiver, chapter 1200-13-14 TennCare Standard, 1 T.A.R. (January 2006) - Filed December 29, 2005; effective through June 12, 2006. (12-41)
- 0620 - Department of Finance and Administration - Bureau of TennCare - Public Necessity Rules allowing for a Presumptive Eligibility process that will provide short term temporary and limited eligibility to persons who are likely to qualify for regular institutional Medicaid eligibility pursuant to DHS Rule 1240-3-3-.02(9) and provide them with home services that will keep them out of nursing homes at no financial risk to the person, chapter 1200-13-1 General Rules, 2 T.A.R. (February 2006) - Filed January 30, 2006; effective through July 14, 2006. (01-38)
- 0800 - Department of Labor and Workforce Development - Division of Workers' Compensation - Public Necessity Rules relating to the comprehensive medical fee schedule and related system, chapter 0800-2-17 Medical Cost Containment Program, 12 T.A.R. (December 2005) - Filed November 16, 2005; effective April 30, 2006. (11-21)
- 0800 - Department of Labor and Workforce Development - Division of Workers' Compensation - Public Necessity Rules relating to the comprehensive medical fee schedule and related system, chapter 0800-2-18 Medical Fee Schedule, 12 T.A.R. (December 2005) - Filed November 16, 2005; effective April 30, 2006. (11-22)

## PUBLIC NECESSITY RULES

- 0800 - Department of Labor and Workforce Development - Division of Workers' Compensation - Public Necessity Rules relating to the comprehensive medical fee schedule and related system, chapter 0800-2-19 In-Patient Hospital Fee Schedule, 12 T.A.R. (December 2005) - Filed November 16, 2005; effective April 30, 2006. (11-23)
- 0800 - Department of Labor and Workforce Development - Division of Workers' Compensation - Public Necessity Rules relating to the comprehensive medical fee schedule and related system, chapter 0800-2-20 Medical Impairment Rating Registry Program, 12 T.A.R. (December 2005) - Filed November 16, 2005; effective April 30, 2006. (11-24)
- 1220 - Tennessee Regulatory Authority - Public Necessity Rules dealing with standards and procedures to implement certain financial security requirements regarding wastewater services by public utilities, Chapter 1220-4-13 Wastewater Regulations, 1 T.A.R. (January 2006) - Filed December 29, 2006; effective through June 12, 2006. (12-36)
- 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)

## **RULEMAKING HEARINGS**

### **TENNESSEE COMMISSION ON AGING AND DISABILITY - 0030**

The Tennessee Commission on Aging and Disability will hold a public hearing to receive comments concerning amended rules regarding the allocation of state funds for senior citizen centers. This hearing will be conducted as prescribed by Uniform Administrative Procedures Act T.C.A. §4-5-201 et. seq., and will take place at the Knowles Senior Citizen Center, 174 Raines Avenue, Nashville, Tennessee at 1:30 p.m. CDT on Wednesday, April 19, 2006.

Written comments will be considered if received by close of business on April 19, 2006 at the office of the Tennessee Commission on Aging and Disability, Andrew Jackson State Office Building, Suite 825, 500 Deaderick Street, Nashville, TN 37243-0860. Written comments may be transmitted in person, by U.S. Postal Service, a commercial courier, e-mail or facsimile. Any form of written comment must be identifiable by the sender's name and address, including zip code. Facsimile submissions will be accepted at 615-741-3309. Electronic mail submissions can be made to [tnaging@state.tn.us](mailto:tnaging@state.tn.us).

Individuals with disabilities wishing to participate in these proceedings (or to review these filings) should contact the Tennessee Commission on Aging and Disability to discuss any auxiliary aids or services needed to facilitate such participation. Such contact may be in person, by writing, telephone, facsimile, e-mail or other means, and should be made no less than one week prior to April 19, 2006 or the date such party intends to review such filings, to allow time to provide such aid or service. Contact the Tennessee Commission on Aging and Disability, ADA Coordinator, Andrew Jackson State Office Building, Suite 825, 500 Deaderick Street, Nashville, TN 37243-0860, 615-741-2056. Hearing impaired callers may use the Tennessee Relay Service (1-800-848-0298) or call the Commission on Aging and Disability TDD number, 615-532-3893.

For complete copies of the text of the notice, please contact Nancy Brode, Tennessee Commission on Aging and Disability, Nashville, TN 37243-0860, telephone 615-741-2056, FAX 615-741-3309 or e-mail [tnaging@state.tn.us](mailto:tnaging@state.tn.us).

## **SUBSTANCE OF PROPOSED RULES**

### **CHAPTER 0030-1-10 FINANCIAL MANAGEMENT STANDARDS AND PROCEDURES**

Paragraph (2) subsection (a) of rule 0030-1-10-.01 Intrastate Funding Formula is amended by deleting the current language in its entirety and submitting the following language so that as amended the subsection shall read:

- (a) Thirty eight percent of the total funds available to senior citizen centers will be distributed among the area agencies using an identical sub-grant for each county in the state multiplied by the number of counties in each planning and service area.

## RULEMAKING HEARINGS

**Authority:** *T.C. A § 71-2-105 and 71-2-104(a).*

The notice of rulemaking set out herein was properly filed in the Department of State on the 28th day of February, 2006. (02-34)

## RULEMAKING HEARINGS

### TENNESSEE DEPARTMENT OF CHILDREN'S SERVICES - 0250 ADMINISTRATIVE SERVICES DIVISION

There will be a hearing before the Tennessee Department of Children Services to consider promulgation of rules pursuant to T.C.A. § 37-5-106. The hearing will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, T.C.A. § 4-5-204 and will take place in conference room B on the seventh floor of the Cordell Hull Building located at 436 6th Avenue North, Nashville, Tennessee, 37243 at 9:00 a.m., central time on the 18<sup>th</sup> day of April, 2006.

Any individuals with disabilities who wish to participate in these proceedings (to review these filings) should contact the Department of Children's Services to discuss any auxiliary aids of services needed to facilitate 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 Department of Children's Services to determine how it may reasonably provide such aid or service. Initial contact may be made with the Department of Children's Services ADA Coordinator, Maggie Winbush, Personnel Analyst 3, at 7th floor of the Cordell Hull Building, 436 6th Avenue North, Nashville, Tennessee, 37243, 615-741-9175.

For a copy of this notice of rulemaking hearing, contact Rob Johnson, 7<sup>th</sup> Floor, Cordell Hull Building, 436 6<sup>th</sup> Avenue North, Nashville, TN 37243-1290. (615) 532-5645.

### SUBSTANCE OF PROPOSED RULES

#### CHAPTER 0250-6-1 ACCESS TO PUBLIC RECORDS OF THE DEPARTMENT OF CHILDREN'S SERVICES

#### NEW RULES

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#### **0250-6-1-.01 PURPOSE AND SCOPE.**

These rules are promulgated for the purpose of providing procedures to allow access to records of the Tennessee Department of Children's Services that are subject to the Tennessee Public Records Act, T.C.A. §§ 10-7-501 et seq., and are promulgated for the additional purpose of implementing and establishing fees to be charged for reproduction of records or for the development of records in a specific format.

**Authority:** T.C.A. §§4-5-201 et seq., 71-1-105; 10-7-503 and 10-7-506; *Tennessean v. Electric Power Board of Nashville*, 979 S.W.2d 297 (Tenn. 1998); *Wells v. Wharton*, 2005 Tenn. App. Lexis 762; and *Op. Tenn. Atty. Gen. 01-021* (Feb. 8, 2001).

## RULEMAKING HEARINGS

### 0250-6-1-.02 DEFINITIONS.

- (1) "Commissioner" is the executive officer in charge of the Tennessee Department of Children's Services.
- (2) "Commissioner's Designee" means Deputy Commissioner, Assistant Commissioners, Staff Attorneys, Directors, Program Managers and/or employees of the Department of Children's Services.
- (3) "Non-routine Copy" is a copy, whether of paper or of electronically stored data, which requires more than minimal staff assistance, i.e., odd or oversize pages, bound documents, or manipulation of electronically stored data.
- (4) "Public Record"
  - (a) "Public Record" means, for purposes of this Chapter, any record of the Department that is deemed to be open to inspection of the public pursuant to the provisions of the Tennessee Public Records Act, T.C.A. §§ 10-7-501 et seq., and pursuant to court order and case law interpreting the Act.
  - (b) The term "Public Record" does not include any data in any record, or any portion of a record, that is:
    1. protected as confidential or privileged pursuant to any state law or regulation, or federal law or regulation, or under any court order; or
    2. protected as privileged under any statutory or common law privilege; or
    3. protected as any attorney work product; or
    4. protected by the attorney/client or any other professional privilege, or
    5. reasonably expected by its disclosure to reveal the name or location of a source that is protected by state or federal law or regulation as part of any statutory or regulatory requirements for reporting of abuse, neglect or harm, or that is protected by state or federal law or regulation as part of any statutory or regulatory requirement for the purpose of protecting any person from the threat of domestic violence.
- (5) "Record"
  - (a) The term "Record" includes, for purposes of this Chapter, any data and/or documents developed and maintained by the Department, or that have been received and are maintained by the Department, during the normal course of the Department's business activities.
  - (b) "Records" subject to this Chapter may be maintained on paper, magnetically, or electronically, on a single computer or computer system, whether on disk, tape or otherwise.
- (6) "Routine Copy" is a paper copy of a record which, to be made, requires minimal staff assistance, i.e., pages which are either 8½ x 11 or 8½ x 14 and can be automatically printed from electronically stored records or automatically fed into a standard copier. Any records, even if stored electronically or magnetically, shall not be deemed routine copies if it is necessary to print the copies of the record by means of a separate screen-print for each individual page of the record.

## RULEMAKING HEARINGS

**Authority:** *T.C.A. §§4-5-201 et seq., 71-1-105; 10-7-503 and 10-7-506; Tennessean v. Electric Power Board of Nashville, 979 S.W.2d 297 (Tenn. 1998); Wells v. Wharton, 2005 Tenn. App. Lexis 762; and Op. Tenn. Atty. Gen. 01-021 (Feb. 8, 2001).*

### **0250-6-1-.03 REQUESTS FOR ACCESS TO RECORDS.**

- (1) A request for access to public records shall be made during the regular business hours of the Department from 8:00 AM to 4:30 PM, Monday through Friday, except for holidays.
- (2) Requests may be made orally or in writing to the office of the Commissioner, or to any Department employee in the State, County, District or Regional Offices of the Department, and shall identify with reasonable specificity the record, set or system of records which is requested. Records requests will be processed on a first-come, first-served basis; provided, that the Commissioner, or the Commissioner's designee, may at any time alter this provision when circumstances warrant.
- (3) Prior Review and Assessment for Confidential, Privileged or Protected Material/Non-Routine Requests.
  - (a) Review, Assessment and Redaction for Access to Records Requests.
    1. Before providing access to the requested record, the Department's staff shall review the requested record or records as quickly as reasonably possible, consistent with the availability of appropriate staff and with regard to the scope of the records request, and make an assessment of the status of the records and the scope of the requested access.
    2. Upon review, the Department's staff may redact any such data or information prior to release of the record, or portion of the record, that it has reason to believe has or may have confidential, privileged or otherwise protected material in the record that is subject to the Tennessee Public Records Act.
  - (b) If the Department determines that none of the provisions of subparagraph (c) below apply and access can otherwise be provided immediately, it shall do so.
  - (c) If it appears from the Department's review and assessment that access to the record, or the system of records, cannot be provided immediately because:
    1. Additional time is required to locate and retrieve the records because the records are not stored on the site or cannot be located;
    2. The record or records require redaction of confidential, privileged or otherwise protected material;
    3. The record is subject to current use as part of an on-going investigation and cannot be provided without interrupting or jeopardizing the investigation and/or its timeliness, or the unavailability of the record to the Department's staff will jeopardize the health, safety or welfare of the persons the investigation is intended to protect or the persons involved in the investigation;

## RULEMAKING HEARINGS

4. A computer or computer system that contains the record is unable to be accessed, is undergoing maintenance or re-programming for any Departmental program purposes, and/or cannot be accessed without substantially interfering with the delivery of services to the public or without damage to the integrity, operability or functioning of any computer or computer system;
5. Production of the record or records will require development of a program or application to provide access to, or a readable format for access to, electronic or magnetic sources of the record or records; or
6. For any other reason, then the Department shall inform the requesting person of the assessment and the reasonable approximate time required in complying with the request and a summary of the basis for the assessment regarding access to the records.

**Authority:** *T.C.A. §§4-5-201 et seq., 71-1-105; 10-7-503 and 10-7-506; Tennessee v. Electric Power Board of Nashville, 979 S.W.2d 297 (Tenn. 1998); Wells v. Wharton, 2005 Tenn. App. Lexis 762; and Op. Tenn. Atty. Gen. 01-021 (Feb. 8, 2001).*

### **0250-6-1-.04 REQUESTS FOR REPRODUCTION OF RECORDS.**

- (1) A request for copies of public records shall be made during the regular business hours of the Department from 8:00 AM to 4:30 PM, Monday through Friday, except for holidays.
- (2) Requests may be made orally or in writing to the office of the Commissioner, or to any Department employee in the State, County, District or Regional Offices of the Department, and shall identify with reasonable specificity the record, set or system of records which is requested. Records requests will be processed on a first-come, first-served basis; provided, that the Commissioner, or the Commissioner's designee, may at any time alter this provision when circumstances warrant.
- (3) Prior Review and Assessment for Confidential, Privileged or Protected Material/Non-Routine Copy Requests.
  - (a) Review, Assessment and Redaction of Records for Copy Request.
    1. Before reproducing copies of the requested record, the Department's staff shall review the requested record or records as quickly as reasonably possible consistent with the availability of appropriate staff and with regard to the scope of the records request and shall make an assessment of the status and scope of the copy request and the difficulty and costs for copies of, or for preparing, any records to determine if the request will require that "routine" or "non-routine" copies, as defined in Section 0250-6-1-.02, or a combination thereof, be provided.
    2. Upon review, the Department's staff may redact any such data or information prior to release of the record, or portion of the record, that it has reason to believe has or that may have confidential, privileged or otherwise protected material in the record that is subject to the Tennessee Public Records Act.

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- (b) If the Department determines that none of the provisions of subparagraph (c) apply and copies can otherwise be provided immediately, it shall do so. If the reproduction of copies of the records is requested and the request involves the reproduction of "routine" copies, it shall inform the requesting person and shall make such records available to the requesting person as soon as reasonably possible.
- (c) If it appears from the Department's assessment that reproduction of the record, or the system of records, cannot be provided immediately because:
  - 1. Additional time is required to locate and retrieve the records because the records are not stored on the site or cannot be located;
  - 2. The record or records require redaction of confidential, privileged or otherwise protected material;
  - 3. The record is subject to current use as part of an on-going investigation and cannot be provided without interrupting or jeopardizing the investigation and/or its timeliness, or the unavailability of the record to the Department's staff will jeopardize the health, safety or welfare of the persons the investigation is intended to protect or the persons involved in the investigation;
  - 4. A computer or computer system that contains the record is unable to be accessed, is undergoing maintenance or re-programming for any Departmental program purposes, and/or cannot be reproduced without substantially interfering with the delivery of services to the public or without damage to the integrity, operability or functioning of any computer or computer system;
  - 5. Reproduction of the record or records will require development of a program or application to provide copies, in a readable format from, electronic or magnetic sources of the record or records, or that the person or entity has requested copies of the record in a specific format, and that such program, application or format does not currently exist; or
  - 6. For any other reason, then the Department shall inform the requesting person of the assessment and the reasonable approximate time required and costs involved in complying with the request and a summary of the basis for the assessment regarding the reproduction of copies of the records.

**Authority:** T.C.A. §§4-5-201 et seq., 71-1-105; 10-7-503 and 10-7-506; *Tennessean v. Electric Power Board of Nashville*, 979 S.W.2d 297 (Tenn. 1998); *Wells v. Wharton*, 2005 Tenn. App. Lexis 762; and *Op. Tenn. Atty. Gen. 01-021* (Feb. 8, 2001).

### **0250-6-1-.05 FEES AND COSTS FOR REPRODUCTION OF RECORDS.**

- (1) Routine paper copies shall be charged at a minimum of Fifteen Cents (\$0.15) per one-sided page and Twenty Cents (\$.20) for a two-sided copy.
- (2) Non-Routine paper copies shall be charged at a minimum of Fifty Cents (\$0.50) per one-sided page and Sixty Cents (\$.60) for a two-sided copy.
- (3) The Department shall not be required to reproduce copies on two (2) sides unless the equipment at the reproduction site is designed to automatically produce a two (2) sided copy on a single piece of paper.

## RULEMAKING HEARINGS

- (4) Electronic copies shall be charged at a minimum of Five Dollars (\$5.00) per floppy disk containing 1.44 megabytes and Ten Dollars (\$10.00) per CD disk containing 650 megabytes, if these media are available.
- (5) Magnetic copies, if available, shall be charged at a minimum of One Hundred Dollars (\$100.00) per magnetic tape containing 20 gigabytes.
- (6) The Department may charge for all costs for reproduction of the record for the person or entity that has made the records request, whether the record is determined to be "routine" or "non-routine". The costs of reproduction shall include the following:
  - (a) Department staff time, paper and other products and rental fees, including, but not limited to, the costs of:
    1. Staff time utilized in copying the record;
    2. Paper or other products such as copy toner or toner cartridges, inks, electronic or magnetic media including, but not limited to floppy disks or compact disks etc., or any per copy charges incurred by the Department on any rented equipment;
  - (b) Development of Computer Programs and Applications, including, but not limited to:
    1. Creation of a new or modified computer program or computer application that is necessary to put the records in a readable and reproducible format or in a specific reproducible format that is requested by the person or entity seeking copies of the record;
    2. In such case, the costs of staff, contractor, or consultant specialist time required for the production of the program or application and the costs of any new or modified software or hardware necessary for the production of the records may also be charged by the Department as costs of reproduction of the record;
  - (c) The costs for delivering the records by mail or any other delivery services or any other mechanisms, electronic, magnetic or otherwise; and
  - (d) Any other costs associated with actually reproducing the requested records, except those out-of-pocket or staff time costs associated with locating or gathering the records.
- (7) Department Staff Time Charges.
  - (a) Staff time of any Department staff shall be charged at the hourly rate for the staff person's position, including the cost of any overtime that is necessary to reproduce the record.
  - (b) The hourly rate is that established by the Department of Personnel for the staff person's position, or the rate determined by dividing the staff person's gross monthly salary by one hundred, sixty-two and one-half (162.5) hours, whichever is greater.
- (8) Contractor or Consultant Costs.

The costs of a contractor or consultant's time shall be charged at the unit rates charged to the Department pursuant to the Department's existing contract or any contract made necessary due to the copy request.

## RULEMAKING HEARINGS

### (9) Specialist Costs.

The costs of a specialist's time shall be charged at the costs invoiced to the Department for the services provided that are related to the reproduction of the record.

### (10) Copying by Requesting Person or Entity.

(a) The Commissioner, or the Commissioner's designee, may, in his or her discretion, permit the requesting person to supply the necessary equipment and supplies to make the requested copies where the records are housed or located for purposes of the records request, and all, or a portion, of the fees required by this Section may, in his or her discretion, be waived by the Department, but no record shall be permitted to be removed from the Department's offices for this purpose without written approval by the Commissioner or the Commissioner's designee.

(b) The Department may provide any personnel to observe the copying process permitted by this paragraph to protect the integrity of the records, and the costs of staff time necessary for this purpose may be charged pursuant to this Section.

**Authority:** *T.C.A. §§4-5-201 et seq., 71-1-105; 10-7-503 and 10-7-506; Tennessean v. Electric Power Board of Nashville, 979 S.W.2d 297 (Tenn. 1998); Wells v. Wharton, 2005 Tenn. App. Lexis 762; and Op. Tenn. Atty. Gen. 01-021 (Feb. 8, 2001).*

### **0250-6-1-.06 PAYMENT FOR RECORDS.**

(1) Prior to copies being made, or prior to developing a specific format for the reproduction of records, payment in full must be made to the Department, unless the payment is waived or delayed pursuant to Section 0250-6-1-.07 below.

(2) Payment shall be made for payment of the costs of reproducing records only by cashier's check or money order.

(3) The cashier's check or money order shall be made payable to the Treasurer, State of Tennessee, and be delivered to the Department contact responsible for reproducing the record.

**Authority:** *T.C.A. §§4-5-201 et seq., 71-1-105; 10-7-503 and 10-7-506; Tennessean v. Electric Power Board of Nashville, 979 S.W.2d 297 (Tenn. 1998); Wells v. Wharton, 2005 Tenn. App. Lexis 762; and Op. Tenn. Atty. Gen. 01-021 (Feb. 8, 2001).*

### **0250-6-1-.07 WAIVER OF FEES.**

(1) The Commissioner or the Commissioner's designee may waive the applicable fees for copies as defined above when the amount for such copies is equal to or less than One Dollar (\$1.00). Costs for reproduction of records above One Dollar (\$1.00) shall be charged as otherwise required by this Chapter, unless waived pursuant to this Section.

(2) The Commissioner or the Commissioner's designee may allow payment to be delayed under such circumstances as the Commissioner or the Commissioner's Designee may, in his or her discretion, determine is appropriate.

## RULEMAKING HEARINGS

- (3) If the Commissioner or the Commissioner's designee determines that the person who seeks copies of these public records is indigent under Federal poverty guidelines, then the Commissioner or the Commissioner's designee may waive the applicable fees.
- (4) Excessive or unreasonable requests for waivers, or requests that can otherwise be reasonably construed as an attempt to avoid the intended compensation for copies that exceed One Dollar (\$1.00), as described in Paragraph (1), may be denied.
- (5) The Commissioner or the Commissioner's designee, may, in his or her discretion, provide copies of rules, policy, state or federal programs, guidance documents, public reports, etc., without charge:
  - (a) for general public information or announcement purposes to applicants for, or recipients of, services from the Department's programs, or to provide information to such persons or their representatives in response to case-specific situations;
  - (b) to legislative, judicial or administrative bodies or tribunals as part of providing general or specific information or clarification regarding the Department's programs or activities or in response to a case-specific request relative to applicants for, or recipients of, services from the Department or its employees, or for any other purpose;
  - (c) to other state, county or local agencies, their investigative, administrative, enforcement, regulatory, audit or law enforcement agencies, or for any other purpose;
  - (d) to advocacy groups, as determined by the Department, for persons served by the Department, to provide information or clarification, regarding Department programs or activities involving the Department's programs and policies;
  - (e) to federal law enforcement, audit, program, administrative or regulatory agencies, or for any other purpose, or
  - (f) if necessary to comply with any provisions of federal or state laws, court orders, regulations or policy directives.

**Authority:** *T.C.A. §§4-5-201 et seq., 71-1-105; 10-7-503 and 10-7-506; Tennessee v. Electric Power Board of Nashville, 979 S.W.2d 297 (Tenn. 1998); Wells v. Wharton, 2005 Tenn. App. Lexis 762; and Op. Tenn. Atty. Gen. 01-021 (Feb. 8, 2001).*

The notice of rulemaking set out herein was properly filed in the Department of State on the 21st day of February, 2006. (02-21)

## 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 pursuant to T.C.A. §§ 4-5-202, 4-5-204, and 63-4-106. 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 Cumberland Room of the Cordell Hull Building located at 425 Fifth Avenue North, Nashville, TN at 3:30 p.m. (CDT) on the 26th day of April, 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 0260-3-.04, Qualifications for Certification, is amended by deleting subparagraph (1) (e) in its entirety and substituting instead the following language, so that as amended, the new subparagraph (1) (e) shall read:

- (1) (e) Provide proof of successful completion of one thousand and forty (1,040) hours of clinical internship supervised by a Tennessee licensed doctor of chiropractic who is required to provide the Board of Chiropractic Examiners a report concerning the applicant's performance in each area of the spine and extremities on forms provided by the Board to become certified as a chiropractic x-ray technologist.

**Authority:** T.C.A. §§4-5-202, 4-5-203, 4-5-204, 63-4-106, and 63-4-119.

The notice of rulemaking set out herein was properly filed in the Department of State on the 28th day of February, 2006. (02-35)

## 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 amendments to rules 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. (CDT) on the 24th day of April, 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 0450-1-.06, Fees, is amended by inserting the following language as new subparagraph (1) (h) and renumbering the current subparagraph (1) (h) as subparagraph (1) (i):

- (1) (h) Temporary License Fee – A refundable fee to be paid by all applicants seeking temporary licensure as a professional counselor.

**Authority:** T.C.A. §§ 4-5-202, 45-5-204, 63-22-102, 63-2-104, and 63-22-121.

Rule 0450-1-.10, Supervision - Post-Masters, is amended by deleting paragraph (1) and subparagraph (5) (d) in their entirety and substituting instead the following language, so that as amended, the new paragraph (1) and the new subparagraph (5) (d) shall read:

- (1) Professional Counselor's Supervision. Supervision required by this rule shall be a professional experience which is supervised by a currently Licensed Professional Counselor, Licensed Professional Counselor with Mental Health Service Provider designation, licensed marital and family therapist, licensed clinical social worker, licensed psychologist with health service provider designation, licensed senior psychological examiner, or licensed psychiatrist, pursuant to rule 0450-1-.01, who has been licensed at least three (3) years and who is providing ongoing, direct clinical review for the purpose of training or teaching and who monitors the performance of a person's supervised interaction with a client and provides regular, documented, face-to-face consultation, guidance, and instructions with respect to the clinical skills and competencies of the person supervised. Supervision may include, without being limited to, the review of case presentations, audio tapes, video tapes, and direct observation.

## RULEMAKING HEARINGS

- (5) (d) Supervisors for applicants pursuing designation as mental health service provider may be currently Licensed Professional Counselors with Mental Health Service Provider designation, licensed marital and family therapists, licensed clinical social workers, licensed psychiatrists, licensed senior psychological examiners, or licensed psychologists with health service provider designation, who have been licensed at least three (3) years and who are in good standing with their respective licensing boards and professional associations.

**Authority:** T.C.A. §§ 4-5-202, 4-5-204, 63-22-102, and 63-22-104.

Rule 0450-1-.12, Continuing Education, is amended by deleting subparagraph (1) (c) in its entirety and substituting instead the following language, so that as amended, the new subparagraph (1) (c) shall read:

- (1) (c) Ethics and Jurisprudence Course Requirement
1. Three (3) clock hours of the ten (10) clock hour annual requirement shall, every two (2) years, pertain to the following subjects:
    - (i) Professional ethics.
    - (ii) Tennessee Code Annotated, Title 63, Chapter 22.
    - (iii) Official Compilation, Rules and Regulations of the State of Tennessee, Chapter 0450-1.
  2. Those persons who hold two (2) certificates and/or licenses regulated by the Tennessee Board for Professional Counselors, Marital and Family Therapists and Clinical Pastoral Therapists shall have three (3) clock hours of the fifteen (15) clock hour annual requirement pertain to ethics and jurisprudence every two (2) years.
  3. A person who holds three (3) certificates and/or licenses shall have three (3) clock hours of the twenty (20) clock hour annual requirement pertain to ethics and jurisprudence every two (2) years.

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

Rule 0450-1-.15, Disciplinary Actions and Civil Penalties, is amended by adding the following language as new paragraph (6):

- (6) Reconsiderations and Stays - The Board authorizes the member who chaired the Board for a contested case to be the agency member to make the decisions authorized pursuant to rule 1360-4-1-.18 regarding petitions for reconsiderations and stays in that case.

**Authority:** T.C.A. §§ 4-5-202, 4-5-204, 63-22-102, and 63-22-110.

Rule 0450-2-.06, Fees, is amended by inserting the following language as new subparagraph (1) (h) and renumbering the current subparagraph (1) (h) as subparagraph (1) (i):

- (1) (h) Temporary License Fee – A refundable fee to be paid by all applicants seeking temporary licensure as a marital and family therapist.

## RULEMAKING HEARINGS

**Authority:** T.C.A. §§ 4-5-202, 4-5-204, 63-22-102, 63-22-106, and 63-22-121.

Rule 0450-2-.12, Continuing Education, is amended by deleting subparagraph (1) (c) in its entirety and substituting instead the following language, so that as amended, the new subparagraph (1) (c) shall read:

- (1) (c) Ethics and Jurisprudence Course Requirement
  - 1. Three (3) clock hours of the ten (10) clock hour annual requirement shall, every two (2) years, pertain to the following subjects:
    - (i) Professional ethics.
    - (ii) Tennessee Code Annotated, Title 63, Chapter 22.
    - (iii) Official Compilation, Rules and Regulations of the State of Tennessee, Chapter 0450-2.
  - 2. Those persons who hold two (2) certificates and/or licenses regulated by the Tennessee Board for Professional Counselors, Marital and Family Therapists and Clinical Pastoral Therapists shall have three (3) clock hours of the fifteen (15) clock hour annual requirement pertain to ethics and jurisprudence every two (2) years.
  - 3. A person who holds three (3) certificates and/or licenses shall have three (3) clock hours of the twenty (20) clock hour annual requirement pertain to ethics and jurisprudence every two (2) years.

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

Rule 0450-2-.15, Disciplinary Actions and Civil Penalties, is amended by adding the following language as new paragraph (6):

- (6) Reconsiderations and Stays - The Board authorizes the member who chaired the Board for a contested case to be the agency member to make the decisions authorized pursuant to rule 1360-4-1-.18 regarding petitions for reconsiderations and stays in that case.

**Authority:** T.C.A. §§ 4-5-202, 4-5-204, 63-22-102, and 63-22-110.

Rule 0450-3-.12, Continuing Education, is amended by deleting subparagraph (1) (c) in its entirety and substituting instead the following language, so that as amended, the new subparagraph (1) (c) shall read:

- (1) (c) Ethics and Jurisprudence Course Requirement
  - 1. Three (3) clock hours of the ten (10) clock hour annual requirement shall, every two (2) years, pertain to the following subjects:
    - (i) Professional ethics.
    - (ii) Tennessee Code Annotated, Title 63, Chapter 22.
    - (iii) Official Compilation, Rules and Regulations of the State of Tennessee, Chapter 0450-3.

## RULEMAKING HEARINGS

2. Those persons who hold two (2) certificates and/or licenses regulated by the Tennessee Board for Professional Counselors, Marital and Family Therapists and Clinical Pastoral Therapists shall have three (3) clock hours of the fifteen (15) clock hour annual requirement pertain to ethics and jurisprudence every two (2) years.
3. A person who holds three (3) certificates and/or licenses shall have three (3) clock hours of the twenty (20) clock hour annual requirement pertain to ethics and jurisprudence every two (2) years.

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

Rule 0450-3-.15, Disciplinary Actions and Civil Penalties, is amended by adding the following language as new paragraph (6):

- (6) Reconsiderations and Stays - The Board authorizes the member who chaired the Board for a contested case to be the agency member to make the decisions authorized pursuant to rule 1360-4-1-.18 regarding petitions for reconsiderations and stays in that case.

**Authority:** T.C.A. §§ 4-5-202, 4-5-204, 63-22-102, and 63-22-110.

The notice of rulemaking set out herein was properly filed in the Department of State on the 17th day of February, 2006. (02-18)

## RULEMAKING HEARINGS

### TENNESSEE DEPARTMENT OF ENVIRONMENT AND CONSERVATION - 0400 DIVISION OF REMEDIATION

There will be a hearing conducted by the Division of Remediation on behalf of the Solid Waste Disposal Control Board to receive public comments regarding the promulgation of amendments to Rule 1200-1-13, Inactive Hazardous Substance Site Remedial Action Program, pursuant to Tennessee Code Annotated 68-212-201 et. seq., the "Hazardous Waste Management Act of 1983". 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 5<sup>th</sup> floor Conference Room of the L&C Annex located at 401 Church Street, Nashville, Tennessee from 10:00 AM to Noon Central Time on the 18<sup>th</sup> day of April, 2006. Written comments will be considered if received by the close of business, April 25, 2006, in the office of Steve Goins, Division of Remediation, 401 Church Street, L&C Annex, 4<sup>th</sup> Floor, Nashville, TN 37243-1538.

Individuals with disabilities who wish to participate in these proceedings (or to review these filings) should contact the Tennessee Department of Environment & Conservation to discuss any auxiliary aids or services needed to facilitate such participation. Such contact may be in person, by writing, telephone, or other means and should be made no less than ten days prior to the hearing date to allow time to provide such aid or services. Contact the ADA Coordinator at 1-866-253-5827 for further information. Hearing impaired callers may use the Tennessee Relay Service (1-800-848-0298).

#### SUBSTANCE OF PROPOSED RULE AMENDMENTS

Rule 1200-1-13-.03(2)(b) Remedial Action Fund is amended so that, as amended, Rule 1200-1-13-.03(2)(b) shall read:

- (b) Liable parties, shall be responsible for their apportioned share of costs incurred by the State of Tennessee as a result of a response. Where costs are incurred by the State on any site, a liable party is subject to an action by the State for the recovery of direct, indirect and actual administrative/overhead expenses. Indirect and overhead charges shall be calculated and assessed on outstanding balances at the time of issuance for each billing. Monies received as payment on the part of a liable party shall be credited towards said party's share of the costs.

**Authority:** T.C.A. §§68-212-207, and §§4-5-201 et. seq.

The notice of rulemaking set out herein was properly filed in the Department of State on the 14th day of February, 2006. (02-12)

RULEMAKING HEARINGS

**DEPARTMENT OF ENVIRONMENT AND CONSERVATION - 0400  
DIVISION OF WATER SUPPLY**

There will a hearing before the Division of Water Supply Staff representing the Water Quality Control Board of the Department of Environment and Conservation to hear comments from the public concerning amendments to the Regulations for Public Water Systems and Drinking Water Quality Chapter 1200-5-1 pursuant to T.C.A. 68-221-701 et seq. The proposed amendments were drafted primarily to incorporate into state regulations the revisions to the Stage 2 Disinfectant/Disinfection Byproducts Rule and the Long Term Enhanced Surface Water Treatment Rules promulgated by the EPA January 4 and 5, 2006.

The Division of Water Supply Staff representing the Water Quality Control Board of the Department of Environment and Conservation will also hear comments from the public concerning amendments to Water Registration Requirements Chapter 1200-5-8 pursuant to T.C.A. 69-7-301 et seq. These amendments were drafted primarily to incorporate the recodification of T.C.A 69 into state regulations and to incorporate three housekeeping corrections to the rules.

The hearings will be held at 10:00 am at the Fleming Training Center, 2022 Blanton Drive, Murfreesboro, at 10:00 am in the large conference room of the TDEC Offices, 1525 Hollywood Drive in Jackson and at 1:00 pm in Knoxville at the KUB Power Operations Center, Corporate Services Building, Room B and C, 4505 Middlebrook Pike, on April 25, 2006.

Written comments will be also considered if received at the Division of Water Supply, 401 Church Street, Nashville, TN 37243-1549 by the close of business May 5, 2006.

Individuals with disabilities who wish to participate in these proceedings (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 contact may be made in person, by writing, telephone, or other means and should be made no less than ten days prior to the (scheduled meeting date) (date such party intends to review such filings), to allow time to provide such aid or service. Contact the ADA Coordinator, 401 Church Street, 7<sup>th</sup> Floor L & C Tower, Nashville, TN 37243, 1-888-867-2757. Hearing impaired callers may use the Tennessee Relay Service (1-800-848-0298). For a copy of the entire text of this notice of rulemaking hearing contact Robert L. Foster, at Division of Water Supply, 401 Church Street, Nashville TN 37243-1549 or call the nearest field office of the Department, Division of Water Supply at 1-888-891-8332.

The text of the rules may also be downloaded from the Department's website at <http://www.state.tn.us/environment/dws/>.

**SUMMARY OF PROPOSED RULES OF  
THE  
TENNESSEE DEPARTMENT OF ENVIRONMENT AND CONSERVATION  
DIVISION OF WATER SUPPLY**

**CHAPTER 1200-5-1  
PUBLIC WATER SYSTEMS**

**AMENDMENTS**

Rule 1200-5-1-.06 is revised to incorporate the locational running average maximum contaminant level for disinfection byproducts.

Rule 1200-5-1-.14 is revised to incorporate the provisions of the latest edition of the federal laboratory certification manual.

## RULEMAKING HEARINGS

Rule 1200-5-1-.20 is revised to require monitoring plans and turbidity records to be kept for five years.

The proposed addition of Rules 1200-5-1-.37 and 1200-5-1-.38 is designed primarily to identify more appropriate monitoring sites for public water systems to determine disinfection byproduct exposures. Disinfection byproducts have been implicated in causing cancer and reproductive and developmental health effects. Rule 1200-5-1-.37 expands the current monitoring requirements to include all wholesale systems and adds additional monitoring requirements on systems that purchase water for resale. The rule requires an initial distribution system evaluation in an attempt to ensure that high risk areas of the distribution system are monitored and that the data are reported to the regulatory agency and public. Rule 1200-5-1-.38 changes the current method of calculating compliance from the system wide average method to a locational running annual average. These rules also provide mechanisms for systems with very small populations (i.e. less than 500) or that historically have had low levels of disinfection byproducts in their distribution system to avoid some of the monitoring and reporting costs.

The proposed addition of Rule 1200-5-1-.39 is designed primarily to incorporate cryptosporidium monitoring, treatment techniques, public notification and reporting for public water systems using surface water or ground water under the direct influence of surface water. Cryptosporidium is a protozoan that forms an oocyst that is resistant to disinfection by free chlorine and must be removed by filtration or by disinfectants other than chlorine. The rules require public water systems to determine their vulnerability to the organism and employ techniques to reduce the concentration in finished drinking water. Systems serving 10,000 or more persons must monitor source water for cryptosporidium, E. coli, and turbidity. Systems serving fewer than 10,000 persons may employ less expensive screening methods to determine vulnerability. Vulnerable systems must employ treatment techniques to reduce the concentration of cryptosporidium in their finished water.

Rule 1200-5-8 is revised to incorporate the recodification of T.C.A. 69 into state regulations. T.C.A. 69-8-301 et seq. changed to T.C.A. 69-7-301 et seq. Three housekeeping changes are also incorporated: volume of water withdrawals are to be reported in million gallons; dewatering is defined more clearly under water use classifications; the identification of water withdrawal and return locations may be given in coordinates (decimal format) obtained with a GPS unit.

The notice of rulemaking set out herein was properly filed in the Department of State on the 23rd of February, 2006. (02-22)

## 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, 1<sup>st</sup> Floor East Conference Room, 310 Great Circle Road, Nashville, Tennessee 37243 at 9:00 a.m. C.D.T. on the 18th day April 2006.

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

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

### SUBSTANCE OF PROPOSED RULE

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

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

- (1) Definitions: The following definitions shall apply for interpretation of this rule:
  - (a) Adult Dental Services - accepted dental procedures which are provided to adult Enrollees (i.e., age 21 years or older) as specified in the Plan of Care. Adult Dental Services may include fillings, root canals, extractions, the provision of dentures and other dental treatments to relieve pain and infection. Preventive dental care is not covered under Adult Dental Services.
  - (b) Behavioral Respite Services - services that provide Respite for an Enrollee who is experiencing a behavioral crisis that necessitates removal from the current residential setting in order to resolve the behavioral crisis.
  - (c) Behavior Services – assessment and amelioration of Enrollee behavior that presents a health or safety risk to the Enrollee or others or that significantly interferes with home or community activities; determination of the settings in which such behaviors occur and the events which precipitate the behaviors; development, monitoring, and revision of crisis prevention and behavior intervention strategies; and training of caregivers who are responsible for direct care of the Enrollee in prevention and intervention strategies.
  - (d) Bureau of TennCare - the bureau in the Tennessee Department of Finance and Administration which is the State Medicaid Agency and is responsible for administration of the Medicaid program in Tennessee.

## RULEMAKING HEARINGS

- (e) Certification - the process by which a physician, who is licensed as a doctor of medicine or doctor of osteopathy, signs and dates a Pre-Admission Evaluation signifying that the named individual requires services provided through the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled as an alternative to care in an Intermediate Care Facility for the Mentally Retarded.
- (f) Covered Services or Covered Waiver Services – The services which are available through Tennessee’s Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled when medically necessary and when provided in accordance with the Waiver as approved by the Centers for Medicare and Medicaid Services.
- (g) Day Services - individualized services and supports that enable an Enrollee to acquire, retain, or improve skills necessary to reside in a community-based setting; to participate in community activities and utilize community resources; to acquire and maintain employment; and to participate in retirement activities.
- (h) Denial - as used in regard to Waiver Services, the term shall mean the termination, suspension, or reduction in amount, scope, and duration of a Waiver Service or a refusal or failure to provide such service.
- (i) Disenrollment - the voluntary or involuntary termination of enrollment of an individual receiving services through the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled.
- (j) Enrollee - a Medicaid Eligible who is enrolled in the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled.
- (k) Environmental Accessibility Modifications – only those interior or exterior physical modifications to the Enrollee’s place of residence which are required to ensure the health, welfare and safety of the Enrollee or which are necessary to enable the Enrollee to function with greater independence.
- (l) Family Model Residential Support – a type of residential service having individualized services and supports that enable an Enrollee to acquire, retain, or improve skills necessary to reside successfully in a family environment in the home of trained caregivers other than the family of origin. The service includes direct assistance as needed with activities of daily living, household chores essential to the health and safety of the enrollee, budget management, attending appointments, and interpersonal and social skills building to enable the Enrollee to live in a home in the community. It also may include medication administration as permitted under Tennessee’s Nurse Practice Act.
- (m) Home (of an Enrollee) - the residence or dwelling in which the Enrollee resides, excluding hospitals, nursing facilities, Intermediate Care Facilities for the Mentally Retarded, Assisted Living Facilities and Homes for the Aged.
- (n) Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled or “Waiver” - the Home and Community Based Services waiver program approved for Tennessee by the Centers for Medicare and Medicaid Services to provide services to a specified number of Medicaid-eligible individuals who have mental retardation and who meet the criteria for Medicaid reimbursement of care in an Intermediate Care Facility for the Mentally Retarded.

## RULEMAKING HEARINGS

- (o) ICF/MR Pre-Admission Evaluation (ICF/MR PAE) – the assessment form used by the State Medicaid Agency to document the current medical and habilitative needs of an individual with mental retardation and to document that the individual meets the Medicaid level of care eligibility criteria for care in an ICF/MR.
- (p) Individual Support Plan – the individualized written Plan of Care.
- (q) Individual Transportation Services –non-emergency transport of an Enrollee to and from approved activities specified in the Plan of Care.
- (r) Intermediate Care Facility for the Mentally Retarded (ICF/MR) - a licensed facility approved for Medicaid vendor reimbursement that provides specialized services for individuals with mental retardation or related conditions and that complies with current federal standards and certification requirements for an ICF/MR.
- (s) Medicaid Eligible - an individual who has been determined by the Tennessee Department of Human Services to be financially eligible to have the State Medicaid Agency make reimbursement for covered services.
- (t) Medical Residential Services – a type of residential service provided in a residence where all residents require direct skilled nursing services and habilitative services and supports that enable an Enrollee to acquire, retain, or improve skills necessary to reside in a community-based setting. Medical Residential Services must be ordered by the Enrollee’s physician, physician assistant, or nurse practitioner, who shall document the medical necessity of the services and specify the nature and frequency of the nursing services. The enrollee who receives Medical Residential Services shall require direct skilled nursing services on a daily basis and at a level which cannot for practical purposes be provided through two or fewer daily skilled nursing visits. The service includes direct assistance as needed with activities of daily living, household chores essential to the health and safety of the enrollee, budget management, attending appointments, and interpersonal and social skills building to enable the enrollee to live in a home in the community. It also may include medication administration as permitted under Tennessee’s Nurse Practice Act.
- (u) Medicaid State Plan - the plan approved by the Centers for Medicare and Medicaid Services which specifies the covered benefits for the Medicaid program in Tennessee.
- (v) Nursing Services –skilled nursing services that fall within the scope of Tennessee’s Nurse Practice Act and that are directly provided to the Enrollee in accordance with a plan of care. Nursing Services shall be ordered by the Enrollee’s physician, physician assistant, or nurse practitioner, who shall document the medical necessity of the services and specify the nature and frequency of the nursing services.
- (w) Nutrition Services - assessment of nutritional needs, nutritional counseling, and education of the Enrollee and of caregivers responsible for food purchase, food preparation, or assisting the Enrollee to eat. Nutrition Services are intended to promote healthy eating practices and to enable the Enrollee and direct support professionals to follow special diets ordered by a physician, physician assistant, or nurse practitioner.
- (x) Occupational Therapy Services – diagnostic, therapeutic, and corrective services which are within the scope of state licensure. Occupational Therapy Services provided to improve or maintain current functional abilities as well as prevent or minimize deterioration of chronic conditions leading to a further loss of function are also included within this definition.

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- (y) Operational Administrative Agency - the approved agency with which the State Medicaid Agency contracts for the administration of the day-to-day operations of the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled.
- (z) Orientation and Mobility Training – assessment of the ability of an Enrollee who is legally blind to move independently, safely, and purposefully in the home and community environment; orientation and mobility counseling; and training and education of the Enrollee and of caregivers responsible for assisting in the mobility of the Enrollee.
- (aa) Personal Assistance – the provision of direct assistance with activities of daily living (e.g., bathing, dressing, personal hygiene, eating, meal preparation excluding cost of food), household chores essential to the health and safety of the enrollee, budget management, attending appointments, and interpersonal and social skills building to enable the Enrollee to live in a home in the community. It also may include medication administration as permitted under Tennessee’s Nurse Practice Act.
- (bb) Personal Emergency Response System - a stationary or portable electronic device used in the Enrollee’s place of residence which enables the Enrollee to secure help in an emergency. The system shall be connected to a response center staffed by trained professionals who respond upon activation of the electronic device.
- (cc) Physical Therapy Services - diagnostic, therapeutic, and corrective services which are within the scope of state licensure. Physical Therapy Services provided to improve or maintain current functional abilities as well as prevent or minimize deterioration of chronic conditions leading to a further loss of function are also included within this definition.
- (dd) Plan of Care – an individualized written Plan of Care which describes the medical and other services (regardless of funding source) to be furnished to the Enrollee, the Waiver Service frequency, and the type of provider who will furnish each Waiver Service and which serves as the fundamental tool by which the State ensures the health and welfare of Enrollees.
- (ee) Qualified Mental Retardation Professional (QMRP) - an individual who meets current federal standards, as published in the Code of Federal Regulations, for a qualified mental retardation professional.
- (ff) Re-evaluation - the annual process approved by the State Medicaid Agency by which a licensed physician or registered nurse or a Qualified Mental Retardation Professional assesses the Enrollee's need for continued Waiver Services and certifies in writing that the Enrollee continues to require Waiver Services.
- (gg) Residential Habilitation - a type of residential service having individualized services and supports that enable an Enrollee to acquire, retain, or improve skills necessary to reside in a community-based setting including direct assistance with activities of daily living essential to the health and safety of the Enrollee, budget management, attending appointments, and interpersonal and social skills building to enable the Enrollee to live in a home in the community. It also may include medication administration as permitted under Tennessee’s Nurse Practice Act.
- (hh) Respite - services provided to an Enrollee when unpaid caregivers are absent or incapacitated due to death, hospitalization, illness or injury, or when unpaid caregivers need relief from routine caregiving responsibilities.

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- (ii) Safety Plan - an individualized plan by which the Operational Administrative Agency ensures the health, safety and welfare of Enrollees who do not have 24-hour direct care services.
- (jj) Specialized Medical Equipment and Supplies and Assistive Technology - assistive devices, adaptive aids, controls or appliances which enable an Enrollee to increase the ability to perform activities of daily living, or to perceive, control or communicate with the environment, and supplies for the proper functioning of such items. Specialized Medical Equipment, Supplies, and Assistive Technology shall be recommended by a qualified health care professional (e.g., occupational therapist, physical therapist, speech language pathologist, physician or nurse practitioner) based on an assessment of the Enrollee's needs and capabilities and shall be furnished as specified in the Plan of Care. Specialized Medical Equipment and Supplies and Assistive Technology may also include a face-to-face consultative assessment by a physical therapist, occupational therapist, or speech therapist to assure that Specialized Medical Equipment and Assistive Technology which requires custom fitting meets the needs of the Enrollee and may include training of the Enrollee by a physical therapist, occupational therapist or speech therapist to effectively utilize such customized equipment.
- (kk) Speech, Language and Hearing Services – diagnostic, therapeutic and corrective services which are within the scope of state licensure which enable an Enrollee to improve or maintain current functional abilities and to prevent or minimize deterioration of chronic conditions leading to a further loss of function.
- (ll) State Medicaid Agency – the bureau in the Tennessee Department of Finance and Administration which is responsible for administration of the Title XIX Medicaid program in Tennessee.
- (mm) Subcontractor - an individual, organized partnership, professional corporation, or other legal association or entity which enters into a written contract with the Operational Administrative Agency to provide Waiver Services to an Enrollee.
- (nn) Support Coordination - case management services that assist the Enrollee in identifying, selecting, obtaining, coordinating and using both paid services and natural supports to enhance the Enrollee's independence, integration in the community and productivity as specified in the Enrollee's Plan of Care. Support Coordination shall be person-centered and shall include, but is not limited to, ongoing assessment of the Enrollee's strengths and needs; development, evaluation and revision of the Plan of Care; assistance with the selection of service providers; provision of general education about the Waiver program, including Enrollee rights and responsibilities; and monitoring implementation of the plan of care and initiating individualized corrective actions as necessary (e.g., reporting, referring, or appealing to appropriate entities).
- (oo) Support Coordinator - the person who is responsible for developing the Individual Support Plan and participating in the development of, monitoring and assuring the implementation of the Plan of Care; who provides Support Coordination services to an Enrollee; and who meets the qualifications for a Support Coordinator as specified in the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled.
- (pp) Supported Living - a type of residential service having individualized services and supports that enable an Enrollee to acquire, retain or improve skills necessary to reside in a home that is under the control and responsibility of the Enrollee. The service includes direct assistance as needed with activities of daily living, household chores essential to the health

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

- (qq) Transfer Form - the form approved by the State Medicaid Agency and used to document the transfer of an Enrollee having an approved unexpired ICF/MR Pre-Admission Evaluation from the Waiver to an ICF/MR or from an ICF/MR to the Waiver.
  - (rr) Vehicle Accessibility Modifications - interior or exterior physical modifications to a vehicle owned by the Enrollee or to a vehicle which is owned by the guardian or conservator of the Enrollee and which is routinely available for transport of the Enrollee. Such modifications must be intended to ensure the transport of the Enrollee in a safe manner.
- (2) Covered Services and Limitations.
- (a) Adult Dental Services.
    - 1. Adult Dental Services shall not include hospital outpatient or inpatient facility services or related anesthesiology, radiology, pathology, or other medical services in such setting.
    - 2. Adult Dental Services shall exclude orthodontic services.
    - 3. Adult Dental Services shall be limited to adults age twenty-one (21) years or older who are enrolled in the waiver.
  - (b) Behavioral Respite Services.
    - 1. Behavioral Respite Services may be provided in a Medicaid-certified ICF/MR, in a licensed respite care facility, or in a home operated by a licensed residential provider.
    - 2. Reimbursement shall not be made for the cost of room and board except when provided as part of Behavioral Respite Services furnished in a facility approved by the State that is not a private residence.
    - 3. Behavioral Respite Services shall be limited to a maximum of sixty (60) days per Enrollee per year.
    - 4. Enrollees who receive Behavioral Respite Services shall be eligible to receive Individual Transportation Services only to the extent necessary during the time period when Behavioral Respite Services is being provided.
  - (c) Behavior Services.
    - 1. Behavior Services shall not be billed when provided during the same time period as Physical Therapy; Occupational Therapy; Nutrition Services; Orientation and Mobility Training; or Speech, Language and Hearing Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently.
    - 2. Behavior Services shall be provided face to face with the Enrollee except that enrollee-specific training of staff may be provided when the Enrollee is not present.

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### (d) Day Services.

1. Day Services may be provided in settings such as specialized facilities licensed to provide Day Services, community centers or other community sites, or job sites. Services may also be provided in the Enrollee's place of residence if there is a health, behavioral, or other medical reason or if the Enrollee has chosen retirement. This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).
2. With the exception of employment that is staff supported, Day Services shall be provided only on weekdays during the day (i.e., between the hours of 7:30 a.m. and 6:00 p.m.), as specified in the Plan of Care.
3. Day Services shall be limited to a maximum of six (6) hours per day and five (5) days per week up to a maximum of 243 days per Enrollee per year.
4. Transportation to and from the Enrollee's place of residence to Day Services and transportation that is needed during the time that the Enrollee is receiving Day Services shall be a component of Day Services and shall be included in the Day Services reimbursement rate (i.e., it shall not be billed as a separate Waiver service) with the following exceptions:
  - (i) Transportation to and from medical services covered through the Medicaid State Plan, which shall not be billed as a Waiver service; or
  - (ii) Transportation necessary for Orientation and Mobility Training.
5. Day Services shall not replace services available under a program funded by the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act.
6. For an Enrollee receiving employment supports, reimbursement shall not be made for incentive payments, subsidies or unrelated vocational training expenses such as the following:
  - (i) Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
  - (ii) Payments that are passed through to users of supported employment programs; or
  - (iii) Payments for vocational training that is not directly related to an Enrollee's supported employment program.

### (e) Environmental Accessibility Modifications.

1. Environmental Accessibility Modifications which are considered improvements to the home (e.g., roof or flooring repair, installing carpet, installation of central air conditioning, construction of an additional room) are excluded from coverage.
2. Any modification which is not of direct medical or remedial benefit to the Enrollee is excluded from coverage.

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3. Modification of an existing room which increases the total square footage of the home is also excluded unless the modification is necessary to improve the accessibility of an Enrollee having limited mobility, in which case the modification shall be limited to the minimal amount of square footage necessary to accomplish the increased accessibility.
  4. Environmental Accessibility Modifications shall be limited to a maximum of \$15,000 per Enrollee per two (2) year period.
- (f) Family Model Residential Support.
1. With the exception of homes that were already providing services to three (3) residents prior to January 1, 2004, a Family Model Residential Support home shall have no more than two (2) residents who receive services and supports.
  2. The Family Model Residential Support provider shall be responsible for providing an appropriate level of services and supports twenty-four (24) hours per day during the hours the Enrollee is not receiving Day Services or is not at school or work.
  3. Transportation shall be a component of Family Model Residential Support and shall be included in the reimbursement rate for such (i.e., it shall not be billed as a separate Waiver service) with the following exceptions:
    - (i) Transportation to and from medical services covered through the Medicaid State Plan, which shall not be billed as a Waiver service;
    - (ii) Transportation necessary for Behavioral Respite Services; or
    - (iii) Transportation necessary for Orientation and Mobility Training.
  4. This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).
  5. Reimbursement for Family Model Residential Support shall not be made for room and board or for the cost of maintenance of the dwelling, and reimbursement shall not include payment made to the Enrollee's parent, step-parent, spouse, child, or sibling or to any other individual who is a conservator unless so permitted in the Order for Conservatorship.
- (g) Individual Transportation Services.
1. An Enrollee receiving Orientation and Mobility Training shall be eligible to receive Individual Transportation Services to the extent necessary for participation in Orientation and Mobility Training. Enrollees who receive Respite, Behavioral Respite Services, or Personal Assistance shall be eligible to receive Individual Transportation Services only to the extent necessary during the time period when Respite, Behavioral Respite Services, or Personal Assistance is being provided.
  2. Individual Transportation Services shall not be used for:
    - (i) Transportation to and from Day Services;
    - (ii) Transportation to and from supported or competitive employment;

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- (iii) Transportation of school aged children to and from school;
  - (iv) Transportation to and from medical services covered by the Medicaid State Plan;  
or
  - (v) Transportation of an Enrollee receiving a residential service, except as described herein for Orientation and Mobility Training or Behavioral Respite Services.
- (h) Medical Residential Services.
1. The Medical Residential Services provider shall be responsible for providing an appropriate level of services and supports twenty-four (24) hours per day when the Enrollee is not receiving Day Services or is not at school or work.
  2. Transportation shall be a component of Medical Residential Services and shall be included in the reimbursement rate for such (i.e., it shall not be billed as a separate Waiver service) with the following exceptions:
    - (i) Transportation to and from medical services covered through the Medicaid State Plan, which shall not be billed as a Waiver service;
    - (ii) Transportation necessary for Behavioral Respite Services; or
    - (iii) Transportation necessary for Orientation and Mobility Training.
  3. Reimbursement for Medical Residential Services shall not include the cost of maintenance of the dwelling, and reimbursement shall not include payment made to members of the Enrollee's immediate family or to the Enrollee's conservator. Reimbursement shall not be made for room and board if the home is rented, leased, or owned by the provider. If the home is rented, leased, or owned by the Enrollee, reimbursement shall not be made for room and board with the exception of a reasonable portion that is attributed to a live-in caregiver who is unrelated to the Enrollee and who provides services to the Enrollee in the Enrollee's place of residence. If an Enrollee owns or leases the place of residence, residential expenses (e.g., phone, cable TV, food, rent) shall be apportioned between the Enrollee, other residents in the home, and (as applicable) live-in or other caregivers.
  4. This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).
  5. Medical Residential Services providers must be licensed by the Department of Mental Health and Developmental Disabilities as a Mental Retardation Residential Habilitation Facility provider or a Supported Living Service provider and ensure that employed nurses are licensed to practice in the state of Tennessee.
- (i) Nursing Services.
1. Nursing Services shall be provided face to face with the Enrollee by a licensed registered nurse or licensed practical nurse under the supervision of a registered nurse.
  2. Nursing assessment and/or nursing oversight shall not be a separate billable service under this definition.

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3. This service shall be provided in home and community settings, as specified in the Plan of Care, excluding inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).
4. An Enrollee who is receiving Medical Residential Services shall not be eligible to receive Nursing Services during the hours Medical Residential Services are being provided.
5. Nursing Services shall not be billed when provided during the same time period as other therapies unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently.
6. Nursing Services are not intended to replace services available through the Medicaid State Plan or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act.

### (j) Nutrition Services.

1. Nutrition Services must be provided face to face with the Enrollee or, for purposes of education, with the caregivers responsible for food purchase, food preparation, or assisting the Enrollee to eat.
2. Nutrition Services shall not be billed when provided during the same time period as Physical Therapy; Occupational Therapy; Speech, Language and Hearing Services; Orientation and Mobility Training; or Behavior Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently.
3. Nutrition Services shall be limited to a maximum of 1.5 hours per Enrollee per day.

### (k) Occupational Therapy Services.

1. Services must be provided by a licensed occupational therapist or by a licensed occupational therapist assistant working under the supervision of a licensed occupational therapist.
2. Occupational Therapy must be provided face to face with the Enrollee.
3. Occupational Therapy therapeutic and corrective services shall not be ordered concurrently with Occupational Therapy assessments (i.e., assess and treat orders are not accepted).
4. Occupational Therapy assessments shall not be billed on the same day with other Occupational Therapy services.
5. Occupational Therapy shall not be billed when provided during the same time period as Physical Therapy; Speech, Language and Hearing Services; Nutrition Services; Orientation and Mobility Training; or Behavior Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently. Occupational Therapy shall not be billed with Day Services if the Day Services are reimbursed on a per hour basis.

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6. Occupational Therapy services are not intended to replace services available through the Medicaid State Plan or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act.
  7. Occupational Therapy assessments shall be limited to a maximum of 3.0 hours per enrollee per day, and other Occupational Therapy services shall be limited to a maximum of 1.5 hours per Enrollee per day.
- (l) Orientation and Mobility Training.
1. Orientation and Mobility Training shall not be billed when provided during the same time period as Physical Therapy; Occupational Therapy; Nutrition Services; Behavior Services; or Speech, Language and Hearing Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently.
  2. Orientation and Mobility Training shall not replace services available under a program funded by the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act.
  3. Orientation and Mobility Training shall be limited to a maximum of sixty (60) hours of services per Enrollee per year.
  4. Enrollees receiving Orientation and Mobility Training shall be eligible to receive Individual Transportation Services to the extent necessary for participation in Orientation and Mobility Training.
- (m) Personal Assistance.
1. Personal Assistance may be provided in the home or community; however, it shall not be provided in school settings and shall not be provided to replace personal assistance services required to be covered by schools or services available through the Medicaid State Plan.
  2. An Enrollee who is receiving a residential service (i.e., Supported Living, Residential Habilitation, Medical Residential Services, or Family Model Residential Support) shall not be eligible to receive Personal Assistance. Personal Assistance shall not be provided during the same time period when the Enrollee is receiving Day Services.
  3. This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).
  4. Family members who provide Personal Assistance must meet the same standards as providers who are unrelated to the Enrollee. The Personal Assistance provider shall not be the spouse and shall not be the Enrollee's parent if the Enrollee is a minor. Reimbursement shall not be made to any other individual who is a conservator unless so permitted in the Order for Conservatorship.
- (n) Personal Emergency Response System.
- The system shall be limited to those who are alone for parts of the day and who have demonstrated mental and physical capability to utilize such a system effectively.

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### (o) Physical Therapy Services.

1. Services must be provided by a licensed physical therapist or by a licensed physical therapist assistant working under the supervision of a licensed physical therapist.
2. Physical Therapy must be provided face to face with the Enrollee.
3. Physical Therapy therapeutic and corrective services shall not be ordered concurrently with Physical Therapy assessments (i.e., assess and treat orders are not accepted).
4. Physical Therapy assessments shall not be billed on the same day with other Physical Therapy services.
5. Physical Therapy shall not be billed when provided during the same time period as Occupational Therapy; Speech, Language and Hearing Services; Nutrition Services; Orientation and Mobility Training; or Behavior Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently. Physical Therapy shall not be billed with Day Services if the Day Services are reimbursed on a per hour basis.
6. Physical Therapy services are not intended to replace services available through the Medicaid State Plan or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act.
7. Physical Therapy assessments shall be limited to a maximum of 3.0 hours per Enrollee per day, and other Physical Therapy services shall be limited to a maximum of 1.5 hours per Enrollee per day.

### (p) Residential Habilitation.

1. A Residential Habilitation home shall have no more than 4 residents with the exception that homes which were already providing services to more than 4 residents prior to July 1, 2000, may continue to do so.
2. The Residential Habilitation provider shall be responsible for providing an appropriate level of services and supports twenty-four (24) hours per day during the hours the Enrollee is not receiving Day Services or is not at school or work.
3. Transportation shall be a component of Residential Habilitation and shall be included in the reimbursement rate for such (i.e., it shall not be billed as a separate Waiver service) with the following exceptions:
  - (i) Transportation to and from medical services covered through the Medicaid State Plan, which shall not be billed as a Waiver service;
  - (ii) Transportation necessary for Behavioral Respite Services; or
  - (iii) Transportation necessary for Orientation and Mobility Training.
4. Reimbursement for Residential Habilitation shall not be made for room and board or for the cost of maintenance of the dwelling, and reimbursement shall not include payment made to members of the Enrollee's immediate family or to the Enrollee's conservator.

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

(q) Respite.

1. Respite may be provided in the Enrollee's place of residence, in a Family Model Residential Support home, in a Medicaid-certified ICF/MR, in a home operated by a licensed residential provider, or in the home of an approved respite provider.
2. An Enrollee receiving a residential service (i.e., Supported Living, Residential Habilitation, Medical Residential Services, or Family Model Residential Support) shall not be eligible to receive Respite as a service.
3. The cost of room and board shall be excluded from Respite reimbursement if Respite is provided in a private residence.
4. Respite shall be limited to a maximum of thirty (30) days per Enrollee per year.
5. Enrollees who receive Respite shall be eligible to receive Individual Transportation Services only to the extent necessary during the time period when Respite is being provided.

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

1. Face-to-face consultative assessment by a physical therapist, occupational therapist, or speech therapist to assure that specialized medical equipment and assistive technology which requires custom fitting meets the needs of the Enrollee and training of the Enrollee by a physical therapist, occupational therapist, or speech therapist to effectively utilize such customized equipment shall be limited to a maximum of three (3) hours per Enrollee per day.
2. Items not of direct medical or remedial benefit to the Enrollee shall be excluded. Items that would be covered by the Medicaid State Plan shall be excluded from coverage. Swimming pools, hot tubs, health club memberships, and recreational equipment are excluded. Prescription and over-the-counter medications, food and food supplements, and diapers and other incontinence supplies are excluded.
3. When medically necessary and not covered by warranty, repair of equipment may be covered when it is substantially less expensive to repair the equipment rather than to replace it.
4. The purchase price for waiver-reimbursed Specialized Medical Equipment, Supplies and Assistive Technology shall be considered to include the cost of the item as well as basic training on operation and maintenance of the item.
5. Specialized Medical Equipment, Supplies and Assistive Technology shall be limited to a maximum of \$10,000 per Enrollee per two (2) year period.

(s) Speech, Language and Hearing Services.

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

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2. Speech, Language and Hearing Services must be provided face to face with the Enrollee.
3. Speech, Language and Hearing therapeutic and corrective services shall not be ordered concurrently with Speech, Language and Hearing assessments (i.e., assess and treat orders are not accepted).
4. Speech, Language and Hearing Services assessments shall not be billed on the same day with other Speech, Language and Hearing Services
5. Speech, Language and Hearing Services shall not be billed when provided during the same time period as Physical Therapy; Occupational Therapy; Nutrition Services; Orientation and Mobility Training; or Behavior Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently. Speech, Language and Hearing Services shall not be billed with Day Services if the Day Services are reimbursed on a per hour basis.
6. Speech, Language and Hearing Services assessments shall be limited to a maximum of 3.0 hours per Enrollee per day, and other Speech, Language and Hearing Services shall be limited to a maximum of 1.5 hours per Enrollee per day.

(t) Support Coordination.

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

(u) Supported Living.

1. The Supported Living provider shall not own the Enrollee's place of residence or be a co-signer of a lease on the Enrollee's place of residence unless the Supported Living provider signs a written agreement with the Enrollee that states that the Enrollee will not be required to move if the primary reason is because the Enrollee desires to change to a different Supported Living provider. A Supported Living provider shall not own, be owned by, or be affiliated with any entity that leases or rents a place of residence to an Enrollee if such entity requires, as a condition of renting or leasing, the Enrollee to move if the Supported Living provider changes.
2. The Supported Living home shall have no more than three (3) residents including the Enrollee.
3. Unless the residence is individually licensed or inspected by a public housing agency utilizing the HUD Section 8 safety checklist, the residence must have an operable smoke detector and a second means of egress.
4. The Supported Living provider shall be responsible for providing an appropriate level of services and supports twenty-four (24) hours per day during the hours the Enrollee is not receiving Day Services or is not at school or work.
5. Transportation shall be a component of Supported Living and shall be included in the reimbursement rate for such (i.e., it shall not be billed as a separate Waiver service) with the following exceptions:

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- (i) Transportation to and from medical services covered through the Medicaid State Plan, which shall not be billed as a Waiver service;
  - (ii) Transportation necessary for Behavioral Respite Services; or
  - (iii) Transportation necessary for Orientation and Mobility Training.
6. Reimbursement for Supported Living shall not be made for room and board with the exception of a reasonable portion that is attributed to a live-in caregiver who is unrelated to the Enrollee and who provides services to the Enrollee in the Enrollee's home. Reimbursement for Supported Living shall not include the cost of maintenance of the dwelling. Residential expenses (e.g., phone, cable TV, food, rent) shall be apportioned between the Enrollee, other residents in the home, and (as applicable) live-in or other caregivers.
7. This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).
8. The Enrollee or the Enrollee's guardian or conservator shall have a voice in choosing the individuals who reside in the Supported Living residence and the staff who provide services and supports.
9. The Enrollee shall have the right to manage personal funds as specified in the Individual Support Plan.
- (v) Vehicle Accessibility Modifications.
- 1. Replacement of tires or brakes, oil changes, and other vehicle maintenance procedures shall be excluded from coverage.
  - 2. Vehicle Accessibility Modifications shall be limited to a maximum of \$20,000 per Enrollee per five (5) year period.
- (w) Out-of-State Services. A provider of Personal Assistance, Residential Habilitation, Supported Living, Medical Residential Services, and Family Model Residential Services may provide such Covered Service outside the State of Tennessee and be reimbursed only when provided in accordance with the following:
- 1. Covered Services provided out of state shall be for the purpose of visiting relatives or for vacations and shall be included in the Enrollee's Plan of Care. Trips to casinos or other gambling establishments shall be excluded from coverage.
  - 2. Covered Services provided out of state shall be limited to a maximum of fourteen (14) days per Enrollee per year.
  - 3. The waiver service provider agency must be able to assure the health and safety of the Enrollee during the period when Covered Services will be provided out of state and must be willing to assume the additional risk and liability of provision of Covered Services out of state.
  - 4. During the period when Covered Services are being provided out of state, the waiver service provider agency shall maintain an adequate amount of staffing to meet the needs of the Enrollee and must ensure that staff meet the applicable provider qualifications.

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5. The provider agency which provides Covered Services out of state shall not receive any additional reimbursement for provision of services out-of-state. The costs of travel, lodging, food, and other expenses incurred by staff during the provision of out-of-state services shall not be reimbursed through the Waiver. The costs of travel, lodging, food, and other expenses incurred by the Enrollee while receiving out-of-state services shall be the responsibility of the Enrollee and shall not be reimbursed through the waiver.
- (x) All Covered Services to be provided prior to the development of the initial Individual Support Plan must be included in the physician's plan of care section of the Pre-Admission Evaluation application.
- (3) Eligibility.
- (a) To be eligible for enrollment in the Waiver, an individual must meet all of the following criteria:
1. The individual must be a resident of the State of Tennessee.
  2. The individual must, but for the provision of Waiver Services, require the level of care provided in an ICF/MR, and must meet the ICF/MR eligibility criteria specified in Medicaid rule 1200-13-1-.15.
  3. The individual's habilitative, medical, and specialized services needs must be such that they can be effectively and safely met through the Waiver, as determined by the Operational Administrative Agency based on a pre-enrollment assessment.
  4. The individual must have an unexpired ICF/MR Pre-Admission Evaluation which has been approved by the State Medicaid Agency or by its designee and which lists the Enrollee's specific Waiver Services with the amount, scope, and duration of the services.
  5. The individual must have a psychological evaluation included as part of the approved Pre-Admission Evaluation and which meets the following:
    - (i) The psychological evaluation shall document that the individual:
      - (I) Has mental retardation manifested before eighteen (18) years of age and have an IQ test score of seventy (70) or below, or
      - (II) Is a child four (4) years of age or younger who has a developmental disability with a high probability of resulting in mental retardation (i.e., a condition of substantial developmental delay or specific congenital or acquired condition with a high probability of resulting in mental retardation).
    - (ii) The psychological evaluation:
      - (I) Shall have been made no more than three (3) calendar months before the date of admission into the Waiver; or
      - (II) If performed more than three (3) calendar months but no more than twelve (12) calendar months before the date of admission, shall have been signed and updated within three (3) calendar months preceding the date of admission into the

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

6. The individual shall have one or more designated adults who shall be present in the individual's home to observe, evaluate, and provide an adequate level of direct care services to ensure the health and safety of the individual.
  - (i) An individual who does not have 24-hour-per-day direct care services shall:
    - (I) Have an individualized Safety Plan that:
      - I. Is based on a written assessment of the individual's functional capabilities and habilitative, medical, and specialized services needs by the Independent Support Coordinator in consultation with individuals who are knowledgeable of the individual's capability of functioning without direct care services twenty-four (24) hours per day;
      - II. Addresses the individual's capability of functioning when direct care staff are not present;
      - III. Addresses the ability of the individual to self-administer medications when direct care staff are not present;
      - IV. Specifies whether a Personal Emergency Response System will be used by the individual to secure help in an emergency;
      - V. Is updated as needed, but no less frequently than annually, by the Operational Administrative Agency to ensure the health and safety of the individual; and
      - VI. Is an attachment to the ICF/MR PAE or, if applicable, to the Transfer Form.
    - (II) Have one or more designated adults who shall be present in the individual's home to observe, evaluate, and provide an adequate level of direct care services to ensure the health and safety of the individual as needed but no less frequently than one day each week.
  - (ii) An individual who does not have 24-hour-per-day direct care services shall:
    - I. Is based on a written assessment of the individual's functional capabilities and habilitative, medical, and specialized services needs by the Independent Support Coordinator in consultation with individuals who are knowledgeable of the individual's capability of functioning without direct care services twenty-four (24) hours per day;
    - II. Addresses the individual's capability of functioning when direct care staff are not present;
    - III. Addresses the ability of the individual to self-administer medications when direct care staff are not present;
    - IV. Specifies whether a Personal Emergency Response System will be used by the individual to secure help in an emergency;
    - V. Is updated as needed, but no less frequently than annually, by the Operational Administrative Agency to ensure the health and safety of the individual; and
    - VI. Is an attachment to the ICF/MR PAE or, if applicable, to the Transfer Form.
7. An individual must have a place of residence with an environment that is adequate to reasonably ensure health, safety and welfare. Any licensed facility in which the individual resides must meet all applicable fire and safety codes.
  - (b) A Transfer Form approved by the State Medicaid Agency:
    1. May be used to transfer an Enrollee having an approved unexpired ICF/MR PAE from the Waiver to an ICF/MR;
    2. May be used to transfer an individual having an approved unexpired ICF/MR PAE from an ICF/MR to the Waiver;
    3. Shall not be used to transfer an individual from one Waiver to a different Home and Community Based Services Waiver Program; and

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4. Shall list the Enrollee's specific Waiver Services with the amount, scope, and duration of the services.
- (4) Intake and Enrollment.
- (a) When an individual is determined to be likely to require the level of care provided by an ICF/MR, the Operational Administrative Agency shall inform the individual or the individual's legal representative of any feasible alternatives available under the Waiver and shall offer the choice of available institutional services or Waiver program services. Notice to the individual shall contain:
    1. A simple explanation of the Waiver and Covered Services;
    2. Notification of the opportunity to apply for enrollment in the Waiver and an explanation of the procedures for enrollment; and
    3. A statement that participation in the Waiver is voluntary.
  - (b) Enrollment in the Waiver shall be voluntary, but shall be restricted to the maximum number of individuals specified in the Waiver, as approved by the Centers for Medicare and Medicaid Services for the State of Tennessee.
  - (c) Enrollment of new Enrollees into the Waiver may be suspended when the average per capita fiscal year expenditure under the Waiver exceeds or is reasonably anticipated to exceed 100% of the average per capita expenditure that would have been made in the fiscal year if the care was provided in an ICF/MR.
- (5) Certification and Re-evaluation.
- (a) The ICF/MR Pre-Admission Evaluation shall include a signed and dated certification by the individual's physician that the individual requires Waiver Services.
  - (b) The Operational Administrative Agency shall perform a re-evaluation of the Enrollee's need for continued stay in the Waiver within twelve (12) calendar months of the date of enrollment and at least every twelve (12) months thereafter. The re-evaluation shall be documented in a format approved by the State Medicaid Agency and shall be performed by a licensed physician or registered nurse or a Qualified Mental Retardation Professional.
  - (c) The Operational Administrative Agency shall maintain in its files for a minimum period of three (3) years a copy of the re-evaluations of need for continued stay.
- (6) Disenrollment.
- (a) Voluntary disenrollment of an Enrollee from the Waiver may occur at any time upon written notice from the Enrollee or the Enrollee's guardian or conservator to the Operational Administrative Agency. Prior to disenrollment the Operational Administrative Agency shall provide reasonable assistance to the Enrollee in locating appropriate alternative placement.
  - (b) An Enrollee may be involuntarily disenrolled from the Waiver for any of the following reasons:
    1. The Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled is terminated.

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2. An Enrollee becomes ineligible for Medicaid or is found to be erroneously enrolled in the Waiver.
  3. An Enrollee moves out of the State of Tennessee.
  4. The condition of the Enrollee improves such that the Enrollee no longer requires the level of care provided by the Waiver.
  5. The Enrollee's medical or behavioral needs become such that the health, safety, and welfare of the Enrollee cannot be assured through the provision of Waiver Services.
  6. The home or home environment of the Enrollee becomes unsafe to the extent that it would reasonably be expected that Waiver Services could not be provided without significant risk of harm or injury to the Enrollee or to individuals who provide covered services to the Enrollee.
  7. The Enrollee or the Enrollee's guardian or conservator refuses to abide by the Plan of Care or related Waiver policies, resulting in the inability of the Operational Administrative Agency to ensure quality care or the health and safety of the Enrollee.
  8. The health, safety, and welfare of the Enrollee cannot be assured due to the lack of an approved Safety Plan.
  9. The Enrollee was transferred to a hospital, nursing facility, Intermediate Care Facility for the Mentally Retarded, Assisted Living Facility, and/or Home for the Aged and has resided there for a continuous period exceeding 120 days.
- (c) The Operational Administrative Agency shall notify the State Medicaid Agency in writing prior to involuntary disenrollment of an Enrollee and shall give advance notice to the Enrollee of the intended involuntary disenrollment and of the Enrollee's right to appeal and have a fair hearing.
- (d) If an Enrollee has been involuntarily disenrolled from the Waiver, the Operational Administrative Agency shall provide reasonable assistance to the Enrollee in locating appropriate alternative placement.
- (7) Plan of Care.
- (a) All Waiver Services for the Enrollee shall be provided in accordance with an approved Plan of Care.
1. Prior to the development of the initial Individual Support Plan, Covered Services shall be provided in accordance with the physician's initial plan of care included in the approved ICF/MR Pre-Admission Evaluation.
  2. Each Enrollee shall have an individualized written Plan of Care (the Individual Support Plan) that shall be developed for an Enrollee within ninety (90) calendar days of admission into the Waiver.
  3. A Safety Plan for Enrollees who do not have 24-hour direct care services shall be maintained with the Plan of Care.

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- (b) To ensure that Waiver Services and other services are being appropriately provided to meet the Enrollee's needs, the Plan of Care shall be reviewed on an ongoing basis and shall be updated and signed in accordance with the following:
  - 1. The Support Coordinator shall review the Plan of Care when needed, but no less frequently than once each calendar month, and shall document such review by a dated signature.
  - 2. A team consisting of the Support Coordinator and other appropriate participants in the development of the Plan of Care shall review the Plan of Care when needed, but no less frequently than every twelve (12) calendar months, and shall document such review by dated signatures. Such annual review shall include, but not be limited to, reviewing outcomes and determining if progress is being made in accordance with the Plan of Care; reviewing the appropriateness of supports and services being provided and determining further needs of the Enrollee.

(8) Physician Services.

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

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

- (b) All Covered Services to be provided prior to the development of the initial Individual Support Plan shall be physician ordered and shall be included in the physician's plan of care section of the Pre-Admission Evaluation application.
- (c) When required by state law, Covered Services shall be ordered or reordered, by a licensed physician, licensed nurse practitioner, physician assistant, a licensed dentist, or other appropriate health care provider.

(9) Waiver Administration.

- (a) The Operational Administrative Agency shall be responsible for the administration of the day-to-day operations of the Waiver under the oversight of the State Medicaid Agency and shall ensure that Covered Services are provided in accordance with state and federal laws, rules, regulations and policies established by the State Medicaid Agency. The Operational Administrative Agency shall be responsible for the following activities, whether provided directly or through subcontract:
  - 1. Marketing of the Waiver to potential Enrollees;
  - 2. Intake and pre-enrollment assessment of the applicant's habilitative, medical and specialized services needs; and appropriateness for enrollment in the Waiver;

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3. Assisting the applicant with the submission of a properly completed ICF/MR Pre-Admission Evaluation;
4. Enrollment of eligible individuals into the Waiver;
5. Provision of a plain language explanation of appeal rights to each Enrollee upon enrollment in the Waiver;
6. Review and approval of Plans of Care (Individual Support Plans) to ensure that Waiver Services have been authorized prior to payment;
7. Ensuring that annual level of care re-evaluations have been performed to document the need for continuation of Waiver Services for the Enrollee;
8. Notification of the State Medicaid Agency in writing prior to involuntary disenrollment of any Enrollee;
9. Ensuring that Waiver providers maintain comprehensive Enrollee records and documentation of services provided to Enrollees in accordance with state and federal laws, rules, regulations and State Medicaid Agency policies;
10. Obtaining approval from the State Medicaid Agency prior to distributing policies and procedures to Waiver providers or Waiver information to Enrollees;
11. Compliance with reporting and record-keeping requirements established by the State Medicaid Agency;
12. Maintaining in its files the original ICF/MR Pre-Admission Evaluation and, where applicable, the original Transfer Form;
13. Assurance of a statewide provider network adequate to meet the needs of Enrollees;
14. Ensuring that Waiver Services providers and subcontractors meet the Waiver provider qualifications approved by the Centers for Medicare and Medicaid Services;
15. Ensuring that Waiver Services providers have a signed provider agreement which includes a requirement for compliance with the Division of Mental Retardation Services Provider Manual in the delivery of waiver services;
16. Assurance of the health and safety of Enrollees through the implementation of a comprehensive quality monitoring program;
17. Reporting instances of abuse, neglect, mistreatment or exploitation to appropriate state agencies;
18. Assurance that Covered Services are provided in accordance with the approved Waiver definitions and in accordance with the State Medicaid Agency guidelines;
19. Compliance with the appeals process specified in TennCare rule 1200-13-13-.11 to ensure that Enrollees are afforded advance notice and the right to appeal an adverse decision and have a fair hearing;

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20. Ensuring that providers and subcontractors comply with the quality monitoring guidelines and requirements established by the State Medicaid Agency, by the Operational Administrative Agency, and by the Centers for Medicare and Medicaid Services, and with other state and federal laws, rules, and regulations affecting the provision of Waiver Services;
21. Collection of applicable patient liability from Enrollees;
22. Reimbursement of Waiver providers in accordance with policies established by the State Medicaid Agency;
23. Recoupment of payments made to Waiver providers when there is lack of documentation to support that services were provided or there is a lack of medical necessity of services, or when inappropriate payments have been made due to erroneous or fraudulent billing; and
24. Expenditure and revenue reporting in accordance with state and federal requirements.

### (10) Reimbursement.

- (a) The average per capita fiscal year expenditure under the Waiver shall not exceed 100% of the average per capita expenditure that would have been made in the fiscal year if care had been provided in an ICF/MR. The total Medicaid expenditure for Waiver Services and other Medicaid services provided to Enrollees shall not exceed 100% of the amount that would have been incurred in the fiscal year if care was provided in an ICF/MR.
- (b) The Operational Administrative Agency shall be reimbursed for Waiver Services at the rate per unit of service actually paid by the Operational Administrative Agency to the Waiver service provider or at the maximum rate per unit of service established by the State Medicaid Agency, whichever is lesser.
- (c) In accordance with 42 CFR § 435.726, the Operational Administrative Agency shall make a diligent effort to collect patient liability if it applies to the Enrollee. The Operational Administrative Agency or its designee shall complete appropriate forms showing the individual's amount of monthly income and shall submit them to the Tennessee Department of Human Services. The Tennessee Department of Human Services shall issue the appropriate forms to the Operational Administrative Agency and to the State Medicaid Agency's fiscal agent that processes and pays vendor claims, specifying the amount of patient liability to be applied toward the cost of care for the Enrollee.
- (d) The Operational Administrative Agency shall submit bills for services to the State Medicaid Agency's fiscal agent using a claim form approved by the State Medicaid Agency. On claim forms, the Operational Administrative Agency shall use a provider number assigned by the State Medicaid Agency.
- (e) Reimbursement shall not be made to the Operational Administrative Agency for therapeutic leave or hospital leave for Enrollees in the Waiver.
- (f) Medicaid benefits other than those specified in the Waiver's scope of Covered Services shall be reimbursed by the State Medicaid Agency as otherwise provided for by federal and state rules and regulations.

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- (g) The Operational Administrative Agency shall be responsible for obtaining the physician's initial certification and subsequent Enrollee re-evaluations. Failure to perform re-evaluations in a timely manner and in the format approved by the State Medicaid Agency shall require a corrective action plan and shall result in partial or full recoupment of all amounts paid by the State Medicaid Agency during the time period when a re-evaluation had lapsed.
  - (h) The State Medicaid Agency shall be responsible for defining and establishing the billing units to be used by the Operational Administrative Agency in billing for Waiver Services.
  - (i) An Operational Administrative Agency that enrolls an individual without an approved ICF/MR Pre-Admission Evaluation or, where applicable, an approved Transfer Form does so without the assurance of reimbursement. An Operational Administrative Agency that enrolls an individual who has not been determined by the Tennessee Department of Human Services to be financially eligible to have Medicaid make reimbursement for covered services does so without the assurance of reimbursement.
- (11) Appeals. An Enrollee shall have the right to appeal an adverse action in accordance with TennCare rule 1200-13-13-.11.

*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 28th day of February, 2006. (02-30)

## 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, 1<sup>st</sup> Floor East Conference Room, 310 Great Circle Road, Nashville, Tennessee 37243 at 9:00 a.m. C.D.T. on the 18th day April 2006.

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

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

### SUBSTANCE OF PROPOSED RULE

Rule Chapter 1200-13-1 General Rules is amended by adding rule 1200-13-1-.28 Home and Community Based Services Waiver for Persons with Mental Retardation which shall read as follows:

#### **1200-13-1-.28 HOME AND COMMUNITY BASED SERVICES WAIVER FOR PERSONS WITH MENTAL RETARDATION.**

- (1) Definitions: The following definitions shall apply for interpretation of this rule:
  - (a) Behavioral Respite Services - services that provide Respite for an Enrollee who is experiencing a behavioral crisis that necessitates removal from the current residential setting in order to resolve the behavioral crisis.
  - (b) Behavior Services – assessment and amelioration of Enrollee behavior that presents a health or safety risk to the Enrollee or others or that significantly interferes with home or community activities; determination of the settings in which such behaviors occur and the events which precipitate the behaviors; development, monitoring, and revision of crisis prevention and behavior intervention strategies; and training of caregivers who are responsible for direct care of the Enrollee in prevention and intervention strategies.
  - (c) Bureau of TennCare - the bureau in the Tennessee Department of Finance and Administration which is the State Medicaid Agency and is responsible for administration of the Medicaid program in Tennessee.
  - (d) Certification - the process by which a physician, who is licensed as a doctor of medicine or doctor of osteopathy, signs and dates a Pre-Admission Evaluation signifying that the named individual requires services provided through the Home and Community Based Services Waiver for Persons with Mental Retardation as an alternative to care in an Intermediate Care Facility for the Mentally Retarded.

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- (e) Covered Services or Covered Waiver Services – The services which are available through Tennessee’s Home and Community Based Services Waiver for Persons with Mental Retardation when medically necessary and when provided in accordance with the Waiver as approved by the Centers for Medicare and Medicaid Services.
- (f) Day Services - individualized services and supports that enable an Enrollee to acquire, retain, or improve skills necessary to reside in a community-based setting; to participate in community activities and utilize community resources; to acquire and maintain employment; and to participate in retirement activities.
- (g) Denial - as used in regard to Waiver Services, the term shall mean the termination, suspension, or reduction in amount, scope, and duration of a Waiver Service or a refusal or failure to provide such service.
- (h) Dental Services - accepted dental procedures which are provided to Enrollees age twenty-one (21) years or older, as specified in the Plan of Care. Dental Services may include preventive dental services, fillings, root canals, extractions, periodontics, the provision of dentures, and other dental treatments to relieve pain and infection.
- (i) Disenrollment - the voluntary or involuntary termination of enrollment of an individual receiving services through the Home and Community Based Services Waiver for Persons with Mental Retardation.
- (j) Enrollee - a Medicaid Eligible who is enrolled in the Home and Community Based Services Waiver for Persons with Mental Retardation.
- (k) Environmental Accessibility Modifications – only those interior or exterior physical modifications to the Enrollee’s place of residence which are required to ensure the health, welfare and safety of the Enrollee or which are necessary to enable the Enrollee to function with greater independence.
- (l) Family Model Residential Support – a type of residential service having individualized services and supports that enable an Enrollee to acquire, retain, or improve skills necessary to reside successfully in a family environment in the home of trained caregivers other than the family of origin. The service includes direct assistance as needed with activities of daily living, household chores essential to the health and safety of the enrollee, budget management, attending appointments, and interpersonal and social skills building to enable the Enrollee to live in a home in the community. It also may include medication administration as permitted under Tennessee’s Nurse Practice Act.
- (m) Home (of an Enrollee) - the residence or dwelling in which the Enrollee resides, excluding hospitals, nursing facilities, Intermediate Care Facilities for the Mentally Retarded, Assisted Living Facilities and Homes for the Aged.
- (n) Home and Community Based Services Waiver for Persons with Mental Retardation or “Waiver” - the Home and Community Based Services waiver program approved for Tennessee by the Centers for Medicare and Medicaid Services to provide services to a specified number of Medicaid-eligible individuals who have mental retardation and who meet the criteria for Medicaid reimbursement of care in an Intermediate Care Facility for the Mentally Retarded.

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- (o) ICF/MR Pre-Admission Evaluation (ICF/MR PAE) – the assessment form used by the State Medicaid Agency to document the current medical and habilitative needs of an individual with mental retardation and to document that the individual meets the Medicaid level of care eligibility criteria for care in an ICF/MR.
- (p) Individual Support Plan – the individualized written Plan of Care.
- (q) Individual Transportation Services –non-emergency transport of an Enrollee to and from approved activities specified in the Plan of Care.
- (r) Intermediate Care Facility for the Mentally Retarded (ICF/MR) - a licensed facility approved for Medicaid vendor reimbursement that provides specialized services for individuals with mental retardation or related conditions and that complies with current federal standards and certification requirements for an ICF/MR.
- (s) Medicaid Eligible - an individual who has been determined by the Tennessee Department of Human Services to be financially eligible to have the State Medicaid Agency make reimbursement for covered services.
- (t) Medical Residential Services – a type of residential service provided in a residence where all residents require direct skilled nursing services and habilitative services and supports that enable an Enrollee to acquire, retain, or improve skills necessary to reside in a community-based setting. Medical Residential Services must be ordered by the Enrollee’s physician, physician assistant, or nurse practitioner, who shall document the medical necessity of the services and specify the nature and frequency of the nursing services. The enrollee who receives Medical Residential Services shall require direct skilled nursing services on a daily basis and at a level which cannot for practical purposes be provided through two or fewer daily skilled nursing visits. The service includes direct assistance as needed with activities of daily living, household chores essential to the health and safety of the enrollee, budget management, attending appointments, and interpersonal and social skills building to enable the enrollee to live in a home in the community. It also may include medication administration as permitted under Tennessee’s Nurse Practice Act.
- (u) Medicaid State Plan - the plan approved by the Centers for Medicare and Medicaid Services which specifies the covered benefits for the Medicaid program in Tennessee.
- (v) Nursing Services –skilled nursing services that fall within the scope of Tennessee’s Nurse Practice Act and that are directly provided to the Enrollee in accordance with a plan of care. Nursing Services shall be ordered by the Enrollee’s physician, physician assistant, or nurse practitioner, who shall document the medical necessity of the services and specify the nature and frequency of the nursing services.
- (w) Nutrition Services - assessment of nutritional needs, nutritional counseling, and education of the Enrollee and of caregivers responsible for food purchase, food preparation, or assisting the Enrollee to eat. Nutrition Services are intended to promote healthy eating practices and to enable the Enrollee and direct support professionals to follow special diets ordered by a physician, physician assistant, or nurse practitioner.
- (x) Occupational Therapy Services – diagnostic, therapeutic, and corrective services which are within the scope of state licensure. Occupational Therapy Services provided to improve or maintain current functional abilities as well as prevent or minimize deterioration of chronic conditions leading to a further loss of function are also included within this definition.

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- (y) Operational Administrative Agency - the approved agency with which the State Medicaid Agency contracts for the administration of the day-to-day operations of the Home and Community Based Services Waiver for Persons with Mental Retardation.
- (z) Orientation and Mobility Training – assessment of the ability of an Enrollee who is legally blind to move independently, safely, and purposefully in the home and community environment; orientation and mobility counseling; and training and education of the Enrollee and of caregivers responsible for assisting in the mobility of the Enrollee.
- (aa) Personal Assistance – the provision of direct assistance with activities of daily living (e.g., bathing, dressing, personal hygiene, eating, meal preparation excluding cost of food), household chores essential to the health and safety of the enrollee, budget management, attending appointments, and interpersonal and social skills building to enable the Enrollee to live in a home in the community. It also may include medication administration as permitted under Tennessee’s Nurse Practice Act.
- (bb) Personal Emergency Response System - a stationary or portable electronic device used in the Enrollee’s place of residence which enables the Enrollee to secure help in an emergency. The system shall be connected to a response center staffed by trained professionals who respond upon activation of the electronic device.
- (cc) Physical Therapy Services - diagnostic, therapeutic, and corrective services which are within the scope of state licensure. Physical Therapy Services provided to improve or maintain current functional abilities as well as prevent or minimize deterioration of chronic conditions leading to a further loss of function are also included within this definition.
- (dd) Plan of Care – an individualized written Plan of Care which describes the medical and other services (regardless of funding source) to be furnished to the Enrollee, the Waiver Service frequency, and the type of provider who will furnish each Waiver Service and which serves as the fundamental tool by which the State ensures the health and welfare of Enrollees.
- (ee) Qualified Mental Retardation Professional (QMRP) - an individual who meets current federal standards, as published in the Code of Federal Regulations, for a qualified mental retardation professional.
- (ff) Re-evaluation - the annual process approved by the State Medicaid Agency by which a licensed physician or registered nurse or a Qualified Mental Retardation Professional assesses the Enrollee’s need for continued Waiver Services and certifies in writing that the Enrollee continues to require Waiver Services.
- (gg) Residential Habilitation - a type of residential service having individualized services and supports that enable an Enrollee to acquire, retain, or improve skills necessary to reside in a community-based setting including direct assistance with activities of daily living essential to the health and safety of the Enrollee, budget management, attending appointments, and interpersonal and social skills building to enable the Enrollee to live in a home in the community. It also may include medication administration as permitted under Tennessee’s Nurse Practice Act.
- (hh) Respite - services provided to an Enrollee when unpaid caregivers are absent or incapacitated due to death, hospitalization, illness or injury, or when unpaid caregivers need relief from routine caregiving responsibilities.

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- (ii) Safety Plan - an individualized plan by which the Operational Administrative Agency ensures the health, safety and welfare of Enrollees who do not have 24-hour direct care services.
- (jj) Specialized Medical Equipment and Supplies and Assistive Technology - assistive devices, adaptive aids, controls or appliances which enable an Enrollee to increase the ability to perform activities of daily living, or to perceive, control or communicate with the environment, and supplies for the proper functioning of such items. Specialized Medical Equipment, Supplies and Assistive Technology shall be recommended by a qualified health care professional (e.g., occupational therapist, physical therapist, speech language pathologist, physician or nurse practitioner) based on an assessment of the Enrollee's needs and capabilities and shall be furnished as specified in the Plan of Care. Specialized Medical Equipment and Supplies and Assistive Technology may also include a face-to-face consultative assessment by a physical therapist, occupational therapist or speech therapist to assure that Specialized Medical Equipment and Assistive Technology which requires custom fitting meets the needs of the Enrollee and may include training of the Enrollee by a physical therapist, occupational therapist or speech therapist to effectively utilize such customized equipment.
- (kk) Speech, Language and Hearing Services – diagnostic, therapeutic and corrective services which are within the scope of state licensure which enable an Enrollee to improve or maintain current functional abilities and to prevent or minimize deterioration of chronic conditions leading to a further loss of function.
- (ll) State Medicaid Agency – the bureau in the Tennessee Department of Finance and Administration which is responsible for administration of the Title XIX Medicaid program in Tennessee.
- (mm) Subcontractor - an individual, organized partnership, professional corporation, or other legal association or entity which enters into a written contract with the Operational Administrative Agency to provide Waiver Services to an Enrollee.
- (nn) Support Coordination - case management services that assist the Enrollee in identifying, selecting, obtaining, coordinating and using both paid services and natural supports to enhance the Enrollee's independence, integration in the community and productivity as specified in the Enrollee's Plan of Care. Support Coordination shall be person-centered and shall include, but is not limited to, ongoing assessment of the Enrollee's strengths and needs; development, evaluation and revision of the Plan of Care; assistance with the selection of service providers; provision of general education about the Waiver program, including Enrollee rights and responsibilities; and monitoring implementation of the plan of care and initiating individualized corrective actions as necessary (e.g., reporting, referring, or appealing to appropriate entities).
- (oo) Support Coordinator - the person who is responsible for developing the Individual Support Plan and participating in the development of, monitoring and assuring the implementation of the Plan of Care; who provides Support Coordination services to an Enrollee; and who meets the qualifications for a Support Coordinator as specified in the Home and Community Based Services Waiver for Persons with Mental Retardation.
- (pp) Supported Living - a type of residential service having individualized services and supports that enable an Enrollee to acquire, retain or improve skills necessary to reside in a home that is under the control and responsibility of the Enrollee. The service includes direct assistance as needed with activities of daily living, household chores essential to the health and safety of the Enrollee, budget management, attending appointments, and interpersonal

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and social skills building to enable the Enrollee to live in a home in the community. It also may include medication administration as permitted under Tennessee's Nurse Practice Act.

- (qq) Transfer Form - the form approved by the State Medicaid Agency and used to document the transfer of an Enrollee having an approved unexpired ICF/MR Pre-Admission Evaluation from the Waiver to an ICF/MR or from an ICF/MR to the Waiver.
  - (rr) Vehicle Accessibility Modifications - interior or exterior physical modifications to a vehicle owned by the Enrollee or to a vehicle which is owned by the guardian or conservator of the Enrollee and which is routinely available for transport of the Enrollee. Such modifications must be intended to ensure the transport of the Enrollee in a safe manner.
  - (ss) Vision Services - routine eye examinations and refraction; standard or special frames for eyeglasses; standard, bifocal, multifocal or special lenses for eyeglasses; contact lenses; and dispensing fees for ophthalmologists, optometrists, and opticians.
- (2) Covered Services and Limitations.
- (a) Behavioral Respite Services.
    - 1. Behavioral Respite Services may be provided in a Medicaid-certified ICF/MR, in a licensed respite care facility, or in a home operated by a licensed residential provider.
    - 2. Reimbursement shall not be made for the cost of room and board except when provided as part of Behavioral Respite Services furnished in a facility approved by the State that is not a private residence.
    - 3. Behavioral Respite Services shall be limited to a maximum of sixty (60) days per Enrollee per year.
    - 4. Enrollees who receive Behavioral Respite Services shall be eligible to receive Individual Transportation Services only to the extent necessary during the time period when Behavioral Respite Services is being provided.
  - (b) Behavior Services.
    - 1. Behavior Services shall not be billed when provided during the same time period as Physical Therapy; Occupational Therapy; Nutrition Services; Orientation and Mobility Training; or Speech, Language and Hearing Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently.
    - 2. Behavior Services shall be provided face to face with the Enrollee except that enrollee-specific training of staff may be provided when the Enrollee is not present.
  - (c) Day Services.
    - 1. Day Services may be provided in settings such as specialized facilities licensed to provide Day Services, community centers or other community sites, or job sites. Services may also be provided in the Enrollee's place of residence if there is a health, behavioral, or other medical reason or if the Enrollee has chosen retirement. This

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

2. With the exception of employment that is staff supported, Day Services shall be provided only on weekdays during the day (i.e., between the hours of 7:30 a.m. and 6:00 p.m.), as specified in the Plan of Care.
  3. Day Services shall be limited to a maximum of six (6) hours per day and five (5) days per week up to a maximum of 243 days per Enrollee per year.
  4. Transportation to and from the Enrollee's place of residence to Day Services and transportation that is needed during the time that the Enrollee is receiving Day Services shall be a component of Day Services and shall be included in the Day Services reimbursement rate (i.e., it shall not be billed as a separate Waiver service) with the following exceptions:
    - (i) Transportation to and from medical services covered through the Medicaid State Plan, which shall not be billed as a Waiver service; or
    - (ii) Transportation necessary for Orientation and Mobility Training.
  5. Day Services shall not replace services available under a program funded by the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act.
  6. For an Enrollee receiving employment supports, reimbursement shall not be made for incentive payments, subsidies or unrelated vocational training expenses such as the following:
    - (i) Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
    - (ii) Payments that are passed through to users of supported employment programs; or
    - (iii) Payments for vocational training that is not directly related to an Enrollee's supported employment program.
- (d) Dental Services.
1. Dental Services shall not include hospital outpatient or inpatient facility services or related anesthesiology, radiology, pathology, or other medical services in such setting.
  2. Dental Services shall exclude orthodontic services.
  3. Dental Services shall be limited to adults age twenty-one (21) years or older who are enrolled in the Waiver.
- (e) Environmental Accessibility Modifications.
1. Environmental Accessibility Modifications which are considered improvements to the home (e.g., roof or flooring repair, installing carpet, installation of central air conditioning, construction of an additional room) are excluded from coverage.
  2. Any modification which is not of direct medical or remedial benefit to the Enrollee is excluded from coverage.

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3. Modification of an existing room which increases the total square footage of the home is also excluded unless the modification is necessary to improve the accessibility of an Enrollee having limited mobility, in which case the modification shall be limited to the minimal amount of square footage necessary to accomplish the increased accessibility.
  4. Environmental Accessibility Modifications shall be limited to a maximum of \$15,000 per Enrollee per two (2) year period.
- (f) Family Model Residential Support.
1. With the exception of homes that were already providing services to three (3) residents prior to January 1, 2004, a Family Model Residential Support home shall have no more than 2 residents who receive services and supports.
  2. The Family Model Residential Support provider shall be responsible for providing an appropriate level of services and supports twenty-four (24) hours per day during the hours the Enrollee is not receiving Day Services or is not at school or work.
  3. Transportation shall be a component of Family Model Residential Support and shall be included in the reimbursement rate for such (i.e., it shall not be billed as a separate Waiver service) with the following exceptions:
    - (i) Transportation to and from medical services covered through the Medicaid State Plan, which shall not be billed as a Waiver service;
    - (ii) Transportation necessary for Behavioral Respite Services; or
    - (iii) Transportation necessary for Orientation and Mobility Training.
  4. This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).
  5. Reimbursement for Family Model Residential Support shall not be made for room and board or for the cost of maintenance of the dwelling, and reimbursement shall not include payment made to the Enrollee's parent, step-parent, spouse, child, or sibling or to any other individual who is a conservator unless so permitted in the Order for Conservatorship.
- (g) Individual Transportation Services.
1. An Enrollee receiving Orientation and Mobility Training shall be eligible to receive Individual Transportation Services to the extent necessary for participation in Orientation and Mobility Training. Enrollees who receive Respite, Behavioral Respite Services, or Personal Assistance shall be eligible to receive Individual Transportation Services only to the extent necessary during the time period when Respite, Behavioral Respite Services, or Personal Assistance is being provided.
  2. Individual Transportation Services shall not be used for:
    - (i) Transportation to and from Day Services;
    - (ii) Transportation to and from supported or competitive employment;

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- (iii) Transportation of school aged children to and from school;
  - (iv) Transportation to and from medical services covered by the Medicaid State Plan;  
or
  - (v) Transportation of an Enrollee receiving a residential service, except as described herein for Orientation and Mobility Training or Behavioral Respite Services.
- (h) Medical Residential Services.
1. The Medical Residential Services provider shall be responsible for providing an appropriate level of services and supports twenty-four (24) hours per day when the Enrollee is not receiving Day Services or is not at school or work.
  2. Transportation shall be a component of Medical Residential Services and shall be included in the reimbursement rate for such (i.e., it shall not be billed as a separate Waiver service) with the following exceptions:
    - (i) Transportation to and from medical services covered through the Medicaid State Plan, which shall not be billed as a Waiver service;
    - (ii) Transportation necessary for Behavioral Respite Services; or
    - (iii) Transportation necessary for Orientation and Mobility Training.
  3. Reimbursement for Medical Residential Services shall not include the cost of maintenance of the dwelling, and reimbursement shall not include payment made to members of the Enrollee's immediate family or to the Enrollee's conservator. Reimbursement shall not be made for room and board if the home is rented, leased, or owned by the provider. If the home is rented, leased, or owned by the Enrollee, reimbursement shall not be made for room and board with the exception of a reasonable portion that is attributed to a live-in caregiver who is unrelated to the Enrollee and who provides services to the Enrollee in the Enrollee's place of residence. If an Enrollee owns or leases the place of residence, residential expenses (e.g., phone, cable TV, food, rent) shall be apportioned between the Enrollee, other residents in the home, and (as applicable) live-in or other caregivers.
  4. This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).
  5. Medical Residential Services providers must be licensed by the Department of Mental Health and Developmental Disabilities as a Mental Retardation Residential Habilitation Facility provider or a Supported Living Service provider and ensure that employed nurses are licensed to practice in the state of Tennessee.
- (i) Nursing Services.
1. Nursing Services shall be provided face to face with the Enrollee by a licensed registered nurse or licensed practical nurse under the supervision of a registered nurse.

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2. Nursing assessment and/or nursing oversight shall not be a separate billable service under this definition.
  3. This service shall be provided in home and community settings, as specified in the Plan of Care, excluding inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).
  4. An Enrollee who is receiving Medical Residential Services shall not be eligible to receive Nursing Services during the hours Medical Residential Services are being provided.
  5. Nursing Services shall not be billed when provided during the same time period as other therapies unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently.
  6. Nursing Services are not intended to replace services available through the Medicaid State Plan or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act.
- (j) Nutrition Services.
1. Nutrition Services must be provided face to face with the Enrollee or, for purposes of education, with the caregivers responsible for food purchase, food preparation, or assisting the Enrollee to eat.
  2. Nutrition Services shall not be billed when provided during the same time period as Physical Therapy; Occupational Therapy; Speech, Language and Hearing Services; Orientation and Mobility Training; or Behavior Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently.
  3. Nutrition Services shall be limited to a maximum of 1.5 hours per Enrollee per day.
- (k) Occupational Therapy Services.
1. Services must be provided by a licensed occupational therapist or by a licensed occupational therapist assistant working under the supervision of a licensed occupational therapist.
  2. Occupational Therapy must be provided face to face with the Enrollee.
  3. Occupational Therapy therapeutic and corrective services shall not be ordered concurrently with Occupational Therapy assessments (i.e., assess and treat orders are not accepted).
  4. Occupational Therapy assessments shall not be billed on the same day with other Occupational Therapy services.
  5. Occupational Therapy shall not be billed when provided during the same time period as Physical Therapy; Speech, Language and Hearing Services; Nutrition Services; Orientation and Mobility Training; or Behavior Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided

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concurrently. Occupational Therapy shall not be billed with Day Services if the Day Services are reimbursed on a per hour basis.

6. Occupational Therapy services are not intended to replace services available through the Medicaid State Plan or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act.
7. Occupational Therapy assessments shall be limited to a maximum of 3.0 hours per enrollee per day, and other Occupational Therapy services shall be limited to a maximum of 1.5 hours per Enrollee per day.

### (l) Orientation and Mobility Training.

1. Orientation and Mobility Training shall not be billed when provided during the same time period as Physical Therapy; Occupational Therapy; Nutrition Services; Behavior Services; or Speech, Language and Hearing Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently.
2. Orientation and Mobility Training shall not replace services available under a program funded by the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act.
3. Orientation and Mobility Training shall be limited to a maximum of sixty (60) hours of services per Enrollee per year.
4. Enrollees receiving Orientation and Mobility Training shall be eligible to receive Individual Transportation Services to the extent necessary for participation in Orientation and Mobility Training.

### (m) Personal Assistance.

1. Personal Assistance may be provided in the home or community; however, it shall not be provided in school settings and shall not be provided to replace personal assistance services required to be covered by schools or services available through the Medicaid State Plan.
2. An Enrollee who is receiving a residential service (i.e., Supported Living, Residential Habilitation, Medical Residential Services, or Family Model Residential Support) shall not be eligible to receive Personal Assistance. Personal Assistance shall not be provided during the same time period when the Enrollee is receiving Day Services.
3. This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).
4. Family members who provide Personal Assistance must meet the same standards as providers who are unrelated to the Enrollee. The Personal Assistance provider shall not be the spouse and shall not be the Enrollee's parent if the Enrollee is a minor. Reimbursement shall not be made to any other individual who is a conservator unless so permitted in the Order for Conservatorship.

### (n) Personal Emergency Response System.

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

(o) Physical Therapy Services.

1. Services must be provided by a licensed physical therapist or by a licensed physical therapist assistant working under the supervision of a licensed physical therapist.
2. Physical Therapy must be provided face to face with the Enrollee.
3. Physical Therapy therapeutic and corrective services shall not be ordered concurrently with Physical Therapy assessments (i.e., assess and treat orders are not accepted).
4. Physical Therapy assessments shall not be billed on the same day with other Physical Therapy services.
5. Physical Therapy shall not be billed when provided during the same time period as Occupational Therapy; Speech, Language and Hearing Services; Nutrition Services; Orientation and Mobility Training or Behavior Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently. Physical Therapy shall not be billed with Day Services if the Day Services are reimbursed on a per hour basis.
6. Physical Therapy services are not intended to replace services available through the Medicaid State Plan or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act.
7. Physical Therapy assessments shall be limited to a maximum of 3.0 hours per Enrollee per day, and other Physical Therapy services shall be limited to a maximum of 1.5 hours per Enrollee per day.

(p) Residential Habilitation.

1. A Residential Habilitation home shall have no more than four (4) residents with the exception that homes which were already providing services to more than 4 residents prior to July 1, 2000, may continue to do so.
2. The Residential Habilitation provider shall be responsible for providing an appropriate level of services and supports twenty-four (24) hours per day during the hours the Enrollee is not receiving Day Services or is not at school or work.
3. Transportation shall be a component of Residential Habilitation and shall be included in the reimbursement rate for such (i.e., it shall not be billed as a separate Waiver service) with the following exceptions:
  - (i) Transportation to and from medical services covered through the Medicaid State Plan, which shall not be billed as a Waiver service;
  - (ii) Transportation necessary for Behavioral Respite Services; or
  - (iii) Transportation necessary for Orientation and Mobility Training.

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4. Reimbursement for Residential Habilitation shall not be made for room and board or for the cost of maintenance of the dwelling, and reimbursement shall not include payment made to members of the Enrollee's immediate family or to the Enrollee's conservator.
5. This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).

### (q) Respite.

1. Respite may be provided in the Enrollee's place of residence, in a Family Model Residential Support home, in a Medicaid-certified ICF/MR, in a home operated by a licensed residential provider, or in the home of an approved respite provider.
2. An Enrollee receiving a residential service (i.e., Supported Living, Residential Habilitation, Medical Residential Services, or Family Model Residential Support) shall not be eligible to receive Respite as a service.
3. The cost of room and board shall be excluded from Respite reimbursement if Respite is provided in a private residence.
4. Respite shall be limited to a maximum of thirty (30) days per Enrollee per year.
5. Enrollees who receive Respite shall be eligible to receive Individual Transportation Services only to the extent necessary during the time period when Respite is being provided.

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

1. Face-to-face consultative assessment by a physical therapist, occupational therapist, or speech therapist to assure that specialized medical equipment and assistive technology which requires custom fitting meets the needs of the Enrollee and training of the Enrollee by a physical therapist, occupational therapist, or speech therapist to effectively utilize such customized equipment shall be limited to a maximum of three (3) hours per Enrollee per day.
2. Items not of direct medical or remedial benefit to the Enrollee shall be excluded. Items that would be covered by the Medicaid State Plan shall be excluded from coverage. Swimming pools, hot tubs, health club memberships, and recreational equipment are excluded. Prescription and over-the-counter medications, food and food supplements, and diapers and other incontinence supplies are excluded.
3. When medically necessary and not covered by warranty, repair of equipment may be covered when it is substantially less expensive to repair the equipment rather than to replace it.
4. The purchase price for waiver-reimbursed Specialized Medical Equipment, Supplies and Assistive Technology shall be considered to include the cost of the item as well as basic training on operation and maintenance of the item.
5. Specialized Medical Equipment, Supplies and Assistive Technology shall be limited to a maximum of \$10,000 per Enrollee per two (2) year period.

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### (s) Speech, Language and Hearing Services.

1. Services must be provided by a licensed speech language pathologist or by a licensed audiologist.
2. Speech, Language and Hearing Services must be provided face to face with the Enrollee.
3. Speech, Language and Hearing therapeutic and corrective services shall not be ordered concurrently with Speech, Language and Hearing assessments (i.e., assess and treat orders are not accepted).
4. Speech, Language and Hearing Services assessments shall not be billed on the same day with other Speech, Language and Hearing Services.
5. Speech, Language and Hearing Services shall not be billed when provided during the same time period as Physical Therapy; Occupational Therapy; Nutrition Services; Orientation and Mobility Training; or Behavior Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently. Speech, Language and Hearing Services shall not be billed with Day Services if the Day Services are reimbursed on a per hour basis.
6. Speech, Language and Hearing Services assessments shall be limited to a maximum of 3.0 hours per Enrollee per day, and other Speech, Language and Hearing Services shall be limited to a maximum of 1.5 hours per Enrollee per day.

### (t) Support Coordination.

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

### (u) Supported Living.

1. The Supported Living provider shall not own the Enrollee's place of residence or be a co-signer of a lease on the Enrollee's place of residence unless the Supported Living provider signs a written agreement with the Enrollee that states that the Enrollee will not be required to move if the primary reason is because the Enrollee desires to change to a different Supported Living provider. A Supported Living provider shall not own, be owned by, or be affiliated with any entity that leases or rents a place of residence to an Enrollee if such entity requires, as a condition of renting or leasing, the Enrollee to move if the Supported Living provider changes.
2. The Supported Living home shall have no more than three (3) residents including the Enrollee.
3. Unless the residence is individually licensed or inspected by a public housing agency utilizing the HUD Section 8 safety checklist, the residence must have an operable smoke detector and a second means of egress.
4. The Supported Living provider shall be responsible for providing an appropriate level of services and supports twenty-four (24) hours per day during the hours the Enrollee is not receiving Day Services or is not at school or work.

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5. Transportation shall be a component of Supported Living and shall be included in the reimbursement rate for such (i.e., it shall not be billed as a separate Waiver service) with the following exceptions:
    - (i) Transportation to and from medical services covered through the Medicaid State Plan, which shall not be billed as a Waiver service;
    - (ii) Transportation necessary for Behavioral Respite Services; or
    - (iii) Transportation necessary for Orientation and Mobility Training..
  6. Reimbursement for Supported Living shall not be made for room and board with the exception of a reasonable portion that is attributed to a live-in caregiver who is unrelated to the Enrollee and who provides services to the Enrollee in the Enrollee's home. Reimbursement for Supported Living shall not include the cost of maintenance of the dwelling. Residential expenses (e.g., phone, cable TV, food, rent) shall be apportioned between the Enrollee, other residents in the home, and (as applicable) live-in or other caregivers.
  7. This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).
  8. The Enrollee or the Enrollee's guardian or conservator shall have a voice in choosing the individuals who reside in the Supported Living residence and the staff who provide services and supports.
  9. The Enrollee shall have the right to manage personal funds as specified in the Individual Support Plan.
- (v) Vehicle Accessibility Modifications.
1. Replacement of tires or brakes, oil changes, and other vehicle maintenance procedures shall be excluded from coverage.
  2. Vehicle Accessibility Modifications shall be limited to a maximum of \$20,000 per Enrollee per five (5) year period.
- (w) Vision Services.
- Vision Services shall be limited to adults age twenty-one (21) years or older who are enrolled in the Waiver.
- (x) Out-of-State Services. A provider of Personal Assistance, Residential Habilitation, Supported Living, Medical Residential Services, and Family Model Residential Services may provide such Covered Service outside the State of Tennessee and be reimbursed only when provided in accordance with the following:
1. Covered Services provided out of state shall be for the purpose of visiting relatives or for vacations and shall be included in the Enrollee's Plan of Care. Trips to casinos or other gambling establishments shall be excluded from coverage.
  2. Covered Services provided out of state shall be limited to a maximum of fourteen (14) days per Enrollee per year.

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3. The waiver service provider agency must be able to assure the health and safety of the Enrollee during the period when Covered Services will be provided out of state and must be willing to assume the additional risk and liability of provision of Covered Services out of state.
  4. During the period when Covered Services are being provided out of state, the waiver service provider agency shall maintain an adequate amount of staffing to meet the needs of the Enrollee and must ensure that staff meet the applicable provider qualifications.
  5. The provider agency which provides Covered Services out of state shall not receive any additional reimbursement for provision of services out-of-state. The costs of travel, lodging, food, and other expenses incurred by staff during the provision of out-of-state services shall not be reimbursed through the Waiver. The costs of travel, lodging, food, and other expenses incurred by the Enrollee while receiving out-of-state services shall be the responsibility of the Enrollee and shall not be reimbursed through the waiver.
- (y) All Covered Services to be provided prior to the development of the initial Individual Support Plan must be included in the physician's plan of care section of the Pre-Admission Evaluation application.
- (3) Eligibility.
- (a) To be eligible for enrollment in the Waiver, an individual must meet all of the following criteria:
1. The individual must be a resident of the State of Tennessee.
  2. The individual must be a class member certified in United States vs. State of Tennessee, et. al. (Arlington Developmental Center).
  3. The individual must, but for the provision of Waiver Services, require the level of care provided in an ICF/MR, and must meet the ICF/MR eligibility criteria specified in Medicaid rule 1200-13-1-.15.
  4. The individual's habilitative, medical, and specialized services needs must be such that they can be effectively and safely met through the Waiver, as determined by the Operational Administrative Agency based on a pre-enrollment assessment.
  5. The individual must have an unexpired ICF/MR Pre-Admission Evaluation which has been approved by the State Medicaid Agency or by its designee and which lists the Enrollee's specific Waiver Services with the amount, scope, and duration of the services.
  6. The individual must have a psychological evaluation included as part of the approved Pre-Admission Evaluation and which meets the following:
    - (i) The psychological evaluation shall document that the individual has mental retardation manifested before eighteen (18) years of age and have an IQ test score of seventy (70) or below, and
    - (ii) The psychological evaluation:

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- (I) Shall have been made no more than three (3) calendar months before the date of admission into the Waiver; or
  - (II) If performed more than three (3) calendar months but no more than twelve (12) calendar months before the date of admission, shall have been signed and updated within three (3) calendar months preceding the date of admission into the Waiver. The update must be done by the person who performed the examination or by the supervising clinical psychologist who signed the initial evaluation.
7. The individual shall have one or more designated adults who shall be present in the individual's home to observe, evaluate, and provide an adequate level of direct care services to ensure the health and safety of the individual.
- (i) An individual who does not have 24-hour-per-day direct care services shall:
    - (I) Have an individualized Safety Plan that:
      - I. Is based on a written assessment of the individual's functional capabilities and habilitative, medical, and specialized services needs by the Independent Support Coordinator in consultation with individuals who are knowledgeable of the individual's capability of functioning without direct care services twenty-four (24) hours per day;
      - II. Addresses the individual's capability of functioning when direct care staff are not present;
      - III. Addresses the ability of the individual to self-administer medications when direct care staff are not present;
      - IV. Specifies whether a Personal Emergency Response System will be used by the individual to secure help in an emergency;
      - V. Is updated as needed, but no less frequently than annually, by the Operational Administrative Agency to ensure the health and safety of the individual; and
      - VI. Is an attachment to the ICF/MR PAE or, if applicable, to the Transfer Form.
    - (II) Have one or more designated adults who shall be present in the individual's home to observe, evaluate, and provide an adequate level of direct care services to ensure the health and safety of the individual as needed but no less frequently than one day each week.
8. An individual must have a place of residence with an environment that is adequate to reasonably ensure health, safety and welfare. Any licensed facility in which the individual resides must meet all applicable fire and safety codes.
- (b) A Transfer Form approved by the State Medicaid Agency:
    - 1. May be used to transfer an Enrollee having an approved unexpired ICF/MR PAE from the Waiver to an ICF/MR;

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2. May be used to transfer an individual having an approved unexpired ICF/MR PAE from an ICF/MR to the Waiver;
  3. Shall not be used to transfer an individual from one Waiver to a different Home and Community Based Services Waiver Program; and
  4. Shall list the Enrollee's specific Waiver Services with the amount, scope, and duration of the services.
- (4) Intake and Enrollment.
- (a) When an individual is determined to be likely to require the level of care provided by an ICF/MR, the Operational Administrative Agency shall inform the individual or the individual's legal representative of any feasible alternatives available under the Waiver and shall offer the choice of available institutional services or Waiver program services. Notice to the individual shall contain:
    1. A simple explanation of the Waiver and Covered Services;
    2. Notification of the opportunity to apply for enrollment in the Waiver and an explanation of the procedures for enrollment; and
    3. A statement that participation in the Waiver is voluntary.
  - (b) Enrollment in the Waiver shall be voluntary, but shall be restricted to the maximum number of individuals specified in the Waiver, as approved by the Centers for Medicare and Medicaid Services for the State of Tennessee.
  - (c) Enrollment of new Enrollees into the Waiver may be suspended when the average per capita fiscal year expenditure under the Waiver exceeds or is reasonably anticipated to exceed 100% of the average per capita expenditure that would have been made in the fiscal year if the care was provided in an ICF/MR.
- (5) Certification and Re-evaluation.
- (a) The ICF/MR Pre-Admission Evaluation shall include a signed and dated certification by the individual's physician that the individual requires Waiver Services.
  - (b) The Operational Administrative Agency shall perform a re-evaluation of the Enrollee's need for continued stay in the Waiver within twelve (12) calendar months of the date of enrollment and at least every twelve (12) months thereafter. The re-evaluation shall be documented in a format approved by the State Medicaid Agency and shall be performed by a licensed physician or registered nurse or a Qualified Mental Retardation Professional.
  - (c) The Operational Administrative Agency shall maintain in its files for a minimum period of three (3) years a copy of the re-evaluations of need for continued stay.
- (6) Disenrollment.
- (a) Voluntary disenrollment of an Enrollee from the Waiver may occur at any time upon written notice from the Enrollee or the Enrollee's guardian or conservator to the Operational Administrative Agency. Prior to disenrollment the Operational Administrative Agency shall provide reasonable assistance to the Enrollee in locating appropriate alternative placement.

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- (b) An Enrollee may be involuntarily disenrolled from the Waiver for any of the following reasons:
    - 1. The Home and Community Based Services Waiver for Persons with Mental Retardation is terminated.
    - 2. An Enrollee becomes ineligible for Medicaid or is found to be erroneously enrolled in the Waiver.
    - 3. An Enrollee moves out of the State of Tennessee.
    - 4. The condition of the Enrollee improves such that the Enrollee no longer requires the level of care provided by the Waiver.
    - 5. The Enrollee's medical or behavioral needs become such that the health, safety, and welfare of the Enrollee cannot be assured through the provision of Waiver Services.
    - 6. The home or home environment of the Enrollee becomes unsafe to the extent that it would reasonably be expected that Waiver Services could not be provided without significant risk of harm or injury to the Enrollee or to individuals who provide covered services to the Enrollee.
    - 7. The Enrollee or the Enrollee's guardian or conservator refuses to abide by the Plan of Care or related Waiver policies, resulting in the inability of the Operational Administrative Agency to ensure quality care or the health and safety of the Enrollee.
    - 8. The health, safety and welfare of the Enrollee cannot be assured due to the lack of an approved Safety Plan.
    - 9. The Enrollee was transferred to a hospital, nursing facility, Intermediate Care Facility for the Mentally Retarded, Assisted Living Facility, and/or Home for the Aged and has resided there for a continuous period exceeding 120 days.
  - (c) The Operational Administrative Agency shall notify the State Medicaid Agency in writing prior to involuntary disenrollment of an Enrollee and shall give advance notice to the Enrollee of the intended involuntary disenrollment and of the Enrollee's right to appeal and have a fair hearing.
  - (d) If an Enrollee has been involuntarily disenrolled from the Waiver, the Operational Administrative Agency shall provide reasonable assistance to the Enrollee in locating appropriate alternative placement.
- (7) Plan of Care.
- (a) All Waiver Services for the Enrollee shall be provided in accordance with an approved Plan of Care.
    - 1. Prior to the development of the initial Individual Support Plan, Covered Services shall be provided in accordance with the physician's initial plan of care included in the approved ICF/MR Pre-Admission Evaluation.

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2. Each Enrollee shall have an individualized written Plan of Care (the Individual Support Plan) that shall be developed for an Enrollee within ninety (90) calendar days of admission into the Waiver.
  3. A Safety Plan for Enrollees who do not have 24-hour direct care services shall be maintained with the Plan of Care.
- (b) To ensure that Waiver Services and other services are being appropriately provided to meet the Enrollee's needs, the Plan of Care shall be reviewed on an ongoing basis and shall be updated and signed in accordance with the following:
1. The Support Coordinator shall review the Plan of Care when needed, but no less frequently than once each calendar month, and shall document such review by a dated signature.
  2. A team consisting of the Support Coordinator and other appropriate participants in the development of the Plan of Care shall review the Plan of Care when needed, but no less frequently than every twelve (12) calendar months, and shall document such review by dated signatures. Such annual review shall include, but not be limited to, reviewing outcomes and determining if progress is being made in accordance with the Plan of Care; reviewing the appropriateness of supports and services being provided and determining further needs of the Enrollee.
- (8) Physician Services.
- (a) The Operational Administrative Agency shall ensure that each Enrollee receives physician services as needed and that each Enrollee has a medical examination, documented in the Enrollee's record, in accordance with the following schedule:
- | <u>Age</u>   | <u>Minimum frequency of medical examinations</u>                            |
|--------------|---|
| Up to age 21 | In accordance with Medicaid EPSDT periodicity standards                     |
| 21-64        | Every one (1) to three (3) years, as determined by the Enrollee's physician |
| Over age 65  | Annually  |
- (b) All Covered Services to be provided prior to the development of the initial Individual Support Plan shall be physician ordered and shall be included in the physician's plan of care section of the Pre-Admission Evaluation application.
- (c) When required by state law, Covered Services shall be ordered or reordered, by a licensed physician, licensed nurse practitioner, physician assistant, a licensed dentist, or other appropriate health care provider.
- (9) Waiver Administration.
- (a) The Operational Administrative Agency shall be responsible for the administration of the day-to-day operations of the Waiver under the oversight of the State Medicaid Agency and shall ensure that Covered Services are provided in accordance with state and federal laws,

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rules, regulations and policies established by the State Medicaid Agency. The Operational Administrative Agency shall be responsible for the following activities, whether provided directly or through subcontract:

1. Marketing of the Waiver to potential Enrollees;
2. Intake and pre-enrollment assessment of the applicant's habilitative, medical and specialized services needs; and appropriateness for enrollment in the Waiver;
3. Assisting the applicant with the submission of a properly completed ICF/MR Pre-Admission Evaluation;
4. Enrollment of eligible individuals into the Waiver;
5. Provision of a plain language explanation of appeal rights to each Enrollee upon enrollment in the Waiver;
6. Review and approval of Plans of Care (Individual Support Plans) to ensure that Waiver Services have been authorized prior to payment;
7. Ensuring that annual level of care re-evaluations have been performed to document the need for continuation of Waiver Services for the Enrollee;
8. Notification of the State Medicaid Agency in writing prior to involuntary disenrollment of any Enrollee;
9. Ensuring that Waiver providers maintain comprehensive Enrollee records and documentation of services provided to Enrollees in accordance with state and federal laws, rules, regulations and State Medicaid Agency policies;
10. Obtaining approval from the State Medicaid Agency prior to distributing policies and procedures to Waiver providers or Waiver information to Enrollees;
11. Compliance with reporting and record-keeping requirements established by the State Medicaid Agency;
12. Maintaining in its files the original ICF/MR Pre-Admission Evaluation and, where applicable, the original Transfer Form;
13. Assurance of a statewide provider network adequate to meet the needs of Enrollees;
14. Ensuring that Waiver Services providers and subcontractors meet the Waiver provider qualifications approved by the Centers for Medicare and Medicaid Services;
15. Ensuring that Waiver Services providers have a signed provider agreement which includes a requirement for compliance with the Division of Mental Retardation Services Provider Manual in the delivery of waiver services;
16. Assurance of the health and safety of Enrollees through the implementation of a comprehensive quality monitoring program;
17. Reporting instances of abuse, neglect, mistreatment or exploitation to appropriate state agencies;

## RULEMAKING HEARINGS

18. Assurance that Covered Services are provided in accordance with the approved Waiver definitions and in accordance with the State Medicaid Agency guidelines;
19. Compliance with the appeals process specified in TennCare rule 1200-13-13-.11 to ensure that Enrollees are afforded advance notice and the right to appeal an adverse decision and have a fair hearing;
20. Ensuring that providers and subcontractors comply with the quality monitoring guidelines and requirements established by the State Medicaid Agency, by the Operational Administrative Agency, and by the Centers for Medicare and Medicaid Services, and with other state and federal laws, rules, and regulations affecting the provision of Waiver Services;
21. Collection of applicable patient liability from Enrollees;
22. Reimbursement of Waiver providers in accordance with policies established by the State Medicaid Agency;
23. Recoupment of payments made to Waiver providers when there is lack of documentation to support that services were provided or there is a lack of medical necessity of services, or when inappropriate payments have been made due to erroneous or fraudulent billing; and
24. Expenditure and revenue reporting in accordance with state and federal requirements.

### (10) Reimbursement.

- (a) The average per capita fiscal year expenditure under the Waiver shall not exceed 100% of the average per capita expenditure that would have been made in the fiscal year if care had been provided in an ICF/MR. The total Medicaid expenditure for Waiver Services and other Medicaid services provided to Enrollees shall not exceed 100% of the amount that would have been incurred in the fiscal year if care was provided in an ICF/MR.
- (b) The Operational Administrative Agency shall be reimbursed for Waiver Services at the rate per unit of service actually paid by the Operational Administrative Agency to the Waiver service provider or at the maximum rate per unit of service established by the State Medicaid Agency, whichever is lesser.
- (c) In accordance with 42 CFR § 435.726, the Operational Administrative Agency shall make a diligent effort to collect patient liability if it applies to the Enrollee. The Operational Administrative Agency or its designee shall complete appropriate forms showing the individual's amount of monthly income and shall submit them to the Tennessee Department of Human Services. The Tennessee Department of Human Services shall issue the appropriate forms to the Operational Administrative Agency and to the State Medicaid Agency's fiscal agent that processes and pays vendor claims, specifying the amount of patient liability to be applied toward the cost of care for the Enrollee.
- (d) The Operational Administrative Agency shall submit bills for services to the State Medicaid Agency's fiscal agent using a claim form approved by the State Medicaid Agency. On claim forms, the Operational Administrative Agency shall use a provider number assigned by the State Medicaid Agency.

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- (e) Reimbursement shall not be made to the Operational Administrative Agency for therapeutic leave or hospital leave for Enrollees in the Waiver.
  - (f) Medicaid benefits other than those specified in the Waiver's scope of Covered Services shall be reimbursed by the State Medicaid Agency as otherwise provided for by federal and state rules and regulations.
  - (g) The Operational Administrative Agency shall be responsible for obtaining the physician's initial certification and subsequent Enrollee re-evaluations. Failure to perform re-evaluations in a timely manner and in the format approved by the State Medicaid Agency shall require a corrective action plan and shall result in partial or full recoupment of all amounts paid by the State Medicaid Agency during the time period when a re-evaluation had lapsed.
  - (h) The State Medicaid Agency shall be responsible for defining and establishing the billing units to be used by the Operational Administrative Agency in billing for Waiver Services.
  - (i) An Operational Administrative Agency that enrolls an individual without an approved ICF/MR Pre-Admission Evaluation or, where applicable, an approved Transfer Form does so without the assurance of reimbursement. An Operational Administrative Agency that enrolls an individual who has not been determined by the Tennessee Department of Human Services to be financially eligible to have Medicaid make reimbursement for covered services does so without the assurance of reimbursement.
- (11) Appeals. An Enrollee shall have the right to appeal an adverse action in accordance with TennCare rule 1200-13-13-.11.

*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 28th day of February, 2006. (02-31)

## 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, 1<sup>st</sup> Floor East Conference Room, 310 Great Circle Road, Nashville, Tennessee 37243 at 9:00 a.m. C.D.T. on the 18th day April 2006.

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

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

### SUBSTANCE OF PROPOSED RULE

Rule Chapter 1200-13-1 General Rules is amended by adding rule 1200-13-1-.29 Tennessee Self-Determination Waiver Program which shall read as follows:

#### **1200-13-1-.29 TENNESSEE SELF-DETERMINATION WAIVER PROGRAM.**

- (1) Definitions: The following definitions shall apply for interpretation of this rule:
  - (a) Adult Dental Services - accepted dental procedures which are provided to adult Enrollees (i.e., age 21 years or older) as specified in the Plan of Care. Adult Dental Services may include fillings, root canals, extractions, the provision of dentures and other dental treatments to relieve pain and infection. Preventive dental care is not covered under Adult Dental Services.
  - (b) Behavioral Respite Services - services that provide Respite for an Enrollee who is experiencing a behavioral crisis that necessitates removal from the current residential setting in order to resolve the behavioral crisis.
  - (c) Behavior Services – assessment and amelioration of Enrollee behavior that presents a health or safety risk to the Enrollee or others or that significantly interferes with home or community activities; determination of the settings in which such behaviors occur and the events which precipitate the behaviors; development, monitoring, and revision of crisis prevention and behavior intervention strategies; and training of caregivers who are responsible for direct care of the Enrollee in prevention and intervention strategies.
  - (d) Bureau of TennCare - the bureau in the Tennessee Department of Finance and Administration which is the State Medicaid Agency and is responsible for administration of the Medicaid program in Tennessee.

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- (e) Case Manager – an individual who assists the Enrollee or potential Enrollee in gaining access to needed Waiver and other Medicaid State Plan services as well as other needed services regardless of the funding source; develops the initial interim Plan of Care and facilitates the development of the Enrollee's Plan of Care; monitors the Enrollee's needs and the provision of services included in the Plan of Care; monitors the Enrollee's budget, and authorizes alternative emergency back-up services for the Enrollee if necessary.
- (f) Certification - the process by which a physician, who is licensed as a doctor of medicine or doctor of osteopathy, signs and dates a Pre-Admission Evaluation signifying that the named individual requires services provided through the Tennessee Self-Determination Waiver Program as an alternative to care in an Intermediate Care Facility for the Mentally Retarded.
- (g) Covered Services or Covered Waiver Services – The services which are available through the Tennessee Self-Determination Waiver Program when medically necessary and when provided in accordance with the Waiver as approved by the Centers for Medicare and Medicaid Services.
- (h) Day Services - individualized services and supports that enable an Enrollee to acquire, retain, or improve skills necessary to reside in a community-based setting; to participate in community activities and utilize community resources; to acquire and maintain employment; and to participate in retirement activities.
- (i) Denial - as used in regard to Waiver Services, the term shall mean the termination, suspension, or reduction in amount, scope, and duration of a Waiver Service or a refusal or failure to provide such service.
- (j) Disenrollment - the voluntary or involuntary termination of enrollment of an individual receiving services through the Tennessee Self-Determination Waiver Program.
- (k) Emergency Assistance – a supplementary increase in the amount of approved Covered Waiver Services for the purpose of preventing the permanent out of home placement of the Enrollee which is provided in one of the following emergency situations:
  - 1. Permanent or temporary involuntary loss of the Enrollee's present residence;
  - 2. Loss of the Enrollee's present caregiver for any reason, including death of a caregiver or changes in the caregiver's mental or physical status resulting in the caregiver's inability to perform effectively for the Enrollee; or
  - 3. Significant changes in the behavioral, medical or physical condition of the Enrollee that necessitate substantially expanded services.
- (l) Enrollee - a Medicaid Eligible who is enrolled in the Tennessee Self-Determination Waiver Program.
- (m) Environmental Accessibility Modifications – only those interior or exterior physical modifications to the Enrollee's place of residence which are required to ensure the health, welfare and safety of the Enrollee or which are necessary to enable the Enrollee to function with greater independence.

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- (n) Financial Administration Entity – an entity which meets the State Medicaid Agency provider qualification requirements for a Financial Administration provider and which has been approved by the Operational Administrative Agency to provide Financial Administration as a Covered Service.
- (o) Financial Administration – a service which facilitates the employment of Waiver Service providers by the Enrollee and the management of the Enrollee’s self-directed budget and is provided to assure that Enrollee-managed funds specified in the Plan of Care are managed and distributed as intended. Financial Administration includes filing claims for Enrollee-managed services and reimbursing individual Covered Waiver Service providers; deducting all required federal, state and local taxes, including unemployment fees, prior to issuing reimbursement or paychecks; making Workers Compensation premium payments for Waiver Service providers employed by the Enrollee; verifying that goods and services for which reimbursement is requested have been authorized in the Plan of Care; ensuring that requests for payment are properly documented and have been approved by the Enrollee or the Enrollee’s guardian or conservator; and assisting the Enrollee in meeting applicable employer-of-record requirements. It also includes maintaining a separate account for each Enrollee’s self-determination budget; preparation of required monthly reports detailing disbursements of self-determination budget funds, the status of the expenditure of self-determination budget funds in comparison to the budget, and expenditures for standard method services made by the state on the Enrollee’s behalf; and notification of the Operational Administrative Agency when expenditure patterns potentially will result in the premature exhaustion of the Enrollee’s self-determination budget. It includes, in addition, verification that self-managed Waiver Service providers meet the State Medicaid Agency provider qualification requirements.
- (p) Home (of an Enrollee) - the residence or dwelling in which the Enrollee resides, excluding hospitals, nursing facilities, Intermediate Care Facilities for the Mentally Retarded, Assisted Living Facilities and Homes for the Aged
- (q) ICF/MR Pre-Admission Evaluation (ICF/MR PAE) – the assessment form used by the State Medicaid Agency to document the current medical and habilitative needs of an individual with mental retardation and to document that the individual meets the Medicaid level of care eligibility criteria for care in an ICF/MR.
- (r) Individual Support Plan – the individualized written Plan of Care.
- (s) Individual Transportation Services –non-emergency transport of an Enrollee to and from approved activities specified in the Pan of Care.
- (t) Intermediate Care Facility for the Mentally Retarded (ICF/MR) - a licensed facility approved for Medicaid vendor reimbursement that provides specialized services for individuals with mental retardation or related conditions and that complies with current federal standards and certification requirements for an ICF/MR.
- (u) Medicaid Eligible - an individual who has been determined by the Tennessee Department of Human Services to be financially eligible to have the State Medicaid Agency make reimbursement for covered services.
- (v) Medicaid State Plan - the plan approved by the Centers for Medicare and Medicaid Services which specifies the covered benefits for the Medicaid program in Tennessee.

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- (w) Nursing Services –skilled nursing services that fall within the scope of Tennessee’s Nurse Practice Act and that are directly provided to the Enrollee in accordance with a plan of care. Nursing Services shall be ordered by the Enrollee’s physician, physician assistant, or nurse practitioner, who shall document the medical necessity of the services and specify the nature and frequency of the nursing services.
- (x) Nutrition Services - assessment of nutritional needs, nutritional counseling, and education of the Enrollee and of caregivers responsible for food purchase, food preparation, or assisting the Enrollee to eat. Nutrition Services are intended to promote healthy eating practices and to enable the Enrollee and direct support professionals to follow special diets ordered by a physician, physician assistant, or nurse practitioner.
- (y) Occupational Therapy Services – diagnostic, therapeutic, and corrective services which are within the scope of state licensure. Occupational Therapy Services provided to improve or maintain current functional abilities as well as prevent or minimize deterioration of chronic conditions leading to a further loss of function are also included within this definition.
- (z) Operational Administrative Agency - the approved agency with which the State Medicaid Agency contracts for the administration of the day-to-day operations of the Tennessee Self-Determination Waiver Program.
- (aa) Orientation and Mobility Training – assessment of the ability of an Enrollee who is legally blind to move independently, safely, and purposefully in the home and community environment; orientation and mobility counseling; and training and education of the Enrollee and of caregivers responsible for assisting in the mobility of the Enrollee.
- (bb) Personal Assistance – the provision of direct assistance with activities of daily living (e.g., bathing, dressing, personal hygiene, eating, meal preparation excluding cost of food), household chores essential to the health and safety of the enrollee, budget management, attending appointments, and interpersonal and social skills building to enable the Enrollee to live in a home in the community. It also may include medication administration as permitted under Tennessee’s Nurse Practice Act.
- (cc) Personal Emergency Response System - a stationary or portable electronic device used in the Enrollee’s place of residence which enables the Enrollee to secure help in an emergency. The system shall be connected to a response center staffed by trained professionals who respond upon activation of the electronic device.
- (dd) Physical Therapy Services - diagnostic, therapeutic, and corrective services which are within the scope of state licensure. Physical Therapy Services provided to improve or maintain current functional abilities as well as prevent or minimize deterioration of chronic conditions leading to a further loss of function are also included within this definition.
- (ee) Plan of Care – an individualized written Plan of Care which describes the medical and other services (regardless of funding source) to be furnished to the Enrollee, the Waiver Service frequency, and the type of provider who will furnish each Waiver Service and which serves as the fundamental tool by which the State ensures the health and welfare of Enrollees.
- (ff) Qualified Mental Retardation Professional (QMRP) - an individual who meets current federal standards, as published in the Code of Federal Regulations, for a qualified mental retardation professional.

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- (gg) Re-evaluation - the annual process approved by the State Medicaid Agency by which a licensed physician or registered nurse or a Qualified Mental Retardation Professional assesses the Enrollee's need for continued Waiver Services and certifies in writing that the Enrollee continues to require Waiver Services.
- (hh) Respite - services provided to an Enrollee when unpaid caregivers are absent or incapacitated due to death, hospitalization, illness or injury, or when unpaid caregivers need relief from routine caregiving responsibilities.
- (ii) Safety Plan - an individualized plan by which the Operational Administrative Agency ensures the health, safety and welfare of Enrollees who do not have 24-hour direct care services.
- (jj) Self-Directed or Self-Determined or Self-Managed – the direct management of one or more Covered Services specified in paragraph (2)(b) with the assistance of a Financial Administration Entity which pays the Enrollee's service providers, handles taxes and other payroll or benefits related to the employment of the service providers, and provides other financial administration services as specified in paragraph (1)(o).
- (kk) Self-Direction or Self-Determination or Self-Management – the process whereby an Enrollee or the Enrollee's guardian or conservator directly manages one or more Covered Services specified in paragraph (2)(b) with the assistance of a Financial Administration Entity which pays the Enrollee's service providers, handles taxes and other payroll or benefits related to the employment of the service providers, and provides other financial administration services as specified in paragraph (1)(o).
- (ll) Specialized Medical Equipment and Supplies and Assistive Technology - assistive devices, adaptive aids, controls or appliances which enable an Enrollee to increase the ability to perform activities of daily living, or to perceive, control or communicate with the environment, and supplies for the proper functioning of such items. Specialized Medical Equipment, Supplies and Assistive Technology shall be recommended by a qualified health care professional (e.g., occupational therapist, physical therapist, speech language pathologist, physician or nurse practitioner) based on an assessment of the Enrollee's needs and capabilities and shall be furnished as specified in the Plan of Care. Specialized Medical Equipment and Supplies and Assistive Technology may also include a face-to-face consultative assessment by a physical therapist, occupational therapist or speech therapist to assure that Specialized Medical Equipment and Assistive Technology which requires custom fitting meets the needs of the Enrollee and may include training of the Enrollee by a physical therapist, occupational therapist or speech therapist to effectively utilize such customized equipment.
- (mm) Speech, Language and Hearing Services – diagnostic, therapeutic and corrective services which are within the scope of state licensure which enable an Enrollee to improve or maintain current functional abilities and to prevent or minimize deterioration of chronic conditions leading to a further loss of function.
- (nn) State Medicaid Agency – the Bureau in the Tennessee Department of Finance and Administration which is responsible for administration of the Title XIX Medicaid program in Tennessee.
- (oo) Subcontractor - an individual, organized partnership, professional corporation, or other legal association or entity which enters into a written contract with the Operational Administrative Agency to provide Waiver Services to an Enrollee.
- (pp) Supports Broker – the person or entity that provides Supports Brokerage services to an Enrollee.

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- (qq) Supports Brokerage – an activity designed to enable an Enrollee to manage self-directed services and provide assistance to the Enrollee to locate, access and coordinate needed services. It includes provision of training to the Enrollee in Enrollee-managed services; assistance in the recruitment of individual providers of Enrollee-managed services and negotiation of payment rates; assistance in the scheduling, training and supervision of individual providers; assistance in managing and monitoring the Enrollee’s budget; and assistance in monitoring and evaluating the performance of individual providers. It may also include assistance in locating and securing services and supports and other community resources that promote community integration, community membership and independence.
  - (rr) Tennessee Self-Determination Waiver Program or “Waiver” - the Home and Community Based Services waiver program approved for Tennessee by the Centers for Medicare and Medicaid Services to provide services to a specified number of Medicaid-eligible individuals on the Waiting List who have mental retardation and who meet the criteria for Medicaid reimbursement of care in an Intermediate Care Facility for the Mentally Retarded.
  - (ss) Transfer Form - the form approved by the State Medicaid Agency and used to document the transfer of an Enrollee having an approved unexpired ICF/MR Pre-Admission Evaluation from the Waiver to an ICF/MR or from an ICF/MR to the Waiver.
  - (tt) Vehicle Accessibility Modifications - interior or exterior physical modifications to a vehicle owned by the Enrollee or to a vehicle which is owned by the guardian or conservator of the Enrollee and which is routinely available for transport of the Enrollee. Such modifications must be intended to ensure the transport of the Enrollee in a safe manner.
  - (uu) Waiting List – A document prepared and updated by the Operational Administrative Agency which lists persons who are seeking home and community-based mental retardation services in Tennessee.
- (2) Self-Direction of Covered Services.
- (a) Self-Directed Services.
    - 1. The Covered Services specified in paragraph (2)(b) may be Self-Directed or Self-Managed by the Enrollee or the Enrollee’s guardian or conservator in accordance with State Medicaid Agency guidelines.
    - 2. The Enrollee or the Enrollee’s guardian or conservator shall have the right to decide whether to Self-Direct the Covered Services specified in paragraph (2)(b) or to receive them through the provider-directed service delivery method. When the Enrollee or the Enrollee’s guardian or conservator does not choose to Self-Direct a Covered Service, such service shall be furnished through the provider-directed service delivery method.
    - 3. When the Enrollee or the Enrollee’s guardian or conservator elects to Self-Direct one or more of the Covered Services specified in paragraph (2)(b), a Financial Administration Entity must be selected to provide Financial Administration services.
  - (b) Covered Services which may be Self-Directed include the following:
    - 1. Day Services which are not facility-based.
    - 2. Environmental Accessibility Modifications.

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3. Individual Transportation Services.
  4. Personal Assistance.
  5. Respite Services when provided by an approved respite provider who serves only one (1) Enrollee.
  6. Supports Brokerage.
  7. Vehicle Accessibility Modifications.
- (c) Covered Services which may not be Self-Directed include the following:
1. Adult Dental Services.
  2. Behavioral Respite Services.
  3. Behavior Services.
  4. Day Services which are facility-based.
  5. Emergency Assistance.
  6. Financial Administration Services.
  7. Nursing Services.
  8. Nutrition Services.
  9. Occupational Therapy Services.
  10. Orientation and Mobility Training.
  11. Personal Emergency Response Systems.
  12. Physical Therapy Services.
  13. Respite Services when provided by an approved respite provider who serves more than one (1) Enrollee.
  14. Specialized Medical Equipment and Supplies and Assistive Technology.
  15. Speech, Language and Hearing Services.
- (d) Termination of Self-Direction of Covered Services.
1. Self-Direction of Covered Services by the Enrollee may be voluntarily terminated by the Enrollee or the Enrollee's guardian or conservator at any time.
  2. Self-Direction of Covered Services by the Enrollee may be involuntarily terminated for any of the following reasons:

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- (i) The Enrollee or the Enrollee's guardian or conservator does not carry out the responsibilities required for the Self-Direction of Covered Services; or
      - (ii) Continued use of Self-Direction as the method of service management would result in the inability of the Operational Administrative Agency to ensure the health and safety of the Enrollee.
    3. Termination of Self-Direction of Covered Services shall not affect the Enrollee's receipt of Covered Services. Covered Services shall continue to be provided through the provider-directed method of service delivery.
  - (e) Changing the Amount of Self-Directed Services by the Enrollee.
    1. The Enrollee shall have the flexibility to change the amount of those Self-Directed Covered Services specified in paragraph (2)(b) that have been approved in the Individual Support Plan if:
      - (i) The change is consistent with the needs, goals, and objectives identified in the Individual Support Plan;
      - (ii) The change does not affect the total amount of the Enrollee's self-determination budget; and
      - (iii) The Enrollee notifies the Financial Administration Entity, the Supports Broker (if applicable) and the Case Manager.
    2. The Case Manager and the Financial Administration Entity shall maintain documentation of such changes by the Enrollee in the amount of the Self-Directed Covered Services for audit purposes.
- (3) Covered Services and Limitations.
- (a) Adult Dental Services.
    1. Adult Dental Services shall not include hospital outpatient or inpatient facility services or related anesthesiology, radiology, pathology, or other medical services in such setting.
    2. Adult Dental Services shall exclude orthodontic services.
    3. Adult Dental Services shall be limited to adults age twenty-one (21) years or older who are enrolled in the waiver.
  - (b) Behavioral Respite Services.
    1. Behavioral Respite Services may be provided in a Medicaid-certified ICF/MR, in a licensed respite care facility, or in a home operated by a licensed residential provider.
    2. Reimbursement shall not be made for the cost of room and board except when provided as part of Behavioral Respite Services furnished in a facility approved by the State that is not a private residence.

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

### (c) Behavior Services.

1. Behavior Services shall not be billed when provided during the same time period as Physical Therapy; Occupational Therapy; Nutrition Services; Orientation and Mobility Training; or Speech, Language and Hearing Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently.
2. Behavior Services shall be provided face to face with the Enrollee except that enrollee-specific training of staff may be provided when the Enrollee is not present.

### (d) Day Services.

1. Day Services may be provided in settings such as specialized facilities licensed to provide Day Services, community centers or other community sites, or job sites. Services may also be provided in the Enrollee's place of residence if there is a health, behavioral, or other medical reason or if the Enrollee has chosen retirement. This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).
2. Day Services provided in a provider's day habilitation facility shall be provided during the provider agency's normal business hours.
3. Transportation to and from the Enrollee's place of residence to Day Services and transportation that is needed during the time that the Enrollee is receiving Day Services shall be a component of Day Services and shall be included in the Day Services reimbursement rate (i.e., it shall not be billed as a separate Waiver service) with the following exceptions:
  - (i) Transportation to and from medical services covered through the Medicaid State Plan, which shall not be billed as a Waiver service; or
  - (ii) Transportation necessary for Orientation and Mobility Training.
4. Day Services shall not replace services available under a program funded by the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act.
5. For an Enrollee receiving employment supports, reimbursement shall not be made for incentive payments, subsidies or unrelated vocational training expenses such as the following:
  - (i) Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
  - (ii) Payments that are passed through to users of supported employment programs; or
  - (iii) Payments for vocational training that is not directly related to an Enrollee's supported employment program.

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### (e) Environmental Accessibility Modifications.

1. Environmental Accessibility Modifications which are considered improvements to the home (e.g., roof or flooring repair, installing carpet, installation of central air conditioning, construction of an additional room) are excluded from coverage.
2. Any modification which is not of direct medical or remedial benefit to the Enrollee is excluded from coverage.
3. Modification of an existing room which increases the total square footage of the home is also excluded unless the modification is necessary to improve the accessibility of an Enrollee having limited mobility, in which case the modification shall be limited to the minimal amount of square footage necessary to accomplish the increased accessibility.

### (f) Financial Administration.

1. Financial Administration shall be a Covered Service only for Enrollees who Self-Direct Covered Services.
2. The use of Financial Administration shall be mandatory whenever the Enrollee is the employer of record of one or more providers of Covered Services.
3. The Financial Administration Entity shall not be a provider of another waiver service, excluding Supports Brokerage, to the Enrollee.

### (g) Individual Transportation Services.

1. An Enrollee receiving Orientation and Mobility Training shall be eligible to receive Individual Transportation Services to the extent necessary for participation in Orientation and Mobility Training. Enrollees who receive Respite, Behavioral Respite Services, or Personal Assistance shall be eligible to receive Individual Transportation Services only to the extent necessary during the time period when Respite, Behavioral Respite Services, or Personal Assistance is being provided.
2. Individual Transportation Services shall not be used for:
  - (i) Transportation to and from Day Services;
  - (ii) Transportation to and from supported or competitive employment;
  - (iii) Transportation of school aged children to and from school; or
  - (iv) Transportation to and from medical services covered by the Medicaid State Plan.

### (h) Nursing Services.

1. Nursing Services shall be provided face to face with the Enrollee by a licensed registered nurse or licensed practical nurse under the supervision of a registered nurse.
2. Nursing assessment and/or nursing oversight shall not be a separate billable service under this definition.

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3. This service shall be provided in home and community settings, as specified in the Plan of Care, excluding inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).
  4. Nursing Services shall not be billed when provided during the same time period as other therapies unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently.
  5. Nursing Services are not intended to replace services available through the Medicaid State Plan or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act.
- (i) Nutrition Services.
1. Nutrition Services must be provided face to face with the Enrollee or, for purposes of education, with the caregivers responsible for food purchase, food preparation, or assisting the Enrollee to eat.
  2. Nutrition Services shall not be billed when provided during the same time period as Physical Therapy; Occupational Therapy; Speech, Language and Hearing Services; Orientation and Mobility Training; or Behavior Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently.
- (j) Occupational Therapy Services.
1. Services must be provided by a licensed occupational therapist or by a licensed occupational therapist assistant working under the supervision of a licensed occupational therapist.
  2. Occupational Therapy must be provided face to face with the Enrollee.
  3. Occupational Therapy therapeutic and corrective services shall not be ordered concurrently with Occupational Therapy assessments (i.e., assess and treat orders are not accepted).
  4. Occupational Therapy assessments shall not be billed on the same day with other Occupational Therapy services.
  5. Occupational Therapy shall not be billed when provided during the same time period as Physical Therapy; Speech, Language and Hearing Services; Nutrition Services; Orientation and Mobility Training; or Behavior Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently. Occupational Therapy shall not be billed with Day Services if the Day Services are reimbursed on a per hour basis.
  6. Occupational Therapy services are not intended to replace services available through the Medicaid State Plan or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act.
- (k) Orientation and Mobility Training.

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1. Orientation and Mobility Training shall not be billed when provided during the same time period as Physical Therapy; Occupational Therapy, Nutrition Services; Behavior Services; or Speech, Language and Hearing Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently.
  2. Orientation and Mobility Training shall not replace services available under a program funded by the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act.
  3. Enrollees receiving Orientation and Mobility Training shall be eligible to receive Individual Transportation Services to the extent necessary for participation in Orientation and Mobility Training.
- (l) Personal Assistance.
1. Personal Assistance may be provided in the home or community; however, it shall not be provided in school settings and shall not be provided to replace personal assistance services required to be covered by schools or services available through the Medicaid State Plan.
  2. Personal Assistance shall not be provided during the same time period when the Enrollee is receiving Day Services.
  3. This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).
  4. Family members who provide Personal Assistance must meet the same standards as providers who are unrelated to the Enrollee. The Personal Assistance provider shall not be the spouse and shall not be the Enrollee's parent if the Enrollee is a minor. Reimbursement shall not be made to any other individual who is a conservator unless so permitted in the Order for Conservatorship.
- (m) Personal Emergency Response System.
- The system shall be limited to those who are alone for parts of the day and who have demonstrated mental and physical capability to utilize such a system effectively.
- (n) Physical Therapy Services.
1. Services must be provided by a licensed physical therapist or by a licensed physical therapist assistant working under the supervision of a licensed physical therapist.
  2. Physical Therapy must be provided face to face with the Enrollee.
  3. Physical Therapy therapeutic and corrective services shall not be ordered concurrently with Physical Therapy assessments (i.e., assess and treat orders are not accepted).
  4. Physical Therapy assessments shall not be billed on the same day with other Physical Therapy services.

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5. Physical Therapy shall not be billed when provided during the same time period as Occupational Therapy; Speech, Language and Hearing Services; Nutrition Services; Orientation and Mobility Training; or Behavior Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently. Physical Therapy shall not be billed with Day Services if the Day Services are reimbursed on a per hour basis.
  6. Physical Therapy services are not intended to replace services available through the Medicaid State Plan or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act.
- (o) Respite.
1. Respite may be provided in the Enrollee's place of residence, in a Family Model Residential Support home, in a Medicaid-certified ICF/MR, in a home operated by a licensed residential provider, or in the home of an approved respite provider.
  2. The cost of room and board shall be excluded from Respite reimbursement if Respite is provided in a private residence.
  3. Enrollees who receive Respite shall be eligible to receive Individual Transportation Services only to the extent necessary during the time period when Respite is being provided.
- (p) Specialized Medical Equipment and Supplies and Assistive Technology.
1. Items not of direct medical or remedial benefit to the Enrollee shall be excluded. Items that would be covered by the Medicaid State Plan shall be excluded from coverage. Swimming pools, hot tubs, health club memberships, and recreational equipment are excluded. Prescription and over-the-counter medications, food and food supplements, and diapers and other incontinence supplies are excluded.
  2. When medically necessary and not covered by warranty, repair of equipment may be covered when it is substantially less expensive to repair the equipment rather than to replace it.
  3. The purchase price for waiver-reimbursed Specialized Medical Equipment, Supplies and Assistive Technology shall be considered to include the cost of the item as well as basic training on operation and maintenance of the item.
- (q) Speech, Language and Hearing Services.
1. Services must be provided by a licensed speech language pathologist or by a licensed audiologist.
  2. Speech, Language and Hearing Services must be provided face to face with the Enrollee.
  3. Speech, Language and Hearing therapeutic and corrective services shall not be ordered concurrently with Speech, Language and Hearing assessments (i.e., assess and treat orders are not accepted).

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4. Speech, Language and Hearing Services assessments shall not be billed on the same day with other Speech, Language and Hearing Services.
  5. Speech, Language and Hearing Services shall not be billed when provided during the same time period as Physical Therapy; Occupational Therapy; Nutrition Services; Orientation and Mobility Training; or Behavior Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently. Speech, Language and Hearing Services shall not be billed with Day Services if the Day Services are reimbursed on a per hour basis.
- (r) Supports Brokerage.
- Supports Brokerage shall not be provided by:
1. A family member who is a provider of another Covered Service to the Enrollee; or
  2. Any other Waiver Service provider who is a provider of another service, excluding Financial Administration, to the Enrollee.
- (s) Vehicle Accessibility Modifications.
- Replacement of tires or brakes, oil changes, and other vehicle maintenance procedures shall be excluded from coverage.
- (t) Out-of-State Services. A provider of Personal Assistance may provide Personal Assistance outside the State of Tennessee and be reimbursed only when provided in accordance with the following:
1. Personal Assistance provided out of state shall be for the purpose of visiting relatives or for vacations and shall be included in the Enrollee's Plan of Care. Trips to casinos or other gambling establishments shall be excluded from coverage.
  2. Personal Assistance provided out of state shall be limited to a maximum of fourteen (14) days per Enrollee per year.
  3. The Personal Assistance provider must be able to assure the health and safety of the Enrollee during the period when Personal Assistance will be provided out of state and must be willing to assume the additional risk and liability of provision of Personal Assistance out of state.
  4. During the period when Personal Assistance is being provided out of state, staffing by qualified Personal Assistance staff shall be maintained in accordance with the Individual Support Plan to meet the needs of the Enrollee.
  5. The Personal Assistance provider or provider agency which provides Personal Assistance out of state shall not receive any additional reimbursement for provision of services out-of-state. The costs of travel, lodging, food, and other expenses incurred by Personal Assistance staff during the provision of out-of-state Personal Assistance shall not be reimbursed through the Waiver. The costs of travel, lodging, food, and other expenses incurred by the Enrollee while receiving out-of-state Personal Assistance shall be the responsibility of the Enrollee and shall not be reimbursed through the waiver.

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- (u) Emergency Assistance.
    - 1. Emergency Assistance shall be provided only in one of the following emergency situations:
      - (i) Permanent or temporary involuntary loss of the Enrollee's present residence;
      - (ii) Loss of the Enrollee's present caregiver for any reason, including death of a caregiver or changes in the caregiver's mental or physical status resulting in the caregiver's inability to perform effectively for the Enrollee; or
      - (iii) Significant changes in the behavioral, medical or physical condition of the Enrollee that necessitate substantially expanded services.
    - 2. Emergency Assistance shall be available only to Enrollees whose needs cannot be accommodated within the \$30,000 budget limitation on Covered Waiver Services.
    - 3. The amount of Emergency Assistance shall be limited to \$6,000 per Enrollee per year. Prior authorization by the Enrollee's Case Manager shall be required and shall be renewed every thirty (30) calendar days.
    - 4. Emergency Assistance shall only be used to provide a supplementary increase in the amount of other Covered Waiver Services.
  - (v) The cost of all Covered Services, including any Emergency Assistance, shall not exceed \$36,000 per year per Enrollee.
  - (w) All Covered Services to be provided prior to the development of the initial Individual Support Plan must be included in the physician's plan of care section of the Pre-Admission Evaluation application.
- (4) Eligibility.
- (a) To be eligible for enrollment in the Waiver, an individual must meet all of the following criteria:
    - 1. The individual must be a resident of the State of Tennessee.
    - 2. The individual must be on the Waiting List; be classified in one of the Crisis, Urgent, or Active Waiting List categories listed below; and, for eligibility purposes shall be prioritized, with the highest priority being individuals in the Crisis category, the second highest priority being individuals in the Urgent category, and the third highest priority being individuals in the Active category, up to the maximum number of persons approved to be served in the Waiver program each year:
      - (i) Crisis: The individual needs services immediately for one of the following reasons:
        - (I) Homelessness:
          - I. The individual is currently homeless; or
          - II. The individual will be homeless within ninety (90) days.

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- (II) Death, incapacitation, or loss of the primary caregiver and lack of an alternate primary caregiver:
    - I. The primary caregiver died;
    - II. The primary caregiver became mentally or physically incapacitated (permanently or expected to last more than thirty (30) days);
    - III. The primary caregiver serves as the primary caregiver for one or more other individuals with serious mental, physical, or developmental disabilities and is unable to provide an acceptable level of care for the enrollee; or
    - IV. The primary caregiver must be employed to provide the sole or primary income for the support of the family.
  - (III) Serious and imminent danger of harm to self or to others by the individual:
    - I. The individual's current pattern of behavior poses a serious and imminent danger of self-harm which cannot be reasonably and adequately managed by the caregiver; or
    - II. The individual's current pattern of behavior poses a serious and imminent danger of harm to others which cannot be reasonably and adequately managed by the primary caregiver.
  - (IV) The individual has multiple urgent needs that are likely to result in a Crisis situation if not addressed immediately, and the individual meets two or more of the Urgent category criteria in subpart (ii) of this part.
- (ii) Urgent: The individual meets one or more of the following criteria:
    - (I) Aging or failing health of caregiver and no alternate available to provide supports;
    - (II) Living situation presents a significant risk of abuse or neglect;
    - (III) Increasing behavioral risk to self or others;
    - (IV) Stability of the current living situation is severely threatened due to extensive support needs or family catastrophe; or
    - (V) Discharge from other service system (e.g., Tennessee Department of Children's Services, a mental health institute, a state forensics unit) is imminent.
  - (iii) Active: The individual or the individual's family or guardian or conservator is requesting access to services but the individual does not have intensive needs which meet the Urgent or Crisis criteria in subparts (i) or (ii) of this part.

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3. The individual shall have an established non-institutional place of residence and shall not require staff-supported residential services provided through a Home and Community Based Services Waiver (e.g., Residential Habilitation and Supported Living as defined in TennCare rule 1200-13-1-.25).
4. The individual must, but for the provision of Waiver Services, require the level of care provided in an ICF/MR, and must meet the ICF/MR eligibility criteria specified in Medicaid rule 1200-13-1-.15.
5. The individual's habilitative, medical, and specialized services needs must be such that they can be effectively and safely met through the Waiver, as determined by the Operational Administrative Agency based on a pre-enrollment assessment.
6. The individual must have an unexpired ICF/MR Pre-Admission Evaluation which has been approved by the State Medicaid Agency or by its designee and which lists the Enrollee's specific Waiver Services with the amount, scope, and duration of the services.
7. The individual must have a psychological evaluation included as part of the approved Pre-Admission Evaluation and which meets the following:
  - (i) The psychological evaluation shall document that the individual:
    - (I) Has mental retardation manifested before eighteen (18) years of age and have an IQ test score of seventy (70) or below, or
    - (II) Is a child four (4) years of age or younger who has a developmental disability with a high probability of resulting in mental retardation (i.e., a condition of substantial developmental delay or specific congenital or acquired condition with a high probability of resulting in mental retardation).
  - (ii) The psychological evaluation:
    - (I) Shall have been made no more than three (3) calendar months before the date of admission into the Waiver; or
    - (II) If performed more than three (3) calendar months but no more than twelve (12) calendar months before the date of admission, shall have been signed and updated within three (3) calendar months preceding the date of admission into the Waiver. The update must be done by the person who performed the examination or by the supervising clinical psychologist who signed the initial evaluation.
8. The individual shall have one or more designated adults who shall be present in the individual's home to observe, evaluate, and provide an adequate level of direct care services to ensure the health and safety of the individual.
  - (i) An individual who does not have 24-hour-per-day direct care services shall:
    - (I) Have an individualized Safety Plan that:

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- I. Is based on a written assessment of the individual's functional capabilities and habilitative, medical, and specialized services needs by the Case Manager in consultation with individuals who are knowledgeable of the individual's capability of functioning without direct care services twenty-four (24) hours per day;
  - II. Addresses the individual's capability of functioning when direct care staff are not present;
  - III. Addresses the ability of the individual to self-administer medications when direct care staff are not present;
  - IV. Specifies whether a Personal Emergency Response System will be used by the individual to secure help in an emergency;
  - V. Is updated as needed, but no less frequently than annually, by the Operational Administrative Agency to ensure the health and safety of the individual; and
  - VI. Is an attachment to the ICF/MR PAE or, if applicable, to the Transfer Form.
- (II) Have one or more designated adults who shall be present in the individual's home to observe, evaluate, and provide an adequate level of direct care services to ensure the health and safety of the individual as needed but no less frequently than one day each week.
9. The individual shall have a place of residence with an environment that is adequate to reasonably ensure health, safety and welfare.
- (b) A Transfer Form approved by the State Medicaid Agency:
1. May be used to transfer an Enrollee having an approved unexpired ICF/MR PAE from the Waiver to an ICF/MR;
  2. May be used to transfer an individual having an approved unexpired ICF/MR PAE from an ICF/MR to the Waiver;
  3. Shall not be used to transfer an individual from one Waiver to a different Home and Community Based Services Waiver Program; and
  4. Shall list the Enrollee's specific Waiver Services with the amount, scope, and duration of the services.
- (5) Intake and Enrollment.
- (a) When an individual is determined to be likely to require the level of care provided by an ICF/MR, the Operational Administrative Agency shall inform the individual or the individual's legal representative of any feasible alternatives available under the Waiver and shall offer the choice of available institutional services or Waiver program services. Notice to the individual shall contain:
1. A simple explanation of the Waiver and Covered Services;

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2. Notification of the opportunity to apply for enrollment in the Waiver and an explanation of the procedures for enrollment; and
  3. A statement that participation in the Waiver is voluntary.
- (b) Enrollment in the Waiver shall be voluntary, but shall be restricted to the maximum number of individuals specified in the Waiver, as approved by the Centers for Medicare and Medicaid Services for the State of Tennessee.
- (6) Certification and Re-evaluation.
- (a) The ICF/MR Pre-Admission Evaluation shall include a signed and dated certification by the individual's physician that the individual requires Waiver Services.
  - (b) The Operational Administrative Agency shall perform a re-evaluation of the Enrollee's need for continued stay in the Waiver within twelve (12) calendar months of the date of enrollment and at least every twelve (12) months thereafter. The re-evaluation shall be documented in a format approved by the State Medicaid Agency and shall be performed by a licensed physician or registered nurse or a Qualified Mental Retardation Professional.
  - (c) The Operational Administrative Agency shall maintain in its files for a minimum period of three (3) years a copy of the re-evaluations of need for continued stay.
- (7) Disenrollment.
- (a) Voluntary disenrollment of an Enrollee from the Waiver may occur at any time upon written notice from the Enrollee or the Enrollee's guardian or conservator to the Operational Administrative Agency. Prior to disenrollment the Operational Administrative Agency shall provide reasonable assistance to the Enrollee in locating appropriate alternative placement.
  - (b) An Enrollee may be involuntarily disenrolled from the Waiver for any of the following reasons:
    1. The Tennessee Self-Determination Waiver Program is terminated.
    2. An Enrollee becomes ineligible for Medicaid or is found to be erroneously enrolled in the Waiver.
    3. An Enrollee moves out of the State of Tennessee.
    4. The condition of the Enrollee improves such that the Enrollee no longer requires the level of care provided by the Waiver.
    5. The Enrollee's medical or behavioral needs become such that the health, safety and welfare of the Enrollee cannot be assured through the provision of Waiver Services.
    6. The home or home environment of the Enrollee becomes unsafe to the extent that it would reasonably be expected that Waiver Services could not be provided without significant risk of harm or injury to the Enrollee or to individuals who provide covered services to the Enrollee.

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7. The Enrollee or the Enrollee's guardian or conservator refuses to abide by the Plan of Care or related Waiver policies, resulting in the inability of the Operational Administrative Agency to ensure quality care or the health and safety of the Enrollee.
  8. The health, safety and welfare of the Enrollee cannot be assured due to the lack of an approved Safety Plan.
  9. The Enrollee was transferred to a hospital, nursing facility, Intermediate Care Facility for the Mentally Retarded, Assisted Living Facility, and/or Home for the Aged and has resided there for a continuous period exceeding 120 days.
  10. The cost for all Covered Waiver services, including Emergency Assistance services, has reached the Waiver limit of \$36,000 per year per Enrollee and the State cannot assure the health and safety of the Enrollee.
- (c) The Operational Administrative Agency shall notify the State Medicaid Agency in writing prior to involuntary disenrollment of an Enrollee and shall give advance notice to the Enrollee of the intended involuntary disenrollment and of the Enrollee's right to appeal and have a fair hearing.
- (d) If an Enrollee has been involuntarily disenrolled from the Waiver, the Operational Administrative Agency shall provide reasonable assistance to the Enrollee in locating appropriate alternative placement.
- (8) Plan of Care.
- (a) All Waiver Services for the Enrollee shall be provided in accordance with an approved Plan of Care.
1. Prior to the development of the initial Individual Support Plan, Covered Services shall be provided in accordance with the physician's initial plan of care included in the approved ICF/MR Pre-Admission Evaluation.
  2. Each Enrollee shall have an individualized written Plan of Care (the Individual Support Plan) that shall be developed for an Enrollee within ninety (90) calendar days of admission into the Waiver.
  3. A Safety Plan for Enrollees who do not have 24-hour direct care services shall be maintained with the Plan of Care.
- (b) To ensure that Waiver Services and other services are being appropriately provided to meet the Enrollee's needs, the Plan of Care shall be reviewed on an ongoing basis and shall be updated and signed in accordance with the following:
1. The Case Manager shall review the Plan of Care when needed, but no less frequently than once each calendar month, and shall document such review by a dated signature.
  2. A team consisting of the Case Manager and other appropriate participants in the development of the Plan of Care shall review the Plan of Care when needed, but no less frequently than every twelve (12) calendar months, and shall document such

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review by dated signatures. Such annual review shall include, but not be limited to, reviewing outcomes and determining if progress is being made in accordance with the Plan of Care; reviewing the appropriateness of supports and services being provided and determining further needs of the Enrollee.

### (9) Physician Services.

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

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

- (b) All Covered Services to be provided prior to the development of the initial Individual Support Plan shall be physician ordered and shall be included in the physician's plan of care section of the Pre-Admission Evaluation application.
- (c) When required by state law, Covered Services shall be ordered or reordered, by a licensed physician, licensed nurse practitioner, physician assistant, a licensed dentist, or other appropriate health care provider.

### (10) Waiver Administration.

- (a) The Operational Administrative Agency shall be responsible for the administration of the day-to-day operations of the Waiver under the oversight of the State Medicaid Agency and shall ensure that Covered Services are provided in accordance with state and federal laws, rules, regulations and policies established by the State Medicaid Agency. The Operational Administrative Agency shall be responsible for the following activities, whether provided directly or through subcontract:
1. Marketing of the Waiver to potential Enrollees;
  2. Intake and pre-enrollment assessment of the applicant's habilitative, medical and specialized services needs; and appropriateness for enrollment in the Waiver;
  3. Assisting the applicant with the submission of a properly completed ICF/MR Pre-Admission Evaluation;
  4. Enrollment of eligible individuals into the Waiver;
  5. Provision of a plain language explanation of appeal rights to each Enrollee upon enrollment in the Waiver;
  6. Review and approval of Plans of Care (Individual Support Plans) to ensure that Waiver Services have been authorized prior to payment;

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7. Ensuring that annual level of care re-evaluations have been performed to document the need for continuation of Waiver Services for the Enrollee;
8. Notification of the State Medicaid Agency in writing prior to involuntary disenrollment of any Enrollee;
9. Ensuring that Waiver providers maintain comprehensive Enrollee records and documentation of services provided to Enrollees in accordance with state and federal laws, rules, regulations and State Medicaid Agency policies;
10. Obtaining approval from the State Medicaid Agency prior to distributing policies and procedures to Waiver providers or Waiver information to Enrollees;
11. Compliance with reporting and record-keeping requirements established by the State Medicaid Agency;
12. Maintaining in its files the original ICF/MR Pre-Admission Evaluation and, where applicable, the original Transfer Form;
13. Assurance of a statewide provider network adequate to meet the needs of Enrollees;
14. Ensuring that Waiver Services providers and subcontractors meet the Waiver provider qualifications approved by the Centers for Medicare and Medicaid Services;
15. Ensuring that Waiver Services providers have a signed provider agreement which includes a requirement for compliance with the Division of Mental Retardation Services Provider Manual in the delivery of waiver services;
16. Assurance of the health and safety of Enrollees through the implementation of a comprehensive quality monitoring program;
17. Reporting instances of abuse, neglect, mistreatment or exploitation to appropriate state agencies;
18. Assurance that Covered Services are provided in accordance with the approved Waiver definitions and in accordance with the State Medicaid Agency guidelines;
19. Compliance with the appeals process specified in TennCare rule 1200-13-13-.11 to ensure that Enrollees are afforded advance notice and the right to appeal an adverse decision and have a fair hearing;
20. Ensuring that providers and subcontractors comply with the quality monitoring guidelines and requirements established by the State Medicaid Agency, by the Operational Administrative Agency, and by the Centers for Medicare and Medicaid Services, and with other state and federal laws, rules, and regulations affecting the provision of Waiver Services;
21. Oversight and monitoring of the Financial Administration entity;
22. Collection of applicable patient liability from Enrollees;

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23. Reimbursement of Waiver providers in accordance with policies established by the State Medicaid Agency;
24. Recoupment of payments made to Waiver providers when there is lack of documentation to support that services were provided or there is a lack of medical necessity of services, or when inappropriate payments have been made due to erroneous or fraudulent billing; and
25. Expenditure and revenue reporting in accordance with state and federal requirements.

### (11) Reimbursement.

- (a) The average per capita fiscal year expenditure under the Waiver shall not exceed 100% of the average per capita expenditure that would have been made in the fiscal year if care had been provided in an ICF/MR. The total Medicaid expenditure for Waiver Services and other Medicaid services provided to Enrollees shall not exceed 100% of the amount that would have been incurred in the fiscal year if care was provided in an ICF/MR. Reimbursement for the cost of all Covered Services, including any Emergency Assistance, shall not exceed \$36,000 per year per Enrollee.
- (b) The Operational Administrative Agency shall be reimbursed for Waiver Services at the rate per unit of service actually paid by the Operational Administrative Agency to the Waiver service provider or at the maximum rate per unit of service established by the State Medicaid Agency, whichever is lesser.
- (c) In accordance with 42 CFR § 435.726, the Operational Administrative Agency shall make a diligent effort to collect patient liability if it applies to the Enrollee. The Operational Administrative Agency or its designee shall complete appropriate forms showing the individual's amount of monthly income and shall submit them to the Tennessee Department of Human Services. The Tennessee Department of Human Services shall issue the appropriate forms to the Operational Administrative Agency and to the State Medicaid Agency's fiscal agent that processes and pays vendor claims, specifying the amount of patient liability to be applied toward the cost of care for the Enrollee.
- (d) The Operational Administrative Agency shall submit bills for services to the State Medicaid Agency's fiscal agent using a claim form approved by the State Medicaid Agency. On claim forms, the Operational Administrative Agency shall use a provider number assigned by the State Medicaid Agency.
- (e) Reimbursement shall not be made to the Operational Administrative Agency for therapeutic leave or hospital leave for Enrollees in the Waiver.
- (f) Medicaid benefits other than those specified in the Waiver's scope of Covered Services shall be reimbursed by the State Medicaid Agency as otherwise provided for by federal and state rules and regulations.
- (g) The Operational Administrative Agency shall be responsible for obtaining the physician's initial certification and subsequent Enrollee re-evaluations. Failure to perform re-evaluations in a timely manner and in the format approved by the State Medicaid Agency shall require a corrective action plan and shall result in partial or full recoupment of all amounts paid by the State Medicaid Agency during the time period when a re-evaluation had lapsed.

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- (h) The Operational Administrative Agency shall be responsible for ensuring that the Financial Administration entity fulfills its financial, ministerial, and clerical responsibilities associated with the provision of Financial Administration services to an Enrollee who Self-Directs one or more Covered Services. Examples of such responsibilities include the hiring and employment of service providers by the Enrollee or the Enrollee's guardian or conservator; management of Enrollee accounts; disbursement of funds to Waiver service providers while withholding appropriate deductions; reviewing documentation of Covered Services to assure Enrollee approval prior to payment; ensuring that Waiver service providers possess the necessary qualifications established by the State Medicaid Agency.
  - (i) The State Medicaid Agency shall be responsible for defining and establishing the billing units to be used by the Operational Administrative Agency in billing for Waiver Services.
  - (j) An Operational Administrative Agency that enrolls an individual without an approved ICF/MR Pre-Admission Evaluation or, where applicable, an approved Transfer Form does so without the assurance of reimbursement. An Operational Administrative Agency that enrolls an individual who has not been determined by the Tennessee Department of Human Services to be financially eligible to have Medicaid make reimbursement for covered services does so without the assurance of reimbursement.
- (12) Appeals. An Enrollee shall have the right to appeal an adverse action in accordance with TennCare rule 1200-13-13-.11.

**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 28th day of February, 2006. (02-32)

## 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, 1<sup>st</sup> Floor East Conference Room, 310 Great Circle Road, Nashville, Tennessee 37243 at 9:00 a.m. D.S.T. on the 18th day April 2006.

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

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

### **SUBSTANCE OF PROPOSED RULE**

A new paragraph (21) is added to rule 1200-13-13-.01 Definitions and subsequent paragraphs are re-numbered accordingly. New paragraph (21) shall read as follows:

- (21) CORE MEDICAID POPULATION shall mean individuals eligible under Title XIX of the Social Security Act, 42 U.S.C. §§ 1396, et seq., with the exception of the following groups: individuals receiving SSI benefits as determined by the Social Security Administration; individuals eligible under a Refugee status; individuals eligible for emergency services as an illegal or undocumented alien; individuals receiving interim Medicaid benefits with a pending Medicaid disability determination; individuals with forty-five (45) days of presumptive or immediate eligibility; and children in DCS custody.

Subparagraph (a) of paragraph (6) of rule 1200-13-13-.02 Eligibility is deleted in its entirety and replaced with a new subparagraph (a) which shall read as follows:

- (a) An enrollee who qualifies for TennCare Medicaid through the TDHS shall recertify his/her TennCare Medicaid eligibility as required by the appropriate category of medical assistance as described in Chapter 1240-3-3 of the rules of the TDHS - Division of Medical Assistance. Prior to termination of Medicaid eligibility for enrollees of the Core Medicaid Population, enrollees' eligibility will be reviewed in accordance with the following process:
  - 1. Request for Information.
    - (i) At least thirty (30) days prior to the expiration of their current eligibility period, the Bureau of TennCare will send a Request for Information to all Core Medicaid enrollees. The Request for Information will include a form to be completed with information needed to determine eligibility for open Medicaid categories.

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- (ii) Enrollees will be given thirty (30) days inclusive of mail time from the date of the Request for Information to return the completed form to TDHS and to provide TDHS with the necessary verifications to determine eligibility for open Medicaid categories.
- (iii) Enrollees with a health, mental health, learning problem or a disability will be given the opportunity to request assistance in responding to the Request for Information. Enrollees with Limited English Proficiency will have the opportunity to request translation assistance for responding to the Request for Information.
- (iv) If an enrollee provides some but not all of the necessary information to TDHS to determine his/her eligibility for open Medicaid categories during the thirty (30) day period following the Request for Information, TDHS will send the enrollee a Verification Request. The Verification Request will provide the enrollee with ten (10) days inclusive of mail time to submit any missing information as identified in the Verification Request.
- (v) Enrollees who respond to the Request for Information within the thirty (30) day period shall retain their eligibility for TennCare Medicaid (subject to any changes in covered services generally applicable to enrollees in their Medicaid category) while TDHS reviews their eligibility for open Medicaid categories.
- (vi) TDHS shall review all information and verifications provided within the requisite time period by an enrollee pursuant to the Request for Information and/or the Verification Request to determine whether the enrollee is eligible for any open Medicaid categories. If TDHS determines that the enrollee remains eligible for his/her current Medicaid category, the enrollee will remain enrolled in such Medicaid category. If TDHS makes a determination that the enrollee is eligible for a different open Medicaid category, TDHS will so notify the enrollee and the enrollee will be enrolled in the appropriate TennCare Medicaid category. When the enrollee is enrolled in the new appropriate TennCare Medicaid category, his/her eligibility in the previous category shall be terminated without additional notice. If a child is reviewed for Medicaid eligibility and is found not to be eligible for any open Medicaid category, the child will be reviewed for eligibility for TennCare Standard under Rule 1200-13-14-.02(3). If TDHS makes a determination that the enrollee is not eligible for any open Medicaid categories or if an enrollee does not respond to the Request for Information within the requisite thirty (30) day time period the TennCare Bureau will send the enrollee a twenty (20) day advance Termination Notice.
- (vii) Enrollees who respond to the Request for Information or the Verification Request after the requisite time period specified in those notices but before the date of termination shall retain their eligibility for TennCare Medicaid (subject to any changes in covered services generally applicable to enrollees in their Medicaid category) while TDHS reviews their eligibility for open Medicaid categories. If TDHS determines that the enrollee remains eligible for his/her current Medicaid category, the enrollee will remain enrolled in such Medicaid category. If TDHS makes a determination that the enrollee is eligible for a different open Medicaid category, TDHS will so notify the enrollee and the enrollee will be enrolled in the new appropriate TennCare Medicaid category. When the enrollee is enrolled in the appropriate TennCare Medicaid category, his/her eligibility in the previous category shall be terminated without additional notice. If a child is reviewed for

## RULEMAKING HEARINGS

Medicaid eligibility and is found not to be eligible for any open Medicaid category, the child will be reviewed for eligibility for TennCare Standard under Rule 1200-13-14-.02(3). If TDHS makes a determination that the enrollee is not eligible for any open Medicaid categories, the TennCare Bureau will send the enrollee a twenty (20) day advance Termination Notice.

- (viii) Individuals may provide the information and verifications specified in the Request for Information after termination of eligibility. TDHS shall review all such information pursuant to the rules, policies and procedures of TDHS and the Bureau of TennCare applicable to new applicants for TennCare Medicaid coverage. The individual shall not be entitled to be reinstated into TennCare Medicaid pending this review. If the individual is subsequently determined to be eligible for an open Medicaid category, s/he shall be granted retroactive coverage to the date of application, or in the case of spend down eligibility for Medically Needy pregnant women and children, to the latter of (a) the date of his or her application, or (b) the date spend down eligibility is met.

### 2. Termination Notice

- (i) The TennCare Bureau will send Termination Notices to all Core Medicaid Population enrollees being terminated pursuant to state and federal law who are not determined to be eligible for open Medicaid categories pursuant to the Request for Information processes described in Rule 1200-13-13-.02(6)(a)1.
- (ii) Termination Notices will be sent twenty (20) days in advance of the date upon which the coverage will be terminated.
- (iii) Termination Notices will provide enrollees with forty (40) days from the date of the notice to appeal the termination and will inform enrollees how they may request a hearing. Appeals will be processed by TDHS in accordance with Rule 1200-13-13-.12.
- (iv) Enrollees with a health, mental health, learning problem or a disability will be given the opportunity to request additional assistance for their appeal. Enrollees with Limited English Proficiency will have the opportunity to request translation assistance for their appeal.

*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 28th day of February, 2006. (02-33)

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 18<sup>th</sup> day of April, 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](http://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 1200-8-2  
STANDARDS FOR PRESCRIBED CHILD CARE CENTERS**

**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 1200-8-24  
STANDARDS FOR BIRTHING CENTERS**

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

**RULEMAKING HEARINGS**

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

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

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

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

**CHAPTER 1200-8-32  
STANDARDS FOR END STAGE RENAL DIALYSIS CLINICS**

**CHAPTER 1200-8-34  
STANDARDS FOR HOMECARE ORGANIZATIONS PROVIDING PROFESSIONAL SUPPORT SERVICES**

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

**AMENDMENTS**

Rule 1200-8-1-.02, Licensing Procedures, is amended by deleting paragraph (4) in its entirety and substituting instead the following language, so that as amended, the new paragraph (4) shall read:

- (4) Each hospital, except those operated by the U.S. Government or the State of Tennessee, making application for license under this chapter shall pay annually to the department a fee based on the number of hospital beds, as follows:
- |                                |             |
|--------------------------------|-------------|
| (a) Less than 25 beds          | \$ 800.00   |
| (b) 25 to 49 beds, inclusive   | \$ 1,000.00 |
| (c) 50 to 74 beds, inclusive   | \$ 1,200.00 |
| (d) 75 to 99 beds, inclusive   | \$ 1,400.00 |
| (e) 100 to 124 beds, inclusive | \$ 1,600.00 |
| (f) 125 to 149 beds, inclusive | \$ 1,800.00 |
| (g) 150 to 174 beds, inclusive | \$ 2,000.00 |
| (h) 175 to 199 beds, inclusive | \$ 2,200.00 |

For hospitals of two hundred (200) beds or more the fee shall be two thousand four hundred dollars (\$2,400.00) plus two hundred dollars (\$200.00) for each twenty-five (25) beds or fraction thereof in excess of one hundred ninety-nine (199) beds. The fee shall be submitted with the application or renewal and is not refundable.



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- (2) (b) Each applicant for a license shall pay an annual license fee in the amount of one thousand eighty dollars (\$1,080.00). The fee must be submitted with the application and is not refundable.

**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 1200-8-11-.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:

- (2) (b) Each applicant for a license shall pay an annual license fee based on the number of beds as follows:

1.	Less than 6 beds	\$ 300.00
2.	6 to 24 beds, inclusive	\$ 800.00
3.	25 to 49 beds, inclusive	\$ 1,000.00
4.	50 to 74 beds, inclusive	\$ 1,200.00
5.	75 to 99 beds, inclusive	\$ 1,400.00
6.	100 to 124 beds, inclusive	\$ 1,600.00
7.	125 to 149 beds, inclusive	\$ 1,800.00
8.	150 to 174 beds, inclusive	\$ 2,000.00
9.	175 to 199 beds, inclusive	\$ 2,200.00

For homes for the aged of two hundred (200) beds or more the fee shall be two thousand four hundred dollars (\$2,400.00) plus two hundred dollars (\$200.00) for each twenty-five (25) beds or fraction thereof in excess of one hundred ninety-nine (199) beds. The fee shall be submitted with the application or renewal and is not refundable.

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

Rule 1200-8-15-.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:

- (2) (b) Each applicant for a license shall pay an annual license fee based on the number of beds as follows:

1.	Less than 25 beds	\$ 800.00
2.	25 to 49 beds, inclusive	\$ 1,025.00
3.	50 to 74 beds, inclusive	\$1,225.00
4.	75 to 99 beds, inclusive	\$1,425.00

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5.	100 to 124 beds, inclusive	\$ 1,625.00
6.	125 to 149 beds, inclusive	\$ 1,825.00
7.	150 to 174 beds, inclusive	\$ 2,025.00
8.	175 to 199 beds, inclusive	\$ 2,225.00

For residential hospice of two hundred (200) beds or more the fee shall be two thousand four hundred dollars twenty-five (\$2,425.00) plus two hundred dollars (\$200.00) for each twenty-five (25) beds or fraction thereof in excess of one hundred ninety-nine (199) beds. The fee shall be submitted with the application or renewal and is not refundable.

**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 1200-8-24-.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:

- (2) (b) Each applicant for a license shall pay an annual license fee in the amount of one thousand eighty dollars (\$1,080.00). The fee must be submitted with the application and is not refundable.

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

Rule 1200-8-25-.02, Licensing Procedures, is amended by deleting paragraph (4) in its entirety and substituting instead the following language, so that as amended, the new paragraph (4) shall read:

- (4) Each ACLF, except those operated by the U.S. Government or the State of Tennessee, making application for license under this chapter shall pay annually to the department a fee based on the number of ACLF beds, as follows:
- |     |                            |             |
|-----|----------------------------|-------------|
| (a) | Less than 25 beds          | \$ 800.00   |
| (b) | 25 to 49 beds, inclusive   | \$ 1,000.00 |
| (c) | 50 to 74 beds, inclusive   | \$ 1,200.00 |
| (d) | 75 to 99 beds, inclusive   | \$ 1,400.00 |
| (e) | 100 to 124 beds, inclusive | \$ 1,600.00 |
| (f) | 125 to 149 beds, inclusive | \$ 1,800.00 |
| (g) | 150 to 174 beds, inclusive | \$ 2,000.00 |
| (h) | 175 to 199 beds, inclusive | \$ 2,200.00 |

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For ACLF's of two hundred (200) beds or more the fee shall be two thousand four hundred dollars (\$2,400.00) plus two hundred dollars (\$200.00) for each twenty-five (25) beds or fraction thereof in excess of one hundred ninety-nine (199) beds. The fee shall be submitted with the application or renewal and is not refundable.

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

Rule 1200-8-26-.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:

- (2) (b) Each applicant for a license shall pay an annual license fee in the amount of one thousand eighty dollars (\$1,080.00). The fee must be submitted with the application and is not refundable.

**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 1200-8-27-.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:

- (2) (b) Each applicant for a license shall pay an annual license fee in the amount of one thousand eighty dollars (\$1,080.00). The fee must be submitted with the application and is not refundable.

**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 1200-8-28-.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:

- (2) (b) Each applicant for a license shall pay an annual license fee based on the number of beds as follows:
- |                               |             |
|-------------------------------|-------------|
| 1. Less than 25 beds          | \$ 800.00   |
| 2. 25 to 49 beds, inclusive   | \$ 1,000.00 |
| 3. 50 to 74 beds, inclusive   | \$1,200.00  |
| 4. 75 to 99 beds, inclusive   | \$1,400.00  |
| 5. 100 to 124 beds, inclusive | \$ 1,600.00 |
| 6. 125 to 149 beds, inclusive | \$ 1,800.00 |
| 7. 150 to 174 beds, inclusive | \$ 2,000.00 |
| 8. 175 to 199 beds, inclusive | \$ 2,200.00 |

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For HIV supportive living facilities of two hundred (200) beds or more the fee shall be two thousand four hundred dollars (\$2,400.00) plus two hundred dollars (\$200.00) for each twenty-five (25) beds or fraction thereof in excess of one hundred ninety-nine (199) beds. The fee shall be submitted with the application or renewal and is not refundable.

**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 1200-8-29-.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:

- (2) (b) Each applicant for a license shall pay an annual license fee in the amount of one thousand eighty dollars (\$1,080.00). The fee must be submitted with the application and is not refundable.

**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 1200-8-32-.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:

- (2) (b) Each initial and renewal application for licensure shall be submitted with the fee of one thousand eighty dollars (\$1,080.00). All fees submitted are nonrefundable. Any applicant who files an application during the fiscal year must pay the full license fee. A fee must be submitted for each facility at each site for which licensure is being sought.

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

Rule 1200-8-34-.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:

- (2) (b) Home care organizations authorized to provide only professional support services shall pay an annual fee of one thousand eighty dollars (\$1,080.00), except that this annual fee shall be two hundred seventy dollars (\$270.00) for (i) home care organizations that also pay a fee to be licensed by the department of mental health and developmental disabilities; (ii) home care organizations owned and operated by therapists who pay a fee to be licensed under Title 63, Chapter 13 or 17; or (iii) home care organizations that are owned and controlled by another home care organization that pay an annual license fee of at least one thousand eighty dollars (\$1,080.00). The fee must be submitted with the application and is not refundable.

**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 1200-8-35-.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:

- (2) (b) Each applicant for a license shall pay an annual license fee in the amount of one thousand eighty dollars (\$1,080.00). The fee must be submitted with the application and is not refundable.

## RULEMAKING HEARINGS

**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.

The notice of rulemaking set out herein was properly filed in the Department of State on the 17th day of February, 2006. (02-17)

## 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 Magnolia 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 17<sup>th</sup> day of April, 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](http://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 1200-8-5 BEHAVIORAL HEALTH UNITS IN NURSING FACILITIES

#### REPEALS

Rule 1200-8-5-.01, Special Services, is repealed.

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

The notice of rulemaking set out herein was properly filed in the Department of State on the 14<sup>th</sup> day of February, 2006. (02-10)

## 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 Magnolia Room on the Ground floor of the Cordell Hull Building located at 425 Fifth Avenue North, Nashville, TN at 11:00 a.m. (CST) on the 17<sup>th</sup> day of April, 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](http://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 1200-8-7 RESIDENTIAL HOME FOR AGED QUALITY ENABLING PROGRAM

#### AMENDMENTS

Rule 1200-8-7-.01, Purpose, is amended by deleting the rule in its entirety and substituting instead the following language, so that as amended, the new rule shall read:

**1200-8-7-.01 PURPOSE.** It is the intent of this rule to improve the quality of care and of service in Tennessee's Residential Homes for the Aged through the mechanism of distributing certain designated and limited state funds. This rule is now jointly promulgated by the Tennessee Board for Licensing Health Care Facilities and Tennessee Department of Health to implement the provisions of Chapter 927 of the Public Acts of 1986.

**Authority:** T.C.A. §§4-5-202, 4-5-204, 53-1310, 68-11-209, and 12-4-320 (Public Acts of 1986, chapter 927).

Rule 1200-8-7-.03, Participation of Providers, is amended by deleting subparagraph (1)(a) in its entirety and substituting instead the following language, so that as amended, the new subparagraph (1)(a) shall read:

- (1) (a) Be currently licensed by the Board as a residential home for the aged;

**Authority:** T.C.A. §§4-5-201 et seq., 4-5-202, 4-5-204, 68-11-209, and 12-4-320 (Public Acts of 1986, chapter 927).

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Rule 1200-8-7-.05, Reimbursement, is amended by deleting subparagraphs (1)(a) and (1)(c) in their entirety and substituting instead the following language, so that as amended, the new subparagraphs (1)(a) and (1)(c) shall read:

- (1) (a) The Department shall reimburse an approved and participating residential home for the aged for each day of care and services given to an approved and participating resident as permitted by allocated funding.
- (1) (c) The Department will reimburse a participating home the current amount as defined in T.C.A. §12-4-320(b) of thirteen dollars (\$13.00) per eligible resident day, not to exceed the maximum allowable percentage rate based on the allotted contract amount for the current fiscal year.

*Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-209, and 12-4-320 (Public Acts of 1986, chapter 927).*

Rule 1200-8-7-.05, Reimbursement, is amended by deleting subparagraph (1)(b) and renumbering the remaining subparagraphs appropriately.

**Authority:** *T.C.A. §§4-5-202, 4-5-204, 68-11-209, and 12-4-320 (Public Acts of 1986, chapter 927).*

Rule 1200-8-7-.06, Termination from Participation, is amended by deleting subparagraph (1)(b) in its entirety and substituting instead the following language, so that as amended, the new subparagraph (1)(b) shall read:

- (1) (b) A resident no longer meets the requirements for participation, set forth in 1200-8-7-.02, or a provider no longer meets the requirements for participation, set forth in 1200-8-7-.03;

**Authority:** *T.C.A. §§4-5-202, 4-5-204, 53-1310, 68-11-209, and 12-4-320 (Public Acts of 1986, chapter 927).*

The notice of rulemaking set out herein was properly filed in the Department of State on the 15th day of February, 2006. (02-14)

## 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 Magnolia Room on the Ground floor of the Cordell Hull Building located at 425 Fifth Avenue North, Nashville, TN at 10:00 a.m. (CST) on the 17<sup>th</sup> day of April, 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](http://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 1200-8-12 TRAUMA CENTERS

#### CHAPTER 1200-8-30 STANDARDS FOR PEDIATRIC EMERGENCY CARE FACILITIES

#### AMENDMENTS

Rule 1200-8-12-.03, Definitions, is amended by adding the following language as three (3), new, appropriately numbered paragraphs, so that as amended, the three (3), new, appropriately numbered paragraphs shall read:

- ( ) Board. Board for Licensing Health Care Facilities.
- ( ) Trauma Registry. A central registry compiled of injury incidence information supplied by designated trauma centers and Comprehensive Pediatric Emergency Centers for the purpose of allowing the Board to analyze data and conduct special studies regarding the causes and consequences of traumatic injury.
- ( ) TRACS. Trauma Registry of American College of Surgeons.

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

## RULEMAKING HEARINGS

Rule 1200-8-12-.04, Requirements, is amended by adding the following language as new paragraphs (1) thru (4) and re-numbering the remaining paragraphs appropriately, so that as amended, the new paragraphs (1) thru (4) shall read:

- (1) Each trauma center shall submit TRACS Registry data electronically to the state trauma registry on all closed patient files no less often than quarterly for the sole purpose of allowing the board to analyze causes and medical consequences of serious trauma while promoting the continuum of care that provides timely and appropriate delivery of emergency medical treatment for people with acute traumatic injury.
- (2) TRACS data shall be transmitted to the state trauma registry and received no later than April 15 for first quarter date; July 15 for second quarter data; October 15 for third quarter data and January 15 for fourth quarter data.
- (3) Failure to timely submit TRACS data to the state trauma registry for three (3) consecutive quarters shall result in the delinquent facility's necessity to appear before the Board for any disciplinary action it deems appropriate, including, but not limited to, citation of civil monetary penalties and/or loss of trauma designation status.
- (4) Trauma Centers shall maintain documentation to show that timely transmissions have been submitted to the state trauma registry on a quarterly basis.

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

Rule 1200-8-30-.01, Definitions, 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) Comprehensive Regional Pediatric Center (CRPC). The facility shall be capable of providing comprehensive specialized pediatric medical and surgical care to all acutely ill and injured children. The center shall be responsible for serving as a regional referral center for the specialized care of pediatric patients or in special circumstances provide safe and timely transfer of children to other resources for specialized care.

**Authority:** T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-209, and 68-11-251.

Rule 1200-8-30-.01, Definitions, is amended by adding the following language as three (3), new, appropriately numbered paragraphs, so that as amended, the three (3), new, appropriately numbered paragraphs shall read:

- ( ) Board. Board for Licensing Health Care Facilities.
- ( ) Trauma Registry. A central registry compiled of injury incidence information supplied by designated trauma centers and Comprehensive Pediatric Emergency Centers (CRPC's) for the purposes of allowing the Board to analyze data and conduct special studies regarding the causes and consequences of traumatic injury.
- ( ) TRACS. Trauma Registry of American College of Surgeons.

**Authority:** T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-209, and 68-11-251.

## RULEMAKING HEARINGS

Rule 1200-8-30-.03, Administration, is amended by deleting subparagraph (3)(g) in its entirety and substituting instead the following language, so that as amended, the new subparagraph (3)(g) shall read:

- (3) (g) Assist in organizing and providing support for regional, state and national data collection efforts for Emergency Medical Services for Children:
  - 1. Each CRPC shall submit TRACS Registry data electronically to the state trauma registry on all closed patient files no less often than quarterly for the sole purpose of allowing the board to analyze causes and medical consequences of serious trauma while promoting the continuum of care that provides timely and appropriate delivery of emergency medical treatment for people with acute traumatic injury.
  - 2. TRACS data shall be transmitted to the state trauma registry and received no later than April 15 for first quarter data; July 15 for second quarter data; October 15 for third quarter data and January 15 for fourth quarter data.
  - 3. Failure to timely submit TRACS data to the state trauma registry for three (3) consecutive quarters shall result in the delinquent facility's necessity to appear before the Board for any disciplinary action it deems appropriate, including, but not limited to, citation of civil monetary penalties and/or loss of CRPC designation status.
  - 4. CRPC's shall maintain documentation to show that timely transmissions have been submitted to the state trauma registry on a quarterly basis.

**Authority:** T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-209, and 68-11-251.

The notice of rulemaking set out herein was properly filed in the Department of State on the 14th day of February, 2006. (02-11)

## RULEMAKING HEARINGS

### BOARD OF RESPIRATORY CARE - 1330

There will be a hearing before the Tennessee Board of Respiratory Care to consider the promulgation of amendments to rules pursuant to T.C.A. §§ 4-5-202, 4-5-204, and 63-27-104. 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. (CDT) on the 25th day of April, 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 1330-1-.19, Board Officers, Consultants, Records, Declaratory Orders, Advisory Rulings, Subpoenas and Screening Panels, is amended by adding the following language as new paragraph (8):

- (8) Reconsiderations and Stays - The Board authorizes the member who chaired the Board for a contested case to be the agency member to make the decisions authorized pursuant to rule 1360-4-1-.18 regarding petitions for reconsiderations and stays in that case.

**Authority:** T.C.A. §§ 4-5-202, 4-5-204, 63-27-104, and 63-27-112.

Rule 1330-1-.22, ABG Endorsement, is amended by deleting paragraph (2) in its entirety and substituting instead the following language, and is further amended by deleting paragraphs (3) and (4) in their entirety, so that as amended, the new paragraph (2) shall read:

- (2) Obtaining ABG Endorsement
  - (a) Registered respiratory therapists and certified respiratory therapists can obtain ABG endorsement by submitting verification to the Board that he/she holds a current CRT or RRT credential issued by the NBRC; or
  - (b) An individual can obtain ABG endorsement by submitting verification to the Board of a current "Special Analyst/ABG" license issued by the Tennessee Medical Laboratory Board.

**Authority:** T.C.A. §§ 4-5-202, 4-5-204, 63-27-104, and 63-27-115.

The notice of rulemaking set out herein was properly filed in the Department of State on the 17th day of February, 2006. (02-20)

RULEMAKING HEARINGS

**BOARD OF SOCIAL WORKER CERTIFICATION AND LICENSURE - 1365  
DIVISION OF HEALTH RELATED BOARDS**

There will be a hearing before the Tennessee Board of Social Worker Certification and Licensure to consider the promulgation of amendments to rules pursuant to T.C.A. §§ 4-5-202, 4-5-204, and 63-23-108. 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. (CDT) on the 17th day of April, 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, Tennessee 37247-1010, (615) 532-4397.

**SUBSTANCE OF PROPOSED RULES**

**AMENDMENTS**

Rule 1365-1-.06, Fees, is amended by deleting subparagraphs (1) (a), (1) (b) and (1) (f), and parts (4) (b) 1. and (4) (b) 4. in their entirety and substituting instead the following language, so that as amended, the new subparagraphs (1) (a), (1) (b) and (1) (f), and the new parts (4) (b) 1. and (4) (b) 4. shall read:

- (1) (a) Application fee - A nonrefundable fee to be paid by all applicants for licensure as a clinical social worker, including those seeking licensure by reciprocity, and must be paid each time an application for licensure is filed.
- (1) (b) Certification fee - A refundable fee to be paid by all applicants for certification as a master social worker, and must be paid each time an application for certification is filed. In order to receive a refund, the applicant must submit a written request no later than sixty (60) days after the certification application was denied or withdrawn.
- (1) (f) License fee - A refundable fee to be paid prior to the issuance of the "artistically designed" license, and applies to applicants seeking licensure as a clinical social worker by examination or by reciprocity. In order to receive a refund, the applicant must submit a written request no later than sixty (60) days after the licensure application was denied or withdrawn.
- (4) (b) 1. Application
  - (i) By Examination \$125.00
  - (ii) By Reciprocity \$325.00
- (4) (b) 4. License \$ 75.00

## RULEMAKING HEARINGS

**Authority:** *T.C.A. §§ 4-5-202, 4-5-204, 63-23-102, 63-23-103, and 63-23-108.*

Rule 1365-1-19, Board Meetings, Officers, Consultant, and Records, is amended by adding the following language as new paragraph (5) and renumbering the remaining paragraphs accordingly:

- (5) Reconsiderations and Stays - The Board authorizes the member who chaired the Board for a contested case to be the agency member to make the decisions authorized pursuant to rule 1360-4-1-.18 regarding petitions for reconsiderations and stays in that case.

**Authority:** *T.C.A. §§ 4-5-202, 4-5-204, 63-23-106, and 63-23-108.*

The notice of rulemaking set out herein was properly filed in the Department of State on the 6th day of February, 2006. (02-07)

## RULEMAKING HEARINGS

### BOARD OF OCCUPATIONAL AND PHYSICAL THERAPY EXAMINERS COMMITTEE OF PHYSICAL THERAPY - 1150

There will be a hearing before the Tennessee Board of Occupational and Physical Therapy Examiners' Committee of Physical Therapy to consider the promulgation of amendments to rules 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. (CDT) on the 18th day of April, 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, Tennessee 37247-1010, (615) 532-4397.

### SUBSTANCE OF PROPOSED RULES

#### AMENDMENTS

Rule 1150-1-.01, Definitions, is amended by deleting paragraphs (6) and (7) in their entirety and substituting instead the following language, so that as amended, the new paragraphs (6) and (7) shall read:

- (6) Clinical Student – A student enrolled in a CAPTE approved developing program, or a CAPTE accredited physical therapy program, or a regionally accredited post professional physical therapist program, or any other program approved by the Committee of Physical Therapy.
- (7) Commission on Accreditation of Physical Therapy Education (CAPTE) – An agency approved by the Committee of Physical Therapy to accredit schools of physical therapy pursuant to T.C.A. §63-13-307(a).

**Authority:** T.C.A. §§ 4-5-202, 4-5-204, 63-13-108, 63-13-304, and 63-13-307.

Rule 1150-1-.04, Qualifications for Licensure, is amended by subparagraph (3) (a) in its entirety and substituting instead the following language, and is further amended by adding the following language as new subparagraph (3) (b) and renumbering the remaining subparagraphs accordingly, so that as amended, the new subparagraphs (3) (a) and (3) (b) shall read:

- (3) (a) Have submitted directly to the Committee's administrative office a validly issued and error-free "Comprehensive Credential Evaluation Certificate for the Physical Therapist" (Type 1 Certificate) from the Foreign Credentialing Commission on Physical Therapy (FCCPT) for the purpose of evaluating and verifying that the applicant's education is substantially equivalent to a curriculum approved by CAPTE.

## RULEMAKING HEARINGS

1. Submitting the "Visa Credential Verification Certificate," also issued by the FCCPT, will not constitute meeting this requirement.
  2. Applicants who cannot obtain a Type 1 Certificate from the FCCPT based on their ineligibility to sit for the Test of Written English (TWE), the Test of Spoken English (TSE), and the Test of English as a Foreign Language (TOEFL) must submit all other components of the Type 1 Certificate directly to the Board's administrative office, for the purpose of evaluating and verifying that the applicant's education is substantially equivalent to a curriculum approved by CAPTE; or
- (3) (b) Have submitted directly to the Committee's administrative office a validly issued and error-free certification from any agency verifying that the applicant's education is substantially equivalent to a curriculum approved by CAPTE.
1. The agency must evaluate the curriculum in a manner similar to the FCCPT educational credentials review.
  2. The result or outcome of the evaluation is the issuance of certification that the Committee considers to be equivalent to the "Comprehensive Credential Evaluation Certificate for the Physical Therapist" (Type 1 Certificate) from the FCCPT.

**Authority:** T.C.A. §§ 4-5-202, 4-5-204, 63-13-108, 63-13-304, and 63-13-307.

Rule 1150-1-.15, Disciplinary Actions, Civil Penalties, Assessment of Costs, and Screening Panels, is amended by adding the following language as new paragraph (7) and renumbering the present paragraph (7) as paragraph (8):

- (7) Reconsiderations and Stays - The Committee authorizes the member who chaired the Committee for a contested case to be the agency member to make the decisions authorized pursuant to rule 1360-4-1-.18 regarding petitions for reconsiderations and stays in that case.

**Authority:** T.C.A. §§ 4-5-202, 4-5-204, 63-13-108, 63-13-304, 63-13-312, 63-13-313, and 63-13-314.

The notice of rulemaking set out herein was properly filed in the Department of State on the 14th day of February, 2006. (02-09)

## RULEMAKING HEARINGS

### BOARD OF VETERINARY MEDICAL EXAMINERS - 1730

There will be a hearing before the Tennessee Board of Veterinary Medical Examiners to consider the promulgation of amendments to rules pursuant to T.C.A. §§ 4-5-202, 4-5-204, 63-12-105 and 63-12-106. 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 Ave. North, Nashville, TN at 3:30 p.m. (CDT) on the 17th day of April, 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 1730-1-01, Definitions, is amended by adding the following language as new, appropriately alphabetized and numbered paragraphs:

- ( ) Accepted livestock management practices - Services which may be performed by persons who are not licensed as veterinarians. Such services are limited to:
  - (a) In livestock of the equine species, the administration of any prescription drug, medicine, or biologic; the use of any manual or mechanical procedure for artificial insemination; the collection of semen; or the intra-uterine administration of medication when any of these procedures are performed under the indirect supervision of a licensed veterinarian in the context of a valid veterinarian-client-patient relationship. The administration of any over the counter drug, medicine or biologic may be provided without veterinarian supervision.
  - (b) In livestock other than the equine species, the administration of any over-the-counter drug, medicine, or biologic; the use of any manual or mechanical procedure for artificial insemination, the implantation of frozen embryos, the collection of semen, acts of surgical dehorning with the exception of surgical, branding, tagging or notching of ears; castration; deworming; the implanting of commercially available growth promotants; clipping of needle teeth; and the feeding of commercially available medicated feed. Prescription drugs, medicine or biologics may be administered under the direct or indirect supervision of a licensed veterinarian in the context of a valid veterinarian-client-patient relationship.
- ( ) Client - The patient's owner, owner's agent, or other person responsible for the patient.
- ( ) Indirect supervision - Services provided pursuant to written or oral instructions issued by a licensed veterinarian for the treatment of an animal or herd after the animal or herd has been examined

## RULEMAKING HEARINGS

by the veterinarian such that a valid doctor-client-patient relationship exists. The licensed veterinarian is not required to be on the premises for services that may be provided under indirect supervision, but must comply with the recordkeeping requirements of Rule 1730-1-.22.

- ( ) Patient - An animal that is examined or treated by a veterinarian.
- ( ) Veterinarian-client-patient relationship
  - (a) A licensed veterinarian has assumed responsibility for making medical judgments regarding the health of the animal(s) and the need for medical treatment, and the client has agreed to follow the instructions of the veterinarian; and
  - (b) There is sufficient knowledge of the animal(s) by the veterinarian to initiate at least a general or preliminary diagnosis of the medical condition of the animal(s). This means that the veterinarian has recently seen and is personally acquainted with the keeping and care of the animal(s) by virtue of an examination of the animal(s), and/or by medically appropriate and timely visits to the premises where the animal(s) is (are) kept; and
  - (c) The veterinarian is routinely and physically available for follow-up in case of adverse reactions or failure of the treatment or regimen or therapy, or has arranged for substitute follow-up care.

**Authority:** T.C.A. §§ 4-5-202, 4-5-204, 63-12-103, 63-12-105, 63-12-106, and 63-12-133.

Rule 1730-1-.03, Necessity of Licensure, is amended by deleting the language of the rule in its entirety and is further amended by adding the following language as paragraphs (1) and (2), so that as amended, the new paragraphs (1) and (2) shall read:

- (1) Prior to engaging in the practice of veterinary medicine in Tennessee, a person must hold a current Tennessee license or valid temporary license from the Board except as provided in T.C.A. § 63-12-133.
- (2) The scope of practice of veterinary medicine as provided in Rule 1730-1-.02, and the definition of accepted livestock management practices as provided in Rule 1730-1-.01 shall not prevent any person or such person's full time employee from administering to the ills and injuries of the person's own animals unless employment is provided for the purpose or with the effect of circumventing T.C.A. §§ 63-12-101, et seq., or any rule lawfully promulgated by the Board.

**Authority:** T.C.A. §§ 4-5-202, 4-5-204, 63-12-105, 63-12-106, and 63-12-133.

Rule 1730-1-.13, Unprofessional Conduct, is amended by deleting paragraph (7) in its entirety and substituting instead the following language, so that as amended, the new paragraph (7) shall read:

- (7) Failure to cooperate with authorities investigating incompetent, unethical or illegal practices.

**Authority:** T.C.A. §§ 4-5-202, 4-5-204, 63-12-105, 63-12-106, 63-12-124, 63-12-128, and 63-12-129.

## RULEMAKING HEARINGS

Rule 1730-1-.15, Disciplinary Actions, Civil Penalties, Assessment of Costs, and Screening Panels, is amended by adding the following language as new paragraph (11):

- (11) Reconsiderations and Stays. The Board authorizes the member who chaired the Board for a contested case to be the agency member to make the decisions authorized pursuant to rule 1360-4-1-.18 regarding petitions for reconsiderations and stays in that case.

**Authority:** T.C.A. §§4-5-202, 4-5-204, 63-12-105, 63-12-106, 63-12-124, and 63-12-128.

Rule 1730-1-.19, Board Consultants, Records and Complaints, and Declaratory Orders, is amended by deleting part (1) (b) 3. in its entirety and renumbering the current part (1) (b) 4. as the new part (1) (b) 3.

**Authority:** T.C.A. §§4-5-202, 4-5-204, 63-12-105, 63-12-106, and 63-12-129.

Rule 1730-1-.21, Prescribing, Dispensing, or Otherwise Distributing Pharmaceuticals, is amended by deleting part (2) (b) 3. in its entirety and substituting instead the following language, so that as amended, the new part (2) (b) 3. shall read:

- (2) (b) 3. The veterinarian is routinely and physically available for follow-up in case of adverse reactions or failure of the treatment or regimen or therapy, or has arranged for substitute follow-up care.

**Authority:** T.C.A. §§ 4-5-202, 4-5-204, 63-12-103, 63-12-105, and 63-12-106.

Rule 1730-1-.22, Recordkeeping, is amended by inserting the following language as new paragraph (4) and renumbering the the current paragraphs (4), (5) and (6) accordingly:

- (4) Veterinarians providing written or oral instructions for persons who are not licensed as veterinarians to perform accepted livestock management practices must record the order, including specific information on the substance of the order and the date given, in the records of the animal.

**Authority:** T.C.A. §§ 4-5-202, 4-5-204, 63-12-105, 63-12-106, and 63-12-133.

Rule 1730-2-.15, Disciplinary Actions, Civil Penalties, Assessment of Costs, and Screening Panels, is amended by adding the following language as new paragraph (11):

- (11) Reconsiderations and Stays. The Board authorizes the member who chaired the Board for a contested case to be the agency member to make the decisions authorized pursuant to rule 1360-4-1-.18 regarding petitions for reconsiderations and stays in that case.

**Authority:** T.C.A. §§4-5-202, 4-5-204, 63-12-105, 63-12-106, 63-12-124, 63-12-128, and 63-12-139.

Rule 1730-3-.15, Disciplinary Actions, Civil Penalties, Assessment of Costs, and Screening Panels, is amended by adding the following language as new paragraph (11):

- (11) Reconsiderations and Stays. The Board authorizes the member who chaired the Board for a contested case to be the agency member to make the decisions authorized pursuant to rule 1360-4-1-.18 regarding petitions for reconsiderations and stays in that case.

## RULEMAKING HEARINGS

**Authority:** T.C.A. §§4-5-202, 4-5-204, 63-12-105, 63-12-106, 63-12-124, 63-12-128, and 63-12-135.

Rule 1730-4-.12, Disciplinary Actions, Civil Penalties, Assessment of Costs, and Screening Panels is amended by adding the following language as new paragraph (9):

- (9) Reconsiderations and Stays. The Board authorizes the member who chaired the Board for a contested case to be the agency member to make the decisions authorized pursuant to rule 1360-4-1-.18 regarding petitions for reconsiderations and stays in that case.

**Authority:** T.C.A. §§4-5-202, 4-5-204, 63-12-105, 63-12-106, 63-12-124, 63-12-128, and 63-12-141.

Rule 1730-5-.12, Disciplinary Actions, Civil Penalties, Assessment of Costs, and Screening Panels, is amended by adding the following language as new paragraph (9):

- (9) Reconsiderations and Stays. The Board authorizes the member who chaired the Board for a contested case to be the agency member to make the decisions authorized pursuant to rule 1360-4-1-.18 regarding petitions for reconsiderations and stays in that case.

**Authority:** T.C.A. §§4-5-202, 4-5-204, 63-12-105, 63-12-106, 63-12-124, 63-12-128, and 63-12-141.

The notice of rulemaking set out herein was properly filed in the Department of State on the 17th day of February, 2006. (02-19)

## RULEMAKING HEARINGS

### TENNESSEE WILDLIFE RESOURCES COMMISSION - 1660

There will be a hearing before the Tennessee Wildlife Resources Commission to consider the promulgation of rules, amendments of rules, or repeals of rules pursuant to Tennessee Code Annotated, Section 70-1-206. 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 Region II Conference Room of the Tennessee Wildlife Resources Agency, Ray Bell Region II Building, 5105 Edmondson Pike, Nashville, Tennessee, at 9:00 a.m., local time, on the 20th day of April, 2006.

Any individuals with disabilities who wish to participate in these proceedings (to review these filings) should contact the Tennessee Wildlife Resources Agency 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 Tennessee Wildlife Resources Agency to determine how it may reasonably provide such aid or service. Initial contact may be made with the Tennessee Wildlife Resources Agency ADA Coordinator, Carolyn Wilson, Room 229, Tennessee Wildlife Resources Agency Building, Ellington Agricultural Center, Nashville, Tennessee 37204, telephone number (615)781-6594.

For a copy of this notice of rulemaking hearing, contact: Sheryl Holtam, Attorney, Tennessee Wildlife Resources Agency, P.O. Box 40747, Nashville, TN 37204, telephone number (615)781-6606.

#### **SUBSTANCE OF PROPOSED RULES**

#### **CHAPTER 1660-1-8 RULES AND REGULATIONS OF HUNTS**

#### **AMENDMENTS**

Rule 1660-1-8-.03, Permit Requirements - Wildlife Management Areas, Refuges And Other Agency Controlled Lands, Paragraph (3) is amended by adding Three Rivers alphabetically in the list so it shall read:

- (3) Before any person, except those under 16 years of age hunting small game and waterfowl, may hunt on a wildlife management area or refuge, he must possess a permit as outlined below.

- (a) A WMA Small Game permit is required on the following wildlife management areas and refuges:

AEDC  
Alpine Mountain  
Arnold Hollow  
Bark Camp Barrens  
Barkley Units I & II  
Bean Switch Refuge  
Bear Hollow Mountain  
Beaver Dam Creek  
Big Sandy (including Gin Creek)  
Black Bayou Refuge  
Bogota  
Bridgestone/Firestone Centennial Wilderness

## RULEMAKING HEARINGS

Browntown  
Buffalo Springs  
Camden Units I & II  
Catoosa  
Cheatham  
Cheatham Lake  
Chickamauga (Candies Creek, Johnson Bottoms, Rogers Creek, Yellow Creek Units)  
Chuck Swan  
Cold Creek  
Cordell Hull  
Cordell Hull Refuge  
Cove Creek  
C. M. Gooch  
Cypress Pond  
Eagle Creek  
Eagle Lake Refuge  
Ernest Rice Sr.  
Foothills  
Forks of the River  
Haley-Jaqueth  
Harmon Creek  
Haynes Bottom  
Henderson Island Refuge  
Hick Hill  
Hickory Flat  
Hiwassee Refuge  
Holly Fork  
Hop-In Refuge  
Jackson Swamp  
Jarrell Switch Refuge  
John Tully  
Kingston Refuge  
Kyker Bottoms Refuge  
Kyles Ford  
Laurel Hill  
Lick Creek  
Lick Creek Bottoms  
Maness Swamp Refuge  
Maple Springs  
Mingo Swamp  
Moss Island  
MTSU  
Natchez Trace  
New Hope  
Nolichucky  
North Chickamauga Creek  
Oak Ridge  
Obion River  
Old Hickory (Unit I)  
Old Hickory Lock 5 Refuge  
Pea Ridge  
Percy Priest (Units I & II)  
Perryville  
Prentice Cooper

## RULEMAKING HEARINGS

Rankin  
Royal Blue  
Shelby Forest  
Shelton Ferry  
Sundquist  
Tellico Lake  
Three Rivers  
Tie Camp  
Watts Bar (Long Island Unit)  
West Sandy  
White Lake Refuge  
White Oak  
Williamsport  
Wolf River  
Woods Reservoir Refuge  
Yanahli  
Yuchi Refuge at Smith Bend

A WMA small game permit is required for individuals participating in dog training. A field trial permit is required on Percy Priest WMA and the Tellico Lake – McGhee-Carson Unit.

- (b) A WMA Small Game and Waterfowl permit is required for hunting waterfowl on the following wildlife management areas and refuges:

AEDC  
Barkley Units I & II  
Big Sandy (including Gin Creek  
Bogota  
Camden Units I & II  
Cheatham Lake  
Chickamauga (Candies Creek, Johnson Bottoms, Rogers Creek, Yellow Creek Units)  
Cold Creek  
Cordell Hull  
Cordell Hull Refuge  
C.M. Gooch  
Ernest Rice Sr.  
Harmon Creek  
Haynes Bottom  
Hiwassee Refuge  
Holly Fork  
Jackson Swamp  
Jarrell Switch Refuge  
Moss Island  
Lick Creek  
Lick Creek Bottoms  
Mingo Swamp  
Moss Island  
New Hope  
Nolichucky  
North Chickamauga Creek  
Oak Ridge  
Obion River  
Old Hickory (Unit I)  
Shelby Forest

## RULEMAKING HEARINGS

Three Rivers  
Tigrett  
Watts Bar (Long Island Unit)  
West Sandy  
White Oak  
Yanahli  
Yuchi Refuge at Smith Bend

- (c) A WMA big game permit is required for hunting deer, bear, boar, feral hogs, and turkey on the following wildlife management areas and refuges:

AEDC  
Alpine Mountain  
Arnold Hollow  
Bark Camp Barrens  
Barkley Units I & II  
Bear Hollow Mountain  
Bean Switch Refuge  
Beaver Dam Creek  
Big Sandy (including Gin Creek  
Bogota  
Bridgestone/Firestone Centennial Wilderness  
Browntown  
Buffalo Springs  
C. M. Gooch  
Camden Units I & II  
Catoosa  
Cheatham  
Cheatham Lake  
Cherokee  
Chickamauga (Candies Creek, Johnson Bottoms, Rogers Creek, Yellow Creek Units)  
Chuck Swan  
Cold Creek  
Cordell Hull  
Cordell Hull Refuge  
Cove Creek  
Cypress Pond  
Eagle Creek  
Eagle Lake Refuge  
Ernest Rice Sr.  
Fall Creek Fall State Park  
Foothills  
Forks of the River  
Gallatin Steam Plant  
Harmon Creek  
Haynes Bottom  
Henderson Island Refuge  
Hick Hill  
Hickory Flat  
Hiwassee Refuge  
Holly Fork  
Hop-In Refuge  
International Paper  
Jackson Swamp

## RULEMAKING HEARINGS

Jarrell Switch Refuge  
John Tully  
Kingston Refuge  
Kyles Ford  
Laurel Hill  
Lick Creek  
Lick Creek Bottoms  
Lovell Field  
Maness Swamp Refuge  
Maple Springs  
Mingo Swamp  
Moss Island  
MTSU  
Natchez Trace  
Nathan B. Forrest State Historical Area  
New Hope  
Nolichucky  
North Chickamauga Creek  
Oak Ridge  
Obion River  
Old Hickory (Unit I)  
Old Hickory Lock 5 Refuge  
Pea Ridge  
Percy Priest (Units I & II)  
Perryville  
Prentice Cooper  
President's Island  
Rankin  
Royal Blue  
Shelby Forest  
Shelton Ferry  
Sundquist  
Tellico Lake  
Three Rivers  
Tie Camp WMA  
Tigrett  
Watts Bar (Long Island Unit)  
West Sandy  
White Lake Refuge  
White Oak  
Williamsport  
Wolf River  
Woods Reservoir Refuge  
Yanahli  
Yuchi Refuge at Smith Bend

- (d) A WMA Small Game or WMA Small Game and Waterfowl permit is required to trap on all areas that require a small game hunting permit.

**Authority:** T.C.A. §§70-1-206 and 70-4-107

RULEMAKING HEARINGS

**CHAPTER 1660-1-14  
RULES AND REGULATIONS FOR REFUGES AND  
WILDLIFE MANAGEMENT AREAS**

**AMENDMENT**

Rule 1660-1-14-.03 Catoosa, Cheatham, Chuck Swan, Forks of the River, Laurel Hill, Pea Ridge, Percy Priest Unit I and Prentice Cooper Wildlife Management Areas is deleted in its entirety, including the title, and inserting the following language so it shall read:

**1660-1-14-.03 CATOOSA, CHEATHAM, FORKS OF THE RIVER, LAUREL HILL, PEA RIDGE, AND PERCY PRIEST UNIT I WILDLIFE MANAGEMENT AREAS.**

- (1) Unauthorized entry or presence on Catoosa, Cheatham, Forks of the River, Laurel Hill, Pea Ridge, and Percy Priest Unit I Wildlife Management Areas is prohibited during the following times and conditions:
  - (a) Between sunset and sunrise.
  - (b) When in the judgment of the area manager, weather conditions are such that travel over roads would result in undue damage to said roads.
  - (c) During such periods as the Wildlife Resources Agency, or other authorized agencies, may be conducting special projects, the nature of which is such that the presence of the general public would have a detrimental effect on such operations or when the nature of the operation may constitute a danger to the public. When Fire hazards exist.
  - (d) When fire hazards exist.
- (2) Said area shall be temporarily posted when any of the conditions under (b), (c) and (d) exist.
- (3) The use of any alcoholic beverage is prohibited on Catoosa, Cheatham, Forks of the River, Laurel Hill, Pea Ridge, and Percy Priest Unit I Wildlife Management Areas, except in designated camping areas.

*Authority: T.C.A. §§70-1-206 and 70-4-107*

**NEW RULE**

**CHAPTER 1660-1-14  
RULES AND REGULATIONS FOR REFUGES AND  
WILDLIFE MANAGEMENT AREAS**

Rule 1660-1-14-.09 REPEALED, is amended by deleting it in its entirety and inserting the following language to read as follows:

**RULE 1660-1-14-.09 HUNTING AND MISCELLANEOUS USES OF WILDLIFE MANAGEMENT AREAS ON STATE FORESTS.**

- (1) General.

## RULEMAKING HEARINGS

- (a) On wildlife management areas, the hunter (except raccoon, opossum, and turkey hunters) may not enter prior to two (2) hours before sunrise, and must be out of the area by one (1) hour after sunset or legal closing time. Raccoon and opossum hunters must be out of the area one (1) hour after sunrise, except on the Martha Sundquist State Forest portion of the Cherokee Wildlife Management Area.
  - (b) Only guides approved by the hunt manager and issued a written permit (see Rule 0080-7-1-.07 Commercial Operations) will be allowed on managed hunts and these may not carry guns while guiding unless they possess a valid hunting license, big game stamp and area hunt permit.
  - (c) When the hunt manager assigns compartments, hunters must remain in the compartment assigned.
  - (d) Unauthorized persons are prohibited from being in the wildlife management area during deer and turkey managed hunts on Chuck Swan and Prentice Cooper Wildlife Management Areas
  - (e) Use, possession or transportation of firearms, bows and arrows or other weapons is expressly prohibited except during times when they may be legally used for hunting or when in route to Division of Forestry or TWRA provided shooting range located on the WMA. Persons possessing a firearm, bow and arrows, or other weapons on a WMA are required to have a valid WMA permit.
  - (f) Target practice is prohibited except at ranges provided by the Tennessee Division of Forestry or Wildlife Resources Agency.
  - (g) The use of wire, nails or other metal materials is prohibited in the building or attaching of climbing devices or hunting stands on or in trees. Hunting is prohibited from any stand attached to a tree with these materials. Portable climbing devices and stands that do not injure trees are excepted from this rule.
  - (h) The use of buckshot for hunting and/or taking of deer and turkey is specifically prohibited.
  - (i) Other miscellaneous uses of WMA on State Forests shall be in accordance with posted notices and/or as indicated on the hunt permit.
- (2) Safety Rules
- (a) The hunter's permit is subject to cancellation if he/she is found to be careless with firearms and no permit fee refund will be made.
  - (b) No hunt participant shall be in possession of any alcoholic beverage, narcotic drug, barbiturate, or marijuana while hunting within the WMA. No person may be under the influence of these substances while hunting on a WMA.
  - (c) Firearms loaded with ammunition in either the chamber or magazine may not be transported in or on motorized vehicles. Except that, muzzleloaders may be transported in a loaded condition if the percussion cap or primer is removed from the nipple or tube. Flintlock muzzleloaders must have the priming powder removed from the pan, the frizzen open and the vent plugged.

## RULEMAKING HEARINGS

- (d) Hunting is specifically prohibited inside posted safety zones on WMAs on State Forests.
  - (e) Possession and official use of firearms by law enforcement officers is permitted.
- (3) Dogs and Pets.
- (a) Use or possession of dogs for hunting, driving, rallying or other purposes that disturbs wildlife is prohibited on Wildlife Management Areas on State Forests except when authorized by Commission proclamation or Regulation.
  - (b) Dogs and other pets must be on a leash or under the handler's control at all times.
  - (c) These rules and regulations shall not be construed to conflict with rules and regulations promulgated by any State or Federal Agency with whom the Wildlife Resources Agency manages any area under terms of a cooperative agreement or memorandum of understanding.
  - (d) Any unleashed dog found on Wildlife Management Areas on State Forests shall be impounded and disposed of according to the procedures outlined in T.C.A. §70-4-118.
- (4) Camping and Picnicking
- (a) Overnight camping may be permitted as authorized by Rules and Regulations 0080-7-1.
  - (b) Houseboats and floats are prohibited from mooring and anchoring overnight along the shorelines of State property on Norris Lake.
- (5) Trail bikes, mini-bikes, and other off-road-vehicles
- (a) Off-road-vehicles are allowed as authorized by Rule 0080-7-1.
  - (b) All incidents resulting in the injury to persons or damage to property must be reported by the person or persons involved as soon as possible to the district forester or area manager. This report does not relieve persons from the responsibility of making any other accident reports which may be required under state law.

**Authority:** T.C.A. §§70-1-206 and 70-4-107

RULEMAKING HEARINGS

**AMENDMENT**

**CHAPTER 1660-1-14  
RULES AND REGULATIONS FOR REFUGES AND  
WILDLIFE MANAGEMENT AREAS**

Rule 1660-1-14-.13 Hunting and Miscellaneous Uses of Wildlife Management Areas and other Tennessee Wildlife Resources Agency Controlled Lands. The title is amended by inserting "excluding State Forests" at the end so that it shall read:

**1660-1-14-.13 HUNTING AND MISCELLANEOUS USES OF WILDLIFE MANAGEMENT AREAS AND OTHER TENNESSEE WILDLIFE RESOURCES AGENCY CONTROLLED LANDS, EXCLUDING STATE FORESTS.**

**Authority:** T.C.A. §§70-1-206 and 70-4-107

**AMENDMENT**

**CHAPTER 1660-2-4  
RULES AND REGULATIONS GOVERNING REPORTING OF BOATING ACCIDENTS**

Rule 1660-2-4-.01(1) Accident Report is amended by deleting paragraph (1) and by substituting a new paragraph (1) that shall read as follows:

- (1) The operator of a vessel shall immediately notify the Wildlife Resources Agency and, within the time period prescribed in Rule 1660-2-4-.01(2), submit the casualty or accident report when, as a result of an occurrence that involved the vessel or its equipment –

Rule 1660-2-4-.01(1)(b) Accident Report is amended by changing the monetary value of damage to the vessel or combination of vessels and other property damage totals from \$200 to \$500, so that as amended, the rule shall read as follows:

- (b) A person is injured and receives medical treatment beyond first aid; damage to the vessel or combination of vessels and other property damage totals more than \$500; or

**Authority:** T.C.A. §§69-9-209 and 70-1-206.

The notice of rulemaking set out herein was properly filed in the Department of State on the 27th day of February, 2006. (02-24)

## **WILDLIFE PROCLAMATIONS**

### **TENNESSEE WILDLIFE RESOURCES COMMISSION - 1660**

#### **PROCLAMATION 06-05**

#### **PROCLAIMING CHARLOTTE ANN FINNELL NEAL WILDLIFE MANAGEMENT AREA**

Pursuant to the authority granted by Title 70, Tennessee Code Annotated, Sections 70-1-206 and 70-5-101, the Tennessee Wildlife Resources Commission hereby proclaims the following area as a wildlife management area to be known as the Charlotte Ann Finnell Neal Wildlife Management Area:

Charlotte Ann Finnell Neal Wildlife Management Area – Those state lands in Bradley County, Tennessee consisting of approximately 500 acres located in the South Chestuee Creek watershed.

The boundary line is posted with “Wildlife Management Area” signs. A more complete description may be found on file in the Real Estate Division office of Tennessee Wildlife Resources Agency, Nashville, Tennessee.

Proclamation No. 06-05 received and recorded this 28th day of February, 2006. (02-26)

WILDLIFE PROCLAMATIONS

**TENNESSEE WILDLIFE RESOURCES COMMISSION - 1660**

**PROCLAMATION 06-06  
PROCLAIMING CUMMINGS COVE WILDLIFE MANAGEMENT AREA**

Pursuant to the authority granted by Title 70, Tennessee Code Annotated, Sections 70-1-206 and 70-5-101, the Tennessee Wildlife Resources Commission hereby proclaims the following area as a wildlife management area to be known as the Cummings Cove Wildlife Management Area:

Cummings Cove Wildlife Management Area – Those state lands on Aetna Mountain in Marion and Hamilton Counties, Tennessee consisting of approximately 1,200 acres located in the Tennessee River Gorge.

The boundary line is posted with “Wildlife Management Area” signs. A more complete description may be found on file in the Real Estate Division office of Tennessee Wildlife Resources Agency, Nashville, Tennessee.

Proclamation No. 06-06 received and recorded this 28th day of February, 2006. (02-27)

WILDLIFE PROCLAMATIONS

**TENNESSEE WILDLIFE RESOURCES COMMISSION - 1660**

**PROCLAMATION 06-07  
PROCLAIMING THE BOILS WILDLIFE MANAGEMENT AREA**

Pursuant to the authority granted by Title 70, Tennessee Code Annotated, Sections 70-1-206 and 70-5-101, the Tennessee Wildlife Resources Commission hereby proclaims the following area as a wildlife management area to be known as The Boils Wildlife Management Area:

The Boils Wildlife Management Area – Those state lands bordering Roaring River and Blackburn Fork Jackson County, Tennessee consisting of approximately 119 acres.

The boundary line is posted with “Wildlife Management Area” signs. A more complete description may be found on file in the Real Estate Division office of Tennessee Wildlife Resources Agency, Nashville, Tennessee.

Proclamation No. 06-07 received and recorded this 28th day of February, 2006. (02-28)

WILDLIFE PROCLAMATIONS

**TENNESSEE WILDLIFE RESOURCES COMMISSION - 1660**

**PROCLAMATION 06-08**

**AMENDING PROCLAMATION 05-15 – WILD TURKEY HUNTING SEASONS AND BAG LIMITS**

Pursuant to the authority granted by Tennessee Code Annotated Sections 70-4-107 and 70-5-108, the Tennessee Wildlife Resources Commission hereby amends proclamation 05-15 by inserting Boils WMA, Cummins Cove WMA, and Charlotte Ann Finnell Neal WMA in Section III. D., so that as amended the section shall read:

**SECTION III.**

D. Wildlife Management Areas and Refuges Open With Statewide Seasons and Bag Limits:

Alpine Mountain, Arnold Hollow, Bark Camp Barrens, Barkley (Units I and II), Bean Switch Refuge, Beaver Dam Creek, Big Sandy (including Gin Creek), Bogota, The Boils, Bridgestone/Firestone, Browntown, Buffalo Springs, Camden (Units I and II), Cedar Hill Swamp, Charlotte Ann Finnell Neal, Chickamauga, Chickasaw State Forest, Cheatham Lake, Cheatham Lake Pardue Pond Refuge and Dyson Ditch Refuge, Cold Creek Refuge, Cordell Hull, Cordell Hull Refuge, Cove Creek, Cummings Cove, Cypress Pond Refuge, Eagle Creek, Edgar Evins State Park, Flintville Hatchery, Gallatin Steam Plant (Archery only), Gooch, Harmon's Creek, Haynes Bottom, Henderson Island, Hick Hill, Hickory Flats, Hop-in Refuge, Horns Bluff Refuge, Jarrell Switch, Jackson Swamp, John Tully, Keyes-Harrison, Lick Creek, Lick Creek Bottoms, Long Pond, Maness Swamp Refuge, Maple Springs, Mingo Swamp, MTSU, Mt. Roosevelt, New Hope, Nolichucky, Normandy, North Cherokee, Obion River, Old Hickory (including Lock 5 Refuge), Owl Hollow Mill, Pea Ridge, Percy Priest Unit I (archery only) and Unit II, Pickett State Forest, Rankin, Royal Blue, Shelton Ferry, Standing Stone State Forest, Sundquist, Three Rivers, West Sandy, Tellico Lake (except McGhee-Carson and Niles Ferry Units), Tie Camp, Tigrett, Tumbleweed, Watts Bar, White Lake Refuge, White Oak, Yanahli are open to coincide with the statewide seasons and bag limits.

Proclamation No. 06-08 received and recorded this 28th day of February, 2006. (02-29)



### 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 February 1, 2006 and ending February 28, 2006.

A handwritten signature in black ink that reads "Riley C. Darnell".

**RILEY C. DARNELL**  
Secretary of State