

**RULES
OF
TENNESSEE DEPARTMENT OF FINANCE
AND ADMINISTRATION
BUREAU OF TENNCARE**

**CHAPTER 1200-13-01
TENNCARE LONG-TERM CARE PROGRAMS**

TABLE OF CONTENTS

1200-13-01-.01	Purpose	1200-13-01-.16	Repealed
1200-13-01-.02	Definitions	1200-13-01-.17	Statewide Home and Community Based Services Waiver for the Elderly and Disabled (Statewide E/D Waiver)
1200-13-01-.03	Nursing Facility (NF) Provider Reimbursement		
1200-13-01-.04	Third Party Resources		
1200-13-01-.05	TennCare CHOICES Program	1200-13-01-.18	Repealed
1200-13-01-.06	Special Federal Requirements Pertaining to Nursing Facilities	1200-13-01-.19	Repealed
		1200-13-01-.20	Repealed
1200-13-01-.07	Repealed	1200-13-01-.21	Provider Noncompliance or Fraud of Medicaid Program
1200-13-01-.08	Personal Needs Allowance (PNA), Patient Liability, Third Party Insurance and Estate Recovery for Persons Receiving LTC	1200-13-01-.22	Repealed
		1200-13-01-.23	Nursing Home Preadmission Screenings for Mental Illness and Mental Retardation
1200-13-01-.09	Third Party Signature		
1200-13-01-.10	Medical (Level of Care) Eligibility Criteria for Medicaid Reimbursement of Care in Nursing Facilities Care	1200-13-01-.24	Repealed
		1200-13-01-.25	Tennessee's Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled under Section 1915(c) of the Social Security Act (Statewide MR Waiver)
1200-13-01-.11	Recipient Abuse and Overutilization of Medicaid Program		
1200-13-01-.12 through		1200-13-01-.26	Repealed
1200-13-01-.14	Repealed	1200-13-01-.27	Repealed
1200-13-01-.15	Medical (LOC) Eligibility Criteria for Medicaid Reimbursement of Care in an Intermediate Care Facility for Persons with Mental Retardation (or Pursuant to Federal Law, Intermediate Care Facility for the Mentally Retarded) (ICF/MR)	1200-13-01-.28	Home and Community Based Services Waiver for Persons with Mental Retardation Under Section 1915(c) of the Social Security Act (Arlington MR Waiver)
		1200-13-01-.29	Tennessee's Self-Determination Waiver Under Section 1915 (c) of the Social Security Act (Self-Determination MR Waiver Program)
		1200-13-01-.30	TennCare ICF/MR Program

1200-13-01-.01 PURPOSE.

- (1) The purpose of this Chapter is to set forth requirements pertaining to the Long-Term Care (LTC) delivery system.
- (2) The Bureau of TennCare (Bureau) offers the following LTC programs and services:
 - (a) Nursing Facility (NF) services.
 1. Until such time as the TennCare CHOICES in Long-Term Care Program (CHOICES) is implemented in a particular Grand Division, NF services shall be administered by the Bureau under a Fee-for-Service (FFS) system and in accordance with this Chapter.
 2. At the time that CHOICES is implemented in a particular Grand Division, NF services for eligible residents of that Grand Division shall be administered by the Managed Care Organizations (MCOs) under the Managed Care System and in accordance with this Chapter.
 3. At the time that CHOICES is fully implemented statewide, all NF services shall be administered by the MCOs under the Managed Care System and in accordance with this Chapter.

(Rule 1200-13-01-.01, continued)

- (b) Statewide Home and Community Based Services Waiver for the Elderly and Disabled (Statewide E/D Waiver). (See Rule 1200-13-01-.17.)
 - 1. Until such time that CHOICES is implemented in a particular Grand Division, the Statewide E/D Waiver shall offer home and community based services (HCBS) to eligible residents of that Grand Division under a FFS system and in accordance with this Chapter.
 - 2. At the time that CHOICES is implemented in a particular Grand Division, the Statewide E/D Waiver shall terminate in that Grand Division and HCBS for eligible residents of that Grand Division shall be administered by the MCOs under the Managed Care System and in accordance with this Chapter. The HCBS waivers for persons with mental retardation (MR) are not affected by the implementation of CHOICES.
 - 3. At the time that CHOICES is fully implemented statewide, the Statewide E/D Waiver shall terminate and all HCBS other than those offered under the HCBS waivers for individuals with MR or the Program of All-Inclusive Care for the Elderly (PACE) shall be administered by the MCOs under the Managed Care System and in accordance with this Chapter.
 - (c) TennCare CHOICES Program (CHOICES). (See Rule 1200-13-01-.05.) This program has two components:
 - 1. NF services.
 - 2. HCBS for adults who are elderly or physically disabled.
 - (d) Intermediate Care Facility services for persons with Mental Retardation (or pursuant to federal law, Intermediate Care Facility services for the Mentally Retarded) (ICFs/MR). (See Rule 1200-13-01-.30.)
 - (e) HCBS waivers for individuals with MR.
 - 1. Statewide MR Waiver. (See Rule 1200-13-01-.25.)
 - 2. Arlington MR Waiver. (See Rule 1200-13-01-.28.)
 - 3. Self-Determination MR Waiver. (See Rule 1200-13-01-.29.)
 - (f) PACE. This is a program for certain dually eligible Medicare and Medicaid beneficiaries that is offered through the Tennessee Medicaid State Plan, Attachment 3.1-A, #26.
- (3) Individuals receiving LTC services shall be enrolled in Managed Care Contractors (MCCs) as follows:
- (a) Individuals receiving TennCare-reimbursed LTC services, other than PACE, are also enrolled in a TennCare MCO for primary care, behavioral health services, and acute care services.
 - (b) In addition to enrollment in an MCO, the following LTC recipients, other than those enrolled in the PACE Program, are enrolled with the TennCare Pharmacy Benefits Manager for coverage of prescription drugs:

(Rule 1200-13-01-.01, continued)

1. Children under the age of twenty-one (21); and
 2. Adults aged twenty-one (21) and older who are not Medicare beneficiaries.
- (c) Children under the age of twenty-one (21) who are LTC recipients are also enrolled with the TennCare Dental Benefits Manager (DBM) for coverage of dental services.
- (4) Acronyms. The following are acronyms used throughout this Chapter and the terms they represent:
- (a) AAAD – Area Agencies on Aging and Disability
 - (b) ACLF – Assisted Care Living Facility
 - (c) ADL – Activity of Daily Living
 - (d) ALA – Administrative Lead Agency
 - (e) CBRA – Community-Based Residential Alternative
 - (f) CD – Consumer Direction
 - (g) CEA – Cost Effective Alternative
 - (h) CMS – Centers for Medicare and Medicaid Services
 - (i) DBM – Dental Benefits Manager
 - (j) DHS – Tennessee Department of Human Services
 - (k) DIDS – Tennessee Department of Finance and Administration's Division of Intellectual Disabilities Services
 - (l) DMHDD – Tennessee Department of Mental Health and Developmental Disabilities
 - (m) E/D – Elderly and/or Disabled
 - (n) EVV – Electronic Visit Verification
 - (o) F&A – Tennessee Department of Finance and Administration
 - (p) FEA – Fiscal Employer Agent
 - (q) FERP – Federal Estate Recovery Program
 - (r) FFS – Fee-for-Service
 - (s) HCBS – Home and Community Based Services
 - (t) HH – Home Health
 - (u) ICF/MR – Intermediate Care Facility for persons with Mental Retardation (or pursuant to federal law, Intermediate Care Facility for the Mentally Retarded)
 - (v) IADL – Instrumental Activity of Daily Living

(Rule 1200-13-01-.01, continued)

- (w) LOC – Level of Care
- (x) LTC – Long-Term Care
- (y) MCC – Managed Care Contractor
- (z) MCO – Managed Care Organization
- (aa) MI – Mental Illness
- (bb) MR – Mental Retardation
- (cc) NF – Nursing Facility
- (dd) OAA – Operational Administrative Agency
- (ee) PACE – Program of All-Inclusive Care for the Elderly
- (ff) PAE – PreAdmission Evaluation
- (gg) PASRR – PreAdmission Screening and Resident Review
- (hh) PBM – Pharmacy Benefits Manager
- (ii) PDN – Private Duty Nursing
- (jj) PERS – Personal Emergency Response System
- (kk) POC – Plan of Care
- (ll) PNA – Personal Needs Allowance
- (mm) QIT – Qualifying Income Trust
- (nn) QMRP – Qualified Mental Retardation Professional
- (oo) SNF – Skilled Nursing Facility (as defined under Medicare)
- (pp) SPOE – Single Point of Entry
- (qq) SSI – Supplemental Security Income
- (rr) SSI FBR – Supplemental Security Income Federal Benefit Rate
- (ss) TCAD – Tennessee Commission on Aging and Disability
- (tt) TPL – Third Party Liability

Authority: T.C.A. 4-5-202, 4-5-208, 71-5-105, 71-5-109, Executive Order No. 11. **Administrative History:** Original rule filed September 10, 1975; effective October 10, 1975. Repealed and refiled July 13, 1977; effective August 12, 1977. Repealed and refiled November 17, 1977; effective December 19, 1977. Amendment filed August 31, 1981; effective October 15, 1981. Amendment filed June 27, 1984; effective July 27, 1984. Amendment filed February 9, 1987; effective April 9, 1987. Amendment filed May 30, 1989; effective July 14, 1989. Amendment filed November 28, 1990; effective January 12, 1991. Amendment filed February 22, 1991; effective April 9, 1991. Amendment filed September 16, 1991; effective October 31, 1991. Amendment filed September 19, 1991; effective November 3, 1991.

(Rule 1200-13-01-.01, continued)

Amendment filed January 10, 1992; effective February 24, 1992. Amendment filed May 1, 1992; effective June 15, 1992. Amendment filed October 20, 1999; effective January 3, 2000. Amendment filed June 29, 2000; effective September 12, 2000. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendment filed May 27, 2010; effective August 25, 2010.

1200-13-01-.02 DEFINITIONS.

- (1) Administrative Lead Agency (ALA). The approved agency or agencies with which the Bureau contracts for the provision of covered services through the Statewide E/D Waiver.
- (2) Adult Care Home. For purposes of CHOICES:
 - (a) A State-licensed CBRA that offers twenty-four (24) hour residential care and support in a single family residence to no more than five (5) elderly or disabled adults who meet NF level of care, but who prefer to receive care in the community in a smaller, home-like setting. The provider must either live on-site in the home, or hire a resident manager who lives on-site so that the person primarily responsible for delivering care on a day-to-day basis is living in the home with the individuals for whom he is providing care.
 - (b) Coverage shall not include the costs of Room and Board.
 - (c) Pursuant to State law, licensure is currently limited to Critical Adult Care Homes for persons who are ventilator dependent or adults with traumatic brain injury.
- (3) Adult Day Care.
 - (a) Community-based group programs of care lasting more than three (3) hours per day but less than twenty-four (24) hours per day and delivered in an Adult Day Care facility licensed by DHS.
 - (b) Services shall be provided pursuant to an individualized POC by a licensed provider not related to the participating adult.
 - (c) The provider shall be responsible for the provision of all assistance and supervision required by program participants. Such assistance is a component of the Adult Day Care benefit and shall not be billed as a separate HCBS.
- (4) Applicant. For purposes of compliance with the Linton Order, an individual who seeks admission to a NF and is not limited to those individuals who have completed an official application or have complied with the NF's preadmission requirements. The term shall include all individuals who have affirmatively expressed an intent to be considered for current or future admission to the NF or requested that their name be entered on any "wait list." Individuals who only make casual inquiry concerning the NF or its admission practices, who request information on these subjects, or who do not express any intention that they wish to be actively considered for admission shall not be considered Applicants. All individuals, whether Applicants or Non-Applicants, who contact a NF to casually inquire about the facility's services or admissions policies shall be informed by the facility of that individual's right to apply for admission and be considered for admission on a nondiscriminatory basis and in conformance with Rule 1200-13-01-.06.
- (5) Area Agencies on Aging and Disability (AAAD). Agencies designated by the Commission on Aging or its successor organization to plan for and provide services to the elderly and disabled within a defined geographic area as provided by T.C.A. Title 71, Chapter 2.

(Rule 1200-13-01-.02, continued)

- (6) Arlington MR Waiver. HCBS Waiver for persons with MR under Section 1915(c) of the Social Security Act (limited to members of the Arlington class certified in United States v. Tennessee, et al.).
- (7) Assisted Care Living Facility (ACLF) Services.
 - (a) For purposes of CHOICES:
 1. CBRA to NF care that provides and/or arranges for Personal Care, Homemaker and other supportive services or health care including medication oversight (to the extent permitted under State law), in a home-like environment to persons who need assistance with ADLs.
 2. Coverage shall not include the costs of Room and Board.
 - (b) For purposes of the Statewide E/D Waiver:
 1. Personal Care Services, Homemaker Services, and medication oversight (to the extent permitted under State law) provided in a home-like environment in a licensed ACLF.
 2. Coverage shall not include the costs of Room and Board.
- (8) Assistive Technology. Assistive devices, adaptive aids, controls or appliances that enable an Enrollee to increase his ability to perform ADLs or to perceive or control his environment. Examples include, but are not limited to, "grabbers" to pick objects off the floor, a strobe light to signify the smoke alarm has been activated, etc.
- (9) Attendant Care. For purposes of CHOICES, services to a Member who, due to age and/or physical disability, needs more extensive assistance than can be provided through intermittent Personal Care Visits (i.e., more than four (4) hours per occurrence) to provide hands-on assistance and related tasks as specified below, and that may also include safety monitoring and/or supervision.
 - (a) Attendant Care may include assistance with any of the following:
 1. ADLs such as bathing, dressing and personal hygiene, eating, toileting, transfers and ambulation.
 2. IADLs that are essential, although secondary, to the personal care tasks needed by the Member in order to continue living at home because there is no household member, relative, caregiver, or volunteer to meet the specified need, such as:
 - (i) Picking up medications or shopping for groceries.
 - (ii) Meal preparation.
 - (iii) Household tasks such as making the bed, washing soiled linens or bedclothes.
 3. Continuous safety monitoring and supervision during the period of service delivery.
 - (b) Attendant Care shall be primarily provided in the Member's place of residence, except as permitted by rule and within the scope of service (e.g., picking up medications or shopping for groceries), when accompanying the Member into the community pursuant

(Rule 1200-13-01-.02, continued)

to rule 1200-13-01-.05(7)(k), or under exceptional circumstances as authorized by an MCO in the POC to accommodate the needs of the Member.

- (c) Attendant Care shall not be provided to Members living in a CBRA facility or receiving Short-Term NF services, or while a Member is receiving Adult Day Care services.

- (d) Attendant Care does not include:

1. Care or assistance including meal preparation or household tasks for other residents of the same household;
2. Yard work; or
3. Care of non-service related pets and animals.

(10) Back-up Plan.

- (a) A written plan that is a required component of the POC for all CHOICES Members receiving Companion Care or non-residential HCBS in their own homes and that specifies unpaid persons as well as paid Consumer-Directed Workers and/or Contract Providers (as applicable) who are available, and have agreed to serve as back-up, and who will be contacted to deliver needed care in situations when regularly scheduled HCBS providers or Workers are unavailable or do not arrive as scheduled.
- (b) A CHOICES Member or his Representative may not elect, as part of the Back-up Plan, to go without services.
- (c) The Back-up Plan shall include the names and telephone numbers of persons and agencies to contact and the services to be provided by each of the listed contacts. The Member and his Representative (as applicable) shall have primary responsibility for the development and implementation of the Back-up Plan for consumer-directed services with assistance from the FEA as needed.

- (11) Bed Hold. The policy by which NFs providing Level 1 care and ICFs/MR are reimbursed for holding a resident's bed while he is away from the facility, in accordance with this Chapter.

- (12) Bureau of TennCare (Bureau). The division of F&A, the single state Medicaid agency, that administers the TennCare Program. For the purposes of this Chapter, the Bureau shall represent the State of Tennessee.

- (13) Care Coordinator. For purposes of CHOICES, a person who is employed or contracted by an MCO to perform the continuous process of care coordination:

- (a) Assessing a Member's physical, behavioral, functional, and psychosocial needs;
- (b) Identifying the physical health, behavioral health, and LTC services and other social support services and assistance (e.g., housing or income assistance) necessary to meet identified needs;
- (c) Ensuring timely access to and provision, coordination and monitoring of physical health, behavioral health, and LTC services needed to help the Member maintain or improve his physical or behavioral health status or functional abilities and maximize independence; and

(Rule 1200-13-01-.02, continued)

- (d) Facilitating access to other social support services and assistance needed in order to ensure the Member's health, safety and welfare, and as applicable, to delay or prevent the need for more expensive institutional placement.
- (14) Caregiver. For purposes of the Statewide E/D Waiver, one or more adult individuals who sign an agreement with the ALA to provide services to an Enrollee participating in the Waiver to meet the needs of the Enrollee during the hours when Waiver services are not being provided by the ALA.
- (15) Case Management. For purposes of the Statewide E/D Waiver, services that will assist individuals who receive Waiver services in gaining access to needed Waiver and other Medicaid State Plan services, as well as needed medical, social, educational, and other services, regardless of the funding source for the services.
- (16) Case Manager. For purposes of the Statewide E/D Waiver:
 - (a) The individual who is responsible for development of the POC and for ongoing monitoring of the provision of services included in the Enrollee's POC. Case Managers shall initiate and oversee the process of assessment and reassessment of the Enrollee's LOC and the review of POCs at such intervals as are specified in the Waiver rules and policies.
 - (b) A Case Manager is prohibited from providing any other services to an Enrollee for whom he serves as Case Manager under the Waiver.
- (17) Centers for Medicare and Medicaid Services (CMS). The agency within the United States Department of Health and Human Services that is responsible for administering Titles XVIII, XIX, and XXI of the Social Security Act.
- (18) Certification.
 - (a) A process by which a Physician who is licensed as a doctor of medicine or doctor of osteopathy signs and dates a PAE signifying the following:
 - 1. The person requires the requested level of institutional care or reimbursement (Level 1 NF, Level 2 NF, Enhanced Respiratory Care, or ICF/MR) or, in the case of a Section 1915(c) HCBS Waiver program, requires HCBS as an alternative to the applicable level of institutional care for which the person would qualify; and
 - 2. The requested LTC services are medically necessary for the individual.
 - (b) Physician certification is not required for CHOICES HCBS.
- (19) CHOICES. See "TennCare CHOICES in Long-Term Care."
- (20) CHOICES 217-Like Group. Individuals age sixty-five (65) and older and adults age twenty-one (21) and older with physical disabilities who meet the NF LOC criteria, who could have been eligible for HCBS under 42 C.F.R. § 435.217 had the State continued its Section 1915(c) Statewide E/D Waiver and who need and are receiving HCBS as an alternative to NF care. This group exists only in the Grand Divisions of Tennessee where CHOICES has been implemented, and participation is subject to the Enrollment Target for CHOICES Group 2.
- (21) CHOICES Group 1. Individuals of all ages who are receiving Medicaid-reimbursed care in a NF.

(Rule 1200-13-01-.02, continued)

- (22) CHOICES Group 2. Individuals age sixty-five (65) and older and adults age twenty-one (21) and older with physical disabilities who meet the NF LOC criteria and who qualify for TennCare either as SSI recipients or in an institutional category (i.e., as Members of the CHOICES 217-Like demonstration population), and who need and are receiving HCBS as an alternative to NF care. The Bureau has the discretion to apply an Enrollment Target to this group, as described in this Chapter.
- (23) CHOICES Member. An individual who has been enrolled by the Bureau into CHOICES.
- (24) Chronic Ventilator Care Reimbursement. The rate of Medicaid reimbursement provided for NF services, including enhanced respiratory care assistance, delivered by a NF that meets the requirements in Rule 1200-13-01-.03(5) to residents determined by the Bureau to meet the medical eligibility criteria in Rule 1200-13-01-.10(5)(d).
- (25) Community Personal Needs Allowance. See "Personal Needs Allowance (PNA)."
- (26) Community-Based Residential Alternatives (CBRA) to institutional care. For purposes of CHOICES:
 - (a) Residential services that offer a cost-effective, community-based alternative to NF care for individuals who are elderly and/or adults with physical disabilities.
 - (b) CBRAs include, but are not limited to:
 - 1. CBRA facilities such as ACLFs and Adult Care Homes; and
 - 2. Companion Care.
- (27) Companion Care. For purposes of CHOICES:
 - (a) A consumer-directed residential model in which a CHOICES Member may choose to select, employ, supervise and pay, using the services of an FEA, on a monthly basis, a live-in companion who will be present in the Member's home and provide frequent intermittent assistance or continuous supervision and monitoring throughout the entire period of service duration.
 - (b) Such model shall be available only for a CHOICES Member who requires and does not have available through family or other caregiving supports frequent intermittent assistance with ADLs or supervision and monitoring for extended periods of time that cannot be accomplished more cost-effectively with other non-residential services.
 - (c) A CHOICES Member who requires assistance in order to direct his Companion Care may designate a Representative to assume CD of Companion Care services on his behalf, pursuant to requirements for Representatives otherwise applicable to CD.
 - (d) Companion Care shall not be provided to Members living in a CBRA facility or receiving Short-Term NF services, or while a Member is receiving Adult Day Care services.
 - (e) Companion Care is only available through CD.
- (28) Competent Adult. For purposes of Self-Direction of Health Care Tasks in CD, a person age twenty-one (21) or older who has the capability and capacity to evaluate knowledgeably the options available and the risks attendant upon each and to make an informed decision acting in accordance with his own preferences and values. A person is presumed competent unless a decision to the contrary is made.

(Rule 1200-13-01-.02, continued)

- (29) Consumer Direction (CD) of HCBS. For purposes of CHOICES, the opportunity for a Member assessed to need specified types of HCBS limited to Attendant Care, Personal Care Visits, Homemaker Services, In-Home Respite Care, or Companion Care to elect to direct and manage (or to have a Representative direct and manage) certain aspects of the provision of such services, primarily the hiring, firing, and day-to-day supervision of Consumer-Directed Workers delivering the needed service(s).
- (30) Consumer-Directed Worker (Worker).
 - (a) An individual who has been hired by a CHOICES Member participating in CD of HCBS or his Representative to provide one or more Eligible HCBS to the Member.
 - (b) Does not include an employee of an agency that is being paid by an MCO to provide HCBS to the Member.
- (31) Continuity of Care Period. For purposes of CHOICES:
 - (a) The period of time immediately following implementation of CHOICES in a Grand Division during which a Member shall continue to receive the same LTC services, as specified in the POC in place prior to CHOICES implementation, from the same LTC providers, regardless of whether such providers have elected to participate in the MCO's network.
 - (b) Such period shall be at least thirty (30) days following implementation, but in the case of CHOICES Group 2 Members, shall continue for up to ninety (90) days or until a comprehensive needs assessment has been performed and a new POC has been developed.
- (32) Contract Provider. A provider who is under contract with an Enrollee's MCO. Also called "Network Provider" or "In-Network provider."
- (33) Cost-Effective Alternative (CEA) Service.
 - (a) A service that is not a covered service but that is approved by TennCare and CMS and provided at an MCO's discretion. There is no entitlement to receive these services.
 - (b) CEA services may be provided because they are:
 - 1. Alternatives to covered Medicaid services that, in the MCO's judgment, are cost-effective; or
 - 2. Preventive in nature and offered to avoid the development of conditions that, in the MCO's judgment, would require more costly treatment in the future.
 - (c) CEA services need not be determined medically necessary except to the extent that they are provided as an alternative to covered Medicaid services. Even if medically necessary, CEA services are not covered services and are provided only at an MCO's discretion.
 - (d) For purposes of CHOICES, CEA services may include the provision of HCBS as an alternative to NF care when the Enrollment Target for CHOICES Group 2 has been reached as described in Rule 1200-13-01-.05.
- (34) Cost Neutrality Cap. For purposes of CHOICES, the average cost of the level of NF reimbursement that would be paid if the Member were institutionalized. The Cost Neutrality Cap functions as a limit on the total cost of HCBS that, when combined with the cost of HH

(Rule 1200-13-01-.02, continued)

Services and PDN Services the person will receive, can be provided to the individual in the home or community setting. The Cost Neutrality Cap shall be individually applied.

- (35) Dental Benefits Manager (DBM). See “Dental Benefits Manager” in Rule 1200-13-13-.01.
- (36) Designated Correspondent. A person or agency authorized by an individual on the PAE form to receive correspondence related to NF or ICF/MR services on his behalf.
- (37) Disenrollment. The voluntary or involuntary termination of an individual's enrollment in a LTC Program.
- (38) Division of Intellectual Disabilities Services (DIDS). The division of F&A that serves as the OAA for day-to-day operations of the HCBS Waivers for persons with MR. Formerly the Division of Mental Retardation Services.
- (39) Electronic Visit Verification (EVV) system. An electronic system that caregivers use to check-in at the beginning and check-out at the end of each period of service delivery. The system is used to monitor Member receipt of HCBS and also to generate claims for submission by the provider.
- (40) Eligible HCBS. For purposes of CD, services that may be consumer-directed are limited to Attendant Care, Personal Care Visits, Homemaker Services, In-Home Respite Care, or Companion Care.
- (41) Employer of Record. The Member participating in CD of HCBS or a Representative designated by the Member to assume the CD of HCBS functions on the Member's behalf.
- (42) Enhanced Respiratory Care Reimbursement. Specified levels of Medicaid reimbursement (i.e., Chronic Ventilator Care, Tracheal Suctioning and Ventilator Weaning) provided for NF services, including enhanced respiratory care assistance, or ventilator weaning services and care during the post-weaning period, delivered by a NF that meets the requirements set forth in Rule 1200-13-01-.03(5) to persons determined by the Bureau or an MCO, as applicable, to meet specified medical eligibility criteria for such level of Medicaid reimbursement.
- (43) Enrollee. A Medicaid-eligible individual who is enrolled in a TennCare LTC Program.
- (44) Enrollment Target.
 - (a) The maximum number of individuals who can be enrolled in CHOICES Group 2 at any given time, subject to the exceptions provided in this Chapter.
 - (b) The Enrollment Target is not calculated on the basis of “unduplicated participants.” Vacated slots in CHOICES Group 2 may be refilled immediately, rather than being held until the next program year, as is required in the HCBS Waiver programs.
- (45) Expiration Date.
 - (a) A date assigned by the Bureau at the time of approval of a PAE after which TennCare reimbursement will not be made unless a new PAE is submitted and approved, or 365 days after the PAE Approval Date when the PAE has not been used.
 - (b) A PAE is “used” when the individual has begun receiving LTC services based on the LOC approved in the PAE.
 - (c) A PAE is “expired” when the individual has not begun receiving LTC services on or before the 365th day.

(Rule 1200-13-01-.02, continued)

- (d) The first claim for reimbursement may be submitted after the 365th day, so long as the first date of service is on or before the 365th day.
- (46) Federal Estate Recovery Program (FERP). A federal program set forth under Section 1917(b) of the Social Security Act that requires states offering Medicaid-reimbursed LTC services to seek adjustment or recovery for certain types of medical assistance from the estates of individuals who were age fifty-five (55) or older at the time such assistance was received, and from permanently institutionalized individuals of any age. For both mandatory populations, the State may elect to recover up to the total cost of all medical assistance provided.
 - (a) For persons age fifty-five (55) and older, the State is obligated to seek adjustment or recovery for NF (including ICF/MR) services, HCBS, and related hospital and prescription drug services.
 - (b) For permanently institutionalized persons, states are obligated to seek adjustment or recovery for the institutional services.
- (47) Fee-for-Service (FFS) System. An arrangement whereby the Bureau, rather than the MCO, is responsible for arranging for covered LTC services and paying claims for these services.
- (48) Fiscal Employer Agent (FEA). An entity contracting with the Bureau and/or an MCO that helps CHOICES Members participating in CD of HCBS. The FEA provides both financial administration and supports brokerage functions for CHOICES Members participating in CD of HCBS. This term is used by the IRS to designate an entity operating under Section 3504 of the IRS code, Revenue Procedure 70-6, and Notice 2003-70 as the agent to Members for the purpose of filing certain federal tax forms and paying federal income tax withholding, FICA, and FUTA taxes. The FEA also files state income tax withholding and unemployment insurance tax forms and pays the associated taxes and processes payroll based on the eligible HCBS authorized and provided.
- (49) Grand Divisions. See “Grand Divisions” in Rule 1200-13-13-.01.
- (50) Health Care Tasks. For CHOICES Members participating in CD, those medical, nursing, or HH Services, beyond ADLs, that:
 - (a) A person without a functional disability or a caregiver would customarily perform without the assistance of a licensed health care provider;
 - (b) The person is unable to perform for himself due to a functional or cognitive limitation;
 - (c) The treating physician, advanced practice nurse, or registered nurse determines can safely be performed in the home and community by an unlicensed Consumer-Directed Worker under the direction of a Competent Adult or caregiver; and
 - (d) Enable the person to maintain independence, personal hygiene, and safety in his own home.
- (51) Home (of an Enrollee). For purposes of the Statewide E/D Waiver, the residence or dwelling in which the Enrollee resides in Tennessee, excluding hospitals, NFs, ICFs/MR, ACLFs, Homes for the Aged (Residential Homes for the Aged), and other CBRAs.
- (52) Home and Community Based Services (HCBS). Services not covered by Tennessee’s Title XIX State Plan that are provided pursuant to a written POC as an alternative to LTC institutional services in a NF or an ICF/MR to individuals for whom there has been a

(Rule 1200-13-01-.02, continued)

determination that, but for the provision of such services, the individuals would require the LOC provided in the institution to which the HCBS offer an alternative. HCBS does not include HH or PDN Services.

(53) Home and Community Based Services (HCBS) Waiver. A Waiver approved by CMS under the Section 1915(c) authority.

(54) Home-Delivered Meals.

(a) Nutritionally well-balanced meals, other than those provided under Title III C-2 of the Older Americans Act, that provide at least one-third but no more than two-thirds of the current daily Recommended Dietary Allowance (as estimated by the Food and Nutrition Board of Sciences – National Research Council) and that will be served in the Enrollee's home. Special diets shall be provided in accordance with the individual POC when ordered by the Enrollee's physician.

(b) Home-Delivered Meals shall not be provided to Members living in a CBRA facility or receiving Short-Term NF services.

(55) Home Health (HH) Services. See "Home Health Services" in Rule 1200-13-13-.01.

(56) Homemaker Services.

(a) For purposes of CHOICES:

1. General household activities and chores such as sweeping, mopping, and dusting in areas of the home used by the Member, changing the Member's linens, making the Member's bed, washing the Member's dishes, doing the Member's personal laundry, ironing or mending, meal preparation and/or educating caregivers about preparation of nutritious meals for the Member, assistance with maintenance of a safe environment, and errands such as grocery shopping and having the Member's prescriptions filled;
2. Provided only for the Member (and not for other household members) and only when the Member is unable to perform such activities and there is no other caregiver or household member available to perform such activities for the Member; and
3. Shall not be provided to Members living in a CBRA facility or receiving Short-Term NF services.

(b) For purposes of the Statewide E/D Waiver:

1. General household activities and chores such as sweeping, mopping, dusting, changing linens, making beds, washing dishes, doing personal laundry, ironing, mending, meal preparation and/or education about preparation of nutritious appetizing meals, assistance with maintenance of safe environment and errands such as grocery shopping and having prescriptions filled;
2. Provided when the Enrollee is unable to perform such activities and the individual regularly responsible for these activities is unable to perform such activities for the Enrollee; and
3. Shall not be provided to Enrollees living in a CBRA facility or receiving Short-Term NF services.

(Rule 1200-13-01-.02, continued)

- (57) ICF/MR Eligible. An individual determined by DHS to qualify for Medicaid ICF/MR services and determined by the Bureau to meet the ICF/MR LOC.
- (58) ICF/MR PAE Approval Date. The beginning date of LOC eligibility for Medicaid-reimbursed care in an ICF/MR for which the ICF/MR PAE has been approved by the Bureau.
- (59) ICF/MR PAE Form. The assessment form used by the Bureau to document the current medical and habilitative needs of an individual with MR and to document that the individual meets the Medicaid LOC eligibility criteria for care in an ICF/MR.
- (60) Identification Screen (Level I). See “PreAdmission Screening/Resident Review.”
- (61) Immediate Eligibility.
 - (a) A mechanism by which the Bureau may elect, based on a preliminary determination of an individual's eligibility for the CHOICES 217-Like Group, to enroll the individual into CHOICES Group 2 and provide immediate access to a limited package of HCBS pending a final determination of eligibility.
 - (b) To qualify an individual must:
 - 1. Be applying to receive covered HCBS;
 - 2. Be determined by the Bureau to meet NF LOC;
 - 3. Have submitted an application for financial eligibility determination to DHS;
 - 4. Be expected to qualify in the CHOICES 217-Like Group based on review of the financial information provided by the applicant; and
 - 5. Meet all other specified criteria for enrollment into CHOICES Group 2, subject to categorical and financial eligibility determination.
 - (c) Immediate Eligibility shall only be for Specified HCBS (no other covered services) and for a maximum of forty-five (45) days.
 - (d) Immediate Eligibility is not available for individuals who are already enrolled in TennCare.
- (62) Immediate Family Member:

For purposes of employment as a consumer directed Worker in CHOICES:

A spouse, parent, grandparent, child, grandchild, sibling, mother-in-law, father-in-law, sister-in-law, brother-in-law, daughter-in-law, and son-in-law. Adopted and step members are included in this definition.
- (63) Individual Cost Neutrality Cap. See “Cost Neutrality Cap.”
- (64) Individual Plan of Care (POC). For purposes of the Statewide E/D Waiver, an individualized written POC that serves as the fundamental tool by which the Bureau ensures the health and welfare of Enrollees and that meets the requirements of this Chapter.
- (65) In-Home Respite Care. For purposes of CHOICES:

(Rule 1200-13-01-.02, continued)

- (a) Services provided to Members unable to care for themselves, furnished on a short-term basis in the Member's place of residence, because of the absence or need for relief of those family members or other unpaid caregivers normally providing the care; and
 - (b) Shall not be provided to Members living in a CBRA facility or receiving Short-Term NF services.
- (66) Inpatient Respite Care. For purposes of CHOICES:
 - (a) Services provided to individuals unable to care for themselves, furnished on a short-term basis in a licensed NF or licensed CBRA facility, because of the absence or need for relief of those family members or other unpaid caregivers normally providing the care.
 - (b) Shall not be provided to Members living in a CBRA facility or receiving Short-Term NF services.
- (67) Inpatient Nursing Care. Nursing services that are available twenty-four (24) hours per day by or under the supervision of a licensed practical nurse or registered nurse and which, in accordance with general medical practice, are usually and customarily provided on an inpatient basis in a NF. Inpatient Nursing Care includes, but is not limited to, routine nursing services such as observation and assessment of the individual's medical condition, administration of legend drugs, and supervision of nurse aides; and other skilled nursing therapies or services that are performed by a licensed practical nurse or registered nurse.
- (68) Institutional Personal Needs Allowance. See "Personal Needs Allowance (PNA)."
- (69) Intermediate Care Facility for Persons with Mental Retardation (or pursuant to federal law, Intermediate Care Facility for the Mentally Retarded) (ICF/MR). A licensed facility approved for Medicaid reimbursement that provides specialized services for individuals with MR or related conditions and that complies with current federal standards and certification requirements set forth in 42 C.F.R., Part 483.
- (70) Involuntary Transfer or Discharge. Any transfer or discharge that is opposed by the resident or a Representative of the resident of a NF or ICF/MR. For purposes of compliance with the requirements of this Chapter, a discharge or transfer is involuntary when the NF initiates the action to transfer or discharge.
- (71) Legally Appointed Representative. Any person appointed by a court of competent jurisdiction or authorized by legal process (e.g., power of attorney for health care treatment, declaration for mental health treatment) to determine the legal and/or health care interests of an individual and/or his estate.
- (72) Level of Care (LOC). Medical eligibility criteria for receipt of an institutional service. An individual who meets the LOC criteria for NF care is an individual who has been determined by the Bureau to meet the medical eligibility criteria established for that service.
- (73) Level 1 Nursing Facility (NF) Care Reimbursement. The level of Medicaid reimbursement provided for NF services delivered to residents eligible for Medicaid-reimbursement of NF services determined by the Bureau to meet the medical eligibility criteria set forth in Rule 1200-13-01-.10(4) by a NF that meets the requirements set forth in Rule 1200-13-01-.03(3), and in accordance with the reimbursement methodology for Level 1 NF Care set forth in Rule 1200-13-01-.03(6).
- (74) Level 2 Nursing Facility (NF) Care Reimbursement. The level of Medicaid reimbursement provided for NF services delivered to residents eligible for Medicaid-reimbursement of NF

(Rule 1200-13-01-.02, continued)

services determined by the Bureau to meet the medical eligibility criteria set forth in Rule 1200-13-01-.10(5) by a NF that meets the requirements set forth in Rule 1200-13-01-.03(4), and in accordance with the reimbursement methodology for Level 2 NF Care set forth in Rule 1200-13-01-.03(7).

- (75) Linton. The lawsuit known as Linton v. Tennessee Commissioner of Health and Environment resulting in a series of Orders issued by the United States District Court and the Sixth Circuit Court of Appeals regarding LTC.
- (76) Long-Term Care (LTC) Enrollee or Participant. An individual who is participating in a TennCare LTC Program.
- (77) Long-Term Care (LTC) Ombudsman. An individual with expertise and experience in the fields of LTC and advocacy, who assists in the identification, investigation, and resolution of complaints that are made by, or on behalf of, NF residents, and persons residing in CBRA settings, including ACLFs and Adult Care Homes. The Tennessee LTC Ombudsmen Program is administered by the TCAD.
- (78) Long-Term Care (LTC) Program. One of the programs offering LTC services to individuals enrolled in TennCare. LTC Programs include institutional programs (NFs and ICFs/MR), as well as HCBS offered either through CHOICES or through a Section 1915(c) HCBS Waiver Program.
- (79) Managed Care Organization (MCO). See “Managed Care Organization” in Rule 1200-13-13-.01.
- (80) Managed Care System. A system under which the MCOs are responsible for arranging for services and paying claims for delivery of these services to members enrolled in their plans.
- (81) Medicaid Eligible. For purposes of this Chapter, an individual who has been determined by DHS to be financially eligible to have Medicaid reimbursement for covered LTC services.
- (82) Medicare Savings Program. The mechanisms by which low-income Medicare beneficiaries can get assistance from Medicaid in paying for their Medicare premiums, deductibles, and/or coinsurance. These programs include the Qualified Medicare Beneficiary (QMB) program, the Specified Low Income Medicare Beneficiary (SLMB) program, and the Qualified Individual (QI) program.
- (83) Member. See “CHOICES Member.”
- (84) Mental Illness (MI). For the purposes of compliance with federal PASRR regulations, an individual who meets the following requirements on diagnosis, level of impairment and duration of illness:
 - (a) The individual has a major mental disorder diagnosable under the Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition, which is a schizophrenic, mood, paranoid, panic or other severe anxiety disorder; somatoform disorder; personality disorder; other psychotic disorder; or another mental disorder that may lead to a chronic disability; but is not a primary diagnosis of dementia, including Alzheimer’s disease or a related disorder, or a non-primary diagnosis of dementia unless the primary diagnosis is a major mental disorder;
 - (b) The level of impairment must result in functional limitations in major life activities within the past three (3) to six (6) months that would be appropriate for the individual’s developmental stage; or

(Rule 1200-13-01-.02, continued)

- (c) The treatment history of the individual has at least one of the following: a psychiatric treatment more intensive than outpatient care more than once in the past two (2) years, or within the last two (2) years, due to a mental disorder, the individual has experienced an episode of significant disruption to the normal living situation, for which supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials.
- (85) Mental Retardation (MR) and Related Conditions. For the purposes of compliance with federal PASRR regulations, an individual is considered to have MR if he has a level of retardation (mild, moderate, severe and profound) as described in the American Association on Mental Deficiency's Manual on Classification in Mental Retardation (1983).
- (a) MR refers to significantly subaverage general intellectual functioning, indicated by an IQ test score of 70 or below, existing concurrently with deficits in adaptive behavior and manifested during the developmental period (i.e., prior to age eighteen).
 - (b) The provisions of this Paragraph also apply to persons with "related conditions", as defined by 42 C.F.R. § 435.1010, which states: "Persons with related conditions" means individuals who have a severe, chronic disability that meets all of the following conditions:
 - 1. It is attributable to:
 - (i) Cerebral palsy or epilepsy, or
 - (ii) Any other condition, other than MI, found to be closely related to MR because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with MR, and requires treatment or services similar to those required for these persons.
 - 2. It is manifested before the person reaches age twenty-two (22).
 - 3. It is likely to continue indefinitely.
 - 4. It results in substantial functional limitations in three or more of the following areas of major life activity:
 - (i) Self-care;
 - (ii) Understanding and use of language;
 - (iii) Learning;
 - (iv) Mobility;
 - (v) Self-direction; and
 - (vi) Capacity for independent living.
- (86) Minor Home Modifications.
- (a) For purposes of CHOICES:
 - 1. Included are the following:

(Rule 1200-13-01-.02, continued)

- (i) The provision and installation of certain home mobility aids, including but not limited to:
 - (I) Wheelchair ramps and modifications directly related to and specifically required for the construction or installation of the ramps;
 - (II) Hand rails for interior or exterior stairs or steps; or
 - (III) Grab bars and other devices.
 - (ii) Minor physical adaptations to the interior of a Member's place of residence that are necessary to ensure his health, welfare and safety, or which increase his mobility and accessibility within the residence, including but not limited to:
 - (I) Widening of doorways; or
 - (II) Modification of bathroom facilities.
 - 2. Excluded are the following:
 - (i) Installation of stairway lifts or elevators;
 - (ii) Adaptations that are considered to be general maintenance of the residence;
 - (iii) Adaptations that are considered improvements to the residence;
 - (iv) Adaptations that are of general utility and not of direct medical or remedial benefit to the individual, including but not limited to:
 - (I) Installation, repair, replacement or roof, ceiling, walls, or carpet or other flooring;
 - (II) Installation, repair, or replacement of heating or cooling units or systems;
 - (III) Installation or purchase of air or water purifiers or humidifiers;
 - (IV) Installation or repair of driveways, sidewalks, fences, decks, and patios; and
 - (v) Adaptations that add to the total square footage of the home are excluded from this benefit.
 - 3. All services shall be provided in accordance with applicable State or local building codes.
 - 4. Minor Home Modifications shall not be provided to Members living in a CBRA facility or receiving Short-Term NF services, except as provided in Rule 1200-13-01-.05 to facilitate transition to the community.
- (b) For purposes of the Statewide E/D Waiver:
- 1. Included are the following:

(Rule 1200-13-01-.02, continued)

- (i) The provision and installation of certain home mobility aids, including but not limited to:
 - (I) Ramps;
 - (II) Rails;
 - (III) Non-skid surfacing;
 - (IV) Grab bars;
 - (ii) Other devices and minor home modifications that facilitate mobility; and
 - (iii) Modifications to the home environment to enhance safety.
2. Excluded are those adaptations or improvements to the home that are of general utility and that are not of direct medical or remedial benefit to the individual, including but not limited to:
- (i) Carpeting;
 - (ii) Roof repair; or
 - (iii) Central air conditioning.
3. Adaptations that add to the total square footage of the home are excluded from this benefit.
4. All services shall be provided in accordance with applicable State or local building codes.

(87) Natural Supports. For purposes of CHOICES:

- (a) Unpaid support and assistance critical to ensuring the health, safety, welfare and quality of life of a Member residing in the community delivered by family members, friends, neighbors, and other entities including clubs, churches and community organizations.
- (b) May be supplemented, but not supplanted by paid HCBS in order to help sustain the Natural Supports over time, and to help ensure the delivery of cost-effective community-based care.

(88) Network Provider. See "Contract Provider."

(89) Non-Contract Provider. A provider who does not have a contract with an Enrollee's MCO. Also called "Out-of-Network Provider."

(90) Notice. When used in rules and regulations pertaining to NFs, information that must be provided by the facility to "residents" or "applicants," and shall also include notification to the person identified in a PAE application as the resident's or applicant's designated representative and any other individual who is authorized by law to act on the resident's or applicant's behalf or who is in fact acting on the resident's or applicant's behalf in dealing with the NF.

(91) Notice of Disposition or Change. A notice issued by DHS of an individual's financial eligibility for Medicaid, including the effective date for which a person may qualify for Medicaid-

(Rule 1200-13-01-.02, continued)

reimbursement of LTC services, subject to level of care and other applicable eligibility/enrollment criteria as defined in this Chapter.

- (92) Nursing Facility (NF). A Medicaid-certified NF approved by the Bureau.
- (93) Nursing Facility (NF) Eligible. An individual determined by DHS to qualify for Medicaid-reimbursement of NF services and determined by the Bureau to meet NF level of care.
- (94) Out-of-Network Provider. See "Non-Contract Provider."
- (95) PAE Approval Date. The beginning date of LOC eligibility for Medicaid-reimbursed care in a NF for which the PAE has been approved by the Bureau and which cannot precede completion of the PASRR process.
- (96) Patient Liability. The amount determined by DHS that a Medicaid Eligible is required to pay for covered services provided by a NF, an ICF/MR, an HCBS waiver program, or CHOICES.
- (97) Personal Care Assistance/Attendant Services. For purposes of the Statewide E/D Waiver:
 - (a) Intermittent provision of direct assistance with activities such as toileting, bathing, dressing, personal hygiene, eating, meal preparation (excluding the cost of food), budget management, attending appointments, and interpersonal and social skill building to enable the Enrollee to live in a community setting.
 - (b) Personal Care Assistance/Attendant Services shall not be provided to Enrollees living in a CBRA facility or receiving Short-Term NF services, or while an Enrollee is receiving Adult Day Care services.
- (98) Personal Care Services. For purposes of the Statewide E/D Waiver:
 - (a) Services provided to assist the Enrollee with ADLs and related essential household tasks (e.g., making the bed, washing soiled linens or bedclothes that require immediate attention), and other activities that enable the Enrollee to remain in the home, as an alternative to NF care, including the following:
 - 1. Assistance with ADLs (e.g., bathing, grooming, personal hygiene, toileting, feeding, dressing, ambulation);
 - 2. Assistance with cleaning that is an integral part of personal care and is essential to the health and welfare of the Enrollee; and/or
 - 3. Assistance with maintenance of a safe environment.
 - (b) Personal Care Services shall be primarily provided in the Enrollee's place of residence, except under exceptional circumstances as authorized in the POC to accommodate the needs of the Enrollee.
 - (c) Personal Care Services shall not be provided to Enrollees living in a CBRA facility or receiving Short-Term NF services, or while an Enrollee is receiving Adult Day Care services.
- (99) Personal Care Visits. For purposes of CHOICES:
 - (a) Visits to a Member who, due to age and/or physical disability, needs assistance that can be provided through intermittent visits of limited duration not to exceed four (4)

(Rule 1200-13-01-.02, continued)

hours per visit and two (2) visits per day to provide hands-on assistance and related tasks as specified below.

(b) Personal Care Visits may include assistance with the following:

1. ADLs such as bathing, dressing and personal hygiene, eating, toileting, transfers and ambulation.
2. IADLs that are essential, although secondary, to the personal care tasks needed by the Enrollee in order to continue living at home because there is no household member, relative, caregiver, or volunteer to meet the specified need, such as:
 - (i) Picking up medications or shopping for groceries.
 - (ii) Meal preparation.
 - (iii) Household tasks such as making the bed, washing soiled linens or bedclothes.

(c) Personal Care Visits shall be primarily provided in the Member's place of residence, except as permitted within the scope of service (e.g., picking up medications or shopping for groceries), when accompanying the Member into the community pursuant to rule 1200-13-01-.05(7)(k), or under exceptional circumstances as authorized by an MCO in the POC to accommodate the needs of the Member.

(d) Personal Care Visits shall not be provided to Members living in a CBRA facility or receiving Short-Term NF services, or while a Member is receiving Adult Day Care services.

(e) Personal care visits do not include:

1. Companion or sitter services, including safety monitoring and supervision.
2. Care or assistance including meal preparation or household tasks for other residents of the same household.
3. Yard work.
4. Care of non-service related pets and animals.

(100) Personal Emergency Response System (PERS).

(a) For purposes of CHOICES:

1. An electronic device that enables certain Members at high risk of institutionalization to summon help in an emergency. The Member may also wear a portable "help" button to allow for mobility. The system is programmed to signal a response center once the "help" button is activated. The response center is staffed by trained professionals who assess the nature of the emergency, and obtain assistance for the individual, as needed. PERS services are limited to those Members who have demonstrated mental and physical capacity to utilize such system effectively and who live alone or who are alone with no caregiver for extended periods of time, such that the Member's safety would be compromised without access to a PERS.

(Rule 1200-13-01-.02, continued)

2. PERS shall not be provided to Members living in a CBRA facility or receiving Short-Term NF services.

(b) For purposes of the Statewide E/D Waiver:

1. An electronic device that enables certain Enrollees at high risk of institutionalization to summon help in an emergency. The Enrollee may also wear a portable "help" button to allow for mobility. The system is connected to the Enrollee's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. PERS services are limited to those Enrollees who are alone for significant parts of the day, who have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.
2. PERS shall not be provided to Enrollees living in a CBRA facility or receiving Short-Term NF services.

(101) Personal Needs Allowance (PNA). A reasonable amount of money that is deducted by DHS from the individual's funds pursuant to federal and State law and the Medicaid State Plan in the application of post-eligibility provisions and the calculation of Patient Liability for LTC services. The PNA is set aside for clothing and other personal needs of the individual while in the institution (Institutional PNA), and to also pay room, board and other living expenses in the community (Community PNA).

(102) Pest Control.

- (a) The use of sprays, poisons and traps, as appropriate, in the Enrollee's residence (excluding NFs or ACLFs) to regulate or eliminate the intrusion of cockroaches, wasps, mice, rats and other species of pests into the household environment thereby removing an environmental issue that could be detrimental to a frail elderly or disabled Enrollee's health and physical well-being.
- (b) Pest Control shall not be provided to Enrollees living in a CBRA facility or receiving Short-Term NF services.
- (c) A treatment visit for Pest Control is a visit by the Pest Control provider to the Enrollee's residence during which the Pest Control treatment is applied.

(103) Pharmacy Benefits Manager (PBM). See "Pharmacy Benefits Manager" in Rule 1200-13-13-.01.

(104) Physical Disabilities.

- (a) One or more medically diagnosed chronic, physical impairments, either congenital or acquired, that limit independent, purposeful physical movement of the body or of one or more extremities, as evidenced by substantial functional limitations in one or more ADLs that require such movement—primarily mobility or transfer—and that are primarily attributable to the physical impairments and not to cognitive impairments or mental health conditions.
- (b) An individual with cognitive impairments or mental health conditions who also has one or more physical disabilities as defined above may qualify as "Physically Disabled," and may be enrolled into the Statewide E/D Waiver or CHOICES Group 2 (as applicable) so long as such individual can be safely served in the community and at a cost that does not exceed the individual's Cost Neutrality Cap. This includes consideration of whether or not the Statewide E/D Waiver or CHOICES Group 2 benefit package (as

(Rule 1200-13-01-.02, continued)

applicable) can adequately address any specialized service needs the applicant may have pertaining to the cognitive impairment or mental health condition, as applicable.

- (105) Physically Disabled. For purposes of enrollment into CHOICES Group 2 or the Statewide E/D Waiver, an adult aged twenty-one (21) or older who has one or more physical disabilities.
- (106) Physician. A doctor of medicine or osteopathy who has received a degree from an accredited medical school and who is licensed to practice his profession in Tennessee.
- (107) Physician's Plan of Care (POC). For purposes of the Statewide E/D Waiver, an individualized written POC developed by the Enrollee's Physician and included on the PAE and reviewed as needed or at least every ninety (90) days.
- (108) Plain Language. Any notice or explanation written at a level that does not exceed the sixth grade reading level as measured by the Flesch Index, Fog Index, or Flesch-Kincaid Index.
- (109) PreAdmission Evaluation (PAE). A process of assessment by the Bureau used to determine an individual's medical (or LOC) eligibility for Medicaid-reimbursed care in a NF or ICF/MR, and in the case of NF services, the appropriate level of reimbursement for such care. For purposes of CHOICES, the PAE application shall be used for the purposes of determining LOC and for calculating the Individual Cost Neutrality Cap.
- (110) PreAdmission Screening/Resident Review (PASRR). The process by which the State determines whether an individual who resides in or seeks admission to a Medicaid-certified NF has, or is suspected of having, MI or MR, and, if so, whether the individual requires specialized services and is appropriate for NF placement.
 - (a) Identification Screen (Level I). The initial screening conducted to determine which NF Applicants or residents have MI or MR and are subject to PASRR. Individuals with a supportable primary diagnosis of Alzheimer's disease or dementia will also be detected through the Identification Screen. NFs are responsible for ensuring that all Applicants receive a Level I identification screen prior to admission to the facility, and for submission of the Level I Identification Screen to the Bureau.
 - (b) PASRR Evaluation (Level II). The process whereby a determination is made about whether the individual identified in the Level I screen requires the level of services provided by a NF or another type of facility and, if so, whether the individual requires specialized services. These reviews shall be the responsibility of the DMHDD and/or DIDS, as applicable.
- (111) Private Duty Nursing (PDN) Services. See "Private Duty Nursing Services" in Rule 1200-13-13-.01.
- (112) Program of All-inclusive Care for the Elderly (PACE). A program for dually eligible Enrollees in need of LTC services that is authorized under the Medicaid State Plan, Attachment 3.1-A, #26.
- (113) Provider. See "Provider" in Rule 1200-13-13-.01. Provider does not include Consumer-Directed Workers (see Consumer-Directed Worker); nor does Provider include the FEA (see Fiscal Employer Agent).
- (114) Qualifying Income Trust (QIT). See "Qualified Income Trust" in DHS Rules Chapter 1240-03-03.

(Rule 1200-13-01-.02, continued)

(115) Recertification. For purposes of the Statewide E/D Waiver, the process approved by the Bureau by which the Enrollee's Physician assesses the medical necessity of continuation of Waiver services and certifies in writing that the Enrollee continues to require Waiver services.

(116) Related Conditions. See "Mental Retardation (MR) and Related Conditions."

(117) Representative.

(a) In general, for CHOICES Members, a Representative is an individual who is at least eighteen (18) years of age and is authorized by the Member to participate in care planning and implementation and to speak and make decisions on the Member's behalf, including but not limited to identification of needs, preference regarding services and service delivery settings, and communication and resolution of complaints and concerns.

(b) As it relates to CD of HCBS, a Representative is an individual who is authorized by the Member to direct and manage the Member's Worker(s), and signs a Representative Agreement. The Representative for CD of HCBS must also:

1. Be at least eighteen (18) years of age;
2. Have a personal relationship with the Member and understand his support needs;
3. Know the Member's daily schedule and routine, medical and functional status, medication regimen, likes and dislikes, and strengths and weaknesses; and
4. Be physically present in the Member's residence on a regular basis or at least at a frequency necessary to supervise and evaluate workers.

(118) Representative Agreement. The agreement between a CHOICES Member electing CD of HCBS who has a Representative direct and manage the Member's Worker(s) and the Member's Representative that specifies the roles and responsibilities of the Member and the Member's Representative.

(119) Reserve Capacity. The State's right to maintain some capacity within an established Enrollment Target to enroll individuals into HCBS under certain circumstances. These circumstances could include, but are not limited to:

- (a) Accommodation of a phased in implementation of CHOICES;
- (b) Discharge from a NF;
- (c) Discharge from an acute care setting where institutional placement is otherwise imminent; or
- (d) Other circumstances which the State may establish from time to time in accord with this Chapter.

(120) Respite Care. For purposes of the Statewide E/D Waiver, Respite Care services:

- (a) Are provided to Enrollees unable to care for themselves.
- (b) Are furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.

(Rule 1200-13-01-.02, continued)

- (c) May be provided Inpatient or in-home.
- (d) Shall not be provided to Enrollees living in a CBRA facility or receiving Short-Term NF services.

(121) Risk Agreement.

- (a) An agreement signed by a Member who will receive HCBS (or his Representative) that includes, at a minimum:
 - 1. Identified risks to the Member of residing in the community and receiving HCBS;
 - 2. The consequences of such risks, strategies to mitigate the identified risks; and
 - 3. The Member's decision regarding his acceptance of risk.
- (b) For Members electing to participate in CD, the Risk Agreement must include any additional risks associated with the Member's decision to act as the Employer of Record, or to have a Representative act as the Employer of Record on his behalf.

(122) Room and Board. Lodging, meals, and utilities that are the responsibility of the individual receiving HCBS in a CBRA facility. The kinds of items that are considered "Room and Board" and are therefore not reimbursable by Medicaid include:

- (a) Rent, or, if the individual owns his home, mortgage payments, depreciation, or mortgage interest;
- (b) Property taxes;
- (c) Insurance (title, mortgage, property and casualty);
- (d) Building and/or grounds maintenance costs;
- (e) Resident "raw" food costs including individual special dietary needs (the cost of preparing, serving, and cleaning up after meals is not included);
- (f) Household supplies necessary for the room and board of the individual;
- (g) Furnishings used by the resident;
- (h) Utilities (electricity, water and sewer, gas);
- (i) Resident telephone; or
- (j) Resident cable or pay television.

(123) Safety Plan. For purposes of the Statewide E/D Waiver, an individualized plan by which the ALA ensures the health, safety, and welfare of Enrollees who do not have twenty-four (24) hour caregiver services and which meets the requirements of this Chapter.

(124) Self-Determination MR Waiver. Tennessee's Self Determination Waiver under Section 1915(c) of the Social Security Act.

(125) Self-Direction of Health Care Tasks.

(Rule 1200-13-01-.02, continued)

- (a) The decision by a CHOICES Member participating in CD to direct and supervise a paid Worker delivering Eligible HCBS in the performance of Health Care Tasks that would otherwise be performed by a licensed nurse.
 - (b) The Self-Direction of Health Care Tasks is not a service, but rather health care-related duties and functions (such as administration of medications) that a CHOICES Member participating in CD may elect to have performed by a Consumer-Directed Worker as part of the delivery of Eligible HCBS he is authorized to receive.
- (126) Service Agreement. The agreement between a CHOICES Member electing CD of HCBS (or the Member's Representative) and the Member's Consumer-Directed Worker that specifies the roles and responsibilities of the Member (or the Member's Representative) and the Worker.
- (127) Short-Term Nursing Facility (NF) Care. For purposes of CHOICES:
- (a) The provision of NF care for up to ninety (90) days to a CHOICES Group 2 Member who was receiving HCBS upon admission and who requires temporary placement in a NF— for example, due to the need for skilled or rehabilitative services upon hospital discharge or due to the temporary illness or absence of a primary caregiver —when such Member is reasonably expected to be discharged and to resume HCBS participation within no more than ninety (90) days.
 - (b) Such CHOICES Group 2 Member must meet the NF LOC upon admission and in such case, while receiving Short-Term NF Care may continue enrollment in Group 2, pending discharge from the NF within no more than ninety (90) days or until such time it is determined that discharge within ninety (90) days from admission is not likely to occur, at which time the Member shall be transitioned to CHOICES Group 1, as appropriate.
 - (c) The Community PNA shall continue to apply during the provision of Short-Term NF care, up to the ninetieth (90th) day, in order to allow sufficient resources for the Member to maintain his community residence for transition back to the community.
 - (d) The PASRR process is required for CHOICES Group 2 Members entering Short-Term NF Care.
 - (e) Persons receiving Short-Term NF Care are not eligible to receive any other HCBS, except as permitted in 1200-13-01-.05 to facilitate transition to the community.
- (128) Single Point of Entry (SPOE). The agency charged with screening, intake, and facilitated enrollment processes for non-Medicaid eligible individuals seeking enrollment into CHOICES.
- (129) Skilled Nursing Service. A Physician-ordered nursing service the complexity of which is such that it can only be safely and effectively provided directly by a registered nurse or licensed practical nurse.
- (130) Skilled Rehabilitative Service. A Physician-ordered rehabilitative service the complexity of which is such that it can only be safely and effectively provided by qualified health care personnel (e.g., registered physical therapist, licensed physical therapist assistant, registered occupational therapist, certified occupational therapy assistance, licensed respiratory therapist, licensed respiratory therapist assistant).
- (131) Specialized Services for Individuals with MI.

(Rule 1200-13-01-.02, continued)

- (a) The implementation of an individualized POC developed under and supervised by a Physician, provided by a Physician and other qualified mental health professionals that accomplishes the following;
 - 1. Prescribes specific therapies and activities for the treatment of individuals who are experiencing an acute episode of severe MI, which necessitates continuous supervision by trained mental health personnel; and
 - 2. Is directed toward diagnosing and reducing the individual's behavioral symptoms that necessitated institutionalization, improving his level of independent functioning, and achieving a functioning level that permits reduction in the intensity of mental health services to below the level of specialized services at the earliest possible convenience.
- (b) Services to maintain generally independent individuals who are able to function with little supervision or in the absence of a continuous specialized services program are not included in this definition.

(132) Specialized Services for Individuals with MR and Related Conditions.

- (a) The implementation of an individualized POC specifying a continuous program for each individual, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services that is directed towards the acquisition of the behaviors necessary for the individual to function with as much self-determination and independence as possible; and the prevention or deceleration of regression or loss of current optimal functional status.
- (b) Services to maintain generally independent individuals who are able to function with little supervision or in the absence of a continuous specialized services program are not included.

(133) Specified HCBS. The HCBS that are available to persons who qualify for and are granted Immediate Eligibility by the Bureau. Specified HCBS are limited to Adult Day Care, Attendant Care, Home-Delivered Meals, Homemaker Services, Personal Care Visits, and PERS.

(134) Statewide E/D Waiver. The Section 1915(c) HCBS Waiver project approved for Tennessee by CMS to provide services to a specified number of Medicaid-eligible adults who reside in Tennessee, who are aged or have physical disabilities, and who meet the medical eligibility (or LOC) criteria for reimbursement of Level 1 NF services.

(135) Statewide MR Waiver. Tennessee's HCBS Waiver for the Mentally Retarded and Developmentally Disabled under Section 1915(c) of the Social Security Act.

(136) Subcontractor. For purposes of the Statewide E/D Waiver, an individual, organized partnership, professional corporation, or other legal association or entity that enters into a written contract with the ALA to provide Waiver services to an Enrollee.

(137) Supports Broker. For purposes of CD:

- (a) An individual assigned by the FEA to each Member who assists the Member/Representative in performing the Employer of Record functions, including, but not limited to: developing job descriptions; locating, recruiting, interviewing, scheduling, monitoring, and evaluating Workers.
- (b) The Supports Broker collaborates with, but does not duplicate, the functions of the Member's Care Coordinator.

(Rule 1200-13-01-.02, continued)

- (c) The Supports Broker does not have authority or responsibility for CD. The Member or Member's Representative must retain authority and responsibility for CD.
- (138) TennCare. The program administered by the Single State Agency as designated by the State and CMS pursuant to Title XIX of the Social Security Act and the Section 1115 Research and Demonstration Waiver granted to the State of Tennessee.
- (139) TennCare CHOICES in Long-Term Care Program (CHOICES). The program in which NF services for TennCare eligibles of any age and HCBS for individuals aged sixty-five (65) and older and/or adults aged twenty-one (21) and older with physical disabilities are integrated into TennCare's Managed Care System.
- (140) Third Party Liability (TPL). See "Third Party Liability" in Rule 1200-13-13-.01.
- (141) Tracheal Suctioning Reimbursement. The rate of Medicaid reimbursement provided for NF services, including enhanced respiratory care assistance, delivered by a NF that meets the requirements set forth in Rule 1200-13-01-.03(5), to residents determined by the Bureau to meet the medical eligibility criteria set forth in Rule 1200-13-01-.10(5)(e) or determined by an MCO to require short-term intensive respiratory intervention during the post-weaning period.
- (142) Transfer Form. For purposes of the ICF/MR program, a form approved by the Bureau which is used in lieu of a new PAE to document the transfer of an ICF/MR eligible individual having an approved unexpired ICF/MR PAE from one ICF/MR to another ICF/MR, from an HCBS MR Waiver Program to an ICF/MR, from an ICF/MR to an HCBS MR Waiver Program, or from one HCBS MR Waiver Program to another HCBS MR Waiver Program.
- (143) Transfer Form. For purposes of the NF program and Statewide E/D Waiver prior to implementation of CHOICES, a form which is used in lieu of a new PAE to document the transfer of a NF eligible individual having an approved unexpired PAE from Level 1 in one NF to Level 1 in another such facility or to the HCBS E/D Waiver, from Level 2 in one NF to Level 2 in another such facility, or from the HCBS E/D Waiver to Level 1 in a NF.
- (144) Transition Allowance. For purposes of CHOICES,
 - (a) A per Member allotment not to exceed two thousand dollars (\$2,000) per lifetime which may, at the sole discretion of an MCO, be provided as a CEA to continued institutional care for a CHOICES Member in order to facilitate transition from a NF to the community when such Member will, upon transition, receive more cost-effective non-residential HCBS or Companion Care.
 - (b) Items which may be purchased or reimbursed are only those items the Member has no other means to obtain and which are essential in order to establish a community residence when such residence is not already established and to facilitate the person's safe and timely transition, including rent and/or utility deposits, essential kitchen appliances, basic furniture, and essential basic household items, such as towels, linens, and dishes.
 - (c) Transition Allowance cannot be provided to CHOICES Members transitioning to a CBRA facility.
- (145) Ventilator Weaning Reimbursement. The rate of Medicaid reimbursement provided for ventilator weaning services delivered by a NF that meets the requirements set forth in Rule 1200-13-01-.03(5) to residents determined by an MCO to require such services based on medical necessity criteria.

(Rule 1200-13-01-.02, continued)

- (146) Wait List. The list maintained by NFs of all individuals who have affirmatively expressed an intent to be considered for current or future admission to the NF or requested that their name be entered on any "wait list."
- (147) Waiting List. For purposes of CHOICES, the list maintained by the Bureau of individuals who have applied for CHOICES Group 2 but who cannot be served because an Enrollment Target has been reached.
- (148) Waiver Eligible. For purposes of the Statewide E/D Waiver, a resident of Tennessee determined by the Bureau to meet the criteria specified in Rule 1200-13-01-.17(5), and determined by DHS to qualify for Medicaid upon enrollment into a Section 1915(c) HCBS Waiver and receipt of HCBS. A Waiver Eligible is not necessarily enrolled into the Waiver.
- (149) Worker. See "Consumer-Directed Worker."

Authority: T.C.A. §§4-5-202, 4-5-208, 14-23-105, 14-23-109, 71-5-105, 71-5-109, and Executive Order No. 23. **Administrative History:** Original rule filed November 17, 1977; effective December 19, 1977. Amendment filed December 31, 1979; effective February 14, 1980. Amendment filed May 26, 1983; effective June 27, 1983. Amendment filed September 16, 1987; effective October 31, 1987. Amendment filed November 10, 1988; effective December 25, 1988. Public necessity rule filed January 30, 2006; effective through July 14, 2006. Public necessity rule filed January 30, 2006, expired on July 14, 2006. On July 15, 2006, rule reverted to status in effect on January 29, 2006. Amendment filed May 3, 2006; effective July 17, 2006. Amendment filed January 30, 2007; effective April 15, 2007. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendment filed May 27, 2010; effective August 25, 2010.

1200-13-01-.03 NURSING FACILITY (NF) PROVIDER REIMBURSEMENT.

- (1) Definitions. See Rule 1200-13-01-.02.
- (2) Level 1, Level 2, and Enhanced Respiratory Care NF Reimbursement.
 - (a) Reimbursement for NF services provided to a Medicaid Eligible enrolled in the TennCare Program shall be categorized according to the needs of the individual and the level of skilled and/or rehabilitative services required as specified in Rule 1200-13-01-.10.
 - (b) Level 2 or Enhanced Respiratory Care NF reimbursement shall be provided only for beds that are certified for both Medicaid and Medicare for the provision of SNF (Level 2) care.
- (3) Conditions for Reimbursement of Level 1 NF Care.
 - (a) A Level 1 NF must enter into a provider agreement with the Bureau or, upon implementation of CHOICES in the Grand Division, one or more TennCare MCOs, for reimbursement of Level 1 NF services.
 - (b) A Level 1 NF must be certified by the Tennessee Department of Health, showing that it has met the standards set out in 42 C.F.R., Part 442.
 - (c) NFs reimbursed for Level 1 NF services participating in TennCare shall be terminated as a TennCare provider if certification or licensure is canceled by CMS or the State.
 - (d) If the resident has resources to apply toward payment, including Patient Liability as determined by DHS, or TPL, which may include LTC insurance benefits, the payment

(Rule 1200-13-01-.03, continued)

for NF services shall be the NF's per diem rate for the applicable level of NF reimbursement authorized minus the resident's available resources.

- (e) Payments for residents requiring reimbursement for Level 1 NF Services shall not exceed per diem costs or charges, whichever is less.
 - (f) Regardless of the reimbursement rate established for a Level 1 NF, no Level 1 NF may charge TennCare Enrollees an amount greater than the amount per day charge to private paying patients for equivalent accommodations and services.
 - (g) Personal laundry services in a Level 1 NF shall be considered a covered service and included in the per diem rate. TennCare Enrollees may not be charged for personal laundry services.
- (4) Conditions for Reimbursement of Level 2 NF Care.
- (a) A Level 2 NF must enter into a provider agreement with the Bureau, or, upon implementation of CHOICES in the Grand Division, one or more TennCare MCOs, for reimbursement of Level 2 NF services.
 - (b) Level 2 NFs (Medicare SNFs and TennCare NFs receiving reimbursement for Level 2 NF care) must be certified by Medicare, showing they have met the federal certification standards. Any of these NFs participating in TennCare shall be terminated as a TennCare provider if certification or licensure is canceled by CMS or the State.
 - (c) If the resident has available resources to apply toward payment, including Patient Liability as determined by DHS, or TPL, which may include LTC insurance benefits, the payment for NF services shall be the NF's per diem rate for the applicable level of NF reimbursement authorized minus the resident's available resources.
 - (d) If the Level 2 NF (upon submission of a cost report and a desk review or examination of its cost), has collected on a per diem basis during the period covered by the cost report and examination, more than cost reimbursement allowed, the Level 2 NF shall be required to reimburse the State for that portion of the reimbursement collected in excess of the actual recorded and examined cost.
 - (e) Regardless of the reimbursement rate established for a Level 2 NF, no Level 2 NF may charge TennCare Enrollees an amount greater than the amount per day charged to private paying patients for equivalent accommodations and services.
- (5) Conditions for Reimbursement of Enhanced Respiratory Care.
- (a) The Level 2 NF must enter into a provider agreement with one or more TennCare MCOs for the provision and reimbursement of ventilator weaning, chronic ventilator services and/or tracheal suctioning in a Level 2 certified and licensed NF.
 - (b) NFs (Medicare SNFs and TennCare NFs providing enhanced respiratory care services in a Level 2 NF) must be certified by Medicare, showing they have met the federal certification standards. Any of these NFs participating in the TennCare Program shall be terminated by all TennCare MCOs as a TennCare provider if certification or licensure is canceled by CMS or the State.
 - (c) NFs providing ventilator weaning or chronic ventilator services and NFs receiving short-term reimbursement at the Tracheal Suctioning Rate for a person who has just been weaned from the ventilator, but who still requires short-term intensive respiratory intervention, shall also meet or exceed the following minimum standards:

(Rule 1200-13-01-.03, continued)

1. A licensed respiratory care practitioner as defined by T.C.A. § 63-27-102(7), shall be on site twenty four (24) hours per day, seven (7) days per week to provide:
 - (i) Ventilator care;
 - (ii) Administration of medical gases;
 - (iii) Administration of aerosol medications; and
 - (iv) Diagnostic testing and monitoring of life support systems.
2. The NF shall ensure that an appropriate individualized POC is prepared for each resident requiring ventilator services. The POC shall be developed with input and participation from a pulmonologist or a physician with experience in ventilator care.
3. The NF shall establish admissions criteria to ensure the medical stability of ventilator-dependent residents prior to transfer from an acute care setting.
4. Arterial Blood Gas (ABG) shall be readily available in order to document the resident's acid base status and/or End Tidal Carbon Dioxide (etCO₂) and continuous pulse oximetry measurements should be performed in lieu of ABG studies.
5. An audible, redundant external alarm system shall be located outside of each ventilator-dependent resident's room for the purpose of alerting caregivers of resident disconnection, ventilator disconnection or ventilator failure.
6. Ventilator equipment shall be connected to electrical outlets connected to back-up generator power.
7. Ventilators shall be equipped with battery back-up systems.
8. The NF shall be equipped to employ the use of current ventilator technology consistent with meeting residents' needs for mobility and comfort.
9. A (one) back-up ventilator shall be available at all times in the facility.
- (d) Except as provided in (c) above, the standards set forth in (c) are not applicable for Tracheal Suctioning Reimbursement; however, the NF must ensure the availability of necessary equipment, supplies, and appropriately trained and licensed nurses or licensed respiratory therapists to perform the specified tasks.
- (e) If the resident has available resources to apply toward payment, including Patient Liability as determined by DHS, or TPL, which may include LTC insurance benefits, the payment made by the Bureau is the per diem rate established by the Bureau minus the resident's available resources.
- (6) Reimbursement methodology for Level 1 Care.
 - (a) A Level 1 NF shall be reimbursed on the lowest of the following:
 1. Allowable cost;
 2. Allowable charges;

(Rule 1200-13-01-.03, continued)

3. An amount representing the sixty-fifth (65th) percentile of all such NFs or beds, whichever is lower, participating in the Level 1 Medicaid NF Program. In determining the sixty-fifth (65th) percentile for purposes of this part, each provider's most recently filed and reviewed cost report shall be inflated from the mid-point of the provider's cost reporting period to the mid-point of the State's payment period. The trending factor shall be computed for NFs that have submitted cost reports covering at least six (6) months of program operations. For NFs that have submitted cost reports covering at least three (3) full years of program participation, the trending factor shall be the average cost increase over the three (3) year period, limited to the seventy-fifth (75th) percentile trending factor of NFs participating for at least three (3) years. Negative averages shall be considered zero (0). For NFs that have not completed three (3) full years in the program, the one (1) year trending factor shall be the fiftieth (50th) percentile trending factor of NFs participating in the program for at least three (3) years. For NFs that have failed to file timely cost reports, the trending factor shall be zero (0);
4. An amount representing the reimbursable cost of the sixty-fifth (65th) percentile of NFs or beds, whichever is lower, participating in the NF Level 1 Program. In determining the sixty-fifth (65th) percentile ceiling for purposes of this part, operating costs from each provider's most recently filed and reviewed cost report will be inflated from the mid-point of the provider's cost reporting period to the mid-point of the state's payment period. The inflation factor shall be as described in Part 3. above. Capital-related costs are not subject to indexing. Capital-related costs are property, depreciation, and amortization expenses included in Section F.18 and F.19 of the NF Cost Report Form. All other costs, including home office costs and management fees, are operating costs. No inflation factor will be allowed for providers not filing timely cost reports. For providers in the program less than three (3) years, the inflation factor shall be the fiftieth (50th) percentile of allowable inflation factors for providers participating in the program for at least three (3) years. Budgeted cost reports receive no inflation allowance; or
5. For State Fiscal Year 1997-98, the budgeted amount for Level 1 and Level 2 care of \$672,040,000. For State Fiscal Year 1998-99, the budgeted amount for Level 1 and Level 2 care of \$705,642,000. For State Fiscal Year 1999-2000 and subsequent years, a proportional share of expenditures not to exceed the amount budgeted by the State for NF reimbursement. Expenditures shall be monitored throughout each year to determine if rate adjustments are necessary to assure that each LOC is within the budgeted amount.
6. To assure the proper application of Part 5. above, the Comptroller's Office shall be authorized to adjust per-diem rates up or down as necessary during the year.
7. The annual NF tax shall be passed through as an allowable cost, but shall be excluded for purposes of computing the inflation allowance and cost-containment incentive. The NF tax shall not be subject to the sixty-fifth (65th) percentile limits but is subject to the limit specified in Rule 1200-13-01-.03(6)(a)5.
8. If the resident has no available resources to apply toward payment, the Medicaid payment is the lower of per-diem cost, charges, or the sixty-fifth (65th) percentile of all such NFs or beds participating in the Medicaid Program, whichever is less. Cost is determined on a facility-by-facility basis.

(Rule 1200-13-01-.03, continued)

9. The cost report closing date for determination of the Level 1 sixty-fifth (65th) percentile shall be the first working day of the month preceding the month in which the recomputed sixty-fifth (65th) percentile is effective. All clean cost reports received by the Comptroller's Office on or before the closing date shall be included in the determination of the sixty-fifth (65th) percentile ceiling. A clean cost report is one upon which rates may be set without additional communication from the provider. Home office cost reports must be filed before any individual NF cost reports included in a chain can be processed.
 - (b) Costs for supplies and other items billed, including any NF staff required to deliver the service, which are billed to Medicare Part B on behalf of all patients must be included as a reduction to reimbursable expenses in Section G of the NF cost report.
 - (c) Once a per-diem rate is determined from a clean cost report, the rate will not be changed until the next ceiling redetermination except for audit adjustments, correction of errors, or termination of a budgeted rate, or as necessary to comply with Rule 1200-13-01-.03(6)(a)5.
- (7) Reimbursement Methodology for Level 2 Care.
- (a) A Level 2 NF shall be reimbursed on the lowest of the following:
 1. Allowable costs;
 2. Allowable charges;
 3. An amount representing the reimbursable cost of the sixty-fifth (65th) percentile of all such NFs or beds, whichever is lower, participating in the Level 2 Medicaid NF Program. In determining the sixty-fifth (65th) percentile for purposes of this part, each provider's most recently filed and reviewed cost report shall be inflated from the mid-point of the provider's cost reporting period to the mid-point of the Bureau's payment period. The trending factor shall be computed for NFs that have submitted cost reports covering at least six (6) months of program operations. For NFs that have submitted cost reports covering at least three (3) full years of program participation, the trending factor shall be the average cost increase over the three (3) year period, limited to the seventy-fifth (75th) percentile trending factor of NFs participating for at least three (3) years. Negative averages shall be considered zero (0). For NFs that have not completed three (3) full years in the program, the one (1) year trending factor shall be the fiftieth (50th) percentile trending factor of NFs participating in the program for at least three (3) years. For NFs that have failed to file timely cost reports, the trending factor shall be zero (0);
 4. A prospective amount representing the reimbursable cost of the sixty-fifth (65th) percentile of NFs or beds, whichever is lower, participating in the NF Level 2 Program. In determining the sixty-fifth (65th) percentile ceiling for purposes of this part, operating costs from each provider's most recently filed and reviewed cost report will be inflated from the midpoint of the provider's cost reporting period to the mid-point of the Bureau's payment period. The inflation factor shall be as described in Part 3. above. Capital-related costs are not subject to indexing. Operating and capital-related costs are as specified on Worksheet B of the Medicare SNF cost report form. Budgeted cost reports receive no inflation allowance; or
 5. For State Fiscal Year 1997-98, the budgeted amount for Level 1 and Level 2 care of \$672,040,000. For State Fiscal Year 1998-99, the budgeted amount for Level

(Rule 1200-13-01-.03, continued)

- 1 and Level 2 care of \$705,642,000. For State Fiscal Year 1999-2000 and subsequent years, a proportional share of expenditures not to exceed the amount budgeted by the State for NF reimbursement. Expenditures shall be monitored throughout each year to determine if rate adjustments are necessary to assure that each LOC is within the budgeted amount.
6. To assure the proper application of Part 5. above, the Comptroller's Office shall be authorized to adjust per-diem rates up or down as necessary during the year.
 7. The cost report closing date for determination of the Level 2 sixty-fifth (65th) percentile shall be the first working day of the month preceding the month in which the recomputed sixty-fifth (65th) percentile is effective. All clean cost reports received by the Comptroller's Office on or before the closing date shall be included in the determination of the sixty-fifth (65th) percentile. A clean cost report is one upon which rates may be set without additional communication from the provider. Home office cost reports must be filed before any individual NF cost reports included in a chain can be processed.
 8. The annual NF tax shall be passed through as an allowable cost, but shall be excluded for purposes of computing the inflation allowance and cost-containment incentive. The NF tax shall not be subject to the sixty-fifth (65th) percentile limits but is subject to the limit specified in Rule 1200-13-01-.03(7)(a)5.
 9. Once a per-diem rate is determined from a clean cost report, the rate shall not be changed until the next ceiling redetermination except for audit adjustments, correction of errors, or termination of a budgeted rate, or as necessary to comply with Rule 1200-13-01-.03(7)(a)5.
 10. If the resident has no available resources to apply toward payment, the Medicaid payment is the lower of per-diem cost, charges, or the sixty-fifth (65th) percentile of beds or NFs, whichever is lower, participating in the Medicaid Program. Cost is determined on a facility by facility basis.
- (b) Medicare Part B charges, including any facility staff required to deliver the service, are non-allowable in calculating Medicaid Level 2 NF reimbursement.
- (8) Reimbursement for enhanced respiratory care services in a Medicare-certified and licensed Level 2 SNF shall be made only by TennCare MCOs in accordance with this Chapter and rates established by the Bureau.
 - (9) Bed holds. A Level 1 NF shall be reimbursed for a resident's bed in the NF during the resident's temporary absence from the NF as follows:
 - (a) Reimbursement shall be made for up to a total of ten (10) days per State fiscal year while the resident is hospitalized or absent from the NF on therapeutic leave. The following conditions must be met in order for a bed hold reimbursement to be made:
 1. The resident intends to return to the NF.
 2. For hospital leave days:
 - (i) Each period of hospitalization is physician ordered and so documented in the resident's medical record in the NF; and
 - (ii) The hospital provides a discharge plan for the resident.

(Rule 1200-13-01-.03, continued)

3. Therapeutic leave days, when the resident is absent from the NF on a therapeutic home visit or other therapeutic absence, are provided pursuant to a physician's order.
 4. At least eighty-five percent (85%) of all other beds in the NF are occupied at the time of the hospital admission or therapeutic absence. An occupied bed is one that is actually being used by a resident. Beds being held for other residents while they are hospitalized or otherwise absent from the facility are not considered to be occupied beds for purposes of this calculation. Computations of occupancy percentages will be rounded to the nearest percentage point.
- (b) NFs shall not be reimbursed for holding a bed for a person receiving Level 2 NF or Enhanced Respiratory Care reimbursement during his temporary absence from the NF.
- (10) Other Reimbursement Issues.
- (a) No change of ownership or controlling interest of an existing Medicaid provider, including NFs, can occur until monies as may be owed to the Bureau or its contractors are provided for. The purchaser shall notify the Bureau of the purchase at the time of ownership change and is financially liable for the outstanding liabilities to the Bureau or its contractors for one (1) year from the date of purchase or for one (1) year following the Bureau's receipt of the provider's Medicare final notice of program reimbursement, whichever is later. The purchaser shall be entitled to use any means available to it by law to secure and recoup these funds from the selling entity. In addition, purchasers of NFs are responsible for obtaining an accurate accounting and transfer of funds held in trust for Medicaid residents at the time of the change of ownership or controlling interest.
 - (b) If the Bureau or an MCO has not reimbursed a business for TennCare services provided under the TennCare Program at the time the business is sold, when such an amount is determined, the Bureau or the MCO shall be required to reimburse the person owning the business provided such sale included the sale of such assets.
 - (c) When a provider was originally paid within a retrospective payment system that is subject to regular adjustments and the provider disputes the proposed adjustment action, the provider must file with the State not later than thirty (30) days after receipt of the notice informing the provider of the proposed adjustment action, a request for hearing. The provider's right to a hearing shall be deemed waived if a hearing is not requested within thirty (30) days after receipt of the notice.

Authority: T.C.A. §§4-5-202, 4-5-205, 4-5-208, 71-5-105, 71-5-109, Executive Order No. 23, and Public Chapter 358 of the Acts of 1993. **Administrative History:** Original rule filed November 17, 1977; effective December 19, 1977. Amendment filed January 31, 1979; effective March 16, 1979. Amendment filed August 31, 1981; effective October 15, 1981. Amendment filed November 4, 1981; effective December 21, 1981. Amendment filed September 27, 1982; effective October 27, 1982. Amendment filed February 11, 1983; effective March 14, 1983. Amendment filed May 27, 1983; effective June 27, 1983. Amendment filed June 23, 1983; effective July 25, 1983. Amendment filed February 14, 1984; effective March 15, 1984. Amendment filed March 12, 1984; effective April 11, 1984. Amendment filed June 27, 1984; effective July 27, 1984. Amendment filed June 25, 1984; effective September 11, 1984. Amendment filed September 10, 1985; effective October 10, 1985. Amendment filed November 4, 1985; effective December 4, 1985. Amendment filed November 4, 1985; effective February 12, 1986. Amendment filed April 29, 1986; effective May 29, 1986. Original rule filed July 30, 1987; effective September 13, 1987. Amendment filed September 30, 1987; effective November 14, 1987. Amendment filed January 22, 1988; effective March 7, 1988. Amendment filed September 30, 1988; effective November 14, 1988. Amendment filed October 27, 1988; effective December 11, 1988. Amendment filed November 10, 1988; effective December 25, 1988. Amendment filed December 15, 1988; effective

(Rule 1200-13-01-.03, continued)

January 29, 1989. Amendment filed May 30, 1989; effective July 14, 1989. Amendment filed July 22, 1989; effective August 4, 1989. Amendment filed August 31, 1989; effective October 15, 1989. Amendment filed November 27, 1989; effective January 11, 1990. Amendment filed January 29, 1990; effective March 15, 1990. Amendment filed March 1, 1990; effective April 15, 1990. Amendment filed November 5, 1990; effective December 20, 1990. Amendment filed January 17, 1991; effective March 3, 1991. Amendment filed January 31, 1991; effective March 17, 1991. Amendment filed February 12, 1991; effective March 29, 1991. Amendment filed February 21, 1991; effective April 7, 1991. Amendment filed February 27, 1991; effective April 13, 1991. Amendment filed June 12, 1991; effective July 27, 1991. Amendment filed September 11, 1991; effective October 26, 1991. Amendment filed September 17, 1991; effective November 1, 1991. Amendment filed October 25, 1991; effective December 9, 1991. Amendment filed November 27, 1991; effective January 11, 1992. Amendment filed March 9, 1992; effective April 23, 1992. Amendment filed March 10, 1992; effective April 24, 1992. Amendment filed March 17, 1992; effective May 1, 1992. Amendment filed April 14, 1992; effective May 29, 1992. Amendment filed April 30, 1992; effective June 14, 1992. Amendment filed May 1, 1992; effective June 15, 1992. Amendment filed December 4, 1992; effective January 19, 1993. Amendment filed November 17, 1993; effective January 31, 1994. Amendment filed December 7, 1993; effective February 20, 1994. Amendment filed March 18, 1994; effective June 1, 1994. Public necessity rule filed July 1, 2005; effective through December 13, 2005. Public necessity rule filed September 26, 2005; effective through March 10, 2006. Amendment filed December 20, 2005; effective March 5, 2006. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendment filed May 27, 2010; effective August 25, 2010.

1200-13-01-.04 THIRD PARTY RESOURCES.

(1) Definitions

- (a) Third party resources shall mean any individual, entity or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished to a Tennessee Medicaid recipient.

Recipient resources acquired through medical malpractice or victim compensation actions or from indemnity insurance, which compensates for loss of work or loss of limb, shall not be considered a third party resource. An indemnity insurance policy which compensates for specific medical services such as inpatient hospital confinement, is a third party resource.

- (b) Third party payment shall mean compensation provided to a Medical provider or to Medicaid by any third party resource which eliminates or reduces Medicaid's indebtedness for medical assistance furnished to a Tennessee Medicaid recipient.
- (c) Direct billing shall mean the process used by Medicaid to collect/recover payments for covered services from any third party resource available to a Medicaid recipient.
- (d) Recipient assignment of rights shall mean that a recipient or responsible party shall assign rights to Medicaid for medical support or other third party payments. The recipient and/or responsible party shall cooperate with Medicaid and providers in obtaining Medical support or payments.
- (e) Third party documentation shall mean:
 1. an insurance company's explanation of benefits (EOB) related to the specific claim, or
 2. a statement on the provider's letterhead indicating contact with the insurance company and the reason for denial. The statement must be signed and dated by an authorized employee of the provider and include the insurance company

(Rule 1200-13-01-.04, continued)

name, policy and group number, the date of contact, the date of service, the recipient name and Medicaid identification number.

- (2) Claims for Medicaid covered services provided to Medicaid eligibles shall not be made against Medicaid until Medicare and other probable third party resources to the recipient have been collected, unless prohibited by federal law except where third party resources are provided by other state agencies under contract with this Department which designated the agency as payor after Medicaid.
 - (a) Medicaid may be bill following formal notification from the third party resources that the services provided are not covered or payable or when third party payment has been received. AD claims submitted shall indicate the third party payment amount received, if third party resources are found to be nonexistent, copies of letter(s) or other supporting documentation shall be attached to the claim.
 1. If third party payment is less than the Medicaid allowable, Medicaid will pay the difference between the third party payment and the Medicaid allowable. No further claim shall be allowed against the recipient and/or the recipient's responsible party(s) for Medicaid services, or
 2. If third party payment is equal to or exceeds the Medicaid allowable no further claim shall be allowed against Medicaid or the Medicaid recipient and/or that recipient's responsible party(s) for Medicaid covered services.
- (3) Providers receiving third party payments following Medicaid payment shall notify and refund Medicaid within 60 days of receipt of the third party payment. The refund to Medicaid shall be the lessor of the third party or Medicaid payment. The provider shall submit a check to Medicaid, or may request Medicaid to setoff the refund amount from the provider's current claim. A Medicaid - Title XIX Adjustment Void Request from identifying the recipient's name and Medicaid number, date(s) of service, remittance advice I number and the name and address of the third party resource, shall be submitted with a check or request for setoff to assure the proper credit is provided and recipient accounts.
- (4) Providers having received third party payments which should have been reported and refundable in whole or in part to Medicaid as specified in parts (2) and (3), which were held more than 60 days and not refunded, and/or which are found in an audit/review shall be subject to any resulting federal monetary assessment against the State Medicaid program.
- (5) Medicaid shall perform audits of provider records to identify third party resources unreported and/or unrefunded to Medicaid as specified in part (3). Provider(s) to be audited shall be selected based upon the potential of the provider and/or provider category (hospitals, physicians, etc.) to receive third party resources.
- (6) Direct Billing
 - (a) Medicaid shall utilize direct billing when it is determined that a previously paid service(s) may have been covered by a third party. Additionally, notwithstanding Section (2). direct billing for some services may be more cost effective than requiring the provider to collect prior to billing Medicaid. These services shall be, but are not limited to, pharmacy claims.
 - (b) Medicaid shall identify to the third party resource, the recipient name and address, the third party group and/or policy number (if appropriate), the name of the responsible party/policyholder, the name of the provider of service, the description of the service that was provided, the date(s) of the service, the amount billed Medicaid by the provider of service, and the amount paid by Medicaid to the provider of service.

(Rule 1200-13-01-.04, continued)

- (c) The third party resources shall submit payment to Medicaid and/or notify Medicaid in writing of no-coverage data such as the date the policy started and lapsed, services that are non-covered, and the identity of any other party having been paid by the third party resource for any of the identified service(s).
 - (d) Medicaid shall notify the Tennessee Department of Human Services in the event an absent parent, court ordered to provided for medical expenses, cannot be located and/or refuses to make full restitution to Medicaid.
- (7) Reserved.
- (8) Provider Billing Requirements
 - (a) Providers shall bill Medicaid for all covered services rendered under the plan and report third party collections.
 - (b) Unless otherwise allocated on the payor's explanation of benefits (EOB), third party payment reported to Medicaid shall be prorated equally over the institutional days or professional services billed.
 - (c) Medicaid will not make payment if the provider is aware of a third party resource prior to rendering service and is denied payment from the third party resource because of provider non-compliance with policy/contract provisions.
- (9) Paid claims, for which a third party resource is later identified, may be voided by Medicaid if the date of service is within one year of the resource identification. The third party resource will be identified to the provider on the remittance advice which identities the voided claim.
- (10) Provider Discrimination

A provider who furnished services and is participating under the plan may not refuse to furnish services to a recipient because of a third party potential liability for payment for the service.
- (11) Assignment of Benefits
 - (a) A recipient assigns rights to Medicaid when the recipient uses a Medicaid card to receive medical assistance.
 - (b) Any document released by a provider to a Medicaid recipient concerning the provision of a covered service shall have "Benefits Assigned" printed boldly on the statement. If a provider refunds third party payments to a recipient the provider is subject to recovery from Medicaid up to the Medicaid paid amount. If a third party pays the recipient directly Medicaid shall recover from the recipient.
 - (c) A provider shall immediately notify Medicaid of a request for medical records from a Medicaid recipient and/or agent or attorney. If proper authorization is received from the recipient the records may be released with the statement "Benefits Assigned." The notification to Medicaid must include:
 - 1. name and Medicaid number of the recipient,
 - 2. dates of service in question.
 - 3. provider name and provider number,

(Rule 1200-13-01-.04, continued)

4. attorney name, address and telephone number, and/or
5. insurance company name, address and telephone number.

(12) Recipient Shall Cooperate with Provider

If the provider documents at least two attempts to obtain recipient cooperation in meeting third party resource policy/plan requirements they may contact the Medicaid TPL Unit for assistance. The provider may bill Medicaid after 180 days with copies of the documentation attached to the claim. Medicaid shall pay the provider and attempt recovery from the recipient and/or third party resource.

(13) Absent Parents

- (a) An absent parent obligated by court order to provide continuing health insurance, medical support or a combination of insurance and support shall:

1. be billed by Medicaid for reimbursement of costs incurred for his/her child, and
2. reimburse Medicaid promptly or provide adequate health insurance coverage information to Medicaid.

Medicaid may bill the insurance carrier directly and request provider assistance in the recovery. Medicaid will enter into a written cooperative agreement for the enforcement of rights to, and collection of, such third party benefits as provided in 42 CFR Section 433.151, as amended.

- (b) An absent parent obligated by court order to pay for paternity expenses only shall be billed for costs incurred for the delivery of his/her child. Failure by the absent parent to reimburse Medicaid will initiate the recovery process in Section (13)(a).

(14) Subrogation Notice

Medicaid shall notify any third party or attorney of the state's claim of subrogation, when either is suspected of representing a Medicaid recipient who has received benefits. If an unauthorized settlement is distributed to the recipient and/or a responsible party after the receipt of the subrogation notice, the person responsible for the distribution shall be financially liable to the State for Medicaid's payments.

(15) Third Party Documentation/Explanation of Benefits

- (a) A provider shall maintain third party documentation/explanation of benefits until audited but no longer than three (3) years from date of service, unless other record requirements apply.
- (b) A provider shall attach explicit documentation of a third party resource denial to the Medicaid claim, except in the case of UB-82 and tape billing. This documentation must provide sufficient information for Medicaid to justify payment. The information will also be used by Medicaid to update its third party resource files as appropriate.
- (c) If a third party resource denial is based on services in excess of an annual limitation, the documentation shall only be valid on claims for the applicable year. Documentation shall be appropriate to the claim submitted or the claim will be denied.

(16) Third party is established and available on the date of service.

(Rule 1200-13-01-.04, continued)

If provider learns of a third party resource after billing Medicaid the provider shall immediately bill the third party. If third party payment is received the provider shall adjust the previous Medicaid payment using the Medicaid Adjustment/Void Request Form. The insurance company name and policy number should be entered on the form. If no third party payment is received the explanation of benefits should be kept on file by the provider.

- (17) Third party is not established or available on the date of service (example: automobile accident - party possibly at fault with liability coverage which may pay recipient medical claims.)
 - (a) A provider may elect to bill the anticipated liable third party for a covered Medicaid service, or
 - (b) If the provider elects to bill Medicaid, Medicaid will recover from the third party.
 - (c) The provider may not include charges for covered services billed to Medicaid in an independent claim to the potentially liable third party.
 - (d) The provider may void a claim previously paid by Medicaid at any time in an attempt to recover a larger payment from a potentially liable third party.
 - (e) Medicaid may not be billed for a covered service under the plan following the expiration of Medicaid's timely filing limits.
- (18) A provider may keep the total third party payment even if it exceeds the Medicaid allowable amount.
- (19) Medical assistance benefits shall be coordinated with third party resources and reimbursement shall not be made for services which would have been reimbursable by the third party except for failure to adhere to the third party's requirements.

Authority: T.C.A. §§4-5-202, 14-23-105 and 14-23-109. **Administrative History:** Original rule filed November 17, 1977; effective December 19, 1977. Amendment filed January 31, 1979; effective March 16, 1979. Amendments filed May 29, 1987; effective July 13, 1987. Amendment filed June 22, 1989; effective August 4, 1989. Amendment filed August 31, 1989; effective October 15, 1989.

1200-13-01-.05 TENNCARE CHOICES PROGRAM.

- (1) Definitions. See Rule 1200-13-01-.02.
- (2) Program components. The TennCare CHOICES Program is a managed LTC program that is administered by the TennCare MCOs under contract with the Bureau. The MCOs are responsible for coordinating all covered physical, behavioral, and LTC services for their members who qualify for and are enrolled in CHOICES. The program consists of two components:
 - (a) NF services, as described in this Chapter.
 - (b) HCBS, as described in this Chapter.
- (3) Eligibility for CHOICES.
 - (a) There are two groups in TennCare CHOICES:

(Rule 1200-13-01-.05, continued)

1. CHOICES Group 1. Participation in CHOICES Group 1 is limited to Medicaid Enrollees of all ages who qualify for and are receiving Medicaid-reimbursed NF services. Medicaid eligibility for LTC services is determined by DHS. Medical (or LOC) eligibility is determined by the Bureau as specified in Rule 1200-13-01-.10. Persons in CHOICES Group 1 must be enrolled in TennCare Medicaid and qualify for Medicaid-reimbursement of LTC services.
2. CHOICES Group 2.
 - (i) Participation in CHOICES Group 2 is limited to TennCare Enrollees who qualify for and are receiving TennCare-reimbursed HCBS. To be eligible for CHOICES Group 2, Enrollees must meet the following criteria:
 - (I) Be in one of the defined target populations;
 - (II) Qualify in one of the specified eligibility categories;
 - (III) Meet NF LOC; and
 - (IV) Have needs that can be safely and appropriately met in the community and at a cost that does not exceed their Individual Cost Neutrality Cap as defined in Rule 1200-13-01-.02.
 - (ii) Target Populations for CHOICES Group 2. Only persons in one of the target populations below may qualify to enroll in CHOICES Group 2:
 - (I) Persons age sixty-five (65) and older.
 - (II) Persons twenty-one (21) years of age and older who have one or more physical disabilities as defined in Rule 1200-13-01-.02.
 - (iii) Eligibility Categories Served in CHOICES Group 2. Participation in CHOICES Group 2 is limited to TennCare Enrollees who qualify in one of the following eligibility categories:
 - (I) SSI eligibles, who are determined eligible for SSI by the Social Security Administration. SSI eligibles are enrolled in TennCare Medicaid.
 - (II) The CHOICES 217-Like Group, as defined in Rule 1200-13-01-.02. Financial and categorical eligibility are determined by DHS. Persons who qualify in the CHOICES 217-Like Group in accordance with Rule 1200-13-14-.02 are enrolled in TennCare Standard.
- (b) Level of Care (LOC).

All Enrollees in TennCare CHOICES must meet the LOC criteria for NF services, as determined by the Bureau in accordance with Rule 1200-13-01-.10. Physician certification of LOC shall be required only for NF services. Upon implementation of CHOICES in the Grand Division, only the CHOICES PAE may be submitted to establish LOC eligibility for CHOICES LTC services. However, an unexpired non-CHOICES PAE eligibility segment may be used as permitted by the Bureau for enrollment into CHOICES, including persons on a Waiting List for HCBS.
- (c) With respect to the PASRR process described in Rule 1200-13-01-.23:

(Rule 1200-13-01-.05, continued)

1. Persons in CHOICES Group 1 must have been determined through the PASRR process described in Rules 1200-13-01-.10 and 1200-13-01-.23 to be appropriate for NF placement.
 2. Persons in CHOICES Group 2 are not required to complete the PASRR process unless they are admitted to a NF for the Short-term NF benefit described in Paragraph (7) of this Rule. Completion of the PASRR process is not required for Members of CHOICES Group 2 who have elected the Inpatient Respite Care benefit described in Paragraph (7) of this Rule, since the service being provided is not NF services, but rather, Inpatient Respite Care, which is an HCBS.
- (d) All Enrollees in TennCare CHOICES must be admitted to a NF and require Medicaid-reimbursement of NF services or be receiving HCBS in CHOICES Group 2.
- (e) All Enrollees in TennCare CHOICES Group 2 must be determined by the AAAD or the MCO, as applicable, to be able to be served safely and appropriately in the community and within their individual cost-neutrality cap, in accordance with this Rule. If a person can be served safely and appropriately in the community and within their individual cost-neutrality cap only through receipt of Companion Care services, the person may not be enrolled into CHOICES until a qualified companion has been identified, an adequate back-up plan has been developed, and the companion has completed all required paperwork and training and is ready to begin delivering Companion Care services immediately upon the person's enrollment into CHOICES. Reasons a person cannot be served safely and appropriately in the community may include, but are not limited to, the following:
1. The home or home environment of the applicant is unsafe to the extent that it would reasonably be expected that HCBS could not be provided without significant risk of harm or injury to the person or to individuals who provide covered services.
 2. The health, safety, and welfare of the individual cannot be assured due to the lack of a signed Risk Agreement, or the person's decision to receive services in the home or community poses an unacceptable level of risk.
 3. The applicant or his caregiver is unwilling to abide by the POC or Risk Agreement, resulting in the inability to ensure the person's health, safety and welfare.
- (f) Immediate Eligibility. See definition in Rule 1200-13-01-.02.
1. The Bureau may elect, based on information provided in a TennCare application that has been submitted to DHS for determination, to grant a forty-five (45) day period of Immediate Eligibility for a person who meets the following criteria:
 - (i) Is deemed likely to qualify for TennCare in the CHOICES 217-Like eligibility category;
 - (ii) Has an approved CHOICES PAE; and
 - (iii) Meets all other specified criteria for enrollment into CHOICES Group 2, subject to categorical and financial eligibility determination.
 2. Individuals admitted to CHOICES under the Immediate Eligibility option are individuals who are not already eligible for TennCare.

(Rule 1200-13-01-.05, continued)

3. Immediate Eligibility is not a covered eligibility category in the Medicaid State Plan or the TennCare Section 1115 Waiver. There is no entitlement to apply or qualify for Immediate Eligibility. Should the Bureau not elect to provide a period of Immediate Eligibility, no notice shall be issued.
 4. If eligibility in the CHOICES 217-Like Group is denied by DHS, the individual shall receive notice and the right to request a fair hearing regarding the DHS eligibility decision. Continuation of HCBS benefits or Immediate Eligibility shall not be granted during the fair hearing process once the forty-five (45) day Immediate Eligibility period has expired. A fair hearing shall not be granted regarding either of the following:
 - (i) A decision by the Bureau to not grant the optional forty-five (45) day period of Immediate Eligibility; or
 - (ii) The end of a forty-five (45) day period of Immediate Eligibility granted by the Bureau.
 5. During a period of Immediate Eligibility, individuals are eligible only for the limited package of HCBS identified in Paragraph (7)(j). They are not eligible for any other TennCare services, including other LTC services.
 6. During a period of Immediate Eligibility, individuals who are also Medicare beneficiaries are not entitled to Medicare crossover payments on their Medicare benefits. They cannot be considered “dual eligibles” since they are not yet Medicaid-eligible.
- (4) Enrollment in TennCare CHOICES. Enrollment into CHOICES shall be processed by the Bureau as follows:
- (a) Enrollment into CHOICES Group 1. To qualify for enrollment into CHOICES Group 1, an individual must:
 1. Have completed the PASRR process as defined in Rules 1200-13-01-.10 and 1200-13-01-.23;
 2. Have an approved unexpired CHOICES PAE for Level 1 services, Level 2 services, or Enhanced Respiratory Care Reimbursement. The Bureau may also accept, at its discretion, an approved, unexpired non-CHOICES PAE for the applicable LOC (Level 1 NF or Level 2 NF) submitted prior to implementation of CHOICES in the Grand Division. Eligibility for Enhanced Respiratory Care Reimbursement may be established only with a CHOICES PAE.
 3. Be approved by DHS for Medicaid reimbursement of NF services.
 4. Be admitted to a NF. The Bureau must have received notification from the NF that Medicaid reimbursement is requested for the effective date of CHOICES enrollment (i.e., the individual is no longer privately paying for NF services and Medicare payment of NF services is not available). Enrollment into CHOICES Group 1 (and payment of a capitation payment for LTC services) cannot begin until the Bureau or the MCO will be responsible for payment of NF services.
 - (b) Enrollment into CHOICES Group 2.
To qualify for enrollment into CHOICES Group 2:

(Rule 1200-13-01-.05, continued)

1. An individual must be in one of the target populations specified in this Rule;
2. An individual must have an approved unexpired CHOICES PAE. The Bureau may also accept, at its discretion, an approved, unexpired non-CHOICES PAE for Level 1 NF care or the Statewide E/D Waiver submitted prior to implementation of CHOICES in the Grand Division;
3. An individual must be approved by DHS for reimbursement of LTC services as an SSI recipient or in the CHOICES 217-Like Group. To qualify in the CHOICES 217-Like Group, an individual must be enrolled in CHOICES Group 2 or be approved by the Bureau for Immediate Eligibility for CHOICES Group 2, subject to categorical and financial eligibility by DHS;
4. The Bureau must have received a determination by the AAAD or MCO, as applicable, that the individual's needs can be safely and appropriately met in the community, and at a cost that does not exceed his Individual Cost Neutrality Cap, as described in this Rule; and
5. There must be capacity within the established Enrollment Target to enroll the individual in accordance with this Rule which may include satisfaction of criteria for reserve capacity, as applicable; or the individual must meet specified exceptions to enroll even when the Enrollment Target has been reached.

(c) Individual Cost Neutrality Cap.

1. Each Member enrolling or enrolled in CHOICES Group 2 shall have an Individual Cost Neutrality Cap, which shall be used to determine:
 - (i) Whether or not he qualifies to enroll in CHOICES Group 2;
 - (ii) Whether or not he qualifies to remain enrolled in CHOICES Group 2; and
 - (iii) The total cost of HCBS, HH Services, and PDN Services he can receive while enrolled in CHOICES Group 2. The Member's Individual Cost Neutrality Cap functions as a limit on the total cost of HCBS that, when combined with the cost of HH Services and PDN Services the Member will receive, can be provided to the Member in the home or community setting.
2. A Member is not entitled to receive services up to the amount of his cost neutrality cap. A Member shall receive only those services that are medically necessary (i.e., required in order to help ensure the Member's health, safety and welfare in the home or community setting and to delay or prevent the need for NF placement). Determination of the services that are needed shall be based on a comprehensive assessment of the Member's needs and the availability of Natural Supports and other (non-TennCare reimbursed) services to meet identified needs which shall be conducted by the Member's Care Coordinator.
3. Calculating a Group 2 Member's Individual Cost Neutrality Cap.
 - (i) Each Group 2 Member will have an Individual Cost Neutrality Cap that is based on the average cost of the level of NF reimbursement that would be paid if the Member were institutionalized in a NF as set forth in Items (I) through (III) below. CHOICES Group 2 does not offer an alternative to hospital level of care.

(Rule 1200-13-01-.05, continued)

- (I) A Member who would qualify only for Level 1 NF reimbursement shall have a cost neutrality cap set at the average cost of Level 1 NF care.
 - (II) A Member who would qualify for Level 2 NF reimbursement shall have a cost neutrality cap set at the average cost of Level 2 (or skilled) NF care.
 - (III) A Member who would qualify for the Enhanced Respiratory Care Reimbursement for persons who are chronically ventilator dependent, or for persons who have a functioning tracheostomy that requires frequent suctioning through the tracheostomy will have a cost neutrality cap that reflects the higher payment that would be made to the NF for such care. There is no cost neutrality cap for Ventilator Weaning Reimbursement, as such service is available only on a short-term basis in a SNF or acute care setting.
 - (ii) The PAE application shall be used to submit information to the Bureau that will be used to establish a Member's Individual Cost Neutrality Cap.
 - (iii) A Member's Individual Cost Neutrality Cap shall be the average cost of Level 1 NF care unless a higher cost neutrality cap is established based on information submitted in the PAE application.
4. Application of the Individual Cost Neutrality Cap.
- (i) The annual cost neutrality cap shall be applied on a calendar year basis. The Bureau and the MCOs will track utilization of HCBS, HH services, and PDN services across calendar year increments.
 - (ii) A Member's Individual Cost Neutrality Cap must be applied prospectively on a twelve (12) month basis. This is to ensure that a Member's POC does not establish a threshold level of supports that cannot be sustained over the course of time. This means that, for purposes of care planning, the AAAD or MCO will always project the total cost of all HCBS (including one-time costs such as Minor Home Modifications, short-term services or short-term increases in services) and HH and PDN Services forward for twelve (12) months in order to determine whether the Member's needs can continue to be safely and cost-effectively met based on the most current POC that has been developed. The cost of one-time services such as Minor Home Modifications, short-term services or short-term increases in services must be counted as part of the total cost of HCBS for a full twelve (12) month period following the date of service delivery.
 - (iii) If it can be reasonably anticipated, based on the HCBS, HH and PDN services currently received or determined to be needed in order to safely meet the person's needs in the community, that the person will exceed his cost neutrality cap, then the person does not qualify to enroll in or to remain enrolled in CHOICES Group 2.
5. As the setting of an individual's Cost Neutrality Cap does not, in and of itself, result in any increase or decrease in a Member's services, notice of action shall not be provided regarding the Bureau's Cost Neutrality Cap calculation.
- (i) A Member has a right to due process regarding his Individual Cost Neutrality Cap when services are denied or reduced, when a determination

(Rule 1200-13-01-.05, continued)

is made that an applicant cannot be enrolled into CHOICES, or a currently enrolled CHOICES Member can no longer remain enrolled in CHOICES because his needs cannot be safely and effectively met in the home and community-based setting at a cost that does not exceed his Individual Cost Neutrality Cap.

- (ii) When an adverse action is taken, notice of action shall be provided, and the applicant or Member shall have the right to a fair hearing regarding any valid factual dispute pertaining to such action, which may include, but is not limited to, whether his Cost Neutrality Cap was calculated appropriately.
 - (I) Denial of or reductions in HCBS based on a Member's Cost Neutrality Cap shall constitute an adverse action under the Grier Revised Consent Decree (Modified) (See Rules 1200-13-13-.01(4) and 1200-13-14-.01(4)), and shall give rise to Grier notice of action and due process rights to request a fair hearing in accordance with Rules 1200-13-13-.11 and 1200-13-14-.11.
 - (II) Denial of enrollment and/or involuntary disenrollment because a person's Cost Neutrality Cap will be exceeded shall constitute an eligibility/enrollment action, and shall give rise to notice of action and due process rights to request a fair hearing in accordance with this rule.

(d) Enrollment Target for CHOICES Group 2.

1. There shall be an Enrollment Target for CHOICES Group 2. The Enrollment Target functions as a cap on the total number of individuals who can be enrolled into CHOICES Group 2 at any given time.
 - (i) Effective March 1, 2010, the Enrollment Target for CHOICES Group 2 will be seven thousand five hundred (7,500).
 - (ii) Effective July 1, 2010, the Enrollment Target for CHOICES Group 2 will be nine thousand five hundred (9,500).
2. Reserve Capacity.
 - (i) The Bureau shall reserve three hundred (300) slots within the CHOICES Group 2 Enrollment Target. These slots are available only when the Enrollment Target has otherwise been reached, and only to the following:
 - (I) Individuals being discharged from a NF; and
 - (II) Individuals being discharged from an acute care setting who are at imminent risk of being placed in a NF setting absent the provision of HCBS.
 - (ii) Once all other available (i.e., unreserved) slots have been filled, individuals who meet specified criteria (including new applicants seeking to establish eligibility in the CHOICES 217-Like Group as well as current SSI-eligible individuals seeking enrollment into CHOICES Group 2) may be enrolled into reserved slots. TennCare may require confirmation of the NF or hospital discharge and in the case of hospital discharge, written explanation of the applicant's circumstances that warrant the immediate provision of NF services unless HCBS are immediately available.

(Rule 1200-13-01-.05, continued)

- (iii) If enrollment into a reserve capacity slot is denied, notice shall be provided to the applicant, including the right to request a fair hearing regarding any valid factual dispute pertaining to the Bureau's decision. If the person otherwise qualifies for enrollment into CHOICES Group 2, but does not meet the specified criteria for reserve capacity, the person shall be placed on a Waiting List for CHOICES Group 2.
 - (iv) Once the Enrollment Target is reached, qualified persons shall not be enrolled into CHOICES Group 2 or qualify in the CHOICES 217-Like eligibility category based on receipt of HCBS until such time that capacity within the Enrollment Target is available, with the following exceptions:
 - (I) NF-to-Community Transitions. A Member being served in CHOICES Group 1 who meets requirements to enroll in CHOICES Group 2 can enroll in CHOICES Group 2 even though the Enrollment Target has been met. This Member will be served in CHOICES Group 2 outside the Enrollment Target but shall be moved within the CHOICES Enrollment Target at such time that a slot becomes available. A request to transition a Member from CHOICES Group 1 to CHOICES Group 2 in excess of the CHOICES Group 2 Enrollment Target must specify the name of the NF where the Member currently resides, the date of admission and the planned date of transition.
 - (II) CEA Enrollment. An MCO with an SSI-eligible recipient who meets all other criteria for enrollment into CHOICES Group 2, but who cannot enroll in CHOICES Group 2 because the Enrollment Target for that group has been met, has the option, at its sole discretion, of offering HCBS as a CEA to the Member. Upon receipt of satisfactory documentation from the MCO of its CEA determination and assurance of provider capacity to meet the Member's needs, the Bureau will enroll the person into CHOICES Group 2, regardless of the Enrollment Target. The person will be served in CHOICES Group 2 outside the Enrollment Target, but shall be moved within the CHOICES Group 2 Enrollment Target at such time that a slot becomes available. Satisfactory documentation of the MCO's CEA determination shall include an explanation of the Member's circumstances that warrant the immediate provision of NF services unless HCBS are immediately available. Documentation of adequate provider capacity to meet the Member's needs shall include a listing of providers for each HCBS in the Member's POC which the MCO has confirmed are willing and able to initiate HCBS within five (5) days of the Member's enrollment into CHOICES.
 - (v) Once the CHOICES Group 2 Enrollment Target is reached, any persons enrolled in excess of the Enrollment Target in accordance with this Rule must receive the first available slots that become available. Only after all persons enrolled in excess of the Enrollment Target have been moved under the Enrollment Target can additional persons be enrolled into CHOICES Group 2.
- (5) Disenrollment from CHOICES.
- A Member may be disenrolled from CHOICES voluntarily or involuntarily.

(Rule 1200-13-01-.05, continued)

- (a) Voluntary disenrollment shall proceed only upon receipt of a statement signed by the Member or his authorized Representative. No notice of action shall be issued regarding a Member's decision to voluntarily disenroll from CHOICES. However, notice shall be provided regarding any subsequent adverse action that may occur as a result of the Member's decision, including any change in benefits, cost-sharing responsibility, or continued eligibility for TennCare when the Member's eligibility was conditioned on receipt of LTC services.
 - (b) A Member may be involuntarily disenrolled from CHOICES only by the Bureau, although such process may be initiated by a Member's MCO. Reasons for involuntary disenrollment include when the Member no longer meets one or more criteria for eligibility and/or enrollment as specified in this Rule. Such reasons include but are not limited to:
 - 1. The Member's needs can no longer be safely met in the community. This may include, but is not limited to the following instances:
 - (i) The home or home environment of the Member becomes unsafe to the extent that it would reasonably be expected that HCBS could not be provided without significant risk of harm or injury to the Member or to individuals who provide covered services to the Member.
 - (ii) The Member or his caregiver refuses to abide by the POC or Risk Agreement, resulting in the inability to ensure the Member's health, safety and welfare.
 - (iii) Even though an adequate provider network is in place, there are no providers who are willing to provide necessary services to the Member.
 - (iv) The health, safety, and welfare of the Member cannot be assured due to the lack of a signed Risk Agreement, or the Member's decision to continue receiving services in the home or community poses an unacceptable level of risk.
 - 2. The Member's needs can no longer be safely met in the community at a cost that does not exceed the Member's Cost Neutrality Cap, as described in this Rule.
 - 3. The Member no longer needs or is no longer receiving LTC services.
 - 4. The Member has refused to pay his Patient Liability. The MCO and/or its participating providers are unwilling to serve the Member in CHOICES because he has not paid his Patient Liability, and/or no other MCO is willing to serve the Member in CHOICES.
- (6) Transitioning into CHOICES and Transitioning Between CHOICES Groups.
- (a) Transition at the time that CHOICES is implemented in a particular Grand Division of the State:
 - 1. All active participants in the existing Statewide E/D Waiver who live in that Grand Division shall be automatically transitioned into CHOICES.
 - 2. All persons receiving TennCare-reimbursed NF services in that Grand Division shall be automatically transitioned into CHOICES.

(Rule 1200-13-01-.05, continued)

3. There shall be no right to a fair hearing regarding the termination of the Section 1915(c) Waiver, and no ability to remain enrolled in the Section 1915(c) Waiver or to continue receiving FFS NF care. Once CHOICES has been implemented in a Grand Division, TennCare Members in that Grand Division may receive LTC services only through CHOICES, with the following exceptions:
 - (i) Institutional and community services for persons with MR will continue to be offered through the ICF/MR program described in Rule 1200-13-01-.30 and the HCBS waiver programs for persons with MR described in Rules 1200-13-01-.25, .28, and .29.
 - (ii) Elderly and disabled residents of Hamilton County may elect to participate in the PACE program, in which case they will not be enrolled with a TennCare MCO.
 4. Members shall remain in their currently assigned MCO. LTC services shall become part of the covered benefit package provided to the Member by his current MCO.
- (b) Continuity of Care period.
1. Members residing in NFs and transitioning into CHOICES Group 1 and Members transitioning from the existing Section 1915(c) Waiver into CHOICES Group 2 shall receive a Continuity of Care period based on their currently authorized POC.
 2. The Continuity of Care period shall last for a minimum of thirty (30) days and will continue for up to ninety (90) days for persons enrolled in CHOICES Group 2 or until a new POC has been implemented.
 3. During the Continuity of Care period:
 - (i) CHOICES Group 1 Members.
 - (I) The Member shall continue to receive NF services from the current NF provider, regardless of whether the NF is a Contract or Non-Contract Provider, unless the Member chooses to move to another NF and such choice is documented.
 - (II) NF providers not participating in the MCO's network shall be reimbursed at the contract rate for the first thirty (30) days following implementation, and thereafter in accordance with Rule 1200-13-01-.05(9)(e)3.
 - (ii) CHOICES Group 2 Members.
 - (I) The Member shall continue to receive the services currently specified in his Waiver POC, except for Case Management Services which shall be replaced with Coordination provided by the Member's MCO.
 - (II) The Member shall continue to receive HCBS from his current Waiver providers, regardless of whether such providers are contracted with the MCO to deliver CHOICES benefits. Non-contract HCBS providers shall be reimbursed at the MCO's full contract rate during the Continuity of Care period, even if such period is extended

(Rule 1200-13-01-.05, continued)

beyond thirty (30) days. In the case of Members receiving services in a CBRA setting, the Member shall remain in that CBRA during the Continuity of Care period, unless he chooses to move to another CBRA and such choice is documented.

- (III) Any action to reduce or change the type, amount, frequency, or duration of Waiver services in order to implement the new POC shall require notice of action in accordance with Rules 1200-13-13-.11 and 1200-13-14-.11.

(c) Transitioning between CHOICES Groups.

1. Transition from Group 1 to Group 2.

- (i) An MCO may request to transition a Member from Group 1 to Group 2 only when the Member chooses to transition from the NF to an HCBS setting. Members shall not be required to transition from Group 1 to Group 2.
- (ii) When Members move from Group 1 to Group 2, DHS must recalculate the Member's Patient Liability based on the Community PNA.

2. Transition from Group 2 to Group 1.

- (i) An MCO may request to transition a Member from Group 2 to Group 1 only under the following circumstances:
 - (I) The Member chooses to transition from HCBS to NF, for example, due to a decline in the Member's health or functional status, or a change in the Member's natural caregiving supports; or
 - (II) The MCO has made a determination that the Member's needs can no longer be safely met in the community and at a cost that does not exceed the average cost of NF services for which the Member would qualify, and the Member chooses to transition to the more appropriate institutional setting in order to safely meet his needs.
- (ii) When Members move from Group 2 to Group 1, DHS must recalculate the Member's Patient Liability based on the Institutional PNA.

- 3. At such time as a transition between groups is made, the MCO shall issue notice of transition to the Member. Because the Member has elected the transition and remains enrolled in CHOICES, such transition between CHOICES groups shall not constitute an adverse action. Thus, the notice will not include the right to appeal or request a fair hearing regarding the Member's decision.

(7) Benefits in the TennCare CHOICES Program.

- (a) CHOICES includes NF care and HCBS benefits, as described in this Chapter. Pursuant to federal regulations, NF services must be ordered by the treating physician. A physician's order is not required for HCBS.
- (b) Members of CHOICES Group 1 receive NF care, in addition to all of the medically necessary covered benefits available for Medicaid recipients, as specified in Rule 1200-13-13-.04. While receiving NF care, Members are not eligible for HCBS.

(Rule 1200-13-01-.05, continued)

- (c) Members of CHOICES Group 2 who are Medicaid eligible receive HCBS as specified in an approved POC, in addition to medically necessary covered benefits available for TennCare Medicaid recipients, as specified in Rule 1200-13-13-.04. While receiving HCBS, Members are not eligible for NF care, except for Short-Term NF care, as described in this Chapter.
- (d) Members of CHOICES Group 2 who are eligible for TennCare Standard in the CHOICES 217-Like Group receive HCBS as specified in an approved POC, in addition to medically necessary covered benefits available for TennCare Standard recipients, as specified in Rule 1200-13-14-.04. While receiving HCBS, Members are not eligible for NF, except for Short-Term NF care, as described in this Chapter.
- (e) Members are not eligible to receive any other HCBS during the time that Short-Term NF services are provided. HCBS such as Minor Home Modifications or installation of a PERS which are required to facilitate transition from the NF back to the home or community may be provided during the NF stay and billed with date of service being on or after discharge from the NF.
- (f) Members receiving CBRA services, other than Companion Care, are eligible to receive only Assistive Technology services, since other types of support and assistance are within the defined scope of the 24-hour CBRA benefit and are the responsibility of the CBRA provider.
- (g) Members receiving Companion Care are eligible to receive only Assistive Technology, Minor Home Modifications, and Pest Control, since all needed assistance with ADLs and IADLs are within the defined scope of the 24-hour CBRA benefit.
- (h) All LTC services, NF services as well as HCBS, must be authorized by the MCO in order for MCO payment to be made for the services. An MCO may elect to accept the Bureau's PAE determination as its prior authorization for NF services. NF care may sometimes start before authorization is obtained, but payment will not be made until the MCO has authorized the service. Except for special provisions which may be made by an MCO during the Continuity of Care period for CHOICES implementation, HCBS must be specified in an approved POC and authorized by the MCO prior to delivery of the service in order for MCO payment to be made for the service.
- (i) HCBS covered under TennCare CHOICES and applicable limits are specified below. The benefit limits are applied across all services received by the Member regardless of whether the services are received through CD and/or a traditional provider agency. Corresponding limitations regarding the scope of each service are defined in Rule 1200-13-01-.02 and in Subparagraphs (a) through (h) above.

Service	Benefits for CHOICES 2 Members	Benefits for Consumer Direction ("Eligible HCBS")	Benefits for Immediate Eligibles ("Specified HCBS")
1. Adult Day Care	Covered with a limit of 2080 hours per calendar year, per CHOICES Member.	No	Yes

(Rule 1200-13-01-.05, continued)

Service	Benefits for CHOICES 2 Members	Benefits for Consumer Direction (“Eligible HCBS”)	Benefits for Immediate Eligibles (“Specified HCBS”)
2. Assistive Technology	Covered with a limit of \$900 per calendar year, per Member.	No	No
3. Attendant Care	Covered when needed for more than 4 hours per occasion. Covered with a limit of 1080 hours per calendar year, per Member. Not covered when the Member is receiving any of the following HCBS: Adult Day Care, CBRA facility services, Short-Term NF Care.	Yes	Yes
4. CBRA	Companion Care. Not covered when the Member is receiving any of the following HCBS: Adult Day Care, CBRA facility services, Short-Term NF Care.	Yes	No
	CBRA facility services (e.g., ACLFs, Adult Care Homes).	No	No
5. Home-Delivered Meals	Covered with a limit of 1 meal per day, per Member. Not covered when the Member is receiving CBRA facility services or Short-Term NF Care.	No	Yes
6. Homemaker Services	Covered with a limit of 3 visits per week, per Member. Not covered when the Member is receiving CBRA facility services or Short-Term NF Care.	Yes	Yes
7. In-Home Respite Care	Covered with a limit of 216 hours per calendar year, per Member. Not covered when the Member is receiving CBRA facility services or Short-Term NF Care.	Yes	No
8. Inpatient Respite Care	Covered with a limit of 9 days per calendar year, per Member. PAE and PASRR approval not required. Not covered when the Member is receiving CBRA facility services or Short-Term NF Care.	No	No
9. Minor Home Modifications	Covered with a limit of \$6,000 per project, \$10,000 per calendar year, and \$20,000 per lifetime. Not covered when the Member is receiving CBRA facility services or Short-Term NF Care, except when provided as a CEA to facilitate transition from a NF to the community. See Rule 1200-13-01-.05(7)(m).	No	No

(Rule 1200-13-01-.05, continued)

Service	Benefits for CHOICES 2 Members	Benefits for Consumer Direction (“Eligible HCBS”)	Benefits for Immediate Eligibles (“Specified HCBS”)
10. Personal Care Visits	Covered with a limit of 2 intermittent visits per day, per Member; visits limited to a maximum of 4 hours per visit and shall not run consecutively. Not covered when the Member is receiving any of the following HCBS: Adult Day Care, CBRA facility services, Short-Term NF Care.	Yes	Yes
11. PERS	Not covered when the Member is receiving CBRA facility services or Short-Term NF Care.	No	Yes
12. Pest Control	Covered with a limit of 9 treatment visits per calendar year, per Member. Not covered when the Member is receiving CBRA facility services or Short-Term NF Care.	No	No
13. Short-Term NF Care	Covered with a limit of 90 days per stay, per Member. Approved PAE and PASRR required. Members receiving Short-Term NF Care are not eligible to receive any other HCBS except when permitted as a CEA to facilitate transition to the community. See Rule 1200-13-01-.05(7)(m).	No	No

- (j) Applicants who qualify as “Immediate Eligibles” are eligible only for certain HCBS covered under CHOICES. They are not eligible for any other TennCare benefits, including other CHOICES benefits. These HCBS, called Specified HCBS, are listed below. The limits are the same as those specified in Subparagraph (i) above. When the limit is an annual limit, the services used in the Immediate Eligibility period count against the annual limit if the applicant should become eligible for TennCare.

1. Personal Care Visits.
2. Attendant Care.
3. Homemaker Services.
4. Home-Delivered Meals.
5. PERS.
6. Adult Day Care.

- (k) Transportation.

(Rule 1200-13-01-.05, continued)

1. Emergency and non-emergency transportation for TennCare covered services other than CHOICES services is provided by the MCOs in accordance with Rules 1200-13-13-.04 and 1200-13-14-.04.
2. Transportation is not provided to HCBS covered by CHOICES, except in the circumstance where a Member requires Adult Day Care that is not available within 30 miles of the Member's residence.

For CHOICES Members not participating in CD, provider agencies delivering HCBS may permit staff to accompany a Member outside the home, but not to personally transport the Member. The decision of whether or not to accompany the Member outside the home is at the discretion of the agency/worker, taking into account such issues as the ability to safely provide services outside the home setting and the cost involved. In no case will additional hours of service and/or an increased rate of reimbursement be provided as a result of an agency/worker decision to accompany a Member outside the home.

3. For CHOICES Members participating in CD, the Member may elect to have his Consumer-Directed Workers (including Companion Care workers) to accompany and/or transport the Member if such an arrangement is agreed to by both the Member and the Workers and specified in the Service Agreement; however, no additional hours or reimbursement will be available. Consumer-Directed Worker(s) must provide to the FEA a valid driver's license and proof of insurance prior to transporting a Member.

(l) Freedom of Choice.

1. CHOICES Members shall be given freedom of choice of NF care or HCBS, so long as the Member meets all criteria for enrollment into CHOICES Group 2, as specified in this Chapter and the Member may be enrolled into CHOICES Group 2 in accordance with requirements pertaining to the CHOICES Group 2 Enrollment Target as described in this Chapter.
2. CHOICES Members shall also be permitted to choose providers for HCBS specified in the POC from the MCO's list of participating providers, if the participating provider selected is available and willing to initiate services timely and to deliver services in accordance with the POC. The Member is not entitled to receive services from a particular provider. A Member is not entitled to a fair hearing if he is not able to receive services from the provider of his choice.

(m) Transition Allowance. For CHOICES Members moving from CHOICES 1 to CHOICES 2, the MCO may, at its sole discretion, provide a Transition Allowance not to exceed two thousand dollars (\$2,000) per lifetime as a CEA to facilitate transition of the Member from the NF to the community. Items that may be purchased or reimbursed are limited to the following:

1. Those items which the Member has no other means to obtain and which are essential in order to establish a community residence when such residence is not already established and to facilitate the person's safe and timely transition;
2. Rent and/or utility deposits; and
3. Essential kitchen appliances, basic furniture, and essential basic household items, such as towels, linens, and dishes.

(8) Consumer-Direction (CD).

(Rule 1200-13-01-.05, continued)

- (a) CD is a model of service delivery that affords CHOICES Group 2 Members the opportunity to have more choice and control with respect to certain types of HCBS that are needed by the Member, in accordance with this Rule. CD is not a service or set of services.
 - 1. The model of CD that will be implemented in CHOICES is a prior authorization model.
 - 2. The determination regarding the services a Member will receive shall be based on a comprehensive needs assessment performed by a Care Coordinator that identifies the Member's needs, the availability of family and other caregivers to meet those needs, and the gaps in care for which paid services may be authorized.
 - 3. Upon completion of the comprehensive needs assessment, CHOICES Members determined to need Eligible HCBS may elect to receive one or more of the Eligible HCBS through a Contract Provider, or they may participate in CD. Companion Care is available only through CD.
 - 4. CHOICES Members who do not need Eligible HCBS shall not be offered the opportunity to enroll in CD.
- (b) HCBS eligible for CD (Eligible HCBS).
 - 1. CD is limited to the following HCBS:
 - (i) Attendant Care.
 - (ii) Companion Care (available only to Members electing CD).
 - (iii) Homemaker Services.
 - (iv) In-Home Respite Care.
 - (v) Personal Care Visits.
 - 2. The amount of a covered benefit available to the Member shall not increase as a result of his decision to participate in CD, even if the rate of reimbursement for the service is lower in CD. The amount of each covered benefit to be provided to the Member is specified in the approved POC.
 - 3. HH Services, PDN Services, and HCBS other than those specified above shall not be available through CD.
- (c) Eligibility for CD. To be eligible for CD, a CHOICES Members must meet all of the following criteria:
 - 1. Be a Member of CHOICES Group 2.
 - 2. Be determined by a Care Coordinator, based on a comprehensive needs assessment, to need one or more of the HCBS eligible for CD.
 - 3. Be willing and able to serve as the Employer of Record for his Consumer-Directed Workers and to fulfill all of the required responsibilities for CD, or he must have a qualified Representative who is willing and able to serve as the

(Rule 1200-13-01-.05, continued)

Employer of Record and to fulfill all of the required responsibilities for CD. Assistance shall be provided to the Member or his Representative by the FEA.

4. Any additional risks associated with a Member's decision to participate in CD must be identified and addressed in a signed Risk Agreement, and the MCO must determine that the Member's needs can be safely and appropriately met in the community while participating in CD.
5. The Member or his Representative for CD and any Workers he employs must agree to use the services of the Bureau's contracted FEA to perform required Financial Administration and Supports Brokerage functions.

(d) Enrollment in CD.

1. A CHOICES Group 2 Member assessed to need one or more eligible HCBS may elect to participate in CD at any time.
2. If the Member is unable to make a decision regarding his participation in CD or to communicate his decision, only a legally appointed Representative may make such decision on his behalf. The Member, or a family member or other caregiver, must sign a CD participation form reflecting the decision the Member has made.
3. If the Member is unable to make a decision regarding CD or to communicate his decision and does not have a legally appointed Representative, the Member cannot participate in CD since there is no one with the legal authority to assume and/or delegate the Member's CD responsibilities.
4. Self-Assessment Tool. If a Member elects to participate in CD, he must complete a self-assessment tool developed by the Bureau to determine whether he requires the assistance of a Representative to perform the responsibilities of CD.
5. Representative. If the Member requires assistance in order to participate in CD, he must designate, or have appointed by a legally appointed Representative, a Representative to assume the CD responsibilities on his behalf.

(i) A Representative must meet all of the following criteria:

- (I) Be at least eighteen (18) years of age;
- (II) Have a personal relationship with the Member and understand his support needs;
- (III) Know the Member's daily schedule and routine, medical and functional status, medication regimen, likes and dislikes, strengths and weaknesses; and
- (IV) Be physically present in the Member's residence on a regular basis or at least at a frequency necessary to supervise and evaluate each Consumer-Directed Worker.

- (ii) If a Member requires a Representative but is unwilling or unable to appoint one, the MCO may submit to the Bureau, for review and approval, a request to deny the Member's participation in CD.

(Rule 1200-13-01-.05, continued)

- (iii) If a Member's Care Coordinator believes that the person selected as the Member's representative for CD does not meet the specified requirements (e.g., the Representative is not physically present in the Member's residence at a frequency necessary to adequately supervise Workers), the Care Coordinator may request that the Member select a different Representative who meets the specified requirements. If the Member does not select another Representative who meets the specified requirements, the MCO may, in order to help ensure the Member's health and safety, submit to the Bureau, for review and approval, a request to deny the Member's participation in CD.
 - (iv) A Member's Representative shall not receive payment for serving in this capacity and shall not serve as the Member's Worker for any Consumer-Directed Service.
 - (v) Representative Agreement. A Representative Agreement must be signed by the Member (or person authorized to sign on the Member's behalf) and the Representative in the presence of the Care Coordinator. By completing a Representative agreement, the Representative confirms that he agrees to serve as a Member's representative and that he accepts the responsibilities and will perform the duties associated with being a Representative.
 - (vi) A Member may change his Representative at any time by notifying his Care Coordinator and his Supports Broker that he intends to change Representatives. The Care Coordinator shall verify that the new Representative meets the qualifications as described above. A new Representative Agreement must be completed and signed, in the presence of a Care Coordinator, prior to the new Representative assuming his respective responsibilities.
- (e) Employer of Record.
- 1. If a Member elects to participate in CD, either he or his Representative must serve as the Employer of Record.
 - 2. The Employer of Record is responsible for the following:
 - (i) Recruiting, hiring and firing Workers;
 - (ii) Determining Workers' duties and developing job descriptions;
 - (iii) Scheduling Workers;
 - (iv) Supervising Workers;
 - (v) Evaluating Worker performance and addressing any identified deficiencies or concerns;
 - (vi) Setting wages from a range of reimbursement levels established by the Bureau;
 - (vii) Training Workers to provide personalized care based on the Member's needs and preferences;

(Rule 1200-13-01-.05, continued)

- (viii) Ensuring that Workers deliver only those services authorized, and reviewing and approving hours worked by Consumer-Directed Workers;
 - (ix) Reviewing and ensuring proper documentation for services provided; and
 - (x) Developing and implementing as needed a Back-up Plan to address instances when a scheduled Worker is not available or fails to show up as scheduled.
 - (f) Denial of Enrollment in CD.
 - 1. Enrollment into CD may be denied by the Bureau when:
 - (i) The person is not enrolled in TennCare or in CHOICES Group 2.
 - (ii) The Member does not need one or more of the HCBS eligible for CD, as specified in the POC.
 - (iii) The Member is not willing or able to serve as the Employer of Record for his Consumer-Directed Workers and to fulfill all of the required responsibilities for CD, and does not have a qualified Representative who is willing and able to serve as the Employer of Record and to fulfill all of the required responsibilities for CD.
 - (iv) The Member is unwilling to sign a Risk Agreement which identifies and addresses any additional risks associated with the Member's decision to participate in CD, or the risks associated with the member's decision to participate in CD pose too great a threat to the Member's health, safety and welfare.
 - (v) The Member does not have an adequate Back-up Plan for CD.
 - (vi) The Member's needs cannot be safely and appropriately met in the community while participating in CD.
 - (vii) The Member or his Representative for CD, or the Consumer-Directed Workers he wants to employ are unwilling to use the services of the Bureau's contracted FEA to perform required Financial Administration and Supports Brokerage functions.
 - (viii) Other significant concerns regarding the Member's participation in CD which jeopardize the health, safety or welfare of the Member.
 - 2. Denial of enrollment in CD gives rise to notice and due process including the right to a fair hearing, as set forth in this rule.
 - (g) Fiscal Employer Agent (FEA).
 - 1. The FEA shall perform the following functions on behalf of all Members participating in CD:
 - (i) Financial Administration functions in the performance of payroll and related tasks; and
 - (ii) Supports Brokerage functions to assist the Member or his Representative with other non-payroll related tasks such as recruiting and training workers.

(Rule 1200-13-01-.05, continued)

2. The FEA shall:
 - (i) Assign a Supports Broker to each CHOICES Member electing to participate in CD of HCBS.
 - (ii) Provide initial and ongoing training to Members and their Representatives (as applicable) on CD and other relevant issues.
 - (iii) Verify Worker qualifications, including conducting background checks on Workers, enrolling Workers into TennCare, assigning Medicaid provider ID numbers, and holding TennCare provider agreements.
 - (iv) Provide initial and ongoing training to workers on CD and other relevant issues.
 - (v) Assist the Member and/or Representative in developing and updating Service Agreements.
 - (vi) Withhold, file and pay applicable federal, state and local income taxes; employment and unemployment taxes; and worker's compensation.
 - (vii) Pay Workers for authorized services rendered within authorized timeframes.
- (h) Back-up Plan for Consumer-Directed Workers.
 1. Each Member participating in CD or his Representative is responsible for the development and implementation of a Back-up Plan that identifies how the Member or Representative will address situations when a scheduled Worker is not available or fails to show up as scheduled.
 2. The Member or Representative may not elect, as part of the Back-up Plan, to go without services.
 3. The Back-up Plan for CD shall include the names and telephone numbers of contacts (Workers, agency staff, organizations, supports) for alternate care, the order in which each shall be notified and the services to be provided by contacts.
 4. Back-up contacts may include paid and unpaid supports; however, it is the responsibility of the Member electing CD and/or his Representative to secure paid (as well as unpaid) back-up contacts who are willing and available to serve in this capacity, and for initiating the back-up plan when needed.
 5. The Member's Back-up Plan for Consumer-Directed Workers shall be integrated into the Member's Back-up Plan for services provided by Contract Providers, as applicable, and the Member's POC.
 6. The Care Coordinator shall review the Back-up Plan developed by the Member and/or his Representative to determine its adequacy to address the Member's needs. If an adequate Back-up Plan cannot be provided to CD, enrollment into CD may be denied, as set forth in this Rule.
 7. The Back-up Plan shall be reviewed and updated at least annually, and as frequently as necessary if there are changes in the type, amount, duration, scope of eligible HCBS or the schedule at which such services are needed, changes in

(Rule 1200-13-01-.05, continued)

Workers (when such Workers also serve as a back-up to other Workers) and changes in the availability of paid or unpaid back-up Workers to deliver needed care.

(i) Consumer-Directed Workers (Workers).

1. Hiring Consumer-Directed Workers.

(i) Members shall have the flexibility to hire individuals with whom they have a close personal relationship to serve as Workers, such as neighbors or friends.

(ii) Members may hire family members, excluding spouses, to serve as Workers. However, a family member shall not be reimbursed for a service that he would have otherwise provided without pay. A member shall not be permitted to employ any person who resides with the member to deliver Personal Care Visits, Attendant Care, Homemaker Services, or In-Home Respite Care. A Member or his Representative for CD shall not be permitted to employ either of the following to deliver Companion Care services:

(I) An immediate Family Member as defined in Rule 1200-13-01-.02.

(II) Any person with whom the member currently resides, or with whom the member has resided in the last five (5) years.

(iii) Members may elect to have a Worker provide more than one service, have multiple Workers, or have both a Worker and a Contract Provider for a given service, in which case, there must be a set schedule which clearly defines when Contract Providers will be used.

2. Qualifications of Consumer-Directed Workers. Workers must meet the following requirements prior to providing services:

(i) Be at least eighteen (18) years of age or older.

(ii) Pass a background check that includes a criminal background check (including fingerprinting), or, as an alternative, a background check from a licensed private investigation company.

(iii) Verification that the person's name does not appear on the State abuse registry.

(iv) Verification that the person's name does not appear on the State and national sexual offender registries and licensure verification, as applicable.

(v) Complete all required training.

(vi) Complete all required applications to become a TennCare provider.

(vii) Sign an abbreviated Medicaid agreement.

(viii) Be assigned a Medicaid provider ID number.

(ix) Sign a Service Agreement.

(Rule 1200-13-01-.05, continued)

- (x) If the Worker will be transporting the Member as specified in the Service Agreement, a valid driver's license and proof of insurance must also be provided.
3. Disqualification from Serving as a Consumer-Directed Worker. A Member cannot waive a background check for a potential Worker. The following findings shall disqualify a person from serving as a Worker:
- (i) Conviction of an offense involving physical, sexual or emotional abuse, neglect, financial exploitation or misuse of funds, misappropriation of property, theft from any person, violence against any person, or manufacture, sale, possession or distribution of any drug.
 - (ii) Entering of a plea of nolo contendere or when a jury verdict of guilty is rendered but adjudication of guilt is withheld with respect to a crime reasonably related to the nature of the position sought or held.
 - (iii) Identification on the abuse registry.
 - (iv) Identification on the State or national sexual offender registry.
 - (v) Failure to have a required license.
 - (vi) Refusal to cooperate with a background check.
4. Exception to Disqualification of a Consumer-Directed Worker.
- If a Worker fails the background check, an exception to disqualification may be granted at the Member's discretion if all of the following conditions are met:
- (i) Offense is a misdemeanor;
 - (ii) Offense occurred more than five (5) years prior to the background check;
 - (iii) Offense is not related to physical or sexual or emotional abuse of another person;
 - (iv) Offense does not involve violence against another person or the manufacture, sale, or distribution of drugs; and
 - (v) There is only one disqualifying offense.
5. Service Agreement.
- (i) A Member shall develop a Service Agreement with each Worker, which includes, at a minimum:
 - (I) The roles and responsibilities of the Worker and the Member;
 - (II) The Worker's schedule (as developed by the Member and/or Representative), including hours and days;
 - (III) The scope of each service (i.e., the specific tasks and functions the Worker is to perform);
 - (IV) The service rate; and

(Rule 1200-13-01-.05, continued)

- (V) The requested start date for services.
 - (ii) The Service Agreement must be in place for each Worker prior to the Worker providing services.
 - (iii) The Service Agreement shall also stipulate if a Worker will provide one or more Self-Directed Health Care Tasks, the specific task(s) to be performed, and the frequency of each Self-Directed Health Care Task.
- 6. Payments to Consumer-Directed Workers.
 - (i) Rates.

With the exception of Companion Care Services, Members participating in CD have the flexibility to set wages for their Workers from a range of reimbursement levels established by TennCare.

 - (I) Monthly Companion Care rates are only available for a full month of service delivery and will be pro-rated when a lesser number of days are actually delivered.
 - (II) The back-up per diem rate is available only when a regularly scheduled companion is ill or unexpectedly unable to deliver services, and shall not be authorized as a component of ongoing Companion Care Services.
 - (ii) Payments to Consumer-Directed Workers. In order to receive payment for services rendered, all Workers must:
 - (I) Deliver services in accordance with the schedule of services specified in the Member's POC and in the MCO's service authorization, and in accordance with Worker assignments determined by the Member or his Representative.
 - (II) Use the EVV system to log in and out at each visit.
 - (III) Provide detailed documentation of service delivery including but not limited to the specific tasks and functions performed for the Member at each visit, which shall be maintained in the Member's home.
 - (IV) Provide no more than forty (40) hours of services within a consecutive seven (7) day period, unless explicitly permitted by program guidelines and in accordance with service authorizations.
 - (iii) Termination of Consumer-Directed Workers' Employment.
 - (I) A Member may terminate a Worker's employment at any time.
 - (II) The MCO may not terminate a Worker's employment, but may request that a Member be involuntarily withdrawn from CD if it is determined that the health, safety and welfare of the Member may be in jeopardy if the Member continues to employ a Worker but the Member and/or Representative does not want to terminate the Worker.

(Rule 1200-13-01-.05, continued)

(j) Self-Direction of Health Care Tasks.

1. A Competent Adult, as defined in this Chapter, with a functional disability living in his own home, enrolled in CHOICES Group 2, and participating in CD, or his Representative for CD, may choose to direct and supervise a Consumer-Directed Worker in the performance of a Health Care Task as defined in this Chapter.
2. For purposes of this rule, home does not include a NF or ACLF.
3. A Member shall not receive additional amounts of any service as a result of his decision to self-direct health care tasks. Rather, the Health Care Tasks shall be performed by the Worker in the course of delivering Eligible HCBS already determined to be needed, as specified in the POC.
4. Health Care Tasks that may be self-directed for the purposes of this Subparagraph are limited to administration of oral, topical and inhaled medications.
5. The Member or Representative who chooses to self-direct a health care task is responsible for initiating self-direction by informing the health care professional who has ordered the treatment which involves the Health Care Task of the individual or caregiver's intent to perform that task through self-direction. The provider shall not be required to prescribe self-direction of the health care task.
6. When a licensed health care provider orders treatment involving a Health Care Task to be performed through self-directed care, the responsibility to ascertain that the Member or caregiver understands the treatment and will be able to follow through on the Self-Directed Health Care Task is the same as it would be for a Member or caregiver who performs the Health Care Task for himself, and the licensed health care provider incurs no additional liability when ordering a Health Care Task which is to be performed through self-directed care.
7. The Member or his Representative for CD will identify one or more Consumer-Directed Workers who will perform the task in the course of delivery of eligible HCBS. If a Worker agrees to perform the Health Care Tasks, the tasks to be performed must be specified in the Service Agreement. The Member or his Representative for CD is solely responsible for identifying a Worker who is willing to perform Health Care Tasks, and for instructing the paid personal aide on the task(s) to be performed.
8. The Member or his Representative for CD must also identify in his Back-up Plan for CD who will perform the Health Care Task if the Worker is unavailable, or stops performing the task for any reason.
9. Ongoing monitoring of the Worker performing self-directed Health Care Tasks is the responsibility of the Member or his Representative. Members are encouraged to use a home medication log as a tool to document medication administration. Medications should be kept in original containers, with labels intact and legible.

(k) Withdrawal from Participation in Consumer Direction (CD).

1. General.
 - (i) Voluntary Withdrawal from CD. Members participating in CD may voluntarily withdraw from participation in CD at any time. The Member's

(Rule 1200-13-01-.05, continued)

request must be in writing. Whenever possible, notice of a Member's decision to withdraw from participation in CD should be provided in advance to permit time to arrange for delivery of services through Contracted Providers.

- (ii) Voluntary or involuntary withdrawal of a Member from CD of HCBS shall not affect a Member's eligibility for LTC services or enrollment in CHOICES, provided the Member continues to meet all requirements for enrollment in CHOICES as defined in this Chapter.
- (iii) If a Member voluntarily withdraws or is involuntarily withdrawn from CD, any Eligible HCBS he receives, with the exception of Companion Care, shall be provided through Contract Providers, subject to the requirements in this Chapter. Companion Care is only available through CD.

2. Involuntary Withdrawal.

- (i) A person may be involuntarily withdrawn from participation in CD of HCBS for any of the following reasons:
 - (I) The person is no longer enrolled in TennCare.
 - (II) The person is no longer enrolled in CHOICES Group 2.
 - (III) The Member no longer needs any of the HCBS eligible for CD, as specified in the POC.
 - (IV) The Member is no longer willing or able to serve as the Employer of Record for his Consumer-Directed Workers and to fulfill all of the required responsibilities for CD, and does not have a qualified Representative who is willing and able to serve as the Employer of Record and to fulfill all of the required responsibilities for CD.
 - (V) The Member is unwilling to sign a Risk Agreement which identifies and addresses any additional risks associated with the Member's decision to participate in CD, or the risks associated with the Member's decision to participate in CD pose too great a threat to the Member's health, safety and welfare.
 - (VI) The health, safety and welfare of the Member may be in jeopardy if the Member or his Representative continues to employ a Worker but the Member or Representative does not want to terminate the Worker.
 - (VII) The Member does not have an adequate Back-up Plan for CD.
 - (VIII) The Member's needs cannot be safely and appropriately met in the community while participating in CD.
 - (IX) The Member or his Representative for CD, or Consumer-Directed Workers he wants to employ are unwilling to use the services of the Bureau's contracted FEA to perform required Financial Administration and Supports Brokerage functions.
 - (X) The Member or his Representative for CD is unwilling to abide by the requirements of the CHOICES CD program.

(Rule 1200-13-01-.05, continued)

- (XI) If a Member's Representative fails to perform in accordance with the terms of the Representative Agreement and the health, safety and welfare of the Member is at risk, and the Member wants to continue to use the Representative.
 - (XII) If a Member has consistently demonstrated that he is unable to manage, with sufficient supports, including appointment of a Representative, his services and the Care Coordinator or FEA has identified health, safety and/or welfare issues.
 - (XIII) A Care Coordinator has determined that the health, safety and welfare of the Member may be in jeopardy if the Member continues to employ a Worker but the Member or Representative does not want to terminate the Worker.
 - (XIV) Other significant concerns regarding the Member's participation in CD which jeopardize the health, safety or welfare of the Member.
 - (ii) The Bureau must review and approve all MCO requests for involuntary withdrawal from CD of HCBS before such action may occur. If the Bureau approves the request, written notice shall be given to the Member at least ten (10) days in advance of the withdrawal. The date of withdrawal may be delayed when necessary to allow adequate time to transition the Member to Contract Provider services as seamlessly as possible.
 - (iii) The Member shall have the right to appeal involuntary withdrawal from CD.
 - (iv) If a person is no longer enrolled in TennCare or in CHOICES, his participation in CD shall be terminated automatically.
- (9) Nursing Facilities (NFs) in CHOICES.
- (a) Conditions of participation. NFs participating in CHOICES must meet all of the conditions of participation and conditions for reimbursement outlined in their provider agreements with the TennCare MCOs.
 - (b) Reimbursement methodology for Level 1 care: See Rule 1200-13-01-.03(6).
 - (c) Reimbursement methodology for Level 2 care: See Rule 1200-13-01-.03(7).
 - (d) Reimbursement methodology for Level 2 care at an Enhanced Respiratory Care rate: See Rule 1200-13-01.03(8).
 - (e) Non-participating providers. NFs that wish to continue serving existing residents without entering into provider agreements with TennCare MCOs will be considered non-participating providers.
 - 1. Non-participating NF providers must comply with Rules 1200-13-01-.03, 1200-13-01-.06, and 1200-13-01-.09.
 - 2. Non-participating providers must sign a modified contract (called a case agreement) with the MCO to continue receiving reimbursement for existing residents, including residents who may become Medicaid eligible.

(Rule 1200-13-01-.05, continued)

3. Non-participating NF providers will be reimbursed eighty percent (80%) of the lowest rate paid to any participating NF provider in Tennessee for the applicable level of NF services except that for the first thirty (30) days following CHOICES implementation in the Grand Division, reimbursement shall be made at the NF's rate as established by the Office of the Comptroller.

(f) Bed holds. See Rule 1200-13-01-.03(9).

(g) Other reimbursement issues. See Rule 1200-13-01-.03(10).

(10) HCBS Providers in CHOICES.

- (a) HCBS providers delivering care under CHOICES must meet specified license requirements and shall meet conditions for reimbursement outlined in their provider agreements with the TennCare MCOs.
- (b) During the Continuity of Care period, both participating and non-participating HCBS providers will be reimbursed by the Member's MCO in accordance with the contract rates for providers of similar services.
- (c) After the Continuity of Care period has ended, non-participating HCBS providers will be reimbursed by the Member's MCO at eighty percent (80%) of the lowest rate paid to any HCBS provider in the state for that service.

(11) Appeals.

- (a) Appeals related to determinations of eligibility for TennCare Medicaid or TennCare Standard are processed by DHS, in accordance with Chapters 1200-13-13 and 1200-13-14.
- (b) Appeals related to the denial, reduction, suspension, or termination of a covered service are processed by the Bureau in accordance with Rules 1200-13-13-.11 and 1200-13-14-.11.
- (c) Appeals related to the PAE process (including decisions pertaining to the PASRR process) are processed by the Bureau's Division of Long-Term Care in accordance with Rule 1200-13-01-.10(6).
- (d) Appeals related to the enrollment or disenrollment of an individual in CHOICES or to denial or involuntary withdrawal from participation in CD are processed by the Division of Long-Term Care in the Bureau, in accordance with the following procedures:
 1. If enrollment into CHOICES or if participation in CD is denied, notice containing an explanation of the reason for such denial shall be provided. The notice shall include the person's right to request a fair hearing within thirty (30) days from receipt of the written notice regarding valid factual disputes pertaining to the enrollment denial decision.
 2. If a Member is involuntarily disenrolled from CHOICES, or if participation in CD is involuntarily withdrawn, advance notice of involuntary disenrollment or withdrawal shall be issued. The notice shall include a statement of the Member's right to request a fair hearing within thirty (30) days from receipt of the written notice regarding valid factual disputes pertaining to the decision.
 3. Appeals regarding denial of enrollment into CHOICES, involuntary disenrollment from CHOICES, or denial or involuntary withdrawal from participation in CD must

(Rule 1200-13-01-.05, continued)

be filed in writing with the TennCare Division of Long-Term Care within thirty-five (35) days of issuance of the written notice if the appeal is filed with the Bureau by fax, and within forty (40) days of issuance of the written notice if the appeal is mailed to the Bureau. This allows five (5) days mail time for receipt of the written notice and when applicable, five (5) days mail time for receipt of the written appeal.

4. In the case of involuntary disenrollment from CHOICES only, if the appeal is received prior to the date of action, continuation of CHOICES benefits shall be provided, pending resolution of the disenrollment appeal.
5. In the case of involuntary withdrawal from participation in CD, if the appeal is received prior to the date of action, continuation of participation in CD shall be provided, unless such continuation would pose a serious risk to the Member's health, safety and welfare, in which case, services specified in the POC shall be made available through Contract Providers pending resolution of the appeal.

Authority: T.C.A. §§4-5-202, 4-5-208, 71-5-105, 71-5-109, and Executive Order Nos. 11 and 23.

Administrative History: Original rule filed November 17, 1977; effective December 19, 1977. Amendment filed January 31, 1979; effective March 16, 1979. Amendment filed April 8, 1981; effective May 26, 1981. Amendment filed August 31, 1981; effective October 15, 1981. Amendment filed November 4, 1981; effective December 21, 1981. Amendment filed January 29, 1982; effective March 15, 1982. Amendment filed May 14, 1982; effective July 1, 1982. Amendment filed May 26, 1983; effective June 27, 1983. Amendment filed June 23, 1983; effective July 25, 1983. Amendment filed June 27, 1984; effective July 27, 1984. Amendment filed November 30, 1984; effective December 30, 1984. Amendment filed September 18, 1985; effective October 18, 1985. Amendment filed February 12, 1986; effective March 14, 1986. Amendment filed February 23, 1987; effective April 9, 1987. Amendment filed March 25, 1987; effective May 9, 1987. Amendment filed July 30, 1987; effective September 13, 1987. Amendment filed September 30, 1987; effective November 14, 1987. Amendment filed October 22, 1987; effective December 6, 1987. Amendment filed October 12, 1987; effective January 27, 1988. Amendment filed August 17, 1988; effective October 1, 1988. Amendment filed July 26, 1989; effective September 10, 1989. Amendment filed February 23, 1990; effective April 9, 1990. Amendment filed May 10, 1990; effective June 24, 1990. Amendment filed June 8, 1990; effective July 23, 1990. Amendment filed August 17, 1990; effective October 1, 1990. Amendment filed September 28, 1990; effective November 12, 1990. Amendment filed November 5, 1990; effective December 20, 1990. Amendment filed November 27, 1990; effective January 11, 1991. Amendment filed January 9, 1991; effective February 23, 1991. Amendment filed February 12, 1991; effective March 29, 1991. Amendment filed February 21, 1991; effective April 7, 1991. Amendment filed February 1991; effective April 9, 1991. Amendment filed February 27, 1991; effective April 13, 1991. Amendment filed April 1, 1991; effective May 16, 1991. Amendment filed June 12, 1991; effective July 27, 1991. Amendment filed November 22, 1991; effective January 6, 1992. Amendment filed April 29, 1992; effective June 13, 1992. Amendment filed May 1, 1992; effective June 15, 1992. Amendment filed October 8, 1992; effective November 22, 1992. Amendment filed October 26, 1992; effective December 10, 1992. Amendment filed November 17, 1993; effective January 31, 1994. Amendment filed March 11, 1994; effective May 25, 1994. Amendment filed March 18, 1994; effective June 1, 1994. Amendment filed May 2, 1994; effective July 16, 1994. Amendment filed November 10, 1994; effective January 24, 1995. Amendment filed March 3, 1995; effective June 15, 1995. Amendment filed June 29, 2000; effective September 12, 2000. Amendment filed August 21, 2001; effective November 4, 2001. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendment filed May 27, 2010; effective August 25, 2010.

1200-13-01-.06 SPECIAL FEDERAL REQUIREMENTS PERTAINING TO NURSING FACILITIES.

- (1) Anti-discrimination.

(Rule 1200-13-01-.06, continued)

No Medicaid-reimbursed resident of a NF shall, on the ground of race, color, or national origin be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination by any such facility.

- (a) A NF may not directly or through contractual or other arrangements, on ground of race, color, or national origin:
 - 1. Deny a Medicaid-reimbursed resident any service or benefit provided under the program.
 - 2. Provide any service or benefit to a Medicaid-reimbursed resident which is different, or is provided in a different manner, from that provided to others under the program.
 - 3. Subject a Medicaid-reimbursed resident to segregation or separate treatment in any matter related to the receipt of any service or benefit under the program.
 - 4. Restrict a Medicaid-reimbursed resident in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any service or benefit under the program.
 - 5. Treat a Medicaid-reimbursed resident differently from others in determining whether he satisfies any admission, enrollment, quota, eligibility, membership or other requirement or condition which the resident must meet in order to be provided any service or benefit provided under the program.
- (b) A NF, in determining the types of services, or benefits which will be provided under any such program, or the Medicaid-reimbursed resident to whom, or the situations in which, such services or benefits will be provided under the program, or the Medicaid-reimbursed resident to be afforded an opportunity to participate in the program, may not, directly or through contractual or other arrangements, utilize criteria or methods of administration which have the effect of subjecting those residents to discrimination because of their race, color, or national origin, or have the effect of defeating or substantially impairing accomplishments of the objective of the program with respect to those residents of a particular race, color, or national origin.
- (c) As used in this rule, the services or benefits provided by a NF shall be deemed to include any service, or benefit provided in or through a facility participating in this program.
- (d) The enumeration of specific forms of prohibited discrimination in this rule does not limit the generality of the prohibition in this rule.
- (e) When a NF has previously discriminated against persons on the ground of race, color, or national origin, the facility must take affirmative action to overcome the effects of prior discrimination.
- (f) Even in the absence of such prior discrimination, a facility may take affirmative action to overcome the effects of conditions which resulted in limiting participation by persons of a particular race, color, or national origin.

(2) Admissions, transfers, and discharges from NFs.

- (a) All NFs shall establish written policies and procedures addressing admission, transfer and discharge, consistent with these rules. These policies and procedures shall be available for inspection by the state.

(Rule 1200-13-01-.06, continued)

- (b) A NF that has entered into a provider agreement with the Bureau of TennCare or an MCO shall admit individuals on a first come, first served basis, except as otherwise permitted by state and federal laws and regulations.
- (c) NFs participating in the Medicaid Program shall not as a condition of admission to or continued stay at the facility request or require:
 - 1. Transfer or discharge of a Medicaid-eligible resident because Medicaid has been or becomes the resident's source of payment for long-term care.
 - 2. Payment of an amount from a Medicaid-eligible resident in excess of the amount of Patient Liability determined by DHS.
 - 3. Payment in excess of the amount of Patient Liability determined by DHS from any resident who is financially eligible for medical assistance but who has not submitted a PAE for consideration or whose appeal rights for a denied PAE have not been exhausted.
 - 4. Any person to forego his or her right to Title XIX Medical Assistance benefits for any period of time.
 - 5. A third party (i.e. responsible party) signature, except as required of a court appointed legal guardian or conservator, or require payment of any kind by a third party on behalf of a Medicaid Eligible individual.
- (d) NFs participating in the Medicaid Program must comply with the following guidelines regarding transfers, discharges and/or readmissions.
 - 1. Transfer and Discharge Rights.
 - (i) A NF must permit each resident to remain in the facility and must not transfer or discharge the resident from the facility unless:
 - (I) The transfer or discharge is necessary to meet the resident's welfare which cannot be met in the facility;
 - (II) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
 - (III) The safety of individuals in the facility is endangered;
 - (IV) The health of individuals in the facility would otherwise be endangered;
 - (V) The resident has failed, after reasonable and appropriate notice, to pay (or to have paid under Title XIX or Title XVIII on the resident's behalf) for a stay at the facility; or
 - (VI) The facility ceases to operate.
 - (ii) In each of the cases described above, no resident shall be discharged or transferred without a written order from the attending physician or through other legal processes and timely notification of next of kin and/or sponsor or authorized representative, if any. Each NF shall establish a policy for

(Rule 1200-13-01-.06, continued)

handling residents who wish to leave the facility against medical advice. The basis for the transfer or discharge must be documented in the resident's clinical record. In the cases described in items (I) and (II) above, the documentation must be made by the resident's physician, and in the case described in item (IV) above, the documentation must be made by a physician. For purposes of item (V), in the case of a resident who becomes eligible for assistance under Title XIX after admission to the facility, only charges which may be imposed under Title XIX shall be considered to be allowable.

- (iii) When a resident is transferred, a summary of treatment given at the facility, condition of resident at time of transfer and date and place to which transferred shall be entered in the record. If transfer is due to an emergency; this information will be recorded within forty-eight (48) hours; otherwise, it will precede the transfer of the resident.
 - (iv) When a resident is transferred, a copy of the clinical summary should, with consent of the resident, be sent to the NF that will continue the care of the resident.
 - (v) Where an involuntary transfer is proposed, in addition to any other relevant factors, the following factors shall be taken into account:
 - (I) The traumatic effect on the resident.
 - (II) The proximity of the proposed NF to the present facility and to the family and friends of the resident.
 - (III) The availability of necessary medical and social services at the proposed NF.
 - (IV) Compliance by the proposed NF with all applicable federal and State regulations.
2. Pre-Transfer and Pre-Discharge Notice. Before effecting a transfer or discharge of a resident, a NF must:
- (i) Notify the resident (and, if known, a family member of the resident or legal Representative) of the transfer or discharge and the reasons therefore.
 - (ii) Record the reasons in the resident's clinical record (including any documentation required pursuant to Part 1. above) and include in the notice the items described in Part 4. below.
 - (iii) Notify the Department of Health and the LTC Ombudsman.
 - (iv) Not transfer or discharge a resident until the above agencies have designated their intention to intervene and until any appeal process is complete, should the resident request a fair hearing.
3. Timing of Notice. The notice under Part 2. above must be made at least thirty (30) days in advance of the resident's transfer or discharge except:
- (i) In a case described in Items 1200-13-01-.06(2)(d)1.(i)(III) and (IV).

(Rule 1200-13-01-.06, continued)

- (ii) In a case described in Item 1200-13-01-.06(2)(d)1.(i)(II) where the resident's health improves sufficiently to allow a more immediate transfer or discharge.
- (iii) In a case described in Item 1200-13-01-.06(2)(d)1.(i)(I) where a more immediate transfer or discharge is necessitated by the resident's urgent medical needs.
- (iv) In a case where a resident has not resided in the facility for thirty (30) days.

In the case of such exceptions, notice must be given as many days before the date of transfer or discharge as is practicable.

4. Items included in notice. Each pre-transfer and pre-discharge notice under Part 2. above must include:
 - (i) Notice of the resident's right to appeal the transfer or discharge.
 - (ii) The name, mailing address, and telephone number of the LTC Ombudsman.
 - (iii) In the case of residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy system for developmentally disabled individuals.
 - (iv) In the case of mentally ill residents, the mailing address and telephone number of the agency responsible for the protection and advocacy system for mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.
 5. Orientation. A NF must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer discharge from the facility.
 6. Notice of Bed-Hold Policy and Readmission. Before a resident of a NF is transferred for hospitalization or therapeutic leave, a NF must provide written information to the resident and a family member or legal representative concerning:
 - (i) The provisions of the State Plan under this Title XIX regarding the period (if any) during which the resident will be permitted under the State Plan to return and resume residence in the facility, and
 - (ii) The policies of the facility consistent with Part 7. below, regarding such a period.
 7. Notice Upon Transfer. At the time of transfer of a resident to a hospital or for therapeutic leave, a NF must provide written notice to the resident and a family member or legal representative of the duration of any period under the State Plan allowed for the resumption of residence in the facility.
- (e) NFs participating in the Medicaid Program must establish and follow a written policy under which an Enrollee, whose hospitalization or therapeutic leave exceeds the bed hold period, is readmitted to the NF immediately upon the first availability of a bed in a semi-private room if the Enrollee:
1. Requires the services provided by the NF; and

(Rule 1200-13-01-.06, continued)

2. Is eligible for the level of NF care services.

(3) Single Wait List.

(a) Each NF participating in the TennCare must develop and consistently implement policies and procedures regarding its admissions, including the development and maintenance of a single Wait List of persons requesting admission to those facilities. This list must at a minimum contain the following information pertaining to each request for admission:

1. The name of the applicant.
2. The name of the contact person or designated representative other than the applicant (if any).
3. The address of the applicant and the contact person or designated representative (if any).
4. The telephone number of the applicant and the contact person or designated representative (if any).
5. The name of the person or agency referring the applicant to the NF.
6. The sex and race of the applicant.
7. The date and time of the request for admission.
8. Reason(s) for refusal/non-acceptance/other-action-taken pertaining to the request for admission.
9. The name and title of the NF staff person taking the application for admission.
10. A notation stating whether the applicant is anticipated to be Medicaid eligible at time of admission or within one year of admission.

(b) The Wait List should be updated and revised at least once each quarter to remove the names of previous applicants who are no longer interested in admission to the NF. Following three (3) contacts each separated by a period of at least ten (10) days, the NF shall, consistent with the written notice required in this section move an applicant to the end of the single admission list whenever an available bed is not accepted at the time of the vacancy, but the applicant wishes to remain on the admissions list. Applicants shall be advised of these policies at the time of their inquiry, and must be notified in writing, in a format approved by the Department of Health, when their name is removed from the list or moved to the end of the list. Such contacts shall be documented in the facility log containing the Wait List. The date, time and method of each contact shall be recorded along with the name of the facility staff person making the contact, and the identity of the applicant or contact person contacted. The log of such contacts shall also summarize the communication between the facility staff person and the applicant or contact person.

(c) Each facility shall send written confirmation that an applicant's name has been entered on the Wait List, their position on the wait list, and a notification of their right of access to the wait list as provided in Subparagraph (h) of this Rule. This confirmation shall include at a minimum the date and time of entry on the wait list and shall be mailed by

(Rule 1200-13-01-.06, continued)

first class postage to the applicant and their designated representative (if any) identified pursuant to the requirements in Subparagraph (a) of this Rule.

- (d) Each NF participating in TennCare shall admit applicants in the chronological order in which the referral or request for admission was received by the facility, except as permitted in Subparagraph (e) of this Rule.
- (e) Documentation justifying deviation from the order of the Wait List must be maintained for inspection by the State. Inspection shall include the right to review and/or make copies of these records. Deviation may be based upon:
 - 1. Medical need, including, but not necessarily limited to, the expedited admission of patients being discharged from hospitals and patients who previously resided in a NF at a different level of care, but who, in both cases, continue to require institutional medical services;
 - 2. The applicant's sex, if the available bed is in a room or a part of the facility that exclusively serves residents of the opposite sex;
 - 3. Necessity to implement the provisions of a plan of affirmative action to admit racial minorities, if the plan has previously been approved by the Department of Health;
 - 4. Emergency placements requested by the Department when evacuating another health care facility or by the Adult Protective Service of the Tennessee Department of Human Services;
 - 5. Other reasons or policies, e.g., previous participation in a community based waiver or other alternative care program, when approved by the Medical Director of the Department of Health's Bureau of Health Licensure and Regulation, provided, however, that no such approval shall be granted if to do so would in any way impair the Department's or the facility's ability to comply with its obligations under federal and state civil rights laws, regulations or conditions of licensure or participation.
 - 6. If a Medicaid-eligible recipient's hospitalization or therapeutic leave exceeds the period paid for under the Tennessee Medicaid program for the holding of a bed in the facility for the resident and if the resident continues to require the services provided by the NF, then the resident must be readmitted to the facility immediately upon the first availability of a bed in the facility, consistent with Part 2. above;
 - 7. Where, with the participation and approval of the Department of Health, expedited admission is approved for residents who are being displaced from another facility or its waiting list as a result of that facility's withdrawal from the Medicaid program.
- (f) Telephone requests to be placed on the Wait List shall be accepted. The information required in Subparagraph (a) of this Rule shall be documented.
- (g) If an applicant, whether on his own behalf or acting through another, requests admission or to be placed on a list of applicants awaiting admission, the information on the waiting list must be recorded and preserved.
- (h) Applicants or their representatives shall have the right to be informed by telephone of their position on the Wait List. Ombudsmen and appropriate State and federal

(Rule 1200-13-01-.06, continued)

personnel shall have access to the Wait List when requested, and such access shall include the right to review and/or copy the Wait List.

- (i) Any referrals received from the DHS shall be handled in the following manner.
 - 1. Applicants shall be placed on a Wait List without formal application until such facility is within sixty (60) days of admission to the facility based on experience.
 - 2. When the applicant is within sixty (60) days of admission to the facility as estimated by the facility based on its experience, the facility shall notify the applicant and DHS in writing so that a formal application can be made prior to consideration for admittance.
 - 3. If, after sixty (60) days from the date notification is issued, the facility has not received a completed application then the facility may remove the applicant's name from the Wait List.
- (4) Physician visits.
 - (a) NFs are responsible for assuring that physician visits are made according to the schedule set out at 42 C.F.R. § 483.40. To meet the requirement for a physician visit, the physician must, at the time of the visit,
 - 1. See the resident;
 - 2. Review the resident's total program of care, including treatments;
 - 3. Verify that the resident continues to need the designated level of NF care and document it in the progress notes or orders;
 - 4. Write, sign, and date progress notes; and
 - 5. Sign all orders.
 - (b) At the option of the physician, required visits after the initial visit may alternate between visits by a physician and visits by a physician assistant or nurse practitioner working under the physician's delegation.
 - (c) A physician visit will be considered to be timely if it occurs not later than ten (10) days after the date of the required visit. Failure of the visit to be made timely will result in non-payment of claims, or a recoupment of all amounts paid by the Bureau or the MCO during the time that the physician visit has lapsed.
 - (d) NFs are responsible for assuring that the physician verify at the time of each physician's visit the Medicaid recipient's continued need for NF LOC and whether or not he is being served at the appropriate LOC.
 - 1. Failure to obtain the verification at the time of the scheduled physician visit may result in a recoupment of all amounts paid by the Bureau or the MCO during the time that the verification/physician visit has lapsed.
 - 2. If such a recoupment is made, the participating facility shall not:
 - (i) Attempt to recoup from the resident; or
 - (ii) Discharge the resident based on the recoupment.

(Rule 1200-13-01-.06, continued)

3. In cases where the physician refused to make the required verification because the physician believes that the LOC is no longer appropriate, a new resident assessment must be completed by the NF.
- (5) Termination of NF provider agreements.
- (a) Facilities requesting voluntary termination of provider agreements shall comply with the following:
1. Facilities that choose to voluntarily terminate their provider agreements may do so by notifying the Bureau or the MCO(s) in writing of such intent. The effective date of the termination will be determined by the Bureau consistent with the terms of the TennCare Provider Agreement then in force between the Bureau or the MCO(s) and the facility.
 2. The facility will not be entitled to payment for any additional or newly admitted TennCare eligible residents from the date of the facility's notice of withdrawal from the TennCare Program. The facility may, however, at its election, continue to receive TennCare payment for those individuals who resided in the facility, on the date of such notice, so long as they continue to reside in and receive services from the facility and provided that such individuals are TennCare-eligible during the period for which reimbursement is sought. The facility's right to continue to receive TennCare payments for such individuals following the date of its notice of intent to withdraw from the TennCare program is contingent upon:
 - (i) The facility's compliance with all requirements for TennCare participation; and
 - (ii) Its agreement to continue to serve, and accept TennCare payment for, on a non-discriminatory basis, all individuals residing in the facility on the date of notification of withdrawal, who are or become TennCare eligible.
 3. The notification must provide the following information:
 - (i) The reason(s) for voluntary termination;
 - (ii) The names and TennCare identification numbers of all TennCare-eligible residents;
 - (iii) Name of the resident and name of the contact person for the resident (if any) for each resident with an application for TennCare eligibility pending;
 - (iv) A copy of the letter the facility will send to each resident informing him of the voluntary termination, and a copy of the letter to be sent to all TennCare-eligible residents regarding this action;
 - (v) A copy of the letter sent to all applicants on the Wait List informing them of the facility's voluntary termination;
 - (vi) Whether or not the facility intends to continue to provide services to non-TennCare residents who were residents of the facility on the date withdrawal was approved, in the event they convert to TennCare eligibility; and a copy of the notice to residents explaining that decision; and,

(Rule 1200-13-01-.06, continued)

- (vii) Other information determined by the Bureau or the MCOs as necessary to process the request for termination.
4. The termination of the provider's involvement in TennCare must be done in such a manner as to minimize the harm to current residents.

- (i) Residents who are currently TennCare-eligible shall be informed, in a notice to be provided by the facility and approved by the Bureau, that the facility has elected to withdraw from the TennCare program. If the facility has elected under Subpart (ii) of the section to continue to receive TennCare payments for residents of the facility as of the date of notice of withdrawal from the TennCare Program, the notice shall inform the resident of the right to remain in the facility as a TennCare resident as long as he wishes to do so and remain otherwise eligible under the rules of the TennCare Program. The notice shall also inform the resident that, if he wishes to transfer to another facility, under the supervision of TennCare, the NF where he now resides will assist in locating a new placement and providing orientation and preparation for the transfer, in accordance with 42 U.S.C.A. §1396r(c)(2)(B) and implementing regulations and guidelines, if any.
- (ii) All other residents of the facility shall receive a separate notice informing them of the facility's intention to withdraw from the TennCare program. The notice will be provided by the facility after having been first reviewed and approved by the Bureau. The notice shall inform such residents that, should they become eligible for TennCare coverage, they will be able to convert to TennCare from their current source of payment and remain in the facility only during a period that ends with the termination of the facility's provider agreement, a date to be determined in accordance with the terms of the provider agreement. They will not be eligible for TennCare coverage of their care in the facility thereafter. Transfer of these residents shall be considered an involuntary transfer and shall comply with federal and State regulations governing involuntary transfer or discharges.

The same notice will caution these residents that, if they require care as TennCare residents after the facility's provider agreement is terminated, they will have to transfer to another facility. The notice will also inform the residents that, when their present facility is no longer participating in the TennCare program, certain legal rights and protections that apply to all residents (regardless of source of payment) in TennCare facilities will no longer be available to those who remain in the NF. Readers of the notice will be informed that, if they wish to transfer, or to have their names placed on Wait Lists at other facilities, the facility that is withdrawing from the program will assist them by providing preparation and orientation under the supervision of the Bureau, as required by 42 U.S.C.A. § 1396r(c)(2)(B) and implementing regulations and guidelines, if any.

- (iii) Applicants whose names are on the facility's Wait List will be notified by the facility on a form that has been reviewed and approved by the Bureau that the facility intends to withdraw from the TennCare Program. They will be cautioned that they will not be able to obtain TennCare coverage for any care that they receive in the facility. The notice shall also inform them that certain legal rights and protections that apply to all residents (regardless of source of payment) in TennCare participating facilities will not be available in the NF to which they have applied, once that facility has withdrawn from the TennCare program.

(Rule 1200-13-01-.06, continued)

Applicants shall be informed in the notice that, if they wish to make application at other facilities, the withdrawing facility, under the supervision of TennCare, shall assist them in seeking placement elsewhere.

5. Following submission of a notice of withdrawal from the TennCare Program a facility cannot opt to receive continued TennCare payments for any resident unless it agrees to accept continual TennCare payment for all individuals who are residents on the date of the notice of withdrawal, and who are or become TennCare-eligible provided, however, that the Bureau or the Enrollee's MCO will pay the facility for all covered services actually provided to TennCare-eligible residents following notice of the facility's withdrawal and pending the resident's transfer or discharge. In instances where facilities elect to continue to receive such TennCare payments, their provider agreements will remain in effect until the last TennCare-eligible individual, who resided in the facility as of the date of notification of withdrawal, has been discharged or transferred from the facility in accordance with TennCare and State licensure requirements.
 6. Facilities which terminate their provider agreement shall not be permitted to participate in TennCare for a period of at least two (2) years from the date the provider agreement is terminated.
 7. Unless the facility notifies the Bureau within thirty (30) days after giving a notice of termination, the facility may not stop the termination procedure consistent with this order without written approval from the Bureau.
- (b) NFs may be involuntarily decertified by the Tennessee Department of Health's Division of Health Care Facilities because of their failure to comply with the provisions of these rules. Facilities that are involuntarily decertified shall not be permitted to participate in the Medicaid program for a minimum of five (5) years from the date of the decertification.

Authority: T.C.A. 4-5-202, 4-5-208, 12-4-301, 71-5-105, 71-5-109, and Executive Order No. 23.
Administrative History: Original rule filed November 17, 1977; effective December 19, 1977. Amendment filed January 31, 1979; effective March 16, 1979. Amendment filed August 31, 1981; effective October 15, 1981. Amendment filed September 16, 1981; effective November 2, 1981. Amendment filed November 6, 1981; effective December 21, 1981. Amendment filed August 18, 1982; effective September 17, 1982. Amendment filed September 2, 1982; effective October 4, 1982. Amendment filed September 27, 1982; effective October 27, 1982. Amendment filed November 12, 1982; effective December 13, 1982. Amendment filed June 23, 1983; effective July 25, 1983. Amendment filed August 31, 1983; effective September 30, 1983. Amendment filed March 12, 1984; effective April 11, 1984. Amendment filed June 27, 1984; effective July 27, 1984. Amendments filed March 27, 1985; effective April 26, 1985. Amendment filed June 4, 1985; effective July 4, 1985. Amendment filed September 18, 1985; effective October 18, 1985. Amendment filed April 29, 1986; effective May 29, 1986. Amendment filed June 30, 1986; effective July 30, 1986. Amendment filed July 17, 1986; effective August 31, 1986. Amendment filed September 2, 1986; effective October 17, 1986. Amendment filed July 30, 1987; effective September 13, 1987. Amendment filed September 30, 1987; effective November 14, 1987. Amendment filed February 19, 1988; effective April 4, 1988. Amendment filed June 2, 1988; effective July 17, 1988. Amendment filed September 6, 1988; effective October 21, 1988. Amendment filed November 10, 1988; effective December 25, 1988. Amendment filed March 22, 1989; effective May 8, 1989. Amendment filed June 22, 1989; effective August 4, 1989. Amendment filed June 29, 1989; effective August 14, 1989. Amendment filed July 26, 1989; effective September 10, 1989. Amendment filed August 31, 1989; effective October 15, 1989. Amendment filed October 11, 1989; effective November 25, 1989. Amendment filed November 30, 1989; effective January 14, 1990. Amendment filed December 8, 1989; effective January 22, 1990. Amendments filed January 29, 1990; effective March 15, 1990. Amendment filed July 5, 1990; effective August 19, 1990. Amendment filed

(Rule 1200-13-01-.06, continued)

August 17, 1990; effective October 1, 1990. Amendment filed November 27, 1990; effective January 11, 1991. Amendment filed December 14, 1990; effective January 28, 1991. Amendment filed January 16, 1991; effective March 2, 1991. Amendment filed February 19, 1991; effective April 5, 1991. Amendment filed February 26, 1991; effective April 12, 1991. Amendment filed May 7, 1991; effective June 21, 1991. Amendment filed June 12, 1991; effective July 27, 1991. Amendment filed June 14, 1991; effective July 29, 1991. Amendment filed September 16, 1991; effective October 31, 1991. Amendment filed September 17, 1991; effective November 1, 1991. Amendment filed September 30, 1991; effective November 14, 1991. Amendment filed October 14, 1991; effective November 28, 1991. Amendment filed October 21, 1991; effective December 5, 1991. Amendment filed October 23, 1991; effective December 7, 1991. Amendment filed March 10, 1992; effective April 24, 1992. Amendment filed March 26, 1992; effective May 10, 1992. Amendment filed April 29, 1992; effective June 13, 1992. Amendment filed September 29, 1992; effective November 13, 1992. Amendment filed October 20, 1992; effective December 4, 1992. Amendment filed December 7, 1993; effective February 20, 1994. Amendment filed March 18, 1994; effective June 1, 1994. Amendment filed May 25, 1994; effective August 9, 1994. Amendment filed November 10, 1994; effective January 24, 1995. Amendment filed August 1, 1995; effective October 14, 1995. Amendment filed October 20, 1995; effective January 3, 1996. Amendment filed July 15, 1996; effective September 28, 1996. Amendment filed April 20, 1998; effective July 4, 1998. Amendment filed October 14, 1998; effective December 28, 1998. Amendment filed January 3, 2000; effective March 18, 2000. Amendment filed June 22, 2000; effective September 5, 2000. Amendment filed January 9, 2002; effective March 25, 2002. Amendment filed July 24, 2003; effective October 7, 2003. Public necessity rule filed July 1, 2005; effective through December 13, 2005. Public necessity rule filed September 26, 2005; effective through March 10, 2006. Amendments filed December 20, 2005; effective March 5, 2006. Amendment filed January 16, 2006; effective April 1, 2006. Amendment filed July 17, 2007; effective September 30, 2007. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendment filed May 27, 2010; effective August 25, 2010.

1200-13-01-.07 REPEALED

Authority: T.C.A. §§4-5-202, 71-5-105, 71-5-109 and Public Chapter 358 of the Acts of 1993.

Administrative History: Original rule filed November 17, 1977; effective December 19, 1977. Amendment filed January 31, 1977; effective March 16, 1979. Amendment filed June 23, 1983; effective July 25, 1983. Amendment filed June 27, 1984; effective July 27, 1984. Amendment filed May 8, 1985; effective August 13, 1985. Amendment filed April 29, 1986; effective May 29, 1986. Amendment filed January 22, 1988; effective March 7, 1988. Amendment filed January 30, 1989; effective March 16, 1989. Amendment filed January 29, 1990; effective March 15, 1990. Amendment filed February 23, 1990; effective April 9, 1990. Amendment filed July 5, 1990; effective August 19, 1990. Amendment filed August 30, 1990; effective October 14, 1990. Amendment filed October 30, 1990; effective December 14, 1990. Amendment filed January 9, 1991; effective February 23, 1991. Amendment filed February 27, 1991; effective April 13, 1991. Amendment filed April 29, 1991; effective June 13, 1991. Amendment filed May 8, 1991; effective June 22, 1991. Amendment filed June 12, 1991; effective July 27, 1991. Amendment filed September 19, 1991; effective November 3, 1991. Amendment filed March 9, 1992; effective April 23, 1992. Amendment filed March 26, 1992; effective May 10, 1992. Amendment filed March 27, 1992; effective May 11, 1992. Amendment filed May 1, 1992; effective June 15, 1992. Amendment filed August 4, 1992; effective September 18, 1992. Amendment filed September 29, 1992; effective November 13, 1992. Amendment filed October 20, 1992; effective December 4, 1992. Amendment filed December 4, 1992; effective January 19, 1993. Amendment filed December 30, 1992; effective February 16, 1993. Amendment filed December 10, 1993; effective February 23, 1994. Amendment filed March 18, 1994; effective June 1, 1994. Repeal filed January 28, 2007; effective April 11, 2007.

1200-13-01-.08 PERSONAL NEEDS ALLOWANCE (PNA), PATIENT LIABILITY, THIRD PARTY INSURANCE AND ESTATE RECOVERY FOR PERSONS RECEIVING LTC.

- (1) Personal Needs Allowance (PNA). The PNA is established for each Enrollee receiving LTC services in accordance with the Tennessee Medicaid State Plan, approved Section 1915(c)

(Rule 1200-13-01-.08, continued)

Waiver applications, and these rules. It is deducted from the Enrollee's monthly income in calculating Patient Liability for LTC services.

- (a) The PNA for each person receiving Medicaid-funded services in a NF or an ICF/MR is \$50. Persons with no income have no PNA. Persons with incomes that are less than \$50 per month (including institutionalized persons receiving SSI payments) may keep the entire amount of their income as their PNA.
- (b) The maximum PNA for persons participating in CHOICES Group 2 is 300% of the SSI FBR.
- (c) The maximum PNA for persons participating in one of the State's Section 1915(c) HCBS Waivers is as follows:
 - 1. The Statewide HCBS E/D Waiver: 200% of the SSI FBR, as defined in Rule 1200-13-01-.02.
 - 2. The Statewide MR Waiver: 200% of the SSI FBR.
 - 3. The Arlington MR Waiver: 200% of the SSI FBR.
 - 4. The Self-Determination MR Waiver: 300% of the SSI FBR.

(2) Patient Liability.

- (a) Enrollees receiving LTC services are required to contribute to the cost of their LTC if their incomes are at certain levels. They are subject to the post-eligibility treatment of income rules set forth in Section 1924 of the Social Security Act (42 U.S.C.A. § 1396r-5), and 42 C.F.R. § 435.725.
- (b) For Enrollees being served in HCBS Waivers, the State must also use institutional eligibility and post-eligibility rules for determining Patient Liability.
- (c) For Members of the CHOICES 217-Like Group, the State uses institutional eligibility and post-eligibility rules for determining Patient Liability in the same manner as specified under 42 C.F.R. §§ 435.217, 435.236, and 435.726 and Section 1924 of the Social Security Act (42 U.S.C.A. § 1396r-5), if the HCBS were provided under a Section 1915(c) Waiver.
- (d) For a Member of CHOICES Group 2 receiving the Short-Term NF Care benefit (for up to 90 days) or an Enrollee in one of the State's Section 1915(c) Waiver programs who is temporarily placed in a medical institution, i.e., a hospital, NF or ICF/MR (for up to 120 days if admitted prior to 3/1/2010, or up to 90 days if admitted on or after 3/1/2010), the post-eligibility calculation shall be performed as if the individual is continuing to receive HCBS. The purpose is to ensure that the individual can maintain a community residence for transition back to the community. After 90 or 120 days, as applicable, or as soon as it appears that the inpatient stay will not be a short-term stay, whichever comes first, a CHOICES Group 2 Member will be transitioned to CHOICES Group 1, or a waiver participant must be disenrolled from the waiver, and the institutional post-eligibility calculation shall apply.
- (e) Patient Liability shall be collected as follows:
 - 1. If the Enrollee resides in a NF, ICF/MR, or CBRA facility (i.e., an ACLF or Critical Adult Care Home), the Enrollee must pay his Patient Liability to the residential facility. The facility shall reduce the amount billed to the Bureau or the MCO, as

(Rule 1200-13-01-.08, continued)

applicable, by the amount of the Enrollee's Patient Liability obligation, regardless of whether such amount is actually collected by the facility.

2. If a CHOICES Group 2 Member does not reside in a CBRA facility, i.e., the Member is receiving HCBS (including Companion Care) in his own home, the Member must pay his Patient Liability to the MCO. The amount of Patient Liability collected will be used to offset the cost of CHOICES Group 2 benefits or CEA services provided as an alternative to covered CHOICES Group 2 benefits that were reimbursed by the MCO for that month. The amount of Patient Liability collected by the MCO cannot exceed the cost of CHOICES Group 2 benefits (or CEA services provided as an alternative to CHOICES Group 2 benefits) reimbursed by the MCO for that month.

- (f) A CHOICES provider, including an MCO, may decline to continue to provide LTC services to a CHOICES Member who fails to pay his Patient Liability. If other Contract Providers or the other TennCare MCO(s) operating in the Grand Division are unwilling to provide LTC services to a CHOICES Member who has failed to pay his Patient Liability, the Member may be disenrolled from the CHOICES program in accordance with the procedures set out in this Chapter.

(3) TPL for LTC.

- (a) LTC insurance policies are considered TPL and are treated like all other TPL policies, as described in Rule 1200-13-01-.04.
- (b) Applicants for the CHOICES program who have LTC insurance policies must report these policies to DHS upon enrollment in the CHOICES program. Applicants may be subject to criminal prosecution for knowingly providing incorrect information.
- (c) Obligations of CHOICES Members receiving NF or CBRA services (other than Companion Care) having insurance that will pay for care in a NF or other residential facility (including cash benefits to the Member for the cost of such services):
 1. If the benefits are assignable, the Member must assign them to the NF or residential facility. These benefits will be used to reduce the amounts that the MCO would otherwise be required to pay the NF or the residential facility for LTC services.
 2. If the benefits are not assignable, the Member must provide payment to the NF or the residential facility immediately upon receipt of the benefits. These benefits will be used to reduce the amounts that the MCO would otherwise be required to pay the NF or the residential facility for LTC services.
- (d) Obligations of CHOICES Members receiving non-residential HCBS or Companion Care services having insurance that will pay for HCBS (including cash benefits to the Member for the cost of such services):
 1. If the benefits are assignable, the Member must assign them to the MCO. These benefits will be used to reduce the amounts that the MCO would otherwise be required to pay for HCBS for the Member.
 2. If the benefits are not assignable, the Member must make payment to the MCO immediately upon receipt of the benefits. These benefits will be used to reduce the amounts that the MCO would otherwise be required to pay for HCBS for the Member.

(Rule 1200-13-01-.08, continued)

- (e) TPL payments do not reduce the amount of Patient Liability a Member is obligated to contribute toward the cost of LTC Services.
 - (f) If benefits received by the policyholder are not paid to the facility or MCO, as applicable, such benefits shall be considered income, and may render the person ineligible for TennCare (including LTC) benefits.
- (4) Estate Recovery. Persons enrolled in TennCare LTC programs are subject to the requirements of the FERP as set forth under Section 1917(b) of the Social Security Act, 42 U.S.C.A. § 1396p(b).
- (a) The State is required to seek adjustment or recovery for certain types of medical assistance from the estates of individuals as follows:
 - 1. For persons age fifty-five (55) and older, the State is obligated to seek adjustment or recovery for NF (including ICF/MR) services, HCBS, and related hospital and prescription drug services.
 - 2. For permanently institutionalized persons under age fifty-five (55), the State is obligated to seek adjustment or recovery for the institutional services.
 - (b) Estate recovery shall apply to the estates of individuals under age fifty-five (55) who are inpatients in a NF, ICF/MR, or other medical institution and who cannot reasonably be expected to be discharged home.
 - (c) A determination that an individual cannot reasonably be expected to be discharged to return home shall be made in accordance with the following.
 - 1. The PAE for LOC that is certified by the physician shall specify whether discharge is expected and the anticipated length of stay in the institution.
 - 2. The following shall be deemed sufficient evidence that a person cannot reasonably be expected to be discharged to return home and is thus permanently institutionalized:
 - (i) An approved PAE certified by the physician indicating that discharge is not expected; or,
 - (ii) The continued stay of a resident of a medical institution at the end of a temporary stay predicted by his physician at the time of admission to be no longer than six (6) months in duration.
 - (d) Written notice of the determination that the individual residing in a medical institution cannot reasonably be expected to be discharged to return home shall be issued to the individual or his Designated Correspondent. The notice shall explain the right to request a reconsideration review. Such request must be submitted in writing to the Bureau, Long Term Care Division, within thirty (30) days of receipt of the written notice. The reconsideration review shall be conducted as a Commissioner's Administrative Hearing in the manner set out in Rule 1200-13-01-.10(6)(f).

Authority: T.C.A. §§4-5-202, 4-5-208, 71-5-105, and 71-5-109. **Administrative History:** Original rule filed May 15, 1980; effective June 29, 1980. Amendment filed May 27, 1983; effective June 27, 1983. Amendment filed February 22, 1991; effective April 9, 1991. Emergency rule filed March 1, 2009; effective through August 28, 2010. Amendment filed May 27, 2010; effective August 25, 2010.

1200-13-01-.09 THIRD PARTY SIGNATURE.

- (1) No facility may require a third party signature for a Medicaid recipient as a condition of application or admission to, or continued stay in, the facility. However, any person appointed by a court of competent jurisdiction to act on behalf of a recipient may be required to perform all requirements normally required of an applicant.
- (2) If a facility has collected an advance payment or deposit from or on behalf of a person retroactively determined to be eligible for Medicaid, the amount collected less the amount determined by the Department of Human Services to be the patient's liability for that period of time shall be refunded within ten (10) days after receiving payment for retroactive period from the state of its agents.
- (3) The facility must file for such retroactive reimbursement for the full period of retroactive eligibility on the next claim for reimbursement filed by the facility following the date of notification of eligibility.

Authority: T.C.A. §§14-1945 and 14-23-109. **Administrative History:** Original rule filed May 15, 1980; effective June 29, 1980. Amendment filed October 8, 1985; effective November 7, 1985.

1200-13-01-.10 MEDICAL (LEVEL OF CARE) ELIGIBILITY CRITERIA FOR MEDICAID REIMBURSEMENT OF CARE IN NURSING FACILITIES.

- (1) Definitions. See Rule 1200-13-01-.02.
- (2) PreAdmission Evaluations and Transfer Forms
 - (a) A PAE is required in the following circumstances:
 1. When a Medicaid Eligible is admitted to a NF for receipt of Medicaid-reimbursed NF Services.
 2. When a private-paying resident of a NF attains Medicaid Eligible status.
 3. When Medicare reimbursement for SNF services has ended and Medicaid reimbursement for Level 2 NF services is requested.
 4. When a NF Eligible is changed from Medicaid Level 1 to Medicaid Level 2, or from Medicaid Level 1 or Level 2 reimbursement to a Chronic Ventilator or Tracheal Suctioning Enhanced Respiratory Care rate, except as specified in Rule 1200-13-01-.10(5)(f).
 5. When a NF Eligible is changed from Medicaid Level 2 or an Enhanced Respiratory Care rate to Medicaid Level 1, unless the individual has an approved unexpired Level 1 PAE.
 6. When a NF Eligible is changed from an Enhanced Respiratory Care rate to Medicaid Level 2, unless the individual has an approved unexpired Level 2 PAE.
 7. When a NF Eligible requires continuation of the same LOC beyond the expiration date assigned by the Bureau.
 8. When a NF Eligible no longer requires the specific skilled nursing or rehabilitative services for which a Level 2 PAE was approved but requires other Level 2 care in a NF.

(Rule 1200-13-01-.10, continued)

- (b) Transfer Forms are not required in Grand Divisions of the State where CHOICES has been implemented. A Transfer Form is required under the FFS program (prior to implementation of the CHOICES Program in the Grand Division) in the following circumstances:
 - 1. When a Medicaid Eligible having an approved unexpired PreAdmission Evaluation transfers from Medicaid Level 1 at one Nursing Facility to Medicaid Level 1 at another such facility; or
 - 2. When a Medicaid Eligible having an approved unexpired PreAdmission Evaluation transfers from Medicaid Level 2 at one Nursing Facility to Medicaid Level 2 at another. A Transfer Form may be used only if there is no change in the skilled nursing or rehabilitative service for which the PreAdmission Evaluation was approved. If the skilled nursing or rehabilitative service changes, a new PreAdmission Evaluation is required.
 - 3. When a Medicaid Eligible having an approved unexpired PAE transfers from Medicaid Level 1 in a NF to the Statewide E/D Waiver or from the Statewide E/D Waiver to Medicaid Level 1 in a NF. This requirement shall be in effect only in those Grand Divisions where the CHOICES Program has not been implemented.
- (c) A PreAdmission Evaluation is not required in the following circumstances:
 - 1. When a Medicaid Eligible with an approved unexpired Level 1 PreAdmission Evaluation returns to the Nursing Facility after being hospitalized.
 - 2. When a Medicaid Eligible with an approved unexpired Level 2 PreAdmission Evaluation returns to the Nursing Facility after being hospitalized, if there has been no change in the skilled nursing or rehabilitative service for which the PreAdmission Evaluation was approved.
 - 3. When a Medicaid Eligible changes from Level 2 to Level 1, if that individual was previously receiving Medicaid-reimbursed Level 1 care and still has an approved unexpired Level 1 PreAdmission Evaluation.
 - 4. When an individual's financial status changes from Medicaid Eligible to private pay and then back to Medicaid Eligible within a 90-day time period.
 - 5. To receive Medicaid co-payment when Medicare is the primary payer of Level 2 care.
 - 6. When a Transfer Form is appropriate in accordance with (2)(b).
 - 7. For authorization by an MCO of Ventilator Weaning services or short-term payment at the Tracheal Suctioning Enhanced Respiratory Care rate for a person who has just been weaned from the ventilator, but who still requires short-term intensive respiratory intervention. Medical necessity determinations and authorization of Ventilator Weaning services and short-term payment at the Tracheal Suctioning Enhanced Respiratory Care rate during the post-weaning period will be managed by the Enrollee's MCO.
- (d) If a NF admits or allows continued stay of a Medicaid Eligible without an approved PAE, it does so at its own risk and in such event the NF shall give the individual a plain language written notice, in a format approved by the Bureau, that Medicaid reimbursement will not be paid unless the PAE is approved and if it is not finally approved the individual can be held financially liable for services provided.

(Rule 1200-13-01-.10, continued)

- (e) An approved PreAdmission Evaluation is valid for ninety (90) calendar days beginning with the PAE Approval Date. An approved PreAdmission Evaluation that has not been used within ninety (90) calendar days of the PAE Approval Date can be updated within 365 calendar days of the PAE Approval Date if the physician certifies that the individual's current medical condition is consistent with that described in the approved PreAdmission Evaluation. If the individual's medical condition has significantly improved such that the previously approved PreAdmission Evaluation does not reasonably reflect the individual's current medical condition and functional capabilities, a new PreAdmission Evaluation shall be required. A PAE that is not used within 365 days of the PAE Approval Date is expired and cannot be updated.
- (f) A PAE must include a recent history and physical or current medical records that support the applicant's functional and/or skilled nursing or rehabilitative needs, as reflected in the PAE. A history and physical performed within 365 calendar days of the PAE Request Date may be used if the patient's condition has not significantly changed. Additional medical records (progress notes, office records, discharge summaries, etc.) may be used to supplement a history and physical and provide current medical information if changes have occurred since the history and physical was performed.
- (g) A PAE may be approved by the Bureau for a fixed period of time with an expiration date based on an assessment by the Bureau of the individual's medical condition and anticipated continuing need for inpatient nursing care. Notice of appeal rights shall be provided when a PAE is approved with an expiration date.
- (h) All individuals who reside in or seek admission to a Medicaid-certified Nursing Facility must have a PASRR Level I screen for mental illness and mental retardation. The initial Level I screen must be completed prior to admission to the Nursing Facility and submitted to TennCare regardless of: (1) payer source; (2) whether the PASRR screening is positive or negative (including specified exemptions); and (3) the level of nursing facility reimbursement requested. If the Level I screen indicates the need for a PASRR Level II evaluation of need for specialized services for mental illness and/or mental retardation, the individual must undergo the PASRR Level II evaluation prior to admission to the Nursing Facility.
- (i) Medicaid payment will not be available for any dates of Nursing Facility services rendered prior to the date the PASRR process is complete and the individual has been determined appropriate for nursing home placement. The PASRR process is complete when either:
 - 1. TennCare has received a negative Level I PASRR screen form and no contradictory information is subsequently received; or
 - 2. For persons with a positive Level I PASRR screen (as submitted or upon review and determination by the Bureau), the Bureau has received a certified exemption or advance categorical determination signed by the physician; or a determination by DMHDD and/or DIDS, as applicable, that the person is appropriate for NF placement. Determination by the Bureau that a Level II PASRR evaluation must be performed may be made:
 - (i) Upon receipt of a positive PASRR screen from the NF or other submitting entity;
 - (ii) Based on TennCare review of a negative PASRR screening form or history and physical submitted by a NF or other entity; or

(Rule 1200-13-01-.10, continued)

- (iii) Upon review of any contradictory information submitted in the PAE application or supporting documentation at any time prior to disposition of the PAE.
 - (j) A NF that has entered into a provider agreement with the Bureau or an MCO shall assist a resident or applicant as follows:
 - 1. The Nursing Facility shall assist a Nursing Facility resident or an applicant for admission in applying for Medicaid eligibility and in applying for Medicaid-reimbursed Nursing Facility care. This shall include assistance in properly completing all necessary paperwork and in providing relevant Nursing Facility documentation to support the PreAdmission Evaluation. Reasonable accommodations shall be made for an individual with disabilities or, alternatively, for a Designated Correspondent with disabilities when assistance is needed with the proper completion and submission of a PreAdmission Evaluation.
 - 2. The Nursing Facility shall request a Notice of Disposition or Change from the Department of Human Services upon learning that a resident or applicant has, or is likely to have, applied for Medicaid eligibility.
 - (k) The Bureau shall process PAEs independently of determinations of Medicaid eligibility by DHS; however, Medicaid reimbursement for NF care shall not be available until the PASRR process has been completed, and both the PAE and financial eligibility have been approved.
- (3) Medicaid Reimbursement
 - (a) A NF that has entered into a provider agreement with the Bureau or an Enrollee's MCO is entitled to receive Medicaid reimbursement for covered services provided to a NF Eligible if:
 - 1. The Nursing Facility has completed the PASRR process as defined in 1200-13-01-.10(2)(i) above.
 - 2. The Bureau has received an approvable PAE for the individual within ten (10) calendar days of the PAE Request Date or the physician certification date, whichever is earlier. The PAE Approval Date shall not be more than ten (10) days prior to date of submission of an approvable PAE. An approvable PAE is one in which any deficiencies in the submitted application are cured prior to disposition of the PAE.
 - 3. Prior to implementation of the CHOICES Program, for the same-level transfer to NF services (Level 1 to Level 1, Level 2 to Level 2, or HCBS to Level 1) of an individual having an approved unexpired PAE, the Bureau has received an approvable Transfer Form within ten (10) calendar days after admission into the same LOC at the admitting NF (i.e., the NF to which the individual is being transferred). For transfer from Level 1 NF services to the Statewide HCBS E/D Waiver, the Transfer Form must be submitted and approved prior to enrollment in HCBS.
 - 4. For a retroactive eligibility determination, the Bureau has received a Notice of Disposition or Change and has received an approvable request to update an approved, unexpired PAE within thirty (30) calendar days of the mailing date of the Notice of Disposition or Change. The effective date of payment for NF services shall not be earlier than the PAE Approval Date of the original approved, unexpired PAE that has been updated.

(Rule 1200-13-01-.10, continued)

5. If the NF participates in the Enrollee's MCO, reimbursement will be made by the MCO to the NF as a Network Provider. If the NF does not participate in the Enrollee's MCO, reimbursement will be made by the MCO to the NF as a non-participating provider, in accordance with Rule 1200-13-01-.05(9).
- (b) Any deficiencies in a submitted PAE application must be cured prior to disposition of the PAE to preserve the PAE submission date for payment purposes.
 1. Deficiencies cured after the PAE is denied but within thirty (30) days of the original PAE submission date will be processed as a new application, with reconsideration of the earlier denial based on the record as a whole (including both the original denied application and the additional information submitted). If approved, the effective date of PAE approval can be no earlier than the date of receipt of the information which cured the original deficiencies in the denied PAE. Payment will not be retroactive back to the date the deficient application was received or to the date requested in the deficient application.
 2. Once a PAE has been denied, the original denied PAE application must be resubmitted along with any additional information which cures the deficiencies of the original application. Failure to include the original denied application may delay the availability of Medicaid reimbursement for nursing facility services.
 - (c) The earliest date of Medicaid reimbursement for care provided in a Nursing Facility shall be the date that all of the following criteria are met:
 1. Completion of the PASRR process, as defined in 1200-13-01-.10(2)(i) above;
 2. The effective date of level of care eligibility as reflected by the PAE Approval Date;
 3. The effective date of Medicaid eligibility; and
 4. The date of admission to the Nursing Facility.
 - (d) A NF that has entered into a provider agreement with the Bureau or an MCO and that admits a Medicaid Eligible without completion of the PASRR process, and without an approved PAE or, where applicable, an approved Transfer Form does so without the assurance of reimbursement from the Bureau or the MCO.
 - (e) Medicaid reimbursement will only be made to a Nursing Facility on behalf of the Nursing Facility Eligible and not directly to the Nursing Facility Eligible.
 - (f) A NF that has entered into a provider agreement with the Bureau or an MCO shall admit individuals on a first come, first served basis, except as otherwise permitted by State and federal laws and regulations.
- (4) Criteria for Reimbursement of Medicaid Level 1 Care in a Nursing Facility
 - (a) The Nursing Facility must have completed the PASRR process as defined in 1200-13-01-.10(2)(i) above.
 - (b) The individual must be determined by DHS to be eligible for Medicaid reimbursement for NF care.

(Rule 1200-13-01-.10, continued)

- (c) An individual must meet both of the following criteria in order to be approved for Medicaid-reimbursed Level 1 care in a Nursing Facility:
1. Medical Necessity of Care: Care in a Nursing Facility must be expected to improve or ameliorate the individual's physical or mental condition, to prevent a deterioration in health status, or to delay progression of a disease or disability, and such care must be ordered and supervised by a physician on an ongoing basis.
 2. Need for Inpatient Nursing Care: The individual must have a physical or mental condition, disability, or impairment that, as a practical matter, requires daily inpatient nursing care. The individual must be unable to self-perform needed nursing care and must meet or equal one or more of the following criteria on an ongoing basis:
 - (i) Transfer - The individual is incapable of transfer to and from bed, chair, or toilet unless physical assistance is provided by others on an ongoing basis (daily or multiple times per week).
 - (ii) Mobility - The individual requires physical assistance from another person for mobility on an ongoing basis (daily or multiple times per week). Mobility is defined as the ability to walk, using mobility aids such as a walker, crutch, or cane if required, or the ability to use a wheelchair if walking is not feasible. The need for a wheelchair, walker, crutch, cane, or other mobility aid shall not by itself be considered to meet this requirement.
 - (iii) Eating - The individual requires gastrostomy tube feedings or physical assistance from another person to place food/drink into the mouth. Food preparation, tray set-up, and assistance in cutting up foods shall not be considered to meet this requirement.
 - (iv) Toileting - The individual requires physical assistance from another person to use the toilet or to perform incontinence care, ostomy care, or indwelling catheter care on an ongoing basis (daily or multiple times per week).
 - (v) Expressive and Receptive Communication - The individual is incapable of reliably communicating basic needs and wants (e.g., need for assistance with toileting; presence of pain) using verbal or written language; or the individual is incapable of understanding and following very simple instructions and commands (e.g., how to perform or complete basic activities of daily living such as dressing or bathing) without continual staff intervention.
 - (vi) Orientation - The individual is disoriented to person (e.g., fails to remember own name, or recognize immediate family members) or is disoriented to place (e.g., does not know residence is a Nursing Facility).
 - (vii) Medication Administration - The individual is not mentally or physically capable of self-administering prescribed medications despite the availability of limited assistance from another person. Limited assistance includes, but is not limited to, reminding when to take medications, encouragement to take, reading medication labels, opening bottles, handing to individual, and reassurance of the correct dose.

(Rule 1200-13-01-.10, continued)

- (viii) Behavior - The individual requires persistent staff intervention due to an established and persistent pattern of dementia-related behavioral problems (e.g., aggressive physical behavior, disrobing, or repetitive elopement).
- (ix) Skilled Nursing or Rehabilitative Services - The individual requires daily skilled nursing or rehabilitative services at a greater frequency, duration, or intensity than, for practical purposes, would be provided through a daily home health visit.

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

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

1. Medical Necessity of Care: Care in a Nursing Facility must be expected to improve or ameliorate the individual's physical or mental condition, to prevent a deterioration in health status, or to delay progression of a disease or disability, and such care must be ordered and supervised by a physician on an ongoing basis.
2. Need for Inpatient Care: The individual must have a physical or mental condition, disability, or impairment that continues to require the availability of daily inpatient nursing care.

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

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

- (a) The Nursing Facility must have completed the PASRR process as defined in 1200-13-01-.10(2)(i) above.
- (b) The individual must be determined by DHS to be eligible for Medicaid reimbursement for NF care.
- (c) An individual must meet both of the following criteria in order to be approved for Medicaid-reimbursed Level 2 care in a Nursing Facility:
 1. Medical Necessity of Care: Care in a Nursing Facility must be expected to improve or ameliorate the individual's physical or mental condition, to prevent a deterioration in health status, or to delay progression of a disease or disability, and such care must be ordered and supervised by a physician on an ongoing basis.
 2. Need for Inpatient Skilled Nursing or Rehabilitative Services on a Daily Basis: The individual must have a physical or mental condition, disability, or impairment that requires skilled nursing or rehabilitative services on a daily basis or skilled rehabilitative services at least five days per week when skilled rehabilitative services constitute the primary basis for the approval of the PreAdmission Evaluation. The individual must require such services at a greater frequency, duration, or intensity than, for practical purposes, would be provided through a daily home health visit. In addition, the individual must be mentally or physically

(Rule 1200-13-01-.10, continued)

unable to perform the needed skilled services or the individual must require skilled services which, in accordance with accepted medical practice, are not usually and customarily self-performed.

For interpretation of this rule, the following shall apply:

- (i) Administration of oral medications, ophthalmics, otics, inhalers, subcutaneous injections (e.g., fixed-dose insulin, subtherapeutic heparin, and calcitonin), topicals, suppositories, nebulizer treatments, oxygen administration, shall not, in and of itself, be considered sufficient to meet the requirement of (5)(c)2.
- (ii) Nursing observation and assessment, in and of itself, shall not be considered sufficient to meet the requirement of (5)(c)2. Examples of nursing services for which Level 2 reimbursement might be provided include, but are not limited to, the following:
 - (I) Gastrostomy tube feeding
 - (II) Sterile dressings for Stage 3 or 4 pressure sores
 - (III) Total parenteral nutrition
 - (IV) Intravenous fluid administration
 - (V) Nasopharyngeal and tracheostomy suctioning
 - (VI) Ventilator services
- (iii) A skilled rehabilitative service must be expected to improve the individual's condition. Restorative and maintenance nursing procedures (e.g., routine range of motion exercises; stand-by assistance during ambulation; applications of splints/braces by nurses and nurses aides) shall not be considered sufficient to fulfill the requirement of (5)(c)2. Factors to be considered in the decision as to whether a rehabilitative service meets, or continues to meet, the requirement of (5)(c)2. shall include, but not be limited to, an assessment of the type of therapy and its frequency, the remoteness of the injury or impairment, and the reasonable potential for improvement in the individual's functional capabilities or medical condition.
- (d) In order to be approved for Medicaid-reimbursed Level 2 care in a NF at the Chronic Ventilator rate of reimbursement, an individual must be ventilator dependent for at least 12 hours each day with an invasive patient end of the circuit (i.e., tracheostomy cannula).
- (e) In order to be approved by the Bureau for Medicaid-reimbursed Level 2 care in a NF at the Tracheal Suctioning rate of reimbursement, an individual must have a functioning tracheostomy and require suctioning through the tracheostomy, at a minimum, multiple times per eight (8) hour shift. The suctioning must be required to remove excess secretions and/or aspirate from the trachea, which cannot be removed by the patient's spontaneous effort. Suctioning of the nasal or oral cavity does not qualify for this higher level of reimbursement. An MCO may authorize, based on medical necessity, short-term payment at the Tracheal Suctioning Enhanced Respiratory Care rate for a person who has just been weaned from the ventilator, but who still requires short-term intensive respiratory intervention during the post-weaning period.
- (f) Determination of medical necessity and authorization for Medicaid reimbursement of Ventilator Weaning services, or short-term payment at the Tracheal Suctioning Enhanced Respiratory Care rate for a person who has just been weaned from the ventilator, but who still requires short-term intensive respiratory intervention shall be managed by the Enrollee's MCO.

(Rule 1200-13-01-.10, continued)

(6) PreAdmission Evaluation Denials and Appeal Rights

- (a) A Medicaid Eligible or the legal representative of the Medicaid Eligible has the right to appeal the denial of a PreAdmission Evaluation and to request a Commissioner's Administrative Hearing by submitting a written letter of appeal to the Bureau of TennCare, Division of Long-Term Care, within thirty (30) calendar days of receipt of the notice of denial.
- (b) If the Bureau denies a PAE, the individual will be notified in the following manner:
 - 1. A written notice of denial shall be sent to the individual and, where applicable, to the designated correspondent. A notice of denial shall also be mailed or faxed to the Nursing Facility. This notice shall advise the individual of the right to appeal the denial decision within thirty (30) calendar days. The notice shall also advise the individual of the right to submit within thirty (30) calendar days either the original PreAdmission Evaluation with additional information for review or a new PreAdmission Evaluation. The notice shall be mailed to the individual's address as it appears upon the PreAdmission Evaluation. If no address appears on the PreAdmission Evaluation and supporting documentation, the notice will be mailed to the Nursing Facility for forwarding to the individual.
 - 2. If the PAE is resubmitted with additional information for review and the Bureau continues to deny the PAE, another written notice of denial shall be sent as described in (6)(b)1.
- (c) The individual has the right to be represented at the hearing by anyone of his/her choice. The hearing will be conducted according to the provisions of the Tennessee Uniform Administrative Procedures Act.
- (d) Reasonable accommodations shall be made for individuals with disabilities who require assistance with an appeal.
- (e) Any notice required pursuant to this section shall be a plain language written notice.
- (f) When a PAE is approved for a fixed period of time with an Expiration Date determined by the Bureau, the individual shall be provided with a notice of appeal rights, including the opportunity to submit an appeal within thirty (30) calendar days prior to the Expiration Date. Nothing in this section shall preclude the right of the individual to submit a new PAE establishing medical necessity of care when the Expiration Date has been reached.

Authority: T.C.A. 4-5-202, 4-5-208, 4-5-209, 71-5-105, 71-5-109, Executive Order No. 11, and Executive Order No. 23. **Administrative History:** Original rule filed October 22, 1981; effective December 7, 1981. Amendment filed March 1, 1982; effective April 15, 1982. Amendment filed June 23, 1983; effective July 25, 1983. Amendment filed May 24, 1985; effective June 23, 1985. Amendment filed November 9, 1988; effective December 24, 1988. Amendment filed March 30, 1995; effective June 15, 1995. Repeal and new rule filed June 29, 2000; effective September 12, 2000. Amendment filed July 24, 2003; effective October 7, 2003. Amendment filed September 30, 2005; effective December 14, 2005. Public necessity rule filed July 1, 2009; effective through December 13, 2009. Amendment filed September 11, 2009; effective December 10, 2009. Emergency rules filed March 1, 2010; effective through August 28, 2010. Amendments filed May 27, 2010; effective August 25, 2010.

1200-13-01-.11 RECIPIENT ABUSE AND OVERUTILIZATION OF MEDICAID PROGRAM.

- (1) Definitions:

(Rule 1200-13-01-.11, continued)

- (a) Abuse: Recipient practices or recipient involvement in practices including overutilization of Medicaid Program service that result in costs to the Medicaid Program which are not medically necessary or medically justified.
 - (b) Commencement of Services: The time at which the first covered service(s) is rendered to a Medicaid recipient for each individual medical condition.
 - (c) Emergency: The sudden and unexpected onset of a medical condition requiring treatment immediately after onset or within 72 hours in order to prevent serious disability or death.
 - (d) Initiating Provider: The provider who renders the first covered service to a Medicaid recipient whose current medical condition requires the services of more than one (1) provider.
 - (e) Lock-in Provider: A provider whom a recipient on lock-in status has chosen and to whom a recipient is assigned by the Bureau for purposes of receiving medical services and referral to other providers.
 - (f) Lock-in Status: The restriction of a recipient to a specified and limited number of health care providers.
 - (g) Overutilization: Recipient initiated use of Medicaid services or items at a frequency or amount that is not medically necessary or medically justified.
 - (h) Prior Approval Status: The restriction of a recipient to a procedure wherein all health care services, except in emergency situations, must be approved by the Bureau prior to the delivery of services.
- (2) When a determination is made by the Bureau that a recipient committed, attempted to commit or aided in the commission of an abuse or overutilization of the Medicaid Program it shall:
- (a) Restrict the recipient by placing the recipient on lock-in status for an initial period of eighteen (18) months; or
 - (b) Restrict the recipient by placing the recipient on prior approval status for an initial period of eighteen (18) months.
- (3) Activities or practices which may evidence overutilization of the Medicaid Program for which the commission or attempted commission justifies placement on lock-in status of all recipients involved, include but are not limited to:
- (a) Treatment by several physicians for the same diagnosis.
 - (b) Obtaining the same or similar controlled substances from several physicians.
 - (c) Obtaining controlled substances in excess of the maximum recommended dose.
 - (d) Receiving combinations of drugs which act synergistically or belong to the same class.
 - (e) Frequent treatment for diagnoses which are highly susceptible to abuse.
 - (f) Receiving services and/or drugs from numerous providers.

(Rule 1200-13-01-.11, continued)

- (g) Obtaining the same or similar drugs on the same day or at frequent intervals.
- (h) Frequent use of emergency room in non-emergency situations.
- (4) Activities or practices which may evidence abuse of the Medicaid Program for which the commission or attempted commission justifies placement on prior approval status of all recipients involved, include but are not limited to:
 - (a) Trading, swapping or selling of Medicaid cards.
 - (b) Forging or altering drug prescriptions.
 - (c) Selling Medicaid paid prescription drugs.
 - (d) Failing to promptly report loss or theft of a Medicaid card when the recipient knew or should have known the card was lost or stolen.
 - (e) Inability to provide for the security and integrity of assigned Medicaid card.
 - (f) Altering a Medicaid card.
 - (g) Failure to control overutilization activity while on lock-in status.
 - (h) Knowingly providing incomplete, inaccurate or erroneous information during Medicaid financial eligibility determination.
 - (i) Knowingly providing false, incomplete, inaccurate or erroneous information to provider(s) in order to receive covered services for which the recipient is ineligible.
 - (j) The use of a Medicaid card by a recipient other than the recipient to which it is assigned to receive or attempt to receive covered medical services.
- (5) The Bureau shall conduct a review of all recipients placed on lock-in or prior approval status upon the expiration of the initial and any additional restriction period(s) and shall:
 - (a) Remove the recipient from lock-in or prior approval status and reinstate the recipient to the normal Medicaid status, or
 - (b) If the recipient's activity indicates continued or attempted abuse of overutilization, regardless of the exact nature of the activity, during the initial and/or additional restriction period(s),
 - 1. continue the recipient on lock-in or prior approval status for an additional eighteen (18) months; or
 - 2. change the recipient from lock-in or prior approval status for an additional eighteen (18) months; or
 - 3. change the recipient from Prior approval to lock-in status for an additional eighteen (18) months.
 - (c) If at any time during which a recipient is on lock-in status, the recipient's activities indicate continued abuse or attempted abuse of the Medicaid Program, the Bureau may review the recipient's status and change the recipient from lock-in status to prior approval status for the remainder of the initial or additional restriction period.

(Rule 1200-13-01-.11, continued)

- (d) The Bureau may reconsider the need to continue a recipient on lock-in or prior approval status upon notification and written verification from a licensed physician that the recipient is suffering from a medical condition including but not limited to:
 - 1. a catastrophic illness such as terminal cancer or renal dialysis; or
 - 2. a condition which necessitates admission to an inpatient facility for an extended period of time.
- (6) A recipient is entitled to a fair hearing in the following circumstances:
 - (a) When the Bureau makes the initial determination to place the recipient on lock-in or prior approval status; and
 - (b) When the Bureau, after any recipient status review, makes a determination to:
 - 1. continue the recipient on lock-in or prior approval status; or
 - 2. change the recipient from lock-in to prior approval status; or
 - 3. change the recipient from prior approval to lock-in status.
 - (c) When the Bureau, pursuant to prior approval procedures, denies a prior approval status recipient's claim to or request for the provision of a covered service.
 - (d) When the action of the Bureau placing a recipient on a restricted status would result or has resulted in the denial of reasonable access to Medicaid services of adequate quality pursuant to subsection (13) of this section.
- (7) Fair Hearing Procedures: The following procedure shall apply when a recipient becomes entitled to a fair hearing pursuant to section (6):
 - (a) The Bureau shall notify the recipient in writing by certified mail, return receipt requested, of its determination. The notice shall contain:
 - 1. the specific and comprehensive reasons for the determination, and
 - 2. a statement of the Bureau's intended action, and
 - 3. a statement of the recipient's right to a hearing pursuant to the Uniform Administrative Procedures Act (T.C.A. Section 4-5-101 et seq.).
 - (b) A recipient must request a hearing within fifteen (15) days of receipt of the notice by filing such request in writing with the Bureau. The request for hearings pursuant to subsection 6(c) must be made in writing within fifteen (15) days of the date on which the claim to or request for services is denied.
 - (c) If a recipient fails to request a hearing within the designated time limit the recipient shall forfeit the right to a hearing on the action specified in the notice and the Bureau shall take such action as it specified in the notice.
 - (d) If a recipient requests a hearing within the designated time limit, the Bureau shall schedule a hearing and notify the recipient of the time and place. The recipient's then existing status will not change pending a final determination after the hearing.

(Rule 1200-13-01-.11, continued)

- (e) A hearing requested pursuant to subsection (6)(c) shall be scheduled within ten (10) days of receipt of the request.
- (8) Lock-in Status Procedures: For services rendered to any lock-in status recipient the following shall apply:
 - (a) The Bureau shall request the recipient to submit the name(s) of the provider(s) from whom the recipient wishes to receive services.
 - (b) If the recipient's condition necessitates the services of more than one (1) physician, other physicians will be allowed to provide needed services and submit a claim to Medicaid; however, the physicians must be of different specialties and Medicaid program participants.
 - (c) The name(s) submitted by the recipient shall become the recipient's lock-in provider(s) unless the Bureau determines that the provider(s) is/are ineligible, unable or unwilling to become the lock-in provider(s) in which case additional provider names will be requested.
 - (d) If the recipient fails to submit the requested provider name(s) within ten (10) days of the receipt of the Bureau's request, the Bureau may assign, as lock-in providers one (1) physician (non-specialist) and one (1) pharmacy from those utilized recently by the recipient, or the recipient will be placed on prior approval status until the requested provider name(s) are received and approved by the Bureau.
 - (e) All referrals from a recipient's lock-in provider to a non-lock-in provider must be reported by telephone or in writing to the Bureau to avoid automatic denial of the referred providers claim.
 - (f) A recipient who is on lock-in status may change providers by giving at least thirty (30) days written notice to the Bureau. Elective changes will only be allowed every six (6) months. Emergency changes (i.e., death of provider, discharge of recipient by provider, etc.) may be accomplished at any time by telephoning the Bureau, but must be followed by a written request within ten (10) days.
 - (g) Upon the change of a lock-in provider pursuant to subsection (8)(f) of this section all referrals to other providers made by the previous lock-in provider shall no longer be valid.
 - (h) All providers are responsible for ascertaining recipient Medicaid status and, except in the case of an emergency or approved referral or admission to a long term care facility, reimbursement for services rendered to a lock-in status recipient by any provider other than the recipient's lock-in provider shall be denied.
- (9) Prior Approval Status Procedures: For services rendered to any prior approval status recipient the following shall apply:
 - (a) The provider is responsible for ascertaining the status of any Medicaid recipient.
 - (b) The provider is responsible for securing prior approval by telephone from the Bureau in all cases, except emergencies, by calling the telephone number listed on the recipient's Medicaid care, in accordance with the following:
 - 1. If the commencement of services is during the normal office hours (8:00 a.m. to 4:30 p.m.) on any state working day, approval must be obtained prior to the

(Rule 1200-13-01-.11, continued)

- commencement of services regardless of the number of services or the length of time services are provided.
2. If the commencement of services is during any time state offices are closed, approval must be obtained no later than the closing hour of the next state working day following the commencement of services regardless of the number of services or the length of time services are provided.
- (c) In either of the circumstances listed in subsection (9)(b) of this section, if a recipient's current medical condition requires the services of more than one (1) provider the following shall apply:
1. If the initiating provider secures prior approval in accordance with the rules, the subsequent provider(s) need not secure prior approval for any medically necessary services rendered.
 2. If the initiating provider fails to secure prior approval in accordance with the rules, all other provider claims arising from that medical condition shall be denied except claims submitted by any subsequent provider who secures prior approval in accordance with the rules.
- (d) The provider may not seek payment from Medicaid or the recipient for any medical services rendered without prior approval or for services rendered beyond the scope of the services contemplated by any prior approval.
- (e) A long term care provider is not at risk of a claim denial under this rule for covered services rendered to a prior approval status recipient. Compliance with all other long term care rules is mandatory to provider reimbursement.
- (f) A provider is not at risk of a claim denial for maintenance prescriptions filled during any time at which state offices are closed, however, prior approval procedures pursuant to subsection (9)(b) must still be followed.
- (g) Services rendered or to be rendered shall be approved or denied based upon:
1. The securing of prior approval;
 2. Medical necessity;
 3. The recipient's medical history;
 4. The recipient's medical records;
 5. The medical timeliness of the services; and
 6. Review by the Medicaid Medical Director upon request by the recipient, provider or the Bureau prior to initial denial.
- (h) A provider is not at risk of a claim denial for inpatient hospital admission and related medical services if preadmission approval has been obtained.
- (10) Emergency Services: Any Medicaid provider may render services to a recipient on lock-in or prior approved status in the event of an emergency, provided however that reimbursement for services provided will be allowed only under the following circumstances:

(Rule 1200-13-01-.11, continued)

- (a) The provider notifies the Bureau by telephone no later than the end of the next state working day following the commencement of services;
 - (b) The provider presents sufficient medical evidence concerning the nature of the emergency to justify reimbursement; and
 - (c) Review by the Medicaid Medical Director upon request by the recipient, provider or the Bureau prior to initial denial.
- (11) Identification Verification of Medicaid Lock-In and Prior Approval Recipients. Medicaid Lock-In and Prior Approval Status Cards:
 - (a) These special cards are pink in color for ready identification and must be signed by the recipient.
 - (b) The date of birth, eligibility period and sex designations on the card shall be utilized to assist in provider verification of card ownership as well as current eligibility status of the Card holder.
 - (c) Each prescription dispensed shall be noted on the Medicaid card by marking through a circled number on the Medicaid card.
 - (d) Pink cards indicating restrictions of SPECIAL PRIOR APPROVAL ONLY require that before commencement of services, the Bureau must be contacted at the telephone number specified on the card in accordance with the rules contained in subsection (9) of this section.
 - (e) Pink cards indicating restrictions of SPECIAL LOCK IN/PHARMACY/MD limit service to the providers listed in the additional information block and in accordance with the rules contained in subsection (8) of this section.
- (12) If reimbursement is denied based on a provider's failure to comply with any rules contained in this section the recipient or the recipient's family shall NOT be held financially responsible for payment for any covered services rendered.
- (13) If the placement of a recipient on lock-in or prior approval status would result or has resulted in the denial of reasonable access - taking into account geographic locations and reasonable travel time - to Medicaid services of adequate quality, the Bureau shall:
 - (a) Prior to the placement on restricted status, take such action as is necessary to assure reasonable access to services of adequate quality; or
 - (b) Reinstate the recipient to the normal Medicaid status until the Bureau can assure reasonable access to services of adequate quality.

Authority: T.C.A. §§4-5-202, 4-5-208, 71-5-105, 71-5-109, and Public Chapter 358 of the Acts of 1993.

Administrative History: Original rule filed June 7, 1982; effective July 22, 1982. Repeal and new rule filed February 23, 1987; effective April 9, 1987. Amendment filed March 22, 1989; effective May 16, 1989. Amendment filed June 8, 1990; effective July 23, 1990. Amendment filed March 18, 1994; effective June 1, 1994. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendments filed May 27, 2010; effective August 25, 2010.

1200-13-01-.12 REPEALED.

Authority: T.C.A. §§4-5-202, 14-23-105, 14-23-109, 71-5-105, and 71-5-109. **Administrative History:** Original rule filed March 2, 1983; effective April 4, 1983. Repeal and new rule filed February 4, 1985;

(Rule 1200-13-01-.12, continued)

effective March 6, 1985. Amendment filed July 5, 1990; effective August 19, 1990. Repeal filed March 18, 1994; effective June 1, 1994.

1200-13-01-.13 REPEALED.

Authority: T.C.A. 4-5-202, 71-5-105, 71-5-109, and Executive Order No. 11. **Administrative History:** Original rule filed June 23, 1983; effective July 25, 1983. Amendment filed March 30, 1995; effective June 15, 1995. Repeal filed June 29, 2000; effective September 12, 2000.

1200-13-01-.14 REPEALED.

Authority: T.C.A. §§4-5-202, 71-5-105, 71-5-109, and Public Chapter 358 of the Acts of 1993. **Administrative History:** Original rule filed February 14, 1984; effective March 15, 1984. Amendment filed August 21, 1984; effective September 20, 1984. Repeal filed March 18, 1994; effective June 1, 1994.

1200-13-01-.15 MEDICAL (LOC) ELIGIBILITY CRITERIA FOR MEDICAID REIMBURSEMENT OF CARE IN AN ICF/MR.

- (1) Definitions. See Rule 1200-13-01-.02.
- (2) ICF/MR PreAdmission Evaluations and Transfer Forms
 - (a) An ICF/MR PreAdmission Evaluation is required to be submitted to the Bureau of TennCare for approval when
 1. A Medicaid Eligible is admitted to an ICF/MR.
 2. A private-paying resident of an ICF/MR attains Medicaid Eligible status or applies for Medicaid eligibility. A new ICF/MR PreAdmission Evaluation is not required when an individual's financial status changes from Medicaid Eligible to private pay and then back to Medicaid Eligible within a 90-day time period.
 - (b) A Transfer Form is required to be submitted to the Bureau of TennCare for approval when an ICF/MR Eligible having an approved unexpired ICF/MR PAE transfers from one ICF/MR to another ICF/MR or from the HCBS MR Waiver Program to an ICF/MR. A Transfer Form is required to be submitted to the Division of Intellectual Disabilities Services for approval when an ICF/MR Eligible having an approved unexpired ICF/MR PAE transfers from an ICF/MR to the HCBS MR Waiver Program.
 - (c) An approved ICF/MR PreAdmission Evaluation is valid for ninety (90) calendar days from the ICF/MR PAE Approval Date. An approved ICF/MR PreAdmission Evaluation that has not been used within ninety (90) calendar days of the ICF/MR PAE Approval Date can be updated within 365 calendar days of the ICF/MR PAE Approval Date if the physician certifies that the individual's current medical condition is consistent with that described in the approved ICF/MR PreAdmission Evaluation. A PAE that is not used within 365 days of the PAE Approval Date is expired and cannot be updated.
 - (d) An ICF/MR PreAdmission Evaluation must include a recent medical history and physical signed by a physician who is licensed as a doctor of medicine or doctor of osteopathy, or by a licensed nurse practitioner or physician's assistant. A medical history and physical performed within 365 calendar days of the ICF/MR PAE Request Date may be used if the individual's condition has not significantly changed. Additional medical records (progress notes, office records, discharge summaries, etc.) may be

(Rule 1200-13-01-.15, continued)

used to supplement a history and physical and provide current medical information if changes have occurred since the history and physical was performed.

- (e) An ICF/MR PAE must include a psychological evaluation of need for care. Pursuant to 42 C.F.R. § 456.370(b), such evaluation must be performed before admission to the ICF/MR or authorization of payment, but not more than three months before admission.

(3) Medicaid Reimbursement

- (a) An ICF/MR which has entered into a provider agreement with the Bureau of TennCare is entitled to receive Medicaid reimbursement for covered services provided to an ICF/MR Eligible if:
 - 1. The Bureau of TennCare has received an approvable ICF/MR PreAdmission Evaluation for the individual within ten (10) calendar days of the ICF/MR PAE Request Date or the physician certification date, whichever is earlier. The PAE Approval Date shall not be more than ten (10) days prior to date of submission of an approvable PAE. An approvable PAE is one in which any deficiencies in the submitted application are cured prior to disposition of the PAE.
 - 2. For the transfer to an ICF/MR of an individual having an approved unexpired ICF/MR PreAdmission Evaluation, the Bureau of TennCare has received an approvable Transfer Form within ten (10) calendar days after the date of the transfer. For transfer from ICF/MR services to an HCBS MR Waiver program, the transfer form must be submitted and approved prior to enrollment in the HCBS MR Waiver program.
 - 3. For a retroactive eligibility determination, the Bureau of TennCare has received a Notice of Disposition or Change and has received an approvable request to update an approved, unexpired ICF/MR PreAdmission Evaluation within thirty (30) calendar days of the mailing date of the Notice of Disposition or Change. The effective date of payment for ICF/MR services shall not be earlier than the PAE Approval Date of the original approved, unexpired PAE which has been updated.
- (b) Any deficiencies in a submitted PAE application must be cured prior to disposition of the PAE to preserve the PAE submission date for payment purposes.
 - 1. Deficiencies cured after the PAE is denied but within thirty (30) days of the original PAE submission date will be processed as a new application, with reconsideration of the earlier denial based on the record as a whole (including both the original denied application and the additional information submitted). If approved, the effective date of PAE approval can be no earlier than the date of receipt of the information which cured the original deficiencies in the denied PAE. Payment will not be retroactive back to the date the deficient application was received or to the date requested in the deficient application.
 - 2. Once a PAE has been denied, the original denied PAE application must be resubmitted along with any additional information which cures the deficiencies of the original application. Failure to include the original denied application may delay the availability of Medicaid reimbursement for ICF/MR services.
- (c) An ICF/MR that admits a Medicaid Eligible without an approved ICF/MR PreAdmission Evaluation or, where applicable, an approved Transfer Form does so without the assurance of reimbursement from the Bureau of TennCare.

(Rule 1200-13-01-.15, continued)

- (4) Criteria for Medicaid-reimbursed Care in an Intermediate Care Facility for the Mentally Retarded (ICF/MR)
 - (a) Medicaid Eligible Status: The individual must be determined by the Tennessee Department of Human Services to be financially eligible for Medicaid-reimbursed care in an Intermediate Care Facility for the Mentally Retarded.
 - (b) An individual must meet all of the following criteria in order to be approved for Medicaid-reimbursed care in an Intermediate Care Facility for the Mentally Retarded:
 - 1. Medical Necessity of Care: Care must be expected to enhance the individual's functional ability or to prevent or delay the deterioration or loss of functional ability. Care in an Intermediate Care Facility for the Mentally Retarded must be ordered and supervised by a physician.
 - 2. Diagnosis of Mental Retardation or Related Conditions.
 - 3. Need for Specialized Services for Mental Retardation or Related Conditions: The individual must require a program of specialized services for mental retardation or related conditions provided under the supervision of a qualified mental retardation professional (QMRP). The individual must also have a significant deficit or impairment in adaptive functioning in one of the following areas: communication, comprehension, behavior, or activities of daily living (e.g., toileting, bathing, eating, dressing/grooming, transfer, mobility).
 - (c) Individuals with mental retardation or related conditions who were in an Intermediate Care Facility for the Mentally Retarded or who were in community residential placements funded by the Division of Intellectual Disabilities on or prior to the effective date of this rule may be deemed by the Bureau of TennCare to meet the requirements of (4)(b)2. and (4)(b)3.
 - (d) For continued Medicaid reimbursement of care in an Intermediate Care Facility for the Mentally Retarded, an individual must continue to meet the criteria specified in (4)(a) and (4)(b), unless otherwise exempted by (4)(c).
- (5) Grievance process
 - (a) A Medicaid Eligible or the legal representative of the Medicaid Eligible has the right to appeal the denial of an ICF/MR PreAdmission Evaluation and to request a Commissioner's Administrative Hearing by submitting a written letter of appeal to the Bureau of TennCare within thirty (30) calendar days of receipt of the notice of denial.
 - (b) If the Bureau of TennCare denies an ICF/MR PreAdmission Evaluation, the individual will be notified in the following manner:
 - 1. A written notice of denial shall be sent to the individual and, where applicable, to the Designated Correspondent. A notice of denial shall also be sent to the ICF/MR. This notice shall advise the individual of the right to appeal the denial decision within thirty (30) calendar days. The notice shall also advise the individual of the right to submit within thirty (30) calendar days either the original ICF/MR PAE with additional information for review or a new ICF/MR PAE. The notice shall be mailed to the individual's address as it appears upon the ICF/MR PAE. If no address appears on the ICF/MR PAE and supporting documentation, the notice will be mailed to the ICF/MR for forwarding to the individual.

(Rule 1200-13-01-.15, continued)

2. If an ICF/MR PreAdmission Evaluation is resubmitted with additional information for review and if the Bureau of TennCare continues to deny the ICF/MR PreAdmission Evaluation, another written notice of denial shall be sent as described in (5)(b)1.
- (c) The individual has the right to be represented at the hearing by anyone of their choice. The hearing will be conducted according to the provisions of the Tennessee Uniform Administrative Procedures Act.
- (d) Reasonable accommodations shall be made for individuals with disabilities who require assistance with appeals.
- (e) Any notice required pursuant to this section shall be a plain language written notice.

Authority: T.C.A. 4-5-202, 4-5-203, 4-5-208, 4-5-209, 71-5-105, 71-5-109, and Executive Order No. 11.
Administrative History: Original rule filed June 22, 2000; effective September 5, 2000. Public necessity rule filed July 1, 2009; effective through December 13, 2009. Amendment filed September 11, 2009; effective December 10, 2009. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendments filed May 27, 2010; effective August 25, 2010.

1200-13-01-.16 REPEALED.

Authority: T.C.A. §§4-5-202, 71-5-105, 71-5-109, and Public Chapter 358 of the Acts of 1993.
Administrative History: Original rule filed September 11, 1987; effective October 31, 1987. Amendment filed March 6, 1991; effective April 20, 1991. Amendment filed September 9, 1991; effective October 24, 1991. Amendment filed November 27, 1991; effective January 11, 1992. Amendment filed October 20, 1992; effective December 4, 1992. Amendment filed December 4, 1992; effective January 19, 1993. Amendment filed March 18, 1994; effective June 1, 1994. Repeal filed January 26, 2007; effective date April 11, 2007. Emergency rule filed March 1, 2010; effective through August 28, 2010.

1200-13-01-.17 STATEWIDE HOME AND COMMUNITY BASED COMMUNITY BASED SERVICES WAIVER FOR THE ELDERLY AND DISABLED (STATEWIDE E/D WAIVER).

- (1) Definitions. See Rule 1200-13-01-.02.
- (2) Waiver Services. Covered Waiver Services shall include the following:
 - (a) Case Management. All case management contacts shall be documented in the Enrollee's medical record and shall include one face-to-face visit per month, by a nurse or a social worker, with the Enrollee in the Enrollee's home. At least every 90 days, the home visit shall be made by a registered nurse unless otherwise directed in the waiver. Such monthly documentation shall note that the Individual Plan of Care has been reviewed and revised as appropriate.
 - (b) Home-delivered Meals.
 1. The Administrative Lead Agency shall ensure that providers of home meals are properly licensed or certified by the appropriate regulatory authority and shall require that such providers comply with all laws, ordinances, and codes regarding preparation, handling, and delivery of food.
 2. For those Enrollees who require medically prescribed diets, the Administrative Lead Agency shall ensure that such meals are planned by a registered dietitian who provides consultation to the licensed nurse supervising the Enrollee's care.
 3. Services are limited to one (1) meal per day.

(Rule 1200-13-01-.17, continued)

(c) Minor Home Modifications.

1. Minor home modifications shall not be provided unless specified in the Individual Plan of Care. The Administrative Lead Agency shall notify the Bureau of TennCare and obtain prior authorization for minor home modifications exceeding \$6,000 prior to initiating the intended modification.
2. The Bureau of TennCare shall be the payor of last resort for minor home modifications.

(d) Personal Care Services.

1. Personal care aides shall meet the standards of education and training required by the Administrative Lead Agency and approved by the Bureau of TennCare. Enrollees with a diagnosis of mental retardation shall receive personal care services only from an agency licensed as a personal support services agency or a home care organization.
2. The personal care aide shall report to the Case Manager any significant changes in the Enrollee's physical or mental status.

(e) Personal Emergency Response Systems. Personal Emergency Response Systems shall be provided, as specified in the Individual Plan of Care and Safety Plan, for Enrollees:

1. Who receive daily caregiver services but who are alone for significant parts of the day and who would otherwise require extensive routine supervision; and
2. Who, based on an assessment by the Administrative Lead Agency of the Enrollee's mental and physical capabilities, have the capability to effectively utilize such a system.
3. Installation is limited to one (1) installation per Waiver program year. A Waiver program year runs from October 1 through September 30.

(f) Homemaker Services. Homemakers shall meet TennCare standards for education and training.

(g) Respite Care.

1. Inpatient Respite Care services will be provided on a short-term basis in a NF or ACLF, not to exceed nine (9) days per Waiver program year (October 1 through September 30).
2. In-Home Respite will be provided on a short-term basis in the patient's residence (excluding NFs and ACLFs) not to exceed two hundred sixteen (216) hours per Waiver program year (October 1 through September 30).

(h) Adult Day Care. Services will be limited to 2080 hours per Waiver program year (October 1 through September 30).

(i) ACLF Services.

(j) Assistive Technology. Services will be limited to nine (9) units of service or \$900.00 per Waiver program year (October 1 through September 30).

(Rule 1200-13-01-.17, continued)

- (k) Personal Care Assistance/Attendant. Services will be limited to 1080 hours per Waiver program year (October 1 through September 30).
 - (l) Pest Control Services will be limited to nine (9) occasions per Waiver program year (October 1 through September 30).
- (3) Documentation of Waiver Services.
 - (a) The Administrative Lead Agency shall ensure that all services are accurately and timely documented.
 - (b) Documentation of Waiver services must adequately demonstrate that services are provided in accordance with the individual plan of care and the approved waiver service definitions.
- (4) Notification. Upon approval of a PreAdmission Evaluation for Nursing Facility care for an individual residing in Tennessee, the Bureau shall provide the individual with the following:
 - (a) A simple explanation of the Waiver and Waiver Services;
 - (b) Notice of the opportunity to apply for enrollment in the Waiver and an explanation of the enrollment process; and
 - (c) A statement that participation in the Waiver program is voluntary.
- (5) Enrollment.
 - (a) When an individual is determined to be likely to require the level of care provided by a Nursing Facility, the Administrative Lead Agency shall inform the individual or the individual's legal representative of all feasible alternatives available under the Waiver and shall offer the choice of either Nursing Facility or Waiver Services.
 - (b) Enrollment in the Waiver shall be voluntary and open to all Waiver Eligibles who reside in Tennessee, but shall be restricted to the maximum number of unduplicated participants specified in the Waiver for the Waiver program year, as approved by the Centers for Medicare and Medicaid Services for the State of Tennessee. Enrollment may also be restricted if sufficient funds are not appropriated by the legislature to support full enrollment.
 - (c) To be eligible for enrollment, an individual must meet all of the following criteria:
 - 1. The individual must be Medicaid Eligible, must meet the Nursing Facility eligibility criteria specified in TennCare Rule 1200-13-01-.10, and must have a PreAdmission Evaluation approved by the Bureau of TennCare.
 - (i) The PreAdmission Evaluation shall include the physician's initial plan of care which includes, but is not limited to, diagnoses and any orders for medications, diet, activities, treatments, therapies, restorative and rehabilitative services, or other physician-ordered services needed by the Enrollee.
 - (ii) The individual's physician must certify on the PreAdmission Evaluation that the individual requires Waiver Services.

(Rule 1200-13-01-.17, continued)

2. The individual's medical, functional, and social needs must be such that they can be effectively and safely met through the Waiver, as determined by the Administrative Lead Agency based on a pre-enrollment screening.
 3. The State must reasonably expect that the cost of Waiver services and TennCare HH and PDN Services the individual will need would not exceed the average cost of Level 1 NF services.
 4. An individual shall have one or more caregivers, as specified in (6)(a), designated to provide caregiver services each day in the Enrollee's home and, as needed, in other locations to ensure the health, safety, and welfare of the Enrollee. An individual shall have 24-hour caregiver services unless it is determined by an assessment that the needs of the individual can be met, and that the health, safety, and welfare of the individual can be assured, through the provision of daily (but less than 24-hour) caregiver services and through provision of a Personal Emergency Response System. Documentation of such assessment shall be included in an individualized Safety Plan that is developed, reviewed, and updated by the Administrative Lead Agency. If it is so determined that the health, safety, and welfare of the individual can be assured without 24-hour caregiver services, the individual shall have caregiver services provided for some portion of the day each day.
 5. An individual who does not have 24-hour caregiver services shall have an individualized Safety Plan that is based on an assessment of the individual's medical, functional, and social needs and capabilities and that is approved, monitored, and updated as needed, but no less frequently than annually, by the Administrative Lead Agency. The Safety Plan shall describe:
 - (i) The medical, functional, and social needs and capabilities of the individual and how such can be met without jeopardizing the health, safety, and welfare of the individual;
 - (ii) The type and schedule of caregiver services to be provided each day, specifying hours per day and number of days per week;
 - (iii) Personal Emergency Response Systems which are designed to enable Enrollees, who meet the requirements of (2)(e), to secure help in an emergency; and
 - (iv) Other services, devices, and supports that ensure the health, safety, and welfare of the Enrollee.
 6. All homes must provide an environment adequate to reasonably ensure the health, safety, and welfare of the Enrollee.
- (d) An individual who is capable of living alone or independently without waiver services shall not be eligible for enrollment or continued enrollment in the Waiver.
- (e) 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 a Nursing Facility.

(6) Caregiver.

(Rule 1200-13-01-.17, continued)

- (a) Caregiver services shall be provided by one or more adult individuals, aged 18 or older, who sign an agreement with the Administrative Lead Agency to provide the following services to the Enrollee, as well as any additional services outlined in the Individual Plan of Care and the Safety Plan, to meet the needs of the Enrollee during the hours when Waiver Services are not being provided by the Administrative Lead Agency:
 - 1. Assistance with grooming, bathing, feeding, and dressing;
 - 2. Assistance with medications that are ordinarily self-administered;
 - 3. Assistance with ambulation as needed;
 - 4. Household services essential to health care and maintenance in the home;
 - 5. Meal preparation; and
 - 6. Any other assistance necessary to support the Enrollee's activities of daily living.
 - (b) One or more caregivers shall be available full time or part time each day in the Enrollee's home, as determined appropriate by the Administrative Lead Agency and as specified in the Individual Plan of Care and the Safety Plan, to provide care to the Enrollee. Enrollees who do not have a 24-hour caregiver shall have a Personal Emergency Response System and shall be mentally and physically capable of using it based on an assessment by the Administrative Lead Agency.
- (7) PreAdmission Evaluations, Transfer Forms, and PASRR Assessments.
- (a) A PreAdmission Evaluation is required when a Medicaid Eligible is admitted to the Waiver.
 - (b) A Transfer Form is required in the following circumstances:
 - 1. When an Enrollee having an approved unexpired PAE transfers from the Waiver to Level 1 care in a NF.
 - 2. When a Waiver Eligible with an approved unexpired PAE transfers from a NF to the Waiver.
 - (c) A Level I PASRR assessment for MI and MR is required in the following circumstances:
 - 1. When an Enrollee with an approved, unexpired PAE transfers from the Waiver to a NF.
 - 2. When an Enrollee with an approved, unexpired PAE requires a short-term stay in a NF.
- A Level II PASRR evaluation is required if a history of MI or MR is indicated by the Level I PASRR assessment, unless criteria for exception are met.
- (d) An Administrative Lead Agency that enrolls an individual without an approved PreAdmission Evaluation or, where applicable, an approved Transfer Form does so without the assurance of reimbursement. An Administrative Lead Agency that enrolls an individual who has not been determined by the Tennessee Department of Human Services to be financially eligible to have Medicaid make reimbursement for covered services does so without the assurance of reimbursement. If an Administrative Lead Agency enrolls a Medicaid Eligible without an approved PreAdmission Evaluation, the

(Rule 1200-13-01-.17, continued)

individual must be informed by the Administrative Lead Agency that Medicaid reimbursement will not be paid until and unless the PreAdmission Evaluation is approved.

- (e) The Administrative Lead Agency shall maintain in its files the original PreAdmission Evaluation and, where applicable, the original Transfer Form.
 - (f) An updated Safety Plan for Enrollees who do not have 24-hour caregiver services shall be required as an attachment to the PreAdmission Evaluation or Transfer Form.
- (8) Individual Plan of Care.
- (a) The Individual Plan of Care shall be an individualized written plan of care that specifies the services designed to meet the medical, functional, and social needs of the Enrollee and that includes, but is not limited to, the following Enrollee information:
 - 1. Diagnoses;
 - 2. A description of Waiver Services and any other services regardless of payment source, including caregiver services, that the Enrollee requires to reside in the community as an alternative to care in a Nursing Facility, including the amount (specific number of hours or units per day rather than a range), frequency (number of days per week), and duration (length of time needed) of services and the type of provider to furnish each service;
 - 3. Outcome objectives;
 - 4. Any treatments, therapies, activities, social services, rehabilitative services, nursing related services, home health aide services, specialized equipment, medications (including dosage, frequency, and route of administration), diet, and other services needed by the Enrollee;
 - 5. The names of each caregiver and each caregiver's schedule, including the amount (specific number of hours per day) and frequency (number of days per week) of caregiver services and provisions for alternate caregivers; and
 - 6. A Safety Plan for Enrollees who do not have 24-hour caregiver services.
 - (b) Within thirty (30) working days after enrollment, the Case Management Team shall review the Physician's Plan of Care and shall develop the Individual Plan of Care. Within ten (10) working days of completion of the Individual Plan of Care, the Administrative Lead Agency shall review and approve the Individual Plan of Care.
 - (c) The Individual Plan of Care shall be periodically reviewed to ensure that the Waiver Services furnished are consistent with the nature and severity of the Enrollee's disability and to determine the appropriateness and adequacy of care and achievement of outcome objectives outlined in the Individual Plan of Care. The minimum schedule for reviews shall be as follows:
 - 1. The Individual Plan of Care shall be reviewed by a registered nurse or Social Worker Case Manager as needed, but no less frequently than every ninety (90) calendar days. If a Social Worker Case Manager is utilized, an in-home visit and review of the Plan of Care must be done by a Registered Nurse at least every ninety (90) days.

(Rule 1200-13-01-.17, continued)

2. The Individual Plan of Care shall be reviewed and signed by the Case Management Team as needed, but no less frequently than annually. The attending physician is not required to sign the Individual Plan of Care if current signed physician orders are included with the Individual Plan of Care.
- (d) Waiver Services shall be provided in accordance with the Enrollee's Individual Plan of Care.
- (9) Physician Services.
 - (a) The Enrollee's attending physician or other licensed physician shall write new orders for the Enrollee as needed and, at a minimum, every ninety (90) calendar days.
 - (b) The Administrative Lead Agency shall ensure that each Enrollee receives physician services as needed and, at a minimum, an annual medical examination or physician visit, and shall document such in the Enrollee's record.
- (10) Reevaluation and Recertification of Need for Continued Stay.
 - (a) The Administrative Lead Agency shall perform reevaluations of the Enrollee's need for continued stay in the Waiver within 365 calendar days of the date of enrollment and at least annually thereafter.
 - (b) Recertifications, documented in a format approved by the Bureau of TennCare, shall be performed by the Enrollee's physician within 365 calendar days of the initial certification date and at least annually thereafter. The Administrative Lead Agency shall maintain in its files a copy of the recertification of need for continued stay.
- (11) Voluntary 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 legal representative to the Administrative Lead Agency. A Level I PASRR assessment for mental illness and mental retardation is required when an Enrollee transfers to a Nursing Facility. If the Level I PASRR assessment indicates the need for a PASRR Level II evaluation of need for specialized services for mental illness or mental retardation, the Enrollee must undergo the PASRR Level II evaluation. Prior to disenrollment, the Administrative Lead Agency shall assist the Enrollee in locating alternate services to provide the appropriate level of care and shall assist in transitioning the enrollee to the new services.
 - (b) If the Enrollee's medical condition or social environment deteriorates such that the medical, functional, and social needs cannot be met by the Waiver, the Enrollee or the Enrollee's legal representative may request disenrollment from the Waiver. The Administrative Lead Agency shall assist the individual with placement in the appropriate level of care.
 - (c) Upon voluntary disenrollment from the Waiver, the individual shall be entitled to receive Medicaid covered services only if still eligible for Medicaid.
- (12) Involuntary Disenrollment.
 - (a) An Enrollee may be involuntarily disenrolled from the Waiver for any of the following reasons:

(Rule 1200-13-01-.17, continued)

1. The Statewide Home and Community Based Services Waiver for the Elderly and Disabled is terminated.
 2. An Enrollee becomes ineligible for Medicaid or is found to be erroneously enrolled in the Waiver.
 3. An Enrollee is no longer a resident 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 condition of the Enrollee deteriorates such that the medical, functional, and social needs of the Enrollee cannot be met by the Waiver.
 6. The State reasonably expects that the cost of Waiver services and TennCare HH and PDN Services the individual would receive will exceed the average cost of Level 1 NF services.
 7. 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.
 8. The Enrollee no longer has a caregiver, as defined herein, or the caregiver is unwilling or unable to provide services needed by the Enrollee, and an alternate caregiver cannot be arranged.
 9. The Enrollee or the Enrollee's caregiver refuses to abide by the Individual Plan of Care, the Physician's Plan of Care, or related Waiver policies, resulting in the inability of the Waiver to assure quality care.
 10. A provider of Waiver Services is unwilling or unable to continue to provide services and an appropriate alternate service provider cannot be arranged.
 11. The health, safety, and welfare of the Enrollee cannot be assured due to the lack of an approved Safety Plan or an approved Individual Plan of Care, or the continuing need for Waiver Services is not recertified by the Enrollee's physician.
 12. The Enrollee does not receive Waiver services for a period exceeding 120 days if such period began prior to March 1, 2010, or a period exceeding 90 days if such period begins on or after March 1, 2010, due to the need for inpatient services in a hospital, NF, or other institutional setting.
- (b) If the individual is involuntarily disenrolled from the Waiver, the Administrative Lead Agency shall assist the Enrollee in locating a Nursing Facility or other alternative providing the appropriate level of care and in transferring the Enrollee. Pursuant to TennCare Rules 1200-13-01-.10 and 1200-13-01-.23, a Level I PASRR screen for mental illness and mental retardation must be completed prior to admission when an Enrollee transfers to a Nursing Facility. If the Level I PASRR screen indicates the need for a PASRR Level II evaluation of need for specialized services for mental illness or mental retardation, the Enrollee must undergo the PASRR Level II evaluation prior to admission to the Nursing Facility.
- (c) The Administrative Lead Agency shall notify the Bureau of TennCare in writing a minimum of 2 working days prior to issuing involuntary disenrollment notice to an Enrollee.

(Rule 1200-13-01-.17, continued)

- (d) Waiver Services shall continue until the date of discharge of the Enrollee from the Waiver.
- (e) Notice of Disenrollment.
 - 1. Except under circumstances when the Statewide E/D Waiver is terminated, or an Enrollee is no longer categorically or financially eligible for Medicaid, or no longer meets medical eligibility (or NF LOC) requirements, the ALA shall provide an Enrollee written advance notice of involuntary disenrollment with an explanation of the Enrollee's right to a hearing pursuant to T.C.A. §71-5-113.
 - 2. When the Statewide E/D Waiver is terminated in a Grand Division upon implementation of the CHOICES program, notice of transition to the CHOICES program shall be provided in accordance with the State's approved Section 1115 Waiver amendment.
 - 3. If a person is involuntarily disenrolled from the Statewide E/D Waiver because his Medicaid eligibility has ended, the Medicaid eligibility termination notice, including the right to request a fair hearing regarding such eligibility decision, shall constitute notice of action for termination of all Medicaid-reimbursed (including Waiver) services. Additional notice regarding involuntary disenrollment from the Waiver shall not be provided.
- (13) Reduction of Services. If the Enrollee's condition substantially improves, the Administrative Lead Agency and the Bureau of TennCare shall have the right to reduce Waiver Services.
- (14) Administration of Services. The Administrative Lead Agency shall ensure the delivery of Waiver Services to Enrollees and shall ensure that related activities including, but not limited to, the following are performed:
 - (a) Pre-enrollment screening of individuals, including assessment of the individual's medical, functional, and social capabilities and needs; appropriateness for placement in the Waiver; and the ability of the caregiver to adequately care for the Enrollee in the home setting;
 - (b) Annual reevaluations of the Enrollee's need for continued stay in the Waiver;
 - (c) Enrollment of Waiver Eligibles into the Waiver after screening;
 - (d) Development, implementation, and monitoring of the Individual Plan of Care, including the Safety Plan if a Safety Plan is required;
 - (e) Coordinating and monitoring the total range of services for Enrollees, regardless of payment source;
 - (f) Initial certification by the Enrollee's physician of the Enrollee's need for care in a Nursing Facility and annual recertification of the medical necessity of the continuation of Waiver Services for the Enrollee;
 - (g) Supervision of support service staff;
 - (h) Ongoing monitoring of Enrollee and family situations and needs;
 - (i) Maintenance of comprehensive medical records and documentation of services provided to Enrollees;

(Rule 1200-13-01-.17, continued)

- (j) Expenditure and revenue reporting in accordance with state and federal requirements;
 - (k) Any marketing activities performed for the purpose of providing information about the program to potential Enrollees;
 - (l) Assurance of quality and accessible Waiver services which are provided in accordance with State and Federal Waiver rules, regulations, policies and definitions;
 - (m) Contacts with Enrollees, caregivers, and service providers in accordance with state and federal requirements;
 - (n) Assurance that each Enrollee has appropriate caregiver services provided each day in the Enrollee's home by one or more competent adult individuals who sign an agreement with the Administrative Lead Agency;
 - (o) Assurance of the safety of the Enrollee through appropriate caregiver services, supervision, and other services and supports, as described in the Individual Plan of Care and the Safety Plan;
 - (p) Implementation of an appeals process approved by the Bureau of TennCare;
 - (q) Provision of expert testimony by appropriate professionals during contested case hearings; and
 - (r) Compliance with all applicable rules of the Tennessee Medicaid Program.
- (15) 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 was provided in a Nursing Facility. 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 a Nursing Facility.
 - (b) The provider of Waiver Services shall be reimbursed based on a rate per unit of service.
 - (c) The Administrative Lead Agency shall ensure that a diligent effort is made to collect patient liability if it applies to the Enrollee in accordance with 42 CFR § 435.726. The Administrative Lead Agency 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 Administrative Lead Agency and to the Bureau of TennCare's fiscal agent, specifying the amount of patient liability to be applied toward the cost of care for the Enrollee.
 - (d) The Provider of waiver services shall submit bills for services to the Bureau of TennCare's fiscal agent using a claim form approved by the Bureau of TennCare. On the claim forms, the waiver service provider shall use a provider number assigned by the Bureau of TennCare.
 - (e) Reimbursement shall not be made to the provider of Waiver Services on behalf of Enrollees for therapeutic leave or fifteen-day hospital leave ("Bed holds") normally available to Level 1 NF patients pursuant to rule 1200-13-01-.03.

(Rule 1200-13-01-.17, continued)

- (f) Medicaid covered services other than those specified in the Waiver's scope of services shall be reimbursed by the Bureau of TennCare as otherwise provided for by federal and state rules and regulations.
 - (g) The Administrative Lead Agency shall ensure that the physician's initial certification and subsequent recertifications are obtained. Failure to perform recertifications in a timely manner and in the format approved by the Bureau of TennCare shall require a corrective action plan and shall result in full or partial recoupment of all amounts paid by the Bureau of TennCare during the time that recertification has lapsed.
- (16) Subcontractors.
 - (a) The Administrative Lead Agency shall ensure that:
 - 1. Services are provided by subcontractors who have signed contracts with the Administrative Lead Agency;
 - 2. Subcontractors comply with the Quality Assurance Guidelines and other state and federal standards, rules, and regulations affecting the provision of Waiver Services; and
 - 3. Subcontractors carry appropriate professional liability insurance and other insurance (e.g., auto insurance if Enrollees are being transported).
 - (b) Contracts between the Administrative Lead Agency and subcontractors for the provision of Waiver Services must be approved in writing by the Bureau of TennCare.
- (17) Appeal Process.
 - (a) Eligibility for the Statewide E/D Waiver.
 - 1. Appeals regarding categorical and financial eligibility for the Statewide E/D Waiver will be handled by DHS.
 - 2. Appeals regarding medical (or LOC) eligibility for the Statewide E/D Waiver will be handled as set forth in Rule 1200-13-01-.10(6).
 - (b) Enrollment and involuntary disenrollment.

Appeals regarding denial of enrollment into the Statewide E/D Waiver or involuntary disenrollment from the Statewide E/D Waiver for reasons other than categorical or financial eligibility or medical eligibility will be handled by the Bureau Division of Long-Term Care.
 - (c) Adverse actions regarding Waiver services.

Appeals regarding adverse actions pertaining to Waiver services covered under the Statewide E/D Waiver will be processed in accordance with TennCare Rule 1200-13-13-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits.

Authority: T.C.A. §§4-5-202, 4-5-203, 4-5-208, 4-5-209, 71-5-105, 71-5-109, and Executive Order No. 23. **Administrative History:** Original rule filed February 12, 1986; effective March 14, 1986. Amendment filed March 1, 1988; effective April 15, 1988. Amendment filed July 28, 2004; effective October 11, 2004. Public necessity rule filed July 1, 2009; effective through December 13, 2009.

(Rule 1200-13-01-.17, continued)

Amendments filed September 11, 2009; effective December 10, 2009. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendments filed May 27, 2010; effective August 25, 2010.

1200-13-01-.18 REPEALED.

Authority: T.C.A. §§4-5-202, 71-5-105, 71-5-109, Executive Order No. 23, and Public Chapter 358 of the Acts of 1993. **Administrative History:** Original rule filed May 1985; effective June 23, 1985. Amendment filed November 5, 1990; effective December 20, 1990. Amendment filed March 18, 1994; effective June 1, 1994. Amendment filed September 18, 2007; effective December 2, 2007.

1200-13-01-.19 REPEALED.

Authority: T.C.A. §§4-5-202, 71-5-105, 71-5-109, and Public Chapter 358 of the Acts of 1993. **Administrative History:** Original rule filed September 10, 1985; effective October 10, 1985. Amendment filed March 18, 1994; effective June 1, 1994. Repeal filed January 26, 2007; effective April 11, 2007.

1200-13-01-.20 REPEALED.

Authority: T.C.A. §§4-5-202, 71-5-105, 71-5-109, and Public Chapter 358 of the Acts of 1994. **Administrative History:** Original rule filed June 2, 1988; effective July 17, 1988. Amendment filed April 19, 1990; effective June 3, 1990. Amendment filed April 30, 1992; effective June 14, 1992. Amendment filed March 18, 1994; effective June 1, 1994. Repeal filed January 26, 2007; effective April 11, 2007.

1200-13-01-.21 PROVIDER NONCOMPLIANCE OR FRAUD OF MEDICAID PROGRAM.

(1) Definitions:

- (a) Agent - means any person who has been delegated the authority to obligate or act on behalf of a provider.
- (b) Bureau of TennCare (herein referred to as "Bureau"). The division of the Tennessee Department of Finance and Administration (the single state Medicaid agency) that administers the TennCare Program. For the purposes of this Rule, the Bureau of TennCare shall represent the State of Tennessee.
- (c) Convicted - means that a judgment of conviction has been entered by a federal, state, or local court, regardless of whether an appeal from that judgment is pending.
- (d) Exclusion - means that period of time that a provider is suspended or terminated from participation in the Medicaid program. Any items or services furnished by an excluded provider shall not be reimbursed under Medicaid.
- (e) Flagrant noncompliance - means one or more activities identified in section (3).
- (f) Fraud - means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.
- (g) Managing employee - means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of, an institution, organization, or agency.

(Rule 1200-13-01-.21, continued)

- (h) Noncompliance - means provider practices that are inconsistent with sound fiscal or business practices or inconsistent with Medicaid rules and regulations, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.
 - (i) Person with an ownership or control interest - means a person or corporation that:
 - 1. has an ownership interest totaling five (5) percent or more in a disclosing entity,
 - 2. has an equity in the capital, the stock or profit (indirect membership) of the disclosing entity equal to five (5) percent or more in a disclosing entity,
 - 3. has a combination of direct and indirect ownership interests equal to five (5) percent or more in a disclosing entity;
 - 4. owns an interest of five (5) percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least five (5) percent of the value of the property or assets of the disclosing entity;
 - 5. is an officer or director of a disclosing entity that is organized as a corporation; or
 - 6. is a partner in a disclosing entity that is organized as a partnership.
 - (j) Provider - means an individual or entity which furnishes items or services for which payment is claimed under Medicaid.
 - (k) Provider responsibility - means the obligation of any health care provider who furnishes or orders health care services to assure that, to the extent of his influence or control, those services are:
 - 1. furnished only when, and to the extent that, they are medically necessary, and
 - 2. of a quality that meets professionally recognized standards of health care.
 - (l) Records - means all paper and electronic media records which contain information relative to medical assistance provided for which payment has been made or sought under the Medicaid program, and/or which contain any other information relative to payments received or sought under the Medicaid program. It shall include records for services which are non-covered or not billed, but which initiate a covered service.
 - (m) Records access - means paper and electronic media records shall be made available during normal business hours by a provider for a stringent onsite review audit and to allow Medicaid to make copies on site in order to review at a later date and/or to document audit findings. Upon written request the provider shall make copies of records (not to exceed five (5) recipients) to document services previously paid. If electronic media records are provided to Medicaid the data layout shall also be provided to Medicaid.
 - (n) Unit - means the Tennessee Bureau of Investigation, Medicaid Fraud Control Unit.
- (2) (a) In addition to the sanctions set out in T.C.A. §71-5-118, the provider may be subject to stringent review/audit procedures which may include clinical evaluation of claim services and a prepayment requirement for documentation and for justification of each claim,

(Rule 1200-13-01-.21, continued)

- (b) Medicaid may withhold payments to a provider in cases of fraud, willful misrepresentation, or flagrant noncompliance,
 - (c) Medicaid may refuse to enter into or may suspend a provider participation agreement with a provider if any person who has an ownership or controlling interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the U.S. Title XX Services Program,
 - (d) Medicaid may refuse to enter into or may suspend a provider participation agreement if it determines that the provider did not fully and accurately make any disclosure of any person who has ownership or controlling interest in the provider, or is an agent or managing employee of the provider and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the U.S. Title XX Services Program since the inception of these programs,
 - (e) Medicaid shall refuse to enter into or shall suspend a provider participation agreement if the appropriate State Board of Licensing or Certification fails to license or certify, the provider at any time for any reason or suspends or revokes a license or certification,
 - (f) Medicaid shall refuse to enter into or shall suspend a provider participation agreement upon notification, by the U.S. Office of Inspector General - Department of Health and Human Services that the provider is not eligible under Medicare or Medicaid for federal financial participation,
 - (g) Medicaid may refuse to enter into or may terminate a provider participation agreement if it is determined that the provider has been flagrantly noncompliant in its violation of segments of section (3) of this chapter, and
 - (h) Medicaid may recover from a provider any payments made by a recipient and/or his family for a covered service when evidence of recipient billing by the provider is determined by Medicaid and repayment by the provider to the recipient and/or his family is not made within 30 days of receiving notification from Medicaid to make repayment. If a provider knowingly bills a recipient and/or family for a Medicaid covered service, in total or in part, except as otherwise permitted by State rules, Medicaid may terminate the provider participation agreement.
- (3) In addition to the grounds for actions set out in T.C.A. §71-5-118, activities or practices which justify sanctions against the contract and/or recoupment of monies incorrectly paid shall include, but not be limited to:
- (a) noncompliance with contractual terms,
 - (b) billing for a service in a quantity which is greater than the amount provided,
 - (c) billing for a service which is not provided or not documented,
 - (d) knowingly providing incomplete, inaccurate, or erroneous information to Medicaid or its agent(s),
 - (e) continued provision of poor record keeping or inappropriate/inadequate medical care,
 - (f) medical assistance of a quality below recognized standards,
 - (g) provider suspension from the Medicare/Medicaid program(s) by the authorized U.S. enforcement agency,

(Rule 1200-13-01-.21, continued)

- (h) partial or total loss (voluntary or otherwise) of a providers federal Drug Enforcement Agency (DEA) dispensing or prescribing certification,
 - (i) restriction to and/or loss of practice by a state licensing board action,
 - (j) acceptance of a pretrial diversion, in state or federal court from a Medicaid or Medicare fraud charge and/or evidence from same,
 - (k) violation of the responsible state licensing board license and/or certification rules,
 - (l) convictions of a felony, conviction of any offense under state or federal drug laws, or conviction of any offense involving moral turpitude,
 - (m) dispensing, prescribing, or otherwise distributing any controlled substance or any other drug not in the course of professional practice, or not in good faith to relieve pain and suffering, or not to cure an ailment, physical and/or mental infirmity or disease,
 - (n) dispensing, prescribing, or otherwise distributing to any person a controlled substance or other drug if such person is addicted to the habit of using control substances without making a bona fide effort to cure the habit of such patient.
 - (o) dispensing, prescribing or otherwise distributing any controlled substance or other drug to any person in violation of any law of the state or of the United States of America,
 - (p) engaging in the provision of medical/dental service when mentally or physically unable to safely do so,
 - (q) billing Medicaid an amount that is greater than the provider's usual and customary charge to the general public for that service, and
 - (r) falsifying or causing to be falsified dates of service, dates of certification or recertification or back dating any record which results in or could result in an inappropriate cost to Medicaid.
 - (s) Reserved.
 - (t) Fragmentation or submitting claims separately on the component parts of a procedure instead of claiming the single procedure code, (which includes the entire procedure, or all component parts) when such approach results in Medicaid paying a greater amount for the component(s) than it would for the entire procedure.
 - (u) Submitting claims for a separate procedure which is commonly carried out as a component part of a larger procedure, unless it is performed alone for a medically justified specific purpose.
- (4) Term of Provider Exclusion
- (a) A provider exclusion based upon either section (2)(c), (d), (e) or (f) shall continue until the excluding re-establishes the license or the Medicare/Medicaid eligibility previously denied or suspended. The provider may resubmit to Medicaid with documentation from the State Board or the U.S. Office of Inspector General - Department of Health and Human Services that the provider's exclusion has been lifted or removed. The provider may then apply to Medicaid for reinstatement consideration as determined by Medicaid.

(Rule 1200-13-01-.21, continued)

- (b) A provider exclusion based upon section (2)(g) shall be eligible for reinstatement as a Medicaid provider as determined by Medicaid.
- (5) Access to Records - The Bureau shall in the furtherance of the administration of the Medicaid Program have access to all provider records. Such access shall include the right to make copies of those records during normal business hours.
- (6) Confidentiality - The Bureau shall be bound by all applicable federal and/or State statutes and regulations relative to confidentiality of records.
- (7) Provider Cooperation - The provider is to cooperate, with Medicaid and/or its agent(s) in the provision of records and in the timely completion of any post review audit. Failure to cooperate may subject the provider to actions identified in section (2) of this rule. Cooperation in a post review audit includes but is not limited to:
 - (a) the provision of a private work area,
 - (b) the availability of provider personnel at an initial and exit conference,
 - (c) the furnishing of records as needed,
 - (d) the provision of access to provider owned copying equipment to expedite the completion of an on site segment of an audit, and
 - (e) the provision of records, requested in writing, for a desk review where ten (10) or less recipient records are at issue.
- (8) Request for Hearing - All provider hearing requests shall be received by Medicaid within fifteen (15) days of the providers receipt of notification of Medicaid action taken under this chapter.
- (9) For services provided prior to January 1, 1994, the rules as set out at 1200-13-01-.21 (1) - (9) shall apply. Effective January 1, 1994, the rules of TennCare as set out at rule chapter 1200-13-12 shall apply except for noncompliance or fraud of Medicaid program as it relates to nursing facilities, intermediate care facilities for the mentally retarded (ICF-MR), Home and Community Based Waiver Services, and payment of Medicare premiums, deductibles and copayments for QMBs and Special Low-Income Medicare Beneficiaries (SLIMBs) which will continue to be enforced in accordance with Medicaid rules in effect prior to January 1, 1994, and as may be amended.

Authority: T.C.A. §§4-5-202, 4-5-208, 71-5-105, 71-5-109, and Public Chapter 358 of the Acts of 1993.

Administrative History: Original rule filed January 29, 1990; effective March 15, 1990. Amendment filed October 24, 1991; effective December 8, 1991. Amendment filed November 27, 1991; effective January 11, 1992. Amendment filed March 10, 1992; effective April 24, 1992. Amendment filed August 4, 1992; effective September 18, 1992. Amendment filed December 4, 1992; effective January 19, 1993. Amendment filed March 18, 1994; effective June 1, 1994. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendments filed May 27, 2010; effective August 25, 2010.

1200-13-01-.22 REPEALED.

Authority: T.C.A. §§4-5-202, 71-5-105, 71-5-109, Executive Order No. 23, and Public Chapter 358 of the Acts of 1993. **Administrative History:** Original rule filed December 1, 1988; effective January 15, 1989. Amendment filed January 29, 1990; effective March 15, 1990. Amendment filed March 18, 1994; effective June 1, 1994. Amendment filed September 18, 2007; effective December 2, 2007.

1200-13-01-.23 NURSING HOME PREADMISSION SCREENINGS FOR MENTAL ILLNESS AND MENTAL RETARDATION.

- (1) Definitions. See Rule 1200-13-01-.02.
- (2) Medicaid-certified nursing facilities may not admit individuals applying for admission unless these persons are screened to determine if they have mental illness or mental retardation regardless of method of payment or "known diagnosis." A Medicaid-certified nursing facility is prohibited from admitting any new resident who has mental illness or mental retardation (or a related condition), unless that individual has been determined by the Tennessee Department of Mental Health and Developmental Disabilities and/or the Division of Intellectual Disabilities Services, as applicable, not to be in need of specialized services and appropriate for placement in a nursing facility. (The individual must also meet the Bureau of TennCare's preadmission criteria for nursing facility services). The criteria to be used in making determinations will be categorized into two levels: 1) identification screens (Level I) and 2) preadmission screening/resident reviews evaluations (Level II).
 - (a) Criteria for Identification Screen (Level I)
 1. Prior to admission of any person to a nursing facility, it must be determined if:
 - (i) For Mental Illness:
 - (I) The individual has a diagnosis of MI. (See definition of MI in Rule 1200-13-01-.02.)
 - (II) The person has any recent (within the last two years) history of mental illness, or has been prescribed a major tranquilizer on a regular basis in the absence of justifiable neurological disorder.
 - (III) There is any presenting evidence of mental illness (except primary diagnosis of Alzheimer's disease or dementia) including possible disturbances in orientation or mood.
 - (ii) For Mental Retardation or Persons with Related Conditions:
 - (I) The individual has a diagnosis of MR. (See definition of MR in Rule 1200-13-01-.02.)
 - (II) There is any history of mental retardation or developmental disability in the identified individual's past.
 - (III) There is any presenting evidence (cognitive or behavior functions) that may indicate the person has mental retardation or developmental disability.
 - (IV) The person is referred by an agency that serves persons with mental retardation (or other developmental disabilities), and the person has been deemed to be eligible for that agency's services.
 - (V) The preceding criteria must also be applied to residents of a nursing facility who have not received an identification screen.
 - (VI) There must be a record of the identification screen results and interpretation in the nursing home resident's record.

(Rule 1200-13-01-.23, continued)

- (VII) Results of the identification screen must be used (unless there is other indisputable evidence that the individual is not mentally ill or mentally retarded) in determining whether an individual has (or is suspected to have) mental illness or mental retardation and therefore must be subjected to the PASRR process. Findings from the evaluation should be used in making determinations about whether an individual has mental illness or mental retardation.
- (b) Any individual for whom there is a negative response for all of the identification evaluative criteria for mental retardation or mental illness and for whom there is no other evidence of a condition of mental illness or mental retardation may be admitted to or continue to reside in a Medicaid-certified nursing facility without being determined appropriate for nursing facility placement through the PASRR evaluation process (Level II).
- (c) Any individual for whom there is a positive response for any of the identification evaluative criteria for mental retardation or mental illness may not be admitted to or continue to reside in a Medicaid-certified nursing facility without being determined appropriate for nursing facility placement through the PASRR evaluation process (Level II).
- (d) Exemptions from Level II Review

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

1. Dementia - This must be a primary diagnosis based on criteria in the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition; or it may be the secondary diagnosis (including Alzheimer's disease and related disorders) as long as the primary diagnosis is not a major mental illness. The primary or secondary diagnosis of dementia (including Alzheimer's disease and related disorders) must be based on a neurological examination. Dementia is not allowed as an exemption if the individual has, or is suspected of having, a diagnosis of mental retardation.
2. Convalescent Care - Any person with MI or MR as long as that person is not a danger to self and/or others, may be admitted to a Medicaid-certified NF after release from an acute care hospital for a period of recovery without being subjected to the PASRR process for evaluation of MI or MR.
3. Terminal Illness - Under 42 U.S.C.A. § 1395x(dd)(3)(A), a Medicare beneficiary is considered to be terminally ill if he has a medical prognosis that his life expectancy is six (6) months or less. This same standard is to be applied to Medicaid recipients with MI, MR, or related conditions who are found to be suffering from a terminal illness. An individual with MI or MR, as long as that person is not a danger to self and/or others, may be admitted to or reside in a Medicaid-certified NF without being subjected to the PASRR/MI or PASRR/MR evaluative process if he is certified by a physician to be "terminally ill," as that term is defined in 42 U.S.C.A. § 1395x(dd)(3)(A), and requires continuous nursing care and/or medical supervision and treatment due to his physical condition.
4. Severity of Illness - Any person with mental illness or mental retardation who is comatose, ventilator dependent, functions at the brain stem level, or has a diagnosis of: Severe Parkinson's Disease, Huntingdon's Disease, Amyotrophic Lateral Sclerosis, Congestive Heart Failure, or Chronic Obstructive Pulmonary

(Rule 1200-13-01-.23, continued)

Disease, and any other diagnosis so determined by the Centers for Medicare and Medicaid Services.

(e) Processes upon expiration of exemption

1. If an individual is admitted to a nursing facility as a Medicare patient, with a "30-day hospital discharge exemption" on the PASRR screen form, and it is determined that the individual will need to extend the stay beyond 30 days, it is the responsibility of the nursing facility to notify TennCare and to ensure that a PASRR evaluation is completed no more than 40 days from the original date of admission (i.e., within 10 days of expiration of the 30-day exemption). If Medicaid reimbursement will be sought, this includes submission and disposition of the PAE which will be required in order to timely complete the PASRR evaluation.
2. If an individual enters the facility with an exemption of "120-day short term stay" on the PASRR screen form and it is determined that the individual will need to extend the stay beyond 120 days, it is the responsibility of the nursing facility to notify TennCare at least seven (7) working days prior to expiration of the 120 days in order to ensure that a PASRR evaluation is completed timely before the 120-day exemption expires. If Medicaid reimbursement will be sought, the PAE must also be submitted to TennCare with sufficient time for review and approval. In such case, it is the responsibility of the nursing facility to notify TennCare and to submit a completed PAE at least ten (10) working days prior to expiration of the 120 days in order to ensure that a PASRR evaluation is completed timely before the 120-day exemption expires.

- (3) Right to Appeal - Each patient has the right to appeal any decision made. The appeal process will be handled in accordance with T.C.A. §71-5-113.

Authority: T.C.A. §§4-5-202, 4-5-208, 4-5-209, 71-5-105 and 71-5-109. **Administrative History:** Original rule filed June 29, 1989; effective; August 14, 1989. Amendment filed March 30, 1995; effective June 15, 1995. Public necessity rule filed July 1, 2009; effective through December 13, 2009. Amendment filed September 11, 2009; effective December 10, 2009. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendments filed May 27, 2010; effective August 25, 2010.

1200-13-01-.24 REPEALED.

Authority: T.C.A. §§4-5-202, 71-5-105, 71-5-109. **Administrative History:** Original rule filed October 21, 1991; effective December 5, 1991. Amendment filed March 18, 1994; effective June 1, 1994. Repeal filed May 5, 2009; effective July 19, 2009.

1200-13-01-.25 TENNESSEE'S HOME AND COMMUNITY BASED SERVICES WAIVER FOR THE MENTALLY RETARDED AND DEVELOPMENTALLY DISABLED UNDER SECTION 1915 (c) OF THE SOCIAL SECURITY ACT (STATEWIDE MR WAIVER).

- (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.

(Rule 1200-13-01-.25, continued)

- (b) Behavioral Respite Services - services that provide Respite for an Enrollee who is experiencing a behavioral crisis that necessitates removal from the current residential setting in order to resolve the behavioral crisis.
- (c) Behavior Services – assessment and amelioration of Enrollee behavior that presents a health or safety risk to the Enrollee or others or that significantly interferes with home or community activities; determination of the settings in which such behaviors occur and the events which precipitate the behaviors; development, monitoring, and revision of crisis prevention and behavior intervention strategies; and training of caregivers who are responsible for direct care of the Enrollee in prevention and intervention strategies.
- (d) Bureau of TennCare - the bureau in the Tennessee Department of Finance and Administration which is the State Medicaid Agency and is responsible for administration of the Medicaid program in Tennessee.
- (e) Certification - the process by which a physician, who is licensed as a doctor of medicine or doctor of osteopathy, signs and dates a Pre-Admission Evaluation signifying that the named individual requires services provided through the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled as an alternative to care in an Intermediate Care Facility for the Mentally Retarded.
- (f) Covered Services or Covered Waiver Services – The services which are available through Tennessee’s Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled when medically necessary and when provided in accordance with the Waiver as approved by the Centers for Medicare and Medicaid Services.
- (g) Day Services - individualized services and supports that enable an Enrollee to acquire, retain, or improve skills necessary to reside in a community-based setting; to participate in community activities and utilize community resources; to acquire and maintain employment; and to participate in retirement activities.
- (h) Denial - as used in regard to Waiver Services, the term shall mean the termination, suspension, or reduction in amount, scope, and duration of a Waiver Service or a refusal or failure to provide such service.
- (i) Disenrollment - the voluntary or involuntary termination of enrollment of an individual receiving services through the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled.
- (j) Enrollee - a Medicaid Eligible who is enrolled in the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled.
- (k) Environmental Accessibility Modifications – only those interior or exterior physical modifications to the Enrollee’s place of residence which are required to ensure the health, welfare and safety of the Enrollee or which are necessary to enable the Enrollee to function with greater independence.
- (l) Family Model Residential Support – a type of residential service having individualized services and supports that enable an Enrollee to acquire, retain, or improve skills necessary to reside successfully in a family environment in the home of trained caregivers other than the family of origin. The service includes direct assistance as needed with activities of daily living, household chores essential to the health and safety of the enrollee, budget management, attending appointments, and interpersonal and social skills building to enable the Enrollee to live in a home in the community. It

(Rule 1200-13-01-.25, continued)

also may include medication administration as permitted under Tennessee's Nurse Practice Act.

- (m) Home (of an Enrollee) - the residence or dwelling in which the Enrollee resides, excluding hospitals, nursing facilities, Intermediate Care Facilities for the Mentally Retarded, Assisted Living Facilities and Homes for the Aged.
- (n) Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled or "Waiver" - the Home and Community Based Services waiver program approved for Tennessee by the Centers for Medicare and Medicaid Services to provide services to a specified number of Medicaid-eligible individuals who have mental retardation and who meet the criteria for Medicaid reimbursement of care in an Intermediate Care Facility for the Mentally Retarded.
- (o) ICF/MR Pre-Admission Evaluation (ICF/MR PAE) – the assessment form used by the State Medicaid Agency to document the current medical and habilitative needs of an individual with mental retardation and to document that the individual meets the Medicaid level of care eligibility criteria for care in an ICF/MR.
- (p) Individual Support Plan – the individualized written Plan of Care.
- (q) Individual Transportation Services –non-emergency transport of an Enrollee to and from approved activities specified in the Plan of Care.
- (r) Intermediate Care Facility for the Mentally Retarded (ICF/MR) - a licensed facility approved for Medicaid vendor reimbursement that provides specialized services for individuals with mental retardation or related conditions and that complies with current federal standards and certification requirements for an ICF/MR.
- (s) Medicaid Eligible - an individual who has been determined by the Tennessee Department of Human Services to be financially eligible to have the State Medicaid Agency make reimbursement for covered services.
- (t) Medicaid State Plan – the plan approved by the Center for Medicare and Medicaid Services which specifies the covered benefits for the Medicaid program in Tennessee.
- (u) 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.
- (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.

(Rule 1200-13-01-.25, continued)

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

(Rule 1200-13-01-.25, continued)

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

(Rule 1200-13-01-.25, continued)

- (oo) Support Coordinator - the person who is responsible for developing the Individual Support Plan and participating in the development of, monitoring and assuring the implementation of the Plan of Care; who provides Support Coordination services to an Enrollee; and who meets the qualifications for a Support Coordinator as specified in the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled.
 - (pp) Supported Living - a type of residential service having individualized services and supports that enable an Enrollee to acquire, retain or improve skills necessary to reside in a home that is under the control and responsibility of the Enrollee. The service includes direct assistance as needed with activities of daily living, household chores essential to the health and safety of the Enrollee, budget management, attending appointments, and interpersonal and social skills building to enable the Enrollee to live in a home in the community. It also may include medication administration as permitted under Tennessee's Nurse Practice Act.
 - (qq) Transfer Form - the form approved by the State Medicaid Agency and used to document the transfer of an Enrollee having an approved unexpired ICF/MR Pre-Admission Evaluation from the Waiver to an ICF/MR, from an ICF/MR to the Waiver or from one MR Waiver program to another MR Waiver program. For purposes of transfer to an MR Waiver program, whether from an ICF/MR or from another MR Waiver program, such Transfer Form shall be processed by TennCare only if submitted by the Division of Intellectual Disabilities Services (DIDS). DIDS shall submit a Transfer Form only after verifying that the person otherwise meets all applicable admission criteria for the applicable MR Waiver program, as the Transfer Form accomplishes only the transfer of the level of care eligibility.
 - (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.

(Rule 1200-13-01-.25, continued)

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 for Enrollee-specific training of staff; behavior assessment and plan development; and presentation of Enrollee behavior information at human rights committee meetings, behavior support committee meetings, and Enrollee planning meetings.
3. Reimbursement for presentation of Enrollee behavior information at meetings shall be limited to a maximum of five (5) hours per Enrollee per year per provider. Reimbursement for behavior assessments shall be limited to a maximum of eight (8) hours per assessment with a maximum of two (2) assessments per year. Reimbursement for behavior plan development resulting from such a behavior assessment and the training of staff on the plan during the first thirty (30) days following its approval for use shall be limited to a maximum of six (6) hours.

(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.

(Rule 1200-13-01-.25, continued)

5. Day Services shall not replace services available under a program funded by the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act.
 6. For an Enrollee receiving employment supports, reimbursement shall not be made for incentive payments, subsidies or unrelated vocational training expenses such as the following:
 - (i) Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
 - (ii) Payments that are passed through to users of supported employment programs; or
 - (iii) Payments for vocational training that is not directly related to an Enrollee's supported employment program.
- (e) Environmental Accessibility Modifications.
1. Environmental Accessibility Modifications which are considered improvements to the home (e.g., roof or flooring repair, installing carpet, installation of central air conditioning, construction of an additional room) are excluded from coverage.
 2. Any modification which is not of direct medical or remedial benefit to the Enrollee is excluded from coverage.
 3. Modification of an existing room which increases the total square footage of the home is also excluded unless the modification is necessary to improve the accessibility of an Enrollee having limited mobility, in which case the modification shall be limited to the minimal amount of square footage necessary to accomplish the increased accessibility.
 4. Environmental Accessibility Modifications shall be limited to a maximum of \$15,000 per Enrollee per two (2) year period.
- (f) Family Model Residential Support.
1. With the exception of homes that were already providing services to three (3) residents prior to January 1, 2004, a Family Model Residential Support home shall have no more than two (2) residents who receive services and supports.
 2. The Family Model Residential Support provider shall be responsible for providing an appropriate level of services and supports twenty-four (24) hours per day during the hours the Enrollee is not receiving Day Services or is not at school or work.
 3. Transportation shall be a component of Family Model Residential Support and shall be included in the reimbursement rate for such (i.e., it shall not be billed as a separate Waiver service) with the following exceptions:
 - (i) Transportation to and from medical services covered through the Medicaid State Plan, which shall not be billed as a Waiver service;
 - (ii) Transportation necessary for Behavioral Respite Services; or
 - (iii) Transportation necessary for Orientation and Mobility Training.

(Rule 1200-13-01-.25, continued)

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.

Individual Transportation Services shall not be used for:

1. Transportation to and from Day Services;
2. Transportation to and from supported or competitive employment;
3. Transportation of school aged children to and from school;
4. Transportation to and from medical services covered by the Medicaid State Plan; or
5. 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 at school and shall be responsible for the cost of Day Services needed by the Enrollee.
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

(Rule 1200-13-01-.25, continued)

apportioned between the Enrollee, other residents in the home, and (as applicable) live-in or other caregivers.

4. This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).
5. Medical Residential Services providers must be licensed by the Department of Mental Health and Developmental Disabilities as a Mental Retardation Residential Habilitation Facility provider or a Supported Living Service provider and ensure that employed nurses are licensed to practice in the state of Tennessee.

(i) Nursing Services.

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

(j) Nutrition Services.

1. Nutrition Services must be provided face to face with the Enrollee except for Enrollee-specific training of caregivers responsible for food purchase, food preparation, or assisting the Enrollee to eat and except for that portion of the assessment involving development of the POC.
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. Reimbursement for a Nutrition Services assessment visit, which includes the Nutritional Services plan development resulting from such an assessment, shall be limited to one (1) assessment visit per month with a maximum of three (3) assessment visits per year per Enrollee per provider Nutrition Services other than such assessments (e.g., Enrollee-specific training of caregivers; monitoring dietary compliance and food preparation) shall be limited to a maximum of one

(Rule 1200-13-01-.25, continued)

(1) visit per day. Nutrition Services assessments shall not be billed on the same day with other Nutrition Services.

(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 except for that portion of the assessment involving development of the POC.
3. Occupational Therapy therapeutic and corrective services shall not be ordered concurrently with Occupational Therapy assessments (i.e., assess and treat orders are not accepted).
4. Occupational Therapy assessments shall not be billed on the same day with other Occupational Therapy services.
5. Occupational Therapy shall not be billed when provided during the same time period as Physical Therapy; Speech, Language and Hearing Services; Nutrition Services; Orientation and Mobility Training; or Behavior Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently. Occupational Therapy shall not be billed with Day Services if the Day Services are reimbursed on a per hour basis.
6. Occupational Therapy services are not intended to replace services available through the Medicaid State Plan or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act.
7. Reimbursement for an Occupational Therapy assessment with development of an Occupational Therapy plan based on such an assessment shall be limited to a maximum of one (1) assessment with plan development per month with a maximum of three (3) assessments per year per Enrollee per provider. Occupational Therapy services other than such assessments (e.g., Enrollee-specific training of caregivers; provision of therapeutic services; monitoring progress) shall be limited to a maximum of one and one-half (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. Reimbursement for an Orientation and Mobility Training assessment with development of the Orientation and Mobility Training plan based on such an assessment shall be limited to a maximum of one (1) assessment with plan development per month with a maximum of three (3) assessments per year per Enrollee per provider. Orientation and Mobility Training assessments shall not

(Rule 1200-13-01-.25, continued)

be billed on the same day with other Orientation and Mobility Training services. Orientation and Mobility Training services other than such assessments (e.g., Enrollee training; Enrollee-specific training of caregivers), which shall be reimbursed on a per diem basis, shall be limited to a maximum of fifty-two (52) hours of services per Enrollee per year.

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

(m) Personal Assistance.

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

(n) Personal Emergency Response System. The system shall be limited to those who are alone for parts of the day and who have demonstrated mental and physical capability to utilize such a system effectively.

(o) Physical Therapy Services.

1. Services must be provided by a licensed physical therapist or by a licensed physical therapist assistant working under the supervision of a licensed physical therapist.
2. Physical Therapy must be provided face to face with the Enrollee except for that portion of the assessment involving development of the POC.
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

(Rule 1200-13-01-.25, continued)

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. Reimbursement for a Physical Therapy assessment with development of a Physical Therapy plan based on such an assessment shall be limited to a maximum of one (1) assessment with plan development per month with a maximum of three (3) assessments per year per Enrollee per provider. Physical Therapy services other than such assessments (e.g., Enrollee-specific training of caregivers; provision of therapeutic services; monitoring progress) shall be limited to a maximum of one and one-half (1.5) hours per Enrollee per day.

(p) Residential Habilitation.

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

(q) Respite.

1. Respite may be provided in the Enrollee's place of residence, in a Family Model Residential Support home, in a Medicaid-certified ICF/MR, in a home operated by a licensed residential provider, or in the home of an approved respite provider.
2. An Enrollee receiving a residential service (i.e., Supported Living, Residential Habilitation, Medical Residential Services, or Family Model Residential Support) shall not be eligible to receive Respite as a service.

(Rule 1200-13-01-.25, continued)

3. The cost of room and board shall be excluded from Respite reimbursement if Respite is provided in a private residence.
 4. Respite shall be limited to a maximum of thirty (30) days per Enrollee per year.
 5. Enrollees who receive Respite shall be eligible to receive Individual Transportation Services only to the extent necessary during the time period when Respite is being provided.
- (r) Specialized Medical Equipment and Supplies and Assistive Technology.
1. Face-to-face consultative assessment by a physical therapist, occupational therapist, or speech therapist to assure that specialized medical equipment and assistive technology which requires custom fitting meets the needs of the Enrollee and training of the Enrollee by a physical therapist, occupational therapist, or speech therapist to effectively utilize such customized equipment shall be limited to a maximum of three (3) hours per Enrollee per day.
 2. Items not of direct medical or remedial benefit to the Enrollee shall be excluded. Items that would be covered by the Medicaid State Plan shall be excluded from coverage. Swimming pools, hot tubs, health club memberships, and recreational equipment are excluded. Prescription and over-the-counter medications, food and food supplements, and diapers and other incontinence supplies are excluded.
 3. When medically necessary and not covered by warranty, repair of equipment may be covered when it is substantially less expensive to repair the equipment rather than to replace it.
 4. The purchase price for waiver-reimbursed Specialized Medical Equipment, Supplies and Assistive Technology shall be considered to include the cost of the item as well as basic training on operation and maintenance of the item.
 5. Specialized Medical Equipment, Supplies and Assistive Technology shall be limited to a maximum of \$10,000 per Enrollee per two (2) year period.
- (s) Speech, Language and Hearing Services.
1. Services must be provided by a licensed speech language pathologist or by a licensed audiologist.
 2. Speech, Language and Hearing Services must be provided face to face with the Enrollee except for that portion of the assessment involving development of the POC.
 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

(Rule 1200-13-01-.25, continued)

- 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. Reimbursement for a Speech, Language, and Hearing Services assessment with development of a Speech, Language, and Hearing Services plan based on such an assessment shall be limited to a maximum of one (1) assessment with plan development per month with a maximum of three (3) assessments per year per Enrollee per provider. Speech, Language, and Hearing Services other than such assessments (e.g., Enrollee-specific training of caregivers; provision of therapeutic services; monitoring progress) shall be limited to a maximum of one and one-half (1.5) hours per Enrollee per day.
- (t) Support Coordination. There must be at least one face-to-face contact with the Enrollee per calendar month. If the Enrollee receives a residential service, the Support Coordinator shall have at least one face-to-face contact with the Enrollee in the Enrollee's place of residence each quarter.
- (u) Supported Living.
1. The Supported Living provider shall not own the Enrollee's place of residence or be a co-signer of a lease on the Enrollee's place of residence unless the Supported Living provider signs a written agreement with the Enrollee that states that the Enrollee will not be required to move if the primary reason is because the Enrollee desires to change to a different Supported Living provider. A Supported Living provider shall not own, be owned by, or be affiliated with any entity that leases or rents a place of residence to an Enrollee if such entity requires, as a condition of renting or leasing, the Enrollee to move if the Supported Living provider changes.
 2. The Supported Living home shall have no more than three (3) residents including the Enrollee.
 3. Unless the residence is individually licensed or inspected by a public housing agency utilizing the HUD Section 8 safety checklist, the residence must have an operable smoke detector and a second means of egress.
 4. The Supported Living provider shall be responsible for providing an appropriate level of services and supports twenty-four (24) hours per day during the hours the Enrollee is not receiving Day Services or is not at school or work.
 5. Transportation shall be a component of Supported Living and shall be included in the reimbursement rate for such (i.e., it shall not be billed as a separate Waiver service) with the following exceptions:
 - (i) Transportation to and from medical services covered through the Medicaid State Plan, which shall not be billed as a Waiver service;
 - (ii) Transportation necessary for Behavioral Respite Services; or
 - (iii) Transportation necessary for Orientation and Mobility Training.
 6. Reimbursement for Supported Living shall not be made for room and board with the exception of a reasonable portion that is attributed to a live-in caregiver who is unrelated to the Enrollee and who provides services to the Enrollee in the Enrollee's home. Reimbursement for Supported Living shall not include the cost

(Rule 1200-13-01-.25, continued)

- of maintenance of the dwelling. Residential expenses (e.g., phone, cable TV, food, rent) shall be apportioned between the Enrollee, other residents in the home, and (as applicable) live-in or other caregivers.
- 7. This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).
- 8. The Enrollee or the Enrollee's guardian or conservator shall have a voice in choosing the individuals who reside in the Supported Living residence and the staff who provide services and supports.
- 9. The Enrollee shall have the right to manage personal funds as specified in the Individual Support Plan.
- (v) Vehicle Accessibility Modifications.
 - 1. Replacement of tires or brakes, oil changes, and other vehicle maintenance procedures shall be excluded from coverage.
 - 2. Vehicle Accessibility Modifications shall be limited to a maximum of \$20,000 per Enrollee per five (5) year period.
- (w) Out-of-State Services. A provider of Personal Assistance, Residential Habilitation, Supported Living, Medical Residential Services, and Family Model Residential Services may provide such Covered Service outside the State of Tennessee and be reimbursed only when provided in accordance with the following:
 - 1. Covered Services provided out of state shall be for the purpose of visiting relatives or for vacations and shall be included in the Enrollee's Plan of Care. Trips to casinos or other gambling establishments shall be excluded from coverage.
 - 2. Covered Services provided out of state shall be limited to a maximum of fourteen (14) days per Enrollee per year.
 - 3. The waiver service provider agency must be able to assure the health and safety of the Enrollee during the period when Covered Services will be provided out of state and must be willing to assume the additional risk and liability of provision of Covered Services out of state.
 - 4. During the period when Covered Services are being provided out of state, the waiver service provider agency shall maintain an adequate amount of staffing to meet the needs of the Enrollee and must ensure that staff meet the applicable provider qualifications.
 - 5. The provider agency which provides Covered Services out of state shall not receive any additional reimbursement for provision of services out-of-state. The costs of travel, lodging, food, and other expenses incurred by staff during the provision of out-of-state services shall not be reimbursed through the Waiver. The costs of travel, lodging, food, and other expenses incurred by the Enrollee while receiving out-of-state services shall be the responsibility of the Enrollee and shall not be reimbursed through the waiver.
- (x) All Covered Services to be provided prior to the development of the initial Individual Support Plan must be included in the physician's plan of care section of the Pre-Admission Evaluation application.

(Rule 1200-13-01-.25, continued)

(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 LOC provided in an ICF/MR, and must meet the ICF/MR eligibility criteria specified in TennCare Rule 1200-13-01-.15, except that requirements pertaining to a psychological evaluation shall be in accordance with Rule 1200-13-01-.25(3)(a)5.
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 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 has an IQ test score of seventy (70) or below; or
- (II) Is a child five (5) years of age or younger who has a developmental disability with a high probability of resulting in mental retardation (i.e., a condition of substantial developmental delay or specific congenital or acquired condition with a high probability of resulting in mental retardation); and

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

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

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:

(Rule 1200-13-01-.25, continued)

- (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.

- 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. May be used to transfer an individual from one MR Waiver to a different Home and Community Based Services MR Waiver Program as specified in 1200-13-01-.25(1)(qq) above; and
- 4. Shall include an initial plan of care that lists the Enrollee's specific Waiver Services with the amount, scope, and duration of the services.

(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

(Rule 1200-13-01-.25, continued)

and shall offer the choice of available institutional services or Waiver program services. Notice to the individual shall contain:

1. A simple explanation of the Waiver and Covered Services;
 2. Notification of the opportunity to apply for enrollment in the Waiver and an explanation of the procedures for enrollment; and
 3. A statement that participation in the Waiver is voluntary.
- (b) Enrollment in the Waiver shall be voluntary, but shall be restricted to the maximum number of individuals specified in the Waiver, as approved by the Centers for Medicare and Medicaid Services for the State of Tennessee.
- (c) Enrollment of new Enrollees into the Waiver may be suspended when the average per capita fiscal year expenditure under the Waiver exceeds or is reasonably anticipated to exceed 100% of the average per capita expenditure that would have been made in the fiscal year if the care was provided in an ICF/MR.
- (5) Certification and Re-evaluation.
- (a) The ICF/MR Pre-Admission Evaluation shall include a signed and dated certification by the individual's physician that the individual requires Waiver Services.
- (b) The Operational Administrative Agency shall perform a re-evaluation of the Enrollee's need for continued stay in the Waiver within twelve (12) calendar months of the date of enrollment and at least every twelve (12) months thereafter. The re-evaluation shall be documented in a format approved by the State Medicaid Agency and shall be performed by a licensed physician or registered nurse or a Qualified Mental Retardation Professional.
- (c) The Operational Administrative Agency shall maintain in its files for a minimum period of three (3) years a copy of the re-evaluations of need for continued stay.
- (6) Disenrollment.
- (a) Voluntary disenrollment of an Enrollee from the Waiver may occur at any time upon written notice from the Enrollee or the Enrollee's guardian or conservator to the Operational Administrative Agency. Prior to disenrollment the Operational Administrative Agency shall provide reasonable assistance to the Enrollee in locating appropriate alternative placement.
- (b) An Enrollee may be involuntarily disenrolled from the Waiver for any of the following reasons:
1. The Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled is terminated.
 2. An Enrollee becomes ineligible for Medicaid or is found to be erroneously enrolled in the Waiver.
 3. An Enrollee moves out of the State of Tennessee.
 4. The condition of the Enrollee improves such that the Enrollee no longer requires the level of care provided by the Waiver.

(Rule 1200-13-01-.25, continued)

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, NF, ICF/MR, Assisted Living Facility, and/or Home for the Aged and has resided there for a continuous period exceeding one hundred twenty (120) days, if such period began prior to March 1, 2010, or a period exceeding ninety (90) days if such period begins on or after March 1, 2010.
- (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 a comprehensive individualized written Plan of Care (the Individual Support Plan) that shall be developed for the Enrollee within sixty (60) calendar days of admission into the Waiver.
 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.

(Rule 1200-13-01-.25, continued)

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

(8) Physician Services.

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

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

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

- (9) Waiver Administration. 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:

- (a) Marketing of the Waiver to potential Enrollees;
- (b) Intake and pre-enrollment assessment of the applicant's habilitative, medical and specialized services needs; and appropriateness for enrollment in the Waiver;
- (c) Assisting the applicant with the submission of a properly completed ICF/MR Pre-Admission Evaluation;
- (d) Enrollment of eligible individuals into the Waiver;
- (e) Provision of a plain language explanation of appeal rights to each Enrollee upon enrollment in the Waiver;
- (f) Review and approval of Plans of Care (Individual Support Plans) to ensure that Waiver Services have been authorized prior to payment;

(Rule 1200-13-01-.25, continued)

- (g) Ensuring that annual level of care re-evaluations have been performed to document the need for continuation of Waiver Services for the Enrollee;
- (h) Notification of the State Medicaid Agency in writing prior to involuntary disenrollment of any Enrollee;
- (i) 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;
- (j) Obtaining approval from the State Medicaid Agency prior to distributing policies and procedures to Waiver providers or Waiver information to Enrollees;
- (k) Compliance with reporting and record-keeping requirements established by the State Medicaid Agency;
- (l) Maintaining in its files the original ICF/MR Pre-Admission Evaluation and, where applicable, the original Transfer Form;
- (m) Assurance of a statewide provider network adequate to meet the needs of Enrollees;
- (n) Ensuring that Waiver Services providers and subcontractors meet the Waiver provider qualifications approved by the Centers for Medicare and Medicaid Services;
- (o) 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;
- (p) Assurance of the health and safety of Enrollees through the implementation of a comprehensive quality monitoring program;
- (q) Reporting instances of abuse, neglect, mistreatment or exploitation to appropriate state agencies;
- (r) Assurance that Covered Services are provided in accordance with the approved Waiver definitions and in accordance with the State Medicaid Agency guidelines;
- (s) 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;
- (t) 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;
- (u) Collection of applicable patient liability from Enrollees;
- (v) Reimbursement of Waiver providers in accordance with policies established by the State Medicaid Agency;
- (w) 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

(Rule 1200-13-01-.25, continued)

- (x) 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 less.
 - (c) In accordance with 42 CFR § 435.726, the Operational Administrative Agency shall make a diligent effort to collect patient liability if it applies to the Enrollee. The Operational Administrative Agency or its designee shall complete appropriate forms showing the individual's amount of monthly income and shall submit them to the Tennessee Department of Human Services. The Tennessee Department of Human Services shall issue the appropriate forms to the Operational Administrative Agency and to the State Medicaid Agency's fiscal agent that processes and pays vendor claims, specifying the amount of patient liability to be applied toward the cost of care for the Enrollee.
 - (d) The Operational Administrative Agency shall submit bills for services to the State Medicaid Agency's fiscal agent using a claim form approved by the State Medicaid Agency. On claim forms, the Operational Administrative Agency shall use a provider number assigned by the State Medicaid Agency.
 - (e) Reimbursement shall not be made to the Operational Administrative Agency for therapeutic leave or hospital leave for Enrollees in the Waiver.
 - (f) Medicaid benefits other than those specified in the Waiver's scope of Covered Services shall be reimbursed by the State Medicaid Agency as otherwise provided for by federal and state rules and regulations.
 - (g) The Operational Administrative Agency shall be responsible for obtaining the physician's initial certification and subsequent Enrollee re-evaluations. Failure to perform re-evaluations in a timely manner and in the format approved by the State Medicaid Agency shall require a corrective action plan and shall result in partial or full recoupment of all amounts paid by the State Medicaid Agency during the time period when a re-evaluation had lapsed.
 - (h) The State Medicaid Agency shall be responsible for defining and establishing the billing units to be used by the Operational Administrative Agency in billing for Waiver Services.
 - (i) An Operational Administrative Agency that enrolls an individual without an approved ICF/MR Pre-Admission Evaluation or, where applicable, an approved Transfer Form does so without the assurance of reimbursement. An Operational Administrative Agency that enrolls an individual who has not been determined by the Tennessee Department of Human Services to be financially eligible to have Medicaid make reimbursement for covered services does so without the assurance of reimbursement.

(Rule 1200-13-01-.25, continued)

- (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, 4-5-208, 4-5-209, 71-5-105, 71-5-109, and Executive Order No. 23. **Administrative History:** Original rule filed July 6, 2001; effective September 19, 2001. Amendment filed June 20, 2007; effective September 3, 2007. Public necessity rule filed July 1, 2009; effective through December 13, 2009. Amendments filed September 11, 2009; effective December 10, 2009. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendments filed May 27, 2010; effective August 25, 2010.

1200-13-01-.26 REPEALED.

Authority: T.C.A. §§4-5-202, 4-5-209, 71-5-105, 71-5-109, and Executive Order No. 23. **Administrative History:** Original rule filed July 28, 2004; effective October 11, 2004. Public necessity rule filed August 30, 2007; effective through February 11, 2008. Amendment filed November 30, 2007; effective February 13, 2008.

1200-13-01-.27 REPEALED.

Authority: T.C.A. §§4-5-202, 4-5-209, 71-5-105, 71-5-109, and Executive Order No. 23. **Administrative History:** Original rule filed July 28, 2004; effective October 11, 2004. Public necessity rule filed December 28, 2007; effective through June 10, 2008. Repeal of rule filed March 27, 2008; effective June 10, 2008.

1200-13-01-.28 HOME AND COMMUNITY BASED SERVICES WAIVER FOR PERSONS WITH MENTAL RETARDATION UNDER SECTION 1915(c) OF THE SOCIAL SECURITY ACT (ARLINGTON MR WAIVER).

- (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.
 - (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.

(Rule 1200-13-01-.28, continued)

- (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.
- (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.

(Rule 1200-13-01-.28, continued)

- (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) 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.
- (u) 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.
- (v) Nursing Services –skilled nursing services that fall within the scope of Tennessee's Nurse Practice Act and that are directly provided to the Enrollee in accordance with a plan of care. Nursing Services shall be ordered by the Enrollee's physician, physician assistant, or nurse practitioner, who shall document the medical necessity of the services and specify the nature and frequency of the nursing services.
- (w) Nutrition Services - assessment of nutritional needs, nutritional counseling, and education of the Enrollee and of caregivers responsible for food purchase, food preparation, or assisting the Enrollee to eat. Nutrition Services are intended to promote healthy eating practices and to enable the Enrollee and direct support professionals to follow special diets ordered by a physician, physician assistant, or nurse practitioner.
- (x) Occupational Therapy Services – diagnostic, therapeutic, and corrective services which are within the scope of state licensure. Occupational Therapy Services provided to improve or maintain current functional abilities as well as prevent or minimize deterioration of chronic conditions leading to a further loss of function are also included within this definition.
- (y) Operational Administrative Agency - the approved agency with which the State Medicaid Agency contracts for the administration of the day-to-day operations of the Home and Community Based Services Waiver for 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

(Rule 1200-13-01-.28, continued)

education of the Enrollee and of caregivers responsible for assisting in the mobility of the Enrollee.

- (aa) Personal Assistance – the provision of direct assistance with activities of daily living (e.g., bathing, dressing, personal hygiene, eating, meal preparation excluding cost of food), household chores essential to the health and safety of the enrollee, budget management, attending appointments, and interpersonal and social skills building to enable the Enrollee to live in a home in the community. It also may include medication administration as permitted under Tennessee's Nurse Practice Act.
- (bb) Personal Emergency Response System - a stationary or portable electronic device used in the Enrollee's place of residence which enables the Enrollee to secure help in an emergency. The system shall be connected to a response center staffed by trained professionals who respond upon activation of the electronic device.
- (cc) Physical Therapy Services - diagnostic, therapeutic, and corrective services which are within the scope of state licensure. Physical Therapy Services provided to improve or maintain current functional abilities as well as prevent or minimize deterioration of chronic conditions leading to a further loss of function are also included within this definition.
- (dd) Plan of Care – an individualized written Plan of Care which describes the medical and other services (regardless of funding source) to be furnished to the Enrollee, the Waiver Service frequency, and the type of provider who will furnish each Waiver Service and which serves as the fundamental tool by which the State ensures the health and welfare of Enrollees.
- (ee) Qualified Mental Retardation Professional (QMRP) - an individual who meets current federal standards, as published in the Code of Federal Regulations, for a qualified mental retardation professional.
- (ff) Re-evaluation - the annual process approved by the State Medicaid Agency by which a licensed physician or registered nurse or a Qualified Mental Retardation Professional assesses the Enrollee's need for continued Waiver Services and certifies in writing that the Enrollee continues to require Waiver Services.
- (gg) Residential Habilitation - a type of residential service having individualized services and supports that enable an Enrollee to acquire, retain, or improve skills necessary to reside in a community-based setting including direct assistance with activities of daily living essential to the health and safety of the Enrollee, budget management, attending appointments, and interpersonal and social skills building to enable the Enrollee to live in a home in the community. It also may include medication administration as permitted under Tennessee's Nurse Practice Act.
- (hh) Respite - services provided to an Enrollee when unpaid caregivers are absent or incapacitated due to death, hospitalization, illness or injury, or when unpaid caregivers need relief from routine caregiving responsibilities.
- (ii) Safety Plan - an individualized plan by which the Operational Administrative Agency ensures the health, safety and welfare of Enrollees who do not have 24-hour direct care services.
- (jj) Specialized Medical Equipment and Supplies and Assistive Technology - assistive devices, adaptive aids, controls or appliances which enable an Enrollee to increase the ability to perform activities of daily living, or to perceive, control or communicate with the environment, and supplies for the proper functioning of such items. Specialized

(Rule 1200-13-01-.28, continued)

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 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, from an ICF/MR to the Waiver or from one MR Waiver program to another MR Waiver program. For purposes of transfer to an MR Waiver program, whether from an ICF/MR or from another MR Waiver

(Rule 1200-13-01-.28, continued)

program, such Transfer Form shall be processed by TennCare only if submitted by the Division of Intellectual Disabilities Services (DIDS). DIDS shall submit a Transfer Form only after verifying that the person otherwise meets all applicable admission criteria for the applicable MR Waiver program, as the Transfer Form accomplishes only the transfer of the level of care eligibility.

- (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 for Enrollee-specific training of staff; behavior assessment and plan development; and presentation of Enrollee behavior information at human rights committee meetings, behavior support committee meetings, and Enrollee planning meetings.
 - 3. Reimbursement for presentation of Enrollee behavior information at meetings shall be limited to a maximum of five (5) hours per Enrollee per year per provider. Reimbursement for behavior assessments shall be limited to a maximum of eight (8) hours per assessment with a maximum of two (2) assessments per year. Reimbursement for behavior plan development resulting from such a behavior assessment and the training of staff on the plan during the first thirty (30) days following its approval for use shall be limited to a maximum of six (6) hours.

(Rule 1200-13-01-.28, continued)

(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 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.

(Rule 1200-13-01-.28, continued)

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

(Rule 1200-13-01-.28, continued)

3. Transportation of school aged children to and from school;
4. Transportation to and from medical services covered by the Medicaid State Plan; or
5. 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 at school and shall be responsible for the cost of Day Services needed by the Enrollee.
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.

(Rule 1200-13-01-.28, continued)

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 except for Enrollee-specific training of caregivers responsible for food purchase, food preparation, or assisting the Enrollee to eat and except for that portion of the assessment involving development of the POC.
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. Reimbursement for a Nutrition Services assessment visit, which includes the Nutritional Services plan development resulting from such an assessment, shall be limited to one (1) assessment visit per month with a maximum of three (3) assessment visits per year per Enrollee per provider Nutrition Services other than such assessments (e.g., Enrollee-specific training of caregivers; monitoring dietary compliance and food preparation) shall be limited to a maximum of one (1) visit per day. Nutrition Services assessments shall not be billed on the same day with other Nutrition Services.

(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 except for that portion of the assessment involving development of the POC.
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.

(Rule 1200-13-01-.28, continued)

5. Occupational Therapy shall not be billed when provided during the same time period as Physical Therapy; Speech, Language and Hearing Services; Nutrition Services; Orientation and Mobility Training; or Behavior Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently. Occupational Therapy shall not be billed with Day Services if the Day Services are reimbursed on a per hour basis.
 6. Occupational Therapy services are not intended to replace services available through the Medicaid State Plan or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act.
 7. Reimbursement for an Occupational Therapy assessment with development of an Occupational Therapy plan based on such an assessment shall be limited to a maximum of one (1) assessment with plan development per month with a maximum of three (30 assessments per year per Enrollee per provider. Occupational Therapy services other than such assessments (e.g., Enrollee-specific training of caregivers; provision of therapeutic services; monitoring progress) shall be limited to a maximum of one and one-half (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. Reimbursement for an Orientation and Mobility Training assessment with development of the Orientation and Mobility Training plan based on such an assessment shall be limited to a maximum of one (1) assessment with plan development per month with a maximum of three (3) assessments per year per Enrollee per provider. Orientation and Mobility Training assessments shall not be billed on the same day with other Orientation and Mobility Training services. Orientation and Mobility Training services other than such assessments (e.g., Enrollee training; Enrollee-specific training of caregivers), which shall be reimbursed on a per diem basis, shall be limited to a maximum of fifty-two (52) 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

(Rule 1200-13-01-.28, continued)

- Residential Support) shall not be eligible to receive Personal Assistance. Personal Assistance shall not be provided during the same time period when the Enrollee is receiving Day Services.
3. This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).
 4. Family members who provide Personal Assistance must meet the same standards as providers who are unrelated to the Enrollee. The Personal Assistance provider shall not be the spouse and shall not be the Enrollee's parent if the Enrollee is a minor. Reimbursement shall not be made to any other individual who is a conservator unless so permitted in the Order for Conservatorship.
- (n) Personal Emergency Response System. The system shall be limited to those who are alone for parts of the day and who have demonstrated mental and physical capability to utilize such a system effectively.
- (o) Physical Therapy Services.
1. Services must be provided by a licensed physical therapist or by a licensed physical therapist assistant working under the supervision of a licensed physical therapist.
 2. Physical Therapy must be provided face to face with the Enrollee except for that portion of the assessment involving development of the POC.
 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. Reimbursement for a Physical Therapy assessment with development of a Physical Therapy plan based on such an assessment shall be limited to a maximum of one (1) assessment with plan development per month with a maximum of three (3) assessments per year per Enrollee per provider. Physical Therapy services other than such assessments (e.g., Enrollee-specific training of caregivers; provision of therapeutic services; monitoring progress) shall be limited to a maximum of one and one-half (1.5) hours per Enrollee per day.
- (p) Residential Habilitation.

(Rule 1200-13-01-.28, continued)

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.
 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.

(Rule 1200-13-01-.28, continued)

2. Items not of direct medical or remedial benefit to the Enrollee shall be excluded. Items that would be covered by the Medicaid State Plan shall be excluded from coverage. Swimming pools, hot tubs, health club memberships, and recreational equipment are excluded. Prescription and over-the-counter medications, food and food supplements, and diapers and other incontinence supplies are excluded.
 3. When medically necessary and not covered by warranty, repair of equipment may be covered when it is substantially less expensive to repair the equipment rather than to replace it.
 4. The purchase price for waiver-reimbursed Specialized Medical Equipment, Supplies and Assistive Technology shall be considered to include the cost of the item as well as basic training on operation and maintenance of the item.
 5. Specialized Medical Equipment, Supplies and Assistive Technology shall be limited to a maximum of \$10,000 per Enrollee per two (2) year period.
- (s) Speech, Language and Hearing Services.
1. Services must be provided by a licensed speech language pathologist or by a licensed audiologist.
 2. Speech, Language and Hearing Services must be provided face to face with the Enrollee except for that portion of the assessment involving development of the POC.
 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. Reimbursement for a Speech, Language, and Hearing Services assessment with development of a Speech, Language, and Hearing Services plan based on such an assessment shall be limited to a maximum of one (1) assessment with plan development per month with a maximum of three (3) assessments per year per Enrollee per provider. Speech, Language, and Hearing Services other than such assessments (e.g., Enrollee-specific training of caregivers; provision of therapeutic services; monitoring progress) shall be limited to a maximum of one and one-half (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.

(Rule 1200-13-01-.28, continued)

(u) Supported Living.

1. The Supported Living provider shall not own the Enrollee's place of residence or be a co-signer of a lease on the Enrollee's place of residence unless the Supported Living provider signs a written agreement with the Enrollee that states that the Enrollee will not be required to move if the primary reason is because the Enrollee desires to change to a different Supported Living provider. A Supported Living provider shall not own, be owned by, or be affiliated with any entity that leases or rents a place of residence to an Enrollee if such entity requires, as a condition of renting or leasing, the Enrollee to move if the Supported Living provider changes.
2. The Supported Living home shall have no more than three (3) residents including the Enrollee.
3. Unless the residence is individually licensed or inspected by a public housing agency utilizing the HUD Section 8 safety checklist, the residence must have an operable smoke detector and a second means of egress.
4. The Supported Living provider shall be responsible for providing an appropriate level of services and supports twenty-four (24) hours per day during the hours the Enrollee is not receiving Day Services or is not at school or work.
5. Transportation shall be a component of Supported Living and shall be included in the reimbursement rate for such (i.e., it shall not be billed as a separate Waiver service) with the following exceptions:
 - (i) Transportation to and from medical services covered through the Medicaid State Plan, which shall not be billed as a Waiver service;
 - (ii) Transportation necessary for Behavioral Respite Services; or
 - (iii) Transportation necessary for Orientation and Mobility Training.
6. Reimbursement for Supported Living shall not be made for room and board with the exception of a reasonable portion that is attributed to a live-in caregiver who is unrelated to the Enrollee and who provides services to the Enrollee in the Enrollee's home. Reimbursement for Supported Living shall not include the cost of maintenance of the dwelling. Residential expenses (e.g., phone, cable TV, food, rent) shall be apportioned between the Enrollee, other residents in the home, and (as applicable) live-in or other caregivers.
7. This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).
8. The Enrollee or the Enrollee's guardian or conservator shall have a voice in choosing the individuals who reside in the Supported Living residence and the staff who provide services and supports.
9. The Enrollee shall have the right to manage personal funds as specified in the Individual Support Plan.

(v) Vehicle Accessibility Modifications.

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

(Rule 1200-13-01-.28, continued)

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.
 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 Rule 1200-13-01-.15, except that requirements pertaining to a psychological evaluation shall be in accordance with Rule 1200-13-01-.28(3)(a)6.

(Rule 1200-13-01-.28, continued)

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 which meets the following:
 - (i) The psychological evaluation shall document that the individual has mental retardation manifested before eighteen (18) years of age and has an IQ test score of seventy (70) or below; and
 - (ii) There is no time limit for when the psychological evaluation is conducted as long as it is completed prior to the submission of the PAE, and as long as the evaluation meets the requirements specified in 1200-13-01-.28(3)(a)6.(i) above, and the person's current medical, social, developmental and psycho-social history continues to support the evaluation.
 - (iii) A new psychological evaluation performed within ninety (90) calendar days preceding the date of admission into the waiver shall be required if the person's condition has significantly changed, or the original evaluation is not otherwise consistent with the person's current medical, social, developmental and psycho-social history.
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;

(Rule 1200-13-01-.28, continued)

- 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;
 - 2. May be used to transfer an individual having an approved unexpired ICF/MR PAE from an ICF/MR to the Waiver;
 - 3. May be used to transfer an individual from one MR Waiver to a different Home and Community Based Services MR Waiver Program as specified in 1200-13-01-.28(1)(qq) above; and
 - 4. Shall include an initial plan of care that lists the Enrollee's specific Waiver Services with the amount, scope, and duration of the services.
- (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.

(Rule 1200-13-01-.28, continued)

- (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 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, NF, ICF/MR, Assisted Living Facility, and/or Home for the Aged and has resided there for a continuous period exceeding one hundred twenty (120) days, if such period began prior to March 1,

(Rule 1200-13-01-.28, continued)

2010, or a period exceeding ninety (90) days if such period begins on or after March 1, 2010.

- (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 a comprehensive individualized written Plan of Care (the Individual Support Plan) that shall be developed for an Enrollee within sixty (60) calendar days of admission into the Waiver.
 - 3. A Safety Plan for Enrollees who do not have 24-hour direct care services shall be maintained with the Plan of Care.
 - (b) To ensure that Waiver Services and other services are being appropriately provided to meet the Enrollee's needs, the Plan of Care shall be reviewed on an ongoing basis and shall be updated and signed in accordance with the following:
 - 1. The Support Coordinator shall review the Plan of Care when needed, but no less frequently than once each calendar month, and shall document such review by a dated signature.
 - 2. A team consisting of the Support Coordinator and other appropriate participants in the development of the Plan of Care shall review the Plan of Care when needed, but no less frequently than every twelve (12) calendar months, and shall document such review by dated signatures. Such annual review shall include, but not be limited to, reviewing outcomes and determining if progress is being made in accordance with the Plan of Care; reviewing the appropriateness of supports and services being provided and determining further needs of the Enrollee.
- (8) Physician Services.
 - (a) The Operational Administrative Agency shall ensure that each Enrollee receives physician services as needed and that each Enrollee has a medical examination, documented in the Enrollee's record, in accordance with the following schedule:

Age	Minimum frequency of medical examinations
Up to age 21	In accordance with Medicaid EPSDT periodicity standards

(Rule 1200-13-01-.28, continued)

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. 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:
- (a) Marketing of the Waiver to potential Enrollees;
 - (b) Intake and pre-enrollment assessment of the applicant's habilitative, medical and specialized services needs; and appropriateness for enrollment in the Waiver;
 - (c) Assisting the applicant with the submission of a properly completed ICF/MR Pre-Admission Evaluation;
 - (d) Enrollment of eligible individuals into the Waiver;
 - (e) Provision of a plain language explanation of appeal rights to each Enrollee upon enrollment in the Waiver;
 - (f) Review and approval of Plans of Care (Individual Support Plans) to ensure that Waiver Services have been authorized prior to payment;
 - (g) Ensuring that annual level of care re-evaluations have been performed to document the need for continuation of Waiver Services for the Enrollee;
 - (h) Notification of the State Medicaid Agency in writing prior to involuntary disenrollment of any Enrollee;
 - (i) 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;
 - (j) Obtaining approval from the State Medicaid Agency prior to distributing policies and procedures to Waiver providers or Waiver information to Enrollees;
 - (k) Compliance with reporting and record-keeping requirements established by the State Medicaid Agency;
 - (l) Maintaining in its files the original ICF/MR Pre-Admission Evaluation and, where applicable, the original Transfer Form;
 - (m) Assurance of a statewide provider network adequate to meet the needs of Enrollees;

(Rule 1200-13-01-.28, continued)

- (n) Ensuring that Waiver Services providers and subcontractors meet the Waiver provider qualifications approved by the Centers for Medicare and Medicaid Services;
 - (o) 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;
 - (p) Assurance of the health and safety of Enrollees through the implementation of a comprehensive quality monitoring program;
 - (q) Reporting instances of abuse, neglect, mistreatment or exploitation to appropriate state agencies;
 - (r) Assurance that Covered Services are provided in accordance with the approved Waiver definitions and in accordance with the State Medicaid Agency guidelines;
 - (s) 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;
 - (t) 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;
 - (u) Collection of applicable patient liability from Enrollees;
 - (v) Reimbursement of Waiver providers in accordance with policies established by the State Medicaid Agency;
 - (w) 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
 - (x) 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 less.
 - (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

(Rule 1200-13-01-.28, continued)

showing the individual's amount of monthly income and shall submit them to the Tennessee Department of Human Services. The Tennessee Department of Human Services shall issue the appropriate forms to the Operational Administrative Agency and to the State Medicaid Agency's fiscal agent that processes and pays vendor claims, specifying the amount of patient liability to be applied toward the cost of care for the Enrollee.

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

Authority: T.C.A. 4-5-202, 4-5-208, 4-5-209, 71-5-105, 71-5-109, Executive Order No. 23.

Administrative History: Original rule filed June 20, 2007; effective September 3, 2007. Public necessity rules filed July 1, 2009; effective through December 13, 2009. Amendments filed September 11, 2009; effective December 10, 2009. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendments filed May 27, 2010; effective August 25, 2010.

1200-13-01-.29 TENNESSEE'S SELF-DETERMINATION WAIVER UNDER SECTION 1915(c) OF THE SOCIAL SECURITY ACT (SELF-DETERMINATION MR 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.

(Rule 1200-13-01-.29, continued)

- (b) Behavioral Respite Services - services that provide Respite for an Enrollee who is experiencing a behavioral crisis that necessitates removal from the current residential setting in order to resolve the behavioral crisis.
- (c) Behavior Services – assessment and amelioration of Enrollee behavior that presents a health or safety risk to the Enrollee or others or that significantly interferes with home or community activities; determination of the settings in which such behaviors occur and the events which precipitate the behaviors; development, monitoring, and revision of crisis prevention and behavior intervention strategies; and training of caregivers who are responsible for direct care of the Enrollee in prevention and intervention strategies.
- (d) Bureau of TennCare - the bureau in the Tennessee Department of Finance and Administration which is the State Medicaid Agency and is responsible for administration of the Medicaid program in Tennessee.
- (e) 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;

(Rule 1200-13-01-.29, continued)

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.
- (n) Financial Administration Entity – an entity which meets the State Medicaid Agency requirements to provide Financial Administration services and which has been approved by the OAA to provide Financial Administration services.
- (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 Plan of Care.

(Rule 1200-13-01-.29, continued)

- (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.
- (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 Services for Impaired Vision 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

(Rule 1200-13-01-.29, continued)

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.
- (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 subparagraph (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 subparagraph (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 subparagraph (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 subparagraph (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.

(Rule 1200-13-01-.29, continued)

- (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.
- (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, from an ICF/MR to the Waiver or from one MR Waiver program to another MR Waiver program. For purposes of transfer to an MR Waiver program, whether from an ICF/MR or from another MR Waiver program, such Transfer Form shall be processed by TennCare only if submitted by the Division of Intellectual Disabilities Services (DIDS). DIDS shall submit a Transfer Form only after verifying that the person otherwise meets all applicable admission criteria for the applicable MR Waiver program, as the Transfer Form accomplishes only the transfer of the level of care eligibility.
- (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.

(Rule 1200-13-01-.29, continued)

(a) Self-Directed Services.

1. The Covered Services specified in subparagraph (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 subparagraph (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 Subparagraph (2)(b), a Financial Administration Entity must provide Financial Administration services.

(b) The following Covered Services may be Self-Directed:

1. Day Services which are not facility-based.
2. Individual Transportation Services.
3. Personal Assistance.
4. Respite Services when provided by an approved respite provider who serves only one (1) Enrollee.

(c) The following Covered Services shall not be Self-Directed:

1. Adult Dental Services.
2. Behavioral Respite Services.
3. Behavior Services.
4. Day Services which are facility-based.
5. Emergency Assistance.
6. Nursing Services.
7. Nutrition Services.
8. Occupational Therapy Services.
9. Orientation and Mobility Training.
10. Personal Emergency Response Systems.
11. Physical Therapy Services.
12. Respite Services when provided by an approved respite provider who serves more than one (1) Enrollee.

(Rule 1200-13-01-.29, continued)

13. Specialized Medical Equipment and Supplies and Assistive Technology.
14. 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:
 - (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 subparagraph (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.

(Rule 1200-13-01-.29, continued)

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. 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 Enrollee-specific training of staff; behavior assessment and plan development; and presentation of Enrollee behavior information at human rights committee meetings, behavior support committee meetings, and Enrollee planning meetings.
3. Reimbursement for presentation of Enrollee behavior information at meetings shall be limited to a maximum of five (5) hours per Enrollee per year per provider. Reimbursement for behavior assessments shall be limited to a maximum of eight (8) hours per assessment with a maximum of two (2) assessments per year. Reimbursement for behavior plan development resulting from such a behavior assessment and the training of staff on the plan during the first thirty (30) days following its approval for use shall be limited to a maximum of six (6) hours.

(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

(Rule 1200-13-01-.29, continued)

- (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.
- (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) Individual Transportation Services.

Individual Transportation Services shall not be used for:

 - 1. Transportation to and from Day Services;
 - 2. Transportation to and from supported or competitive employment;
 - 3. Transportation of school aged children to and from school; or
 - 4. Transportation to and from medical services covered by the Medicaid State Plan.
- (g) Reserved
- (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.

(Rule 1200-13-01-.29, continued)

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 except for Enrollee-specific training of caregivers responsible for food purchase, food preparation, or assisting the Enrollee to eat and except for that portion of the assessment involving development of the POC.
 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. Reimbursement for a Nutrition Services assessment visit, which includes the Nutritional Services plan development resulting from such an assessment, shall be limited to one (1) assessment visit per month with a maximum of three (3) assessment visits per year per Enrollee per provider Nutrition Services other than such assessments (e.g., Enrollee-specific training of caregivers; monitoring dietary compliance and food preparation) shall be limited to a maximum of one (1) visit per day. Nutrition Services assessments shall not be billed on the same day with other Nutrition Services.
- (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 except for that portion of the assessment involving development of the POC.
 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

(Rule 1200-13-01-.29, continued)

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

6. Occupational Therapy services are not intended to replace services available through the Medicaid State Plan or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act.
7. Reimbursement for an Occupational Therapy assessment with development of an Occupational Therapy plan based on such an assessment shall be limited to a maximum of one (1) assessment with plan development per month with a maximum of three (3) assessments per year per Enrollee per provider. Occupational Therapy services other than such assessments (e.g., Enrollee-specific training of caregivers; provision of therapeutic services; monitoring progress) shall be limited to a maximum of one and one-half (1.5) hours per Enrollee per day.

(k) Orientation and Mobility Services for Impaired Vision.

1. Orientation and Mobility Services for Impaired Vision 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 (2) services to be provided concurrently.
2. Orientation and Mobility Services for Impaired Vision shall not replace services available under a program funded by the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act.
3. Reimbursement for an Orientation and Mobility Services for Impaired Vision assessment with development of the Orientation and Mobility Services for Impaired Vision plan based on such an assessment shall be limited to a maximum of one (1) assessment with plan development per month with a maximum of three (3) assessments per year per Enrollee per provider. Orientation and Mobility Services for Impaired Vision assessments shall not be billed on the same day with other Orientation and Mobility services. Orientation and Mobility Services for Impaired Vision other than such assessments (e.g., Enrollee training; Enrollee-specific training of caregivers), which shall be reimbursed on a per diem basis, shall be limited to a maximum of fifty-two (52) hours of services per Enrollee per year.

(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

(Rule 1200-13-01-.29, continued)

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 except for that portion of the assessment involving development of the POC.
 - 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. Reimbursement for a Physical Therapy assessment with development of a Physical Therapy plan based on such an assessment shall be limited to a maximum of one (1) assessment with plan development per month with a maximum of three (3) assessments per year per Enrollee per provider. Physical Therapy services other than such assessments (e.g., Enrollee-specific training of caregivers; provision of therapeutic services; monitoring progress) shall be limited to a maximum of one and one-half (1.5) hours per Enrollee per day.
- (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.

(Rule 1200-13-01-.29, continued)

(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 except for that portion of the assessment involving development of the POC.
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. Reimbursement for a Speech, Language, and Hearing Services assessment with development of a Speech, Language, and Hearing Services plan based on such an assessment shall be limited to a maximum of one (1) assessment with plan development per month with a maximum of three (3) assessments per year per Enrollee per provider. Speech, Language, and Hearing Services other than such assessments (e.g., Enrollee-specific training of caregivers; provision of therapeutic services; monitoring progress) shall be limited to a maximum of one and one-half (1.5) hours per Enrollee per day.

(r) Vehicle Accessibility Modifications. Replacement of tires or brakes, oil changes, and other vehicle maintenance procedures shall be excluded from coverage.

(s) 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:

(Rule 1200-13-01-.29, continued)

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.
- (t) 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.
- (u) The cost of all Covered Services, including any Emergency Assistance, shall not exceed \$36,000 per year per Enrollee.

(Rule 1200-13-01-.29, continued)

- (v) 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 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 1200-13-01-.25).
 - 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 TennCare Rule 1200-13-01-.15, except that requirements pertaining to a psychological evaluation shall be in accordance with Rule 1200-13-01-.29(4)(a)6.
 - 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 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 has an IQ test score of seventy (70) or below; or
 - (II) Is a child five (5) years of age or younger who has a developmental disability with a high probability of resulting in mental retardation (i.e., a condition of substantial developmental delay or specific congenital or acquired condition with a high probability of resulting in mental retardation); and
 - (ii) There is no time limit for when the psychological evaluation is conducted as long as it is completed prior to the submission of the PAE, and as long as the evaluation meets the requirements specified in 1200-13-01-.29(4)(a)6.(i) above, and the person's current medical, social, developmental and psycho-social history continues to support the evaluation.
 - (iii) A new psychological evaluation performed within ninety (90) calendar days preceding the date of admission into the waiver shall be required if the

(Rule 1200-13-01-.29, continued)

person's condition has significantly changed, or the original evaluation is not otherwise consistent with the person's current medical, social, developmental and psycho-social history.

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

(Rule 1200-13-01-.29, continued)

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

(Rule 1200-13-01-.29, continued)

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, NF, ICF/MR, Assisted Living Facility, and/or Home for the Aged and has resided there for a continuous period exceeding one hundred twenty (120) days, if such period began prior to March 1, 2010, or a period exceeding ninety (90) days if such period begins on or after March 1, 2010.
 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 sixty (60) 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.

(Rule 1200-13-01-.29, continued)

- (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 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:

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

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

(10) Waiver Administration. 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:

- (a) Marketing of the Waiver to potential Enrollees;
- (b) Intake and pre-enrollment assessment of the applicant's habilitative, medical and specialized services needs; and appropriateness for enrollment in the Waiver;
- (c) Assisting the applicant with the submission of a properly completed ICF/MR Pre-Admission Evaluation;
- (d) Enrollment of eligible individuals into the Waiver;

(Rule 1200-13-01-.29, continued)

- (e) Provision of a plain language explanation of appeal rights to each Enrollee upon enrollment in the Waiver;
- (f) Review and approval of Plans of Care (Individual Support Plans) to ensure that Waiver Services have been authorized prior to payment;
- (g) Ensuring that annual level of care re-evaluations have been performed to document the need for continuation of Waiver Services for the Enrollee;
- (h) Notification of the State Medicaid Agency in writing prior to involuntary disenrollment of any Enrollee;
- (i) 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;
- (j) Obtaining approval from the State Medicaid Agency prior to distributing policies and procedures to Waiver providers or Waiver information to Enrollees;
- (k) Compliance with reporting and record-keeping requirements established by the State Medicaid Agency;
- (l) Maintaining in its files the original ICF/MR Pre-Admission Evaluation and, where applicable, the original Transfer Form;
- (m) Assurance of a statewide provider network adequate to meet the needs of Enrollees;
- (n) Ensuring that Waiver Services providers and subcontractors meet the Waiver provider qualifications approved by the Centers for Medicare and Medicaid Services;
- (o) 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;
- (p) Assurance of the health and safety of Enrollees through the implementation of a comprehensive quality monitoring program;
- (q) Reporting instances of abuse, neglect, mistreatment or exploitation to appropriate state agencies;
- (r) Assurance that Covered Services are provided in accordance with the approved Waiver definitions and in accordance with the State Medicaid Agency guidelines;
- (s) 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;
- (t) 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;
- (u) Oversight and monitoring of the Financial Administration entity;
- (v) Collection of applicable patient liability from Enrollees;

(Rule 1200-13-01-.29, continued)

- (w) Reimbursement of Waiver providers in accordance with policies established by the State Medicaid Agency;
 - (x) 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
 - (y) 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 less.
 - (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.

(Rule 1200-13-01-.29, continued)

- (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, 4-5-208, 4-5-209, 71-5-105, 71-5-109, Executive Order No. 23.
Administrative History: Original rule filed June 20, 2007; effective September 3, 2007. Public necessity rules filed July 1, 2009; effective through December 13, 2009. Amendments filed September 11, 2009; effective December 10, 2009. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendments filed May 27, 2010; effective August 25, 2010.

1200-13-01-.30 TENNCARE ICF/MR SERVICES.

- (1) Definitions. See Rule 1200-13-01-.02.
- (2) Eligibility for Medicaid-reimbursed care in an ICF/MR.
 - (a) The individual must be determined by DHS to be financially and categorically eligible for Medicaid-reimbursed LTC services.
 - (b) The individual must have a valid, unexpired ICF/MR PAE that has been approved by the Bureau in accordance with Rule 1200-13-01-.15.
- (3) Conditions of participation for ICFs/MR.
 - (a) The ICF/MR must enter into a provider agreement with the Bureau.
 - (b) The ICF/MR must be certified by the State, showing it has met the standards set out in 42 C.F.R., Part 442, Subpart C and 42 C.F.R., Part 483.
 - (c) ICFs/MR participating in the State of Tennessee's TennCare Program shall be terminated as TennCare providers if certification or licensure is canceled by the State.
 - (d) If the resident has resources to apply toward payment, the payment made by the State will be his current maximum payment per day, charges or per diem cost (whichever is less), minus the available patient resources.

(Rule 1200-13-01-.30, continued)

- (e) Payments for residents requiring ICF/MR services will not exceed per diem costs or charges, whichever is less.
 - (f) If an ICF/MR (upon submission of a cost report and audit of its cost), has collected on a per diem basis during the period covered by the cost report and audit, more than cost reimbursement allowed for the ICF/MR patient, the facility shall be required to reimburse the State (through the Bureau and/or the ICF/MR's Third Party), for that portion of the reimbursement collected in excess of the cost reimbursement allowed.
 - (g) Regardless of the reimbursement rate established for an ICF/MR, no ICF/MR may charge TennCare Enrollees an amount greater than the amount per day charge to private paying patients for equivalent accommodations and services.
 - (h) Personal laundry services in an ICF/MR shall be considered a covered service and included in the per diem rate. TennCare Enrollees may not be charged for personal laundry services.
- (4) Conditions that ICFs/MR must meet to receive Medicaid reimbursement.
- (a) An ICF/MR that has entered into a provider agreement with the Bureau of TennCare is entitled to receive Medicaid reimbursement for covered services provided to an ICF/MR Eligible if
 - 1. The Bureau has received an approvable ICF/MR PAE for the individual within ten (10) calendar days of the ICF/MR PAE Request Date or the physician certification date, whichever is earlier. The PAE Approval Date shall not be more than ten (10) days prior to date of submission of an approvable PAE. An approvable PAE is one in which any deficiencies in the submitted application are cured prior to disposition of the PAE.
 - 2. For the transfer to an ICF/MR of an individual having an approved unexpired ICF/MR PAE, the Bureau has received an approvable Transfer Form within ten (10) calendar days after the date of the transfer. For transfer from ICF/MR services to an HCBS MR Waiver program, the transfer form must be submitted and approved prior to enrollment in the HCBS MR Waiver Program.
 - 3. For a retroactive eligibility determination, the Bureau has received a Notice of Disposition or Change and has received an approvable request to update an approved, unexpired ICF/MR PAE within thirty (30) calendar days of the mailing date of the Notice of Disposition or Change. The effective date of payment for ICF/MR services shall not be earlier than the PAE Approval Date of the original approved, unexpired PAE which has been updated.
 - (b) Any deficiencies in a submitted PAE application must be cured prior to disposition of the PAE to preserve the PAE submission date for payment purposes.
 - 1. Deficiencies cured after the PAE is denied but within thirty (30) days of the original PAE submission date will be processed as a new application, with reconsideration of the earlier denial based on the record as a whole (including both the original denied application and the additional information submitted). If approved, the effective date of PAE approval can be no earlier than the date of receipt of the information which cured the original deficiencies in the denied PAE. Payment will not be retroactive back to the date the deficient application was received or to the date requested in the deficient application.

(Rule 1200-13-01-.30, continued)

2. Once a PAE has been denied, the original denied PAE application must be resubmitted along with any additional information which cures the deficiencies of the original application. Failure to include the original denied application may delay the availability of Medicaid reimbursement for ICF/MR services.
 - (c) An ICF/MR that admits a Medicaid Eligible without an approved ICF/MR PreAdmission Evaluation or, where applicable, an approved Transfer Form does so without the assurance of reimbursement from the Bureau.
- (5) Reimbursement methodology for ICFs/MR.
- (a) Private for-profit and private not-for-profit ICFs/MR shall be reimbursed at the lower of Medicaid cost or charges. An annual inflation factor will be applied to operating costs. The trending factor shall be computed for facilities that have submitted cost reports covering at least six (6) months of program operations. For facilities that have submitted cost reports covering at least three (3) full years of program participation, the trending factor shall be the average cost increase over the three-year (3-year) period, limited to the seventy-fifth (75th) percentile trending factor of facilities participating for at least three (3) years. Negative averages shall be considered zero (0). For facilities that have not completed three (3) full years in the program, the one-year (1-year) trending factor shall be the fiftieth (50th) percentile trending factor of facilities participating in the program for at least three (3) years. For facilities that have failed to file timely cost reports, the trending factor shall be zero (0). Capital-related costs are not subject to indexing. Capital-related costs are property, depreciation, and amortization expenses included in Section F.18 and F.19 of the Nursing Facility Cost Report Form. All other costs, including home office costs and management fees, are operating costs. Once a per-diem rate is determined from a clean cost report, the rate will not be changed until the next rate determination except for audit adjustments, correction of errors, or termination of a budgeted rate.
 - (b) Public ICFs/MR that are owned by government shall be reimbursed at one hundred percent (100%) of allowable Medicaid costs with no cost-containment incentive. Reimbursement shall be based on Medicare principles of retrospective cost reimbursement with year-end cost report settlements. Interim per-diem rates for the fiscal year beginning July 1, 1995 and ending June 30, 1996 shall be established from budgeted cost and patient day information submitted by the government ICF/MR facilities. Thereafter, interim rates shall be based on the providers' cost reports. There will be a tentative year-end cost settlement within thirty (30) days of submission of the cost reports and a final settlement within twelve (12) months of submission of the cost reports.
 - (c) Costs for supplies and other items, including any facility staff required to deliver the service, which are billed to Medicare Part B on behalf of all patients must be included as a reduction to reimbursable expenses in Section G of the NF cost report.
- (6) Bed holds.

An ICF/MR will be reimbursed in accordance with this Paragraph for the recipient's bed in that facility during the recipient's temporary absence from that facility in accordance with the following:

- (a) For days not to exceed fifteen (15) days per occasion while the recipient is hospitalized and the following conditions are met:
 1. The resident intends to return to the ICF/MR.

(Rule 1200-13-01-.30, continued)

2. The hospital provides a discharge plan for the resident.
 3. At least eighty-five percent (85%) of all other beds in the ICF/MR certified at the recipient's designated level of care (i.e., intensive training, high personal care or medical), when computed separately, are occupied at the time of hospital admission. An occupied bed is one that is actually being used by a patient. Beds being held for other patients while they are hospitalized or otherwise absent from the facility are not considered to be occupied beds, for purposes of this calculation. Computations of occupancy percentages will be rounded to the nearest percentage point.
 4. Each period of hospitalization must be physician ordered and so documented in the patient's medical record in the ICF/MR.
- (b) For days not to exceed sixty (60) days per state fiscal year and limited to fourteen (14) days per occasion while the recipient, pursuant to a physician's order, is absent from the facility on a therapeutic home visit or other therapeutic absence.
- (7) Other reimbursement issues.
- (a) No change of ownership or controlling interest of an existing Medicaid provider, including ICFs/MR, can occur until monies as may be owed to the Bureau or its contractors are provided for. The purchaser shall notify the Bureau of the purchase at the time of ownership change and is financially liable for the outstanding liabilities to the Bureau or its contractors for one (1) year from the date of purchase or for one (1) year following the Bureau's receipt of the provider's Medicare final notice of program reimbursement, whichever is later. The purchaser shall be entitled to use any means available to it by law to secure and recoup these funds from the selling entity. In addition, purchasers of ICFs/MR are responsible for obtaining an accurate accounting and transfer of funds held in trust for Medicaid residents at the time of the change of ownership or controlling interest.
 - (b) If the Bureau or an MCO has not reimbursed a business for TennCare services provided under the TennCare Program at the time the business is sold, when such an amount is determined, the Bureau or the MCO shall be required to reimburse the person owning the business provided such sale included the sale of such assets.
 - (c) When a provider was originally paid within a retrospective payment system that is subject to regular adjustments and the provider disputes the proposed adjustment action, the provider must file with the State not later than thirty (30) days after receipt of the notice informing the provider of the proposed adjustment action, a request for hearing. The provider's right to a hearing shall be deemed waived if a hearing is not requested within thirty (30) days after receipt of the notice.

Authority: T.C.A. §§ 4-5-202, 4-5-208, 71-5-105 and 71-5-109. **Administrative History:** Emergency rule filed March 1, 2010; effective through August 28, 2010. Original rule filed May 27, 2010; effective August 25, 2010.