

**RULES
OF
THE TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF TENNCARE**

**CHAPTER 1200-13-21
COVERKIDS**

TABLE OF CONTENTS

1200-13-21-.01	Scope and Authority	1200-13-21-.06	Exclusions
1200-13-21-.02	Definitions	1200-13-21-.07	Cost Sharing
1200-13-21-.03	Eligibility	1200-13-21-.08	Disenrollment
1200-13-21-.04	Enrollment and Reassignment	1200-13-21-.09	Review of CoverKids Decisions
1200-13-21-.05	Benefits	1200-13-21-.10	Providers

1200-13-21-.01 SCOPE AND AUTHORITY.

- (1) The CoverKids program was created by the CoverKids Act of 2006, T.C.A. §§ 71-3-1101, et seq., and placed under the authority of the Tennessee Department of Finance and Administration ("Department").
- (2) The Department is authorized to establish, administer and monitor the program, including contracting for the provision of services and adopting rules for governing the program.
- (3) The Commissioner of the Tennessee Department of Finance and Administration placed the CoverKids Program into the Division of Health Care Finance & Administration under the oversight of the Deputy Commissioner/Director of TennCare on March 31, 2011, for the purposes of coordination of resources and to achieve greater effectiveness and efficiencies. The Division was renamed the Division of TennCare effective August 7, 2017.
- (4) The purpose of the CoverKids program is to provide health care coverage for uninsured children who are not eligible for TennCare coverage.
- (5) The CoverKids program is a federal program, the "State Child Health Plan Under Title XXI of the Social Security Act State Children's Health Insurance Program" and is distinct and separate from the Title XIX TennCare program.

Authority: T.C.A. §§ 4-5-202, 71-3-1103 through 71-3-1108, and 71-3-1110 and the Tennessee Title XXI Children's Health Insurance Program State Plan. **Administrative History:** Original rules filed November 28, 2018; effective February 26, 2018.

1200-13-21-.02 DEFINITIONS.

- (1) Covered services. Benefits and services listed in this Chapter and provided for enrollees in the CoverKids program by an MCO, DBM, PPA or other entity under contract with the Division of TennCare.
- (2) CoverKids. The program created by T.C.A. §§ 71-3-1101, et seq., its authorized employees and agents, as the context of this Chapter requires, and administered through the Division of TennCare, which provides health coverage for children under nineteen (19) years of age and pregnant women, who do not have health insurance and do not qualify for TennCare.
- (3) CoverKids network. A group of health care providers that have entered into contracts with an MCO, DBM, PPA or other entity under contract with the Division of TennCare to furnish covered services to CoverKids enrollees.

(Rule 1200-13-21-.02, continued)

- (4) CoverKids Pregnant Women. The part of the CoverKids program that provides coverage for the unborn children of pregnant women with no source of health coverage who meet the CoverKids eligibility requirements.
- (5) CoverKids provider. A health care provider who accepts as payment in full for furnishing benefits to a CoverKids enrollee the amounts paid pursuant to an approved agreement with a TennCare contractor. Such payment may include copayments from the enrollee or the enrollee's responsible party. A CoverKids provider, including an Out-of-State Emergency Provider as defined in Rule 1200-13-13-.01, must be enrolled with TennCare and must abide by all CoverKids rules and regulations, including requirements regarding provider billing of patients as found in Rule .10. CoverKids providers must be appropriately licensed for the services they deliver and must not be providers who have been excluded from participation in the federal Medicare, Medicaid or CHIP programs.
- (6) Days. Calendar days, not business days.
- (7) Dental Benefits Manager (DBM). The entity responsible for the administrative services associated with providing covered dental services, preventive, routine and orthodontic, to CoverKids enrollees.
- (8) Emergency services. Includes emergency medical, emergency mental health and substance abuse emergency treatment services, furnished by a provider qualified to furnish the services, needed to evaluate, treat, or stabilize an emergency medical condition manifested by the sudden and unexpected onset of acute symptoms of sufficient severity, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:
 - (a) Placing the person's (or with respect to a pregnant woman, her unborn child's) health in serious jeopardy;
 - (b) Serious impairment to bodily functions; or
 - (c) Serious dysfunction of any bodily organ or part.
- (9) Managed Care Organization (MCO). An appropriately licensed Health Maintenance Organization (HMO) approved by the Division of TennCare as capable of providing medical, behavioral, and long-term care services which has signed a Contractor Risk Agreement, as defined in 1200-13-13-.01, with the Division of TennCare and operates a provider network to provide covered services to CoverKids enrollees.
- (10) Medically necessary. A medical item or service which meets all the following criteria:
 - (a) Recommended by a licensed physician who is treating the enrollee or other licensed healthcare provider practicing within his scope of licensure who is treating the enrollee;
 - (b) Required in order to diagnose or treat an enrollee's medical condition;
 - (c) Safe and effective;
 - (d) The least costly alternative course of diagnosis or treatment that is adequate for the medical condition of the enrollee; and
 - (e) Not experimental or investigational.

(Rule 1200-13-21-.02, continued)

- (11) Non-CoverKids provider. A health care provider of non-emergency services that does not participate in the network of a TennCare-contracted MCO, DBM, or PPA or other entity contracted to administer CoverKids benefits.
- (12) Parent. A natural or adoptive father or mother of a minor child; or, a guardian as defined by T.C.A. § 34-1-101, subject to court orders entered or recognized by the courts of the state of Tennessee.
- (13) Pharmacy Plan Administrator (PPA). The entity responsible for the administrative services associated with providing pharmaceutical related covered services to CoverKids enrollees.

Authority: T.C.A. §§ 4-5-202, 4-5-203, 4-5-204, 71-3-1106, and 71-3-1110; 42 U.S.C. §§ 1397aa, et seq.; and the Tennessee Title XXI Children's Health Insurance Program State Plan. **Administrative History:** Original rules filed November 28, 2018; effective February 26, 2018. Amendments filed January 11, 2021; effective April 11, 2021.

1200-13-21-.03 ELIGIBILITY. Financial and Technical Eligibility Requirements. See Chapter 1200-13-20.

Authority: T.C.A. §§ 4-5-202, 71-3-1106, and 71-3-1110 and the Tennessee Title XXI Children's Health Insurance Program State Plan. **Administrative History:** Original rules filed November 28, 2018; effective February 26, 2018.

1200-13-21-.04 ENROLLMENT AND REASSIGNMENT.

- (1) Enrollment. CoverKids enrollees are enrolled into MCOs for the provision of covered medical and behavioral health services, a DBM for provision of covered dental services, and a PPA for administration of covered pharmacy services. Enrollment procedures differ according to the type of managed care entity, the geographic area, and the number of managed care entities operating in each geographic area.
 - (a) Managed Care Organizations (MCOs).
 - 1. Individuals or families determined eligible for CoverKids shall select an MCO at the time of application. The MCO must be available in the Grand Division, as defined in Rule 1200-13-13-.01, in which the enrollee lives. All family members living in the same household and enrolled in CoverKids must be assigned to the same MCO. An enrollee is given his choice of MCOs when possible. If the requested MCO cannot accept new enrollees, the Division of TennCare will assign each enrollee to an MCO that is accepting new enrollees.
 - 2. A CoverKids enrollee may change MCOs one (1) time within the initial ninety (90) calendar days (inclusive of mail time) from the date of the letter informing the enrollee of his MCO assignment, if there is another MCO in the enrollee's Grand Division that is currently accepting new enrollees. No additional changes will be allowed except as otherwise specified in this rule. An enrollee shall remain a member of the designated plan until he is given an opportunity to change once each year during an annual change period. The annual change period will occur each year in March for enrollees in West Tennessee, in May for enrollees in Middle Tennessee, and in July for enrollees in East Tennessee. Thereafter, an MCO change is permitted only during an annual change period, unless the Division of TennCare authorizes a change as the result of the resolution of an appeal requesting a "hardship" reassignment as specified in Paragraph (2)(b) below. When an enrollee changes MCOs, the enrollee's medical care will be the responsibility of the current MCO until he is enrolled in the requested MCO.

(Rule 1200-13-21-.04, continued)

3. Each MCO shall offer its enrollees, to the extent possible, freedom of choice among CoverKids providers. If after notification of enrollment the enrollee has not chosen a primary care provider (PCP), one will be selected for him by the MCO. The period during which an enrollee may choose his primary care provider shall not be less than fifteen (15) calendar days.
 4. In the event a pregnant woman entering an MCO's plan is:
 - (i) Receiving medically necessary prenatal care the day before enrollment, the MCO shall be responsible for the costs of continuation of such medically necessary services, without any form of prior approval and without regard to whether such services are being provided within or outside the MCO's provider network until such time as the MCO can reasonably transfer the enrollee to a service and/or network provider without impeding service delivery that might be harmful to the enrollee's health.
 - (ii) In her second or third trimester of pregnancy and is receiving medically necessary prenatal care services the day before enrollment, the MCO shall be responsible for providing continued access to the provider (regardless of network affiliation) through the postpartum period. Reimbursement to an out-of-network provider shall be as set out in Rule .10.
 - (b) Dental Benefits Manager (DBM). Children enrolled in CoverKids shall be assigned to the DBM under contract with the Division of TennCare to provide dental benefits through the CoverKids Program.
 - (c) Pharmacy Plan Administrator (PPA). CoverKids enrollees shall be assigned to the PPA under contract with the Division of TennCare to provide pharmacy benefits for both medical and behavioral health services through the CoverKids Program.
- (2) Reassignment.
- (a) Reassignment to an MCO other than the current MCO in which the CoverKids enrollee is enrolled is subject to another MCO's capacity to accept new enrollees and must be approved by the Division of TennCare in accordance with one of the following:
 1. During the initial ninety (90) day period following notification of MCO assignment as described at Paragraph (1), a CoverKids enrollee may request a change of MCOs.
 2. A CoverKids enrollee must change MCOs if he moves outside the MCO's Grand Division, and that MCO is not authorized to operate in the enrollee's new place of residence. Until the CoverKids enrollee selects or is assigned to a new MCO and his enrollment is deemed complete, his medical care will remain the responsibility of the original MCO.
 3. If an enrollee's MCO withdraws from participation in the CoverKids Program, TennCare will assign him to an MCO operating in his Grand Division, if one is available. The enrollee will be provided notice of the change and will have ninety (90) days to select another MCO in his Grand Division.
 4. An enrollee shall be given an opportunity to change MCOs once each year during an annual change period. Only one (1) MCO change is permitted every twelve (12) months, unless the Division of TennCare authorizes a change as the

(Rule 1200-13-21-.04, continued)

result of the resolution of an appeal requesting a “hardship” reassignment. When an enrollee changes MCOs, the enrollee’s medical care will be the responsibility of the current MCO until enrolled in the requested MCO. If an enrollee changes MCOs during an annual change period, all family members living in the same household and enrolled in CoverKids shall also be changed.

- (b) A CoverKids enrollee may change MCOs if the Division of TennCare has granted a request for a change in MCOs or an appeal of a denial of a request for a change in MCOs has been resolved in his favor based on hardship criteria.
 - 1. The following situations will not be determined to be “hardships”:
 - (i) The enrollee is unhappy with the current MCO or PCP, but there is no hardship medical situation (as stated in Part 2. below);
 - (ii) The enrollee claims lack of access to services but the plan meets the state’s access standard;
 - (iii) The enrollee is unhappy with a current PCP or other providers, and has refused alternative PCP or provider choices offered by the MCO;
 - (iv) The enrollee is concerned that a current provider might drop out of the plan in the future;
 - (v) The enrollee’s PCP is no longer in the MCO’s network, the enrollee wants to continue to see the current PCP and has refused alternative PCP or provider choices offered by the MCO.
 - 2. Requests for hardship MCO reassignments must meet all of the following six (6) hardship criteria for reassignment. Determinations will be made on an individual basis.
 - (i) An enrollee has a medical condition that requires complex, extensive, and ongoing care; and
 - (ii) The enrollee’s specialist has stopped participating in the member’s current MCO network and has refused continuation of care to the enrollee in his current MCO assignment; and
 - (iii) The ongoing medical condition of the enrollee is such that another physician or provider with appropriate expertise would be unable to take over his care without significant and negative impact on his care; and
 - (iv) The current MCO has been unable to negotiate continued care for this enrollee with the current specialist; and
 - (v) The current provider of services is in the network of one or more alternative MCOs; and
 - (vi) An alternative MCO is available to the enrollee (i.e., has not given notice of withdrawal from the CoverKids Program, is not in receivership, and is not at member capacity for the member’s region).
- (c) Requests to change MCOs submitted by CoverKids enrollees shall be evaluated in accordance with the hardship criteria referenced in Subparagraph (b) above. If an enrollee’s request to change MCOs is granted due to hardship, all family members

(Rule 1200-13-21-.04, continued)

living in the same household and enrolled in CoverKids will be assigned to the new MCO. Upon denial of a request to change MCOs, enrollees shall be provided notice and appeal rights as described in applicable provisions of Rule .09.

- (d) The Division of TennCare shall only accept a request to change MCO assignment from the affected enrollee, his parent, guardian, or spouse.

Authority: T.C.A. §§ 4-5-202, 4-5-204, 71-3-1106, and 71-3-1110; 42 U.S.C. §§ 1397aa, et seq.; and the Tennessee Title XXI Children's Health Insurance Program State Plan. **Administrative History:** New rule filed January 11, 2021; effective April 11, 2021.

1200-13-21-.05 BENEFITS.

- (1) The following benefits are covered by the CoverKids program for children under age 19 as medically necessary, subject to the limitations stated:
 - (a) Ambulance services, air and ground.
 - (b) Care coordination services.
 - (c) Case management services.
 - (d) Chiropractic care. Maintenance visits not covered when no additional progress is apparent or expected to occur.
 - (e) Clinic services and other ambulatory health care services.
 - (f) Dental benefits:
 - 1. Dental services. Limited to a \$1,000 annual benefit maximum per enrollee.
 - 2. Orthodontic services. Limited to a \$1,250 lifetime benefit maximum per enrollee. Covered only after a 12-month waiting period.
 - (g) Disposable medical supplies.
 - (h) Durable medical equipment and other medically-related or remedial devices:
 - 1. Limited to the most basic equipment that will provide the needed care.
 - 2. Hearing aids are limited to one per ear per calendar year up to age 5, and limited to one per ear every two years thereafter.
 - (i) Emergency care.
 - (j) Home health services. Prior approval required. Limited to 125 visits per enrollee per calendar year.
 - (k) Hospice care.
 - (l) Inpatient hospital services, including rehabilitation hospital services.
 - (m) Inpatient mental health and substance abuse services.
 - (n) Laboratory and radiological services.

(Rule 1200-13-21-.05, continued)

- (o) Outpatient mental health and substance abuse services.
- (p) Outpatient services.
- (q) Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders. Limited to 52 visits per calendar year per type of therapy.
- (r) Physician services.
- (s) Prenatal care and prepregnancy family services and supplies.
- (t) Prescription drugs.
- (u) Routine health assessments and immunizations.
- (v) Skilled Nursing Facility services. Limited to 100 days per calendar year following an approved hospitalization.
- (w) Surgical services.
- (x) Vision benefits:
 - 1. Annual vision exam including refractive exam and glaucoma screening.
 - 2. Prescription eyeglass lenses. Limited to one pair per calendar year. \$85 maximum benefit per pair.
 - 3. Eyeglass frames. Coverage for replacement frames limited to once every two calendar years. \$100 maximum benefit per pair.
 - 4. Prescription contact lenses in lieu of eyeglasses. Limited to one pair per calendar year. \$150 maximum benefit per pair.
- (2) Mothers of eligible unborn children who are over age 19 receive all benefits listed in Paragraph (1), subject to the same limitations and as medically necessary, except chiropractic services, routine dental services, vision services, and hearing aids and cochlear implants are not covered for these enrollees.
- (3) Infant Diapers, as defined in Rule 1200-13-13-.01, are covered for enrollees under age 2, as described in Rule 1200-13-13-.04.
- (4) All services covered by CoverKids must be medically necessary.
- (5) An MCO or DBM may provide non-covered items or services as cost effective alternatives to covered items or services. Such cost effective alternative services may be provided because they are either (1) alternatives to covered CoverKids services that, in the judgment of the MCO or DBM, are cost-effective or (2) preventative in nature and offered to avoid the development of conditions that, in the judgment of the MCO or DBM, would require more costly treatment in the future. Cost effective alternative services are not covered services and are provided only at the discretion of the MCO or DBM, subject to approval by the Division of TennCare.

Authority: T.C.A. §§ 4-5-202, 4-5-203, 4-5-204, 4-5-208, 71-3-1104, 71-3-1106, and 71-3-1110; 42 U.S.C. §§ 1397aa, et seq.; and the Tennessee Title XXI Children's Health Insurance Program State Plan.
Administrative History: Original rules filed November 28, 2018; effective February 26, 2018. Rule was

(Rule 1200-13-21-.05, continued)

originally numbered 1200-13-21-.04 but was renumbered 1200-13-21-.05 with the introduction of new rule 1200-13-21-.04 filed January 11, 2021; effective April 11, 2021. Amendments filed January 11, 2021; effective April 11, 2021. Emergency rules filed August 7, 2024; effective through February 3, 2025. Amendments filed November 4, 2024; effective February 2, 2025.

1200-13-21-.06 EXCLUSIONS.

- (1) The services and items set out in the TennCare Medicaid Exclusions Rule 1200-13-13-.10(1) and (3)(b) are excluded from coverage by the CoverKids program.
- (2) In addition to the services and items excluded by Paragraph (1), the following services, products and supplies are also excluded from coverage by the CoverKids program:
 - (a) Audiological therapy or training
 - (b) Beds and bedding equipment as follows:
 1. Powered air flotation beds, air fluidized beds (including Clinatron beds), water pressure mattress, or gel mattress
 2. Bead beds, or similar devices
 3. Bed boards
 4. Bedding and bed casings
 5. Ortho-prone beds
 6. Oscillating beds
 7. Springbase beds
 8. Vail beds, or similar beds
 - (c) Biofeedback
 - (d) Cushions, pads, and mattresses as follows:
 1. Aquamatic K Pads
 2. Elbow protectors
 3. Heat and massage foam cushion pads
 4. Heating pads
 5. Heel protectors
 6. Lamb's wool pads
 7. Steam packs
 - (e) Diagnostic tests conducted solely for the purpose of evaluating the need for a service which is excluded from coverage under these rules
 - (f) Ear plugs

(Rule 1200-13-21-.06, continued)

- (g) Floor standers, meaning stationary devices not attached to a wheelchair base and not built into the operating system of a power wheelchair that are designed to hold in an upright position an enrollee who uses a wheelchair and who has limited or no ability to stand on his own
- (h) Food supplements and substitutes including formulas
- (i) Humidifiers (central or room) and dehumidifiers
- (j) Medical supplies, over-the-counter, as follows:
 - 1. Alcohol, rubbing
 - 2. Band-aids
 - 3. Cotton balls
 - 4. Eyewash
 - 5. Peroxide
 - 6. Q-tips or cotton swabs
- (k) Nutritional supplements and vitamins
- (l) Purchase, repair, or replacement of materials or equipment when the reason for the purchase, repair, or replacement is the result of enrollee abuse
- (m) Purchase, repair, or replacement of materials or equipment that has been stolen or destroyed except when the following documentation is provided:
 - 1. Explanation of continuing medical necessity for the item, and
 - 2. Explanation that the item was stolen or destroyed, and
 - 3. Copy of police, fire department, or insurance report if applicable
- (n) Radial keratotomy
- (o) Reimbursement to a provider or enrollee for the replacement of a rented durable medical equipment (DME), as defined in 1200-13-13-.01, item that is stolen or destroyed
- (p) Repair of DME items not covered by CoverKids
- (q) Repair of DME items covered under the provider's or manufacturer's warranty
- (r) Repair of a rented DME item
- (s) Standing tables

Authority: T.C.A. §§ 4-5-202, 4-5-204, 71-3-1106, and 71-3-1110; 42 U.S.C. §§ 1397aa, et seq.; and the Tennessee Title XXI Children's Health Insurance Program State Plan. **Administrative History:** New rule filed January 11, 2021; effective April 11, 2021.

1200-13-21-.07 COST SHARING.

- (1) There are no premiums or deductibles required for participation in CoverKids.
- (2) Copays.
 - (a) The following services are exempt from copays:
 1. Ambulance services.
 2. Emergency services.
 3. Lab and x-ray services.
 4. Routine health assessments (well-child visits) and immunizations given under American Academy of Pediatrics guidelines.
 - (b) The following copays are required, based on the enrollee's household income:

Service	Copay When Household Income Is Less than 200% FPL	Copay When Household Income Is Between 200% FPL and 250% FPL
MEDICAL BENEFITS		
Chiropractic care	\$5 per visit	\$15 per visit
Emergency room	\$10 copay per use for non-emergency	\$50 copay per use for non-emergency
Hospital admissions and other inpatient services	\$5 per admission (waived if readmitted within 48 hours for same episode)	\$100 per admission (waived if readmitted within 48 hours for same episode)
Inpatient mental health and substance abuse treatment	\$5 per admission (waived if readmitted within 48 hours for same episode)	\$100 per admission (waived if readmitted within 48 hours for same episode)
Outpatient mental health and substance abuse treatment	\$5 per session	\$15 per session
Physical, speech, and occupational therapy	\$5 per visit	\$15 per visit
Physician office visit	\$5 per visit (primary care); \$5 per visit (specialist)	\$15 per visit (primary care); \$20 per visit (specialist)
Prescription drugs	\$1 generic; \$3 preferred brand; \$5 non-preferred brand	\$5 generic; \$20 preferred brand; \$40 non-preferred brand
Vision services	\$5 for lenses; \$5 for frames (when lenses and frames are ordered at the same time, only one copay is charged)	\$15 for lenses; \$15 for frames (when lenses and frames are ordered at the same time, only one copay is charged)
DENTAL BENEFITS		
Dental services	\$5 per visit No copay for routine preventive oral exam, x-rays, and fluoride application	\$15 per visit No copay for routine preventive oral exam, x-rays, and fluoride application
Orthodontic services	\$5 per visit	\$15 per visit

(Rule 1200-13-21-.07, continued)

- (3) An enrollee's annual cost sharing obligations shall not exceed five percent (5%) of his household's annual income.
- (4) Eligible children who do not pay a required copay remain enrolled in the program. An individual provider may at his discretion refuse service for non-payment of a copay unless a medical emergency exists. The state does not participate in collection action or impose any benefit limitations if enrollees do not pay their copays.
- (5) Children receiving hospice services are exempt from all copay requirements.
- (6) Pregnant enrollees are exempt from all copay requirements.

Authority: T.C.A. §§ 4-5-202, 4-5-203, 4-5-204, 71-3-1106, and 71-3-1110; 42 U.S.C. §§ 1397aa, et seq.; and the Tennessee Title XXI Children's Health Insurance Program State Plan. **Administrative History:** Original rules filed November 28, 2018; effective February 26, 2018. Rule was originally numbered 1200-13-21-.05 but was renumbered 1200-13-21-.07 with the introduction of new rules 1200-13-21-.04 and 1200-13-01-.06 filed January 11, 2021; effective April 11, 2021. Amendments filed January 11, 2021; effective April 11, 2021.

1200-13-21-.08 DISENROLLMENT.

- (1) Grounds for Disenrollment from CoverKids. Children enrolled in CoverKids at or below 250% of the FPL are financially eligible for 12 months, except in the following situations which will result in disenrollment from CoverKids coverage prior to the end of the 12 month period:
 - (a) An enrollee, through an authorized family member, requests disenrollment.
 - (b) Admission of a CoverKids enrollee into a correctional facility or an institution for mental disease.
 - (c) A CoverKids enrollee moves from the state.
 - (d) Death of a CoverKids enrollee.
 - (e) A CoverKids enrollee is enrolled in TennCare.
 - (f) A CoverKids enrollee meets a TennCare Medicaid spend-down.
 - (g) A CoverKids enrollee turns age 19.
 - (h) A woman 19 or older who was enrolled because of pregnancy is no longer eligible after the last day of the month in which the sixtieth postpartum day occurs.
 - (i) A CoverKids enrollee is discovered not to have been eligible for CoverKids at the time of enrollment. This includes, but is not limited to, enrollees whose enrollment was obtained by fraud or misrepresentation by an enrollee, parent, guardian, or representative.
- (2) Procedures. Disenrollment shall be conducted as set out in Chapter 1200-13-19.

Authority: T.C.A. §§ 4-5-202, 71-3-1106, 71-3-1110, and the Tennessee Title XXI Children's Health Insurance Program State Plan. **Administrative History:** Original rules filed November 28, 2018; effective February 26, 2018. Rule was originally numbered 1200-13-21-.06 but was renumbered 1200-13-21-.08 with the introduction of new rules 1200-13-21-.04 and 1200-13-01-.06 filed January 11, 2021; effective April 11, 2021.

1200-13-21-.09 REVIEW OF COVERKIDS DECISIONS.

- (1) Eligibility and Enrollment Matters. Administrative review of matters related to eligibility and enrollment shall be conducted as set out in Chapter 1200-13-19.
- (2) Adverse Medical and Dental Benefit Determination Matters. A parent or authorized representative of a CoverKids enrollee may request review of a CoverKids action to delay, deny, reduce, suspend, or terminate medical and dental services, or a failure to approve, furnish, or provide payment for medical and dental services in a timely manner, according to Rule 1200-13-13-.11, except that enrollees shall not be entitled to continuation of benefits pursuant to 42 CFR § 457.1260.
- (3) Adverse Pharmacy Benefit Determination Matters. A parent or authorized representative of a CoverKids enrollee may request review of a CoverKids action to delay, deny, reduce, suspend, or terminate pharmacy services, or a failure to approve, furnish, or provide payment for pharmacy services in a timely manner, according to the following provisions:
 - (a) Notice. Any decision denying or delaying a requested pharmacy service, reducing, suspending or terminating an existing pharmacy service, or failure to approve, furnish or provide payment for pharmacy services in a timely manner shall be in writing and must contain the reason for the determination, an explanation of review rights and procedures, the standard and expedited time frames for review, the manner of requesting a review, and the circumstances under which existing pharmacy services may continue pending review unless there is question that the existing pharmacy services are harmful.
 - (b) Pharmacy Plan Administrator (PPA) Review. A parent or authorized representative may commence the review process by submitting a written request to the PPA within 30 days of issuance of written notice of the action or, if no notice is provided, from the time the enrollee becomes aware of the action, not to exceed six (6) months from when the action occurred. The PPA will review this request and issue a written decision within 30 days of receipt of this request. Expedited reviews (within 72 hours) will be available for situations in which a benefit determination or a preauthorization denial has been made prior to services being received and the attending medical professional determines the medical situation to be life threatening or would seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain or regain maximum function. This determination should be made in legible writing with an original signature.
 - (c) State Informal Review. After the PPA's internal review is completed, the parent or authorized representative of an enrollee who disagrees with the decision may request further review by telephone or by submitting a letter or form to the Division of TennCare, CoverKids Appeals, which must be received within 8 days of the PPA's decision. The Appeals Coordinator will review the matter and gather supplemental information from the family, physician, and/or insurer as needed. The Appeals Coordinator will request review by the state's independent medical consultant and a written decision will be issued within 20 days of receipt of the request for further review.
 - (d) State Review Committee. If the informal review does not grant the relief requested by the parent or authorized representative, the request will be scheduled for review by the CoverKids Review Committee. The Committee will be composed of five members, including Division of TennCare staff and at least one independent licensed medical professional. The members of the Committee will not have been directly involved in the matter under review. The parent or authorized representative will be given the opportunity to review the file, be represented by a representative of the parent's or

(Rule 1200-13-21-.09, continued)

authorized representative's choice, and provide supplemental information. The Committee may allow the parent or authorized representative to appear in person if it finds that scheduling the appearance will not cause delay in the review process. The Review Committee is not required to provide an in-person hearing or a contested case under the Uniform Administrative Procedures Act. The parent or authorized representative will receive written notification of the final decision stating the reasons for the decision. The decision of the CoverKids Review Committee is the final administrative recourse available to the member.

- (e) Time for Reviews. Review of all non-expedited pharmacy services appeals will be completed within 90 days of receipt of the initial request for review by the PPA. Reviews by both the Appeals Coordinator and the Committee may be expedited (completed within 72 hours at each of the PPA and state levels) for situations in which a benefit determination or a preauthorization denial has been made prior to services being received and the attending medical professional determines the medical situation to be life threatening or would seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain or regain maximum function. This determination should be made in legible writing with an original signature.
- (4) Scope of Review. CoverKids will not provide a review process for a change in enrollment, eligibility, or coverage under the health benefits package required by a change in the state plan or federal and state law requiring an automatic change that affects all or a group of applicants or enrollees without regard to their individual circumstances.

Authority: T.C.A. §§ 4-5-202, 4-5-204, 71-3-1106, and 71-3-1110; 42 U.S.C. §§ 1397aa, et seq.; and the Tennessee Title XXI Children's Health Insurance Program State Plan. **Administrative History:** Original rules filed November 28, 2018; effective February 26, 2018. Rule was originally numbered 1200-13-21-.07 but was renumbered 1200-13-21-.09 with the introduction of new rules 1200-13-21-.04 and 1200-13-01-.06 filed January 11, 2021; effective April 11, 2021. Amendments filed January 11, 2021; effective April 11, 2021.

1200-13-21-.10 PROVIDERS.

- (1) Payment in full.
 - (a) All CoverKids providers, as defined in this Chapter, must accept as payment in full for provision of covered services to a CoverKids enrollee, the amount paid by the MCO, DBM, or PPA, plus any copayment required by the CoverKids program to be paid by the individual.
 - (b) Any non-CoverKids providers who furnish CoverKids covered services by authorization from the MCO, DBM, or PPA must accept as payment in full for provision of covered services to CoverKids enrollees the amounts paid by the MCO, DBM, or PPA plus any copayment required by the CoverKids program to be paid by the individual.
 - (c) CoverKids will not pay for non-emergency services furnished by non-CoverKids providers unless these services are authorized by the MCO, DBM, or PPA. Any non-CoverKids provider who furnishes CoverKids Program covered non-emergency services to a CoverKids enrollee without authorization from the MCO, DBM, or PPA does so at his own risk. He may not bill the patient for such services except as provided in Paragraph (3).
- (2) Non-CoverKids Providers.
 - (a) When the MCO, DBM, or PPA authorizes a service to be rendered by a non-CoverKids provider, payment to the provider shall be no less than 80% of the lowest rate paid by

(Rule 1200-13-21-.10, continued)

the MCO, DBM, or PPA to equivalent participating CoverKids network providers for the same service, consistent with the methodology contained in Rule 1200-13-13-.08(2)(a).

- (b) Covered medically necessary outpatient emergency services, when provided to CoverKids enrollees by non-CoverKids network hospitals, shall be reimbursed at 74% of the 2006 Medicare rates for the services, consistent with the methodology contained in Rule 1200-13-13-.08(2)(b). Emergency care to enrollees shall not require preauthorization.
 - (c) Covered medically necessary inpatient hospital admissions required as the result of emergency outpatient services, when provided to CoverKids enrollees by non-CoverKids network hospitals, shall be reimbursed at 57% of the 2008 Medicare DRG rates (excluding Medical Education and Disproportionate Share components) determined according to 42 CFR § 412 for the services, consistent with the methodology contained in Rule 1200-13-13-.08(2)(c). Such an inpatient stay will continue until no longer medically necessary or until the patient can be safely transported to a network hospital, whichever comes first.
- (3) Participation in the CoverKids program will be limited to providers who:
- (a) Accept, as payment in full, the amounts paid by the MCO, DBM, or PPA, including copays from the enrollee, or the amounts paid in lieu of the MCO, DBM, or PPA by a third party (Medicare, insurance, etc.);
 - (b) Maintain Tennessee, or the state in which they practice, medical licenses and/or certifications as required by their practice, or licensure by the Tennessee Department of Mental Health and Substance Abuse Services, if appropriate;
 - (c) Are not under a federal Drug Enforcement Agency (DEA) restriction of their prescribing and/or dispensing certification for scheduled drugs (relative to physicians, osteopaths, dentists and pharmacists);
 - (d) Agree to maintain and provide access to the Division of TennCare and/or its agent all CoverKids enrollee medical records for ten (10) years from the date of service or upon written authorization from TennCare following an audit, whichever is shorter;
 - (e) Provide medical assistance at or above recognized standards of practice; and
 - (f) Comply with all contractual terms between the provider and the MCO, DBM, or PPA (as appropriate) and CoverKids policies as outlined in federal and state rules and regulations and CoverKids provider manuals and bulletins.
 - (g) Failure to comply with any of the above provisions (a) through (f) may subject a provider to the following actions:
 - 1. The provider may be subject to stringent review/audit procedures, which may include clinical evaluation of services and a prepayment requirement for documentation and justification for each claim.
 - 2. The Division of TennCare may withhold or recover payments to an MCO, DBM, or PPA in cases of provider fraud, willful misrepresentation, or flagrant noncompliance with contractual requirements and/or CoverKids policies.
 - 3. The Division of TennCare may refuse to approve or may suspend provider participation 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

(Rule 1200-13-21-.10, continued)

provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the US Title XX Services Program.

4. The Division of TennCare may refuse to approve or may suspend provider participation 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 US Title XX Services Program since the inception of these programs.
5. The Division of TennCare shall refuse to approve or shall suspend provider participation 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.
6. The Division of TennCare shall refuse to approve or shall suspend provider participation upon notification by the US Office of Inspector General Department of Health and Human Services that the provider is not eligible under Medicare, Medicaid, or CHIP for federal financial participation.
7. The Division of TennCare may recover from an MCO, DBM, or PPA any payments made by an enrollee and/or his family for a covered service, in total or in part, except as permitted. If a provider knowingly bills an enrollee and/or his family for a covered service, in total or in part, except as permitted, the Division of TennCare may terminate the provider's participation in CoverKids.

(4) Solicitations and Referrals

- (a) MCOs, DBMs, PPAs, and providers shall not solicit CoverKids enrollees by any method offering as enticements other goods and services (free or otherwise) for the opportunity of providing the enrollee with CoverKids-covered services that are not medically necessary and/or that overutilize the CoverKids program.
 - (b) An MCO, DBM, or PPA may request a waiver from this restriction in writing to the Division of TennCare. TennCare shall determine the value of a waiver request based upon the medical necessity and need for the solicitation. The MCO, DBM, or PPA may implement the solicitation only upon receipt of a written waiver approval from TennCare. This waiver is not transferable and may be canceled by TennCare upon written notice.
 - (c) CoverKids payments for services related to a non-waivered solicitation enticement shall be considered by the Division of TennCare as a non-covered service and recouped. Neither the MCO, DBM, PPA nor the provider may bill the enrollee for non-covered services recouped under this authority.
 - (d) A provider shall not offer or receive remuneration in any form related to the volume or value of referrals made or received from or to another provider.
- (5) Providers may seek payment from a CoverKids enrollee only under the following circumstances. These circumstances include situations where the enrollee may choose to seek a specific covered service from a non-CoverKids provider.
- (a) If the services are not covered by the CoverKids program and, prior to providing the services, the provider informed the enrollee that the services were not covered.

(Rule 1200-13-21-.10, continued)

- (b) If the services are not covered because they are in excess of an enrollee's benefit limit and one of the following circumstances applies:
 - 1. The provider has information in her own records to support the fact that the enrollee has reached his benefit limit for the particular service being requested and, prior to providing the service, informs the enrollee that the service is not covered and will not be paid for by CoverKids. This information may include:
 - (i) A previous written denial of a claim on the basis that the service was in excess of the enrollee's benefit limit for a service within the same benefit category as the service being requested, if the time period applicable to the benefit limit is still in effect;
 - (ii) That the provider had personally provided services to the enrollee in excess of his benefit limit within the same benefit category as the service being requested, if the time period applicable to that benefit period is still in effect; or
 - (iii) The enrollee's MCO, DBM, or PPA has provided confirmation to the provider that the enrollee has reached his benefit limit for the applicable service.
 - 2. The provider submits a claim for service to the MCO, DBM, or PPA and receives a written denial of that claim on the basis that the service exceeds the enrollee's benefit limit. After informing the enrollee and within the remainder of the period applicable to that benefit limit, the provider may bill the enrollee for services within that same exhausted benefit category without having to submit claims for those subsequent services for repeated MCO, DBM, or PPA denial. If the provider informed the enrollee prior to providing the service for which the claim was denied that the service would exceed the enrollee's benefit limit and would not be paid for by CoverKids, the provider may bill the enrollee for that service.
 - 3. The provider had previously taken the steps in Parts 1. or 2. above and determined that the enrollee had reached his benefit limit for the particular service being requested, if the time period applicable to the benefit limit is still in effect, and informs the enrollee, prior to providing the service, that the service is not covered and will not be paid for by CoverKids.
 - (c) If the services are covered only with prior authorization and prior authorization has been requested but denied, or is requested and a specified lesser level of care is approved, and the provider has given prior notice to the enrollee that the services are not covered, the enrollee may elect to receive those services for which prior authorization has been denied or which exceed the authorized level of care and be billed by the provider for such services.
- (6) Providers may not seek payment from a CoverKids enrollee under the following conditions:
- (a) The provider knew or should have known about the patient's CoverKids enrollment prior to providing services.
 - (b) The claim submitted to the MCO, DBM, or PPA for payment was denied due to provider billing error or a CoverKids claim processing error.

(Rule 1200-13-21-.10, continued)

- (c) The provider accepted CoverKids assignment on a claim and it is determined that another payer paid an amount equal to or greater than the CoverKids allowable amount.
 - (d) The provider failed to comply with CoverKids policies and procedures or provided a service which lacks medical necessity or justification.
 - (e) The provider failed to submit or resubmit claims for payment within the time periods required by the MCO, DBM, PPA, or CoverKids.
 - (f) The provider failed to inform the enrollee prior to providing a service not covered by CoverKids that the service was not covered and the enrollee may be responsible for the cost of the service. Services which are non-covered by virtue of exceeding limitations are exempt from this requirement if the provider has complied with Paragraph (3) above.
 - (g) The enrollee failed to keep a scheduled appointment(s).
- (7) Providers may seek payment from a person whose CoverKids eligibility is pending at the time services are provided if the provider informs the person that CoverKids assignment will not be accepted whether or not eligibility is established retroactively.
 - (8) Providers may seek payment from a person whose CoverKids eligibility is pending at the time services are provided. Providers may bill such persons at the provider's usual and customary rate for the services rendered. However, all monies collected for CoverKids-covered services rendered during a period of CoverKids eligibility must be refunded when a claim is submitted to CoverKids if the provider agreed to accept CoverKids assignment once retroactive CoverKids eligibility was established.
 - (9) Providers of inpatient hospital services, outpatient hospital services, skilled nursing facility services, independent laboratory and x-ray services, hospice services, and home health agencies must be approved for Title XVIII Medicare in order to be certified as providers under the CoverKids program; in the case of hospitals, the hospital must meet state licensure requirements and be approved by the Division of TennCare as an acute care hospital as of the date of enrollment in CoverKids. Children's hospitals and state mental hospitals may participate in CoverKids without having been Medicare approved; however, the hospital must be approved by the Joint Commission for Accreditation of Health Care Organizations as a condition of participation.
 - (10) Pharmacy providers may not waive pharmacy copayments for CoverKids enrollees as a means of attracting business to their establishments. This does not prohibit a pharmacy from exercising professional judgment in cases where an enrollee may have a temporary or acute need for a prescribed drug, but is unable, at that moment, to pay the required copayment.
 - (11) All claims must be filed with an MCO, DBM, or PPA and must be submitted in accordance with the requirements and timeframes set forth in the MCO, DBM, or PPA's contract.

Authority: T.C.A. §§ 4-5-202, 4-5-203, 4-5-204, 71-3-1106, and 71-3-1110; 42 U.S.C. §§ 1397aa, et seq.; and the Tennessee Title XXI Children's Health Insurance Program State Plan. **Administrative History:** Original rules filed November 28, 2018; effective February 26, 2018. Rule was originally numbered 1200-13-21-.08 but was renumbered 1200-13-21-.10 with the introduction of new rules 1200-13-21-.04 and 1200-13-01-.06 filed January 11, 2021; effective April 11, 2021. Amendments filed January 11, 2021; effective April 11, 2021.