Revision: HCFA-PM-86-20 (BERC)
SEPTEMBER 1986

State/Territory: TENNESSEE

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): PREGNANT WOMEN/REASONABLE CLASSIFICATIONS OF INDIVIDUALS UNDER AGE 21

The following ambulatory services are provided. (within limitations).

1. Inpatient hospital
2. Outpatient hospital
3. Rural health clinic
4. Other laboratory and x-ray
5. EPSD&T
6. Family planning services
7. Physicians
8. Home Health
9. Clinic
10. Dental Services
11. Prescribed drugs
12. Prosthetic devices
13. Eyeglasses
14. Inpatient psychiatric facility
15. Extended services for pregnant women
16. Transportation
17. Care and services provided in Christian Science Sanitoria
18. Skilled Nursing facility services
19. Emergency hospital services

*Description provided on attachment.

Revision: HCFA-PM-91- 4 (BPD)
AUGUST 1991

State/Territory: TENNESSEE

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Aged, Blind, Disabled, Children Under 21
Parent (s)/ Caretaker(s), Pregnant Women

1. Inpatient hospital services other than those provided in an institution for mental diseases.

/X/Provided: /_/No limitations /X/With limitations*

2.a.Outpatient hospital services.

/X/Provided: /_/No limitations /X/With limitations*

b.Rural health clinic services and other ambulatory services furnished by a rural health clinic which are otherwise covered under the plan.
/X/Provided: /X/No limitations /_/With limitations*

c.Federally qualified health center(FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA - Pub. 45-4).
Provided: X No limitation __ With limitation*

3. Other laboratory and X-ray services.

/X/ Provided: /_/ No limitations /X/With limitations*

4.a.Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

/X/Provided: /_/No limitations /X/With limitations*

b.Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*
X Provided

c.Family planning services and supplies for individuals of childbearing age.

/X/Provided: /X/No limitations /_/With limitations*

*Description provided on attachment.

State: Tennessee

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED MEDICALLY NEEDY GROUP(S): Children Under 21, Pregnant Women

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4.d. Tobacco Cessation Counseling Services for Pregnant Women

1) Face-to-Face Tobacco Cessation Counseling Services provided (by):

[X] (i) By or under supervision of a physician;

[](ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services *other* than tobacco cessation services; or

(iii) Any other health care professional legally authorized to provide tobacco cessation services under State law *and* who is specifically *designated* by the Secretary in regulations. (None are designated at this time; this item is reserved for future use.)

2) Face-to-Face Tobacco Cessation Counseling Services Benefit Package for Pregnant Women

Provided: [X] No limitations [] With limitations*

5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility, or elsewhere.

Provided: [ ] No limitations [X] With limitations*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

Provided: [ ] No limitations [X] With limitations*

Description provided on attachment.

State/Territory: Tennessee

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Aged, Blind, Disabled, Children Under 21, Parent(s)/Caretaker(s), Pregnant Women

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' Services

/X/ Provided: /_/ No limitations /X/ With limitations*

b. Optometrists' Services

/X/ Provided: /_/ No limitations /X/ With limitations*

c. Chiropractors' Services

/_/ Provided: /_/ No limitations /_/ With limitations*

d. Other Practitioners' Services

/X/ Provided: /_/ No limitations /X/ With limitations*

7. Home Health Services

a. Intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area.

/X/ Provided: /_/ No limitations /X/ With limitations*

b. Home health aide services provided by a home health agency.

/X/ Provided: /_/ No limitations /X/ With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

/X/ Provided: /_/ No limitations /X/ With limitations*

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

/X/ Provided: /_/ No limitations /X/ With limitations*

*Description provided on attachment.

Received 8/15/89

State/Territory: Tennessee

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Children Under 21, Pregnant Women.

8. Private duty nursing services.
/ / Provided / / No limitation / / With limitations*

9. Clinic services.
/X / Provided / / No limitation / X/ With limitations*

10. Dental services.
/ / Provided / / No limitation / / With limitations*

11. Physical therapy and related services.
   a. Physical therapy.
   / / Provided / / No limitation / / With limitations*
   b. Occupational therapy.
   / / Provided / / No limitation / / With limitations*
   c. Services for individuals with speech, hearing, and language disorders provided by or under supervision of a speech pathologist or audiologist.
   / / Provided / / No limitation / / With limitations*

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.
   a. Prescribed drugs.
   / X/ Provided / / No limitation /X / With limitations*
   b. Dentures.
   / / Provided / / No limitation / / With limitations*

*Description provided on attachment.

D1015193

State/Territory: TENNESSEE

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Aged, Blind, Disabled, Children Under 21, Parent(s)/Caretaker(s), Pregnant Women

c. Prosthetic devices.

/X/ Provided: /_/ No limitations /X/ With limitations*

d. Eyeglasses.

/_/ Provided: /_/ No limitations /_/ With limitations*

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in this plan.

a. Diagnostic services.

/_/ Provided: /_/ No limitations /_/ With limitations*

b. Screening services.

/_/ Provided: /_/ No limitations /_/ With limitations*

c. Preventive services.

/_/ Provided: /_/ No limitations /_/ With limitations*

d. Rehabilitative services.

/X/ Provided: /_/ No limitations /X/ With limitations*

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

/X/ Provided: /X/ No limitations /_/ With limitations*

b. Nursing facility services.

/X/ Provided: /_/ No limitations /X/ With limitations*

*Description provided on attachment.

State/Territory: Tennessee

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED MEDICALLY NEEDY GROUP(S): Children Under 21, Pregnant Women

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15. Services in an intermediate care facility for the mentally retarded (other than in an institution for mental diseases) for individuals who are determined, in accordance with Section 1902(a)(31), to be in need of such care.

    [X] Provided [ ] No Limitations [X] With limitations*

16. Inpatient psychiatric facility services for individuals under 22 years of age.

    [X] Provided [ ] No limitations [X] With limitations*

17. Nurse-midwife services

    [X] Provided [ ] No limitations [X] With limitations*

18. Hospice care (in accordance with section 1905(o) of the Act).

    [X] Provided [ ] No limitations

    [X] Provided in accordance with section 2302 of the Affordable Care Act

    [X] With limitations*

*Description provided on attachment

State/Territory: Tennessee

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Aged, Blind, Disabled
Children Under 21, Parent(s)/Caretaker(s), Pregnant Women

19. Case management services and Tuberculosis related services

a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

X Provided: X With limitations*

___ Not provided.

b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act.

___ Provided: ___ With limitations*

X Not provided.

20. Extended services for pregnant women.

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and for any remaining days in the month in which the 60th day falls.

X Provided: + ___ Additional coverage ++

b. Services for any other medical conditions that may complicate pregnancy.

X Provided: + ___ Additional coverage ++ ___ Not provided.

21. Certified pediatric or family nurse practitioners' services.

X Provided: ___ No limitations X With limitations*

___ Not provided.

\+ Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.) and limitations on them, if any, that are available as pregnancy-related services or services for any other medical condition that may complicate pregnancy.

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

*Description provided on attachment.

State/Territory: TENNESSEE

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Aged, Blind, Disabled, Children Under 21, Parent(s)/Caretaker(s), Pregnant Women

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

/X/ Provided: / / No limitations /X/ With limitations*

b. Services of Christian Science nurses.

/ / Provided: / / No limitations / / With limitations*

c. Care and services provided in Christian Science sanitoria.

/X/ Provided: / / No limitations /X/ With limitations*

d. Nursing facility services provided for patients under 21 years of age.

/X/ Provided: / / No limitations /X/ With limitations*

e. Emergency hospital services.

/X/ Provided: / / No limitations /X/ With limitations*

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and furnished by a qualified person under supervision of a registered nurse.

/ / Provided: / / No limitations / / With limitations*

State/Territory: TENNESSEE

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Aged, Blind, Disabled, Children Under 21, Parent(s)/ Caretaker(s), Pregnant Women.

24. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

___ Provided X Not Provided

State: Tennessee

Amount, Duration and Scope of Medical and Remedial Care Services Provided To the Medically Needy

25. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A.

X Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

___ No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

D1012044

State/Territory: Tennessee

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED MEDICALLY NEEDY GROUP(S): Children Under 21, Pregnant Women

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26.(i) **Licensed or Otherwise State-Approved Freestanding Birth Centers**

Provided: [X] No Limitations [] With limitations*

[ ] None licensed or approved

26.(ii) **Licensed or otherwise State-Recognized covered professionals providing services in the Freestanding Birth Center**

Provided: [ ] No limitations [X] With limitations*

[] Not Applicable (there are no licensed or State approved Freestanding Birth Centers)

Please check all that apply:

[X] (a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan (i.e., physicians and certified nurse Midwives).

[] (b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife).*

[] (c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.)*

*For (b) and (c) above, please list and identify below each type of professional who will be providing birth center services:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE TENNESSEE

LIMITATION ON AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

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1. Inpatient hospital services other than those provided in an institution for mental diseases.

   Except for the organ transplants listed below, inpatient hospital days shall be covered as medically necessary. The following organ transplants are limited to the number of inpatient hospital days listed below.

	Transplant Procedure	Total Allowable Days Per Transplant
a.	Heart transplants	43 days
b.	Liver transplants	67 days
c.	Bone Marrow transplants	40 days

   Exceptions to the above list of transplants may be made for other non-experimental transplants if it is found to be medically necessary and cost effective as determined by Medicaid. The allowable inpatient days will be the average length of stay for that transplant.

   Any hospital days paid by insurance or other third party benefits will be considered to be days paid by the Medicaid program. Friday and Saturday admissions will be limited to emergencies or surgery the same or next day.

D1030009

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE TENNESSEE

LIMITATION ON AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

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2. a. Outpatient hospital services.

Limited to 30 visits per fiscal year.

3. Other Laboratory and X-ray Services.

Limited to services provided on 30 occasions per fiscal year. An occasion is interpreted to mean laboratory and/or X-ray services performed during a recipient visit, e.g., to a radiologist; or to procedures, e.g., laboratory tests performed for a recipient on a given day by an independent laboratory.

Attachment 3.1.B.1

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE TENNESSEE

LIMITATION ON AMOUNT, DURATION AND SCOPE OF
MEDICAL CARE AND SERVICES PROVIDED

4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Nursing facility services to include Level I and Level II (other than services in an institution for mental diseases) will be covered. Medicaid will apply medical criteria for admission and continued stay at the level of care designated and approved by the Tennessee Medicaid program.

The recipient on Level I Care must require on a daily basis, 24 hours a day, licensed nursing services which as a practical matter can only be provided on an inpatient basis.

The recipient on Level II Care must require on a daily basis, 24 hours a day, skilled/complex nursing or skilled/complex rehabilitative services which as a practical matter can only be provided on an inpatient basis.

Attachment 3.1.B.1

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE TENNESSEE

LIMITATION ON AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

4.b. Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found.

(1) Screening services are limited to individuals who are under 21 years of age, and limitations of those services.

(a) EPSDT screenings are provided at intervals which meet reasonable standards of medical practice, as approved by the Tennessee Chapter of the American Academy of Pediatrics.

(b) Screening services must include those components as set out in section 1905(r)(1)(b). Interperiodic screenings will be covered when medically necessary to determine the existence of certain physical or mental illnesses or conditions.

(c) Appropriate laboratory tests and immunizations are covered as described in the Tennessee Medicaid EPSDT Manual (laboratory tests, section 304.2 and immunizations, section 305).

(2) Vision Services

(a) The following is the Tennessee Medicaid approved schedule for vision screening examinations:

Age	Number of Visits
0 through 2 years	3
3 through 11 years	9
12 through 20 years	9

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE TENNESSEE

LIMITATION ON AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

4.b. continued

(b) The following vision services are covered for eligible Medicaid recipients under 21 years of age, and limitation of those services includes:

1. one eye examination and refraction per recipient, per fiscal year is covered. Additional screening examinations are covered based on medical necessity.
2. one permanent pair of eyeglasses per recipient, per fiscal year is covered.
3. one dispensing fee per recipient, per fiscal year is covered for Ophthalmologists, Optometrists and Opticians.
4. optical labs can only be reimbursed for the lenses and frames; a dispensing fee is not allowed.
5. one replacement lens and frames for eyeglasses if the original pair are lost, broken or damaged beyond repair, or are no longer usable due to a change in the recipient's vision so that a new prescription is required.
6. one replacement dispensing fee for Ophthalmologists, Optometrists and Opticians.
7. diagnosis and treatment of amblyopia is covered only for recipients 8 years of age and under.
8. orthoptic training, eye exercise is not covered by Medicaid.

(c) Those vision services requiring prior approval are listed in the Tennessee EPSDT Vision Manual, section 304.

(3) Speech and/or hearing services are covered for eligible Medicaid recipients only through speech and hearing centers approved by the Tennessee Department of Health and Environment.

(a) The following is the Tenessee Medicaid approved schedule for speech and/or hearing examinations:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE TENNESSEE

LIMITATION ON AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

4.b. continued

Age	Number of Visits
0 through 2 years	6
3 through 11 years	18
12 through 20 years	18

Speech and/or hearing examinations are provided on the basis of two examinations per recipient per state fiscal year, except for ages 0 through 1 year of age for which only hearing examinations are covered.

(4) Dental services:

(a) The following is the Tennessee Medicaid approved schedule for dental screening examinations:

Age	Number of Visits
0 through 2 years	4
3 through 11 years	18
12 through 20 years	18

Dental screening examinations are provided once every 6 months per recipient per state fiscal year.

(b) Requests for dental services requiring prior approval shall include a complete plan of treatment including all procedures to be performed regardless of whether a specified procedure requires prior approval, charting of all procedures to be done, and full-mouth set of X-rays; however, when an emergency situation exists and the recipient has had full mouth X-rays or a panorex within the previous three fiscal years, bitewings and a periapical X-ray shall constitute sufficient X-rays.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE TENNESSEE

LIMITATION ON AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

4.b. continued

(c) The following list of services, to the extent they are covered by Medicaid, shall require prior approval from the Medicaid medical director, or a designated representative, in order for the services to be reimbursed by Medicaid:

1. Preventive periodontics, routine periodontal scaling, root planing, subgingival curettage per quadrant.

2. Pulpotomy on permanent teeth is limited to apexification only.

3. Root canals shall be limited to one per tooth, per recipient, per lifetime.

4. Porcelain to metal crowns, permanent anterior teeth only; when a tooth cannot be restored satisfactorily with a filling material; and, there must be evidence of tooth maturity.

5. Space maintainers; approval for which shall be limited to fixed unilateral band type, fixed lingual or palatal arch band type (to be approved only when tooth adjacent does not require a stainless steel crown), and fixed band type with crown included.

6. Oral surgery, approval for which shall be limited to routine extractions of permanent teeth requiring prosthetic replacement, surgical extractions of primary or permanent teeth with complicating factors, treatment of soft tissue impaction, partial impaction or complete bony impaction root recovery (removal of residual root), and periodontal surgery where there are related medical factors.

7. Complete dentures and partial dentures with acrylic bases, without clasps or with wrought wire clasps or with cast clasps and lingual or palatal strengthening bar, and unilateral or one tooth partial plate with cast clasps and an acrylic base.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE TENNESSEE

LIMITATION ON AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

4.b. continued

8. Non-conforming procedures or services.

9. Orthodontics, prior approval requests for which shall include, in addition to the requirements listed above for all prior approval requests, diagnostic models, an estimate of the total length of planned treatment not to exceed 24 months for orthodontic treatment and a schedule for monthly adjustments.

10. Hospitalization for dental services.

11. Prosthetic appliances which shall be limited to reconstruction in conjunction with previously completed oblative surgery primarily done in cases of cancer therapy and/or conjoint efforts at maxillofacial surgical reconstruction. Services must be rendered by a board certified prosthodontist.

12. Intravenous sedation for dental services given on an ambulatory basis for recipients with extenuating physical or mental health problems. Approval will be granted only when sedation is administered by a dentist who is:

    a. Board eligible or board certified in oral and maxillofacial surgery; or

    b. Authorized by the Tennessee Board of Dentistry to use general anesthesia or intravenous sedation pursuant to T.C.A. 63-5-108(d) et seq. of the Board of Dentistry.

(d) Routine services not requiring prior approval are:

1. Routine examinations; bitewing x-rays, oral prophylaxis, and application of fluoride once every six months, per recipient;

2. Panographic or full-mouth x-rays limited to one set per three (3) fiscal years, per recipient;

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE TENNESSEE

LIMITATION ON AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

4.b. continued

3. Amalgam restorations which shall be limited to two restorations per tooth surface, per fiscal year;

4. Pins for the retention of multi-surface plastic or amalgam restorations;

5. Silicate, acrylic, plastic or composite resin or acid-etch which shall be limited to two restorations per tooth surface, per fiscal year, per recipient;

6. Stainless steel single crowns;

7. Pulp cap direct limited to one per tooth, per recipient; and

8. Primary-pulpotomy which shall be limited to one per tooth, per recipient, per lifetime.

D1040136

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Attachment 3.1.B.1

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE TENNESSEE

LIMITATION ON AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

5. Physician's services furnished by a physician, whether furnished in the office, the patient's home, a hospital, a skilled nursing facility, or elsewhere; and medical and surgical services furnished by a dentist in accordance with Section 1905(a)(5) of the Act as amended by Section 4103(a) of P.L. 100-203 (OBRA '87).

   a. Limit office visits to 24 per state fiscal year. Visits made for podiatry and optometry services will count toward this limit.

   b. Inpatient hospital visits will be limited to twenty (20) per state fiscal year except when certain transplant procedures occur. Additional inpatient hospital visits will be available as indicated below for the following transplant procedures:

      Liver transplant - 47 visits
      Heart transplant - 23 visits
      Bone marrow transplant - 20 visits

   c. Prior approval by the Medicaid Medical Director is required for those procedures established by the Single State Agency.

   d. Inpatient psychiatric physician visits for individual under 21 years of age is limited to the allowable inpatient psychiatric under 21 hospital days per state fiscal year.

   e. Except for an emergency the delivery of a newborn infant will be covered only when provided in a hospital or in an Ambulatory Surgical Center classified to provide maternity services.

GW/D2051060

Attachment 3.1.B.1

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE TENNESSEE

LIMITATION ON AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

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6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

6a. Podiatrists' Services

Limited to:

1. Routine foot care such as cutting or removing corns, calluses or nails when the patient has a systemic disease of sufficient severity that unskilled performance of such procedure would be hazardous. The patient's condition must have been the result of severe circulatory embarrassment or because of areas of desensitization in the legs or feet.

2. Routine services if they are performed as a necessary and integral part of otherwise covered services, such as the diagnosis and treatment of diabetic ulcers, wounds, and infections.

3. Debridement of mycotic toenails to the extent such debridement is performed no more frequently than once every 60 days, unless the medical necessity for more frequent treatment is documented by the billing podiatrist.

4. Office visits will be limited to two (2) per recipient per fiscal year. These visits will count toward the twenty-four (24) physician visit limit as set out in Attachment 3.1.A.1, Item 5 of the Tennessee State Plan.

5. All other limitations that apply to physician services as set out in Attachment 3.1.B.1 of the Tennessee State Plan.

GW/D2071060

Attachment 3.1.B.1

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE TENNESSEE

LIMITATION ON AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

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6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

6b. Optometrists' services

Limited to:

1. The performance of external and internal examination of the human eye or eyelid and any diagnosis, treatment (other than by surgery) of patients with infections, inflammations, and abrasions of the eye or eyelid with topically applied drops, ointments or creams, or any referral of patients for consultation or treatment. Optometrists also have the authority to administer benadryl, epinephine or equivalent medication to counteract anaphylaxis or anaphylactic reaction. An optometrist may use or prescribe topical steroids for not more than seven (7) calendar days from the onset of treatment.

2. The same standards of care as those of primary care physicians providing similar services.

3. Removal of superficial foreign bodies from the conjunctiva of the eye and eyelid.

4. Optometry services for recipients over age 21 do not include services for the purposes of prescribing or providing eyeglasses or contact lenses. Office visits will be limited to four (4) per recipient per fiscal year and will count toward the twenty-four (24) physician visit limit as set out in Attachment 3.1.A.1, Item 5 of the Tennessee State Plan.

5. All other limitations that apply to physician services as set out in Attachment 3.1.B.1 of the Tennessee State Plan.

GW/D2081060

Attachment 3.1.B.1

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE TENNESSEE

LIMITATION ON AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

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6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

6d. Other practitioners' services

1. Physician Assistant

   a. Services of a physician assistant (other than as an assistant-at-surgery) when rendered at an SNF, ICF, or hospital.

   b. Services of a physician assistant as an assistant-at-surgery.

   c. All services provided by a physician assistant must be ordered and billed by a physician.

2. Certified Registered Nurse Anesthetist

   Services by a Certified Registered Nurse Anesthetist are covered when she/he has completed an advanced course in anesthesia, and holds a current certification from the American Association of Nurse Anesthetists as a nurse anesthetist.

D1089166

TN No. 89-17 DATE/RECEIPT 8/15/89
SUPERSEDES DATE/APPROVED 8/29/89
TN No. NEW DATE/EFFECTIVE 7/1/89

Attachment 3.1.B.1

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE TENNESSEE

LIMITATION ON AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

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7. Home Health Services

Provided to persons who are homebound and limited to a total of sixty (60) services per year provided in accordance with 7a., b. and d.

c. Durable medical equipment and supplies will be covered when provided through either of these approved Medicaid providers; home health agency or DME supplier, and in accordance with guidelines of the Agency.

1. The list of covered DME and supplies will be established by the Single State Agency.

2. Those items requiring prior approval by the Medicaid Director (or designee) shall also be established by the Single State Agency.

3. Durable medical equipment and supplies will not be counted against the sixty (60) home health services per year.

d. Speech evaluation must be provided by a certified speech pathologist.

D3071218

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: TENNESSEE

LIMITATION ON AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

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9. Clinic Services

The following types of clinic services are covered with limitations described for each.

a. Community Mental Health Centers – Services limited to those authorized to be provided.

b. Community Clinics

(1) Community Health Clinics, Community Health Agencies, Community Services Clinics.

Services limited to those authorized to be provided by each of the above type clinics

(2) Ambulatory Surgical Centers – Services limited to those procedures designated by the state agency that can be performed outside the inpatient facility setting.

(3) Methadone clinic services are covered.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: TENNESSEE

LIMITATION ON AMOUNT DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

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12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

12.a. Prescribed drugs

(1) Prescription outpatient drugs of any manufacturer which has entered into and complies with an agreement under Section 1927(a) of the Social Security Act will be a covered benefit for all TennCare members when prescribed by an authorized licensed prescriber, unless coverage is excluded or otherwise restricted by TennCare in accordance with the following:

(a) TennCare will not cover any drugs that are permitted to be excluded or restricted under the Social Security Act, Section 1927(d)(2), except agents when used to promote smoking cessation. Effective January 1, 2006, the Medicaid agency will not cover any Medicare Part D drug for full benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

(b) Coverage of prescription drugs for Medically Needy beneficiaries will be limited to five (5) prescriptions per month, pursuant to which at least three (3) out of any five (5) prescriptions or refills in the same month must be generic and no more than two (2) prescriptions or refills in the same month may be for brand name (branded) products. Any branded prescriptions are subject to a requirement of prior authorization by the TennCare Bureau as a condition of coverage, and the State shall designate the covered outpatient drugs to which a prior authorization requirement applies. The monthly coverage limitation shall not apply to medications included on a list to be maintained by the State in accordance with the State's Uniform Administrative Procedures Act. Pharmacies, providers and beneficiaries shall be made aware of this list through appropriate notice. Individuals under the age of 21 who are receiving benefits under the EPSDT Program, as well as individuals 21 years of age or older who receive services in nursing facilities (NFs) or in intermediate care facilities for individuals with intellectual disabilities (ICFs/IID), will not be subject to this benefit limit.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: TENNESSEE

LIMITATION ON AMOUNT DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

(c) Buprenorphine and buprenorphine/naloxone products and sedative hypnotics for persons aged 21 and older are restricted to the quantity limits specified below:

(i) Generic buprenorphine, Subutex (buprenorphine), and Suboxone (buprenorphine/naloxone) products shall not exceed sixteen milligrams (16 mg) per day for a period of up to six (6) months from the initiation of therapy. For enrollees who are pregnant while receiving this dosage, the six-month period does not begin until the enrollee is no longer pregnant. At the end of either six-month period, the covered dosage amount shall not exceed eight milligrams (8 mg) per day.

(ii) Sedative hypnotic medications shall not exceed fourteen (14) pills per month for sedative hypnotic formulations in pill form such as Ambien and Lunesta, one hundred forty milliliters (140 ml) per month of chloral hydrate, or one (1) bottle every sixty (60) days of Zolpimist.

(2) No payment will be made for an innovator multiple source drug (brand name drug) if, under applicable State law, a less expensive multiple source drug could have been dispensed, but only to the extent that such amount exceeds the upper payment limit for such multiple source drug. In the event a prescriber indicates on the face of the prescription ("dispense as written") that he is requiring a specific brand name drug be dispensed for a specific TennCare member or if a TennCare member appeals coverage of a generic drug and the appeal process

results in approval of a specific brand name drug, then the reimbursement methodology for that prescription will the same as that for innovator single source drugs covered under the TennCare pharmacy program.

(3) A prior approval system for drugs requiring prior authorization will comply with Section 1927 of the Act and be administered by the pharmacy benefits manager (PBM) or pharmacy benefits administrator (PBA) under contract to TennCare to provide those services. The prior authorization process provides for a turn-around response by either telephone or other telecommunications device within twenty-four hours of receipt of a prior authorization request. In emergency situations, providers may dispense at least a seventy-two hour supply of medication.

(4) Participating pharmaceutical manufacturers will be furnished drug rebate utilization data and allowed to audit this data as set forth and according to the Centers for Medicare and Medicaid Services (CMS) guidelines pursuant to the Act.

(5) As provided by the Act, a new drug manufactured by a company which has entered into a rebate agreement may be covered subject to prior approval, unless the drug is subject to the allowable exclusion categories provided by the Act.

(6) As specified in section 1927(b)(3)(D) of the Act, notwithstanding any other provision of law, information disclosed by manufacturers shall not be disclosed by the State in a form which discloses the identity of a specific manufacturer or prices charged for drugs by such manufacturers, except as the Secretary determines to be necessary and/or to permit the Comptroller General to review the information provided.

(7) Separate agreements between the State and the manufacturers require CMS authorization. The State has CMS authorization for the collection of supplemental rebates that are negotiated with pharmaceutical manufacturers pursuant to the TennCare preferred drug list (PDL) as required by the Act. TennCare will report supplemental rebates from separate agreements to CMS.

(8) The state is in compliance with Section 1927 of the Social Security Act.

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STATE TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

Except as otherwise specifically provided in this State Plan, the state will cover drugs of federal rebate participating manufacturers. The state is in compliance with reporting requirements for utilization and applicable restrictions to coverage. Pharmaceutical manufacturers can audit utilization data. The unit rebate amount is confidential and cannot be disclosed for purposes other than rebate invoicing and verification.

The state will be negotiating supplemental rebates in addition to the federal rebates provided for in Title XIX. Rebate agreements between the state and a pharmaceutical manufacturer will be separate from the federal rebates.

CMS has authorized the state of Tennessee to enter into supplemental rebate agreements with drug manufacturers for drugs provided to Medicaid beneficiaries. The Supplemental Rebate Agreement (SRA) submitted to CMS on August 28, 2015, has been authorized for pharmaceutical manufacturers' new agreements and renewals.

Supplemental rebates received by the State in excess of those required under the national drug rebate agreement will be shared with the Federal government on the same percentage basis as applied under the national rebate agreement.

All drugs covered by the program, irrespective of a prior authorization agreement, will comply with the provisions of the national drug rebate agreement.

(9) Reserved.

(10) In accordance with the provisions of the Act, TennCare began the development and implementation of a preferred drug list (PDL) on July 1, 2003. TennCare will move to a single, statewide preferred drug list (PDL) for the entire pharmacy program. Furthermore, TennCare will employ a single pharmacy benefits manager (PBM) to process all TennCare pharmacy claims and respond to all prior approval requests.

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Pursuant to 42 U.S.C. Section 1396r-8 the state is establishing a preferred drug list with prior authorization for drugs not included on the preferred drug list. Prior authorization will be provided with a 24-hour turn-around from receipt of request and a 72-hour supply of drugs in emergency situations.

Prior authorization will be established for certain drug classes, particular drugs or medically accepted indication for uses and doses.

The state will appoint a Pharmaceutical and Therapeutic Committee or utilize the drug utilization review committee in accordance with Federal law.

(11) When a provider with prescribing authority prescribes a covered medication for a TennCare member, and the prescription is presented at a pharmacy that participates in the TennCare program, the member is entitled to either:

(a) The drug as prescribed, if the drug is covered by TennCare and does not require prior authorization; or

(b) The drug as prescribed, if the prescribing provider has obtained prior authorization or established the medical necessity for the medication; or

(c) An alternative medication, if the pharmacist consults the prescribing provider when the member presents the prescription to be filled, and the provider prescribes the substituted drug; or

(d) An emergency supply of the prescribed drug, if the pharmacist is unable, when the member presents the prescription to be filled, to obtain authorization from either TennCare or the designated TennCare point-of-sale (POS) pharmacy claims processor to fill the prescription as written or the prescribing provider's authorization to substitute an alternative medication. If the member does not receive the medication of the type and amount prescribed, the pharmacist shall immediately provide written notice of the right to appeal, including the right to request continuation of services pending appeal, as required by the *Grier* Revised Consent Decree. The member's entitlement to receive an emergency supply of the prescribed drug is subject to the provisions as set out below.

(12) The member is entitled to an emergency supply of the prescribed drug provided that:

(a) The manufacturer has a rebate agreement and the medication is not classified by the FDA or regarded by CMS to be less than effective (DESI, LTE or IRS drug); or

(b) The medication is not a drug in a non-covered TennCare therapeutic category or class of drugs or products such as:

1. Agents used for anorexia, weight loss or weight gain;
2. Agents used to promote fertility;
3. Agents not listed on the TennCare preferred drug list used for the symptomatic relief of cough and colds;
4. Agents used for cosmetic purposes or hair growth;
5. Agents not listed on the TennCare preferred drug list which are vitamin and mineral products;
6. Agents not listed on the TennCare preferred drug list which are nonprescription (over-the-counter) products and drugs, except for nonprescription drugs for smoking cessation.

TennCare will exclude from coverage all of the allowable exclusions described above; or

(c) Use of the medication has not been determined to be medically contraindicated because of the member's medical condition or possible adverse drug interaction; or

(d) The prescriber did not prescribe a total quantity less than an emergency supply, in which case the pharmacist must provide a supply up to the amount prescribed.

(13) There are some cases in which it is not feasible for the pharmacist to dispense an emergency supply because the drug is packaged by the manufacturer to be sold as the original unit or because the usual and customary pharmacy practice would be to dispense the drug in the original packaging (inhalers, eye drops, topicals, etc.). When coverage of an emergency supply of a prescription would otherwise be required and when, as described above, it is not feasible for the pharmacist to

dispense an emergency supply, it shall be the responsibility of TennCare to provide coverage for either the emergency supply or the usual dispensing amount, whichever is greater.

(14) Pharmacies should bill prescriptions for TennCare members with other third party insurance to the appropriate third party payer (primary insurer) and bill any applicable copays for covered drugs to TennCare.

(15) Covered drugs under the TennCare Pharmacy Program shall be limited to:

(a) Those legend drugs covered under the Medicaid Drug Rebate Program as described in Section 1927 (k) of the Social Security Act and outlined in the TennCare Pharmacy Program Preferred drug list; and

(b) Non-legend drugs which are listed on the covered OTC drug list; and

(c) Legend and non-legend drugs which are covered and prescribed by an authorized prescriber; and

(d) Those drugs which are not included in the list of excluded therapeutic categories or classes contained in Section 1927(d) of the Social Security Act (listed above in (12)(b); and

(e) Those drugs not considered to be DESI, less-than-effective (LTE) or identical, related or similar (IRS) to DESI drugs; and

(f) Select active pharmaceutical ingredients (APIs) and excipients used in extemporaneously compounded prescriptions when dispensed by a pharmacist, who is employed by a pharmacy participating in the PBM National Network or the TennCare Network pursuant to a prescription issued by a licensed prescriber following all State and Federal laws. This includes only APIs and excipients that are determined by the State to be cost effective to TennCare (compared to other covered alternatives). APIs that have been identified as being cost effective by TennCare are identified at http://www.tn.gov/tenncare/pro-pharmacy.html.

Attachment 3.1.B.1.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE TENNESSEE

LIMITATION ON AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

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12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

12.c. Prosthetic Services

Prostheses, including braces, will be provided on the written request of the attending physician with proper documentation of necessity and prior approval of the Medicaid Director.

D1071086

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13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

13.d. Rehabilitative Services

A. Rehabilitative Services by Community Mental Health Centers

Rehabilitative services which are restricted to mental health services are covered for eligible Medicaid recipients. Providers of rehabilitation services will meet the following criteria:

1) provide services to individuals with mental illness;

2) provide an array of community mental health services which, at a minimum include outpatient services, crisis intervention services, and symptom management services;

3) comply with applicable "Licensure Rules of the Tennessee Department of Mental Health and Mental Retardation" and have appropriate licensure;

4) comply with all applicable program standards as defined by "Community Mental Health Center Standards";

5) adhere to the Bureau of Medicaid's and the Department of Mental Health and Mental Retardation's fiscal reporting requirements;

6) have a documented ability to provide off-site mental health services; and

7) offer services that are compatible with the Department of Mental Health and Mental Retardation's Mental Health Master Plan.

It is important for providers to meet these criteria in order to assure that recipients of services under the rehabilitation option receive the highest quality and most appropriate services possible. The services to be covered under the rehabilitation services option meet the definition of rehabilitation services found in 42 CFR 440.130(d) and include the following:

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13.d. Rehabilitative Services (continued)

1) individual therapy treatment by individual interview including psychotherapy, relationship therapy, insight therapy, psychoanalysis, and counseling;

2) group therapy treatment through the use of group interactions including group psychotherapy, group psychoanalysis, therapy with groups of families or married couples or similar services;

3) family therapy applied to a family as a unit, where significant members of the family are seen together;

4) couple therapy through planned therapeutic sessions involving two people in a marital relationship who are seen together as a unit;

5) medication maintenance treatment through individual interview and through the use of psychotropic drugs, including prescribing medication and monitoring the patient's condition and progress;

6) psychological evaluation and testing through evaluation of cognitive processes and emotions and problems of adjustments in individuals or in groups, through interpretations of tests of mental abilities, aptitudes, interests, attitudes, emotions, motivation and personality characteristics, including the interpretation of psychological tests of individuals;

7) psychiatric evaluation using the psychodiagnostic process, including a medical history and mental status, which notes the attitudes, behavior, estimate of intellectual functioning, memory functioning, orientation and an inventory of the patient's assets in a descriptive (but not an interpretative) fashion, impressions, and recommendations;

8) symptom management services aimed exclusively at medical treatment which includes ongoing monitoring of the patient's mental illness symptoms and response to treatment interventions to help the patient manage his/her symptoms, assistance with medication compliance and the understanding of the effects of

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LIMITATION ON AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

13.d. Rehabilitative Services (continued)

medication, introduction of the patient to symptom management techniques to alleviate symptoms not reduced by medication, assisting the patient in developing coping skills, and consultation with family, legal guardian, and/or significant others to promote understanding and management of the patient's mental illness; and

9) crisis intervention services using short term, intensive services, including crisis oriented counseling, support, and medication, aimed at stabilizing individuals experiencing a psychiatric crisis in order to assist them to return to their pre-crisis level of functioning, and services to assist individuals and members of their natural support systems to resolve situations that may have precipitated or contributed to the crisis.

Service providers will be offering a comprehensive array of mental health services to eligible individuals throughout the state of Tennessee and will be offering them in the most appropriate settings possible (for example, their homes). All services to an individual are provided as directed in an individualized treatment program by a physician or other licensed practitioner of the healing arts within the scope of his/her practice under state law. The treatment plan also directs the duration and scope of services to be provided in order to achieve the goals and objectives of the plan. Therefore, it can be assured that each service to be offered under the rehabilitation services option will be sufficient in amount, duration, and scope to reasonably achieve its purpose.

Provision of services where the family is involved will be directed to meeting the identified client's treatment needs. Services provided to non-Medicaid eligible family members independent of meeting the identified client's treatment needs are not covered by Medicaid.

B. Rehabilitative Services by Community Mental Retardation Clinics

Rehabilitative services which are restricted to Community Mental Retardation Clinics are covered for eligible Medicaid recipients. Providers of rehabilitation services shall meet the following criteria:

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LIMITATION ON AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

13.d. Rehabilitative Services (continued)

1) Be under contract with the Department of Mental Health and Mental Retardation to provide community mental retardation services;

2) The agency will have a minimum of three years experience in serving persons with mental retardation;

3) The agency will be licensed by the Department of Mental Health and Mental Retardation and demonstrate a consistent history of conformity to licensure law;

4) There shall be a person specified by the clinic who shall have the authority and responsibility for the management, control, and administration of the clinic; This person should have at least three years experience in the field of providing services to persons with mental retardation and a degree in the field of human services;

5) Medical personnel employed and treatment services delivered in a mental retardation clinic shall be under the supervision, control and responsibility of a physician currently licensed in the State of Tennessee. The physician shall visit the clinic as required to insure good quality care;

6) There shall be a licensed person (Physician, RN, LPN, Teacher, Social Worker, Psychologist) on the grounds of the facility whenever services are being provided;

7) The agency will maintain an adequate accounting system as required by the Comptroller's office and must adhere to the Department of Mental Health and Mental Retardation's fiscal reporting requirements;

8) The authority, responsibility, and function for each category of staff shall be clearly defined in the form of written policies and job descriptions;

9) The agency will maintain adequate treatment records on all clients including an individual habilitation plan, social history, medical history, and a record of all services provided under the clinic option;

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LIMITATION ON AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

13.d. Rehabilitative Services (continued)

10) The agency will meet DMR Quality Assurance Standards and must not have had any critical standards deficient in the past three years which were not corrected in a timely manner;

11) The agency must have a letter of support from the Superintendent and be approved as a mental retardation clinic provider by the Division of Mental Retardation and the Department of Health, and must have an approved provider contract for clinic services with the Department of Health, Bureau of Medicaid prior to providing any services;

12) Be willing to submit quarterly reports to the Division of Mental Retardation on the numbers served and the units of service provided to each person;

13) The applicant may not be a hospital.

14) In order to qualify as a Mental Retardation Clinic provider, an agency must meet the eligibility criteria of a clinic, be approved by DMR, and must obtain a certificate of authority from the Department of Health. The agency must submit a completed application on a form prepared and furnished by the Department of Health. The application shall contain the name of the provider, the person in charge of the Clinic, the type of persons to be served, the location of the facility, the physician in charge, the names and official capacity of the governing body, and any other required information. The application will also be reviewed by DMR and upon approval by both Departments. DOH will execute a contract.

15) The facility must meet the conditions of participation outlined above which include a physician direction requirement and a requirement that each facility have a licensed staff person on the premises when services are being delivered. The licensed person can be a physician, R.N., L.P.N., social worker, or teacher.

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LIMITATION ON AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

13.d. Rehabilitative Services (continued)

It is important for providers to meet these criteria in order to assure that recipients of services under this rehabilitation option receive the highest quality and most appropriate services possible. The services to be covered under this rehabilitation services option meet the definition of rehabilitation services found in 42 CFR 440.130(d) and include the following:

1) Child Treatment - Home Based Services - Home Based Services are defined as: The provision of goal directed training in the home of a child to assist the child in learning self-help, communication, and gross motor skills by training parents how to direct and carry over the training begun by the trainers. These services are provided by licensed teachers (B.S. or M.S.) and/or teacher assistants (A.A. or H.S. education), under the direction of a licensed teacher.

2) Day Treatment Services - The provision of services which assist individuals who are past school age in acquiring and maintaining personal and community living skills and to further develop their physical, mental, and social functioning. Includes programs designed to teach independent living, self-help, and communication. Off Site Services are defined as the provision of services designed to assist individuals in acquiring community living and independent living skills. These services may be provided in the clients home or in other community settings which enhance the clients integration into normal community activities.

3) Diagnostic and Evaluation Services - The provision of diagnostic evaluations by qualified professionals in order to determine strengths and weaknesses in the areas of physical health, speech, hearing, intellectual functioning, motor function and coordination.

D1052262

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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LIMITATION ON AMOUNT, DURATION AND SCOPE OF
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14. Services for individuals age 65 or older in institutions for mental diseases.

14.b. Nursing facility services.

Nursing facility services for individuals age 65 or older will be provided at Level I or Level II Care. Medicaid will apply medical criteria for admission and continued stay at the level of care designated and approved by the Tennessee Medicaid program.

The recipient on Level I Care must require on a daily basis, 24 hours a day, licensed nursing services which as a practical matter can only be provided on an inpatient basis.

The recipient on Level II Care must require on a daily basis, 24 hours a day, skilled/complex nursing or skilled/complex rehabilitative services which as a practical matter can only be provided on an inpatient basis.

Attachment 3.1.B.1

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE TENNESSEE

LIMITATION ON AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

15. Services in an intermediate care facility for the mentally retarded (other than in an institution for mental diseases) for individuals who are determined, in accordance with Section 1902(a)(31)(A), to be in need of such care.

Intermediate care facility services in a institution (or distinct part thereof) for the mentally retarded or persons with related conditions shall be limited to persons who have a preadmission evaluation approved by the Tennessee Medicaid program.

Attachment 3.1.B.1

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE TENNESSEE

LIMITATION ON AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

16. Inpatient psychiatric facility services for individuals under 22 years of age.

Inpatient psychiatric facility services for individuals under 22 years of age are limited to an acute level of psychiatric hospital care for recipients who meet state established medical necessity criteria as specified in subparagraph (w) of paragraph (1) of state administrative rule 1200-13-1-.03. Acute psychiatric inpatient care is hospital based treatment provided under the direction of a physician for a psychiatric condition which has a relatively sudden onset and a short, severe course. The psychiatric condition should be of such a nature as to pose a significant and immediate danger to self, others, or the public safety or one which has resulted in marked psychosocial dysfunction or grave mental disability of the patient. The therapeutic intervention should be aggressive and aimed at expeditiously moving the patient to a less restricted environment.

Effective October 1, 1992, education costs will be considered as a part of the operating component, when educational services are an integral part of a recipient's acute inpatient psychiatric care involving active treatment, pursuant to an individual plan of care developed by an inter-disciplinary treatment team, and ordered by the recipient's attending physician.

D3120347

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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LIMITATION ON AMOUNT, DURATION
AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

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17. Nurse-midwife services

a. Restriction of Practice: All delegated medical tasks and drug management services must be rendered in accordance with a protocol jointly developed by the physician and nurse-midwife. Maternity services performed by the nurse-midwife are not to include the assisting of child birth by an artificial, forcible, surgical or mechanical means not addressed in the protocol. Newborn services are limited to routine newborn care.

b. Participation: In order for a nurse-midwife to obtain a Medicaid provider number and receive reimbursement the following requirements must be met:

1. Completion and submission of a nurse-midwife enrollment form which includes a copy of the certification issued by the American College of Nurse-Midwives and a copy of a current Tennessee Registered Nurse license;

2. Submission of a nurse-midwife consultation and referral agreement with a physician(s) actually engaged in the practice of obstetrics and participating in the Tennessee Medicaid program; and

3. Execution of a Medicaid provider agreement.

c. Covered Services: Medicaid covered services provided by the nurse-midwives are limited to those diagnoses and procedures related to an uncomplicated maternity cycle, an uncomplicated delivery, and routine newborn care. Reimbursement for these services will not be made unless one of the diagnoses and procedures listed below are documented on the claim.

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LIMITATION ON AMOUNT, DURATION
AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

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17. Nurse-midwife services (continued)

1. Covered Classifications are:

   i. Supervision of normal first pregnancy;

   ii. Supervision of other normal pregnancy;

   iii. Single liveborn - except for an emergency, only when born in a hospital or in an Ambulatory Surgical Center classified to provide maternity services; or

   iv. Delivery in a completely normal case.

2. Covered Procedures are:

   i. Total obstetric care (all-inclusive, "global" care) includes antepartum care, vaginal delivery and postpartum care. This excludes forceps or breech delivery.

   ii. Vaginal delivery only including in-hospital postpartum care (separate procedure). This excludes forceps or breech delivery.

   iii. Antepartum care only (separate procedure).

   iv. Postpartum care only (separate procedure).

   v. Antepartum office visits (new or established patient).

   vi. Newborn care in hospital, including physical examination of baby and conference(s) with patient(s).

   vii. Assist at surgery for Cesarean deliveries.
   8/23/89

D1049066

TN No. 89-9 DATE/RECEIPT 8/15/89
SUPERSEDES DATE/APPROVED 8/28/89
TN No. 89-8 DATE/EFFECTIVE 7/1/89

Attachment 3.1.B.1

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE TENNESSEE

LIMITATION ON AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

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18. Hospice Care (in accordance with section 1905(o) of the Act).

Hospice services will be covered with an established maximum limit of:

210 days of hospice care consisting of three (3) benefit periods - two (2) 90-day periods and one (1) subsequent 30-day period.

Hospice benefits paid by Medicare or other insurance will be considered to be benefits paid by the Medicaid program.

D3050136(3)

TN No. 90-12 DATE/RECEIPT 7/11/90
SUPERSEDES DATE/APPROVED 11/27/
TN No. NEW DATE/EFFECTIVE 7/1/9

Attachment 3.1.B.1
(Program A)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE TENNESSEE

LIMITATION ON AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

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19. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

Program (A) - Pregnant Women

Prenatal case management is limited to pregnant women who would be eligible for a Title V program. Services will be provided in accordance with the Medicaid/Title V agency agreement. There is also a limit of one home visit per month.

D2039195

Attachment 3.1.B.1
(Program B)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE TENNESSEE

LIMITATION ON AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

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19. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

Program (B) - Infants and Children to Age 2

Infant and child case management services are limited to infants and children to age 2 who would be eligible for a Title V program. Services will be provided in accordance with the Medicaid/Title V agency agreement. There is also a limit of one (1) home visit per month.

GW/D2199194

Attachment 3.1.B.1
(Program C)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE TENNESSEE

LIMITATION ON AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

19. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

Program (C) - Mental Health

Case management services will be limited to those Medicaid eligible clients who meet the criteria as specified below:

Children under age 21 must meet at least one of the following conditions:

a. have a history of hospitalization or out-of-home placements for serious emotional problems; or

b. be at imminent risk (placement within 48 hours) of hospitalization or out-of-home placement at state expense for emotional problems; or

c. be seriously emotionally disturbed, as evidenced by the clinical diagnosis of major mental illness, such as pervasive developmental disorders, childhood schizophrenia, schizophrenia of adult type manifesting in adolescence, severe behavioral disorders requiring long-term residential care, mental retardation/developmental disabilities with accompanying mental disorders, or other disorders fitting disability requirements of this definition (or likely to have a duration of) at least one year; or

d. have functional problems of sufficient severity to result in substantial limitations of major life activities in two or more of the following categories: self-care at an appropriate developmental level, perceptive and expressive language, learning, self-direction, and capacity for living in a family or family equivalent.

Recipients over age 21 must meet at least one of the following conditions:

a. have a history of hospitalization for psychiatric problem(s) within the past five years; or

b. have a major DSM III-R psychiatric diagnosis, i.e., schizophrenia, mood disorders (bipolar disorders, major depression), delusional (paranoid) disorder; and organic mental disorder (except substance abuse); or

c. have a rating of 6 (very poor) or 7 (grossly impaired) on Axis V of DSM III-R.

D1011060

Attachment 3.1.B.1
(Program D)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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LIMITATION ON AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

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19. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

Program (D) Children In State Custody or At Risk of State Custody

Case management services are limited to children to age of 21 in or entering state custody or at imminent/serious risk of entering state custody. Services will be provided in accordance with Medicaid/Title V agency agreement.

D1172071

Attachment 3.1.B.1
(Program E)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE TENNESSEE

LIMITATION ON AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

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19. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or sectin 1915(g) of the Act).

PROGRAM (E) - Children's Special Services (CSS) Targeted Case Management

Case management services are limited to infants and children to age 21 enrolled in the Children's Special Services Program. Services will be provided in accordance with Medicaid/Title V interagency agreement by providers who are Title V agencies or who are subcontractors to a Title V agency.

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21. Certified Pediatric or Family Nurse Practitioners Services.

Limited to services provided through the TennCare waiver and Medicare crossovers.

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20. Extended Services for Pregnant Women

Subject to the same medical services, limitations as other Medicaid recipients (i.e., days for inpatient hospital, physician visits, etc.).

22. Respiratory Care Services

Respiratory Care Services are limited to the medical equipment and medical supplies that are listed as medically necessary by the attending physician.

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23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

23.a. Transportation

Transportation in compliance with 42 CFR 440.170 will be covered under the following conditions:

(1) Emergency ambulance transportation shall be provided for recipients in case of injury or acute medical condition where the same is liable to cause death or severe injury or illness as determined by the attending physician, paramedic, emergency medical technician, or registered nurse. Coverage shall be limited to one-way transportation to the nearest appropriate facility. Appropriate facility shall mean an institution that is generally equipped and staffed to provide the needed hospital care for the illness or injury involved. The fact that a more distant institution may be better equipped to care for the patient shall not warrant a finding that a closer institution does not have "appropriate facilities". An institution shall not be considered an appropriate facility if there is no bed available.

Coverage of air ambulance transportation shall be limited to situations where transportation by land ambulance was contraindicated because the point of pickup was inaccessible by land vehicle or the time/distance to reach a hospital with appropriate facilities was prohibitive because of the patient's medical condition.

(2) Non-Emergency Ambulance services will be reimbursed when the recipient's condition is such that use of any other method of transportation is contraindicated. For reimbursement, a physician, paramedic, emergency medical technician, registered nurse, or licensed practical nurse must prepare written documentation that the patient's condition warrants such services. This documentation must be attached to the ambulance provider's request for payment. Assurance of transportation in accordance with 42 CFR 431.53 is provided in section 3.1-D of the Tennessee State Plan.

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23.a. Transportation - Continued

(3) Commercial transportation services such as taxicabs, buses, vans, common carriers etc. will be covered for recipients who are determined eligible for transportation services.

(4) Volunteer transportation services such as those provided by friends, neighbors and family members will be covered for recipients who are determined eligible for transportation services.

(5) The Bureau of Health Services Administration (HSA) and Health System Developments (HSD) through intradepartmental agreements are responsible for negotiating the most cost effective provider agreements between commercial providers and Medicaid. HSA and HSD are also responsible for actually arranging transportation services and for monitoring provider compliance with provider agreements. State employees or other employees of HSA and HSD who transport recipients will do so only as a last resort. Reimbursement for transportation services provided by state employees will be requested at the administrative match rate.

Attachment 3.1.B.1

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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23.c. Care and services provided in Christian Science Sanitoria

Limited to 10 days per fiscal year.

23.d. Nursing facility services for patients under 21 years of age.

Nursing facility services to include Level I and Level II (other than services in an institution for mental diseases) will be covered. Medicaid will apply medical criteria for admission and continued stay at the level of care designated and approved by the Tennessee Medicaid program.

The recipient on Level I Care must require on a daily basis, 24 hours a day, licensed nursing services which as a practical matter can only be provided on an inpatient basis.

The recipient on Level II Care must require on a daily basis, 24 hours a day, skilled/complex nursing or skilled/complex rehabilitative services which as a practical matter can only be provided on an inpatient basis.

23.e. Emergency Hospital Services

Subject to the same limitations as item 1 (inpatient hospital services).