

# TAR

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**Volume 31, Number 7**

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

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## PREFACE

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

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

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

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

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

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

**Reproduction** - There are no restrictions on the reproduction of official documents appearing in the Tennessee Administrative Register.

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## ANNOUNCEMENTS

### **DEPARTMENT OF FINANCE AND ADMINISTRATION - 0620 BUREAU OF TENNCARE**

#### **ANNOUNCEMENT OF ELIMINATION OF MEDICAID/TENNCARE COVERAGE OF RESERVING BEDS IN NURSING FACILITIES**

The Commissioner of the Tennessee Department of Finance and Administration is providing official notification pursuant to 42 CFR 447.205 that the Bureau of TennCare has received approval from the Centers for Medicare and Medicaid Services (CMS) to eliminate coverage of payments made to reserve a bed during a recipient's temporary absence from a nursing facility (NF) while receiving Level I (intermediate) care effective July 1, 2005. It is the state's intent to begin implementing this August 1, 2005.

J. D. Hickey  
Deputy Commissioner

(06-28)

ANNOUNCEMENTS

**DEPARTMENT OF FINANCIAL INSTITUTIONS – 0180**

**ANNOUNCEMENT OF FORMULA RATE OF INTEREST**

Pursuant to the provisions of Chapter 464, Public Acts of 1983, the Commissioner of Financial Institutions hereby announces that the formula rate of interest is 10.00%.

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

Kevin P. Lavender

**DEPARTMENT OF FINANCIAL INSTITUTIONS – 0180**

**ANNOUNCEMENT OF MAXIMUM EFFECTIVE RATE OF INTEREST**

The Federal National Mortgage Association has discontinued its free market auction system for commitments to purchase conventional home mortgages. Therefore, the Commissioner of Financial Institutions hereby announces that the maximum effective rate of interest per annum for home loans as set by the General Assembly in 1987, Public Chapter 291, for the month of August 2005 is 8.23 percent per annum.

The rate as set by the said law is an amount equal to four percentage points above the index of market yields of long-term government bonds adjusted to a thirty (30) year maturity by the U. S. Department of the Treasury. For the most recent weekly average statistical data available preceding the date of this announcement, the calculated rate is 4.23 percent.

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

Kevin P. Lavender

## ANNOUNCEMENTS

### **GOVERNMENT OPERATIONS COMMITTEES**

#### **ANNOUNCEMENT OF PUBLIC HEARINGS**

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

## ANNOUNCEMENTS

SEQ. NO.	DATE FILED	DEPARTMENT AND DIVISION	TYPE OF FILING	DESCRIPTION	RULE NUMBER AND RULE TITLE	LEGAL CONTACT	EFFECTIVE DATE
06-01	June 1, 2005	<b>1240 Human Services</b> Child Support Services	Rulemaking Hearing Rules	Amendments	<i>Chapter 1240-2-4 Child Support Guidelines</i> 1240-2-4-.03 The Income Shares Model 1240-2-4-.04 Determination of Child Support 1240-2-4-.05 Modification of Child Support Orders 1240-2-4-.08 Worksheets and Instructions	Kim Beals Assistant General Counsel Citizens Plaza Bldg 15th Fl 400 Deaderick St Nashville TN 37248-0006 615-313-4731	Aug 15, 2005
06-02	June 3, 2005	<b>1540 TN Higher Education Commission</b>	Public Necessity Rules	Amendment	<i>Chapter 1540-1-4 Public Higher Education Fee Waivers for State Employees</i> 1540-1-4-.01 Definitions	Will Burns Suite 1900 Pkwy Twrs 404 J Robertson Pkwy Nashville TN 37243-0830 615-741-7571	June 3, 2005 through Nov 15, 2005
06-03	June 3, 2005	<b>1540 TN Higher Education Commission</b>	Proposed Rules	Amendment	<i>Chapter 1540-1-4 Public Higher Education Fee Waivers for State Employees</i> 1540-1-4-.01 Definitions	Will Burns Suite 1900 Pkwy Twrs 404 J Robertson Pkwy Nashville TN 37243-0830 615-741-7571	Oct 28, 2005
06-04	June 3, 2005	<b>1540 TN Higher Education Commission</b>	Public Necessity Rules	Amendment	<i>Chapter 1540-1-5 Public Higher Education Fee Discounts for Children of Licensed Public School Teachers and State Employees</i> 1540-1-5-.01 Definitions	Will Burns Suite 1900 Pkwy Twrs 404 J Robertson Pkwy Nashville TN 37243-0830 615-741-7571	June 3, 2005 through Nov 15, 2005
06-05	June 3, 2005	<b>1540 TN Higher Education Commission</b>	Proposed Rules	Amendment	<i>Chapter 1540-1-5 Public Higher Education Fee Discounts for Children of Licensed Public School Teachers and State Employees</i> 1540-1-5-.01 Definitions	Will Burns Suite 1900 Pkwy Twrs 404 J Robertson Pkwy Nashville TN 37243-0830 615-741-7571	Oct 28, 2005
06-06	June 3, 2005	<b>0620 Finance and Administration</b> Bureau of TennCare	Public Necessity Rules	Amendment	<i>Chapter 1200-13-13 TennCare Medicaid</i> 1200-13-13-.01 Definitions 1200-13-13-.02 Eligibility	George Woods Bureau of TennCare 729 Church St Nashville TN 37247-6501 615-741-0145	June 3, 2005 through Nov 15, 2005
06-07	June 3, 2005	<b>0620 Finance and Administration</b> Bureau of TennCare	Public Necessity Rules	Amendment	<i>Chapter 1200-13-14 TennCare Medicaid</i> 1200-13-14-.01 Definitions 1200-13-14-.02 Eligibility 1200-13-14-.05 Enrollee Cost Sharing	George Woods Bureau of TennCare 729 Church St Nashville TN 37247-6501 615-741-0145	June 3, 2005 through- Nov 15, 2005

## ANNOUNCEMENTS

SEQ. NO.	DATE FILED	DEPARTMENT AND DIVISION	TYPE OF FILING	DESCRIPTION	RULE NUMBER AND RULE TITLE	LEGAL CONTACT	EFFECTIVE DATE
06-08	June 8, 2005	<b>0240</b> Children's Services Fiscal Division	Rulemaking Hearing Rules	Amendments	<i>Chapter 0250-7-10</i> <i>Administration Of Collective Fund Accounts</i> 0250-7-10-.01 Purpose 0250-7-10-.02 Definitions 0250-7-10-.03 Policy 0250-7-10-.04 Custodian of Collective Funds 0250-7-10-.05 Accounting for Funds 0250-7-10-.06 Authorized Expenditures 0250-7-10-.07 Interest on Funds 0250-7-10-.08 Administrative Charges 0250-7-10-.09 Management of Child Information 0250-7-10-.10 Accounting for Personal Accounts 0250-7-10-.11 Additional Rules for Social Security Benefits	Mary Jane Davis Esq. DCS Central Legal Office Cordell Hull Bldg 436 6th Ave N. 7th Fl Nashville TN 37243 615-253-4482	Aug 22, 2005
06-09	June 8, 2005	<b>0800</b> Labor and Workforce Development Workers' Compensation	Proposed Rules	New rules	<i>Chapter 0800-2-5</i> <i>Benefit Review Process Rules</i> 0800-2-5-.01 Definitions 0800-2-5-.02 Request for Assistance or Mediation 0800-2-5-.03 Requirements for Request for Assistance 0800-2-5-.04 Requirements for Requests for Benefit Review Conference 0800-2-5-.05 Documents to be Provided upon Request of Workers' Compensation Specialist 0800-2-5-.06 Discovery 0800-2-5-.07 Benefit Review Conferences 0800-2-5-.08 Approval of Settlement by the Commissioner or the Commissioner's Designee 0800-2-5-.09 Exhaustion of the Benefit Review Conference Process 0800-2-5-.10 Penalties	E. Blaine Sprouse Workers' Compensation Labor & Workforce Development Andrew Johnson Twr, 2nd Fl 710 J Robertson Pkwy Nashville TN 37243-0661 615-253-0064	Oct 28, 2005
06-10	June 8, 2005	<b>0620</b> Finance and Administration Bureau of TennCare	Public Necessity Rules		<i>Chapter 1200-13-13</i> <i>TennCare Medicaid</i> 1200-13-13-.12 Other Appeals By TennCare Applicants and Enrollees	George Woods Bureau of TennCare 729 Church St Nashville TN 37247-6501 615-741-0145	June 8, 2005 through Nov 20, 2005
06-11	June 8, 2005	<b>0620</b> Finance and Administration Bureau of TennCare	Public Necessity Rules	Amendment	<i>Chapter 1200-13-14</i> <i>TennCare Standard</i> 1200-13-14-.12 Other Appeals By TennCare Applicants and Enrollees	George Woods Bureau of TennCare 729 Church St Nashville TN 37247-6501 615-741-0145	June 8, 2005 through Nov 20, 2005

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SEQ. NO.	DATE FILED	DEPARTMENT AND DIVISION	TYPE OF FILING	DESCRIPTION	RULE NUMBER AND RULE TITLE	LEGAL CONTACT	EFFECTIVE DATE
06-12	June 9, 2005	<b>1720</b> <b>University of TN</b> UT Knoxville	Proposed Rules	Amendments	<i>1720-4-4</i> <i>Student Housing Regulations</i> 1720-4-4-.11 Differentiated Housing 1720-4-4-.12 Open House and Visitation Procedures	Ronald C. Leadbetter, University of TN Office of General Counsel 719 Andy Holt Tower Knoxville, TN 37996-0170 (865) 974-3247	Oct 28, 2005
06-13	June 14, 2005	<b>0800</b> <b>Labor and Workforce Development</b> Division of Labor Standards	Proposed Rules	New Rules	<i>Chapter 0800-5-3</i> <i>Board of Employee Assistance</i> <i>Professionals Rules</i> 0800-5-3-.07 Requirements for Internship 0800-5-3-.08 Requirements for Licensure 0800-5-3-.09 Requirements for Renewal of License	Sydne Ewell, Attorney Department of Labor & Workforce Development 2nd Floor, Andrew Johnson Tower 710 James Robertson Parkway Nashville, TN 37243 615-741-4356	Oct 28, 2005
06-14	June 15, 2005	<b>0800</b> <b>Labor and Workforce Development</b> Workers' Compensation	Public Necessity Rules	New Rules	<i>Chapter 0800-2-17</i> <i>Medical Cost Containment Program</i> 0800-2-17-.01 Purpose and Scope 0800-2-17-.02 Severability and Preemption 0800-2-17-.03 Definitions 0800-2-17-.04 Information Program Involving Rules 0800-2-17-.05 Procedure Codes/Adoption of CMS' Medicare Procedures, Guidelines and Amounts 0800-2-17-.06 Procedures for Which Codes Are Not Listed 0800-2-17-.07 Modifier Codes 0800-2-17-.08 Total Procedures Billed Separately 0800-2-17-.09 Independent Medical Examination to Evaluate Medical Aspects of Case 0800-2-17-.10 Payment 0800-2-17-.11 Reimbursement for Employee-Paid Services 0800-2-17-.12 Recovery of Payment 0800-2-17-.13 Penalties for Violations of Fee Schedule Rules 0800-2-17-.14 Missed Appointment 0800-2-17-.15 Medical Report of Initial Visit & Progress Reports for Other than Inpatient Hospital Care	E. Blaine Sprouse Workers' Compensation Labor & Workforce Development A Johnson Twr 2nd Fl 710 J Robertson Pkwy Nashville TN 37243-0661 615-253-0064	June 15, 2005 through Nov 27, 2005

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SEQ. NO.	DATE FILED	DEPARTMENT AND DIVISION	TYPE OF FILING	DESCRIPTION	RULE NUMBER AND RULE TITLE	LEGAL CONTACT	EFFECTIVE DATE
06-14, cont.					0800-2-17-.16 Additional Reports 0800-2-17-.17 Deposition/Witness Fee Limitation 0800-2-17-.18 Out-of-State Providers 0800-2-17-.19 Preauthorization 0800-2-17-.20 Process for Resolving Differences Between Carriers and Providers Regarding Bills 0800-2-17-.21 Administrative Review of Fee Schedule Disputes/Hearings 0800-2-17-.22 Utilization Review 0800-2-17-.23 Rule Review 0800-2-17-.24 Provider and Facility Fees for Copies of Medical Records 0800-2-17-.25 Penalties for Violations of Fee Schedule Rules and Medical Cost Containment Program Rules 0800-2-17-01 Purpose and Scope		
06-15	June 15, 2005	<b>0800</b> <b>Labor and Workforce Development</b> Workers' Compensation	Public Necessity Rules	New Rules	<i>Chapter 0800-2-18</i> <i>Medical Fee Schedule</i> 0800-2-18-01 Medicare-basis for System, Applicability, Effective Date and Coding References 0800-2-18-02 General Information and Instructions for Use 0800-2-18-03 General Guidelines 0800-2-18-04 Surgery Guidelines 0800-2-18-05 Anesthesia Guidelines 0800-2-18-06 Injections Guidelines 0800-2-18-07 Ambulatory Surgical Centers and Outpatient Hospital Care (Including Emergency Room Facility Charges) 0800-2-18-08 Chiropractic Services Guidelines 0800-2-18-09 Physical and Occupational Therapy Guidelines 0800-2-18-10 Durable Medical Equipment Guidelines 0800-2-18-11 Orthotics, Prosthetics and Implants Guidelines 0800-2-18-12 Pharmacy Schedule Guidelines 0800-2-18-13 Ambulance Services Guidelines 0800-2-18-14 Clinical Psychological Service Guidelines 0800-2-18-15 Penalties for Violations of Fee Schedules	E. Blaine Sprouse Workers' Compensation Labor & Workforce Development A Johnson Twr 2nd Fl 710 J Robertson Pkwy Nashville TN 37243-0661 615-253-0064	June 15, 2005 through Nov 27, 2005

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SEQ. NO.	DATE FILED	DEPARTMENT AND DIVISION	TYPE OF FILING	DESCRIPTION	RULE NUMBER AND RULE TITLE	LEGAL CONTACT	EFFECTIVE DATE
06-16	June 15, 2005	<b>0800 Labor and Workforce Development</b> Workers' Compensation	Public Necessity Rules	New Rules	<i>Chapter 0800-2-19 In-Patient Hospital Fee Schedule</i> 0800-2-19-.01 General Rules 0800-2-19-.02 Definitions 0800-2-19-.03 Special Ground Rules – Inpatient Hospital Services 0800-2-19-.04. Preauthorization 0800-2-19- 05 Other Services 0800-2-19-.06 Penalties for Violations of Fee Schedules	E. Blaine Sprouse Workers' Compensation Labor & Workforce Development Andrew Johnson Twr, 2nd Fl 710 J Robertson Pkwy Nashville TN 37243-0661 615-253-0064	June 15, 2005 through Nov 27, 2005
06-17	June 15, 2005	<b>0520 Board of Education</b>	Proposed Rule	Amendments	<i>Chapter 0520-1-2 Administrative Rules and Regulations</i> 0520-1-2-.03 Employment Standards	Debra E. Owens State Board of Education 9th Fl Andrew Johnson Twr 710 J Robertson Pkwy Nashville TN 37243-1050 (615) 741-2966	Oct 28, 2005
06-18	June 15, 2005	<b>0780 Commerce and Insurance</b> Insurance Division	Rulemaking Hearing Rules	Amendments	<i>Chapter 0780-1-61 Long-Term Care Insurance</i> 0780-1-61-.01 Purpose 0780-1-61-.02 Authority 0780-1-61-.03 Applicability and Scope 0780-1-61-.04 Definitions 0780-1-61-.05 Policy Definitions 0780-1-61-.06 Policy Practices and Provisions 0780-1-61-.07 Unintentional Lapse 0780-1-61-.08 Required Disclosure Provisions 0780-1-61-.09 Required Disclosure of Rating Practices to Consumers  0780-1-61-.10 0780-1-61-.11 Initial Filing Requirements Prohibition Against Post-Claims Underwriting  0780-1-61-.12 Minimum Standards for Home Health and Community Care Benefits in Long-Term Care Insurance Policies  0780-1-61-.13 Requirement to Offer Inflation Protection  0780-1-61-.14 Requirements for Application Forms and Replacement Coverage  0780-1-61-.15 Reporting Requirements 0780-1-61-.16 Licensing 0780-1-61-.17 Discretionary Powers of Commissioner  0780-1-61-.18 Reserve Standards 0780-1-61-.19 Loss Ratio	John F. Morris Commerce and Insurance Davy Crockett Twr 5th Fl 500 J Robertson Pkwy Nashville TN 37243 (615) 741-2199	Aug 29, 2005

## ANNOUNCEMENTS

SEQ. NO.	DATE FILED	DEPARTMENT AND DIVISION	TYPE OF FILING	DESCRIPTION	RULE NUMBER AND RULE TITLE	LEGAL CONTACT	EFFECTIVE DATE
06-18, cont.					0780-1-61-.20 Premium Rate Schedule Increases 0780-1-61-.21 Filing Requirement 0780-1-61-.22 Filing Requirements for Advertising 0780-1-61-.23 Standards for Marketing Suitability 0780-1-61-.24 Prohibition Against Preexisting Conditions and Probationary Periods in Replacement Policies or Certificates 0780-1-61-.26 Nonforfeiture Benefit Requirement 0780-1-61-.27 Standards for Benefit Triggers 0780-1-61-.28 Additional Standards for Benefit Triggers for Qualified Long-Term Care Insurance Contracts 0780-1-61-.29 Standard Format Outline of Coverage 0780-1-61-.30 Requirement to Deliver Shopper's Guide Appendix A. Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long-Term Care Insurance Appendix B. Notice to Applicant Regarding Replacement of Accident and Sickness or Long-Term Care Insurance Appendix C. Rescission Reporting Form Appendix D. Long-Term Care Insurance Personal Worksheet Appendix E. Things You Should Know Before You Buy Long-Term Care Insurance Appendix F. Long-Term Care Insurance Suitability Letter Appendix G. Claims Denial Reporting Form Appendix H. Format for Outline of Coverage for Long-Term Care Insurance Appendix I. Potential Rate Increase Disclosure Form Appendix J. Replacement and Lapse Reporting Form		

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SEQ. NO.	DATE FILED	DEPARTMENT AND DIVISION	TYPE OF FILING	DESCRIPTION	RULE NUMBER AND RULE TITLE	LEGAL CONTACT	EFFECTIVE DATE
06-19	June 15, 2005	<b>0800 Labor and Workforce Development</b> Workers' Compensation	Proposed Rules	New Rules	<p><i>Chapter 0800-2-20 Medical Impairment Rating Registry Program</i></p> <p>0800-2-20-.01 Definitions. 0800-2-20-.02 Purpose and scope. 0800-2-20-.03 Severability and Preemption. 0800-2-20-.04 Requisite Physician Qualifications for Inclusion on Medical Impairment Rating Registry. 0800-2-20-.05 Application Procedures for Physicians to Join the Registry. 0800-2-20-.06 Requests for a MIR Registry Three-Physician List. 0800-2-20-.07 Payments/Fees. 0800-2-20-.08 Multiple Impairment Rating Evaluations. 0800-2-20-.09 Communication with Registry Physicians. 0800-2-20-.10 Requirements for the Evaluation. 0800-2-20-.11 Requirements for the "MIR Impairment Rating Report." 0800-2-20-.12 Peer Review. 0800-2-20-.13 Removal of a Physician from the Registry. 0800-2-20-.14 Other Penalties. 0800-2-20-.15 Time Limits. 0800-2-20-.16 Claimant Cooperation. 0800-2-20-.17 Overturning a MIR Physician's Opinion.</p>	E. Blaine Sprouse Workers' Compensation Labor & Workforce Development Andrew Johnson Twr, 2nd Fl 710 J Robertson Pkwy Nashville TN 37243-0661 615-253-0064	Oct 28, 2005
06-20	June 15, 2005	<b>0800 Labor and Workforce Development</b> Workers' Compensation	Public Necessity Rules	New Rules	<p><i>Chapter 0800-2-20 Medical Impairment Rating Registry Program</i></p> <p>0800-2-20-.01 Definitions. 0800-2-20-.02 Purpose and scope. 0800-2-20-.03 Severability and Preemption. 0800-2-20-.04 Requisite Physician Qualifications for Inclusion on Medical Impairment Rating Registry. 0800-2-20-.05 Application Procedures for Physicians to Join the Registry. 0800-2-20-.06 Requests for a MIR Registry Three-Physician List. 0800-2-20-.07 Payments/Fees. 0800-2-20-.08 Multiple Impairment Rating Evaluations. 0800-2-20-.09 Communication with Registry Physicians. 0800-2-20-.10 Requirements for the Evaluation. 0800-2-20-.11 Requirements for the "MIR Impairment Rating Report."</p>	E. Blaine Sprouse Workers' Compensation Labor & Workforce Development Andrew Johnson Twr, 2nd Fl 710 J Robertson Pkwy Nashville TN 37243-0661 615-253-0064	June 15, 2005 through Nov 27, 2005

## ANNOUNCEMENTS

SEQ. NO.	DATE FILED	DEPARTMENT AND DIVISION	TYPE OF FILING	DESCRIPTION	RULE NUMBER AND RULE TITLE	LEGAL CONTACT	EFFECTIVE DATE
06-20, cont.					0800-2-20-.12 Peer Review. 0800-2-20-.13 Removal of a Physician from the Registry. 0800-2-20-.14 Other Penalties. 0800-2-20-.15 Time Limits. 0800-2-20-.16 Claimant Cooperation. 0800-2-20-.17 Overturning a MIR Physician's Opinion.		
06-21	June 15, 2005	<b>1680 Transportation</b> Civil Rights Division	Rulemaking Hearing Rules	New Rules	<i>Chapter 1680-8-3 Construction Management Development Program</i> 1680-8-3-.01 Purpose 1680-8-3-.02 Definition of Terms 1680-8-3-.03 Construction Management Development Program Application 1680-8-3-.04 Needs Assessment 1680-8-3-.05 Eligibility for the Construction Management Development Program 1680-8-3-.06 Enrollment Procedures for the Construction Management Development Program 1680-8-3-.07 Classroom Instruction 1680-8-3-.08 On-the-Job Instruction 1680-8-3-.09 Exemption from the Construction Management Development Program 1680-8-3-.10 Certification of Proficiency 1680-8-3-.11 Revocation 1680-8-3-.12 Forms	Brian R. Carroll, Transportation OGC Suite 300, J. K. Polk Bldg 505 Deaderick St Nashville TN 37243 741-2941	Aug 29, 2005
06-22	June 15, 2005	<b>1680 Transportation</b> Civil Rights Division	Rulemaking Hearing Rules	New Rules	<i>Chapter 1680-8-4 Bond Guarantee Program</i> 1680-8-4-.01 Purpose 1680-8-4-.02 Definition of Terms 1680-8-4-.03 Bond Guarantee Program 1680-8-4-.04 Revocation 1680-8-4-.05 Implementation 1680-8-4-.06 Forms	Brian R. Carroll, Transportation OGC Suite 300, J. K. Polk Bldg 505 Deaderick St Nashville TN 37243 741-2941	Aug 29, 2005
06-23	June 15, 2005	<b>0800 Labor and Workforce</b> Development Workers' Compensation Penalty Program	Proposed Rules	Amendments	<i>Chapter 0800-2-13 Penalty Program</i> 0800-2-13-.02 Investigation of Unpaid or Untimely Paid Workers' Compensation Benefits 0800-2-13-.03 Departmental Actions 0800-2-13-.04 Administrative Appeal of an Agency Decision Assessing a Civil Penalty for Unpaid or Untimely Paid Workers' Compensation Benefits	Peter B. Halverstadt Labor and Workforce Development A Johnson Twr 2nd Fl 710 J Robertson Pkwy Nashville TN 37243-0661 (615) 532-2403	Oct 28, 2005

## ANNOUNCEMENTS

SEQ. NO.	DATE FILED	DEPARTMENT AND DIVISION	TYPE OF FILING	DESCRIPTION	RULE NUMBER AND RULE TITLE	LEGAL CONTACT	EFFECTIVE DATE
06-24	June 15, 2005	<b>0800 Labor and Workforce Development</b> Workers' Compensation	Proposed Rules	Amendments	<i>Chapter 0800-2-16 Deposition Fees</i> 0800-2-16-.01 Deposition Fees	Mark Finks Workers' Compensation Labor and Workforce Development A Johnson Twr 2nd Fl 710 J Robertson Pkwy Nashville TN 37243-0661 (615) 253-6267	Oct 28, 2005
06-29	June 23, 2005	<b>1177 Private Probation Services Council</b>	Rulemaking Hearing Rules	New Rules	<i>Chapter 1177-1 Application, Registration and Fee Requirements</i> 1177-1-.01 Purpose 1177-1-.02 Definitions 1177-1-.03 Registration with Council 1177-1-.04 Exemptions 1177-1-.05 Application and Quarterly Report to Courts 1177-1-.06 Education and Experience 1177-1-.07 Renewal and Update of Registration 1177-1-.08 Quarterly Provider Fee	Janice Macke Davy Crockett Twr, Room 140 500 J Robertson Pkwy Nashville TN 37243-1162 615-741-3072	Sept 6, 2005
06-30	June 22, 2005	<b>0600 Equalization</b>	Rulemaking Hearing Rules	Amendments	<i>Chapter 0600-4 Assessment Certification and Education Program</i> 0600-4-.01 General Requirements for Candidacy-Definitions 0600-4-.02 Assessment Level I-Certification Requirements 0600-4-.03 Assessment Level II-Certification Requirements 0600-4-.04 Tennessee Certified Assessor-Certification Requirements 0600-4-.05 Assessment Level IV-Certification Requirements 0600-4-.06 Assessment Level V/Tennessee Master Assessor-Certification Requirements 0600-4-.08 Continuing Education Procedures 0600-4-.12 Courses Approved for Continuing Education Credit	Kelsie Jones State Board of Equalization Ste. 1700 505 Deaderick St Nashville, TN 37243-0280 615/747-5379	Sept 5, 2005
06-31	June 22, 2005	<b>0080 Agriculture</b> Regulatory Services	Proposed Rules	Amendments	<i>Chapter 0080-5-12 Kerosene And Motor Fuels Quality Inspection Regulations</i> 0080-5-12-.01 Definitions 0080-5-12-.02 Standard Specifications 0080-5-12-.03 Classification and Method of Sale of Petroleum Products 080-5-12-.08 Test Methods and Reproducibility Limits	Phyllis A. Childs Agriculture P.O. Box 406627 Nashville, TN 37204 615-837-5093	Oct 28, 2005

## ANNOUNCEMENTS

SEQ. NO.	DATE FILED	DEPARTMENT AND DIVISION	TYPE OF FILING	DESCRIPTION	RULE NUMBER AND RULE TITLE	LEGAL CONTACT	EFFECTIVE DATE
06-31, cont.					0080-5-12-.10 Disposition of Sample Retains		
06-32	June 23, 2005	<b>1680 Transportation</b> Maintenance Division	Proposed Rules		<i>Chapter 1680-2-5 Truck Lane Restrictions Along Interstates and Multi-Lane Access Controlled Highways</i> 1680-2-5-.01 Purpose and Scope 1680-2-5-.02 Definitions 1680-2-5-.03 Truck Lane Restrictions 1680-2-5-.04 Guidelines for Establishing Truck Lane Restrictions on Eligible Highways	John H. Reinbold General Counsel Transportation Suite 300 J K Polk Bldg 505 Deaderick St Nashville TN 37243 (615) 741-2941	Oct 28, 2005
06-35	June 27, 2005	1680 Wildlife Resources Commission	Proclamation		Proclamation 05-17 Proclaiming Kyles Ford Wildlife Management Area		June 27, 2005
06-36	June 28, 2005	1680 Wildlife Resources Commission	Proclamation		Proclamation 05-16 Importation of Cervid Carcasses and Parts		June 28, 2005
06-37	June 28, 2004	<b>0180 Financial Institutions</b>	Proposed Rule	New Rules	0180-33-.01 Fees	Kevin C. Bartels Financial Institutions 4th Fl Nashville City Ctr 511 Union St Nashville TN 37219 (615) 741-0346	Oct 28, 2005
06-38	June 28, 2005	<b>0240 Board of Regents</b> State University and Community College System of Tennessee Austin Peay State University	Proposed Rules	Amendments	<i>Chapter 0240-3-1 Student Disciplinary Rules</i> 0240-3-1-.02 Disciplinary Offenses 0240-3-1-.04 Disciplinary Sanctions 0240-3-1-.05 Disciplinary Procedures 0240-3-1-.07 Traffic and Parking Regulations	Nancy Washington 1415 Murfreesboro Road Suite 350 Nashville TN 37217 615-366-4438	Oct 28, 2005
06-39	June 28, 2005	<b>0240 Board of Regents</b> State University and Community College System of Tennessee East Tennessee State University	Proposed Rules	Amendments	<i>Chapter 0240-3-2 Student Disciplinary Rules</i> 0240-3-2-.02 Disciplinary Offenses 0240-3-2-.04 Disciplinary Sanctions 0240-3-2-.05 Disciplinary Procedures	Nancy Washington 1415 Murfreesboro Road Suite 350 Nashville TN 37217 615-366-4438	Oct 28, 2005

## ANNOUNCEMENTS

SEQ. NO.	DATE FILED	DEPARTMENT AND DIVISION	TYPE OF FILING	DESCRIPTION	RULE NUMBER AND RULE TITLE	LEGAL CONTACT	EFFECTIVE DATE
06-40	June 28, 2005	<b>0240 Board of Regents</b> State University and Community College System of Tennessee University Of Memphis	Proposed Rules	Amendments	<i>Chapter 0240-3-3</i> <i>Student Disciplinary Rules</i> 0240-3-3-.02 Definitions 0240-3-3-.03 Judicial Authority 0240-3-3-.04 Proscribed Conduct 0240-3-3-.05 Academic Misconduct 0240-3-3-.06 Disciplinary Procedures 0240-3-3-.09 Traffic and Parking Regulations	Nancy Washington 1415 Murfreesboro Road Suite 350 Nashville TN 37217 615-366-4438	Oct 28, 2005
06-41	June 28, 2005	<b>0240 Board of Regents</b> State University and Community College System of Tennessee Middle Tennessee State University	Proposed Rules	Amendments	<i>Chapter 0240-3-4</i> <i>Student Disciplinary Rules</i> 0240-3-4-.05 Guidelines for Social Activities	Nancy Washington 1415 Murfreesboro Road Suite 350 Nashville TN 37217 615-366-4438	Oct 28, 2005
06-42	June 28, 2005	<b>0240 Board of Regents</b> State University and Community College System of Tennessee Tennessee Technological University	Proposed Rules	Amendments	<i>Chapter 0240-3-6</i> <i>Student Disciplinary Rules</i> 0240-3-6-.07 Traffic and Parking Regulations	Nancy Washington 1415 Murfreesboro Road Suite 350 Nashville TN 37217 615-366-4438	Oct 28, 2005
06-43	June 28, 2005	<b>0240 Board of Regents</b> State University and Community College System of Tennessee Chattanooga State Technical Community College	Proposed Rules	Amendments	<i>Chapter 0240-3-7</i> <i>Student Disciplinary Rules</i> 0240-3-7-.02 Definitions 0240-3-7-.03 Judicial Authority 0240-3-7-.05 Academic and Classroom Misconduct	Nancy Washington 1415 Murfreesboro Road Suite 350 Nashville TN 37217 615-366-4438	Oct 28, 2005
06-44	June 28, 2005	<b>0240 Board of Regents</b> State University and Community College System of Tennessee Cleveland State Community College	Proposed Rules	Amendments	<i>Chapter 0240-3-8</i> <i>Student Disciplinary Rules</i> 0240-3-8-.06 Traffic and Parking Regulations	Nancy Washington 1415 Murfreesboro Road Suite 350 Nashville TN 37217 615-366-4438	Oct 28, 2005
06-45	June 28, 2005	<b>0240 Board of Regents</b> State University and Community College System of Tennessee Columbia State Community College	Proposed Rules	Amendments	<i>Chapter 0240-3-9</i> <i>Student Disciplinary Rules</i> 0240-3-9-.05 Disciplinary Procedures	Nancy Washington 1415 Murfreesboro Road Suite 350 Nashville TN 37217 615-366-4438	Oct 28, 2005

## ANNOUNCEMENTS

SEQ. NO.	DATE FILED	DEPARTMENT AND DIVISION	TYPE OF FILING	DESCRIPTION	RULE NUMBER AND RULE TITLE	LEGAL CONTACT	EFFECTIVE DATE
06-46	June 28, 2005	<b>0240 Board of Regents</b> State University and Community College System of Tennessee Dyersburg State Community College	Proposed Rules	Amendments	<i>Chapter 0240-3-10 Student Disciplinary Rules</i> 0240-3-10-.02 Disciplinary Offenses 0240-3-10-.06 Traffic and Parking Regulations	Nancy Washington 1415 Murfreesboro Road Suite 350 Nashville TN 37217 615-366-4438	Oct 28, 2005
06-47	June 28, 2005	<b>0240 Board of Regents</b> State University and Community College System of Tennessee Jackson State Community College	Proposed Rules	Amendments	<i>Chapter 0240-3-11 Student Disciplinary Rules</i> 0240-3-11-.05 Disciplinary Procedures 0240-3-11-.06 Traffic and Parking Regulations	Nancy Washington 1415 Murfreesboro Road Suite 350 Nashville TN 37217 615-366-4438	Oct 28, 2005
06-48	June 28, 2005	<b>0240 Board of Regents</b> State University and Community College System of Tennessee Motlow State Community College	Proposed Rules	Amendments	<i>Chapter 0240-3-12 Student Disciplinary Rules</i> 0240-3-12-.05 Disciplinary Procedures	Nancy Washington 1415 Murfreesboro Road Suite 350 Nashville TN 37217 615-366-4438	Oct 28, 2005
06-49	June 28, 2005	<b>0240 Board of Regents</b> State University and Community College System of Tennessee Roane State Community College	Proposed Rules	Amendments	<i>Chapter 0240-3-13 Student Disciplinary Rules</i> 0240-3-13-.05 Disciplinary Procedures	Nancy Washington 1415 Murfreesboro Road Suite 350 Nashville TN 37217 615-366-4438	Oct 28, 2005
06-50	June 28, 2005	<b>0240 Board of Regents</b> State University and Community College System of Tennessee Southwest Tennessee Community College	Proposed Rules	Amendments	<i>Chapter 0240-3-14 Student Disciplinary Rules</i> 0240-3-14-.03 Classroom Misconduct 0240-3-14-.06 Traffic and Parking Regulations	Nancy Washington 1415 Murfreesboro Road Suite 350 Nashville TN 37217 615-366-4438	Oct 28, 2005
06-51	June 28, 2005	<b>0240 Board of Regents</b> State University and Community College System of Tennessee Volunteer State Community College	Proposed Rules	Amendments	<i>Chapter 0240-3-15 Student Disciplinary Rules</i> 0240-3-15-.02 Disciplinary Offenses 0240-3-15-.03 Academic and Classroom Misconduct	Nancy Washington 1415 Murfreesboro Road Suite 350 Nashville TN 37217 615-366-4438	Oct 28, 2005
06-52	June 28, 2005	<b>0240 Board of Regents</b> State University and Community College System of Tennessee Walters State Community College	Proposed Rules	Amendments	<i>Chapter 0240-3-16 Student Disciplinary Rules</i> 0240-3-16-.06 Traffic and Parking Regulations	Nancy Washington 1415 Murfreesboro Road Suite 350 Nashville TN 37217 615-366-4438	Oct 28, 2005

## ANNOUNCEMENTS

SEQ. NO.	DATE FILED	DEPARTMENT AND DIVISION	TYPE OF FILING	DESCRIPTION	RULE NUMBER AND RULE TITLE	LEGAL CONTACT	EFFECTIVE DATE
06-53	June 28, 2005	<b>0240 Board of Regents</b> State University and Community College System of Tennessee Pellissippi State Technical Community College	Proposed Rules	Amendments	<i>Chapter 0240-3-18 Student Disciplinary Rules</i> 0240-3-18-.02 Disciplinary Offenses 0240-3-18-.03 Academic and Classroom Misconduct  0240-3-18-.04 Disciplinary Sanctions 0240-3-18-.05 Disciplinary Procedures 0240-3-18-.06 Traffic and Parking Regulations	Nancy Washington 1415 Murfreesboro Road Suite 350 Nashville TN 37217 615-366-4438	Oct 28, 2005
06-54	June 28, 2005	<b>0240 Board of Regents</b> State University and Community College System of Tennessee Northeast State Community College	Proposed Rules	Amendments	<i>Chapter 0240-3-20 Student Disciplinary Rules</i> 0240-3-20-.02 Disciplinary Offenses 0240-3-20-.03 Academic and Classroom Misconduct  0240-3-20-.05 Disciplinary Procedures	Nancy Washington 1415 Murfreesboro Road Suite 350 Nashville TN 37217 615-366-4438	Oct 28, 2005
06-55	June 28, 2005	<b>0240 Board of Regents</b> State University and Community College System of Tennessee Tennessee Technology Centers	Proposed Rules	Amendments	<i>Chapter 0240-3-21 Student Disciplinary Rules</i> 0240-3-21-.05 Disciplinary Procedures	Nancy Washington 1415 Murfreesboro Road Suite 350 Nashville TN 37217 615-366-4438	Oct 28, 2005
06-56	June 28, 2005	<b>0240 Board of Regents</b> State University and Community College System of Tennessee East Tennessee State University	Proposed Rules	Amendments	<i>Chapter 0240-4-2 Student Housing Rules</i> 0240-4-2-.02 Residence Hall Conduct and Disciplinary Sanctions	Nancy Washington 1415 Murfreesboro Road Suite 350 Nashville TN 37217 615-366-4438	Oct 28, 2005
06-57	June 28, 2005	<b>0240 Board of Regents</b> State University and Community College System of Tennessee Middle Tennessee State University	Proposed Rules	Amendments	<i>Chapter 0240-4-4 Student Housing Rules</i> 0240-4-4-.03 Residence Hall Conduct and Disciplinary Sanctions	Nancy Washington 1415 Murfreesboro Road Suite 350 Nashville TN 37217 615-366-4438	Oct 28, 2005
06-58	June 28, 2005	<b>0240 Board of Regents</b> State University and Community College System of Tennessee Tennessee Technological University	Proposed Rules	Amendments	<i>Chapter 0240-4-6 Student Housing Rules</i> 0240-4-6-.02 Residence Hall Conduct and Disciplinary Sanctions  0240-4-6-.04 Visitation	Nancy Washington 1415 Murfreesboro Road Suite 350 Nashville TN 37217 615-366-4438	Oct 28, 2005
06-63	June 30, 2005	<b>0520 Education</b>	Proposed Rules	Amendments	<i>Chapter 0520-1-3 Curriculum</i> 0520-1-3-.05 Curriculum, Requirement D 0520-1-3-.06 Graduation, Requirement E	Rich Haglund Board of Education 9th Fl A Johnson Twr 710 J Robertson Pkwy Nashville TN 37243-1050 (615) 741-2966	Oct 28, 2005

## ANNOUNCEMENTS

SEQ. NO.	DATE FILED	DEPARTMENT AND DIVISION	TYPE OF FILING	DESCRIPTION	RULE NUMBER AND RULE TITLE	LEGAL CONTACT	EFFECTIVE DATE
06-64	June 9, 2005	<b>0400 Health and Environment (1200)</b>	Rulemaking Hearing rules	Amendments	Chapter 1200-1-11 Harzardous Waste Management		Aug 23, 2005
06-65	June 30, 2005	<b>0520 Education</b>	Proposed Rules	Amendments	<i>Chapter 0520-2-4 Licensure</i> 0520-2-4-.01 General Information and Regulations	Rich Haglund Board of Education 9th Fl A Johnson Twr 710 J Robertson Pkwy Nashville TN 37243-1050 (615) 741-2966	Oct 28, 2005

ANNOUNCEMENTS

**TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY - 0720**

**NOTICE OF BEGINNING OF REVIEW CYCLE**

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

ANNOUNCEMENTS

**DEPARTMENT OF LABOR - 0800**

**NOTICE OF PETITION FOR RULEMAKING HEARING**

The Tennessee Hospital Association (THA), representing 130 acute care hospitals statewide, is submitting this letter to request that a public rulemaking hearing be held on the three sets of proposed rules comprising the workers' compensation medical fee schedule as published in the June 2005 Tennessee Administrative Register.

THA, founded in 1938 serves as an advocate for hospitals, health systems, home health agencies and other health care organizations and the patients they serve. As health care providers, hospitals across the state will be greatly impacted by the proposed rules.

We appreciate your attention to this matter.

Craig A. Becker  
President

(06-59)

ANNOUNCEMENTS

**DEPARTMENT OF REVENUE - 1320**

**NOTICE OF DETERMINATION OF INTEREST RATE**

Pursuant to T.C.A. Section 67-1-801(a)(1) through (3), notice is hereby given that the rate of interest on all taxes collected or administered by the Department of Revenue shall be ten percent (10.00%) effective on or after July 1, 2005, through June 30, 2006.

Loren L. Chumley  
Commissioner of Revenue

**NOTICE OF DETERMINATION OF INTEREST RATE FOR INSTALLMENT PAYMENTS**

Pursuant to T.C.A. Section 67-1-801(a)(4)(D), notice is hereby given that the rate of interest on all tax liabilities paid in installments by agreement with the Commissioner of Revenue shall be thirteen percent (13.00%) effective on or after July 1, 2005, through June 30, 2006.

Loren L. Chumley  
Commissioner of Revenue

(06-25)

## **EMERGENCY RULES**

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

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

- 1240 - Department of Human Services - Child Support Services Division - Emergency rules pertaining to the calculation of additional expenses in split parenting cases and cases where parenting time is divided on a 50/50 basis, chapter 1240-2-4 Child Support Guidelines, 4 T.A.R., (April 2005) - Filed March 3, 2005; effective through August 15, 2005.
- 1360 - Department of State - Division of Charitable Solitation - Charitable gaming Division - Emergency rules covering procedures for filing applications, amendments and financial accounting reports for organizations exempt from federal income taxation pursuant to Section 501(c)(3) of the Internal Revenue Code (IRC) who have been authorized by the Tennessee General Assembly to operate charitable gaming events, chapter 1360-3-2 Procedures for Operating Gaming Events, 4 T.A.R., (April 2005) - Filed March 4, 2005; effective through August 16, 2005.

## PROPOSED RULES

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

#### CHAPTER 0080-5-12 KEROSENE AND MOTOR FUELS QUALITY INSPECTION REGULATIONS

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

For copies of the entire text of the proposed amendments, contact: Jimmy Hopper, Director, Division of Regulatory Services Division, Department of Agriculture, Ellington Agricultural Center, 615-837-5150.

The text of the proposed amendments is as follows:

#### AMENDMENTS

Rule 0080-5-12-.01 Definitions is amended by adding the following and renumbering the sections accordingly:

- (8) "Biodiesel" means a fuel comprised of mono-alkyl esters of long chain fatty acids derived from vegetable oils or animal fats, designated B100.
- (9) "Biodiesel Blend" means a fuel comprised of a blend of biodiesel fuel with petroleum-based diesel fuel, designated BXX. In the abbreviation BXX, the XX represents the liquid volume percentage of biodiesel fuel in the blend.
- (28) "Lubricity" means a qualitative term describing the ability of a fluid to affect friction between, and wear to, surfaces in relative motion under load.

**Authority:** T.C.A. §47-18-1309

Rule 0080-5-12-.01 Definitions is amended by deleting the following and renumbering the sections accordingly:

## PROPOSED RULES

- (13) “Energy Content” means the gross energy content or heating value of diesel fuel as defined by its heat of combustion – the heat released when a known quantity of fuel is burned completely under specific conditions as determined by ASTM Standard Test Method D 240.
- (17) “Fuel Injector Cleanliness” means a characteristic of the fuel which allows engine operation without fuel contribution to excessive injector deposits.

**Authority:** T.C.A. §47-18-1309

Rule 0080-5-12-.02 Standard Specifications is amended in Paragraph (2) Subparagraph (a) by deleting the current language in its entirety and substituting the following language so that the new Paragraph (2) Subparagraph (a) shall read:

- (a) Premium Diesel Fuel - All diesel fuels identified on retail dispensers, bills of lading, invoices, shipping papers, or other documentation with terms such as premium, super, supreme, plus, or premier must conform to the following requirements:
1. Cetane Number - A minimum cetane number of 47.0 as determined by ASTM Standard Test Method D 613.
  2. Low Temperature Operability - A cold flow performance measurement which meets the ASTM D 975 tenth percentile minimum ambient air temperature charts and maps by either ASTM Standard Test Method D 2500 (Cloud Point) or ASTM Standard Test Method D 4539 (Low Temperature Flow Test, LTFT). Low temperature operability is only applicable October 1 - March 31 of each year.
  3. Thermal Stability - A minimum reflectance measurement of 80 percent as determined by ASTM Standard Test Method D 6468 (180 minutes, 150°C [302°F]).
  4. Lubricity – A maximum wear scar diameter of 520 microns as determined by ASTM D 6079. If an enforcement jurisdiction’s single test of more than 560 microns is determined, a second test shall be conducted. If the average of the two tests is more than 560 microns, the sample does not conform to the requirements of this part.

**Authority:** T.C.A. §47-18-1309

Rule 0080-5-12-.02 Standard Specifications is amended in Paragraph (2) Subparagraph (b) by deleting the current language in its entirety.

**Authority:** T.C.A. §47-18-1309

Rule 0080-5-12-.02 Standard Specifications is amended adding the following new paragraphs:

- (12) Biodiesel Fuel – Biodiesel (B100) intended for blending with diesel fuel shall meet the most recent version of ASTM D 6751, “Standard Specification for Biodiesel Fuel (B100) Blend Stock for Distillate Fuels.”

## PROPOSED RULES

- (13) Biodiesel Blends – Blends of biodiesel and diesel fuels shall meet the following requirements: the base diesel fuel shall meet the most current requirements of ASTM D 975, Standard Specification for Diesel Fuel Oils; the biodiesel blend stock shall meet the most current requirements of ASTM D 6751, Standard Specification for Biodiesel Fuel (B100) Blend Stock for Distillate Fuels, with the following exception: Biodiesel may be blended with diesel fuel whose sulfur or aromatic levels are outside specification ASTM D 975, Standard Specification for Diesel Fuel Oils, Grades 1-D, low sulfur 1-D, 2-D, or low sulfur 2-D, provided the finished mixture meets pertinent national and local specifications and requirements for these properties.

**Authority:** T.C.A. §47-18-1309

Rule 0080-5-12-.03 Classification and Method of Sale of Petroleum Products is amended by deleting Subparagraphs:

Paragraph (3) Subparagraph (c) is amended by deleting the current language in its entirety.

Paragraph (3) Subparagraph (d) is amended by deleting the current language in its entirety.

**Authority:** T.C.A. §47-18-1309

Rule 0080-5-12-.08 Test Methods and Reproducibility Limits is amended in Paragraph (2) Subparagraph (a) by deleting the current language in its entirety and substituting the following language so that the new Paragraph (2) Subparagraph (a) shall read:

- (a) Lubricity – ASTM D 6079;

**Authority:** T.C.A. §47-18-1309

Rule 0080-5-12-.08 Test Methods and Reproducibility Limits is amended in Paragraph (2) Subparagraph (e) by deleting the current language in its entirety.

**Authority:** T.C.A. §47-18-1309

Rule 0080-5-12-.08 Test Methods and Reproducibility Limits is amended in Paragraph (3) Subparagraph (b) by deleting the current language in its entirety and substituting the following language so that the new Paragraph (3) Subparagraph (b) shall read:

- (b) "Tests Other Than AKI," the reproducibility limits of the ASTM or other accepted standard test method used for each test performed shall be acknowledged for enforcement purposes, except as indicated in 0080-5-12-.08 (3)(a) and in 0080-5-12-.02 (2)(a)4. However, if recurrent values are determined at or near the reproducibility limit from a single marketer, the Commissioner may take necessary enforcement actions to correct the condition.

**Authority:** T.C.A. §47-18-1309

## PROPOSED RULES

Rule 0080-5-12-.10 Disposition of Sample Retains Paragraph (1) is amended by deleting the current language in its entirety and substituting the following language so that as amended the paragraph shall read:

- (1) All unused portions of samples remaining after testing shall be disposed of either by use in official state vehicles or through proper waste disposal procedures. If the unused portions of samples are used in official state vehicles, the state or contract laboratory shall be responsible for storing and dispensing product to authorized vehicles. A log of all product transfers shall be maintained by the state or contract laboratory.

**Authority:** T.C.A. §47-18-1309

The proposed rules set out herein were properly filed in the Department of State on the 22nd day of June, 2005, and pursuant to the instructions set out above, and in the absence of the filing of a petition calling for a rulemaking hearing, will become effective on the 28th day of October, 2005. (06-31)

## PROPOSED RULES

### THE STATE BOARD OF EDUCATION - 0520

#### CHAPTER 0520-1-2 ADMINISTRATIVE RULES AND REGULATIONS

Presented herein are the proposed amendments of the State Board of Education submitted pursuant to T. C. A. § 4-5-202 in lieu of a rulemaking hearing. It is the intent of the State Board of Education to promulgate the amendments without a rulemaking hearing unless a petition requesting such hearing is filed within thirty (30) days of the publication date of the issue of the Tennessee Administrative Register in which the proposed amendments are published. Such petition to be effective must be filed with the State Board of Education, 9th Floor, Andrew Johnson Tower, 710 James Robertson Parkway, Nashville, Tennessee 37243-1050, and in the Department of State, 8<sup>th</sup> Floor – William Snodgrass Building, 312 8<sup>th</sup> Avenue North, Nashville, Tennessee 37243, and must be signed by twenty-five (25) persons who will be affected by the amendments, or submitted by a municipality which will be affected by the amendments, or an association of twenty-five (25) or more members, or any standing committee of the General Assembly.

For a copy of the proposed amendments, contact Debra E. Owens, State Board of Education, 9th Floor, Andrew Johnson Tower, 710 James Robertson Parkway, Nashville, TN, 37243-1050, (615) 741-2966.

The text of the proposed amendments is as follows:

#### AMENDMENTS

Subparagraph (i) of paragraph (10) of Rule 0520-1-2-.03 Employment Standards is amended by deleting the subparagraph in its entirety and substituting instead the following language so that as amended it shall read:

- (i) Persons holding vocational education supervisory positions, including local directors, supervisors, coordinator specialists, assistant principals for vocational education, and center administrators, shall have one of the following sets of qualifications:
  1. A bachelor's degree in vocational education from an accredited four-year college or university, three years of teaching experience in an approved vocational-technical education program and two years of appropriate employment experience in a recognized occupation, or
  2. A bachelor's degree with a vocational education endorsement, three years teaching experience, two years of appropriate work experience, and completion of (by July 1, 2008 or within a three-year period from the date of employment) the required matrix of vocational-technical core competencies for professional development, or
  3. An endorsement as a PreK-12 administrator or secondary supervisor or principal and completion of (by July 1, 2008 or within a three-year period from the date of employment) the required matrix of vocational-technical core competencies for professional development.

**Authority:** T.C.A. § 49-1-302, 49-5-108.

The proposed amendments set out herein were properly filed in the Department of State on the 15th day of June, 2005, pursuant to the instructions set out above, and in the absence of the filing of an appropriate petition calling for a rulemaking hearing, will become effective on the 28th day of October, 2005. (06-17)

## PROPOSED RULES

### THE STATE BOARD OF EDUCATION - 0520

#### CHAPTER 0520-1-3 CURRICULUM

Presented herein are the proposed amendments of the State Board of Education submitted pursuant to T.C.A. § 4-5-202 in lieu of a rulemaking hearing. It is the intent of the State Board of Education to promulgate the amendments without a rulemaking hearing unless a petition requesting such hearing is filed within thirty (30) days of the publication date of the issue of the Tennessee Administrative Register in which the proposed amendments are published. Such petition to be effective must be filed with the State Board of Education, 9th Floor, Andrew Johnson Tower, 710 James Robertson Parkway, Nashville, Tennessee 37243-1050, and in the Department of State, 8<sup>th</sup> Floor – William Snodgrass Building, 312 8<sup>th</sup> Avenue North, Nashville, Tennessee 37243, and must be signed by twenty-five (25) persons who will be affected by the amendments, or submitted by a municipality which will be affected by the amendments, or an association of twenty-five (25) or more members, or any standing committee of the General Assembly.

For a copy of the proposed amendments, contact Art Fuller, State Board of Education, 9th Floor, Andrew Johnson Tower, 710 James Robertson Parkway, Nashville, TN, 37243-1050, (615) 741-2966.

The text of the proposed amendments is as follows:

#### AMENDMENTS

Part 2 of subparagraph (b) of paragraph (6) of Rule 0520-1-3-.05, Curriculum, Requirement D is amended by deleting the part in its entirety and substituting instead the following language so that as amended the part shall read:

2. Grades 9-12. Three units of credit in mathematics shall be required for graduation. Students shall be required to achieve, by the time they graduate, at least one of the following: Algebra I, Technical Algebra (formerly Math for Technology II), or Integrated Mathematics I. Students who enter high school beginning in 2005-06 will also be required to complete one of the following: Geometry, Technical Geometry, Algebra II, or Integrated Mathematics II as part of the three required units. Calculators shall be provided for use in all mathematics courses.

Part 1 of subparagraph (b) of paragraph (1) of Rule 0520-1-3-.06, Graduation, Requirement E is amended by adding new language at the end of the asterisk note regarding the Mathematics units so that as amended the asterisk note shall read:

- \* Students who enter 9th grade in 1994-95 and thereafter shall be required to achieve, by the time they graduate, at least one of the following: Algebra I, Technical Algebra (formerly Math for Technology II), or Integrated Mathematics I. Students who enter high school beginning in 2005-06 will also be required to complete one of the following: Geometry, Technical Geometry, Algebra II, or Integrated Mathematics II as part of the three required units.

Part 8 of subparagraph (e) of paragraph (1) of Rule 0520-1-3-.06, Graduation, Requirement E is amended by deleting the part in its entirety and substituting instead the following language so that as amended the part 8 shall read:

## PROPOSED RULES

### 8. Mathematics<sup>1</sup>

#### (i) Traditional Mathematics Course Sequence

- (I) Foundations I, II<sup>2</sup>
- (II) Technical Math<sup>2</sup>
- (III) Algebra I<sup>3</sup>
- (IV) Technical Algebra<sup>3</sup>
- (V) Algebra II<sup>4,5</sup>
- (VI) Geometry<sup>4,5</sup>
- (VII) Technical Geometry<sup>4</sup>
- (VIII) Advanced Algebra and Trigonometry
- (IX) Statistics
- (X) Discrete Mathematics with Statistics & Probability
- (XI) PreCalculus
- (XII) Calculus

#### (ii) Integrated Mathematics Course Sequence

- (I) Foundations I, II<sup>2</sup>
- (II) Technical Math<sup>2</sup>
- (III) Integrated Mathematics I<sup>3</sup>
- (IV) Integrated Mathematics II<sup>4,5</sup>
- (V) Integrated Mathematics III<sup>4,5</sup>
- (VI) Advanced Algebra and Trigonometry
- (VII) Statistics
- (VIII) Discrete Mathematics with Statistics & Probability
- (IX) PreCalculus
- (X) Calculus

1 All students must earn three credits in high school mathematics.

## PROPOSED RULES

- 2 Students who enter high school beginning in 2005-06 may receive a maximum of one mathematics credit for a course in Foundations I, Foundations II, or Technical Math (formerly known as Mathematics for Technology I). Students who enter high school prior to 2005-06 may receive a maximum of two credits for these courses.
- 3 In order to fulfill the mathematics requirement for graduation, students must earn credit in one of the following: Algebra I, Technical Algebra (formerly Mathematics for Technology II), or Integrated Mathematics I. Students may receive mathematics credit in only one of the three courses.
- 4 Students who enter high school beginning in 2005-06 will also be required to complete one of the following: Geometry, Technical Geometry, Algebra II, or Integrated Mathematics II as part of the three required units.
- 5 Students in the university preparation curriculum must earn two credits in Algebra II, Geometry, or other advanced mathematics courses or they must earn two credits in Integrated Mathematics II and Integrated Mathematics III.

Part 11 of subparagraph (e) of paragraph (1) of Rule 0520-1-3-.06 Graduation, Requirement E is amended by adding a new subpart and an accompanying asterisk so that as amended the subpart shall read as follows:

(xviii) International Baccalaureate, History of the Americas HL\*\*\*

\*\*\*The United States history and United States government requirements may be satisfied by completion of the two-year sequence International Baccalaureate, History of the Americas HL.

Part 4 of subparagraph (f) of paragraph (1) of Rule 0520-1-3-.06 Graduation, Requirement E, Marketing Education, is amended by adding a new subpart (xix) so that as amended the subpart shall read:

(xix) Virtual Enterprise International\*

\* Completion of one of the core marketing education courses as signified by \* satisfies the economics requirement for graduation.

Part 7 of subparagraph (f) of paragraph (1) of Rule 0520-1-3-.06 Graduation, Requirement E is amended by deleting the heading "Technology Preparation" and substituting it with the heading "Contextual Academics" so that as amended the part shall read:

7. Contextual Academics

**Authority:** T.C.A. § 49-1-302.

The proposed amendments set out herein were properly filed in the Department of State on the 30th day of June, 2005, pursuant to the instructions set out above, and in the absence of the filing of an appropriate petition calling for a rulemaking hearing, will become effective on the 28th day of October, 2005. (06-63)

PROPOSED RULES

**THE STATE BOARD OF EDUCATION - 0520**

**CHAPTER 0520-2-4  
LICENSURE**

Presented herein are the proposed amendments of the State Board of Education submitted pursuant to T.C.A. § 4-5-202 in lieu of a rulemaking hearing. It is the intent of the State Board of Education to promulgate the amendments without a rulemaking hearing unless a petition requesting such hearing is filed within thirty (30) days of the publication date of the issue of the Tennessee Administrative Register in which the proposed amendments are published. Such petition to be effective must be filed with the State Board of Education, 9th Floor, Andrew Johnson Tower, 710 James Robertson Parkway, Nashville, Tennessee 37243-1050, and in the Department of State, 8<sup>th</sup> Floor – William Snodgrass Building, 312 8<sup>th</sup> Avenue North, Nashville, Tennessee 37243, and must be signed by twenty-five (25) persons who will be affected by the amendments, or submitted by a municipality which will be affected by the amendments, or an association of twenty-five (25) or more members, or any standing committee of the General Assembly.

For a copy of the proposed amendments, contact Rich Haglund, State Board of Education, 9th Floor, Andrew Johnson Tower, 710 James Robertson Parkway, Nashville, TN, 37243-1050, (615) 741-2966.

The text of the proposed amendments is as follows:

**AMENDMENTS**

Paragraph (15) of Rule 0520-2-4-.01 General Information and Regulations is amended by deleting the rule in its entirety and substituting instead the following language so that as amended the rule shall read:

**0520-2-4-.01 GENERAL INFORMATION AND REGULATIONS**

(15) Advanced Academic Training Acceptable for Purposes of Salary Rating on the License.

(a) Master's Degree Designation.

An individual who holds a master's degree from a regionally accredited institution shall be granted the master's degree designation for salary purposes if the courses taken are functionally related to the area(s) of endorsement on the teaching license held by the individual or if the degree indicates by the nature of the courses that public education was the primary aim.

(b) Master's Degree Plus 30 Designation.

An individual who meets the master's degree designation shall be granted the master's degree plus 30 designation for salary purposes upon completion of 30 additional graduate semester hours of credit if the courses taken are functionally related to the area(s) of endorsement on the teaching license held by the individual or if the nature of the courses indicates that public education was the primary aim. Such credit must be earned from an institution that is regionally accredited.

(c) Education Specialist's Degree Designation.

## PROPOSED RULES

1. An individual who holds an education specialist degree from a regionally accredited institution shall be granted the Education Specialist's degree designation for salary purposes.
2. An individual who has earned a terminal professional degree (e.g. Doctor of Medicine, Doctor of Jurisprudence, etc.) shall be given credit at the Education Specialist level if the courses taken are functionally related to the area(s) of endorsement on the teaching license held by the individual. The degree must be earned from an institution that is regionally accredited, accredited by the American Bar Association or the Liaison Committee on Medical Education or approved by a branch of state government.

(d) Doctor's Degree Designation.

An individual who holds a Doctor of Philosophy, Doctor of Education, or Doctor of Arts from a regionally accredited institution shall be granted the doctor's degree designation for salary purposes if the courses taken are functionally related to the area(s) of endorsement on the teaching license held by the individual or if the degree indicates by the nature of the courses that public education was the primary aim.

- (e) Teachers of occupational education shall receive credit for advanced academic training on the same basis as other teachers provided they hold a professional occupational education license.
- (f) Individuals who seek or hold a license on a professional school service personnel license shall be granted the advanced degree designation for salary purposes if the courses taken are functionally related to the area of endorsement and an institution of higher education with an approved program recommends the individual for licensure.

**Authority:** T.C.A. § 49-1-302, 49-5-108.

The proposed amendments set out herein were properly filed in the Department of State on the 30th day of June, 2005, pursuant to the instructions set out above, and in the absence of the filing of an appropriate petition calling for a rulemaking hearing, will become effective on the 28th day of October, 2005. (06-65)

PROPOSED RULES

**THE TENNESSEE DEPARTMENT OF FINANCIAL INSTITUTIONS - 0620**

**CHAPTER 0180-33  
RULES PERTAINING TO TITLE PLEDGE LENDERS**

Presented herein are proposed new rules establishing fees for title pledge lenders in Chapter 0180-33 of the Department of Financial Institutions and are submitted pursuant to Tenn. Code Ann. § 4-5-202 in lieu of a rulemaking hearing. It is the intent of the Department to promulgate these rules without a rulemaking hearing unless a petition requesting such hearing is filed within thirty (30) days of the publication date of the issue of the Tennessee Administrative Register in which the proposed amendments are published. Such petition to be effective must be filed in the office of the Department of Financial Institutions, Fourth Floor, of the Nashville City Center, located at 511 Union Street, Nashville, Tennessee and in the Department of State, Eighth Floor, Tennessee Tower, William Snodgrass Building, 312 8th Avenue North, Nashville, Tennessee 37243, and must be signed by twenty-five (25) persons who will be affected by the rule, or submitted by a municipality which will be affected by the rule, or an association of twenty-five (25) or more members, or any standing committee of the General Assembly.

Should the Department receive a properly executed and timely filed petition for a hearing on these proposed Rules, any individuals with disabilities who wish to participate in these proceedings should contact the Department to discuss any auxiliary aids or services needed to facilitate such participation. Such initial contact may be made no less than ten (10) days prior to the scheduled meeting date to allow time for the Department to determine how it may reasonably provide such aid or service. Initial contact may be made with the Department's ADA Coordinator, Debbie Curry, at the Nashville City Center, 511 Union Street, Suite 400, Nashville, Tennessee 37243 at (615) 741-2236.

For a copy of the proposed rule, please contact Kevin C. Bartels at (615) 741-0346.

**SUBSTANCE OF PROPOSED RULES**

**CHAPTER 0180-33  
RULES PERTAINING TO TITLE PLEDGE LENDERS**

**NEW RULES**

**0180-33-.01 FEES.**

- (1) The commissioner hereby prescribes the following fees:
  - (a) An application for a license as a title pledge lender shall be accompanied by a filing fee of seven hundred dollars (\$700.00). The filing fee shall not be subject to refund, but shall constitute the license fee for the first license year or part thereof for each title pledge office location. Each title pledge lender shall pay a license renewal fee of seven hundred dollars (\$700.00) for each title pledge office location to the commissioner on or before October 1 of each year for the following year's license commencing on November 1.
  - (b) Fees for licensure of each title pledge office location.

PROPOSED RULES

- 1. Initial license.....\$700.00
- 2. Annual renewal of license .....\$700.00

(2) Fees paid to the commissioner are non-refundable.

Authority: 2005 Tenn. Pub. Acts, Ch. 440.

The proposed rules set out herein were properly filed in the Department of State on the 28th day of June, 2005, and will become effective on the 28th day of October, 2005. (06-37)

PROPOSED RULES

**TENNESSEE HIGHER EDUCATION COMMISSION - 1540**

**CHAPTER 1540-1-4**

**PUBLIC HIGHER EDUCATION FEE WAIVERS FOR STATE EMPLOYEES**

Presented herein are amended rules of the Tennessee Higher Education Commission submitted pursuant to T.C.A. § 4-5-202 in lieu of a rulemaking hearing. It is the intent of the Tennessee Higher Education Commission to promulgate these rules without a rulemaking hearing unless a petition requesting such hearing is filed within thirty (30) days of the publication date of the issue to the Tennessee Administrative Register in which the proposed amendments are published. Such petition to be effective must be filed in Suite 1900 of Parkway Towers located at 404 James Robertson Parkway, Nashville, Tennessee 37243 and in the Department of State, Administrative Procedures Division, Eighth Floor, William R. Snodgrass Tower, 312 Eighth Avenue North, Nashville, Tennessee 37243 and must be signed by twenty-five (25) persons who will be affected by the rule, or submitted by a municipality which will be affected by the rule, or an association of twenty-five (25) or more members, or any standing committee of the General Assembly.

For a copy of these proposed rules, contact: Rosie Padgett, Suite 1900, Parkway Towers, 404 James Robertson Parkway, Nashville, Tennessee 37243, (615) 741-3605.

**AMENDMENTS**

Chapter 1540-1-4-.01 Definitions is amended by deleting paragraph (2) "Full-time Employees of the State of Tennessee or Employee" in its entirety and replacing it with the following new definition:

**1540-1-4-.01 DEFINITIONS**

- (1) Full-time employee of the State of Tennessee: Employee of the executive, judicial, or legislative branches of Tennessee state government:
  - (a) classified as "full-time" and scheduled to work one thousand nine hundred and fifty (1,950) hours or more per fiscal year; or
  - (b) employees, regardless of classification, and scheduled to work one thousand six hundred (1,600) hours per fiscal year and who receive employment benefits provided to all full-time employees.

**Authority:** T.C.A. § 8-50-114.

The proposed rules set out herein were properly filed in the Department of State on the 3rd day of June, 2005, and pursuant to the instructions set out above, and in the absence of the filing of an appropriate petition calling for a rulemaking hearing, will become effective on the 28th day of October, 2005. (06-03)

PROPOSED RULES

**TENNESSEE HIGHER EDUCATION COMMISSION - 1540**

**CHAPTER 1540-1-5**

**PUBLIC HIGHER EDUCATION FEE WAIVERS FOR CHILDREN OF LICENSED PUBLIC SCHOOL  
TEACHERS AND STATE EMPLOYEES**

Presented herein are amended rules of the Tennessee Higher Education Commission submitted pursuant to T.C.A. § 4-5-202 in lieu of a rulemaking hearing. It is the intent of the Tennessee Higher Education Commission to promulgate these rules without a rulemaking hearing unless a petition requesting such hearing is filed within thirty (30) days of the publication date of the issue to the Tennessee Administrative Register in which the proposed amendments are published. Such petition to be effective must be filed in Suite 1900 of Parkway Towers located at 404 James Robertson Parkway, Nashville, Tennessee 37243 and in the Department of State, Administrative Procedures Division, Eighth Floor, William R. Snodgrass Tower, 312 Eighth Avenue North, Nashville, Tennessee 37243 and must be signed by twenty-five (25) persons who will be affected by the rule, or submitted by a municipality which will be affected by the rule, or an association of twenty-five (25) or more members, or any standing committee of the General Assembly.

For a copy of these proposed rules, contact: Rosie Padgett, Suite 1900, Parkway Towers, 404 James Robertson Parkway, Nashville, Tennessee 37243, (615) 741-3605.

**AMENDMENTS**

Chapter 1540-1-5-.01 Definitions is amended by deleting paragraph (6) "Full-time Employees of the State of Tennessee or Employee" in its entirety and replacing it with the following new definition:

**1540-1-4-.01 DEFINITIONS**

- (6) Full-time employee of the State of Tennessee: Employee of the executive, judicial, or legislative branches of Tennessee state government:
  - (a) classified as "full-time" and scheduled to work one thousand nine hundred and fifty (1,950) hours or more per fiscal year; or
  - (b) employees, regardless of classification, and scheduled to work one thousand six hundred (1,600) hours per fiscal year and who receive employment benefits provided to all full-time employees.

**Authority:** T.C.A. § 8-50-114 49-7-119.

The proposed rules set out herein were properly filed in the Department of State on the 3rd day of June, 2005, and pursuant to the instructions set out above, and in the absence of the filing of an appropriate petition calling for a rulemaking hearing, will become effective on the 28th day of October, 2005. (06-05)

PROPOSED RULES

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

**CHAPTER 0800-2-5  
BENEFIT REVIEW PROCESS RULES**

Presented herein are proposed rules of the Tennessee Department of Labor and Workforce Development submitted pursuant to T.C.A. Section 4-5-202 in lieu of a rulemaking hearing. It is the intent of the Tennessee Department of Labor and Workforce Development to promulgate these rules without a rulemaking hearing unless a petition requesting such hearing is filed within thirty (30) days of the publication date of the issue of the Tennessee Administrative Register in which the proposed rules are published. Such petition to be effective must be filed with the Workers' Compensation Division, Second Floor of the Andrew Johnson Tower located at 710 James Robertson Parkway, Nashville, TN 37243-0661 and in the Department of State, Eighth Floor, Tennessee Tower, William Snodgrass Building, 312 8<sup>th</sup> Avenue North, Nashville, TN 37243, and must be signed by twenty-five (25) persons who will be affected by the rule, or submitted by a municipality which will be affected by the rules, or an association of twenty-five (25) or more members, or any standing committee of the General Assembly.

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

**NEW RULES**

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0800-2-5-.02	Request for Assistance or Mediation	0800-2-5-.07	Benefit Review Conferences
0800-2-5-.03	Requirements for Request for Assistance	0800-2-5-.08	Approval of Settlement by the Commissioner or the Commissioner's Designee
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0800-2-5-.05	Documents to be Provided upon Request of Workers' Compensation Specialist	0800-2-5-.10	Penalties

**0800-2-5-.01 DEFINITIONS.** The following definitions are for the purposes of this chapter only:

- (1) "Act" means the Tennessee Workers' Compensation Act, T.C.A. § 50-6-101, et seq., as amended.
- (2) "Administrator" means the Administrator of the Workers' Compensation Division of the Tennessee Department of Labor and Workforce Development.
- (3) "Benefit Review Conference" means a non-adversarial, informal dispute resolution proceeding to fully and finally resolve workers' compensation disputes as provided in the Act.
- (4) "Benefit Review Section" means the section of the Tennessee Department of Labor and Workforce Development, Workers' Compensation Division, which provides assistance regarding Workers' Compensation issues.

## PROPOSED RULES

- (5) "Commissioner" means the Commissioner of the Tennessee Department of Labor and Workforce Development or the Commissioner's designee.
- (6) "Court" means any court which has jurisdiction to hear a workers' compensation case under T.C.A., Title 50, Chapter 6.
- (7) "Designated Discovery Attorney" means an attorney currently licensed to practice law in Tennessee who is a Workers' Compensation Specialist employed by the Tennessee Department of Labor and Workforce Development designated by the Commissioner to act pursuant to T.C.A. § 50-6-236(i).
- (8) "Designee" means any person whom the Commissioner indicates, selects, appoints, nominates, or sets apart for a purpose or duty.
- (9) "Employee" shall have the same meaning as set forth in T.C.A. § 50-6-102.
- (10) "Employer" shall have the same meaning as set forth in T.C.A. § 50-6-102.
- (11) "Exhaustion of the Benefit Review Process" means the completion of the statutorily-mandated Benefit Review Process, as provided in Rule 0800-2-5-.10.
- (12) "Party" means any person or entity which either could be liable for payment of workers' compensation benefits or a person who has a potential right to receive workers' compensation benefits. "Party" shall include a legal representative of a party.
- (13) "Request for Assistance" means a request for a determination by a Workers' Compensation Specialist regarding temporary disability, medical benefits, causation, compensability and/or penalties.
- (14) "Request for Benefit Review Conference" means a request for mediation of all issues related to the final resolution of a claim.
- (15) "Responding party" means the party responding to a Request for Assistance or a Request for Benefit Review Conference filed with the Workers' Compensation Benefit Review Section.
- (16) "Wage Statement" means the form prescribed by the Division of Workers' Compensation which will include all gross wages paid to an employee for at least fifty-two (52) weeks preceding the date of injury.
- (17) "Workers' Compensation Specialist" or "Specialist" means a department employee who has the following authority, including but not limited to: a) provide information regarding workers' compensation for employees, employers and medical providers; b) issue Orders pursuant to statutory authority; c) conduct Benefit Review Conferences; d) review settlements for approval; e) and perform other duties to achieve the purposes of the Act.

**Authority:** T.C.A. §§ 50-6-101 through 50-6-103, 50-6-206, 50-6-233, 50-6-236 through 50-6-242.

## PROPOSED RULES

### **0800-2-5-.02 REQUEST FOR ASSISTANCE OR MEDIATION.**

- (1) Any party may contact the Workers' Compensation Division during regular business hours to obtain information about their rights and obligations under the Workers' Compensation Law.
- (2) Any party may file a Request for Assistance for investigation of issues involving temporary disability and/or medical treatment. This shall include resolution of issues of causation and/or compensability. An injured employee or his or her representative may also file a Request for Assistance requesting assessment of penalties for untimely payment of temporary disability benefits.
- (3) Any party may file a Request for Benefit Review Conference in order to negotiate final settlement of all workers' compensation issues.
- (4) Any party may file a Request for Settlement Approval in order to have a proposed settlement reviewed for purposes of approving the settlement and making it final and binding.
- (5) A Workers' Compensation Specialist shall provide all necessary forms and instructions and may offer assistance in completing and submitting such forms.

**Authority:** T.C.A. §§ 50-6-101 through 50-6-103, 50-6-233, 50-6-236 through 50-6-242, 4-5-202.

### **0800-2-5-.03 REQUIREMENTS FOR REQUEST FOR ASSISTANCE.**

- (1) A Request for Assistance shall be filed on a form prescribed by the Commissioner.
- (2) A Request for Assistance shall be deemed to be filed on the date it is received in any office of the Benefit Review Program.
- (3) All Requests for Assistance filed by an employee or employee's legal representative shall be accompanied by a medical release signed by the employee.
- (4) A party filing a Request for Assistance shall provide a copy thereof to any opposing party.
- (5) Upon receipt of a Request for Assistance, a Workers' Compensation Specialist shall gather information, analyze issues and attempt to facilitate an agreed resolution of the dispute through mediation.

**Authority:** T.C.A. §§ 50-6-101 through 50-6-103, 50-6-233, 50-6-236 through 50-6-242.

### **0800-2-5-.04 REQUIREMENTS FOR REQUESTS FOR BENEFIT REVIEW CONFERENCE.**

- (1) A Request for Benefit Review Conference shall be signed by the requesting party.
- (2) A Request for Benefit Review Conference shall be deemed filed for purposes of the Act on the date of receipt in any office of the Workers' Compensation Benefit Review Program.
- (3) A party filing a Request for Benefit Review Conference shall provide a copy thereof to any opposing party.

## PROPOSED RULES

- (4) A Workers' Compensation Specialist shall receive process and evaluate all requests for a Benefit Review Conference filed with the Workers' Compensation Benefit Review Section.

**Authority:** T.C.A. §§ 50-6-101 through 50-6-103, 50-6-233, 50-6-236 through 50-6-242.

### **0800-2-5-.05 DOCUMENTS TO BE PROVIDED UPON REQUEST OF WORKERS' COMPENSATION SPECIALIST.**

- (1) Upon request by the Workers' Compensation Specialist, a party to a Request for Assistance or a Request for a Benefit Review Conference shall provide all documentation relevant to resolution of the dispute both to the Specialist and to all parties, including but not limited to the following:
  - (a) Medical Records, including impairment ratings given;
  - (b) Medical Bills;
  - (c) Employer's First Report of Injury;
  - (d) Wage Statement;
  - (e) Employment Application and/or Personnel records, including work status;
  - (f) Statutory basis for denial and documentation supporting such;
  - (g) Job Description/Analysis of employee's job prior to injury;
  - (h) Education level of the employee;
  - (i) Employment history of the employee;
  - (j) Issues in dispute;
  - (k) Prior medical records of employee, including psychiatric records if relevant to the merits of the claim;
  - (l) List of all the employee's prior workers' compensation claims;
  - (m) List of any prior litigation the employee has been involved in;
  - (n) List of any prior criminal convictions which would be admissible pursuant to the Tennessee Rules of Evidence.
- (2) Any party has an ongoing obligation to supplement and/or correct any documentation or information otherwise required by the Specialist to be produced.
- (3) Any unexcused failure to produce these documents as determined by the Administrator or Workers' Compensation Specialist will be subject to the penalty provisions contained in the workers' compensation law and/or these rules.

**Authority:** T.C.A. §§ 50-6-101 through 50-6-103, 50-6-233, 50-6-236 through 50-6-242.

## PROPOSED RULES

### 0800-2-5-.06 DISCOVERY.

(1) Purpose and Scope.

The Division's Benefit Review process is designed to provide an informal, expeditious resolution to disputes between injured workers and employers. Parties involved in a workers' compensation case are strongly encouraged, where practicable, to attempt to achieve any necessary discovery informally, in order to avoid undue expense and delay in the resolution of the matter. When such attempts have failed, or where the complexity of the case is such that informal discovery is not practicable, a Workers' Compensation Specialist may request the assistance of the Designated Discovery Attorney.

(2) Methods of Discovery

- (a) For the purpose of conducting discovery as part of a Request for Assistance, the parties shall provide any documentation requested by a Workers' Compensation Specialist. The Workers' Compensation Specialist shall share all information provided with any party without privilege or confidentiality.
- (b) For the purpose of conducting discovery as part of a Benefit Review Conference, the parties shall complete a standard discovery form prescribed by the Commissioner. Completed copies shall be provided to each party and to the Workers' Compensation Specialist assigned to the case. In keeping with the principles of mediation, information and/or documentation presented and discussed during a Benefit Review Conference need not be shared with all parties.

(3) Referral to Designated Discovery Attorney

- (a) Workers' Compensation Specialists may, at the request of either party, or in the Specialist's own discretion, refer a matter to the Designated Discovery Attorney within the Department.
- (b) If any of the items listed in these rules are not furnished as requested, the Workers' Compensation Specialist may request a subpoena for those items from the Designated Discovery Attorney. The Designated Discovery Attorney shall have the authority to issue a subpoena for such items.
- (c) The Designated Discovery Attorney may, in his/her discretion, authorize the use of any method of discovery provided for in the Act.
- (d) The Designated Discovery Attorney shall decide any motion relating to discovery under these Rules. Decisions on such discovery requests shall be final and not subject to appeal for purposes of the Benefit Review process.

(4) Any party has an ongoing obligation to supplement and/or correct any documentation or information otherwise required to be produced.

(5) Sanctions for Failure to Comply with Orders and Subpoenas. Failure to comply with any lawful order or subpoena of the Designated Discovery Attorney may be deemed failure to comply with a Specialist's Order and thereby may be cause for issuance of any or all civil penalties pursuant to T.C.A. § 50-6-238(d). Additionally, the Designated Discovery Attorney may apply to the

## PROPOSED RULES

appropriate Circuit or Chancery court for an order to compel in the same manner as set forth in T.C.A. § 4-5-311, which may result in contempt sanctions.

**Authority:** T.C.A. §§ 50-6-203, 50-6-236, 50-6-238, 4-5-311.

### **0800-2-5-.07 BENEFIT REVIEW CONFERENCES.**

- (1) A Request for Benefit Review Conference must be filed within the statute of limitations provided by T.C.A. § 50-6-203.
- (2) Assignment for a Benefit Review Conference:

The Request for Benefit Review Conference shall be assigned to the Benefit Review office designated for the county where the employee lives.
- (3) Scheduling of Benefit Review Conference:
  - (a) A Benefit Review Conference shall not be scheduled until Maximum Medical Improvement is reached, except upon request by a party and determination by the Director that extraordinary circumstances require otherwise.
  - (b) Scheduling of a Benefit Review Conference shall be within the time limitations provided by statute.
  - (c) All parties are required to cooperate in the scheduling of a Benefit Review Conference pursuant to T.C.A. § 50-6-239.
- (4) Notice and Response of Benefit Review Conference:
  - (a) Upon scheduling of a Benefit Review Conference, notice of date, time, and location shall be sent to all parties.
  - (b) Accompanying the notice of the Benefit Review Conference, the parties shall receive a standard discovery form showing all required information and documentation which shall be exchanged between the parties and the requirements for submitting such documentation.
  - (c) In cases involving a claim against the Second Injury Fund, the Fund shall receive notice of any Benefit Review Conference, with the opportunity to participate.
- (5) Continuances
  - (a) Prior to Benefit Review Conference: A request for a continuance prior to a Benefit Review Conference may be granted upon a finding, in the sole discretion of the Specialist, that extraordinary circumstances require such continuance.
  - (b) After convening a Benefit Review Conference, a Workers' Compensation Specialist has the sole discretion to continue the conference.
- (6) Conduct of the Benefit Review Conference

## PROPOSED RULES

- (a) The conduct of the Benefit Review Conference shall be in the control of the Workers' Compensation Specialist.
  - (b) Either party may be represented by an attorney, but legal representation is not required at a Benefit Review Conference.
  - (c) Only in a situation where a collective bargaining relationship or a memorandum of understanding exists between an employer and a collective bargaining agent may a representative of that collective bargaining agent appear with and assist an employee at the Benefit Review Conference. No provision of this chapter shall authorize a representative of a collective bargaining agent to engage in the "practice of law" or "law business", prohibited by Tenn. Code Ann. § 23-3-103, or Rules of the Tennessee Supreme Court, Rule 7, § 1.01, as a part of the informal mediation procedure set forth in this chapter unless the representative is an attorney licensed to practice law in the State of Tennessee.
- (7) Preparation and submission of Documentation
- (a) If a mediated settlement occurs, the Workers' Compensation Specialist shall prepare a mediated settlement agreement to be signed by the parties and by the Specialist at the time of the conference. The signed mediated settlement agreement shall be filed by the Specialist with the Commissioner. The Workers' Compensation Specialist is not required to prepare a mediated settlement agreement in cases involving the Second Injury Fund.
  - (b) If there is no settlement, the Specialist may declare an impasse. Upon declaring impasse, the Specialist shall prepare a written report pursuant to T.C.A. §50-6-240 to be provided to the parties and filed with the Commissioner.

**Authority:** T.C.A. §§ 50-6-101 through 50-6-103, 50-6-236 through 50-6-239.

### **0800-2-5-.08 APPROVAL OF SETTLEMENT BY THE COMMISSIONER OR THE COMMISSIONER'S DESIGNEE.**

- (1) No settlement is effective unless and until it is approved by the Commissioner or the Commissioner's designee, or a court of competent jurisdiction in accordance with T.C.A. §50-6-206.
- (2) Proposed settlements shall be submitted on a form prescribed by the Commissioner. The employee shall be interviewed by a Workers' Compensation Specialist prior to a proposed settlement.

**Authority:** T.C.A. §§ 50-6-110, 50-6-208, 50-6-233, 50-6-236 through 50-6-243, 50-6-505.

### **0800-2-5-.09 EXHAUSTION OF THE BENEFIT REVIEW CONFERENCE PROCESS.**

- (1) The Benefit Review Conference Process shall be deemed exhausted only upon occurrence of any of the following:
  - (a) The issuance of an Order of Denial based on compensability of the claim by a Workers' Compensation Specialist;

## PROPOSED RULES

- (b) Reaching of a mediated settlement, as evidence by a signed document executed by the proper parties, including the Workers' Compensation Specialist;
  - (c) Issuance of an impasse report signed by the Workers' Compensation Specialist;
  - (d) Issuance of a waiver signed by the Director of the Benefit Program or the Director's designee;
- (2) If the parties have mutually agreed to a settlement without a Benefit Review Conference, the parties shall not be required to exhaust the Benefit Review Conference Process before submitting the settlement to an appropriate Court or to the Workers' Compensation Specialist for approval. If the settlement is not approved, the parties shall then be required to exhaust the Benefit Review Conference Process.
- (3) The Benefit Review Conference Process shall not be deemed exhausted upon the occurrence of the following:
- (a) The filing of a Request for Assistance or a determination thereof on grounds other than non-compensability pursuant to T.C.A. §§ 50-6-236 or 50-6-238;
  - (b) Any penalty Orders pursuant to T.C.A. Title 50, Chapter 6;
  - (c) Voluntary withdrawal of a Request for Benefit Review Conference or claim;
  - (d) Involuntary dismissal pursuant to T.C.A. § 50-6-203(f).

**Authority:** T.C.A. §§ 50-6-101 through 50-6-103, 50-6-118, 50-6-203, 50-6-233, 50-6-236 through 50-6-242.

### **0800-2-5-.10 PENALTIES.**

- (1) Any party or Specialist may bring to the Administrator's attention any violation of the workers' compensation law and/or these Rules for which civil penalties may be assessed in an amount not less than fifty dollars (\$50.00), nor more than ten thousand dollars (\$10,000.00), at the discretion of the Administrator or the Administrator's designee, depending on the severity of the violation.
- (2) In addition to any other penalties provided by Rule and/or law, parties to a Request for a Benefit Review Conference who fail to attend a properly scheduled and noticed benefit review conference may be assessed a penalty of not less than fifty dollars (\$50.00), nor more than five thousand dollars (\$5,000.00), at the discretion of the Administrator or the Administrator's designee.
- (3) Any penalties assessed by the Department pursuant to these rules shall follow the procedures set out in the Penalty Program Rules 0800-2-13-.01 et seq. and/or the workers' compensation law.

**Authority:** T.C.A. §§ 50-6-101 through 50-6-103, 50-6-118, 50-6-233, 50-6-236 through 50-6-242, 4-5-202.

## PROPOSED RULES

### REPEAL

Rules 0800-2-5-.01 through 0800-2-5-.08 are hereby repealed in their entirety.

**Authority:** *T.C.A. §§ 50-6-101 through 50-6-103, 50-6-233, 50-6-236 through 50-6-242.*

The proposed rules set out herein were properly filed in the Department of State on the 9th day of June, 2005, and pursuant to the instructions set out above, and in the absence of the filing of an appropriate petition calling for a rulemaking hearing, will become effective on the 28th day of October, 2005. (06-09)

PROPOSED RULES

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

**CHAPTER 0800-2-13  
PENALTY PROGRAM**

Presented herein are proposed amendments to the Rules of the Tennessee Department of Labor and Workforce Development submitted pursuant to T.C.A. Section 4-5-202 in lieu of a rulemaking hearing. It is the intent of the Tennessee Department of Labor and Workforce Development to promulgate these proposed amendments without a rule making hearing unless a petition requesting such hearing is filed within thirty (30) days of the publication date of the issue of the Tennessee Administrative Register in which the proposed amendments are published. Such petition to be effective must be filed with the Penalty Program, Workers' Compensation Division, Tennessee Department of Labor and Workforce Development, Second Floor of the Andrew Johnson Tower located at 710 James Robertson Parkway, Nashville, TN 37243 and in the Department of State, Eighth Floor, William Snodgrass Building, Tennessee Tower, 312 8<sup>th</sup> Ave. North, Nashville, TN 37243, and must be signed by twenty-five (25) persons who will be affected by the rule, or submitted by a municipality which will be affected by the rule, or an association of twenty-five (25) or more members, or any standing committee of the General Assembly.

For a copy of the proposed amendments, contact: Erol Eryasa, TN Dept. of Labor and Workforce Dev., Division of Workers' Compensation, Penalty Program, Andrew Johnson Tower, Second Floor, 710 James Robertson Parkway, Nashville, TN 37243-0661, Telephone: (615) 253-1606.

The text of the proposed amendments is as follows:

**AMENDMENTS**

Subparagraph (2) of subparagraph (b) of paragraph (4) of rule 0800-2-13-.02 Investigation of Unpaid or Untimely Paid Workers' Compensation Benefits is amended by adding a semicolon (";") and the word "or" after the word "employee" and by adding a subparagraph (3) "the insurer has acted diligently, as determined by the Commissioner or Commissioner's Designee, to obtain necessary information to process the claim and has not been able to obtain it." so that as amended the subparagraph shall read:

- (2) all workers' compensation benefits owed to an employee under the Workers' Compensation Law have been and continue to be timely paid to the employee; or
- (3) the insurer has acted diligently, as determined by the Commissioner or Commissioner's Designee, to obtain necessary information to process the claim and has not been able to obtain it.

Paragraph (5) of rule 0800-2-13-.02 Investigation of Unpaid or Untimely Paid Workers' Compensation Benefits is amended by adding the phrase "A benefit is paid on the date the employer or insurer places the benefits into the mail for delivery to the injured employee." after the word "paid" and the punctuation period "." and before the word "After" so that as amended the subparagraph shall read:

- (5) In deciding whether a benefit is unpaid or untimely paid, compensation shall be deemed promptly paid if the first payment is made fifteen (15) calendar days after the employer has knowledge of the injury and every subsequent payment is made within consecutive fifteen (15) calendar day increments, until all temporary benefits have been paid. A benefit is paid on the date the employer or insurer places the benefits into the mail for delivery to the injured employee. After twenty (20) calendar days from the date of the employer's knowledge of any disability that would qualify for

## PROPOSED RULES

benefits, the twenty-five percent (25%) penalty will attach to all payments unpaid or untimely paid.

Subparagraph (2) of subparagraph (a) of paragraph (1) of rule 0800-2-13-.03 Departmental Actions is amended by adding a semicolon (“;”) and the word “or” after the word “Law” and by adding a subparagraph (3) “in the sole discretion of the Commissioner or the Commissioner’s Designee, the Commissioner or Commissioner’s Designee finds that the insurer has acted diligently to obtain necessary information to process the claim and has not been able to obtain it.” so that as amended the subparagraph shall read:

- (2) the employer or insurer does not owe any workers’ compensation benefits under the Workers’ Compensation Law; or
- (3) in the sole discretion of the Commissioner or the Commissioner’s Designee, the Commissioner or Commissioner’s Designee finds that the insurer has acted diligently to obtain necessary information to process the claim and has not been able to obtain it.

Paragraph (3) of rule 0800-2-13-.03 Departmental Actions is amended by adding a comma (“,”) and the phrase “or the Commissioner’s Designee” and a second comma (“,”) after the word “Commissioner” and before the word “shall” so that as amended the paragraph shall read:

- (3) The Commissioner, or the Commissioner’s Designee, shall have the sole discretion not to issue a penalty even if the technical requirements of subparagraph (1)(b) are satisfied.

Rule 0800-2-13-.04 Administrative Appeal of an Agency Decision Assessing a Civil Penalty for Unpaid or Untimely Paid Workers’ Compensation Benefits is amended by inserting a new subparagraph:

- (1) “An employer or insurer assessed a civil penalty for unpaid or untimely paid worker’s compensation benefits has the right to file, in writing, a petition for informal reconsideration by the Commissioner or Commissioner’s Designee, other than the Specialist who issued the Agency Decision, to determine if the civil penalty should have been assessed. However, the filing of the petition shall not be a prerequisite for requesting a contested case hearing, and the fifteen calendar day period for a party to request a contested case hearing shall not be tolled by the filing of a petition for informal reconsideration. The petition for informal reconsideration shall be made in writing by an employer or insurer which has been assessed a civil penalty for unpaid or untimely paid workers’ compensation benefits and shall be filed with the Designee who issued the Agency Decision assessing the civil penalty within seven (7) calendar days of the date upon which the Agency Decision was issued.” and the existing subparagraphs shall be renumbered so that as amended the rule shall read:

### **0800-2-13-.04 ADMINISTRATIVE APPEAL OF AN AGENCY DECISION ASSESSING A CIVIL PENALTY FOR UNPAID OR UNTIMELY PAID WORKERS’ COMPENSATION BENEFITS**

- (1) An employer or insurer assessed a civil penalty for unpaid or untimely paid worker’s compensation benefits has the right to file, in writing, a petition for informal reconsideration by the Commissioner or Commissioner’s Designee, other than the specialist who issued the Agency Decision, to determine if the civil penalty should have been assessed. However, the filing of the petition shall not be a prerequisite for requesting a contested case hearing, and the fifteen calendar day period for a party to request a contested case hearing shall not be tolled by the filing of a petition for informal reconsideration. The petition for informal reconsideration shall be made in writing by an employer or insurer which has been assessed a civil penalty for unpaid or untimely paid workers’ compensation benefits and shall be filed with the Designee who issued the Agency Decision

## PROPOSED RULES

assessing the civil penalty within seven (7) calendar days of the date upon which the Agency Decision was issued.

- (2) An employer or insurer assessed a civil penalty for unpaid or untimely paid workers' compensation benefits has the right to request a contested case hearing to determine if the civil penalty should have been assessed.
- (3) The request for a hearing shall be made in writing by an employer or insurer which has been assessed a civil penalty for unpaid or untimely paid workers' compensation benefits.
- (4) Any request for a hearing shall be filed with the Designee who issued the Agency Decision assessing the penalty within fifteen (15) calendar days of the date upon which the Agency Decision was issued. Failure to file a request for a hearing within fifteen (15) calendar days of the date of entry of the agency decision shall result in the Agency Decision becoming a Final Order not subject to further review.
- (5) The Commissioner, Commissioner's Designee, or an agency member appointed by the Commissioner shall have authority to hear the matter as a contested case and determine if the civil penalty assessed for unpaid or untimely paid workers compensation benefits should have been assessed.
- (6) Upon receipt of a timely request for a hearing, the Commissioner shall issue a Notice of Hearing to the employer or insurer.

**Authority:** *T.C.A. §§50-6-412, 50-6-233, 50-6-118, and 50-6-801*

The proposed rules set out herein were properly filed in the Department of State on the 15th day of June, 2005, and pursuant to the instructions set out above, and in the absence of the filing of an appropriate petition calling for a rulemaking hearing, will become effective on the 28th day of October, 2005. (06-23)

PROPOSED RULES

**THE TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT – 0800-2  
DIVISION OF WORKERS' COMPENSATION**

**CHAPTER 0800-2-16  
DEPOSITION FEES**

Presented herein are proposed amendments by the Tennessee Department of Labor and Workforce Development submitted pursuant to T.C.A. Section 4-5-202 in lieu of a rulemaking hearing. It is the intent of the Tennessee Department of Labor and Workforce Development to promulgate these amendments without a rulemaking hearing unless a petition requesting such hearing is filed within thirty (30) days of the publication date of the issue of the Tennessee Administrative Register in which the proposed amendments are published. Such petition to be effective must be filed with the Uninsured Employers Fund, Workers' Compensation Division, Tennessee Department of Labor and Workforce Development, Second Floor of the Andrew Johnson Tower located at 710 James Robertson Parkway, Nashville, TN 37243 and in the Department of State, Eighth Floor, William Snodgrass Building, Tennessee Tower, 312 8th Ave. North, Nashville, TN 37243, and must be signed by twenty-five (25) persons who will be affected by the amendments, or submitted by a municipality which will be affected by the amendments, or an association of twenty-five (25) or more members, or any standing committee of the General Assembly.

For a copy of these proposed amendments, contact: Shara Hamlett, TN Dept. of Labor and Workforce Dev., Division of Workers' Compensation, Uninsured Employers Fund, Andrew Johnson Tower, Second Floor, 710 James Robertson Parkwa, Nashville, TN 37243-0661, Telephone: (615) 253-6261.

The text of the proposed amendments is as follows:

**AMENDMENTS**

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**0800-2-16-.01 DEPOSITION FEES**

Rule 0800-2-16-.01 Deposition Fees shall be amended by deleting paragraphs (1) and (2) in their entirety and substituting the following language so that, as amended, the rule shall read:

- (1) Licensed physicians may charge their usual and customary fee for providing testimony by deposition to be used in a workers' compensation claim, provided that such fee does not exceed seven hundred fifty dollars (\$750) for the first hour's time.
- (2) Depositions requiring over one (1) hour in duration shall be pro-rated at the licensed physician's usual and customary fee as set forth above, not to exceed four hundred fifty dollars (\$450) per hour for deposition time in excess of one (1) hour. Physicians shall not charge for the first quarter hour of preparation time. In instances requiring over one quarter hour of preparation time, a physician's preparation time in excess of one quarter hour shall be added to and included in the deposition time and billed at the same rates as for the deposition.

**Authority:** T.C.A. § 50-6-235(d)

## PROPOSED RULES

The proposed rules set out herein were properly filed in the Department of State on the 15th day of June, 2005, and pursuant to the instructions set out above, and in the absence of the filing of an appropriate petition calling for a rulemaking hearing, will become effective on the 28th day of October, 2005. (06-24)

PROPOSED RULES

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

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

Presented herein are proposed rules of the Tennessee Department of Labor and Workforce Development submitted pursuant to T.C.A. Section 4-5-202 in lieu of a rulemaking hearing. It is the intent of the Tennessee Department of Labor and Workforce Development to promulgate these rules without a rulemaking hearing unless a petition requesting such hearing is filed within thirty (30) days of the publication date of the issue of the Tennessee Administrative Register in which the proposed rules are published. Such petition to be effective must be filed with the Workers' Compensation Division, Second Floor of the Andrew Johnson Tower located at 710 James Robertson Parkway, Nashville, TN 37243-0661 and in the Department of State, Eighth Floor, Tennessee Tower, William Snodgrass Building, 312 8th Avenue North, Nashville, TN 37243, and must be signed by twenty-five (25) persons who will be affected by the rule, or submitted by a municipality which will be affected by the rules, or an association of twenty-five (25) or more members, or any standing committee of the General Assembly.

For a copy of these proposed rules, contact: Vickie Gregory, Administrative Secretary, Tennessee Department of Labor and Workforce Development, Division of Workers' Compensation, Andrew Johnson Tower, Second Floor, 710 James Robertson Parkway, Nashville, TN 37243-0661, (615) 253-1613.

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

**NEW RULES**

**TABLE OF CONTENTS**

0800-2-20-.01 Definitions.	0800-2-20-.11 Requirements for the "MIR Impairment Rating Report."
0800-2-20-.02 Purpose and scope.	0800-2-20-.12 Peer Review.
0800-2-20-.03 Severability and Preemption.	0800-2-20-.13 Removal of a Physician from the Registry.
0800-2-20-.04 Requisite Physician Qualifications for Inclusion on Medical Impairment Rating Registry.	0800-2-20-.14 Other Penalties.
0800-2-20-.05 Application Procedures for Physicians to Join the Registry.	0800-2-20-.15 Time Limits.
0800-2-20-.06 Requests for a MIR Registry Three-Physician List.	0800-2-20-.16 Claimant Cooperation.
0800-2-20-.07 Payments/Fees.	0800-2-20-.17 Overturning a MIR Physician's Opinion.
0800-2-20-.08 Multiple Impairment Rating Evaluations.	
0800-2-20-.09 Communication with Registry Physicians.	
0800-2-20-.10 Requirements for the Evaluation.	

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

- (1) "Act" means the Tennessee Workers' Compensation Act, T.C.A. 50-6-101 et seq., as amended.
- (2) "Administrator" means the chief administrative officer of the Workers' Compensation Division of the Tennessee Department of Labor and Workforce Development.
- (3) "Commissioner" means the Commissioner of the Tennessee Department of Labor and Workforce Development or the Commissioner's designee.

## PROPOSED RULES

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

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

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

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

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

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

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

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

## PROPOSED RULES

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

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

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

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

- (1) Appointment to the MIR Registry shall be for a two (2) year term, except as otherwise set forth in these Rules. Physicians may seek renewal appointments by the same process as the initial application described herein. The Division reserves the right to charge physicians a non-refundable application fee upon appointment, renewal, or reinstatement to the MIR Registry. The Commissioner or the Commissioner's designee, upon the advice of the Medical Director shall have the sole and exclusive authority to approve or reject applications for inclusion in the MIR Registry.
- (2) Physicians seeking appointment to the MIR Registry shall complete an "Application for Appointment to the MIR Registry," available upon request from the Program Coordinator or on-line at [www.state.tn.us/labor-wfd/mainforms.html](http://www.state.tn.us/labor-wfd/mainforms.html), certify to and, upon approval of the application, comply with the following conditions:
  - (a) Unless otherwise approved by the Program Coordinator, conduct all MIR evaluations based on the guidelines in the applicable edition of the AMA Guides and submit the original "MIR Impairment Rating Report" with all attachments to the Program Coordinator. In cases not covered by the applicable AMA Guides, any impairment rating allowed under the Act shall be appropriate;
  - (b) Decline the Program Coordinator's request to conduct an evaluation only on the basis of good cause shown, as determined by the Program Coordinator. Consideration will be given to a physician's schedule and other previously arranged or emergency obligations;
  - (c) Comply with the MIR Registry's Rules;

## PROPOSED RULES

- (d) While on the MIR Registry, agree to maintain an active and unrestricted license to practice medicine or osteopathy in Tennessee and to immediately notify the Program Coordinator of any change in the status of the license, including any restrictions placed upon the license;
- (e) While on the MIR Registry, agree to maintain all board certifications listed on the application and to immediately notify the Program Coordinator of any change in their status;
- (f) Conduct MIR evaluations in an objective and impartial manner, and shall:
  - 1. Conduct these evaluations only in a professional medical office suitable for medical or psychiatric evaluations where the primary use of the site is for medical services; not residential, commercial, educational, legal, or retail in nature. Exceptions will be made only on the basis of good cause shown, as determined by the Program Coordinator.
  - 2. Comply with all local, state and federal laws, regulations, and other requirements with regard to business operations, including specific requirements for the provision of medical services.
  - 3. Not conduct a physical examination on a claimant of the opposite sex without a witness of the same sex as the claimant present.
- (g) Not refer any MIR Registry claimant to another physician for any treatment or testing nor suggest referral or treatment;
- (h) Not become the treating physician for the claimant regarding the work-related injury;
- (i) Not evaluate an MIR Registry claimant without prior consent of the Program Coordinator if a conflict of interest exists. A conflict of interest includes, but is not limited to, instances where the physician has treated or evaluated the claimant for the subject injury or has appeared on a panel of doctors made available to the claimant at the time of injury or subsequent to the injury in the course of medical treatment. If an employer provides a claimant with the name of a group of physicians rather than individual physician names, the entire group of physicians shall be considered to have a conflict of interest for purposes of the MIR Registry Program;
- (j) Not employ invasive diagnostic procedures, except venipuncture for obtaining a blood sample, without prior approval of the Program Coordinator;
- (k) Not substitute, or allow to be substituted, anyone else, including any other physician, physician assistant, nurse practitioner, physical therapist or staff member, as the physician to conduct the evaluation without prior written permission from the Program Coordinator;
- (l) No later than thirty (30) calendar days after the cancellation of an evaluation, refund to the paying party part or all of the fee paid by that party, as may be required by the Rules, the Commissioner or the Commissioner's designee; and
- (m) For each MIR Registry case assigned, address only the issue of permanent impairment rating and make appropriate findings.

## PROPOSED RULES

- (3) Physicians denied appointment to the MIR Registry on their initial application may seek reconsideration of their application by submitting a request for reconsideration stating the grounds for such reconsideration to the Program Coordinator within fifteen (15) calendar days of the issuance of the Notice of Denial of their application. The Commissioner or the Commissioner's designee may affirm or reverse the initial determination upon reconsideration of the initial decision. The Commissioner or the Commissioner's designee shall issue a Notice of Final Determination which shall be the final decision.

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

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

- (1) Prior to Division participation, the parties may attempt to negotiate selection of any physician to conduct a medical impairment rating evaluation. Physicians whose names appear on the MIR Registry but are selected in a manner other than through the Division pursuant to these Rules shall have no greater legal presumption of correctness given to their opinion than any other provider's impairment rating when the physician was not selected pursuant to these procedures.
- (2) Application process: If there is no agreed upon selection of a physician, or if an agreement that was reached fails, either party may request the Division participate in selecting the three-physician list. A written opinion as to the permanent impairment rating given by the MIR Registry physician selected pursuant to the Division's procedures in these Rules shall be presumed to be the accurate impairment rating. However, this presumption may be rebutted by clear and convincing evidence to the contrary.
- (3) Form Required: The "Application for a Medical Impairment Rating" available upon request from the Program Coordinator or online at [www.state.tn.us/labor-wfd/mainforms.html](http://www.state.tn.us/labor-wfd/mainforms.html), or a materially substantial equivalent duplication approved by the Program Coordinator, shall be used in all cases to request an MIR three-physician listing. The Commissioner requires the request designate:
  - (a) All body part(s) or medical condition(s) to be evaluated, including whether mental impairment shall be evaluated;
  - (b) The names of all physicians that have previously evaluated, treated, or are currently evaluating or treating the claimant for the work-related injury at employer and/or employee expense;
  - (c) The names of all physicians made available to the claimant at the time of the injury (Form C-42). If an employer provides the claimant with the name of a group of physicians rather than with individual physician names, the same information shall be included on the request form;
  - (d) The state file number assigned to the claims.
- (4) The submitting party shall certify that all parties, as well as the Program Coordinator, have been sent the completed application form at the same time. The application will not be processed by the Program Coordinator until all required information has been provided.
- (5) Generating the three-physician listing.

## PROPOSED RULES

- (a) Within five (5) business days of receipt of the completed "Application for a Medical Impairment Rating," the Program Coordinator will produce a listing of three qualified physicians drawn from the Division's MIR Registry, from which one physician shall be designated to perform the evaluation. The three-physician listing created will be comprised of physicians qualified, based on the information provided by the physician and on their accreditation by the Program Coordinator, to perform evaluations of the body part(s) and/or medical condition(s) designated on the application for an evaluation, excluding those who have a conflict of interest as described in the Rules. Psychiatric or psychological evaluations regarding mental and/or behavioral impairment shall be performed by a psychiatrist.
  - (b) If an evaluation is requested for a particular area of expertise not represented in the MIR Registry, the Program Coordinator shall provide a three-physician listing upon the recommendation of the Medical Director. The Program Coordinator will verify qualifications prior to assigning a listing of Temporary MIR physicians. Approval to serve as a Temporary MIR physician shall be limited to the specific case for which services are requested.
  - (c) To guarantee randomness, all three-physician listings shall be derived from the computer-generated pool of qualified physicians. The pool of physician names will be kept confidential. The Program Coordinator will notify the parties in writing only the names and the medical specialties of the physicians on the listing.
- (6) MIR Registry physician selection process.
- (a) Within three (3) business days of the issuance of the three-physician listing by the Program Coordinator, the employer shall strike one name and inform the other party and the Program Coordinator of that name. Within three (3) business days of the date of receipt of that name from the employer, the claimant shall strike one of the two remaining names and inform the Program Coordinator and the employer of the name of the remaining physician, who will perform the evaluation.
  - (b) If the Program Coordinator is not notified of the selected physician within ten (10) calendar days of the date the Program Coordinator issued the three-physician listing, the Program Coordinator may randomly select one name from the three-physician listing to perform the evaluation. If one party fails to timely strike a name from the listing, the other party shall notify the Program Coordinator, within these ten (10) calendar days, and at the same time provide to the Program Coordinator the name that it wishes to strike. In that situation, the Program Coordinator will randomly select one physician from the remaining two, and that physician shall perform the evaluation. The Program Coordinator shall inform the parties of the name of the selected physician in writing.
  - (c) If a selected physician is unable to perform the evaluation, the Program Coordinator shall provide one replacement name to the original listing using the same criteria and process set forth above, and present that revised listing to the parties and each shall again strike one name according to the above procedures. Additionally, if a physician is removed from the three-physician listing for any reason other than having been struck by one of the parties, the Program Coordinator will issue one replacement physician name.
- (7) Appointment date.

## PROPOSED RULES

- (a) Within three (3) business days of providing or receiving notice of the physician selection, the Program Coordinator shall call the MIR Registry physician to schedule the evaluation, and shall immediately notify both parties, and the Workers' Compensation Specialist if currently assigned, of the date and time of the evaluation. Only after this notification should the employer or insurance carrier contact the MIR Registry physician and only to arrange for payment and for medical records submission required by these Rules.
- (8) Submission of Medical Records.
- (a) The employer's representative shall concurrently provide to the MIR registry physician and the claimant a complete copy of all pertinent medical records pertaining to the subject injury, postmarked or hand-delivered at least ten (10) calendar days prior to the evaluation or as otherwise arranged by the Program Coordinator with the MIR physician. If deemed necessary by the Program Coordinator, the claimant shall promptly sign a "MIR Waiver and Consent" permitting the release of information to the MIR physician. The form shall include the release of all existing medical reports relevant to the subject injury including all previous impairment rating reports, the actual images of all pertinent imaging studies, the reports of all imaging studies and diagnostic tests, all hospital admission "history and physical examination" documents, all hospital discharge summaries, and all operation reports.
  - (b) The employer's representative shall be responsible for promptly sending a copy of the consent form to all treating and evaluating physicians or other healthcare providers, diagnostic centers, and hospitals involved in the care of the claimant requiring the form to ensure that this information will be forwarded to the MIR physician prior to the date of the scheduled evaluation. If the employer's representative fails to adhere to these time limits, the claimant may submit all medical records he/she has in his/her possession no later than five (5) calendar days prior to the evaluation or as otherwise arranged by the Program Coordinator with the MIR registry physician.
  - (c) In cases involving untimely medical record submission by either party, the Program Coordinator at his/her sole discretion, may elect to reschedule the evaluation to allow the physician adequate time for record review. Otherwise, the physician shall perform the evaluation and shall produce an "MIR Impairment Rating Report" utilizing the information properly made available to the physician.
- (9) Form/Content of Medical Records Package.
- (a) The medical file shall include a dated cover sheet listing the claimant's name, MIR Registry physician's name, MIR Registry case number, date and time of the appointment, and the state file number. The medical file shall be in chronological order, by provider, and tabbed by year. It shall include a written summary by the treating physician with the range of dates of treatment. Medical records not meeting these requirements shall be resubmitted in the correct format within three (3) calendar days of notification by the Program Coordinator.
  - (b) Medical bills, adjustor notes, surveillance tapes, denials, vocational rehabilitation reports, non-treating case manager records or commentaries to the MIR Registry physician shall not be submitted without prior permission of the Program Coordinator. Medical depositions may be submitted as part of the medical records package only by written agreement of the parties.

PROPOSED RULES

- (10) Supplemental medical records shall be prepared in the same manner described above, and shall be mailed or hand-delivered by any party concurrently to the MIR Registry physician and the other party no later than five (5) calendar days prior to the date of the evaluation, or as otherwise arranged by the Program Coordinator.
- (11) Claimants can bring an adult friend or family member to the evaluation to provide comfort and reassurance. However, the accompanying person cannot be the claimant’s attorney, paralegal, or other legal representative or any other personnel employed by the claimant’s attorney or legal representative. The guest may be asked to leave the evaluation at the discretion of the MIR Registry physician. Any forms that the MIR physician requests to be completed should be completed by the claimant only. If the claimant needs assistance in completing these forms for any reason, the claimant should notify the MIR Registry physician prior to the evaluation so that assistance can be provided by the MIR Registry physician’s staff.
- (12) The claimant shall notify the Program Coordinator of the necessity for a language interpreter concurrently with his/her notification of the chosen physician’s name. The employer shall be responsible for arranging for the services of and paying for such language interpreter. The language interpreter shall be impartial and independent, and have no professional or personal affiliation with any party to the claim or to the MIR Registry physician.
- (13) When a claimant is required to travel outside a radius of fifteen (15) miles from the claimant’s residence or workplace, then such claimant shall be reimbursed by the employer for reasonable travel expenses as defined in the Act.

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

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

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

## PROPOSED RULES

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

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

## PROPOSED RULES

to the rescheduled MIR fee.

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

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

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

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

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

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

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

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

- (1) The MIR Registry physician's responsibilities prior to the evaluation are to:
  - (a) Review all materials provided by the parties subject to these Rules; and,
  - (b) Review the purpose of the evaluation and the impairment questions to be answered in the evaluation report.

## PROPOSED RULES

- (2) The MIR Registry physician's responsibilities following the evaluation are to:
  - (a) Consider all medical evidence obtained in the evaluation and provided by the parties subject to the Rules;
  - (b) Complete an "MIR Impairment Rating Report";
  - (c) Notify the Program Coordinator when the report has been completed;
  - (d) Send that complete report with all required attachments to the Program Coordinator only, via overnight delivery. The Program Coordinator will acknowledge, to the physician, receipt of the report.
- (3) No physician-patient relationship is created between the MIR physician and the claimant through the MIR Registry evaluation. The sole purpose of the evaluation is to establish an impairment rating and not to recommend future treatment or to provide a diagnosis or other medical advice.

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

### **0800-2-20-.11 REQUIREMENTS FOR THE "MIR IMPAIRMENT RATING REPORT."**

- (1) After conducting the evaluation, the MIR physician shall produce the "MIR Impairment Rating Report". The format, available by using the Program's electronic access, available upon request from the Program Coordinator or available online at [www.state.tn.us/labor-wfd/mainforms.html](http://www.state.tn.us/labor-wfd/mainforms.html), or a materially substantial equivalent approved by the Program Coordinator shall be used in all cases to detail the evaluation's results. The MIR physician shall first review the determination by the attending physician that the claimant has reached Maximum Medical Improvement (MMI).
- (2) If, after reviewing the records, taking a history from the claimant and performing the evaluation, the MIR Registry physician concurs with the attending doctor's determination of MMI, the report shall, at a minimum, contain the following:
  - (a) A brief description and overview of the claimant's medical history as it relates to the subject injury, including reviewing and recapping all previous treatments.
  - (b) A statement of concurrence with the attending doctor's determination of MMI;
  - (c) Pertinent details of the physical or psychiatric evaluation performed (both positive and negative findings);
  - (d) Results of any pertinent diagnostic tests performed (both positive and negative findings). Include copies of these tests with the report;
  - (e) An impairment rating consistent with the findings and utilizing a standard method as outlined in the applicable AMA Guides, calculated as a total to the whole person if appropriate. In cases not covered by the AMA Guides, an impairment rating by any appropriate method used and accepted by the medical community is allowed, however, a statement that the AMA Guides fails to cover the case as well as a statement of the system on which the rating was based shall be included;

## PROPOSED RULES

- (f) The rationale for the rating based on reasonable medical certainty, supported by specific references to the clinical findings, especially objective findings and supporting documentation including the specific rating system, sections, tables, figures, and AMA Guides page numbers, when appropriate, to clearly show how the rating was derived; and
- (g) A true or electronic signature and date by the MIR physician performing the evaluation certifying to the following:
  - 1. "It is my opinion, both within and to a reasonable degree of medical certainty that, based upon all information available to me at the time of the MIR impairment evaluation and by utilizing the relevant AMA Guides or other appropriate method as noted above, that the claimant has the permanent impairment so described in this report. I certify that the opinion furnished is my own, that this document accurately reflects my opinion, and that I am aware that my signature attests to its truthfulness. I further certify that my statement of qualifications to serve on the MIR Registry is both current and completely accurate."
- (3) If, after reviewing the records, taking a history from the claimant and performing the evaluation, the MIR physician does not concur with the attending doctor's determination of MMI, a report shall be completed similar to the one outlined above which documents and certifies to, in sufficient detail, the rationale for disagreeing and, if possible to determine, the expected date of full or partial recovery. The physician is still entitled to collect/retain the appropriate MIR fee.
- (4) Services rendered by an MIR Registry physician shall conclude upon the Program Coordinator's acceptance of the final "MIR Impairment Rating Report." An MIR report is final and accepted for the purpose of these Rules when it includes the requested determination regarding final medical impairment rating and any necessary worksheets, as determined by the Program Coordinator. Once the report has been accepted the Program Coordinator will distribute copies of the report to the other parties and the Workers' Compensation Specialist, if one is currently assigned. After acceptance of the "MIR Impairment Rating Report" the medical records file, including the final "MIR Impairment Rating Report," shall be stored and/or disposed of by the MIR registry physician in a manner used for similar health records containing private information and within a time frame consistent with the Tennessee Board of Medical Examiners' rules.

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

### **0800-2-20-.12 PEER REVIEW.**

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

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

## PROPOSED RULES

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

- (1) Written complaints regarding any MIR Registry physician shall be submitted to the Program Coordinator. The Commissioner or the Commissioner's designee, upon the advice of the Medical Director, may remove a physician from the MIR Registry permanently or temporarily by placing a physician on inactive status based upon any of the following grounds:
  - (a) Misrepresentation on the "Application for Appointment to the MIR Registry" as determined by the Program Coordinator;
  - (b) Failure to timely report a conflict of interest in a case assignment, as determined by the Program Coordinator;
  - (c) Refusal or substantial failure to comply with the provisions of these Rules, including, but not limited to, repeated failure to determine impairment ratings correctly using the AMA Guides, as determined by the Medical Director;
  - (d) Failure to maintain the requirements of the Rules, as determined by the Program Coordinator; or
  - (e) Any other reason for the good of the Registry as determined solely and exclusively by the Commissioner or the Commissioner's designee.
- (2) Upon receipt of a complaint regarding a MIR Registry physician, the Program Coordinator shall send written notice of the complaint to such physician, stating the grounds of the complaint, and notifying the physician that he or she is at risk of being removed from the MIR Registry.
  - (a) The physician shall have thirty (30) calendar days from the date the Notice of Complaint is issued to the physician in which to respond in writing to the complaint(s), and may submit any responsive supporting documentation to the Program Coordinator for consideration. Failure of the physician to submit a timely response to the Notice of Complaint may result in removal of the physician from the MIR Registry without further notice or recourse.
  - (b) The Commissioner or the Commissioner's designee, in consultation with the Medical Director, shall consider the complaint(s) and any response(s) from the physician in reaching a decision as to whether the physician shall be removed from the MIR Registry, and if removed, whether the removal will be permanent or temporary.
  - (c) Upon reaching a determination on the complaint(s), the Commissioner or the Commissioner's designee shall issue a written Notice of Determination and set forth the basis for the decision in such Notice. The determination set forth shall become final fifteen (15) days after issuance of the Notice of Determination, unless a timely request for reconsideration is received.
  - (d) A MIR Registry physician may seek reconsideration of an adverse decision from the Commissioner or the Commissioner's designee by submitting a request for reconsideration stating the grounds for such reconsideration to the Program Coordinator within fifteen (15) calendar days of the issuance of the Notice of Determination. The Commissioner or the Commissioner's designee may affirm, modify or reverse the initial determination upon reconsideration of the initial decision. The Commissioner or the Commissioner's designee shall issue a Notice of Determination upon Reconsideration which shall be the final decision.

## PROPOSED RULES

- (e) MIR Registry physicians shall remain active on the MIR Registry pending a final decision on any complaint(s).
- (3) A physician who has been removed from the MIR Registry by the Commissioner or the Commissioner's designee may apply for reinstatement six (6) months after the date of removal by submitting a written request to the Program Coordinator.

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

### **0800-2-20-.14 OTHER PENALTIES.**

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

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

### **0800-2-20-.15 TIME LIMITS.**

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

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

### **0800-2-20-.16 CLAIMANT COOPERATION.**

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

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

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

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

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

## PROPOSED RULES

The proposed rules set out herein were properly filed in the Department of State on the 15th day of June, 2005, and pursuant to the instructions set out above, and in the absence of the filing of an appropriate petition calling for a rulemaking hearing, will become effective on the 28th day of October, 2005. (06-19)

PROPOSED RULES

**DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT - 0800  
DIVISION OF LABOR STANDARDS**

**CHAPTER 0800-5-3  
BOARD OF EMPLOYEE ASSISTANCE PROFESSIONALS RULES**

Presented herein are proposed rules and amendments of the Board of Employee Assistance Professionals, Department of Labor and Workforce Development submitted pursuant to T.C.A. § 4-5-202 in lieu of a rulemaking hearing. It is the intent of the Board of Employee Assistance Professionals, Department of Labor and Workforce Development to promulgate these rules without a rulemaking hearing unless a petition requesting such hearing is filed within thirty (30) days of the publication date of the issue of the Tennessee Administrative Register in which the proposed rules and amendments are published. Such petition to be effective must be filed in the Division of Labor Standards of the Department of Labor and Workforce Development on the 16th Floor of the Parkway Towers Building, Suite 1606, located at 404 James Robertson Parkway, Nashville, TN 37243-0657, and in the Administrative Procedures Division of the Department of State, 8th Floor, Tennessee Tower, William R. Snodgrass Building, 312 Eighth Avenue North, Nashville, TN 37243-0310, and must be signed by twenty-five (25) persons who will be affected by the rules, or submitted by a municipality which will be affected by the rules, or an association of twenty-five (25) or more members, or any standing committee of the General Assembly.

For a copy of the proposed rules and amendments, contact: Mary Ellen Grace, Director of Labor Standards, Department of Labor and Workforce Development, 16th Floor of the Parkway Towers Building, Suite 1606, located at 404 James Robertson Parkway, Nashville, TN 37243-0657, 615-741-2858 (option 3).

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

**NEW RULES**

**TABLE OF CONTENTS**

0800-5-3-.07 Requirements for Internship  
0800-5-3-.08 Requirements for Licensure

0800-5-3-.09 Requirements for Renewal of License

**0800-5-3-.07 REQUIREMENTS FOR INTERNSHIP.**

- (1) To be eligible for licensure, an employee assistance intern must request an application packet from the Board and comply with the following requirements:
  - (a) Enter into a Board approved contractual agreement with a LEAP who will provide supervision.
  - (b) Submit a copy of your high school diploma or general education development (GED).
  - (c) Submit a completed application for EAP internship.
  - (d) Submit proof of current liability insurance, \$1,000,000/occurrence; \$3,000,000/aggregate.
  - (e) Submit an affidavit of applicant.

## PROPOSED RULES

- (f) Submit the intern application fee as required by Rule 0800-5-3-.05(4).
- (g) Submit every six (6) months until completion of the required hours in T.C.A. § 62-42-104 (a)(2):
  - 1. An EAP intern evaluation form that must be completed and jointly reviewed by the EAP intern and the supervising LEAP.
  - 2. Proof of at least five hundred (500) supervision hours that have been completed on the EAP intern supervision form. The supervision hours should not be duplicated on any EAP intern supervision forms.
    - (i) Supervision will be a combination of individual or group sessions until three thousand (3000) hours have been completed. Supervision must also be face to face with the supervising LEAP for at least two (2) hours a month.
    - (h) Submit proof of required CEH/PDH on a completed CEH/PDH form during the period of internship as required by Rules 0800-5-3-.03(1) and (3).

**Authority:** T.C.A. §§ 4-3-1411, 62-42-103, 62-42-104, and 62-42-119.

### **0800-5-3-.08 REQUIREMENTS FOR LICENSURE.**

- (1) Applications for licensure shall contain the following:
  - (a) Completed application for EAP licensure.
  - (b) Affidavit of applicant.
  - (c) Copy of your high school diploma or general education development (GED).
  - (d) Proof of current liability insurance, \$1,000,000/occurrence; \$3,000,000/aggregate.
  - (e) Employment Resume.
  - (f) Certified copy of nationally recognized professional certification, if applicable.
  - (g) Certified copy of licenses or certifications from other state(s), if the applicant is an out-of-state practitioner who resides or is employed in Tennessee.
  - (h) Application fee as required by Rule 0800-5-3-.05(1).
  - (i) Upon acceptance and approval of the application, the applicant will submit the appropriate initial license fee as required by Rule 0800-5-3-.05(2) before a state license will be issued.

**Authority:** T.C.A. §§ 4-3-1411, 62-42-103, 62-42-105, 62-42-106, 62-42-107, 62-42-112, and 62-42-119.

## PROPOSED RULES

### **0800-5-3-.09 REQUIREMENTS FOR RENEWAL OF LICENSE.**

- (1) All renewal applications shall contain the following:
  - (a) Completed renewal application to be returned to the Board on or before January 1 of each even-numbered year.
  - (b) Proof of required CEH/ PDH on a completed CEH/PDH form as required by Rule 0800-5-3-.03 (1) and (2)
  - (c) Proof of current liability insurance, \$1,000,000/occurrence; \$3,000,000/aggregate.
    1. The applicant shall include his or her name and license number on the proof of insurance form.
  - (d) Renewal license fee as required by Rule 0800-5-3-.05(3).

**Authority:** T.C.A. §§ 4-3-1411, 62-42-103, 62-42-105, 62-42-106, and 62-42-119.

## **AMENDMENTS**

Rule 0800-5-3-.02 Definitions is amended by deleting the rule in its entirety and substituting the following language so that as amended the rule shall read:

### **0800-5-3-.02 DEFINITIONS.**

- (1) "Clock hour" means sixty minutes in a continuing education activity. Providers who measure continuing education activities in "continuing education units" shall define them in clock hours.
- (2) "Continuing education" means education beyond the basic licensing educational requirement that is related to the practice of employee assistance professionals.
- (3) "Continuing education hour" or "Professional development hour" means one clock hour of training or professional development. Converting between continuing education hours (CEH) or professional development hours (PDH) and continuing education units (CEU) shall be as follows: 1.0 CEU equals 10 CEH or 10 PDH; 10 CEH or 10 PDH equals 1.0 CEU; and 1.0 CEH or 1.0 PDH equals 0.10 (1/10) CEU.
- (4) "EAP" means employee assistance professional.
- (5) "Intern/Supervisee" means an uncertified/unlicensed employee assistance intern - a counselor performing the duties of an employee assistance professional under the direct supervision of a licensed employee assistance professional.
- (6) "LEAP" means licensed employee assistance professional.
- (7) "Supervision" means ongoing monitoring, consultation, instruction and evaluations of the intern's (supervisee's) employee assistance activities. As used here, "monitoring" means the ability to oversee general activities; "instruction" means to provide or arrange ongoing training and devel-

## PROPOSED RULES

opment of employee assistance activities; “consultation” means to provide one-to-one review of employee assistance activity on a regularly scheduled basis; and “evaluation” means the written documentation of performance review.

- (8) “Supervisor” means a Tennessee state licensed employee assistance professional.

**Authority:** T.C.A. §§ 4-3-1411, 62-42-103, and 62-42-119.

Rule 0800-5-3-.03 Continuing Education is amended by deleting the rule in its entirety and substituting the following language so that as amended the rule shall read:

### **0800-5-3-.03 CONTINUING EDUCATION.**

- (1) All LEAPs and employee assistance interns shall complete either ten (10) continuing education hours (CEH) or ten (10) professional development hours (PDH) or a combination thereof in the areas of work organizations, human resources management, EAP policy administration, EAP direct services, chemical dependency and other addictions, or personal and psychological problems.
- (2) CEH/PDH will be submitted on a completed CEH/PDH form on or before January 1 of each year.
- (3) Interns shall meet the same CEH/PDH requirements, submitting CEH/PDH forms during the period of internship.

**Authority:** T.C.A. §§ 4-3-1411, 62-42-103, 62-42-104, and 62-42-119.

Rule 0800-5-3-.05 Fees is amended by deleting the rule in its entirety and substituting the following language so that as amended the rule shall read:

### **0800-5-3-.05 FEES.**

- (1) The applicant must submit an application fee of fifty dollars (\$50.00) in order to be considered for licensure by the Board. The fee shall be nonrefundable.
- (2) The initial license fee shall be two hundred dollars (\$200.00) for two (2) years and may be prorated.
  - (a) The licensure fee will be prorated on a quarterly basis at a rate of twenty-five dollars (\$25.00) per quarter.
- (3) The renewal license fee shall be two hundred dollars (\$200.00) for a two (2) year period.
- (4) The intern application fee shall be fifty dollars (\$50.00). The fee shall be nonrefundable.

**Authority:** T.C.A. §§4-3-1411, 62-42-103, 62-42-105, 62-42-106, 62-42-107, and 62-42-119.

## PROPOSED RULES

The proposed rules set out herein were properly filed in the Department of State on the 14th day of June, 2005, and pursuant to the instructions set out above, and in the absence of the filing of an appropriate petition calling for a rulemaking hearing, will become effective on the 28th day of October, 2005. (06-13)

PROPOSED RULES

**THE TENNESSEE BOARD OF REGENTS - 0260  
STATE UNIVERSITY AND COMMUNITY COLLEGE SYSTEM OF TENNESSEE**

**AUSTIN PEAY STATE UNIVERSITY**

**CHAPTER 0240-3-1  
STUDENT DISCIPLINARY RULES**

Presented herein are proposed amendments of the Tennessee Board of Regents submitted pursuant to Tennessee Code Annotated, §4-5-202 in lieu of a rulemaking hearing. It is the intent of the Tennessee Board of Regents to promulgate these rules without a rulemaking hearing unless a petition requesting such hearing is filed within thirty (30) days of the publication date of the issue of the Tennessee Administrative Register in which the proposed amendments are published. Such petition to be effective must be filed in Suite 350 of the Genesco Park Building located at 1415 Murfreesboro Road, Nashville, TN 37217 and in the Department of State, Eighth Floor, William R. Snodgrass Tower, 312 Eighth Avenue, North, Nashville, TN 37243, and must be signed by twenty-five (25) persons who will be affected by the rules, or submitted by a municipality which will be affected by the rule, or an association of twenty-five (25) or more members, or any standing committee of the General Assembly.

For a copy of this proposed rule, contact: Mary M. Slater, 1415 Murfreesboro Road, Suite 350, Nashville, Tennessee 37217, Tennessee Board of Regents, 615-366-4438.

The text of the proposed amendments is as follows:

**AMENDMENTS**

Subparagraphs (b) and (c) of paragraph (2) of Rule 0240-3-1-.02 Disciplinary Offenses are amended by deleting the text of the subparagraphs and substituting the following language, so that, as amended, subparagraphs (b) and (c) shall read:

- (b) Hazing. Violations of this section include any act of hazing, on or off the Austin Peay State University campus or University controlled property, by an Austin Peay State University individual, group of individuals or registered student organization. Hazing means any intentional or reckless act in Tennessee on or off the property of any higher education institution by one (1) student acting alone or with others which is directed against any other student, that endangers the mental or physical health or safety of that student, or which induces or coerces a student to endanger such student's mental or physical health or safety. Hazing does not include customary athletic events or similar contests or competitions, and is limited to those actions taken and situations created in connection with initiation into or affiliation with any organization.
- (c) Disorderly conduct. Any individual or group behavior which is abusive, obscene, lewd, indecent, violent, excessively noisy, disorderly, or which unreasonably disturbs [or may reasonably provoke] other groups or individuals [this may include verbal abuse, non-verbal gestures, and] inappropriate behavior resulting from the use of or being under the influence of alcoholic beverages or drugs);

Subparagraph (g) of paragraph (2) of Rule 0240-3-1-.02 Disciplinary Offenses is further amended by deleting the text of the subparagraph and substituting the following language, so that, as amended, subparagraph (g) shall read:

## PROPOSED RULES

- (g) Misuse of Austin Peay State University documents or identification cards. Any forgery, alteration of or unauthorized use of University documents, forms, records or identification cards, including the giving of any false information, or withholding of necessary information, in connection with a student's admission, enrollment or status in the University; failure to carry the APSU ID card at all times or to show it upon proper request.

Subparagraph (l) of paragraph (2) of Rule 0240-3-1-.02 Disciplinary Offenses is further amended by deleting the text of the subparagraph and substituting the following language, so that, as amended, subparagraph (l) shall read:

- (l) Gambling. Participation in any gambling or gambling-related activities on campus or on University controlled property that have not been approved and/or administered in accordance with the laws and regulations of the State of Tennessee. Any permitted gambling or gambling-related activity must also be operated under the auspices of the University's foundation.

Subparagraph (w) of paragraph (2) of Rule 0240-3-1-.02 Disciplinary Offenses is further amended by deleting the text of the subparagraph and substituting the following language, so that, as amended, subparagraph (w) shall read:

- (w) Tobacco. The use of tobacco products is prohibited in University buildings (except in individual resident rooms or otherwise designated areas) and in vehicles owned or operated exclusively by the University. (See APSU Policy 99-022 for further information and specifications concerning areas outside entrances to buildings.)

**Authority:** T.C.A. §49-8-203.

Paragraph (1) of Rule 0240-3-1-.04 Disciplinary Sanctions is amended by deleting the text of the paragraph and substituting the following language, so that, as amended, paragraph (1) shall read:

- (1) Upon a determination that a student or organization has violated any of the rules, regulations or disciplinary offenses set forth in these regulations, the following disciplinary sanctions may be imposed, either singly or in combination, by the appropriate institution officials. (Note: The final results of disciplinary proceedings, as the term 'final results' is defined by Tennessee Law, in which the student perpetrator is deemed to have committed a violation of the University's student disciplinary rules for an offense that includes violent acts or nonforcible sex offenses, as defined by Tennessee Law, may be released without permission of the student perpetrator.)

**Authority:** T.C.A. §49-8-203.

Subparagraph (a) of paragraph (1) of Rule 0240-3-1-.05 Disciplinary Procedures is amended by deleting the text of the subparagraph and substitute the following language, so that, as amended, subparagraph (a) shall read:

- (a) Procedures conforming to the Tennessee Uniform Administrative Procedures Act. All cases which may result in (i) suspension or expulsion of a student from the institution for disciplinary reasons, or (ii) revocation of registration of a student organization during the term of the registration are subject to the contested case provisions of the Tennessee Uniform Administrative Procedures Act (TUAPA) and shall be processed in accordance

## PROPOSED RULES

with the uniform contested case procedures adopted by the Board of Regents, unless the student waives those procedures in writing and elects to have his or her case heard by the University Hearing Board.

**Authority:** T.C.A. §49-8-203.

Subparagraph (a) of paragraph (2) of Rule 0240-3-1-.07 Traffic and Parking Regulations is amended by adding a sentence at the beginning of the subparagraph, so that, as amended, subparagraph (a) shall read:

- (a) Every Austin Peay State University student, faculty and staff member who chooses to park a vehicle on campus at any time must obtain and display a current, valid parking decal. All members of the campus community will be afforded the opportunity to become familiar with these regulations. All persons receiving a parking decal will be offered a copy of the parking regulations along with a detailed map of parking locations by category. Persons are expected to read and familiarize themselves with these regulations. Accordingly, when found in violation, ignorance of these regulations is no excuse or defense.

Subparagraph (e) of paragraph (2) of Rule 0240-3-1-.07 Traffic and Parking Regulations is further amended by deleting the last sentence of the paragraph, so that, as amended, subparagraph (e) shall read:

- (e) Austin Peay State University acknowledges that there are a limited number of parking spaces within the immediate vicinity of many facilities. Notwithstanding, there are a sufficient number of total spaces on campus grounds and adjacent city streets for everyone to park legally. Possession of a valid decal is the recipient's right to secure available, legal parking on campus - it is not a guarantee for parking in particular categories of spaces. The limited number of designated spaces for visitors, resident hall students, faculty/staff and disabled persons mandates stringent enforcement of parking regulations. Everyone is encouraged to respect the rights of others, and to allow sufficient time, usually a maximum of 5-10 minutes, to walk from available parking spaces to classrooms or facilities.

Subparagraph (f) of paragraph (2) of Rule 0240-3-1-.07 Traffic and Parking Regulations is further amended by deleting the words "or Director of Housing," so that, as amended, subparagraph (f) shall read:

- (f) Vehicles parked on campus are required to be maintained in operating condition. No maintenance involving replacement of major components such as engines, or the replacement of hazardous fluids such as oil and transmission fluid, is authorized without consent of the Director of Safety/Chief of Campus Police. Vehicles not maintained in operating condition and left un-moved for extended periods of time will be considered abandoned, and disposed of consistent with state law.

Subparagraph (a) of paragraph (3) of Rule 0240-3-1-.07 Traffic and Parking Regulations is further amended by deleting the text of the subparagraph and substituting the following language, so that, as amended, subparagraph (a) shall read:

- (a) Faculty and Staff spaces. These spaces are also authorized for those with visitor passes and disabled decals at all hours. Parking in faculty/staff spaces is not enforced on days when the University is officially closed (weekends, holidays, etc.), and not enforced from 6:00 p.m. through 6:00 a.m. when school is in session.

Part 1. of subparagraph (a) of paragraph (4) of Rule 0240-3-1-.07 Traffic and Parking Regulations is further amended by deleting the text of the part and substituting the following language, so that, as amended, part 1. shall read:

## PROPOSED RULES

1. Decals are only valid for one calendar year, beginning with the first day of classes for the Fall Semester. A new decal must be obtained at the beginning of each academic year. Annual parking fee for all persons is no less than \$25.00 nor more than \$30.00 per decal, except disabled persons' decals, which are free of charge. The annual registration period lasts from August 16 through August 15. The University is authorized to charge a prorated fee for summer or other reduced periods.

Part 3. of subparagraph (a) of paragraph (4) of Rule 0240-3-1-.07 Traffic and Parking Regulations is further amended by deleting the text of the part and substituting the following language, so that, as amended, part 3. shall read:

3. Additional decals. Because decals may be used on any vehicle desired under control of the operator/decal holder, only Emerald Hills/married housing students and families qualify automatically for an additional decal. Only students/faculty/staff that present extraordinary circumstances in writing, approved by the Director/Chief, are authorized an additional decal. Additional decals cost no less than \$25.00 or more than \$30.00. Resident hall students will not be awarded an additional decal. Everyone is reminded and encouraged to use the temporary and visitor pass provisions below when desired.

**Authority:** T.C.A. §49-8-203.

The proposed rules set out herein were properly filed in the Department of State on the 28th day of June, 2005, and pursuant to the instructions set out above, and in the absence of the filing of an appropriate petition calling for a rulemaking hearing, will become effective on the 28th day of October, 2005. (06-38)

PROPOSED RULES

**THE TENNESSEE BOARD OF REGENTS - 0240  
STATE UNIVERSITY AND COMMUNITY COLLEGE SYSTEM OF TENNESSEE**

**EAST TENNESSEE STATE UNIVERSITY  
CHAPTER 0240-3-2  
STUDENT DISCIPLINARY RULES**

Presented herein are proposed amendments of the Tennessee Board of Regents submitted pursuant to Tennessee Code Annotated, §4-5-202 in lieu of a rulemaking hearing. It is the intent of the Tennessee Board of Regents to promulgate these rules without a rulemaking hearing unless a petition requesting such hearing is filed within thirty (30) days of the publication date of the issue of the Tennessee Administrative Register in which the proposed amendments are published. Such petition to be effective must be filed in Suite 350 of the Genesco Park Building located at 1415 Murfreesboro Road, Nashville, TN 37217 and in the Department of State, Eighth Floor, William R. Snodgrass Tower, 312 Eighth Avenue, North, Nashville, TN 37243, and must be signed by twenty-five (25) persons who will be affected by the rules, or submitted by a municipality which will be affected by the rule, or an association of twenty-five (25) or more members, or any standing committee of the General Assembly.

For a copy of this proposed rule, contact: Mary M. Slater, 1415 Murfreesboro Road, Suite 350, Nashville, Tennessee 37217, Tennessee Board of Regents, 615-366-4438.

The text of the proposed amendments is as follows:

**AMENDMENTS**

Subparagraph (k) of paragraph (2) of Rule 0240-3-2-.02 Disciplinary Offenses is amended by deleting the text of the subparagraph and substituting the following language, so that, as amended, subparagraph (k) shall read:

- (k) Drugs: The unlawful use, possession, distribution, sale or manufacture, of any drug or controlled substance (including any stimulant, depressant, narcotic, or hallucinogenic drug or substance, or marijuana); being under the influence of any such drug or controlled substance, possession of drug paraphernalia, or the misuse of legally prescribed or “over the counter” drugs on property owned or controlled by the institution; at an institution-sponsored event; or property owned or controlled by an affiliated clinical site; or in violation of any term of the East Tennessee State University Drug-Free Schools and Communities Policy Statement.

Part 8. of subparagraph (v) of paragraph (2) of Rule 0240-3-2-.02 Disciplinary Offenses is further amended by deleting the text of the part and substituting the following language, so that, as amended, part 8. shall read:

- 8. Threatening the accuser or attempting to influence another person to commit an abuse of the judicial system.

**Authority:** T.C.A. §49-8-203.

## PROPOSED RULES

Subparagraphs (k), (l) and (m) of paragraph (2) of Rule 0240-3-2-.04 Disciplinary Sanctions are amended by deleting the text of the subparagraphs and substituting the following language, so that, as amended, subparagraphs (k), (l) and (m) shall read:

- (k) Suspension. If a student or student organization is suspended, the student or student organization is separated from the institution for a stated period of time with condition of readmission or registration, respectively, stated in the notice of suspension.
- (l) Expulsion. Expulsion entails a permanent separation from the institution. The imposition of this sanction is a permanent bar to the student's readmission to the institution or to the student organization's registration with the institution.
- (m) Interim or summary suspension. Though as a general rule, the status of a student accused of violations of these regulations should not be altered until a final determination has been made in regard to the charges against him, summary suspension may be imposed upon a finding by the appropriate institutional official that the continued presence of the accused on campus constitutes an immediate threat to the physical safety and well-being of the accused or of any other member of the institution community or its guest, destruction of property, or substantial disruption of classroom or other campus activities. An interim suspension may be invoked only by the president or his designee, the Provost/Vice President for Academic Affairs, or the Senior Associate Vice President for Student Affairs and Chief Student Affairs Officer in consultation with other University officials. In any case of immediate suspension, the student shall be given an opportunity at the time of the decision or immediately thereafter to contest the suspension, and if there are disputed issues of fact or cause and effect, the student shall be provided a hearing on the suspension as soon as practicable.

**Authority:** T.C.A. §49-8-203.

Subparts (ii) and (iii) of part 2. of subparagraph (a) of paragraph (2) of Rule 0240-3-2-.05 Disciplinary Procedures are further amended by deleting the text of the subparts and substituting the following language, so that, as amended, subparts (ii) and (iii) shall read:

- (ii) The Director of Student Activities, where the alleged violation is of the regulations of the Inter-Fraternity Council (IFC) or the Panhellenic Council (PC), or the Pan-Hellenic Council (PC).
- (iii) The Dean of Students, where the alleged violation is of University regulations other than those of the RHA, the IFC or the PC.

Part 6. of subparagraph (a) of paragraph (2) of Rule 0240-3-2-.05 Disciplinary Procedures is further amended by deleting the word "Assistant" so that, as amended, part 6. shall read:

- 6. The Dean of Students is authorized to hear under the Institutional Administrative Procedures all cases of alleged misconduct of students from April 15 through September 15 of each year if judicial boards are not functioning.

Subparts (i) through (iii) of part 1. of subparagraph (b) of paragraph (2) of Rule 0240-3-2-.05 Disciplinary Procedures are further amended by deleting the text of the subparts and substituting the following language, so that, as amended, subparts (i) through (iii) shall read:

## PROPOSED RULES

- (i) The Director of Housing, Assistant Director of Housing, Area Coordinators, or Apartments Manager, where the alleged violation is of the regulations of the Residence Hall Association (RHA).
- (ii) The Director of Student Activities, where the alleged violation is of the regulations of the Inter-Fraternity Council (IFC), the Panhellenic Council (PC), or the Pan-Hellenic Council.
- (iii) The Dean of Students where the alleged violation is of University regulations other than those of the RHA, the IFC or the PCs.

Subparts (i) and (ii) of part 5. of subparagraph (b) of paragraph (2) of Rule 0240-3-2-.05 Disciplinary Procedures are further amended by deleting the text of the subparts and substituting the following language, so that, as amended, subparts (i) and (ii) shall read:

- (i) Cases heard by the Director of Housing or the Director of Student Activities may be appealed to the Dean of Students.
- (ii) Cases heard by the Dean of Students may be appealed to the Senior Associate Vice President for Student Affairs and the Chief Student Affairs Officer.

Part 1. of subparagraph (c) of paragraph (3) of Rule 0240-3-2-.05 Disciplinary Procedures is further amended by deleting the text of the part and substituting the following language, so that, as amended, part 1. shall read:

1. The University Judicial Committee shall be composed of the Dean of Students, President of the Student Government Association (SGA), Chief Justice of SGA, an Associate Justice, and three (3) faculty. Alternates for the Chief Justice and Associate Justice shall be selected by the SGA to hear cases on appeal from the Student Court.

Part 1. of subparagraph (d) of paragraph (3) of Rule 0240-3-2-.05 Disciplinary Procedures is amended by deleting the text of the part and substituting the following language, so that, as amended, part 1. shall read:

1. The University Judicial Committee shall exercise the highest judicial authority on campus, next to that of the Senior Associate Vice President for Student Affairs and Chief Student Affairs Officer and the University President or his designee. This committee's authority shall include the right to suspend or expel a student. The University President reserves the right to uphold or reverse any decision made by any judicial body.

Subpart (i) of subparagraph (e) of paragraph (3) of Rule 0240-3-2-.05 Disciplinary Procedures is further amended by deleting the text of the subpart and substituting the following language, so that, as amended, subpart (i) shall read:

- (i) Violations of official University regulations other than regulations of the RHA, the IFC or the PCs shall be reported directly to the Dean of Students who shall either direct that the case be reviewed under the Institutional Administrative Procedures or referred to the appropriate judicial board.

Item (II) of subpart (ii) of part 1. of subparagraph (e) of paragraph (3) of Rule 0240-3-2-.05 Disciplinary Procedures is further amended by deleting the text of the item and substituting the following language, so that, as amended, item (II) shall read:

## PROPOSED RULES

- (II) The IFC-PC authorities shall report the case to the Director of Student Activities who shall either direct that the case be reviewed under the Institutional Administrative Procedures or referred to the Inter-Fraternity Judicial Board, the Panhellenic Judicial Board or the Pan-Hellenic Judicial Committee.

Subpart (iii) of part 1. of subparagraph (e) of paragraph (3) of Rule 0240-3-2-.05 is further amended by deleting the word "Assistant" so that, as amended, subpart (iii) shall read:

- (iii) Violations of the Student Government Constitution or Code of Laws shall be reported to the Student Government Vice President, who shall refer the case to the Dean of Students. The Dean of Students shall direct that the case be heard by the Student Court.

Part 2. of subparagraph (e) of paragraph (3) of Rule 0240-3-2-.05 Disciplinary Procedures is further amended by deleting the text of the part and substituting the following language, so that, as amended, part 2. shall read:

- 2. All judicial decisions must be reported in writing to the Dean of Students within two (2) class days from such time as the decision has been reached.

Part 5. of subparagraph (e) of paragraph (3) of Rule 0240-3-2-.05 Disciplinary Procedures is further amended by deleting the word "Assistant" so that, as amended, part 5. shall read:

- 5. All official correspondence concerning the decision of a judicial board, court, or committee shall be executed by the Dean of Students or his/her designated representative except in cases involving interpretation of the Student Government Constitution or Code of Laws. The Chief Justice of the Student Court shall make a written report of the decision and the circumstances surrounding it, taking care to exclude any information of a personal nature, to the Secretary of Legislative Affairs.

Part 7. of subparagraph (e) of paragraph (3) of Rule 0240-3-2-.05 Disciplinary Procedures is further amended by deleting the text of the part and substituting the following language, so that, as amended, part 7. shall read:

- 7. All subsequent hearings concerning readmission of students or reinstatement of organizational charters shall be initiated through the Dean of Students or his/her designated representative.

Subparts (i) and (ii) of part 1. of subparagraph (f) of paragraph (5) of Rule 0240-3-2-.05 Disciplinary Procedures are further amended by deleting the word "Assistant" so that, as amended, subparts (i) and (ii) shall read:

- (i) The University Judicial Committee shall hear those cases involving a student who is accused of violating general University regulations and who, if found guilty, may be subjected to suspension or expulsion from the institution, and other cases deemed appropriate by the Dean of Students.
- (ii) The Student Court shall have original jurisdiction in those cases involving alleged violations of general University regulations which do not warrant suspension or expulsion. The Student Court shall also hear those cases involving alleged violations of the Student Government Constitution or Code of Laws, and any other cases deemed appropriate by the Dean of Students.

## PROPOSED RULES

Part 1. of subparagraph (g) of paragraph (3) of Rule 0240-3-2-.05 Disciplinary Procedures is further amended by deleting the text of the part and substituting the following language, so that, as amended, part 1. shall read:

1. All cases may be appealed by the student or organization in question to the next higher judicial authority in accordance with the Appeal Procedures provided below. The right to appeal to the next judicial authority shall be afforded only to the accused.

Subparts (i) through (iii) of part 3. of subparagraph (g) of paragraph (3) of Rule 0240-3-2-.05 Disciplinary Procedures are further amended by deleting the text of the subparts and substituting the following language, so that, as amended, subparts (i) through (iii) shall read:

- (i) If the accused desires to appeal, a statement of reasons for appealing must be forwarded to the Dean of Students. This statement must be filed by the accused within three (3) days following receipt of a copy of the decision being appealed.
- (ii) The statement of reasons for appeal will be forwarded to the appropriate appeal board or officer, which will set a date for reviewing the case and notify the accuser.
- (iii) The appeal board or officer, upon reviewing the case, will have several options. The original decision may be affirmed or reversed. In cases where the original action is inappropriate as a result of issues involved in the appeal, the appeal board or officer may revert the case back to the original board or hearing officer, modify the original action, or hold a completely new hearing. The accuser will be notified of the outcome, as permitted under Tennessee law.

Subparagraphs (d) and (e) of paragraph (6) of Rule 0240-3-2-.05 Disciplinary Procedures are further amended by deleting the text of the subparagraphs and substituting the following language, so that, as amended, subparagraphs (d) and (e) shall read:

- (d) Student organizations are vicariously liable for the conduct and action of each member and invited guest of the organization while acting in the capacity of a member or while attending or participating in any activity of the organization.
- (e) All student organizations shall be registered with the University prior to engaging in any organizational activity. (See TBR Policy No. 3:01:01:00). In addition, Greek letter social organizations are required to be members of one of the Greek governing councils on campus.

Part 1. of subparagraph (f) of paragraph (6) of Rule 0240-3-2-.05 Disciplinary Procedures is further amended by deleting the text of the part and substituting the following language, so that, as amended, Part 1. shall read:

1. A "student organizational function" is any meeting, event, banquet or program for social educational, recreational, cultural or spiritual purpose(s) planned and/or attended by members and/or their invited guests.

Parts 1. and 2. of subparagraph (g) of paragraph (6) of Rule 0240-3-2-.05 Disciplinary Procedures are further amended by deleting the text of the parts and substituting the following language, so that, as amended, parts 1. and 2. shall read:

## PROPOSED RULES

1. All student organizational functions involving the serving or consumption of alcohol shall be registered with the Student Organization Resource Center at least seven (7) business days prior to the date of the function (see Procedures for Student Organization Events with Alcohol -- available in the Student Organization Resource Center). When functions are to take place in University owned, leased or controlled property, policies concerning use of that property should be consulted and must be complied with.
2. Student organizational functions where alcohol will be present are limited to houses owned by social fraternities recognized by ETSU and commercial establishments owned by licensed and insured third party vendors. Third party vendor locations are subject to administrative approval.

Part 4. of subparagraph (g) of paragraph (6) of Rule 0240-3-2-.05 Disciplinary Procedures is further amended by deleting the text of the part and substituting the following language, so that, as amended, part 4. shall read:

4. Alcoholic beverages are permitted at functions only on a "bring your own can" basis or through a contract with a licensed server at a commercial establishment and shall not be made available on a self-serve basis. That is, students attending functions shall not have open or unlimited access to alcoholic beverages.

Part 7. of subparagraph (g) of paragraph (6) of Rule 0240-3-2-.05 Disciplinary Procedures is further amended by deleting the text of the part and substituting the following language, so that, as amended, part 7. shall read:

7. Any student organizational function at which alcohol is present must have a minimum of two (2) bonded security guards present at the site of the function.

Subparagraph (g) of paragraph (6) of Rule 0240-3-2-.05 Disciplinary Procedures is further amended by adding a new part 8. New part 8. shall read:

8. On an annual basis by August 1st, all social fraternities with houses are required to submit a current report from the fire marshal approving the house for occupancy and specifying the capacity limits of the facility, including the capacity limits of public areas. The report must be submitted in writing to the Coordinator of Greek Life. Attendance at student organizational functions must be restricted to the facility's public areas. The capacity limits of the public areas are determined by the fire marshal. In houses of social fraternities recognized by ETSU, attendance at student organizational functions with alcohol will not exceed two (2) invited guests for each active organization member, regardless of the capacity of the facility.

Subparagraphs (h) and (i) of paragraph (6) of Rule 0240-3-2-.05 Disciplinary Procedures are further amended by deleting text of the subparagraphs and substituting the following language, so that, as amended, subparagraph (h) and (i) shall read:

- (h) Complaints about a student organization shall be brought to the attention of the Director of Student Activities. Mediation among parties may result or disciplinary charges may be referred to the ETSU Judicial System for hearing.

## PROPOSED RULES

- (i) Student Organization Sanctions. Any registered student organization may be subject to the following disciplinary sanctions, as listed here and defined in Section 0240-3-2-.04 Disciplinary Sanctions: warning, reprimand, restitution, probation, suspension of registration, withdrawal of registration. These sanctions may be imposed either singly or in combination, and such action will be taken only pursuant to disciplinary procedures established by these rules.

**Authority:** T.C.A. §49-8-203.

The proposed rules set out herein were properly filed in the Department of State on the 28th day of June, 2005, and pursuant to the instructions set out above, and in the absence of the filing of an appropriate petition calling for a rulemaking hearing, will become effective on the 28th day of October, 2005. (06-39)

PROPOSED RULES

**THE TENNESSEE BOARD OF REGENTS - 0240  
STATE UNIVERSITY AND COMMUNITY COLLEGE SYSTEM OF TENNESSEE**

**THE UNIVERSITY OF MEMPHIS**

**CHAPTER 0240-3-3  
STUDENT DISCIPLINARY RULES**

Presented herein are proposed amendments of the Tennessee Board of Regents submitted pursuant to Tennessee Code Annotated, §4-5-202 in lieu of a rulemaking hearing. It is the intent of the Tennessee Board of Regents to promulgate these rules without a rulemaking hearing unless a petition requesting such hearing is filed within thirty (30) days of the publication date of the issue of the Tennessee Administrative Register in which the proposed amendments are published. Such petition to be effective must be filed in Suite 350 of the Genesco Park Building located at 1415 Murfreesboro Road, Nashville, TN 37217 and in the Department of State, Eighth Floor, William R. Snodgrass Tower, 312 Eighth Avenue, North, Nashville, TN 37243, and must be signed by twenty-five (25) persons who will be affected by the rules, or submitted by a municipality which will be affected by the rule, or an association of twenty-five (25) or more members, or any standing committee of the General Assembly.

For a copy of this proposed rule, contact: Mary M. Slater, 1415 Murfreesboro Road, Suite 350, Nashville, Tennessee 37217, Tennessee Board of Regents, 615-366-4438.

The text of the proposed amendments is as follows:

**AMENDMENTS**

Paragraphs (8) through (10) of Rule 0240-3-3-.02 Definitions are amended by deleting the text of the paragraphs and substituting the following language, so that, as amended, paragraphs (8) through (10) shall read:

- (8) The term “disciplinary body” means any person or persons authorized by the President of the University to determine whether a student has violated the Code of Student Rights and Responsibilities and to recommend imposition of sanctions. The term “disciplinary body” does not include the University Appeals Committee or the President of the University.
- (9) The term “Office of Student Judicial and Ethical Programs” means a University official authorized by the Vice President of Student Affairs to file charges and to impose sanctions on students who choose to admit to violation of the Code of Student Rights and Responsibilities. The duties of the Office of Student Judicial and Ethical Programs will usually be performed by the Assistant Dean of Students for the Office of Judicial Affairs; however, the Vice President of Student Affairs may appoint another individual to perform the duties of the Office of Student Judicial and Ethical Programs.
- (10) The term “University Appeals Committee” means any person or persons authorized by the President to consider an appeal from a disciplinary body’s determination that a student has violated the Code of Student Rights and Responsibilities, or from sanctions imposed by the Office of Student Judicial and Ethical Programs.

## PROPOSED RULES

Paragraph (13) of Rule 0240-3-3-.02 Definitions is further amended by deleting the text of the paragraph and substituting the following language, so that, as amended, paragraph (13) shall read:

- (13) The "Vice President of Student Affairs" is that person designated by the University President to be responsible for the administration of the Code of Student Rights and Responsibilities.

**Authority:** T.C.A. §49-8-203.

Rule 0240-3-3-.03 Judicial Authority is amended by deleting the text of the title and substituting the following language, so that, as amended, Rule 0240-3-3-.03 shall read:

### **0240-3-3-.03 DISCIPLINARY AUTHORITY.**

Subparagraph (d) of paragraph (1) of Rule 0240-3-3-.03 Disciplinary Authority is further amended by deleting the text of the subparagraph and substituting the following language, so that, as amended, subparagraph (d) shall read:

- (d) Hearing before an Administrator - If a student chooses to admit violation of a provision of the Code, the student may either accept the sanction proposed by the Office of Student Judicial and Ethical Programs, or choose to have a hearing before another administrator appointed by the Vice President of Student Affairs regarding his or her sanction. At this hearing, the student may present witnesses and other evidence relevant to the offense that may mitigate in the student's favor.

Paragraphs (2) through (4) of Rule 0240-3-3-.03 Disciplinary Authority are further amended by deleting paragraphs (2) through (4) in their entirety.

**Authority:** T.C.A. §49-8-203.

Rule 0240-3-3-.04 Proscribed Conduct is amended by adding text to the end of the title, so that, as amended, the title of Rule 0240-3-3-.04 shall read:

### **0240-3-3-.04 PROSCRIBED CONDUCT BY STUDENTS AND UNIVERSITY JURISDICTION.**

Paragraph (1) of Rule 0240-3-3-.04 Proscribed Conduct by Students and University Jurisdiction is further amended by deleting the text of the paragraph and substituting the following language, so that, as amended, paragraph (1) shall read:

- (1) Generally, University jurisdiction and discipline shall be limited to conduct which occurs on University premises or conduct occurring off-campus which adversely affects the University's educational mission and/or objectives. Any student found to have committed the following misconduct is subject to the disciplinary sanctions outlined below:

Paragraph (2) of Rule 0240-3-3-.04 Proscribed Conduct by Students and University Jurisdiction is further amended by deleting the title "Prohibitive Conduct," so that, as amended, paragraph (2) shall read:

- (2) Any student found to have committed the following misconduct is subject to the disciplinary sanctions outlined in Rule 02403-3-.06 (2) below:

## PROPOSED RULES

Subparagraphs (b) and (c) of paragraph (3) of Rule 0240-3-3-.04 Proscribed Conduct by Students and University Jurisdiction are further amended by deleting the text of the subparagraphs and substituting the following language, so that, as amended, subparagraphs (b) and (c) shall read:

- (b) University disciplinary proceedings may be instituted against a student charged with violation of a law which is also a violation of the Code of Student Rights and Responsibilities, for example, if both violations result from the same factual situation, without regard to the pendency of civil litigation in court or criminal arrest and prosecution. Proceedings under this Code of Student Rights and Responsibilities may be carried out prior to, simultaneously with, or following civil or criminal proceedings off-campus.
- (c) When a student is charged by federal, state, or local authorities with a violation of law, the University will not request or agree to special consideration for that individual because of his or her status as a student. If the alleged offense is also the subject of a proceeding before a disciplinary body under the Code of Student Rights and Responsibilities, however, the University may advise off-campus authorities of the existence of the Code of Student Rights and Responsibilities and of how such matters will be handled internally within the University community consistent with student record confidentiality requirements under state and federal law. The University will cooperate fully with law enforcement of criminal law on campus and in the conditions imposed by criminal courts for the rehabilitation of student violators. Individual students and faculty members, acting in their personal capacities, remain free to interact with governmental representatives as they deem appropriate.

Paragraph (4) of Rule 0240-3-3-.04 Proscribed Conduct by Students and University Jurisdiction is further amended by deleting the first sentence of the paragraph, so that, as amended, paragraph (4) shall read:

- (4) The procedures described under the Tennessee Uniform Administrative Procedures Act represent an alternative route when the alleged misconduct is such that the University seeks to impose a penalty of (1) suspension or expulsion from the University for disciplinary reasons or (2) revocation of registration of a student organization during the term of the registration. In such cases, the student elects the procedures of his or her choices.

**Authority:** *T.C.A. §49-8-203.*

Paragraph (1) of Rule 0240-3-3-.05 Academic Misconduct is amended by deleting the text of the paragraph and substituting the following language, so that, as amended, paragraph (1) shall read:

- (1) Proceedings before the Academic Integrity Committee may be initiated by a faculty member or student as provided below:

Subparagraph (a) of paragraph (1) of Rule 0240-3-3-.05 Academic Misconduct is further amended by deleting the text of the subparagraph and substituting the following language, so that, as amended, subparagraph (a) shall read:

- (a) Request for Hearing by Faculty Member: a faculty member who has good cause to believe that a student has engaged in academic misconduct in connection with a course taught by the faculty member or an examination proctored by the faculty member, or his or her designee, may request a hearing of the allegation of academic misconduct by contacting the Chair of the Academic Integrity Committee or the Office of Student Judicial and Ethical Programs.

## PROPOSED RULES

Parts 1. and 2. of subparagraph (a) of paragraph (1) of Rule 0240-3-3-.05 Academic Misconduct are further amended by deleting the text of the parts and substituting the following language, so that, as amended, parts 1. and 2. shall read:

1. A student found responsible for academic misconduct by the Academic Integrity Committee may be awarded a grade of "F" for the course, assignment, or examination at issue, and is also subject to additional disciplinary sanctions outlined in Rule 0240-3-3-.06 (2) below.
2. The Academic Integrity Committee shall determine and impose sanctions independently of the Office of Student Judicial and Ethical Programs.

Subparagraph (b) of paragraph (1) of Rule 0240-3-3-.05 Academic Misconduct is further amended by deleting the text of the subparagraph and substituting the following language, so that, as amended, subparagraph (b) shall read:

- (b) Summary Discipline: a faculty member who has good cause to believe that a student has engaged in academic misconduct in connection with a course taught by a faculty member or an examination proctored by the faculty member or his or her designee may choose to exercise Summary Discipline as outlined below.

Parts 2. and 3. of subparagraph (b) of paragraph (1) of Rule 0240-3-3-.05 Academic Misconduct are further amended by deleting the text of the parts and substituting the following language, so that, as amended, parts 2. and 3. shall read:

2. If a faculty member exercises Summary Discipline, the faculty shall notify the appropriate department chairperson of the action. The department chairperson shall notify the affected student in writing of the faculty member's exercise of Summary Discipline and advise the student of his or her right to appeal the Summary Discipline to the Academic Integrity Committee.
3. Student Appeal of Summary Discipline: a student may appeal an exercise of Summary Discipline by a faculty member to the Academic Integrity Committee. To initiate an appeal of Summary Discipline, the student must contact the Chair of the Academic Integrity Committee or the Office of Student Judicial and Ethical Programs within five (5) class days of receipt of notification of the summary action.

**Authority:** T.C.A. §49-8-203.

Rule 0240-3-3-.06 Judicial Procedures is amended by deleting the text of the title and substituting the following language, so that, as amended, the title of Rule 0240-3-3-.06 shall read:

### **0240-3-3-.06 DISCIPLINARY PROCEDURES.**

Paragraph (1) of Rule 0240-3-3-.06 Disciplinary Procedures is amended by deleting the text of the paragraph and substituting the following language, so that, as amended, paragraph (1) shall read:

- (1) Charges:

## PROPOSED RULES

Subparagraphs (a) and (b) of paragraph (1) of Rule 0240-3-3-.06 Disciplinary Procedures are further amended by deleting the text of the subparagraphs and substituting the following language, so that, as amended, subparagraphs (a) and (b) shall read:

- (a) Any member of the University community may file a complaint against any student for misconduct. Complaints shall be prepared in writing and directed to the Office of Student Judicial and Ethical Programs. A complaint should be submitted as soon as possible after the event takes place, preferably within ten (10) days of the alleged misconduct.
- (b) The Office of Student Judicial and Ethical Programs may conduct an investigation to determine if the complaint has merit and/or if it can be disposed of administratively by the Office of Student Judicial and Ethical Programs or by mutual consent of the parties involved on a basis acceptable to the Office of Student Judicial and Ethical Programs. Such disposition shall be final and there shall be no subsequent proceedings.

Subparagraph (d) of paragraph (1) of Rule 0240-3-3-.06 Disciplinary Procedures is further amended by deleting the text of the subparagraph and substituting the following language, so that, as amended, subparagraph (d) shall read:

- (d) All written notices will be mailed or hand-delivered to the address of the student as it appears on the official University records. Students are responsible for keeping the Office of the Registrar informed of a current address.

Subparagraph (e) of paragraph (1) of Rule 0240-3-3-.06 Disciplinary Procedures is further amended by deleting the text of the subparagraph and substituting the following language, so that, as amended, subparagraph (e) shall read:

- (e) Hearings:

Parts 2. through 5. of subparagraph (e) of paragraph (1) of Rule 0240-3-3-.06 Disciplinary Procedures are further amended by deleting the text of the parts and substituting the following language, so that, as amended, parts 2. through 5. shall read:

- 2. In hearings involving more than one accused student, the chairperson of the disciplinary body, in his or her discretion, may permit the hearings concerning each student to be conducted separately.
- 3. The complainant and the accused have the right to be assisted by any advisor they choose, at their own expense. The advisor may be an attorney. The accused is responsible for presenting his or her own case and advisors are not permitted to speak or to participate directly in any hearing before a disciplinary body.
- 4. The University, the accused and the disciplinary body shall have the privilege of presenting witnesses, subject to the right of questioning by the disciplinary body.
- 5. Pertinent records, exhibits and written statements may be accepted as evidence for consideration by a disciplinary body at the discretion of the chairperson.

Subparagraph (e) of paragraph (1) of Rule 0240-3-3-.06 Disciplinary Procedures is further amended by adding a new part 6. and renumbering the remaining parts accordingly. New part 6. shall read:

## PROPOSED RULES

6. There shall be a record, such as a tape recording, of all hearings before a disciplinary body. The record shall be the property of the University.

Subparts (i) and (ii) of part 7. (formerly part 6.) of subparagraph (e) of paragraph (1) of Rule 0240-3-3-.06 Disciplinary Procedures are further amended by deleting the text of the subparts and substituting the following language, so that, as amended, subparts (i) and (ii) shall read:

- (i) Reading of the alleged violation(s).
- (ii) The student's denial or admission of the alleged violation(s).

Parts 8. through 10. (formerly parts 7.- 9.) of subparagraph (e) of paragraph (1) of Rule 0240-3-3-.06 Disciplinary Procedures are further amended by deleting the text of the parts and substituting the following language, so that, as amended, parts 8. through 10. shall read:

8. After the hearing, the disciplinary body shall determine by majority vote (if the disciplinary body consists of more than one person) whether the student has violated each section of the Code of Student Rights and Responsibilities which the student is charged with violating.
9. The disciplinary body's determination shall be made on the basis of whether it is "more likely than not" that the accused student violated the Code of Student Rights and Responsibilities.
10. The student shall be notified in writing of the decision within five (5) days of the disciplinary body's decision. Every attempt will be made to verbally notify the student of the decision prior to the five-day period. In cases involving alleged sexual assault, both the accused and accuser shall be notified in writing within five (5) days of the disciplinary body's decision.

Subparagraph (f) of paragraph (1) of Rule 0240-3-3-.06 Disciplinary Procedures is further amended by deleting the subparagraph in its entirety and relettering the remaining subparagraphs accordingly.

Subparagraph (f) (formerly subparagraph (g)) of paragraph (1) of Rule 0240-3-3-.06 Disciplinary Procedures is further amended by deleting the text of the subparagraph and substituting the following language, so that, as amended, subparagraph (f) shall read:

- (f) No student may be found to have violated the Code of Student Rights and Responsibilities solely because the student failed to appear before a disciplinary body. In all cases, the evidence in support of the charges shall be presented and considered.

Paragraph (2) of Rule 0240-3-3-.06 Disciplinary Procedures is further amended by deleting the title "Sanctions" and substituting the following title, so that, as amended, the title of the paragraph (2) shall read:

### (2) Disciplinary Sanctions

Subparagraph (a) of paragraph (2) of Rule 0240-3-3-.06 Disciplinary Procedures is further amended by deleting the text of the subparagraph and substituting the following language, so that, as amended, subparagraph (a) shall read:

- (a) The following sanctions may be imposed upon any student found responsible for violating the Code of Student Rights and Responsibilities.

## PROPOSED RULES

Part 2. of subparagraph (a) of paragraph (2) of Rule 0240-3-3-.06 Disciplinary Procedures is further amended by deleting the text of the part and substituting the following language, so that, as amended, part 2. shall read:

2. Probation.

Probation is for a designated period of time and includes the probability of more severe disciplinary sanctions if the student is found responsible for violating specific and/or any institutional regulation(s) during the probationary period.

Part 4. (including subparts (i) - (iii)) of subparagraph (a) of paragraph (2) of Rule 0240-3-3-.06 Disciplinary Procedures is further amended by deleting the text of the part and subparts and substituting the following language, so that, as amended, part 4. and subparts (i) - (iii) shall read:

4. Fines.

In cases involving violation of the University alcohol and drug regulations, fines in the following amounts may be imposed:

- |                      |          |
|----------------------|----------|
| (i) First offense:   | \$50.00  |
| (ii) Second offense: | \$100.00 |
| (iii) Third offense: | \$125.00 |

Part 6. of subparagraph (a) of paragraph (2) of Rule 0240-3-3-.06 Disciplinary Procedures is further amended by deleting the text of the part and substituting the following language, so that, as amended, part 6. shall read:

6. Discretionary Sanctions - Work assignments, service to the University or other related discretionary assignments (such assignments must have the prior approval of the Office of Student Judicial and Ethical Programs).

Subparagraph (b) of paragraph (2) of Rule 0240-3-3-.06 Disciplinary Procedures is further amended by deleting the subparagraph in its entirety and relettering the remaining subparagraphs accordingly.

Subparagraph (b) (formerly (c)) of paragraph (2) of rule 0240-3-3-.06 Disciplinary Procedures is further amended by deleting the text of the subparagraph and substituting the following language, so that, as amended, subparagraph (b) shall read:

- (b) If, after a finding of a violation of the Code of Student Rights and Responsibilities, the disciplinary body determines that the violator intentionally selected the person or organization against whom the violation was committed, or selected the property that was damaged, because of race, gender, religion, sexual orientation, national origin or ancestry of that person or persons in the organization or the owner of occupier of that property, the disciplinary body may impose a more serious sanction.

Subparagraph (e) (formerly (f)) of paragraph (2) of Rule 0240-3-3-.06 Disciplinary Procedures is further amended by deleting the text of the subparagraph and substituting the following language, so that, as amended, subparagraph (e) shall read:

- (e) In each case in which a disciplinary body, other than the Academic Integrity Committee, determines that a student has violated the Code of Student Rights and Responsibilities,

## PROPOSED RULES

the sanction(s) shall be determined and imposed by the Office of Student Judicial and Ethical Programs, unless the disciplinary body that heard the charges overrules the proposed sanction(s) by a majority vote. Following the hearing, the disciplinary body and/or the Office of Student Judicial and Ethical Programs shall advise the accused student in writing of its determination and of the sanction(s) imposed, if any.

Paragraph (3) of Rule 0240-3-3-.06 Disciplinary Procedures is further amended by deleting the text of the paragraph and substituting the following language, so that, as amended, paragraph (3) shall read:

### (3) Interim Suspension

In certain circumstances, the Vice President of Student Affairs or the Office of Student Judicial and Ethical Programs may impose a University or residence hall suspension prior to the hearing before a disciplinary body.

Subparagraph (b) of paragraph (3) of Rule 0240-3-3-.06 Disciplinary Procedures is further amended by deleting the text of the subparagraph and substituting the following language, so that, as amended, subparagraph (b) shall read:

- (b) During the interim suspension, students shall be denied access to the residence halls and/or to the campus (including classes) and/or all other University activities or privileges for which the student might otherwise be eligible, as the Vice President of Student Affairs or the Office of Student Judicial and Ethical Programs determine to be appropriate.

Subparagraph (a) of paragraph (4) of Rule 0240-3-3-.06 Disciplinary Procedures is further amended by deleting the text of the subparagraph and substituting the following language, so that, as amended, subparagraph (a) shall read:

- (a) A decision reached by a disciplinary body and sanction imposed may be appealed by accused students to the University Appeals Committee within five (5) class days of notification of the decision. Such appeals must be in writing and shall be delivered to the Office of Student Judicial and Ethical Programs.

Subparagraph (c) of paragraph (4) of Rule 0240-3-3-.06 Disciplinary Procedures is further amended by deleting the text of the subparagraph and substituting the following language, so that, as amended, subparagraph (c) shall read:

- (c) The Office of Student Judicial and Ethical Programs shall prepare a summary of the proceedings before the original hearing body that may be considered by the University Appeals Committee. The appealing student shall have a right to review the summary and submit a response challenging any statements in the summary. At the request of the Chair of the Committee, the Office of Student Judicial and Ethical Programs may attend a hearing of the University Appeals Committee to answer any questions concerning procedure at the original hearing.

Part 2. of subparagraph (d) of paragraph (4) of Rule 0240-3-3-.06 Disciplinary Procedures is further amended by deleting the text of the part and substituting the following language, so that, as amended, part 2. shall read:

- 2. To determine whether the sanction(s) imposed were appropriate for the violation of the Code of Student Rights and Responsibilities that the student or organization was found to have committed.

## PROPOSED RULES

Part 1. of subparagraph (c) of paragraph (5) of Rule 0240-3-3-3.06 Disciplinary Procedures is further amended by deleting the text of the part and substituting the following language, so that, as amended, part 1. shall read:

1. To meet with the Office of Judicial and Ethical Programs to discuss the disciplinary process.

Part 3. of subparagraph (e) of paragraph (6) of Rule 0240-3-3-.06 Disciplinary Procedures is further amended by deleting the text of the part and substituting the following language, so that, as amended, part 3. shall read:

3. Alternative Procedures

If either party is dissatisfied with the mediation process at any step prior to the signing of a written agreement, that party may request that the mediation process cease. Once the mediation process for a particular incident has been discontinued, it cannot be reinitiated. The sexual assault charge may be pursued by the complainant within the University discipline system as provided for in the Code of Student Rights and Responsibilities in the Student Handbook.

Subparagraph (f) of paragraph (6) of Rule 0240-3-3-.06 Disciplinary Procedures is further amended by deleting the text of the subparagraph and substituting the following language, so that, as amended, subparagraph (f) shall read:

- (f) Confidentiality

In order to promote honest, direct communication between the parties themselves and the mediator, and to facilitate the completion of agreed-upon terms, all information shared in the mediation process must remain confidential. In the event that a hearing is requested after some part of the mediation process has taken place, information disclosed during the mediation process may be admitted in the University's investigation or hearing processes only by the party who made the original disclosure. The Office of Student Judicial and Ethical Programs will maintain copies of the original complaint, the mediation agreement, and any documentation concerning completion of the agreed-upon activities or behavior. Other records generated during the mediation process will be destroyed.

Parts 1. and 2. of subparagraph (b) of paragraph (7) of Rule 0240-3-3-.06 Disciplinary Procedures are further amended by deleting the text of the parts and substituting the following language, so that, as amended, parts 1. and 2. shall read:

1. Violations of University policy shall be reported to the Office of Student Judicial and Ethical Programs. Violations involving student organizational governing body rules shall be reported to the Offices of Student Involvement and Leadership or the appropriate council and/or advisor.
2. A preliminary conference with organizational officers will be held within ten (10) class days to determine if formal disciplinary action is warranted by the Office of Student Judicial and Ethical Programs or the Office of Student Involvement and Leadership or their designee. Allegations of violations should be reported in writing as soon as possible, preferably within ten (10) class days of the alleged infractions(s).

## PROPOSED RULES

Part 1. of subparagraph (c) of paragraph (7) of Rule 0240-3-3-.06 Disciplinary Procedures is further amended by deleting the text of the part and substituting the following language, so that, as amended, part 1. shall read:

1. The Associate Dean for Student Judicial and Ethical Programs may suspend on an interim basis any or all of the activities of a student organization while the organization is under investigation or engaged in the disciplinary hearing process for alleged violations of University rules and regulations. Student organizations are subject to interim suspension under one or more of the following conditions:

Part 2. of subparagraph (c) of paragraph (7) of Rule 0240-3-3-.06 Disciplinary Procedures is further amended by deleting the text of the part and substituting the following language, so that, as amended, part 2. shall read:

2. Organizations shall be notified in writing of their interim suspension and entitled to a hearing within ten (10) class days of notification. The interim suspension of a student organization shall continue until the disciplinary process has concluded or the Associate Dean of Student Judicial and Ethical Programs determines that the interim suspension is no longer necessary.

Part 5. of subparagraph (f) of paragraph (7) of Rule 0240-3-3-.06 Disciplinary Procedures is further amended by deleting the text of the part and substituting the following language, so that, as amended, part 5. shall read:

5. Probated Suspension: Warning that a finding of responsibility for violations of the University's Code of Student Rights and Responsibilities may result in a suspension.

Subparagraphs (a) and (b) of paragraph (8) of Rule 0240-3-3-.06 Disciplinary Procedures are further amended by deleting the text of the subparagraphs and substituting the following language, so that, as amended, subparagraphs (a) and (b) shall read:

- (a) Any question of interpretation regarding the Code of Student Rights and Responsibilities shall be referred to the Vice President of Student Affairs, or his or her designee, for final determination.
- (b) The Code of Student Rights and Responsibilities shall be reviewed annually under the direction of the Office of Student Judicial and Ethical Programs.

**Authority:** T.C.A. §49-8-203.

Subparagraph (g) of paragraph (5) of Rule 0240-3-3-.09 Traffic and Parking Regulations is amended by deleting the text of the subparagraph and substituting the following language, so that, as amended, subparagraph (g) shall read:

- (g) Illegal Entry. Vehicles shall not enter an area marked "Do Not Enter" or a gated lot by driving on sidewalks, grounds, by using a permit illegally, or tail-gating another vehicle to gain access.

**Authority:** T.C.A. §49-8-203.

## PROPOSED RULES

The proposed rules set out herein were properly filed in the Department of State on the 28th day of June, 2005, and pursuant to the instructions set out above, and in the absence of the filing of an appropriate petition calling for a rulemaking hearing, will become effective on the 28th day of October, 2005. (06-40)

PROPOSED RULES

**THE TENNESSEE BOARD OF REGENTS - 0240  
STATE UNIVERSITY AND COMMUNITY COLLEGE SYSTEM OF TENNESSEE**

**MIDDLE TENNESSEE STATE UNIVERSITY**

**CHAPTER 0240-3-4  
STUDENT DISCIPLINARY RULES**

Presented herein are proposed amendments of the Tennessee Board of Regents submitted pursuant to Tennessee Code Annotated, §4-5-202 in lieu of a rulemaking hearing. It is the intent of the Tennessee Board of Regents to promulgate these rules without a rulemaking hearing unless a petition requesting such hearing is filed within thirty (30) days of the publication date of the issue of the Tennessee Administrative Register in which the proposed amendments are published. Such petition to be effective must be filed in Suite 350 of the Genesco Park Building located at 1415 Murfreesboro Road, Nashville, TN 37217 and in the Department of State, Eighth Floor, William R. Snodgrass Tower, 312 Eighth Avenue, North, Nashville, TN 37243, and must be signed by twenty-five (25) persons who will be affected by the rules, or submitted by a municipality which will be affected by the rule, or an association of twenty-five (25) or more members, or any standing committee of the General Assembly.

For a copy of this proposed rule, contact: Mary M. Slater, 1415 Murfreesboro Road, Suite 350, Nashville, Tennessee 37217, Tennessee Board of Regents, 615-366-4438.

The text of the proposed amendments is as follows:

**AMENDMENTS**

Paragraphs (1) and (2) of Rule 0240-3-4-.05 Guidelines for Social Activities are amended by deleting the text of the paragraphs and substituting the following language, so that, as amended, paragraphs (1) and (2) shall read:

- (1) In order to maintain an environment that promotes a student centered learning environment, social activities must be conducted in accordance with established guidelines.
- (2) Social activities may include, but are not limited to, open houses, parties, dances, mixers, and musical performances, or any other activity of a social purpose planned by registered student organizations or national Greek letter organizations. Social activities must be approved for registration by the appropriate University official.

Subparagraphs (a) and (b) of paragraph (3) of Rule 0240-3-4-.05 Guidelines for Social Activities are amended by deleting the text of the subparagraphs and substituting the following language, so that, as amended, subparagraphs (a) and (b) shall read:

- (a) Social activities are limited to University students with MTSU IDs and/or to persons with written invitations. National Greek letter organizations must comply with policies set forth by the Office of Greek Life and their national office.
- (b) Social activities with unrestricted access by non-members of the organization without specific invitation are prohibited. Specific invitations must be approved by the Office of Student Organizations and Community Service or the Office of Greek Life. An announcement of general circulation to the campus is not considered to be an invitation.

## PROPOSED RULES

Paragraph (3) of Rule 0240-3-4-.05 Guidelines for Social Activities is further amended by adding a new subparagraph (g), which shall read:

- (g) Events sponsored by registered student organizations and National Greek letter organizations may not conflict with official Welcome Week activities. All events that occur during Welcome Week must be approved in advance by the Office of Student Development.

**Authority:** T.C.A. §49-8-203.

The proposed rules set out herein were properly filed in the Department of State on the 28th day of June, 2005, and pursuant to the instructions set out above, and in the absence of the filing of an appropriate petition calling for a rulemaking hearing, will become effective on the 28th day of October, 2005. (06-41)

PROPOSED RULES

**THE TENNESSEE BOARD OF REGENTS - 0240  
STATE UNIVERSITY AND COMMUNITY COLLEGE SYSTEM OF TENNESSEE**

**TENNESSEE TECHNOLOGICAL UNIVERSITY  
CHAPTER 0240-3-6  
STUDENT DISCIPLINARY RULES**

Presented herein are proposed amendments of the Tennessee Board of Regents submitted pursuant to Tennessee Code Annotated, §4-5-202 in lieu of a rulemaking hearing. It is the intent of the Tennessee Board of Regents to promulgate these rules without a rulemaking hearing unless a petition requesting such hearing is filed within thirty (30) days of the publication date of the issue of the Tennessee Administrative Register in which the proposed amendments are published. Such petition to be effective must be filed in Suite 350 of the Genesco Park Building located at 1415 Murfreesboro Road, Nashville, TN 37217 and in the Department of State, Eighth Floor, William R. Snodgrass Tower, 312 Eighth Avenue, North, Nashville, TN 37243, and must be signed by twenty-five (25) persons who will be affected by the rules, or submitted by a municipality which will be affected by the rule, or an association of twenty-five (25) or more members, or any standing committee of the General Assembly.

For a copy of this proposed rule, contact: Mary M. Slater, 1415 Murfreesboro Road, Suite 350, Nashville, Tennessee 37217, Tennessee Board of Regents, 615-366-4438.

The text of the proposed amendments is as follows:

**AMENDMENTS**

Subparagraph (d) of paragraph (1) of Rule 0240-3-6-.07 Traffic and Parking Regulations is amended by deleting the text of the subparagraph and substituting the following language, so that, as amended, subparagraph (d) shall read:

- (d) The driver and/or owner of the TTU parking permit shall be responsible for all parking citations issued against the vehicle. Moving violations will be charged to the operator of the vehicle.

**Authority:** T.C.A. §49-8-203.

The proposed rules set out herein were properly filed in the Department of State on the 28th day of June, 2005, and pursuant to the instructions set out above, and in the absence of the filing of an appropriate petition calling for a rulemaking hearing, will become effective on the 28th day of October, 2005. (06-42)

PROPOSED RULES

**THE TENNESSEE BOARD OF REGENTS - 0240  
STATE UNIVERSITY AND COMMUNITY COLLEGE SYSTEM OF TENNESSEE**

**CHATTANOOGA STATE TECHNICAL COMMUNITY COLLEGE**

**CHAPTER 0240-3-7  
STUDENT DISCIPLINARY RULES**

Presented herein are proposed amendments of the Tennessee Board of Regents submitted pursuant to Tennessee Code Annotated, §4-5-202 in lieu of a rulemaking hearing. It is the intent of the Tennessee Board of Regents to promulgate these rules without a rulemaking hearing unless a petition requesting such hearing is filed within thirty (30) days of the publication date of the issue of the Tennessee Administrative Register in which the proposed amendments are published. Such petition to be effective must be filed in Suite 350 of the Genesco Park Building located at 1415 Murfreesboro Road, Nashville, TN 37217 and in the Department of State, Eighth Floor, William R. Snodgrass Tower, 312 Eighth Avenue, North, Nashville, TN 37243, and must be signed by twenty-five (25) persons who will be affected by the rules, or submitted by a municipality which will be affected by the rule, or an association of twenty-five (25) or more members, or any standing committee of the General Assembly.

For a copy of this proposed rule, contact: Mary M. Slater, 1415 Murfreesboro Road, Suite 350, Nashville, Tennessee 37217, Tennessee Board of Regents, 615-366-4438.

The text of the proposed amendments is as follows:

**AMENDMENTS**

Paragraph (2) of Rule 0240-3-7-.02 Definitions is amended by deleting the text of the paragraph and substituting the following language, so that, as amended, paragraph (2) shall read:

- (2) For the purpose of these rules only, the term "student" includes all full-time and part-time participants in credit, non-credit, clock hour and other college sponsored programs.

Paragraphs (9) and (10) of Rule 0240-3-7-.02 Definitions are further amended by deleting the text of the paragraphs and substituting the following language, so that, as amended, paragraphs (9) and (10) shall read:

- (9) The term "Judicial Officer" refers to a College official authorized by the Vice President for Student Affairs to oversee judicial procedures, the investigative process and file charges against students accused of violating the Student Code of Conduct. The Judicial Officer shall also impose sanctions upon students who admit to violations of the Code.
- (10) The term "Judicial Committee" refers to a college-wide body authorized by the President to establish and monitor the Student Code of Conduct and disciplinary sanctions, policies and procedures. The Committee also considers appeals of the Disciplinary Hearing Board's determination that a student has violated the Student Code of Conduct or sanctions sponsored by the Judicial Officer or Hearing Board.

**Authority:** T.C.A. §49-8-203.

## PROPOSED RULES

Subparagraphs (a) through (c) of paragraph (1) of Rule 0240-3-7-.03 Judicial Authority are amended by deleting the text of the subparagraphs and substituting the following language, so that, as amended, subparagraphs (a) through (c) shall read:

- (a) Hearing by the Judicial Officer -- If a student chooses to admit violation of a provision of the Code, the student may either accept sanctions proposed by the Judicial Officer, or choose to have a hearing before the Disciplinary Hearing Body composed of faculty, staff and student members.
- (b) Hearing before the Disciplinary Hearing Board. A hearing before a college-wide body who are responsible for the review and adjudication of disciplinary cases referred by Judicial Officer. The board will make a finding on the merits of the charges and shall impose an appropriate sanction(s) in accordance with 0240-3-7-.06.
- (c) Judicial Committee -- a college-wide body who considers appeals of the Disciplinary Hearing Board's determination that a student has violated the Student Code of Conduct or sanctions imposed by the Judicial Officer or Hearing Board. This body also reviews judicial policies and procedures and makes recommendations when changes are necessary.

Subparagraph (d) (formerly subparagraph (c)) of paragraph (1) of Rule 0240-3-7-.03 Judicial Authority is further amended by deleting the text of the subparagraph and substituting the following language, so that, as amended, subparagraph (d) shall read:

- (d) Tennessee Uniform Administrative Procedures Act (TUAPA) -- disciplinary charges that may result in suspension or expulsion from the College may, at the student's option, be heard in conformance with the requirements of the Tennessee Uniform Administrative Procedures Act. The TUAPA is an official state act defining certain procedures that are required when a student chooses to have his or her case heard through the Act's provisions. A more detailed description of the Act and its provisions may be obtained from the office of the Vice President for Student Affairs.

**Authority:** T.C.A. §49-8-203.

Rule 0240-3-7-.05 Academic and Classroom Misconduct is amended by adding a new beginning sentence which shall read:

(A more complete description of campus procedures associated with academic integrity issues can be found in the student handbook.)

Paragraph (3) of Rule 0240-3-7-.05 Academic and Classroom Misconduct is further amended by deleting paragraph (3) in its entirety.

**Authority:** T.C.A. §49-8-203.

The proposed rules set out herein were properly filed in the Department of State on the 28th day of June, 2005, and pursuant to the instructions set out above, and in the absence of the filing of an appropriate petition calling for a rulemaking hearing, will become effective on the 28th day of October, 2005. (06-43)

PROPOSED RULES

**THE TENNESSEE BOARD OF REGENTS - 0240  
STATE UNIVERSITY AND COMMUNITY COLLEGE SYSTEM OF TENNESSEE**

**CLEVELAND STATE COMMUNITY COLLEGE**

**CHAPTER 0240-3-8  
STUDENT DISCIPLINARY RULES**

Presented herein are proposed amendments of the Tennessee Board of Regents submitted pursuant to Tennessee Code Annotated, §4-5-202 in lieu of a rulemaking hearing. It is the intent of the Tennessee Board of Regents to promulgate these rules without a rulemaking hearing unless a petition requesting such hearing is filed within thirty (30) days of the publication date of the issue of the Tennessee Administrative Register in which the proposed amendments are published. Such petition to be effective must be filed in Suite 350 of the Genesco Park Building located at 1415 Murfreesboro Road, Nashville, TN 37217 and in the Department of State, Eighth Floor, William R. Snodgrass Tower, 312 Eighth Avenue, North, Nashville, TN 37243, and must be signed by twenty-five (25) persons who will be affected by the rules, or submitted by a municipality which will be affected by the rule, or an association of twenty-five (25) or more members, or any standing committee of the General Assembly.

For a copy of this proposed rule, contact: Mary M. Slater, 1415 Murfreesboro Road, Suite 350, Nashville, Tennessee 37217, Tennessee Board of Regents, 615-366-4438.

The text of the proposed amendments is as follows:

**AMENDMENTS**

Subparagraph (b) of paragraph (3) of Rule 0240-3-8-.06 Traffic and Parking Regulations is amended by deleting the subparagraph in its entirety.

Subparagraph (e) of paragraph (5) of Rule 0240-3-8-.06 Traffic and Parking Regulations is further amended by deleting the text of the subparagraph and substituting the following language, so that, as amended, subparagraph (e) shall read:

- (e) A staff member who persists in violating these regulations or fails to answer a citation will be reported to the Vice President.

**Authority:** T.C.A. §49-8-203.

Paragraph (5) of Rule 0240-3-8-.07 Registration of Motor Vehicles is amended by deleting the text of the paragraph and substituting the following language, so that, as amended, paragraph (5) shall read:

- (5) Special permits for the physically disabled or for medical reasons are available. Details are available from the Campus Safety and Security Office located in the Security Building.

**Authority:** T.C.A. §49-8-203.

The proposed rules set out herein were properly filed in the Department of State on the 28th day of June, 2005, and pursuant to the instructions set out above, and in the absence of the filing of an appropriate petition calling for a rulemaking hearing, will become effective on the 28th day of October, 2005. (06-44)

PROPOSED RULES

**THE TENNESSEE BOARD OF REGENTS - 0240  
STATE UNIVERSITY AND COMMUNITY COLLEGE SYSTEM OF TENNESSEE**

**COLUMBIA STATE COMMUNITY COLLEGE**

**CHAPTER 0240-3-9  
STUDENT DISCIPLINARY RULES**

Presented herein are proposed amendments of the Tennessee Board of Regents submitted pursuant to Tennessee Code Annotated, §4-5-202 in lieu of a rulemaking hearing. It is the intent of the Tennessee Board of Regents to promulgate these rules without a rulemaking hearing unless a petition requesting such hearing is filed within thirty (30) days of the publication date of the issue of the Tennessee Administrative Register in which the proposed amendments are published. Such petition to be effective must be filed in Suite 350 of the Genesco Park Building located at 1415 Murfreesboro Road, Nashville, TN 37217 and in the Department of State, Eighth Floor, William R. Snodgrass Tower, 312 Eighth Avenue, North, Nashville, TN 37243, and must be signed by twenty-five (25) persons who will be affected by the rules, or submitted by a municipality which will be affected by the rule, or an association of twenty-five (25) or more members, or any standing committee of the General Assembly.

For a copy of this proposed rule, contact: Mary M. Slater, 1415 Murfreesboro Road, Suite 350, Nashville, Tennessee 37217, Tennessee Board of Regents, 615-366-4438.

The text of the proposed amendments is as follows:

**AMENDMENTS**

Rule 0240-3-9-.05 Disciplinary Procedures is amended by deleting the entire rule and substituting the following language, so that, as amended, Rule 0240-3-9-.05 shall read:

**0240-3-9-.05 DISCIPLINARY PROCEDURES**

- (1) Preliminary Conference. Misconduct involving the violation of college regulations shall be reported to the Vice President for Student Services and Enrollment Management or appropriate designee. The Vice President for Student Services and Enrollment Management or appropriate designee shall call the accused student to a preliminary conference where the student shall be informed of the charges against him or her and apprised of his or her basic rights as stated in these rules. The Vice President for Student Services and Enrollment Management or appropriate designee shall investigate the validity of the alleged misconduct.
- (2) Following completion of the informal investigation, the Vice President for Student Services and Enrollment Management or appropriate designee may: (a) determine that there is an insufficient basis, in fact, and dismiss the matter; (b) conclude that there is a sufficient factual basis for discipline and that discipline less than suspension or expulsion or removal of the college privileges would be appropriate; or (c) conclude that there is a sufficient factual basis for discipline and that discipline, including the possibility of suspension or expulsion or removal of college privileges, would be appropriate.
- (3) If discipline less than suspension or expulsion or removal of college privileges is contemplated, the Vice President for Student Services and Enrollment Management or appropriate designee may,

## PROPOSED RULES

after an informal hearing, impose such discipline specified in 0240-3-9-.04: Disciplinary Sanctions, except suspension or expulsion or removal of college privileges, as he or she believes appropriate. As used herein, informal hearing means the opportunity for the student to be informed of the basis for the conclusion of the Vice President for Services and Enrollment Management or appropriate designee, and to present argument and evidence on his or her behalf. The student shall be informed of his or her right to appeal the vice president's decision.

- (4) If discipline including suspension or expulsion or removal of college privileges is contemplated, the student shall be afforded an opportunity to contest the charge(s) through procedures initiated by and coordinated with the Vice President for Student Services and Enrollment Management or appropriate designee. The student shall be informed of the right to elect the procedure he or she wishes to pursue toward the disposition of a proposed action against him or her. The student shall indicate his or her selection in writing from the procedures listed below.
- (a) Tennessee Uniform Administrative Procedures Act (TUAPA). All cases which may result in (i) suspension or expulsion of a student from the institution for disciplinary reasons, or (ii) revocation of registration of a student organization during the term of the registration are subject to the contested case provisions of the TUAPA and shall be processed in accordance with the contested case procedures adopted by the Board of Regents unless the student waives those procedures in writing and elects to have his or her case disposed of in accordance with college procedures established by these rules.
- (b) Disposition by the Vice President for Student Services and Enrollment Management. In discipline cases other than academic dishonesty, a student may request that the Vice President for Student Services and Enrollment Management adjudicate the case. If such a decision is made, the following procedures apply.
1. The Vice President for Student Services and Enrollment Management or appropriate designee shall inform the student, in person if possible, of the charges against him or her and proceed to gather information concerning the case including, but not limited to, interviews with all relevant parties (accused, accuser, and possible witnesses).
  2. The Vice President for Student Services and Enrollment Management or appropriate designee shall review the evidence, determine whether there appears to have been a violation of the college regulations and, if so, decide upon a proper disciplinary sanction within five (5) class days. The student will be informed, in writing, of the specific disciplinary offenses and sanctions at this time.
  3. The accused student and the Vice President for Student Services and Enrollment Management or appropriate designee shall meet and discuss the vice president's findings and recommended disciplinary sanction(s). The student shall be informed of his or her right to appeal the vice president's decision.
  4. If the student disagrees with the Vice President for Student Services and Enrollment Management's disposition of the case, he or she may request a hearing by the Student Discipline Committee. The request must be made in writing to the Chairperson of the Student Discipline Committee within three (3) class days.
- (c) Hearing by the Student Discipline Committee. A student may choose to have the case heard by the Student Discipline Committee. If such a hearing is initiated, the following procedures shall apply:

## PROPOSED RULES

1. The Student Discipline Committee is a college standing committee composed of students, faculty, and student services representatives.
  2. The accused student shall be informed in writing of the date, time and place of the hearing, not less than five (5) working days prior to the day of the hearing.
  3. All hearings shall be closed unless the student requests an open hearing in writing.
  4. The Vice President for Student Services and Enrollment Management or appropriate designee shall read the charges and present the results of the investigation.
  5. The student shall be given an opportunity to respond to the evidence against him or her. He or she shall have an opportunity to present his or her position, make such admissions, denials or explanations as he or she thinks appropriate and testify or present such other evidence as is available to him or her. The technical rules of evidence normally followed in civil and criminal trial shall not apply.
  6. The student may be accompanied by an advisor whose participation shall be limited to advising the student and shall not include representing the student.
  7. The student shall have the right to call witnesses on his or her behalf and the right to hear and question the witnesses against him or her.
  8. Members of the committee shall have the right to ask questions.
  9. All evidence upon which the decision is made shall be presented at the proceedings before the committee.
  10. After all the presentations of evidence and testimony, the committee shall retire to discuss the case and render a decision.
  11. The student shall be notified of the decision, in writing, within five (5) days of the hearing and shall be advised of his or her right to appeal the decision of the Student Discipline Committee to the President of the College.
- (5) Summary Suspension. A student may be summarily suspended from the college if, in the judgment of college officials, the student's continued presence represents an immediate threat to himself or herself, other students and/or college employees, or will result in the destruction of property or substantial disruption of campus activities. In any case of summary suspension, the student shall be provided a hearing on the suspension as soon as possible.
- (6) Appeal Procedures
- (a) Appeal of decision of a hearing held pursuant to TUAPA. A student's right to appeal a decision resulting from a hearing held pursuant to the TUAPA shall be governed by the provisions of the TUAPA - defined above in (4) (a).
  - (b) Appeal of decision of the Vice President for Student Services and Enrollment Management. A student who wishes to challenge the disciplinary sanction(s) imposed by the vice president must file an appeal, in writing, with the Chairperson of the Student Discipline Committee within three (3) class days after sanction(s) are imposed.

## PROPOSED RULES

1. The committee will consider the following in hearing the appeal:
  - (i) was the hearing process followed;
  - (ii) was the evidence in the case substantial enough to justify a decision against the student;
  - (iii) has new and substantial evidence been discovered to justify a new hearing;
  - (iv) was the sanction imposed by the Vice President for Student Services and Enrollment Management in keeping with the gravity of the offense.
  
2. The committee may affirm, or reverse in whole or in part, or remand the matter for a new hearing.
  - (c) Appeal of decision of Student Discipline Committee. A student may appeal a decision of the Student Discipline Committee to the President of the College. Such appeal must be filed within three (3) class days of receipt of the committee's decision.
  
- (7) Cases of Alleged Sexual Assault. Regardless of the method chosen by the student for disposition of the disciplinary matter, in cases of alleged sexual assault, both the accused and the accuser shall be informed of the following:
  - (a) Both the accuser and the accused are entitled to the same opportunity to have others present during a disciplinary proceeding.
  - (b) Both the accuser and the accused shall be informed of the outcome of any disciplinary proceeding involving allegations of sexual assault within five (5) days of the decision.

**Authority:** T.C.A. §49-8-203.

The proposed rules set out herein were properly filed in the Department of State on the 28th day of June, 2005, and pursuant to the instructions set out above, and in the absence of the filing of an appropriate petition calling for a rulemaking hearing, will become effective on the 28th day of October, 2005. (06-45)

PROPOSED RULES

**THE TENNESSEE BOARD OF REGENTS - 0240  
STATE UNIVERSITY AND COMMUNITY COLLEGE SYSTEM OF TENNESSEE**

**DYERSBURG STATE COMMUNITY COLLEGE**

**CHAPTER 0240-3-10  
STUDENT DISCIPLINARY RULES**

Presented herein are proposed amendments of the Tennessee Board of Regents submitted pursuant to Tennessee Code Annotated, §4-5-202 in lieu of a rulemaking hearing. It is the intent of the Tennessee Board of Regents to promulgate these rules without a rulemaking hearing unless a petition requesting such hearing is filed within thirty (30) days of the publication date of the issue of the Tennessee Administrative Register in which the proposed amendments are published. Such petition to be effective must be filed in Suite 350 of the Genesco Park Building located at 1415 Murfreesboro Road, Nashville, TN 37217 and in the Department of State, Eighth Floor, William R. Snodgrass Tower, 312 Eighth Avenue, North, Nashville, TN 37243, and must be signed by twenty-five (25) persons who will be affected by the rules, or submitted by a municipality which will be affected by the rule, or an association of twenty-five (25) or more members, or any standing committee of the General Assembly.

For a copy of this proposed rule, contact: Mary M. Slater, 1415 Murfreesboro Road, Suite 350, Nashville, Tennessee 37217, Tennessee Board of Regents, 615-366-4438.

The text of the proposed amendments is as follows:

**AMENDMENTS**

Subparagraph (h) of paragraph (2) of Rule 0240-3-10-.02 Disciplinary Offenses is amended by deleting the text of the subparagraph and substituting the following language, so that, as amended, subparagraph (h) shall read:

- (h) Firearms and other dangerous weapons. Any possession of or use of firearms or dangerous weapons of any kind. T.C.A. §39-17-1309 prohibits the possession of weapons, including firearms, on any property owned, used or operated by TBR. Notice must be posted and verbiage for such notice is provided. The notice must state: Felony. State law prescribes a maximum penalty of six (6) years imprisonment and a fine not to exceed three thousand dollars (\$3,000.00) for carrying weapons on school property.

Subparagraph (k) of paragraph (2) of Rule 0240-3-10-.02 Disciplinary Offenses is further amended by deleting the text of the subparagraph and substituting the following language, so that, as amended, subparagraph (k) shall read:

- (k) The unlawful use, possession, distribution, sale or manufacture, of any drug or controlled substances (including any stimulant, depressant, narcotic, or hallucinogenic drug or substance, or marijuana), being under the influence of any drug or controlled substance, or the misuse of legally prescribed or "over the counter" drugs on property owned or controlled by the institution; at an institution sponsored event; on property owned or controlled by an affiliated site; or in violation of any term of the DSCC Drug-Free Schools and Communities Policy Statement.

**Authority:** T.C.A. §49-8-203 and T.C.A. §39-17-1309.

## PROPOSED RULES

Paragraph (2) of Rule 0240-3-10-.06 Traffic and Parking Regulations is amended by adding a new subparagraph (a) and relettering the remaining subparagraphs accordingly. New subparagraph (a) shall read:

- (a) All motor vehicles on campus must meet the registration requirements of the owner's state of residence.

Subparagraph (i) (formerly subparagraph (h)) of paragraph (2) of Rule 0240-3-10-.06 Traffic and Parking Regulations is further amended by deleting the text of the subparagraph and substituting the following language, so that, as amended, subparagraph (i) shall read:

- (i) Change in license plates by students must be reported to the Student Services Office within five (5) working days of such change. Employees should report the changes to the Business Office.

Part 2. of subparagraph (b) of paragraph (3) of Rule 0240-3-10-.06 Traffic and Parking Regulations is further amended by deleting the text of the part and substituting the following language, so that, as amended, part 2. shall read:

- 2. In areas designated handicapped, parking is limited to vehicles displaying handicapped decals. Decals may be obtained in the Student Services Office.

Part 3. of subparagraph (a) of paragraph (5) of Rule 0240-3-10-.06 Traffic and Parking Regulations is further amended by deleting the text of the part and substituting the following language, so that, as amended, part 3. shall read:

- 3. For a moving vehicle violation: \$10.00 for each ticket issued and \$20.00 for subsequent tickets.

Subparagraph (c) of paragraph (5) of Rule 0240-3-10-.06 Traffic and Parking Regulations is further amended by deleting the text of the subparagraph and substituting the following language, so that, as amended, subparagraph (c) shall read:

- (c) Traffic Citations Appeal Committee. The committee shall have four (4) voting members -- one representative each from faculty, staff, and student body, the Vice President for Finance and Administrative Services (chairperson) and one (1) ex officio member -- President of the College. The committee decision will be final, with no further appeal available. The committee will meet monthly as needed but no less frequently than once at the end of every semester.

**Authority:** T.C.A. §49-8-203.

The proposed rules set out herein were properly filed in the Department of State on the 28th day of June, 2005, and pursuant to the instructions set out above, and in the absence of the filing of an appropriate petition calling for a rulemaking hearing, will become effective on the 28th day of October, 2005. (06-46)

PROPOSED RULES

**THE TENNESSEE BOARD OF REGENTS - 0240  
STATE UNIVERSITY AND COMMUNITY COLLEGE SYSTEM OF TENNESSEE**

**JACKSON STATE COMMUNITY COLLEGE**

**CHAPTER 0240-3-11  
STUDENT DISCIPLINARY RULES**

Presented herein are proposed amendments of the Tennessee Board of Regents submitted pursuant to Tennessee Code Annotated, §4-5-202 in lieu of a rulemaking hearing. It is the intent of the Tennessee Board of Regents to promulgate these rules without a rulemaking hearing unless a petition requesting such hearing is filed within thirty (30) days of the publication date of the issue of the Tennessee Administrative Register in which the proposed amendments are published. Such petition to be effective must be filed in Suite 350 of the Genesco Park Building located at 1415 Murfreesboro Road, Nashville, TN 37217 and in the Department of State, Eighth Floor, William R. Snodgrass Tower, 312 Eighth Avenue, North, Nashville, TN 37243, and must be signed by twenty-five (25) persons who will be affected by the rules, or submitted by a municipality which will be affected by the rule, or an association of twenty-five (25) or more members, or any standing committee of the General Assembly.

For a copy of this proposed rule, contact: Mary M. Slater, 1415 Murfreesboro Road, Suite 350, Nashville, Tennessee 37217, Tennessee Board of Regents, 615-366-4438.

The text of the proposed amendments is as follows:

**AMENDMENTS**

Paragraphs (1) and (2) of Rule 0240-3-11-.05 Disciplinary Procedures are amended by deleting the text of the paragraphs and substituting the following language, so that, as amended, paragraphs (1) and (2) shall read:

- (1) The principle of due process in student discipline is assured at Jackson State Community College. Any student accused of a disciplinary offense or academic misconduct will be afforded an opportunity to contest the charge through procedures initiated by and coordinated with the Vice President for Academic Affairs.
- (2) Tennessee Uniform Administrative Procedures Act (TUAPA). All cases which may result in: (i) suspension or expulsion of a student from the institution, a program, or a course for disciplinary reasons; (ii) revocation of registration of a student organization during the term of the registration are subject to the contested case provisions of the TUAPA and shall be processed in accordance with the Uniform Contested Case Procedures adopted by the Board of Regents unless the student waives those procedures in writing and elects to have his or her case disposed of in accordance with College procedures established by these rules.

Subparagraphs (a) and (b) of paragraph (3) of Rule 0240-3-11-.05 Disciplinary Procedures are further amended by deleting the text of the subparagraphs and substituting the following language, so that, as amended, subparagraphs (a) and (b) shall read:

- (a) The student can elect to choose disposition by the Vice President for Academic Affairs or to be heard before the Student Disciplinary Committee.

## PROPOSED RULES

- (b) Disposition by the Vice President for Academic Affairs. A student may request that the Vice President for Academic Affairs adjudicate the case. If such is made, the following procedures shall apply:

Part 1. of subparagraph (b) of paragraph (3) of Rule 0240-3-11-.05 Disciplinary Procedures is further amended by deleting the text of the part and substituting the following language, so that, as amended, part 1. shall read:

1. The Vice President for Academic Affairs shall advise the student in writing of the alleged charges against him or her and proceed to gather information concerning the case.

Parts 3. through 5. of subparagraph (b) of paragraph (3) of Rule 0240-3-11-.05 Disciplinary Procedures are further amended by deleting the text of the parts and substituting the following language, so that, as amended, parts 3. through 5. shall read:

3. The Vice President for Academic Affairs shall review the evidence, make a determination of innocence or guilt, and decide upon a proper disciplinary sanction.
4. The accused student and the Vice President for Academic Affairs shall meet and discuss the Vice President's findings and recommended disciplinary sanction. The findings shall cite specific disciplinary offenses and specific sanctions as described in these rules.
5. The student shall be advised of his or her right to appeal the decision of the Vice President for Academic Affairs to the President of the College.

Part 1. of subparagraph (c) of paragraph (3) of Rule 0240-3-11-.05 Disciplinary Procedures is further amended by deleting the text of the part and substituting the following language, so that, as amended, part 1. shall read:

1. The Vice President for Academic Affairs shall advise the student in writing of the alleged charges against him or her and initiate an investigation.

Part 4. of subparagraph (c) of paragraph (3) of Rule 0240-3-11-.05 Disciplinary Procedures is further amended by deleting the text of the part and substituting the following language, so that, as amended, part 4. shall read:

4. The Vice President for Academic Affairs shall present the result of the investigation and when appropriate, make a recommendation to the Committee. Witnesses and/or statements from witnesses may be entered as evidence.

Subparagraph (a) of paragraph (25) of Rule 0240-3-11-.05 Disciplinary Procedures is further amended by deleting the text of the subparagraph and substituting the following language, so that, as amended, subparagraph (a) shall read:

- (a) Allegations of violation of this policy shall be referred by the designee of the President (typically, the Computer Center Director) to the appropriate person(s) for disciplinary action. If a student, the policy violation will be referred to the Vice President for Academic Affairs under TBR Policy 3:02:00:01. If an employee, the policy violation will be referred to the immediate supervisor. If there is a policy violation, which the designee believes rises to the

## PROPOSED RULES

level of a serious violation of this or any other TBR policy, the designee is authorized to temporarily revoke access privileges. In those cases, the revocation of access must be reviewed by the appropriate disciplinary authority for review and final determination of access privileges. In such cases the authorization of the designee carries with it the authorization to make subjective judgments, such as whether material or statements violate TBR Policy.

Subparagraph (a) of paragraph (27) of Rule 0240-3-11-.05 Disciplinary Procedures is further amended by deleting the text of the subparagraph and substituting the following language, so that, as amended, subparagraph (a) shall read:

- (a) Sanctions imposed upon students at Jackson State Community College and imposed at the discretion of the Computer Center Director (or other designee of the President) may be appealed to the Vice President for Academic Affairs. Other sanctions may be appealed under established institution procedure.

**Authority:** T.C.A. §49-8-203.

Subparagraph (b) (including its parts) of paragraph (6) of Rule 0240-3-11-.06 Traffic and Parking Regulations is further amended by deleting the text of the subparagraph (including its parts) and substituting the following language, so that, as amended, subparagraph (b) shall read:

(b) Violations and Fines

1. Parking on grass	\$ 25.00
2. Parking in designated employee area	\$ 50.00
3. Parked within 15ft of a fire hydrant	\$ 50.00
4. Parked in loading zone	\$ 25.00
5. Double parked	\$ 25.00
6. Parked in reserved employee area	\$ 50.00
7. Parked in disabled area	\$100.00
8. No parking decal	\$ 50.00
9. Improper parking	\$ 25.00

Part 1. of subparagraph (c) of paragraph (6) of Rule 0240-3-11-.06 Traffic and Parking Regulations is further amended by deleting the text of the part and substituting the following language, so that, as amended, part 1. shall read:

1. If a citation is issued and you believe you have a justifiable reason that may affect the traffic citation, you may appeal to the Vice President for Academic Affairs. Appeals must be in writing and received within five (5) working days of the issuance of the citation.

**Authority:** T.C.A. §49-8-203.

The proposed rules set out herein were properly filed in the Department of State on the 28th day of June, 2005, and pursuant to the instructions set out above, and in the absence of the filing of an appropriate petition calling for a rulemaking hearing, will become effective on the 28th day of October, 2005. (06-47)

PROPOSED RULES

**THE TENNESSEE BOARD OF REGENTS - 0240  
STATE UNIVERSITY AND COMMUNITY COLLEGE SYSTEM OF TENNESSEE**

**MOTLOW STATE COMMUNITY COLLEGE**

**CHAPTER 0240-3-12  
STUDENT DISCIPLINARY RULES**

Presented herein are proposed amendments of the Tennessee Board of Regents submitted pursuant to Tennessee Code Annotated, §4-5-202 in lieu of a rulemaking hearing. It is the intent of the Tennessee Board of Regents to promulgate these rules without a rulemaking hearing unless a petition requesting such hearing is filed within thirty (30) days of the publication date of the issue of the Tennessee Administrative Register in which the proposed amendments are published. Such petition to be effective must be filed in Suite 350 of the Genesco Park Building located at 1415 Murfreesboro Road, Nashville, TN 37217 and in the Department of State, Eighth Floor, William R. Snodgrass Tower, 312 Eighth Avenue, North, Nashville, TN 37243, and must be signed by twenty-five (25) persons who will be affected by the rules, or submitted by a municipality which will be affected by the rule, or an association of twenty-five (25) or more members, or any standing committee of the General Assembly.

For a copy of this proposed rule, contact: Mary M. Slater, 1415 Murfreesboro Road, Suite 350, Nashville, Tennessee 37217, Tennessee Board of Regents, 615-366-4438.

The text of the proposed amendments is as follows:

**AMENDMENTS**

Paragraph (2) of Rule 0240-3-12-.05 Disciplinary Procedures is amended by deleting the text of the paragraph and substituting the following language, so that, as amended, paragraph (2) shall read:

- (2) Tennessee Uniform Administrative Procedures Act (TUAPA). All cases which may result in (i) suspension or expulsion of a student from the institution for disciplinary reasons or (ii) revocation of registration of a student organization during the term of the registration are subject to the contested case provisions of the TUAPA and shall be processed in accordance with the Uniform Contested Case Procedures adopted by the Board of Regents unless the student waives those procedures in writing and elects to have the case disposed of in accordance with College Procedures established by these rules.

**Authority:** T.C.A. §49-8-203.

The proposed rules set out herein were properly filed in the Department of State on the 28th day of June, 2005, and pursuant to the instructions set out above, and in the absence of the filing of an appropriate petition calling for a rulemaking hearing, will become effective on the 28th day of October, 2005. (06-48)

PROPOSED RULES

**THE TENNESSEE BOARD OF REGENTS - 0240  
STATE UNIVERSITY AND COMMUNITY COLLEGE SYSTEM OF TENNESSEE**

**ROANE STATE COMMUNITY COLLEGE**

**CHAPTER 0240-3-13  
STUDENT DISCIPLINARY RULES**

Presented herein are proposed amendments of the Tennessee Board of Regents submitted pursuant to Tennessee Code Annotated, §4-5-202 in lieu of a rulemaking hearing. It is the intent of the Tennessee Board of Regents to promulgate these rules without a rulemaking hearing unless a petition requesting such hearing is filed within thirty (30) days of the publication date of the issue of the Tennessee Administrative Register in which the proposed amendments are published. Such petition to be effective must be filed in Suite 350 of the Genesco Park Building located at 1415 Murfreesboro Road, Nashville, TN 37217 and in the Department of State, Eighth Floor, William R. Snodgrass Tower, 312 Eighth Avenue, North, Nashville, TN 37243, and must be signed by twenty-five (25) persons who will be affected by the rules, or submitted by a municipality which will be affected by the rule, or an association of twenty-five (25) or more members, or any standing committee of the General Assembly.

For a copy of this proposed rule, contact: Mary M. Slater, 1415 Murfreesboro Road, Suite 350, Nashville, Tennessee 37217, Tennessee Board of Regents, 615-366-4438.

The text of the proposed amendments is as follows:

**AMENDMENTS**

Paragraph (2) of Rule 0240-3-13-.05 Disciplinary Procedures is amended by deleting the text of the paragraph and substituting a new paragraph (2) (including subparagraphs (a) and (b)), so that, as amended, paragraph (2) (including subparagraphs (a) and (b)) shall read:

- (2) Policy 1:06:00:05 (Subject: Uniform Procedures for Cases Subject to the Tennessee Uniform Administrative Procedures Act (TUAPA). (URL Address to the entire text of the policy - [http://www.tbr.state.tn.us/policies\\_guidelines/governance\\_policies/1-06-00.htm](http://www.tbr.state.tn.us/policies_guidelines/governance_policies/1-06-00.htm))

(a) Purpose

The purpose of these procedures is to provide a basis for uniform procedures to be used by institutions and technology centers governed by the Tennessee Board of Regents, for the hearing of cases which may be subject to the TUAPA, Title 4, Chapter 5, Tennessee Code Annotated (hereinafter referred to as "Act").

(b) Scope

These procedures (TUAPA) may be applicable in cases involving: (1) suspension of employees for cause, or termination of employees when the termination is in violation of the employee's contract, e.g., termination prior to the expiration of the contract term; (2) suspension or expulsion of a student, or revocation of recognition of a student organization, for misconduct or disciplinary reasons; (3) support staff employees who are demoted, suspended without pay, or terminated and elect to pursue a TUAPA hearing instead of an employee panel hearing as the final step of the grievance process; and (4)

## PROPOSED RULES

such other cases as may be designated by the Chancellor of the State Board of Regents or president of the institution or director of the school. These procedures are not applicable to termination of faculty for adequate cause which are subject to the provisions of Chapter 839 of the Public Acts of 1976. Prior to the initiation of any hearing pursuant to these procedures, the institution or school shall contact the Office of General Counsel for advice on the applicability of these procedures and for possible assistance in the hearing of the case.

**Authority:** T.C.A. §49-8-203.

The proposed rules set out herein were properly filed in the Department of State on the 28th day of June, 2005, and pursuant to the instructions set out above, and in the absence of the filing of an appropriate petition calling for a rulemaking hearing, will become effective on the 28th day of October, 2005. (06-49)

## PROPOSED RULES

### **THE TENNESSEE BOARD OF REGENTS - 0240 STATE UNIVERSITY AND COMMUNITY COLLEGE SYSTEM OF TENNESSEE**

#### **SOUTHWEST TENNESSEE COMMUNITY COLLEGE**

##### **CHAPTER 0240-3-14 STUDENT DISCIPLINARY RULES**

Presented herein are proposed amendments of the Tennessee Board of Regents submitted pursuant to Tennessee Code Annotated, §4-5-202 in lieu of a rulemaking hearing. It is the intent of the Tennessee Board of Regents to promulgate these rules without a rulemaking hearing unless a petition requesting such hearing is filed within thirty (30) days of the publication date of the issue of the Tennessee Administrative Register in which the proposed amendments are published. Such petition to be effective must be filed in Suite 350 of the Genesco Park Building located at 1415 Murfreesboro Road, Nashville, TN 37217 and in the Department of State, Eighth Floor, William R. Snodgrass Tower, 312 Eighth Avenue, North, Nashville, TN 37243, and must be signed by twenty-five (25) persons who will be affected by the rules, or submitted by a municipality which will be affected by the rule, or an association of twenty-five (25) or more members, or any standing committee of the General Assembly.

For a copy of this proposed rule, contact: Mary M. Slater, 1415 Murfreesboro Road, Suite 350, Nashville, Tennessee 37217, Tennessee Board of Regents, 615-366-4438.

The text of the proposed amendments is as follows:

#### **AMENDMENTS**

Paragraph (1) of Rule 0240-3-14-.03 Classroom Misconduct is amended by deleting the text of the paragraph and substituting the following language, so that, as amended, paragraph (1) shall read:

- (1) The instructor has the primary responsibility for control over classroom behavior and the maintenance of academic integrity and can order the temporary removal or exclusion from the classroom of any student engaged in disruptive conduct or conduct that violates the general rules and regulations of the College. Extended or permanent exclusion can be affected only through appropriate procedures of the College.

Paragraph (2) of Rule 0240-3-14-.03 Classroom Misconduct is further amended by adding a comma (,) in the first sentence, so that, as amended, paragraph (2) shall read:

- (2) Disruptive conduct shall include, but is not limited to, any intentional interference with the normal classroom procedure or the presentation of the instructor and/or other students and the interference with other students' rights to pursue course work.

Paragraph (3) of Rule 0240-3-14-.03 Classroom Misconduct is further amended by deleting the text of the paragraph and substituting the following language, so that, as amended, paragraph (3) shall read:

- (3) The instructor shall report to the Coordinator of Student Activities and the Academic Department chairperson any incident of disruptive conduct that results in the student being asked to leave the classroom. The Coordinator of Student Activities will meet with the instructor and chairperson to determine the appropriate action before the next class period. If there is disagreement about readmission, the student will be excluded from the classroom pending a

## PROPOSED RULES

hearing. The hearing shall be conducted by the Student Disciplinary Committee. The purpose of the hearing is to determine whether the student will be readmitted to the classroom. The hearing must be conducted utilizing the appropriate due process procedures (See Southwest Policy No. 3:02:01:00/9). Students may appeal decisions of the committee to the Dean of Student Services and Enrollment Management.

Rule 0240-3-14-.03 Classroom Misconduct is further amended by adding new paragraphs (5) and (6) which shall read:

- (5) Should a student(s) be disruptive in the classroom, and refuse any request on the instructor's part to stop such behavior, the instructor has several options. The first option is to ask the student to leave the classroom. Should the student impose any harm to him/herself or to others, continue to be disruptive to the class, and refuse to leave at the instructor's request, the instructor should call Campus Police immediately to have the student removed. The instructor should then fill out an Information Report. The Campus Police Information Report provides for a formal record of an incident should further administrative discipline be necessary by the Dean of Student Services and Enrollment Management. The second option is to report the in-class incident of disruptive behavior to the Coordinator of Student Activities and the department chair of the department where the course is housed, and request that the student not return to class until further notice by the Coordinator. All students are accountable for their behavior when it leads to a breach of conduct.
- (6) When, in the opinion of the Dean for Student Services and Enrollment Management or his/her designee, a student has demonstrated indications of emotional distress and/or substance abuse which could affect his or her functioning as a member of the Southwest College community, an Administrative Referral to the Office of Advising, Counseling and Articulation may be made. This referral requires that the student meet with a counselor from the Advising, Counseling and Articulation staff to be evaluated by that professional counselor, the general conclusions of which will be shared with the Dean as needed within the bounds of confidentiality.

**Authority:** T.C.A. §49-8-203.

Subparagraphs (d) and (e) of paragraph (1) of Rule 0240-3-14-.06 Traffic and Parking Regulations are amended by deleting the text of the subparagraphs and substituting the following language, so that, as amended, subparagraphs (d) and (e) shall read:

- (d) While the State of Tennessee and Southwest Tennessee Community College has no legal responsibility for the care and/or protection of any vehicle operated or parked on a Southwest facility, there is a moral concern for the safety of such vehicles.
- (e) If a vehicle and/or its contents are stolen or damaged in any way while on Southwest property, this information should be immediately reported to the Campus Police Office. Campus Police will offer assistance in processing reports and/or claims to the appropriate agencies.

Subparagraph (g) of paragraph (2) of Rule 0240-3-14-.06 Traffic and Parking Regulations is further amended by deleting the text of the subparagraph and substituting the following language, so that, as amended, subparagraph (g) shall read:

- (g) Temporary Parking Permit - A permit issued by the Campus Police Office for a brief period of time, usually no more than three (3) working days. This permit is also issued to visitors and guests.

## PROPOSED RULES

Subparagraph (a) of paragraph (6) of Rule 0240-3-14-.06 Traffic and Parking Regulations is further amended by deleting the text of the subparagraph and substituting the following language, so that, as amended, subparagraph (a) shall read:

- (a) Citations issued for violations are payable within thirty (30) days at the Cashier's Office.

Subparagraph (d) of paragraph (6) of Rule 0240-3-124-.06 Traffic and Parking Regulations is further amended by deleting the text of the subparagraph and substituting the following language, so that, as amended, subparagraph (d) shall read:

- (d) Appeal forms are available in the Campus Police Office.

Part 2. of subparagraph (a) of paragraph (9) of Rule 0240-3-14-.06 Traffic and Parking Regulations is further amended by deleting the part and substituting the following language, so that, as amended, part 2. shall read:

- 2. Motorcycles and motor bikes - The permit will be permanently affixed to the windshield headlamp, or gas tank in a position where it is readily visible. Non-registered vehicles are not permitted to park in any Southwest Tennessee Community College parking facility unless a temporary permit is obtained in accordance with paragraph (2), subparagraph (g) above.

Subparagraph (d) of paragraph (11) of Rule 0240-3-14-.06 Traffic and Parking Regulations is further amended by deleting the text of the subparagraph and substituting the following language, so that, as amended, subparagraph shall read:

- (d) Limitations

Once a citation is issued to a student, notice of such is to be entered into the computer by the Campus Police Office, which results in a "hold" being placed on the student's records and denial of permission to register.

**Authority:** T.C.A. §49-8-203.

The proposed rules set out herein were properly filed in the Department of State on the 28th day of June, 2005, and pursuant to the instructions set out above, and in the absence of the filing of an appropriate petition calling for a rulemaking hearing, will become effective on the 28th day of October, 2005. (06-50)

PROPOSED RULES

**THE TENNESSEE BOARD OF REGENTS - 0240  
STATE UNIVERSITY AND COMMUNITY COLLEGE SYSTEM OF TENNESSEE**

**VOLUNTEER STATE COMMUNITY COLLEGE**

**CHAPTER 0240-3-15  
STUDENT DISCIPLINARY RULES**

Presented herein are proposed amendments of the Tennessee Board of Regents submitted pursuant to Tennessee Code Annotated, §4-5-202 in lieu of a rulemaking hearing. It is the intent of the Tennessee Board of Regents to promulgate these rules without a rulemaking hearing unless a petition requesting such hearing is filed within thirty (30) days of the publication date of the issue of the Tennessee Administrative Register in which the proposed amendments are published. Such petition to be effective must be filed in Suite 350 of the Genesco Park Building located at 1415 Murfreesboro Road, Nashville, TN 37217 and in the Department of State, Eighth Floor, William R. Snodgrass Tower, 312 Eighth Avenue, North, Nashville, TN 37243, and must be signed by twenty-five (25) persons who will be affected by the rules, or submitted by a municipality which will be affected by the rule, or an association of twenty-five (25) or more members, or any standing committee of the General Assembly.

For a copy of this proposed rule, contact: Mary M. Slater, 1415 Murfreesboro Road, Suite 350, Nashville, Tennessee 37217, Tennessee Board of Regents, 615-366-4438.

The text of the proposed amendments is as follows:

**AMENDMENTS**

Subparagraph (j) of paragraph (2) of Rule 0240-3-15-.02 Disciplinary Offenses is amended by deleting the text of the subparagraph and substituting the following language, so that, as amended, subparagraph (j) shall read:

- (j) Alcohol beverages. The use and/or possession of alcoholic beverages on college owned or controlled property. This offense includes the violation of any local ordinance or state or federal law concerning alcoholic beverages, on or off institution or school owned or controlled property, where an affiliated group or organization has alcoholic beverages present and available for consumption.

Paragraph (2) of Rule 0240-3-15-.02 Disciplinary Offenses is further amended by adding new subparagraphs (t) and (u) which shall read:

- (t) Pets. With the exception of "service animals" and the exception of animals used for academic research purposes, animals are prohibited on institution or school owned or controlled facilities. The term "service animal" is defined as any animal individually trained to do work or perform tasks for the benefit of a person with a disability (e.g., a guide dog, signal dog, etc.). "Service animals" perform some of the functions and tasks that the individual with a disability cannot perform for him/herself. The institution or school may require reasonable documentation that the individual seeking the assistance of a "service animal" while on its premises, provide appropriate certification of the medical necessity for the same prior to approval.

## PROPOSED RULES

- (u) Filing a false complaint or statement. Any behavior whereby a student knowingly submits a false complaint or statement alleging a violation of these regulations by a student, organization, institution, or school employee.

**Authority:** T.C.A. §49-8-203.

Paragraph (1) of Rule 0240-3-15-.03 Academic and Classroom Misconduct is amended by deleting the word "exclusion" in the last sentence and adding the word "expulsion" so that, as amended, paragraph (1) shall read:

- (1) The instructor has the primary responsibility for control over classroom behavior and maintenance of academic integrity, and can order the temporary removal or expulsion from the classroom of any student engaged in disruptive conduct or conduct that violates the general rules and regulations of the institution. Extended or permanent expulsion from the classroom or further disciplinary action can be effected only through appropriate procedures of the institution.

**Authority:** T.C.A. §49-8-203.

The proposed rules set out herein were properly filed in the Department of State on the 28th day of June, 2005, and pursuant to the instructions set out above, and in the absence of the filing of an appropriate petition calling for a rulemaking hearing, will become effective on the 28th day of October, 2005. (06-51)

PROPOSED RULES

**THE TENNESSEE BOARD OF REGENTS - 0240  
STATE UNIVERSITY AND COMMUNITY COLLEGE SYSTEM OF TENNESSEE**

**WALTERS STATE COMMUNITY COLLEGE  
CHAPTER 0240-3-16  
STUDENT DISCIPLINARY RULES**

Presented herein are proposed amendments of the Tennessee Board of Regents submitted pursuant to Tennessee Code Annotated, §4-5-202 in lieu of a rulemaking hearing. It is the intent of the Tennessee Board of Regents to promulgate these rules without a rulemaking hearing unless a petition requesting such hearing is filed within thirty (30) days of the publication date of the issue of the Tennessee Administrative Register in which the proposed amendments are published. Such petition to be effective must be filed in Suite 350 of the Genesco Park Building located at 1415 Murfreesboro Road, Nashville, TN 37217 and in the Department of State, Eighth Floor, William R. Snodgrass Tower, 312 Eighth Avenue, North, Nashville, TN 37243, and must be signed by twenty-five (25) persons who will be affected by the rules, or submitted by a municipality which will be affected by the rule, or an association of twenty-five (25) or more members, or any standing committee of the General Assembly.

For a copy of this proposed rule, contact: Mary M. Slater, 1415 Murfreesboro Road, Suite 350, Nashville, Tennessee 37217, Tennessee Board of Regents, 615-366-4438.

The text of the proposed amendments is as follows:

**AMENDMENTS**

Part 4. of subparagraph (a) of paragraph (7) of Rule 0240-3-16-.06 Traffic and Parking Regulations is amended by deleting the text of the part and substituting the following language, so that, as amended, part 4. shall read:

4. The President of the Student Government Association shall set the dates for traffic court each semester and shall notify the Justices of the dates set.

Parts 1. through 5. of subparagraph (b) of paragraph (7) of Rule 0240-3-16-.06 Traffic and Parking Regulations are further amended by deleting the parts in their entirety.

Subparagraph (b) of paragraph (7) of Rule 0240-3-16-.06 Traffic and Parking Regulation is further amended by adding new parts 1. through 4. New parts 1. through 4. shall read:

1. The WSCC Traffic Court operates to hear parking and traffic violation cases that students contest. The decision of the Traffic Court shall be final unless the Vice President for Student Affairs feels there is a violation of due process. In no case will an appeal be considered on the basis that the court's decision was too severe. In cases where a student makes an appeal because of additional evidence or a violation of due process, the student must do so within forty-eight (48) hours to the Vice President for Student Affairs. If the Vice President for Student Affairs feels there is justification for a hearing, the case will be reheard at the next regular Traffic Court. For extenuating circumstances, the Vice President for Student Affairs may make a decision regarding a student's traffic violation without referring the student to the WSCC Traffic Court. In such cases, the Vice President for Student Affairs will file a written statement explaining actions to the President of the College with

## PROPOSED RULES

a copy being forwarded to the Student Traffic Court. Parking and traffic violation cases involving staff members may be appealed to the Vice President for Business Affairs; cases involving faculty members may be appealed to the Vice President for Academic Affairs. Any exception to this policy shall be approved by the President of the College.

2. The WSCC Traffic Court shall hear only those cases for which an appeal has been filed. The necessary appeal form may be obtained in the Office of Student Affairs, Room 120 CCEN.
3. Student Justices receiving citations may contest the citations before the WSCC Traffic Court. However, their cases can be heard only on a court date for which they are not actively serving.
4. If a student fails to appear before the WSCC Traffic Court on the designated date, the right to a hearing is forfeited; and charges cited must be accepted.

**Authority:** T.C.A. §49-8-203.

The proposed rules set out herein were properly filed in the Department of State on the 28th day of June, 2005, and pursuant to the instructions set out above, and in the absence of the filing of an appropriate petition calling for a rulemaking hearing, will become effective on the 28th day of October, 2005. (06-52)

PROPOSED RULES

**THE TENNESSEE BOARD OF REGENTS - 0240  
STATE UNIVERSITY AND COMMUNITY COLLEGE SYSTEM OF TENNESSEE**

**PELLISSIPPI STATE TECHNICAL COMMUNITY COLLEGE  
CHAPTER 0240-3-18  
STUDENT DISCIPLINARY RULES**

Presented herein are proposed amendments of the Tennessee Board of Regents submitted pursuant to Tennessee Code Annotated, §4-5-202 in lieu of a rulemaking hearing. It is the intent of the Tennessee Board of Regents to promulgate these rules without a rulemaking hearing unless a petition requesting such hearing is filed within thirty (30) days of the publication date of the issue of the Tennessee Administrative Register in which the proposed amendments are published. Such petition to be effective must be filed in Suite 350 of the Genesco Park Building located at 1415 Murfreesboro Road, Nashville, TN 37217 and in the Department of State, Eighth Floor, William R. Snodgrass Tower, 312 Eighth Avenue, North, Nashville, TN 37243, and must be signed by twenty-five (25) persons who will be affected by the rules, or submitted by a municipality which will be affected by the rule, or an association of twenty-five (25) or more members, or any standing committee of the General Assembly.

For a copy of this proposed rule, contact: Mary M. Slater, 1415 Murfreesboro Road, Suite 350, Nashville, Tennessee 37217, Tennessee Board of Regents, 615-366-4438.

The text of the proposed amendments is as follows:

**AMENDMENTS**

Part 2. of subparagraph (d) of paragraph (2) of Rule 0240-3-18-.02 Disciplinary Offenses is amended by deleting the text of the part and substituting the following language, so that, as amended, part 2. shall read:

2. Interference with the right of any college staff member or other authorized person to gain access to any college or college-controlled activity, program, event, or facilities.

**Authority:** T.C.A. §49-8-203.

Subparagraphs (a) and (b) of paragraph (2) of Rule 0240-3-18-.03 Academic and Classroom Misconduct are amended by deleting the text of the subparagraphs and substituting the following language, so that, as amended, subparagraphs (a) and (b) shall read:

- (a) Cheating, including, but not limited to, unauthorized assistance from material, people, or devices when taking a test, quiz, or examination, writing papers or reports, solving problems, or completing academic assignments.
- (b) Plagiarism, including, but not limited to, paraphrasing, summarizing, or direct quotation of published or unpublished work of another person, including on-line computerized services, without proper documentation of the original source.

Paragraph (3) of Rule 0240-3-18-.03 Academic and Classroom Misconduct is further amended by deleting the text of the paragraph and substituting the following language, so that, as amended, paragraph (3) shall read:

## PROPOSED RULES

- (3) Pellissippi State instructors are responsible for communicating information to their students about college and classroom requirements meant to promote academic honesty. Included in this information should be a discussion of the College's Statement of Academic Honesty. Instructors also have the responsibility to ensure that exams, etc., are appropriately proctored to discourage instances of academic misconduct.

Paragraph (4) of Rule 0240-3-18-.03 Academic and Classroom Misconduct is further amended by deleting the text of the paragraph and substituting the following, so that, as amended, paragraph (4) shall read:

- (4) Upon discovery of a student's participation in academic misconduct, the student is immediately responsible to the instructor of the class, who will meet with the offending student with evidence of the misconduct. In addition to other possible disciplinary sanctions that may be imposed as a result of academic misconduct, the instructor has the authority to assign either (1) an "F" or zero ("0") for the assignment or (2) an "F" for the course.

Paragraph (6) of Rule 0240-3-18.03 Academic and Classroom Misconduct is further amended by deleting the text of the paragraph and substituting the following language, so that, as amended, paragraph (6) shall read:

- (6) The instructor will inform the department head of the violation, and the department head will forward written notice of the violation to the Associate Vice President of Student Affairs and Satellite Campuses who will keep records of the incident.

**Authority:** T.C.A. §49-8-203.

Subparagraph (h) of paragraph (1) of Rule 0240-3-18-.04 Disciplinary Sanctions is amended by deleting the text of the subparagraph and substituting the following language, so that, as amended, subparagraph (h) shall read:

- (h) Interim or summary suspension. Though as a general rule, the status of a student accused of violations of College regulations should not be altered until a final determination has been made in regard to the charges against the student. Summary suspension may be imposed upon a finding by the Associate Vice President of Student Affairs and Satellite Campuses or his/her designated representative that the continued presence of the accused on campus constitutes an immediate threat to the physical safety and well-being of the accused, or of any other member of the Pellissippi State community or its guest; destruction of property; or substantial disruption of classroom or other campus activities. In any case of immediate suspension, the student shall be given an opportunity at the time of the decision or immediately thereafter to contest the suspension, and if there are disputed issues of fact or cause and effect, the student shall be provided a hearing on the suspension as soon as possible.

Subparagraph (i) of paragraph (1) of Rule 0240-3-18-.04 Disciplinary Sanctions is further amended by deleting the text of the subparagraph and substituting the following language, so that, as amended, subparagraph (i) shall read:

- (i) In cases involving second and/or third instances of academic misconduct, the student will be subject to further disciplinary action. The Associate Vice President of Student Affairs and Satellite Campuses will notify the student, and a hearing shall be afforded the student according to the procedures outlined in the College Catalog and Handbook.

## PROPOSED RULES

**Authority:** T.C.A. §49-8-203.

Subparagraphs (a) through (c) of paragraph (4) of Rule 0240-3-18-.05 Disciplinary Procedures are amended by deleting the text of the subparagraphs and substituting the following language, so that, as amended, subparagraphs (a) through (c) shall read:

- (a) All complaints of alleged misconduct of a student shall be made in writing to the Associate Vice President of Student Affairs and Satellite Campuses. The complaint shall contain a statement of facts outlining each alleged act of misconduct and shall state the regulation which the student is alleged to have violated.
- (b) The Associate Vice President of Student Affairs and Satellite Campuses shall investigate the complaint. If it is determined that the complaint is without merit, the investigation shall promptly cease. If it is determined that there is probable cause to believe a violation did occur, the process is outlined below.
- (c) The student shall be notified in writing by the Associate Vice President of Student Affairs and Satellite Campuses that he/she is accused of a violation and will be asked to come in for a conference to discuss the complaint.

Subparagraph (d) of paragraph (4) of Rule 0240-3-18-.05 Disciplinary Procedures is further amended by deleting the text of the subparagraph and substituting the following language, so that, as amended, subparagraph (d) shall read:

- (d) Tennessee Uniform Administrative Procedures Act (TUAPA) may be applicable in cases involving (i) suspension or expulsion of a student for disciplinary misconduct or (ii) revocation of recognition of a student organization for disciplinary misconduct.

Subparagraph (e) of paragraph (4) of Rule 0240-3-18-.05 Disciplinary Procedures is further amended by deleting the text of the subparagraph and substituting the following language, so that, as amended, subparagraph (e) shall read:

- (e) In cases referred to the Student Disciplinary Hearing Body, the Associate Vice President of Student Affairs and Satellite Campuses shall, at least five (5) days in advance of the hearing, notify the student in writing concerning the following:

Subparagraph (h) of paragraph (4) of Rule 0240-3-18-.05 Disciplinary Procedures is further amended by deleting the text of the subparagraph and substituting the following language, so that, as amended, subparagraph (h) shall read:

- (h) A student shall be notified in writing of his or her right to appeal the decision of the Student Disciplinary Hearing Body to the president of Pellissippi State through the Chair of the Student Disciplinary Hearing Body within five (5) days of receipt of decision. In cases of appeal, any action assessed by the Student Disciplinary Hearing Body shall be suspended pending outcome of the appeal. A copy of the final decisions shall be mailed to the student.

## PROPOSED RULES

Subparagraph (c) of paragraph (2) of Rule 0240-3-18-.06 Traffic and Parking Regulations is amended by deleting the text of the subparagraph and substituting the following language, so that, as amended, subparagraph (c) shall read:

- (c) Parking is permitted only in areas designated for parking.

Subparagraph (b) of paragraph (3) of Rule 0240-3-18-.06 Traffic and Parking Regulations is further amended by deleting the text of the subparagraph and substituting the following language, so that, as amended, subparagraph (b) shall read:

- (b) Parking in a restricted area (fire zone, loading zone, cross walks, etc.);

Subparagraph (f) of paragraph (3) of Rule 0240-3-18-.06 Traffic and Parking Regulations is further amended by deleting the text of the subparagraph and substituting the following language, so that, as amended, subparagraph (f) shall read:

- (f) Parking or driving against the flow of traffic on a one-way street;

Subparagraph (j) of paragraph (3) of Rule 0240-3-18-.06 Traffic and Parking Regulations is further amended by deleting the text of the subparagraph and substituting the following language, so that, as amended, subparagraph (j) shall read:

- (j) Parking in a disabled zone without proper placard and/or license plate in accordance with T.C.A. §55-21-108.

Subparagraph (c) of paragraph (8) of Rule 0240-3-18-.06 Traffic and Parking Regulations is further amended by deleting the text of the subparagraph and substituting the following language, so that, as amended, subparagraph (c) shall read:

- (c) For illegal parking in a fire zone - \$15.00 all violations. For illegal parking in a disabled zone - \$100.00 all violations. Motor vehicles illegally parking in these areas are subject to being towed.

Subparagraph (h) of paragraph (8) of Rule 0240-3-18-.06 Traffic and Parking Regulations is further amended by deleting the text of the subparagraph and substituting the following language, so that, as amended, subparagraph (h) shall read:

- (h) All who habitually or flagrantly disregard these regulations may be subject to disciplinary action and/or may have their parking privileges revoked. Persons who continue to park on PSTCC property after their privileges have been revoked will have their vehicles towed from the property.

Subparagraph (b) of paragraph (9) of Rule 0240-3-18-.06 Traffic and Parking Regulations is further amended by deleting the text of the subparagraph and substituting the following language, so that, as amended, subparagraph (b) shall read:

- (b) The person receiving a citation may complete and submit electronically an appeal form on the Safety and Security web page: <http://www.pstcc.cc.tn.us/security/appeal.html>.

## PROPOSED RULES

Subparagraph (d) of paragraph (9) of Rule 0240-3-18-.06 Traffic and Parking Regulations is further amended by deleting the text of the subparagraph and substituting the following language, so that, as amended, subparagraph (d) shall read:

- (d) The person will present his or her case to the committee in person or by written explanation on an appeal form.

Paragraph (9) of Rule 0240-3-18-.06 Traffic and Parking Regulations is further amended by adding a new subparagraph (f) and relettering the remaining subparagraphs accordingly. New subparagraph (f) shall read:

- (f) The committee will hear cases at 2:00 p.m. on the second Friday of each month.

Subparagraph (i) (formerly (h)) of paragraph (9) of Rule 0240-3-18-.06 Traffic and Parking Regulations is further amended by deleting the subparagraph in its entirety and relettering the remaining subparagraphs accordingly.

**Authority:** T.C.A. §49-8-203.

The proposed rules set out herein were properly filed in the Department of State on the 28th day of June, 2005, and pursuant to the instructions set out above, and in the absence of the filing of an appropriate petition calling for a rulemaking hearing, will become effective on the 28th day of October, 2005. (06-53)

PROPOSED RULES

**THE TENNESSEE BOARD OF REGENTS - 0240  
STATE UNIVERSITY AND COMMUNITY COLLEGE SYSTEM OF TENNESSEE**

**NORTHEAST STATE COMMUNITY COLLEGE**

**CHAPTER 0240-3-20  
STUDENT DISCIPLINARY RULES**

Presented herein are proposed amendments of the Tennessee Board of Regents submitted pursuant to Tennessee Code Annotated, §4-5-202 in lieu of a rulemaking hearing. It is the intent of the Tennessee Board of Regents to promulgate these rules without a rulemaking hearing unless a petition requesting such hearing is filed within thirty (30) days of the publication date of the issue of the Tennessee Administrative Register in which the proposed amendments are published. Such petition to be effective must be filed in Suite 350 of the Genesco Park Building located at 1415 Murfreesboro Road, Nashville, TN 37217 and in the Department of State, Eighth Floor, William R. Snodgrass Tower, 312 Eighth Avenue, North, Nashville, TN 37243, and must be signed by twenty-five (25) persons who will be affected by the rules, or submitted by a municipality which will be affected by the rule, or an association of twenty-five (25) or more members, or any standing committee of the General Assembly.

For a copy of this proposed rule, contact: Mary M. Slater, 1415 Murfreesboro Road, Suite 350, Nashville, Tennessee 37217, Tennessee Board of Regents, 615-366-4438.

The text of the proposed amendments is as follows:

**AMENDMENTS**

Paragraph (4) of Rule 0240-3-20-.02 Disciplinary Offenses is amended by deleting the text of the paragraph and substituting the following language, so that, as amended, paragraph (4) shall read:

- (4) Violations of Computer Resource Guidelines. Violators of the college computer use guidelines will be subject to immediate suspension of their user account; referral to police agencies in the case of suspected federal or state law violations; loss of computing access privileges; and possible suspension or expulsion from the college.

**Authority:** T.C.A. §49-8-203.

Paragraph (2) of Rule 0240-3-20-.03 Academic and Classroom Misconduct is amended by deleting the text of the paragraph and substituting the following language, so that, as amended, paragraph (2) shall read:

- (2) Plagiarism, cheating, and other forms of academic dishonesty are prohibited. A student guilty of academic misconduct, either directly or indirectly through participation or assistance, is immediately responsible to the instructor of the class. In addition to other disciplinary sanctions which may be imposed through institutional procedures, the instructor has the authority to assign a grade of 'F' or a '0' for the exercise or examination or to assign an 'F' for the final grade of the course. If a student believes that he or she has been erroneously accused of academic misconduct, and if his or her final grade has been lowered as a result, the student may appeal the case through the appropriate institutional procedures.

**Authority:** T.C.A. §49-8-203.

## PROPOSED RULES

Subparagraph (a) of paragraph (2) of Rule 0240-3-20-.05 Disciplinary Procedures is amended by deleting the text of the subparagraph and substituting the following language, so that, as amended, subparagraph (a) shall read:

- (a) Tennessee Uniform Administrative Procedures Act (TUAPA) may be applicable in cases involving suspension or expulsion of a student, or revocation of recognition of a student organization, for misconduct or disciplinary reasons.

**Authority:** *T.C.A. §49-8-203.*

The proposed rules set out herein were properly filed in the Department of State on the 28th day of June, 2005, and pursuant to the instructions set out above, and in the absence of the filing of an appropriate petition calling for a rulemaking hearing, will become effective on the 28th day of October, 2005. (06-54)

PROPOSED RULES

**THE TENNESSEE BOARD OF REGENTS - 0240  
STATE UNIVERSITY AND COMMUNITY COLLEGE SYSTEM OF TENNESSEE**

**TENNESSEE TECHNOLOGY CENTERS**

**CHAPTER 0240-3-21  
STUDENT DISCIPLINARY RULES**

Presented herein are proposed amendments of the Tennessee Board of Regents submitted pursuant to Tennessee Code Annotated, §4-5-202 in lieu of a rulemaking hearing. It is the intent of the Tennessee Board of Regents to promulgate these rules without a rulemaking hearing unless a petition requesting such hearing is filed within thirty (30) days of the publication date of the issue of the Tennessee Administrative Register in which the proposed amendments are published. Such petition to be effective must be filed in Suite 350 of the Genesco Park Building located at 1415 Murfreesboro Road, Nashville, TN 37217 and in the Department of State, Eighth Floor, William R. Snodgrass Tower, 312 Eighth Avenue, North, Nashville, TN 37243, and must be signed by twenty-five (25) persons who will be affected by the rules, or submitted by a municipality which will be affected by the rule, or an association of twenty-five (25) or more members, or any standing committee of the General Assembly.

For a copy of this proposed rule, contact: Mary M. Slater, 1415 Murfreesboro Road, Suite 350, Nashville, Tennessee 37217, Tennessee Board of Regents, 615-366-4438.

The text of the proposed amendments is as follows:

**AMENDMENTS**

Subparagraph (a) of paragraph (3) of Rule 0240-3-21-.05 Disciplinary Procedures is amended by deleting the text of the subparagraph and substituting the following language, so that, as amended, subparagraph (a) shall read:

(a) TUAPA

The only cases which are subject to a Tennessee Uniform Administrative Procedures Act (TUAPA) hearing are those which may result in: (1) suspensions or expulsions of a student from the school for disciplinary offenses or (2) revocation of registration of an official student organization during the term of registration. Those cases are subject to the contested case provisions of the TUAPA and shall be processed in accordance with the Uniform Contested Case Procedures unless the student waives these procedures in writing and elects to have his/her case disposed of in accordance with the school procedures.

**Authority:** T.C.A. §49-8-203.

The proposed rules set out herein were properly filed in the Department of State on the 28th day of June, 2005, and pursuant to the instructions set out above, and in the absence of the filing of an appropriate petition calling for a rulemaking hearing, will become effective on the 28th day of October, 2005. (06-55)

PROPOSED RULES

**THE TENNESSEE BOARD OF REGENTS - 0240  
STATE UNIVERSITY AND COMMUNITY COLLEGE SYSTEM OF TENNESSEE**

**EAST TENNESSEE STATE UNIVERSITY**

**CHAPTER 0240-4-2  
STUDENT HOUSING RULES**

Presented herein are proposed amendments of the Tennessee Board of Regents submitted pursuant to Tennessee Code Annotated, §4-5-202 in lieu of a rulemaking hearing. It is the intent of the Tennessee Board of Regents to promulgate these rules without a rulemaking hearing unless a petition requesting such hearing is filed within thirty (30) days of the publication date of the issue of the Tennessee Administrative Register in which the proposed amendments are published. Such petition to be effective must be filed in Suite 350 of the Genesco Park Building located at 1415 Murfreesboro Road, Nashville, TN 37217 and in the Department of State, Eighth Floor, William R. Snodgrass Tower, 312 Eighth Avenue, North, Nashville, TN 37243, and must be signed by twenty-five (25) persons who will be affected by the rules, or submitted by a municipality which will be affected by the rule, or an association of twenty-five (25) or more members, or any standing committee of the General Assembly.

For a copy of this proposed rule, contact: Mary M. Slater, 1415 Murfreesboro Road, Suite 350, Nashville, Tennessee 37217, Tennessee Board of Regents, 615-366-4438.

The text of the proposed amendments is as follows:

**AMENDMENTS**

Subparagraphs (b) and (c) of paragraph (3) of Rule 0240-4-2-.02 Residence Hall Conduct and Disciplinary Sanctions are amended by deleting the text of the subparagraphs and substituting the following language, so that, as amended, subparagraphs (b) and (c) shall read:

- (b) Conference with Resident Director (RD); Assistant Resident Director (ARD);
- (c) Resident Director - Warning;

**Authority:** *T.C.A. §49-8-203.*

The proposed rules set out herein were properly filed in the Department of State on the 28th day of June, 2005, and pursuant to the instructions set out above, and in the absence of the filing of an appropriate petition calling for a rulemaking hearing, will become effective on the 28th day of October, 2005. (06-56)

PROPOSED RULES

**THE TENNESSEE BOARD OF REGENTS - 0240  
STATE UNIVERSITY AND COMMUNITY COLLEGE SYSTEM OF TENNESSEE**

**MIDDLE TENNESSEE STATE UNIVERSITY**

**CHAPTER 0240-4-4  
STUDENT HOUSING RULES**

Presented herein are proposed amendments of the Tennessee Board of Regents submitted pursuant to Tennessee Code Annotated, §4-5-202 in lieu of a rulemaking hearing. It is the intent of the Tennessee Board of Regents to promulgate these rules without a rulemaking hearing unless a petition requesting such hearing is filed within thirty (30) days of the publication date of the issue of the Tennessee Administrative Register in which the proposed amendments are published. Such petition to be effective must be filed in Suite 350 of the Genesco Park Building located at 1415 Murfreesboro Road, Nashville, TN 37217 and in the Department of State, Eighth Floor, William R. Snodgrass Tower, 312 Eighth Avenue, North, Nashville, TN 37243, and must be signed by twenty-five (25) persons who will be affected by the rules, or submitted by a municipality which will be affected by the rule, or an association of twenty-five (25) or more members, or any standing committee of the General Assembly.

For a copy of this proposed rule, contact: Mary M. Slater, 1415 Murfreesboro Road, Suite 350, Nashville, Tennessee 37217, Tennessee Board of Regents, 615-366-4438.

The text of the proposed amendments is as follows:

**AMENDMENTS**

Paragraph (15) of Rule 0240-4-4-.03 Residence Hall Conduct and Disciplinary Sanctions is amended by deleting the text of the paragraph and substituting the following language, so that, as amended, paragraph (15) shall read:

- (15) Telephone Service. MTSU residence hall rooms have one touch-tone telephone line with two (2) jacks for which students provide their own telephone sets for telecommunication services. MTSU's responsibility for telephone repair extends only to the telephone line and/or jack and not to problems associated with the use of equipment which may be incompatible with the campus telephone system. This includes, but is not limited to, answering machines that use voice monitoring instead of a timer to control the recording of incoming calls and cordless telephones that may experience static, cross-talk, and wrong numbers dialed. The repair of a student's telephone set is the student's responsibility.

Subparagraph (a) of paragraph (15) of Rule 0240-4-4-.03 Residence Hall Conduct and Disciplinary Sanctions is further amended by deleting the text of the subparagraph and substituting the following language, so that, as amended, subparagraph (a) shall read:

- (a) Dialing Instructions. Listed below are basic dialing instructions for MTSU residential service. Additional dialing information can be obtained in the Telecommunication Services Handbook for Resident Students, copies of which are available from the area coordinator.

Subpart (v) of part 3. of subparagraph (a) of paragraph (15) of Rule 0240-4-.03 Residence Hall Conduct and Disciplinary Sanctions is further amended by deleting the text of the subpart and substituting the following language, so that, as amended, subpart (v) shall read:

## PROPOSED RULES

- (v) Operator Assisted Calls (0 +). Person-to-person, outgoing collect, and billed-to-third-number calls can be placed from University residence hall telephone lines by dialing 9 + 0 + area code + number. Charges for calls may be billed to phone company calling cards, some credit cards, third number, and collect.

Subparagraph (a) of paragraph (15) of Rule 0240-4-4-.03 Residence Hall Conduct and Disciplinary Sanctions) is further amended by adding new parts 6. through 8. which shall read:

6. Voice Mail. Voice mail service is available for purchase by all students. Voice mail gives students their own personal voice mailbox to answer incoming calls when they are on another line or unavailable. This mailbox makes it easy to store and record messages with technology that is superior to that of an ordinary answering machine. To request voice mail service, a Telecommunication Services order form must be completed and signed. Forms are available online at <http://www.mtsu.edu/~itdtele/students>, in the Telecommunications Building, Room 200, or at the Cope Administration Building, cashier windows.
7. Caller ID. Caller ID service is available for purchase by resident students. MTSU Telecommunication Services provides the caller ID feature only. It is the responsibility of the student to obtain a telephone that will display caller ID information. To request caller ID, a Telecommunication Services order form must be completed and signed. Forms are available online at <http://www.mtsu.edu/~itdtele/students> in the Telecommunications Building, Room 200, or at the Cope Administration Building, cashier windows.
8. Private Telephone Line. Payment for a private telephone line includes caller ID and voice mail at no additional charge. The student is responsible for any long distance charges incurred on the private line. If a STAR1 authorization code is used to place long distance calls, the long distance charges will be billed monthly through the STAR1 long distance billing system. To request a private telephone line, a Telecommunication Services form must be completed and signed, and prepayment must be made. Forms are available online at <http://mts.edu/~itdtele/students>, in the Telecommunications Building, Room 200, or at the Cope Administration Building, cashier windows.

Part 1. of subparagraph (a) of paragraph (28) of Rule 0240-4-4-.03 Residence Hall Conduct and Disciplinary Sanctions is further amended by deleting the text of the part and substituting the following language, so that, as amended, part 1. shall read:

1. Access is provided to enhance the learning environment and experience.

**Authority:** T.C.A. §49-8-203.

The proposed rules set out herein were properly filed in the Department of State on the 28th day of June, 2005, and pursuant to the instructions set out above, and in the absence of the filing of an appropriate petition calling for a rulemaking hearing, will become effective on the 28th day of October, 2005. (06-57)

PROPOSED RULES

**THE TENNESSEE BOARD OF REGENTS - 0240  
STATE UNIVERSITY AND COMMUNITY COLLEGE SYSTEM OF TENNESSEE**

**TENNESSEE TECHNOLOGICAL UNIVERSITY**

**CHAPTER 0240-4-6  
STUDENT HOUSING RULES**

Presented herein are proposed amendments of the Tennessee Board of Regents submitted pursuant to Tennessee Code Annotated, §4-5-202 in lieu of a rulemaking hearing. It is the intent of the Tennessee Board of Regents to promulgate these rules without a rulemaking hearing unless a petition requesting such hearing is filed within thirty (30) days of the publication date of the issue of the Tennessee Administrative Register in which the proposed amendments are published. Such petition to be effective must be filed in Suite 350 of the Genesco Park Building located at 1415 Murfreesboro Road, Nashville, TN 37217 and in the Department of State, Eighth Floor, William R. Snodgrass Tower, 312 Eighth Avenue, North, Nashville, TN 37243, and must be signed by twenty-five (25) persons who will be affected by the rules, or submitted by a municipality which will be affected by the rule, or an association of twenty-five (25) or more members, or any standing committee of the General Assembly.

For a copy of this proposed rule, contact: Mary M. Slater, 1415 Murfreesboro Road, Suite 350, Nashville, Tennessee 37217, Tennessee Board of Regents, 615-366-4438.

The text of the proposed amendments is as follows:

**AMENDMENTS**

Paragraph (6) of Rule 0240-4-6-.02 Residence Hall Conduct and Disciplinary Sanctions is amended by deleting the text of the paragraph and substituting the following language, so that, as amended, paragraph (6) shall read:

- (6) University officials reserve the right to enter and inspect residence hall rooms and apartments at any time. Inspections will occur when necessary to protect and maintain the property of the University, to render service or repairs, the health and safety of its students, or whenever necessary to aid in the basic responsibility of the University regarding discipline and maintenance of an educational atmosphere. Additionally, University officials may remove any signs, fixtures, alterations or other objects not in conformity with these Housing Rules, other rules of the institution, or applicable law.

**Authority:** T.C.A. §49-8-203.

Paragraph (4) of Rule 0240-4-6-.03 Resident Responsibilities is amended by deleting the paragraph in its entirety and renumbering the remaining paragraphs accordingly.

**Authority:** T.C.A. §49-8-203.

## PROPOSED RULES

Rule 0240-4-6-.04 is amended by deleting the existing text in its entirety and adding new language, so that, as amended, Rule 0240-4-6-.04 shall read:

### **0240-4-6-.04 VISITATION**

- (1) Unless otherwise designated, Open House/Residence Hall Visitation will be noon - midnight, seven (7) days a week. Based on written request and approval by the Director of Residential Life, open house hours may be granted on special occasions. Requests should be made forty- eight (48) hours prior to the beginning of visitation period. Open House and/or Residence Hall Visitation may be differentiated by residence halls as necessary to accommodate, within limits, student preferences. The most open visitation option for a residence hall will be twelve (12) hours per day (between noon and midnight). The most restrictive option will be no visitation. A variety of options between these extremes may be offered in keeping with student surveyed preferences, with final approval being made by the Director of Residential Life.
- (2) Residential Life staff members will be available during the entire period of visitation, except during zone coverage, during which time housing personnel will be responsible for a specified area.
- (3) Each guest must be escorted from the lobby to the host/hostess's room and from the room back to the lobby. Guests are not to be unattended at any time inside or outside the room.
- (4) Visitation privileges require a greater responsibility to be shared. The primary responsibility for management of the total visitation program rests with the individual resident. Other assistance can be provided by the Residence Hall Association, the residence hall para-professional staff and residential life administrative/support staff.
- (5) During visitation, proper conduct and decorum are important and expected of both the host/hostess and the guest(s). A guest may be asked to leave the building and/or be prohibited from visiting if found to be violating policies, damaging property, or being a potential harm to themselves or others.

**Authority:** T.C.A. §49-8-203.

The proposed rules set out herein were properly filed in the Department of State on the 28th day of June, 2005, and pursuant to the instructions set out above, and in the absence of the filing of an appropriate petition calling for a rulemaking hearing, will become effective on the 28th day of October, 2005. (06-58)

## PROPOSED RULES

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

#### **CHAPTER 1720-4-4 STUDENT HOUSING REGULATIONS**

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

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

The text of the proposed amendments is as follows:

#### **AMENDMENTS**

Rule 1720-4-4-.11 Differentiated Housing (2) is amended by deleting the current language of subparagraph (c) and substituting new language in subparagraph (c), and by deleting the chart at the end of the paragraph and substituting a new chart, so that, as amended, the paragraph shall read:

- (2) The differentiated housing programs offer five distinct types of living atmospheres:
  - (a) Group A: Residence hall units with programming, regulations, and supervision; no hall open houses or visitation periods; staff responsibility focuses on assisting residents with problems and orientation to university living.
  - (b) Group B: Residence hall units with programming, regulations, and supervision; hall open houses\* supervised and restricted to a maximum of three per week of no more than fourteen hours duration; staff responsibility focuses on assisting residents with problems and orientation to university living.
  - (c) Group C: Residence hall units with programming, regulations, and supervision; minimally supervised open houses\* of seven per week of not more than fourteen hours on days preceding class days and twenty-four hours on days preceding weekends and holidays; staff responsibility focuses on assisting residents with problems and orientation to University living.
  - (d) Group D: Graduate and upper class residence hall units with programming, regulations, supervision and visitation privileges (up to 24 hours daily) as determined by the housing unit. (Not available to freshmen, i.e., fewer than two (2) terms in residence or 30 semester hours credit.)

PROPOSED RULES

- (e) Group E: Apartments with minimal programming, regulations, and supervision; and 24 hours visitation. (Not available to freshmen, i.e., fewer than two (2) terms in residence or 30 semester hours credit.)

\*Hall open houses are scheduled time periods in which members of the opposite sex may visit rooms for a designated period of time not to extend beyond 1:00 a.m. on nights preceding class days and twenty-four hours on days preceding weekends and holidays as determined by the respective Residence Hall Association in conjunction with the Hall Director.

GROUP B VISITATION

	VISITATION HOURS
Monday	No Visitation
Tuesday	No Visitation
Wednesday	No Visitation
Thursday	No Visitation
Friday	11:00 a.m. – 1:00 a.m.
Saturday	11:00 a.m. – 1:00 a.m.
Sunday	11:00 a.m. – 1:00 a.m.

GROUP C VISITATION

	VISITATION HOURS
Monday	11:00 a.m. – 1:00 a.m.
Tuesday	11:00 a.m. – 1:00 a.m.
Wednesday	11:00 a.m. – 1:00 a.m.
Thursday	11:00 a.m. – 1:00 a.m.
Friday	11:00 a.m. – 12:00 a.m.
Saturday	24 Hours
Sunday	12:00 a.m. – 1:00 a.m.

**Authority:** T.C.A. §49-9-209(e).

Rule 1720-4-4-.12 Open House And Visitation Procedures (1)(b)1 is amended by deleting “10:00” and substituting “11:00” so that, as amended, the part reads:

## PROPOSED RULES

1. Hall open houses/visitation periods may begin at 11:00 a.m.

**Authority:** T.C.A. §49-9-209(e).

Rule 1720-4-4-.12 Open House And Visitation Procedures (1)(b)2 is amended by deleting the current language of part 2 and substituting new language in part 2, so that, as amended, the part shall read:

2. Hall open houses are scheduled time periods not to extend beyond 1:00 a.m. on nights preceding class days and twenty-four hours on nights preceding weekends and holidays as determined by the respective Residence Hall Association in conjunction with the Hall Director.

**Authority:** T.C.A. §49-9-209(e).

The proposed rules set out herein were properly filed in the Department of State on the 9th day of June, 2005, and pursuant to the instructions set out above, and in the absence of the filing of an appropriate petition calling for a rulemaking hearing, will become effective on the 28th day of October, 2005. (06-12)

PROPOSED RULES

**THE TENNESSEE DEPARTMENT OF TRANSPORTATION - 1680  
MAINTENANCE DIVISION**

**CHAPTER 1680-2-5  
TRUCK LANE RESTRICTIONS ALONG INTERSTATES AND  
MULTI-LANE ACCESS CONTROLLED HIGHWAYS**

Presented herein are proposed new rules of the Tennessee Department of Transportation, Maintenance Division, submitted pursuant to T.C.A. § 4-5-202 in lieu of a rulemaking hearing. It is the intent of the Tennessee Department of Transportation to promulgate these new rules without a rulemaking hearing unless a petition requesting such hearing is filed within thirty (30) days of the publication date of the issue of Tennessee Administrative Register in which the proposed rules are published. Such petition to be effective must be filed with the Tennessee Department of Transportation, Legal Office, Suite 300, James K. Polk Building, 505 Deaderick Street, Nashville, Tennessee 37243-0326, and in the Department of State, Division of Publications, 312 Eighth Avenue North, 8th Floor, William R. Snodgrass Tower, Nashville, Tennessee 37243-0307, and must be signed by twenty-five (25) persons who will be affected by the rule, or an association of twenty-five (25) or more members, or any standing committee of the General Assembly.

For a copy of the text of these proposed new rules, contact the Tennessee Department of Transportation, Legal Office, Suite 300, James K. Polk Building, 505 Deaderick Street, Nashville, Tennessee 37243, telephone number (615) 741-2941.

The text of the proposed new rules is as follows:

**NEW RULES**

**TABLE OF CONTENTS**

1680-2-5-.01 Purpose and Scope	1680-2-5-.04 Guidelines for Establishing Truck Lane Restrictions on Eligible Highways
1680-2-5-.02 Definitions	
1680-2-5-.03 Truck Lane Restrictions	

**1680-2-5-.01 PURPOSE AND SCOPE.**

- (1) The purpose of these rules is to implement Tennessee Code Annotated § 55-8-194 by establishing criteria for the designation and enforcement of lane restrictions for truck tractors and semi trailers as defined in Tennessee Code Annotated § 55-8-101 and in these rules.
- (2) The truck lane restrictions established under these rules shall apply only in designated areas where appropriate signage has been posted on eligible highways as defined in these rules.

**Authority:** T.C.A. § 55-8-194.

**1680-2-5-.02 DEFINITIONS.**

- (1) "Access controlled highway" means a highway or street especially designed for through traffic, with grade-separated interchanges rather than at-grade intersections, and to which owners or occupants of abutting land or other persons have no legal right or easement of access from abutting land.

## PROPOSED RULES

- (2) "Bus" means every motor vehicle designed for carrying more than ten (10) passengers and used for the transportation of persons, and every motor vehicle, other than a taxicab, designed and used for the transportation of persons for compensation.
- (3) "Eligible highways" means highways on the Interstate Highway System and access controlled, multilane divided highways on the state highway system that have three (3) or more lanes in each direction of travel.
- (4) "Semi trailer" means every vehicle with or without motive power, other than a pole trailer, designed for carrying persons or property and for being drawn by a motor vehicle and so constructed that some part of its weight and that of its load rests upon or is carried by another vehicle.
- (5) "Truck tractor" means every motor vehicle designed and used primarily for drawing other vehicles and not so constructed as to carry a load other than a part of the weight of the vehicle and load so drawn.

**Authority:** T.C.A. § 55-8-194.

### **1680-2-5-.03 TRUCK LANE RESTRICTIONS.**

- (1) Except as otherwise provided in these rules, truck tractors and semi trailers shall be restricted to the right two (2) lanes of travel in designated areas of eligible highways where appropriate signage has been posted.
- (2) Truck lane restrictions shall not apply when truck tractors and semi trailers are passing other motor vehicles. The passing maneuver shall be safely completed in as short a time period as feasible. The passing maneuver shall consist of passing one motor vehicle at a time.
- (3) Buses are not subject to the restrictions established in these rules.

**Authority:** T.C.A. § 55-8-194.

### **1680-2-5-.04 GUIDELINES FOR ESTABLISHING TRUCK LANE RESTRICTIONS ON ELIGIBLE HIGHWAYS.**

- (1) Interstate highways and other access controlled, multilane divided highways that have three (3) or more through lanes in each direction of travel are eligible for truck lane restrictions.
- (2) Only those portions of eligible highways approved by the Department of Transportation and where appropriate signage has been installed shall be considered as having truck lane restrictions.
- (3) Truck lane restrictions shall terminate within two (2) miles of a left lane exit to allow ample time for lane transitions.
- (4) Existing truck lane restrictions may be temporarily terminated or modified during highway construction and other special events at the discretion of the Department of Transportation.
- (5) Truck lane restrictions should be avoided in areas where the average truck spacing is less than 500 feet per lane.

## PROPOSED RULES

- (6) Signs shall be placed in accordance with the Manual on Uniform Traffic Control Devices (MUTCD) to provide motorists with notification of the restricted zone. Examples of the signs may be found in the current edition of the Tennessee Supplement to Standard Highway Signs and the MUTCD.
- (7) These rules do not apply to those portions of highways where “truck climbing lanes” have been established due to excessive grades or where special truck lane restrictions have been established in construction zones.
- (8) The Commissioner of the Department of Transportation reserves the authority to remove or modify truck lane restriction zones established under these rules.

**Authority:** T.C.A. § 55-8-194.

The proposed rules set out herein were properly filed in the Department of State on the 23rd day of June, 2005, and pursuant to the instructions set out above, and in the absence of the filing of an appropriate petition calling for a rulemaking hearing, will become effective on the 28th day of October, 2005. (06-32)

## **PUBLIC NECESSITY RULES**

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

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

- 0180 - Department of Financial Institutions - Compliance Division - Public Necessity rules relating to registration of loan originators, chapter 0180-17 Rules Pertaining to Mortgage Lending, Loan Servicing and Loan Brokering, 4 T.A.R. (April 2005) - Filed March 8, 2005; effective through August 20, 2005. (03-09)
- 0620 - Department of Finance and Administration - Bureau of TennCare - Public Necessity Rules required to conform the current TennCare Standard rules to reflect changes resulting from the amendment of the TennCare waiver, chapter 1200-13-13 TennCare Medicaid, 6 T.A.R. (June 2005) - Filed May 5, 2005; effective through October 17, 2005. (05-05)
- 0620 - Department of Finance and Administration - Bureau of TennCare - Public Necessity required to modify the current TennCare rules to reflect changes resulting from the Balanced Budget Act of 2003, chapter 1200-13-14 TennCare Standard, 6 T.A.R. (June 2005) - Filed May 5, 2005; effective through October 17, 2005. (05-06)
- 0620 - Department of Finance and Administration - Bureau of TennCare - Public Necessity Rules required to conform the current TennCare Standard rules to reflect changes resulting from the amendment of the TennCare waiver, chapter 1200-13-14 TennCare Medicaid, 5 T.A.R. (May 2005) - Filed April 29, 2005; effective through October 11, 2005. (04-18)
- 0620 - Department of Finance and Administration - Bureau of TennCare - Public Necessity Rules required to conform the current TennCare Standard rules to reflect changes resulting from the amendment of the TennCare waiver, chapter 1200-13-14 TennCare Standard, 5 T.A.R. (May 2005) - Filed April 29, 2005; effective through October 11, 2005. (04-17)
- 1240 - Department of Human Services - Child Support Division - Public Necessity Rules required in order to maintain compliance with federal requirements, chapter 1240-2-2 Forms for Income Assignments, 6 T.A.R. (June 2005) - Filed May 20, 2005; effective through November 1, 2005. (05-20)

PUBLIC NECESSITY RULES

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

**CHAPTER 1200-13-13  
TENNCARE MEDICAID**

**STATEMENT OF NECESSITY REQUIRING PUBLIC NECESSITY RULES**

I am herewith submitting amendments to the rules of the Tennessee Department of Finance and Administration, Bureau of TennCare, for promulgation pursuant to the public necessity provisions of the Uniform Administrative Procedures Act, T.C.A. § 4-5-209 and the Medical Assistance Act, T.C.A. § 71-5-134.

The State of Tennessee has received federal approval for certain eligibility amendments to the TennCare Demonstration Project (No. 11-W-0015 1/4). Approval of the project modification is granted under the authority of Section 1115 (a) of the Social Security Act. The amendments are approved through the period ending June 30, 2007. The TennCare program is a managed care program for both the Medicaid population and the expansion population.

This amendment enables the State to disenroll non-pregnant adult Medically Needy individuals upon the expiration of their current eligibility periods.

Tennessee Code Annotated, Section 71-5-134, states that in order to comply with or to implement the provisions of any federal waiver or state plan amendment obtained pursuant to the Medical Assistance Act as amended by Acts 1993, the Commissioner of Finance and Administration is authorized to promulgate public necessity rules pursuant to Tennessee Code Annotated, Section 4-5-209.

I have made a finding that these amendments are required to conform the current TennCare Medicaid rules to reflect changes resulting from the amendment of the TennCare waiver.

For a copy of this public necessity rule, contact George Woods at the Bureau of TennCare by mail at 729 Church Street, Nashville, Tennessee 37247-6501 or by telephone at (615) 741-0145.

J. D. Hickey  
Deputy Commissioner  
Tennessee Department of Finance  
and Administration

PUBLIC NECESSITY RULES

**PUBLIC NECESSITY RULES  
OF  
TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION**

**BUREAU OF TENNCARE**

**CHAPTER 1200-13-13  
TENNCARE MEDICAID**

**AMENDMENT**

Rule 1200-13-13-.01 Definitions is amended by adding new paragraphs (69) and (101) and renumbering current paragraph (69) as (70) and current paragraph (101) as (102) and renumbering subsequent paragraphs accordingly so as amended new paragraphs (69) and (101) shall read as follows:

(69) OPEN MEDICAID CATEGORIES shall mean those Medicaid eligibility categories for which enrollment has not been closed pursuant to authority granted by CMS as part of the TennCare demonstration project.

(101) TENNCARE MEDICAID ELIGIBILITY REFORMS shall mean the amendments to the TennCare demonstration project approved by CMS on March 24, 2005, to close enrollment into TennCare Medicaid for non-pregnant adults age twenty-one (21) or older who qualify as Medically Needy under Tennessee's Title XIX State Plan for Medical Assistance and to terminate coverage for currently enrolled non-pregnant Medically Needy adults age twenty-one (21) or older at the expiration of their current eligibility periods.

Rule 1200-13-13-.02 Eligibility paragraph (4) is amended by adding subparagraph (c) which shall read as follows:

- (c) The individual who is eligible as a non-pregnant Medically Needy adult in accordance with Rule 1240-2-1-.03 of the Department of Human Services is found to meet the following criteria:
1. S/he is aged twenty-one (21) or older,
  2. S/he has completed his/her twelve (12) month period of eligibility for TennCare, and
  3. S/he has not been determined eligible in an open Medicaid category.

Rule 1200-13-13-.02 Eligibility is amended by adding paragraph (7) which shall read as follows:

(7) Disenrollment Related to TennCare Medicaid Eligibility Reforms

Prior to the disenrollment of adult non-pregnant Medically Needy TennCare enrollees based on coverage terminations resulting from TennCare Medicaid Eligibility Reforms, Medicaid eligibility shall be reviewed in accordance with the following.

- (a) Ex Parte Review

## PUBLIC NECESSITY RULES

DHS will conduct an ex parte review of eligibility for open Medicaid categories for all non-pregnant adult Medically Needy enrollees in eligibility groups due to be terminated as part of the TennCare Medicaid eligibility reforms. Such ex parte review shall be conducted in accordance with federal requirements as set forth by CMS in the Special Terms and Conditions of the TennCare demonstration project.

### (b) Request for Information

1. At least thirty (30) days prior to the expiration of their current eligibility period, the Bureau of TennCare will send a Request for Information to all non-pregnant adult Medically Needy enrollees in eligibility groups being terminated pursuant to the TennCare Medicaid eligibility reforms. The Request for Information will include a form to be completed with information needed to determine eligibility for open Medicaid categories as well as a list of the types of proof needed to verify certain information.
2. Enrollees will be given thirty (30) days inclusive of mail time from the date of the Request for Information to return the completed form to TDHS and to provide TDHS with the necessary verifications to determine eligibility for open Medicaid categories.
3. Enrollees with a health, mental health, or learning problem or a disability will be given the opportunity to request assistance in responding to the Request for Information. Enrollees with Limited English Proficiency will have the opportunity to request translation assistance for responding to the Request for Information.
4. Enrollees will be given an opportunity until the date of termination to request one extension for good cause of the thirty (30) day timeframe for responding to the Request for Information. The good cause extension is intended to allow a limited avenue for possible relief for certain enrollees who face significant unforeseen circumstances, or who, as a result of a health, mental health, or learning problem, or a disability, or limited English proficiency are unable to respond timely, as an alternative to imposing a standard with no exceptions whatsoever. The good cause exception does not confer an entitlement upon enrollees and the application of this exception will be within the discretion of TDHS. Only one thirty (30) day good cause extension can be granted to each enrollee. Good cause is determined by TDHS eligibility staff. Good cause is not requested nor determined through filing an appeal. Requests for an extension of the 30-day timeframe to respond to the Request for Information must be initiated by the enrollee. However, the enrollee may receive assistance in initiating such request. TDHS will not accept a request for extension of the thirty (30) day timeframe submitted by a family member, advocate, provider, or CMHC acting on the enrollee's behalf without the involvement and knowledge of the enrollee, for example, to allow time for such entity to locate the enrollee if his/her whereabouts is unknown. All requests for good cause extension must be made prior to termination of Medicaid eligibility. A good cause extension will be granted if TDHS determines that a health, mental health or learning problem or disability or limited English proficiency prevented an enrollee from understanding or responding timely to the Request for Information. Except in the aforementioned circumstances, a good cause extension will only be granted if such request is submitted in writing to TDHS prior to termination of Medicaid eligibility and TDHS determines that serious personal circumstances such as illness or death prevent an enrollee from responding to the Request for Information for an extended period of time. Proof of the serious personal circumstances is required with the submission of the written request in order for a good cause extension to be granted. Good cause extensions will be granted at the sole discretion of TDHS and if granted shall provide

## PUBLIC NECESSITY RULES

the enrollee with an additional thirty (30) days inclusive of mail time from the date of TDHS's decision to grant the good cause extension. TDHS will send enrollees a letter granting or denying the request for good cause extensions. TDHS's decisions with respect to good cause extensions shall not be appealable.

5. If an enrollee provides some but not all of the necessary information to TDHS to determine his/her eligibility for open Medicaid categories during the thirty (30) day period following the Request for Information, TDHS will send the enrollee a Verification Request. The Verification Request will provide the enrollee with ten (10) days inclusive of mail time to submit any missing information as identified in the Verification Request. Enrollees will not have the opportunity to request an extension for good cause of the ten (10) day timeframe for responding to the Verification Request.
6. Enrollees who respond to the Request for Information within the thirty (30) day period or within any extension of such period granted by TDHS shall retain their eligibility for TennCare Medicaid (subject to any changes in covered services generally applicable to enrollees in their Medicaid category) while TDHS reviews their eligibility for open Medicaid categories.
7. TDHS shall review all information and verifications provided within the requisite time period by an enrollee pursuant to the Request for Information and/or the Verification Request to determine whether the enrollee is eligible for any open Medicaid categories. If TDHS makes a determination that the enrollee is eligible for an open Medicaid category, TDHS will so notify the enrollee and the enrollee will be enrolled in the appropriate TennCare Medicaid category. Once the enrollee is enrolled in the appropriate TennCare Medicaid category, his/her eligibility as a non-pregnant Medically Needy adult shall then be terminated without additional notice. If TDHS makes a determination that the enrollee is not eligible for any open Medicaid categories or if an enrollee does not respond to the Request for Information within the requisite thirty (30) day time period or any extension of such period granted by TDHS, the TennCare Bureau will send the enrollee a twenty (20) day advance Termination Notice.
8. Enrollees who respond to the Request for Information or the Verification Request after the requisite time period specified in those notices or after any extension of such time period granted by TDHS but before the date of termination shall retain their eligibility for TennCare Medicaid (subject to any changes in covered services generally applicable to enrollees in their Medicaid category) while TDHS reviews their eligibility for open Medicaid categories. If TDHS makes a determination that the enrollee is eligible for an open Medicaid category, TDHS will so notify the enrollee and the enrollee will be enrolled in the appropriate TennCare Medicaid category. Once the enrollee is enrolled in the appropriate TennCare Medicaid category, his/her eligibility as a non-pregnant Medically Needy adult shall then be terminated without additional notice. If TDHS makes a determination that the enrollee is not eligible for any open Medicaid categories, the TennCare Bureau will send the enrollee a twenty (20) day advance Termination Notice.
9. Individuals may provide the information and verifications specified in the Request for Information after termination of eligibility. TDHS shall review all such information pursuant to the rules, policies and procedures of TDHS and the Bureau of TennCare applicable to new applicants for TennCare coverage. The individual shall not be entitled to be reinstated into TennCare pending this review. If the individual is subsequently determined to be eligible for an open Medicaid category, s/he shall be granted

## PUBLIC NECESSITY RULES

retroactive coverage to the date of application, or in the case of spend down eligibility for Medically Needy pregnant women and children, to the latter of (a) the date of his or her application or (b) the date spenddown eligibility is met.

### (c) Termination Notice

1. The TennCare Bureau will send Termination Notices to all non-pregnant adult Medically Needy enrollees being terminated pursuant to the TennCare Medicaid eligibility reforms who are not determined to be eligible for open Medicaid categories pursuant to the Ex Parte Review or Request for Information processes described in this subsection.
2. Termination Notices will be sent twenty (20) days in advance of the date upon which the coverage will be terminated.
3. Termination Notices will provide enrollees with forty (40) days from the date of the notice to appeal valid factual disputes related to the disenrollment and will inform enrollees how they may request a hearing.
4. Enrollees with a health, mental health, or learning problem or a disability will be given the opportunity to request additional assistance for their appeal. Enrollees with Limited English Proficiency will have the opportunity to request translation assistance for their appeal.
5. Enrollees will not have the opportunity to request an extension for good cause of the forty (40) day timeframe in which to request a hearing.

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

he Public Necessity rules set out herein were properly filed in the Department of State on the 3rd day of June, 2005, and will be effective from the date of filing for a period of 165 days. The Public Necessity rules remain in effect through the 15th day of November, 2005. (06-06)

PUBLIC NECESSITY RULES

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

**CHAPTER 1200-13-13  
TENNCARE MEDICAID**

**STATEMENT OF NECESSITY REQUIRING PUBLIC NECESSITY RULES**

I am herewith submitting amendments to the rules of the Tennessee Department of Finance and Administration, Bureau of TennCare, for promulgation pursuant to the public necessity provisions of the Uniform Administrative Procedures Act, T.C.A. § 4-5-209 and the Medical Assistance Act, T.C.A. § 71-5-134.

The State of Tennessee has received federal approval for certain eligibility amendments to the TennCare Demonstration Project (No. 11-W-0015 1/4). Approval of the project modification is granted under the authority of Section 1115 (a) of the Social Security Act. The amendments are approved through the period ending June 30, 2007. The TennCare program is a managed care program for both the Medicaid population and the expansion population.

This amendment sets forth provisions for granting fair hearings based on valid factual disputes before a Hearing Officer or Administrative Law Judge. In addition, this amendment defines clear requirements for timely submission of eligibility-based appeals and the continuation of benefits pending resolution of such appeals, including appeals related to disenrollment as a result of certain eligibility amendments to the TennCare Demonstration Project.

Tennessee Code Annotated, Section 71-5-134, states that in order to comply with or to implement the provisions of any federal waiver or state plan amendment obtained pursuant to the Medical Assistance Act as amended by Acts 1993, the Commissioner of Finance and Administration is authorized to promulgate public necessity rules pursuant to Tennessee Code Annotated, Section 4-5-209.

I have made a finding that these amendments are required to conform the current TennCare Medicaid rules to reflect changes resulting from the amendment of the TennCare waiver.

For a copy of this public necessity rule, contact George Woods at the Bureau of TennCare by mail at 729 Church Street, Nashville, Tennessee 37247-6501 or by telephone at (615) 741-0145.

J. D. Hickey  
Deputy Commissioner  
Tennessee Department of  
Finance and Administration

PUBLIC NECESSITY RULES

**PUBLIC NECESSITY RULES**

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

**CHAPTER 1200-13-13  
TENNCARE MEDICAID**

**AMENDMENT**

Rule 1200-13-13-.12 Other Appeals By TennCare Applicants and Enrollees is amended by deleting paragraph (1) in its entirety and by substituting instead the following new language so that as amended paragraph (1) shall read as follows:

- (1) Appeal Rights of TennCare Medicaid Applicants or Enrollees.
  - (a) Appeal Time; Continuation of Services.
    1. TennCare Medicaid Appeals.
      - (i) TennCare Medicaid applicants or enrollees will be given the opportunity to have an administrative hearing before a Hearing Officer or an Administrative Law Judge, as determined by the Department of Human Services, regarding valid factual disputes concerning denial of his/her application, cost sharing disputes, limitation, reduction or termination of coverage, failure to act upon a request or application within required timeframes, and disputes regarding disenrollment from TennCare Medicaid. A valid factual dispute is a dispute that, if resolved in favor of the appellant, would prevent the state from taking the adverse action that is the subject of the appeal. The TennCare Bureau designates TDHS to review each request for a hearing to determine if it is based on a valid factual dispute. If TDHS determines that an appeal does not present a valid factual dispute, then TDHS will send the appellant a letter asking him or her to submit additional clarification regarding the appeal within ten (10) days (inclusive of mail time). Unless such clarification is timely received and is determined by TDHS to establish a valid factual dispute, TDHS will dismiss the appeal. TDHS' decisions with respect to determination of whether an appeal raises a valid factual dispute shall not be appealable.
      - (ii) Requests for appeals must be made within forty (40) calendar days (inclusive of mail time) of the date of the notice to the applicant/enrollee regarding the intended action, notwithstanding anything else in these rules or in the Department of Human Services' administrative procedures rules to the contrary.
      - (iii) Enrollees who request a hearing within twenty (20) calendar days (inclusive of mail time) of the date of notice or prior to the date of termination specified in the notice shall retain their eligibility (subject to any changes in covered services generally applicable to enrollees in their TennCare category) pending a determination that the enrollee has not raised a valid factual dispute or until the appeal is otherwise resolved, whichever comes first. If the appeal results in the State's action being sustained, the State reserves its right to recover from the enrollee the cost of services provided to the enrollee during the pendency of the appeal.

## PUBLIC NECESSITY RULES

- (b) Such appeals will be conducted by the Department of Human Services for TennCare Medicaid applicants/enrollees under the Department of Human Services' administrative procedures rules, and in accordance with any other applicable rules, laws or court orders governing those programs.
- (c) Appeal Rights for Disenrollment Related to TennCare Medicaid Eligibility Reforms
1. TennCare Medicaid enrollees, who have not been determined eligible for open Medicaid categories pursuant to the Ex Parte Review or Request for Information processes described in 1200-13-13-.02, will have the right to request a hearing for 40 days (inclusive of mail time) from the date of the Termination Notice, notwithstanding anything else in these rules or in the Department of Human Services' administrative procedures rules to the contrary.
  2. Such appeals will be conducted by the Department of Human Services for TennCare Medicaid applicants/enrollees under the Department of Human Services' administrative procedures rules, and in accordance with any other applicable rules, laws or court orders governing those programs.
  3. Enrollees will not have the opportunity to request an extension for good cause of the forty (40) day timeframe in which to request a hearing.
  4. Enrollees who request a hearing prior to the date of termination specified in the Termination Notice shall retain their eligibility (subject to any changes in covered services generally applicable to enrollees in their TennCare Medicaid category) pending a determination that the enrollee has not raised a valid factual dispute or until the appeal is otherwise resolved, whichever comes first.
  5. The TennCare Bureau designates TDHS to review each request for hearing to determine if it is based on a valid factual dispute. Enrollees will be given the opportunity to have an administrative hearing before a Hearing Officer or an Administrative Law Judge, as determined by TDHS, regarding valid factual disputes related to termination. If TDHS makes an initial determination that the request for a hearing is not based on a valid factual dispute, the appellant will receive a notice which provides ten (10) days (inclusive of mail time) to provide additional clarification of any factual dispute on which his/her appeal is based. Unless such clarification is timely received and is determined by TDHS to establish a valid factual dispute, a fair hearing will not be granted.
  6. TDHS will grant hearings only for those enrollees raising valid factual disputes related to the action of disenrollment. A valid factual dispute is a dispute that, if resolved in favor of the appellant, would prevent the state from taking the adverse action that is the subject of the appeal. Appeals that do not raise a valid factual dispute will not proceed to a hearing. Valid factual disputes include:
    - (i) Enrollee received the Termination Notice in error (e.g., they are currently enrolled in a TennCare Medicaid category that is not ending);
    - (ii) TDHS failed to timely process information submitted by the enrollee during the requisite time period following the Request for Information or Verification Request;

## PUBLIC NECESSITY RULES

- (iii) TDHS granted a “good cause” extension of time to reply to the Request for Information Notice but failed to extend the time (this is the only circumstance surrounding good cause which can be appealed) ;
  - (iv) Enrollees requested assistance because of a health, mental health, learning problem or disability but did not receive this assistance; or
  - (v) The TennCare Bureau sent the Request for Information or Termination Notice to the wrong address as defined under state law.
7. When an enrollee requests a hearing prior to the date of termination as identified in the Termination Notice, benefits will continue either until TDHS determines that the enrollee has not raised a valid factual dispute or the appeal is otherwise resolved.
  8. If the enrollee does not appeal prior to the date of termination as identified in the Termination Notice, the enrollee will be terminated from TennCare Medicaid.
  9. If the enrollee is granted a hearing and the hearing decision sustains the State’s action, the State reserves its right to recover from the enrollee the cost of services provided during the hearing process.

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

The Public Necessity rules set out herein were properly filed in the Department of State on the 8th day of June, 2005, and will be effective from the date of filing for a period of 165 days. The Public Necessity rules remain in effect through the 20th day of November, 2005. (06-10)

PUBLIC NECESSITY RULES

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

**CHAPTER 1200-13-14  
TENNCARE STANDARD**

**STATEMENT OF NECESSITY REQUIRING PUBLIC NECESSITY RULES**

I am herewith submitting amendments to the rules of the Tennessee Department of Finance and Administration, Bureau of TennCare, for promulgation pursuant to the public necessity provisions of the Uniform Administrative Procedures Act, T.C.A. § 4-5-209 and the Medical Assistance Act, T.C.A. § 71-5-134.

The State of Tennessee has received federal approval for certain eligibility amendments to the TennCare Demonstration Project (No. 11-W-0015 1/4). Approval of the project modification is granted under the authority of Section 1115 (a) of the Social Security Act. The amendments are approved through the period ending June 30, 2007. The TennCare program is a managed care program for both the Medicaid population and the expansion population.

This amendment enables the State to disenroll TennCare Standard adults aged nineteen (19) and older. The amendment also provides clarification of the TennCare Enrollee Cost Sharing poverty level percentages.

Tennessee Code Annotated, Section 71-5-134, states that in order to comply with or to implement the provisions of any federal waiver or state plan amendment obtained pursuant to the Medical Assistance Act as amended by Acts 1993, the Commissioner of Finance and Administration is authorized to promulgate public necessity rules pursuant to Tennessee Code Annotated, Section 4-5-209.

I have made a finding that these amendments are required to conform the current TennCare Medicaid rules to reflect changes resulting from the amendment of the TennCare waiver.

For a copy of this public necessity rule, contact George Woods at the Bureau of TennCare by mail at 729 Church Street, Nashville, Tennessee 37247-6501 or by telephone at (615) 741-0145.

J. D. Hickey  
Deputy Commissioner  
Tennessee Department of  
Finance and Administration

**PUBLIC NECESSITY RULES  
OF  
TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION**

**BUREAU OF TENNCARE**

**CHAPTER 1200-13-14  
TENNCARE STANDARD**

**AMENDMENT**

Rule 1200-13-14-.01 Definitions is amended by adding new paragraphs (69) and (106) and renumbering current paragraph (69) as (70) and (106) as (107) and renumbering subsequent paragraphs accordingly so as amended new paragraphs (69) and (106) shall read as follows:

## PUBLIC NECESSITY RULES

(69) OPEN MEDICAID CATEGORIES shall mean those Medicaid eligibility categories for which enrollment has not been closed pursuant to authority granted by CMS as part of the TennCare demonstration project.

(106) TENNCARE STANDARD ELIGIBILITY REFORMS shall mean the amendments to the TennCare demonstration project approved by CMS on March 24, 2005, to terminate coverage for adults aged 19 and older in TennCare Standard eligibility groups.

Rule 1200-13-14-.02 Eligibility paragraph (3) is amended by adding subparagraph (h) which shall read as follows:

- (h) Effective July 6, 2005, all TennCare Standard eligibility groups for adults aged nineteen (19) and older are terminated, notwithstanding anything else in these rules to the contrary.

Rule 1200-13-14-.02 Eligibility paragraph (4) is amended by adding subparagraph (a) which shall read as follows:

- (a) Effective July 6, 2005, all TennCare Standard eligibility groups for adults aged nineteen (19) and older are terminated, notwithstanding anything else in these rules to the contrary.

Rule 1200-13-14-.02 Eligibility paragraph (5) is amended by adding subparagraph (t) which shall read as follows:

- (t) The individual who is eligible for TennCare Standard in accordance with paragraphs (3) and (4) of this section is found to meet the following criteria:
  1. S/he is aged nineteen (19) or older,
  2. His/her eligibility category has been terminated from TennCare, and
  3. S/he has not been determined eligible in an open Medicaid category.

Rule 1200-13-14-.02 Eligibility is amended by deleting paragraph (7) in its entirety and renumbering subsequent paragraphs accordingly.

Rule 1200-13-14-.02 Eligibility is amended by adding a new renumbered paragraph (9) which shall read as follows:

### (9) Disenrollment Related to TennCare Standard Eligibility Reforms

Prior to the disenrollment of TennCare Standard enrollees based on coverage terminations resulting from TennCare Standard Eligibility Reforms, Medicaid eligibility shall be reviewed in accordance with the following.

#### (a) Ex Parte Review

TDHS will conduct an ex parte review of eligibility for open Medicaid categories for all TennCare Standard enrollees in eligibility groups due to be terminated as part of the TennCare Standard eligibility reforms. Such ex parte review shall be conducted in accordance with federal requirements as set forth by CMS in the Special Terms and Conditions of the TennCare demonstration project.

## PUBLIC NECESSITY RULES

### (b) Request for Information

1. At least thirty (30) days prior to the expiration of their current eligibility period, the Bureau of TennCare will send a Request for Information to all TennCare Standard enrollees in eligibility groups being terminated pursuant to the TennCare Standard eligibility reforms. The Request for Information will include a form to be completed with information needed to determine eligibility for open Medicaid categories as well as a list of the types of proof needed to verify certain information.
2. Enrollees will be given thirty (30) days inclusive of mail time from the date of the Request for Information to return the completed form to TDHS and provide TDHS with the necessary verifications to determine eligibility for open Medicaid categories.
3. Enrollees with a health, mental health, or learning problem or a disability will be given the opportunity to request assistance in responding to the Request for Information. Enrollees with Limited English Proficiency will have the opportunity to request translation assistance for responding to the Request for Information.
4. Enrollees will be given an opportunity until the date of termination to request one extension for good cause of the thirty (30) day timeframe for responding to the Request for Information. The good cause extension is intended to allow a limited avenue for possible relief for certain enrollees who face significant unforeseen circumstances, or who, as a result of a health, mental health, or learning problem, or disability, or limited English proficiency are unable to respond timely, as an alternative to imposing a standard with no exceptions whatsoever. The good cause exception does not confer an entitlement upon enrollees and the application of this exception will be within the discretion of TDHS. Only one 30-day good cause extension can be granted to each enrollee. Good cause is determined by TDHS eligibility staff. Good cause is not requested nor determined through filing an appeal. Requests for an extension of the thirty (30) day timeframe to respond to the Request for Information must be initiated by the enrollee. However, the enrollee may receive assistance in initiating such request. TDHS will not accept a request for extension of the thirty (30) day timeframe submitted by a family member, advocate, provider, or CMHC acting on the enrollee's behalf without the involvement and knowledge of the enrollee, for example, to allow time for such entity to locate the enrollee if his/her whereabouts are unknown. All requests for good cause extension must be made prior to termination of TennCare eligibility. A good cause extension will be granted if TDHS determines that a health, mental health or learning problem, or disability, or limited English proficiency prevented an enrollee from understanding or responding timely to the Request for Information. Except in the aforementioned circumstances, a good cause extension will only be granted if such request is submitted in writing to DHS prior to termination of TennCare eligibility and TDHS determines that serious personal circumstances such as illness or death prevent an enrollee from responding to the Request for Information for an extended period of time. Proof of the serious personal circumstances is required with the submission of the written request in order for a good cause extension to be granted. Good cause extensions will be granted at the sole discretion of TDHS and if granted shall provide the enrollee with an additional thirty (30) days inclusive of mail time from the date of TDHS's decision to grant the good cause extension. TDHS will send enrollees a letter granting or denying the request for good cause extensions. TDHS's decisions with respect to good cause extensions shall not be appealable.

## PUBLIC NECESSITY RULES

5. If an enrollee provides some but not all of the necessary information to TDHS to determine his/her eligibility for open Medicaid categories during the thirty (30) day period following the Request for Information, TDHS will send the enrollee a Verification Request. The Verification Request will provide the enrollee with ten (10) days inclusive of mail time to submit any missing information as identified in the Verification Request. Enrollees will not have the opportunity to request an extension for good cause of the ten (10) day timeframe for responding to the Verification Request.
6. Enrollees who respond to the Request for Information within the thirty (30) day period or within any extension of such period granted by TDHS shall retain their eligibility for TennCare Standard (subject to any changes in covered services generally applicable to enrollees in their TennCare Standard category) while TDHS reviews their eligibility for open Medicaid categories.
7. TDHS shall review all information and verifications provided within the requisite time period by an enrollee pursuant to the Request for Information and/or the Verification Request to determine whether the enrollee is eligible for any open Medicaid categories. If TDHS makes a determination that the enrollee is eligible for an open Medicaid category, TDHS will so notify the enrollee and the enrollee will be enrolled in appropriate TennCare Medicaid category. Once the enrollee is enrolled in TennCare Medicaid, his/her TennCare Standard eligibility shall then be terminated without additional notice. If TDHS makes a determination that the enrollee is not eligible for any open Medicaid categories or if an enrollee does not respond to the Request for Information within the requisite thirty (30) day time period or any extension of such period granted by TDHS, the TennCare Bureau will send the enrollee a twenty (20) day advance Termination Notice.
8. TDHS shall, pursuant to the rules, policies and procedures of TDHS and the Bureau of TennCare applicable to new applicants for TennCare coverage, review all information and verifications provided by an enrollee after the thirty (30) day period following the Request for Information or after any extension of such period granted by TDHS, but the enrollee shall not be entitled to retain eligibility for TennCare Standard pending this review. If the individual is subsequently determined to be eligible for an open Medicaid category, s/he shall be granted retroactive coverage to the date of application, or in the case of spend down eligibility for Medically Needy pregnant women and children, to the latter of (a) the date of his or her application or (b) the date spenddown eligibility is met.

### (c) Termination Notice

1. The TennCare Bureau will send Termination Notices to all TennCare Standard enrollees being terminated pursuant to the TennCare Standard eligibility reforms who are not determined to be eligible for open Medicaid categories pursuant to the Ex Parte Review or Request for Information processes described in this subsection.
2. Termination Notices will be sent twenty (20) days in advance of the date upon which the coverage will be terminated.
3. Termination Notices will provide enrollees with forty (40) days from the date of the notice to appeal valid factual disputes related to the disenrollment and inform enrollees how they may request a hearing.

PUBLIC NECESSITY RULES

4. Enrollees with a health, mental health, or learning problem or a disability will be given the opportunity to request additional assistance for their appeal. Enrollees with Limited English Proficiency will have the opportunity to request translation assistance for their appeal.
5. Enrollees will not have the opportunity to request an extension for good cause of the forty (40) day timeframe in which to request a hearing.

Rule 1200-13-14-.05 Enrollee Cost Sharing paragraph (1) subparagraph (b) is amended by revising the first two columns in the “Percentage of Poverty” section from “0%-100%” and “101%-149%” to “0%-99%” and “100%-149%” respectively so as amended subparagraph (b) shall read as follows:

(b) Effective January 1, 2002, the Bureau will update its Premium Sliding Scale Schedule monthly income brackets used for the determination of enrollee cost sharing to reflect the most current poverty levels as published by the Centers for Medicare and Medicaid Services. The Premium Sliding Scale effective January 1, 2002, follows:

Individual Monthly Premium	\$0	\$20.00	\$35.00	\$100.00	\$150.00
Family Monthly Premium	\$0	\$40.00	\$70.00	\$250.00	\$375.00
Percentage of Poverty	0% - 99%	100% - 149%	150% - 199%	200% - 249%	250% - 299%
Individual Monthly Premium	\$200.00	\$250.00	\$350.00	\$450.00	\$550.00
Family Monthly Premium	\$500.00	\$625.00	\$875.00	\$1,125.00	\$1,375.00
Percentage of Poverty	300% - 349%	350% - 399%	400% - 499%	500% - 599%	600% - Over

Rule 1200-13-14-.05 Enrollee Cost Sharing paragraph (3) is amended by adding the phrase “is equal to or” between the words “income” and “exceeds” in the first sentence and by deleting references to deductibles and 2% copayments which are no longer applicable so as amended paragraph (3) shall read as follows:

- (3) In accordance with the following schedules, families and individuals who enroll in TennCare who are not Medicaid-eligible and whose income is equal to or exceeds 100% of the poverty level shall pay-copayments for services other than preventive services.

Rule 1200-13-14-.05 Enrollee Cost Sharing paragraph (3) subparagraph (a) is amended by revising the first two Poverty Levels in the chart from “0%-100%” and “101%-199%” to “0%-99%” and “100%-199%” respectively and by deleting the reference to the TennCare deductible so as amended subparagraph (a) shall read as follows:

- (a) Effective January 1, 2000, or at such date thereafter as the change is approved by the Health Care Financing Administration and can be implemented, the annual TennCare Maximum

PUBLIC NECESSITY RULES

Out-of-Pocket Expenditures described below shall apply for both uninsured and uninsurable designations, based on the poverty level.

TENNCARE MAXIMUM ANNUAL OUT-OF-POCKET EXPENDITURES.

POVERTY LEVELS	Individual Maximum Annual Out-of-Pocket	Family Maximum Annual Out-of-Pocket
0% - 99%	\$ 0.00	\$ 0.00
100% - 199%	\$ 1,000.00	\$ 2,000.00
200% and above	\$ 2,000.00	\$ 4,000.00

Managed care organizations participating in the TennCare program shall be specifically prohibited from waiving, or discouraging TennCare enrollees from paying, the amounts described in this provision.

Rule 1200-13-14-.05 Enrollee Cost Sharing paragraph (3) subparagraph (b) is amended by revising the first two Poverty Levels in the chart from “0%-100%” and “101%-199%” to “0%-99%” and “100%-199%” respectively so as amended subparagraph (b) shall read as follows:

- (b) Effective January 1, 2000, or at such date thereafter as the change is approved by the CMS and can be implemented, the following TennCare copayment schedule shall apply for both Uninsured and Uninsurable designations, based on the poverty level. Effective August 1, 2002 the poverty levels will be those as used by TDHS.

TENNCARE COPAYMENT AMOUNTS.

POVERTY LEVELS	COPAYMENT AMOUNTS
0% - 99%	\$ 0.00
100% - 199%	\$ 25.00 for hospital emergency room (waived if admitted) \$ 5.00 for primary care provider and Community Mental Health Agency services other than preventive care \$ 15.00 for physician specialists \$ 5.00 for prescription or refill \$ 100.00 per inpatient hospital admission
200% and above	\$ 50.00 for hospital emergency room (waived if admitted) \$ 10.00 for primary care provider and Community Mental Health Agency services other than preventive care \$ 25.00 for physician specialists \$ 10.00 for prescription or refill \$ 200.00 per inpatient hospital admission

PUBLIC NECESSITY RULES

Managed care organizations participating in the TennCare program shall be specifically prohibited from waiving, or discouraging TennCare enrollees from paying, the amounts described in this provision.

Rule 1200-13-14-.05 Enrollee Cost Sharing paragraph (4) subparagraph (a) is amended by revising the first two column in the "Percentage of Poverty" section from "0%-100%" and "101%-149%" to "0%-99%" and "100%-149%" respectively so as amended subparagraph (a) shall read as follows:

- (a) The following premiums were effective January 1, 2002 as approved by the Centers for Medicare and Medicaid Services, and apply to the TennCare Standard enrollees who are classified as uninsured or medically eligible.

Individual Monthly Premium	\$0	\$20.00	\$35.00	\$100.00	\$150.00
Family Monthly Premium	\$0	\$40.00	\$70.00	\$250.00	\$375.00
Percentage of Poverty	0% - 99%	100% - 149%	150% - 199%	200% - 249%	250% - 299%
Individual Monthly Premium	\$200.00	\$250.00	\$350.00	\$450.00	\$550.00
Family Monthly Premium	\$500.00	\$625.00	\$875.00	\$1,125.00	\$1,375.00
Percentage of Poverty	300% - 349%	350% - 399%	400% - 499%	500% - 599%	600% - Over

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

The Public Necessity rules set out herein were properly filed in the Department of State on the 3rd day of June, 2005, and will be effective from the date of filing for a period of 165 days. The Public Necessity rules remain in effect through the 15th day of November, 2005. (06-07)

PUBLIC NECESSITY RULES

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

**CHAPTER 1200-13-14  
TENNCARE STANDARD**

**STATEMENT OF NECESSITY REQUIRING PUBLIC NECESSITY RULES**

I am herewith submitting amendments to the rules of the Tennessee Department of Finance and Administration, Bureau of TennCare, for promulgation pursuant to the public necessity provisions of the Uniform Administrative Procedures Act, T.C.A. § 4-5-209 and the Medical Assistance Act, T.C.A. § 71-5-134.

The State of Tennessee has received federal approval for certain eligibility amendments to the TennCare Demonstration Project (No. 11-W-0015 1/4). Approval of the project modification is granted under the authority of Section 1115 (a) of the Social Security Act. The amendments are approved through the period ending June 30, 2007. The TennCare program is a managed care program for both the Medicaid population and the expansion population.

This amendment sets forth provisions for granting fair hearings based on valid factual disputes before a Hearing Officer or Administrative Law Judge. In addition, this amendment defines clear requirements for timely submission of eligibility-based appeals and the continuation of benefits pending resolution of such appeals, including appeals related to disenrollment as a result of certain eligibility amendments to the TennCare Demonstration Project.

Tennessee Code Annotated, Section 71-5-134, states that in order to comply with or to implement the provisions of any federal waiver or state plan amendment obtained pursuant to the Medical Assistance Act as amended by Acts 1993, the Commissioner of Finance and Administration is authorized to promulgate public necessity rules pursuant to Tennessee Code Annotated, Section 4-5-209.

I have made a finding that these amendments are required to conform the current TennCare Standard rules to reflect changes resulting from the amendment of the TennCare waiver.

For a copy of this public necessity rule, contact George Woods at the Bureau of TennCare by mail at 729 Church Street, Nashville, Tennessee 37247-6501 or by telephone at (615) 741-0145.

J. D. Hickey  
Deputy Commissioner  
Tennessee Department  
of Finance and Administration

PUBLIC NECESSITY RULES

**PUBLIC NECESSITY RULES  
OF  
TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION**

**BUREAU OF TENNCARE**

**CHAPTER 1200-13-14  
TENNCARE STANDARD**

**AMENDMENT**

Rule 1200-13-14-.12 Other Appeals By TennCare Applicants and Enrollees is amended by deleting subparagraph (1)(a) in its entirety and substituting instead the following new language, and is further amended by adding the following new subparagraphs (1)(b) and (1)(c) and renumbering the remaining subparagraphs accordingly, so that the new subparagraphs (1)(a), (1)(b) and (1)(c) shall read as follows:

- (1) Appeal Rights of TennCare Standard Applicants or Enrollees.
  - (a) Appeal Time; Continuation of Services.
    1. TennCare Standard Appeals.
      - (i) TennCare Standard applicants or enrollees will be given the opportunity to have an administrative hearing before a Hearing Officer or an Administrative Law Judge, as determined by the Department of Human Services, regarding valid factual disputes concerning denial of his/her application, cost sharing disputes, limitation, reduction or termination of coverage, failure to act upon a request or application within required timeframes, and disputes regarding disenrollment from TennCare Standard. A valid factual dispute is a dispute that, if resolved in favor of the appellant, would prevent the state from taking the adverse action that is the subject of the appeal. The TennCare Bureau designates TDHS to review each request for a hearing to determine if it is based on a valid factual dispute. If TDHS determines that an appeal does not present a valid factual dispute, then TDHS will send the appellant a letter asking him or her to submit additional clarification regarding the appeal within ten (10) days (inclusive of mail time). Unless such clarification is timely received and is determined by TDHS to establish a valid factual dispute, TDHS will dismiss the appeal. TDHS' decisions with respect to determination of whether an appeal raises a valid factual dispute shall not be appealable.
      - (ii) Requests for appeals must be made within forty (40) calendar days (inclusive of mail time) of the date of the notice to the applicant/enrollee regarding the intended action, notwithstanding anything else in these rules or in the Department of Human Services' administrative procedures rules to the contrary.
      - (iii) Enrollees who request a hearing within twenty (20) calendar days (inclusive of mail time) of the date of notice or prior to the date of termination specified in the notice shall retain their eligibility (subject to any changes in covered services generally applicable to enrollees in their TennCare category) pending a determination that the enrollee has not raised a valid factual dispute or until the appeal is otherwise resolved, whichever comes first. If the appeal results in the State's action being sustained, the State reserves its right to recover from the enrollee the cost of services provided to the enrollee during the pendency of the appeal.

## PUBLIC NECESSITY RULES

- (b) Such appeals will be conducted by the Department of Human Services for TennCare Standard applicants/enrollees under the Department of Human Services' administrative procedures rules, and in accordance with any other applicable rules, laws or court orders governing those programs.
- (c) Appeal Rights for Disenrollment Related to TennCare Standard Eligibility Reforms
  1. TennCare Standard enrollees, who have not been determined eligible for open Medicaid categories pursuant to the Ex Parte Review or Request for Information processes described in 1200-13-14-.02, will have the right to request a hearing for 40 days (inclusive of mail time) from the date of the Termination Notice, notwithstanding anything else in these rules or in the Department of Human Services' administrative procedures rules to the contrary.
  2. Such appeals will be conducted by the Department of Human Services for TennCare Standard applicants/enrollees under the Department of Human Services' administrative procedures rules, and in accordance with any other applicable rules, laws or court orders governing those programs.
  3. Enrollees will not have the opportunity to request an extension for good cause of the forty (40) day timeframe in which to request a hearing.
  4. Enrollees who request a hearing prior to the date of termination specified in the Termination Notice shall retain their eligibility (subject to any changes in covered services generally applicable to enrollees in their TennCare category) pending a determination that the enrollee has not raised a valid factual dispute or until the appeal is otherwise resolved, whichever comes first.
  5. The TennCare Bureau designates TDHS to review each request for hearing to determine if it is based on a valid factual dispute. Enrollees will be given the opportunity to have an administrative hearing before a Hearing Officer or an Administrative Law Judge, as determined by TDHS, regarding valid factual disputes related to termination. If TDHS makes an initial determination that the request for a hearing is not based on a valid factual dispute, the appellant will receive a notice which provides ten (10) days (inclusive of mail time) to provide additional clarification of any factual dispute on which his/her appeal is based. Unless such clarification is timely received and is determined by TDHS to establish a valid factual dispute, a fair hearing will not be granted.
  6. TDHS will grant hearings only for those enrollees raising valid factual disputes related to the action of disenrollment. A valid factual dispute is a dispute that, if resolved in favor of the appellant, would prevent the state from taking the adverse action that is the subject of the appeal. Appeals that do not raise a valid factual dispute will not proceed to a hearing. Valid factual disputes include:
    - (i) Enrollee received the Termination Notice in error (e.g., they are currently enrolled in a TennCare Medicaid or TennCare Standard category that is not ending);
    - (ii) TDHS failed to timely process information submitted by the enrollee during the requisite time period following the Request for Information or Verification Request;

## PUBLIC NECESSITY RULES

- (iii) TDHS granted a “good cause” extension of time to reply to the Request for Information Notice but failed to extend the time (this is the only circumstance surrounding good cause which can be appealed) ;
  - (iv) Enrollees requested assistance because of a health, mental health, learning problem or disability but did not receive this assistance; or
  - (v) The TennCare Bureau sent the Request for Information or Termination Notice to the wrong address as defined under state law.
7. When an enrollee requests a hearing prior to the date of termination as identified in the Termination Notice, benefits will continue either until TDHS determines that the enrollee has not raised a valid factual dispute or the appeal is otherwise resolved.
  8. If the enrollee does not appeal prior to the date of termination as identified in the Termination Notice, the enrollee will be terminated from TennCare.
  9. If the enrollee is granted a hearing and the hearing decision sustains the State’s action, the State reserves its right to recover from the enrollee the cost of services provided during the hearing process.

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

The Public Necessity rules set out herein were properly filed in the Department of State on the 8th day of June, 2005, and will be effective from the date of filing for a period of 165 days. The Public Necessity rules remain in effect through the 20th day of November, 2005. (06-11)

PUBLIC NECESSITY RULES

**THE TENNESSEE HIGHER EDUCATION COMMISSION - 1540**

**STATEMENT OF NECESSITY REQUIRING PUBLIC NECESSITY RULES**

The waiver of tuition and fees for full-time state employees at public postsecondary institutions authorized by Tennessee Code Annotated Section 8-50-114 went into effect on July 1, 1990. Pursuant to Section 8-50-114(e), the Tennessee Higher Education Commission promulgated rules to, among other things, define "full-time state employee". Through discussions with the Department of Personnel, it was determined that the Department recognized a class of full-time state employees that do not fall under the current definition found in these rules. A public necessity rule is necessary to address the problem so that the employees affected by this rule change will not be denied this benefit for the Summer and Fall 2005 semesters.

For a copy of this public necessity rule contact Rosie Padgett, Tennessee Higher Education Commission, Suite 1900, Parkway Towers, 404 James Robertson Parkway, Nashville, Tennessee 37243, telephone 615-741-3605.

Richard G. Rhoda, Executive Director  
Tennessee Higher Education Commission

**PUBLIC NECESSITY RULES  
OF  
TENNESSEE HIGHER EDUCATION COMMISSION**

**1540-1-4  
PUBLIC HIGHER EDUCATION FEE WAIVERS FOR STATE EMPLOYEES**

**AMENDED RULES**

Chapter 1540-1-4-.01 Definitions is amended by deleting paragraph (2) "Full-time Employees of the State of Tennessee or Employee" in its entirety and replacing it with the following new definition:

**1540-1-4-.01 DEFINITIONS**

- (1) Full-time employee of the State of Tennessee: Employee of the executive, judicial, or legislative branches of Tennessee state government:
  - (a) classified as "full-time" and scheduled to work one thousand nine hundred and fifty (1,950) hours or more per fiscal year; or
  - (b) employees, regardless of classification, and scheduled to work one thousand six hundred (1,600) hours per fiscal year and who receive employment benefits provided to all full-time employees.

**Authority:** T.C.A. § 8-50-114.

The public necessity rules set out herein were properly filed in the Department of State on the 3rd day of June, 2005 and will become effective from the date of filing for a period of 165 days. These public necessity rules will remain in effect through the 15th day of November, 2005. (06-02)

PUBLIC NECESSITY RULES

**TENNESSEE HIGHER EDUCATION COMMISSION - 1540**

**STATEMENT OF NECESSITY REQUIRING PUBLIC NECESSITY RULES**

The tuition discount at public postsecondary institutions for the children of state employees authorized by Tennessee Code Annotated Section 8-50-115 went into effect on July 1, 1992. Pursuant to Section 8-50-115(b), the Tennessee Higher Education Commission promulgated rules to, among other things, define "full-time state employee". Through discussions with the Department of Personnel it was determined that the Department recognized a class of full-time state employees that do not fall under the current definition found in these rules. A public necessity rule is necessary to address the problem so that the children of employees affected by this rule change will not be denied this benefit for the Summer and Fall 2005 semesters.

For a copy of this public necessity rule contact Rosie Padgett, Tennessee Higher Education Commission, Suite 1900, Parkway Towers, 404 James Robertson Parkway, Nashville, Tennessee 37243, telephone 615-741-3605.

Richard G. Rhoda, Executive Director  
Tennessee Higher Education Commission

**PUBLIC NECESSITY RULES  
OF  
TENNESSEE HIGHER EDUCATION COMMISSION**

**CHAPTER 1540-1-5  
PUBLIC HIGHER EDUCATION FEE DISCOUNTS FOR CHILDREN  
OF LICENSED PUBLIC SCHOOL TEACHERS AND STATE EMPLOYEES**

**AMENDED RULES**

Chapter 1540-1-5-.01 Definitions is amended by deleting paragraph (6) "Full-time Employees of the State of Tennessee" in its entirety and replacing it with the following new definition:

**1540-1-5-.01 DEFINITIONS**

- (6) Full-time employee of the State of Tennessee: Employee of the executive, judicial, or legislative branches of Tennessee state government:
  - (a) classified as "full-time" and scheduled to work one thousand nine hundred and fifty (1,950) hours or more per fiscal year; or
  - (b) employees, regardless of classification, and scheduled to work one thousand six hundred (1,600) hours per fiscal year and who receive employment benefits provided to all full-time employees.

**Authority:** T.C.A. §§ 8-50-115, 49-7-119.

The Public Necessity rules set out herein were properly filed in the Department of State on the 3rd day of June, 2005, and will be effective from the date of filing for a period of 165 days. The Public Necessity rules remain in effect through the 15th day of November, 2005. (06-04)

PUBLIC NECESSITY RULES

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

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

**STATEMENT OF NECESSITY REQUIRING PUBLIC NECESSITY RULES**

The Commissioner of the Tennessee Department of Labor and Workforce Development ("Commissioner") makes this statement pursuant to Tenn. Code Ann. §§ 4-5-209 and 50-6-204(i)(5) (Supp. 2004). The Commissioner hereby promulgates the following public necessity rules establishing an Medical Cost Containment Program as part of the comprehensive medical fee schedule and related system applicable to all medical treatment under the Workers' Compensation Law as administered by the Workers' Compensation Division of the Tennessee Department of Labor and Workforce Development.

Tennessee Code Annotated 50-6-204(i)(1) (Supp. 2004), mandates the Commissioner establish a comprehensive medical fee schedule and related system which includes, but is not limited to, procedures for review of charges, enforcement procedures and appeal hearings, to implement the fee schedule. In addition, the General Assembly specifically authorized the Commissioner to promulgate these rules, if appropriate, as public necessity rules. Tenn. Code Ann. § 50-6-204(i)(5) (Supp. 2004). The General Assembly also mandated that these rules must take effect on July 1, 2005. To insure compliance with the General Assembly's directive that the rules establishing a Medical Cost Containment Program take effect on July 1, 2005, the Commissioner is therefore required to implement these rules within a prescribed period of time which precludes utilization of the other rulemaking procedures for the promulgation of permanent rules.

James Neeley, Commissioner  
Tennessee Department of Labor & Workforce Development

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

**NEW RULES**

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## PUBLIC NECESSITY RULES

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

- (1) Purpose. Pursuant to Tenn. Code Ann. § 50-6-204 (Supp. 2004), the following Medical Cost Containment Program Rules, together with the Medical Fee Schedule Rules, Chapter 0800-2-18-.01 et seq., and the In-patient Hospital Fee Schedule Rules, Chapter 0800-2-19.01 et seq., are hereby adopted by the Commissioner in order to establish a comprehensive medical fee schedule and a related system which includes, but is not limited to, procedures for review of charges, enforcement procedures and appeal hearings, to implement a medical fee schedule. The Commissioner promulgates these Medical Cost Containment Program Rules together with the Medical Fee Schedule and In-patient Hospital Fee Schedule rules to establish the maximum allowable fees for health care services falling within the purview of the Tennessee Workers' Compensation Act ("Act"). These Medical Cost Containment Program Rules must be used in conjunction with the Medical Fee Schedule Rules and In-patient Hospital Fee Schedule Rules. The Medical Cost Containment Program Rules, Medical Fee Schedule Rules and In-patient Hospital Fee Schedule Rules (collectively herein "Rules") establish maximum allowable fees. Employers, carriers and providers may negotiate and contract lesser fees as are agreeable between them, but in no event shall reimbursement be in excess of the Rules, subject to the civil penalties prescribed in the Rules, as assessed by, and in the discretion of, the Commissioner, the Commissioner's designee, or an agency member appointed by the Commissioner.
- (2) Scope. These rules do all of the following:
  - (a) Establish procedures by which the employer shall furnish, or cause to be furnished to an employee who receives a personal injury, or suffers an occupational disease, arising out of and in the course of employment, reasonable and necessary medical, surgical, and hospital services and medicines, or other attendance or treatment recognized by the laws of the state as legal, when needed. The employer shall also supply to the injured employee dental services, crutches, artificial limbs, eyes, teeth, eyeglasses, hearing apparatus, and other appliances necessary to cure, so far as reasonably and necessarily possible, and relieve from the effects of the injury or occupational disease.
  - (b) Establish schedules of maximum fees by a health facility or health care provider for such treatment or attendance, service, device, apparatus, or medicine.
  - (c) Establish procedures by which a health care provider shall be paid the lesser of: (1) the provider's usual charge, (2) the maximum fee established under these Rules, or (3) the MCO/PPO or any other negotiated and contracted price, where applicable. In no event shall reimbursement be in excess of these Rules. Reimbursement in excess of these Rules may, at the Commissioner's discretion, result in civil penalties of ten thousand dollars (\$10,000.00) per violation each assessed severally against the provider accepting such fee and the carrier or employer paying the excessive fee, if a pattern or practice of such activity is found. At the Commissioner's discretion, such provider may also be reported to the appropriate certifying board, and may be subject to exclusion from participating in providing care under the Act.
  - (d) Identify utilization of health care and health services which is above the usual range of utilization for such services, based on medically accepted standards. Also to provide the ability by a carrier and the Division to obtain necessary records, medical bills, and other information concerning any health care or health service under review.

## PUBLIC NECESSITY RULES

- (e) Establish a system for the evaluation by a carrier of the appropriateness in terms of both the level of and the quality of health care and health services provided to injured employees, based upon medically accepted standards.
- (f) Authorize carriers to withhold payment from, or recover payment from, health facilities or health care providers which have made excessive charges or which have required unjustified and/or unnecessary treatment, hospitalization, or visits.
- (g) Permit review by the Division of the records and medical bills of any health facility or health care provider which has been determined not to be in compliance with these Rules, or to be requiring unjustified and/or unnecessary treatment, hospitalization or office visits.
- (h) Establish that when a health care facility or health care provider provides health care or health care service that is not usually associated with, is longer in duration than, is more frequent than, or extends over a greater number of days than the health care or service usually does with a diagnosis or condition for which the patient is being treated, the health care provider may be required by the carrier to explain the necessity in writing.
- (i) Implement the Division's review and decision responsibility. These Rules and definitions are not intended to modify the workers' compensation laws, other administrative rules of the Division, or court decisions interpreting the laws or the Division's administrative rules.
- (j) Establish maximum fees for depositions/witnesses.
- (k) Establish maximum fees for medical reports.
- (l) Provide for uniformity of billing for provider services.
- (m) Establish the effective date for implementation of these Rules.
- (n) Adopt by reference as part of this rule the American Medical Association's CPT, Medical Fee Schedule, the In-patient Hospital Fee Schedule and any amendments to the fee schedule.
- (o) Establish procedures for reporting of medical claims.
- (p) Establish procedures for preauthorization of non-emergency hospitalizations, transfers between facilities, and outpatient services.
- (q) Establish procedures for imposing and collecting civil penalties for violations of these Rules.
- (r) The Rules shall be effective July 1, 2005.

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

## PUBLIC NECESSITY RULES

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

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

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

### 0800-2-17-.03 DEFINITIONS

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

- (1) "Act" means Tennessee's Workers' Compensation Act, Tenn. Code Ann. §§ 50-6-101 et seq., as amended.
- (2) "Adjust" means that a carrier or a carrier's agent reduces a health care provider's request for payment such as:
  - (a) Applies the Division's maximum fee;
  - (b) Applies an agreed upon discount to the provider's usual charge;
  - (c) Adjusts to a reasonable amount when the maximum fee is by report;
  - (d) Recodes a procedure;
  - (e) Reduces payment as a result of utilization review.
- (3) "Administrator" means the chief administrative officer of the Workers' Compensation Division of the Tennessee Department of Labor and Workforce Development.
- (4) "Appropriate care" means health care that is suitable for a particular person, condition, occasion, or place as determined by the Commissioner or the Commissioner's designee after consultation with the Medical Director.
- (5) "Bill" means a request by a provider submitted to a carrier for payment for health care services provided in connection with a compensable injury, illness or occupational disease.
- (6) "Bill adjustment" means a reduction of a fee on a provider's bill.
- (7) "BR" (By Report) means that the procedure is not assigned a maximum fee and requires a written description. The description shall be included on the bill or attached to the bill and shall include the following information, as appropriate:
  - (a) Copies of operative reports.

## PUBLIC NECESSITY RULES

- (b) Consultation reports.
  - (c) Progress notes.
  - (d) Office notes or other applicable documentation.
  - (e) Description of equipment or supply (when that is the charge).
- (8) "Carrier" means any stock company, mutual company, or reciprocal or inter-insurance exchange or self-insured employer authorized to write or carry on the business of workers' compensation insurance in this state; whenever required by the context, the term 'carrier' shall be deemed to include duly qualified self-insureds or self-insured groups.
- (9) "Case" means a compensable injury, illness or occupational disease identified by the worker's name and date of injury, illness or occupational disease.
- (10) "Case record" means the complete health care record maintained by the carrier pertaining to a compensable injury, illness or occupational disease and includes the circumstances or reasons for seeking health care; the supporting facts and justification for initial and continual receipt of health care; all bills filed by a health care service provider; and actions of the carrier which relate to the payment of bills filed in connection with a compensable injury, illness or occupational disease.
- (11) "CMS" means the U.S. Centers for Medicare & Medicaid Services (formerly HCFA).
- (12) "Commissioner" means the Commissioner of the Tennessee Department of Labor and Workforce Development, the Commissioner's designee, or an agency member appointed by the Commissioner.
- (13) "Complete procedure" means a procedure containing a series of steps which are not to be billed separately.
- (14) "Consultant service" means; in regard to the health care of a covered injury and illness; an examination, evaluation, and opinion rendered by a health care specialist when requested by the authorized treating practitioner or by the employee; and which includes a history, examination, evaluation of treatment, and a written report. If the consulting practitioner assumes responsibility for the continuing care of the patient, subsequent service(s) cease(s) to be a consultant service.
- (15) "Compensable injury, illness or occupational disease" means an injury, illness or occupational disease for which health care treatment is mandated under Tennessee Workers' Compensation Act.
- (16) "CPT" means the most current edition of the American Medical Association's Current Procedural Terminology.
- (17) "Critical care" has the same meaning as that in the most current version of the CPT.
- (18) "Day" means a calendar day, unless otherwise designated in these Rules.
- (19) "Department" means the Tennessee Department of Labor and Workforce Development.

## PUBLIC NECESSITY RULES

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

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

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

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- (60) "Package" means a surgical procedure that includes but is not limited to all of the following components:
- (a) The operation itself.
  - (b) Local infiltration.
  - (c) Topical anesthesia when used.
  - (d) The normal, uncomplicated follow-up care/visits. This includes a standard postoperative period of 30 days.
- (61) "Pharmacy" means the place where the science, art, and practice of preparing, preserving, compounding, dispensing, and giving appropriate instruction in the use of drugs is practiced.
- (62) "Practitioner" means a person licensed, registered, or certified as an audiologist, doctor of chiropractic, doctor of dental surgery, doctor of medicine, doctor of osteopathy, doctor of podiatry, doctor of optometry, nurse, nurse anesthetist, nurse practitioner, occupational therapist, orthotist, pharmacist, physical therapist, physician's assistant, prosthetist, psychologist, or other person licensed, registered, or certified as a health care professional.
- (63) Prevailing Charge: The charge at the 50th percentile in any array of weighted customary charges made for the same geographical location. This is the upper limit of charges allowed for reimbursement of services which have no Medicare amount available and are not assigned a fee in the Tennessee Workers' Compensation Medical and In-patient Fee Schedules.
- (64) "Primary procedure" means the therapeutic procedure most closely related to the principle diagnosis.
- (65) "Procedure" means a unit of health service.
- (66) "Procedure code" means a 5-digit numerical sequence or a sequence containing an alpha or alphas and followed by three or four digits, which identifies the service performed and billed.
- (67) "Properly submitted bill" means a request by a provider for payment of health care services submitted to a carrier on the appropriate forms which are completed pursuant to this rule. Properly submitted bills shall include appropriate documentation as required by this rule.
- (68) "Prosthesis" means an artificial substitute for a missing body part.
- (69) "Prosthetist" means a person skilled in the construction and application of prosthesis.
- (70) "Provider" means a facility, health care organization, or a practitioner.
- (71) "Reasonable amount" means a payment based upon the amount generally paid in the state for a particular procedure code using data available from but not limited to the provider, the carrier, or the Tennessee Workers' Compensation Division.
- (72) "Reject" means that a carrier or a carrier's agent denies payment to a provider or denies a provider's request for reconsideration.

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- (73) "Secondary procedure" means a surgical procedure which is performed to ameliorate conditions that are found to exist during the performance of a primary surgery and which is considered an independent procedure that may not be performed as a part of the primary surgery or for the existing condition.
- (74) "Stop-Loss Payment" or "SLP" means an independent method of payment for an unusually costly or lengthy stay.
- (75) "Stop-Loss Reimbursement Factor" or "SLRF" means a factor established by the Commissioner to be used as a multiplier to establish a reimbursement amount when total hospital charges have exceeded specific stop-loss thresholds.
- (76) "Stop-Loss Threshold" or "SLT" means a threshold of charges established by the Commissioner, beyond which reimbursement is calculated by multiplying the applicable SLRF times the total charges identifying that particular threshold.
- (77) "Surgical admission" means any hospital admission where there is an operating room charge, the patient with has a surgical procedure code, or the patient has a surgical DRG as defined by the CMS.
- (78) "Transfer between facilities" means to move or remove a patient from one facility to another for a purpose related to obtaining or continuing medical care. The transfer may or may not involve a change in the admittance status of the patient, i.e., patient transported from one facility to another to obtain specific care, diagnostic testing, or other medical services not available in the facility in which the patient has been admitted. The transfer between facilities shall include costs related to transportation of patient to obtain medical care.
- (79) "Usual and customary charge" means a particular provider's average charge for a procedure to all payment sources, and includes itemized charges previously billed separately which are included in the package for that procedure as defined by these Rules.
- (80) "UB-92, HCFA-1450, 1500 or CMS-1450" means the health insurance claim form maintained by HCFA/CMS for use by institutional care providers. Currently this form is known as the UB-92.
- (81) "Wage loss case" means a case that involves the payment of wage loss compensation.
- (82) "Workers' Compensation Standard Per Diem Amount" or "SPDA" means a standardized per diem amount established for the reimbursement of hospitals for services rendered.

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

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

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

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

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

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

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

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

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

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

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### 0800-2-17-.07 MODIFIER CODES

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

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

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

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

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

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

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

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

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

### 0800-2-17-.10 PAYMENT

- (1) Reimbursement for all health care services and supplies shall be the lesser of (a) the provider's usual charge, or (b) the maximum fee calculated according to these Rules (and/or any amendments to these Rules), or (c) the MCO/PPO or any other contracted price, wherever applicable. A licensed provider shall receive no more than the maximum allowable payment, in accordance with these Rules, for appropriate health care services rendered to a person who is entitled to health care services under the Act.
- (2) The most current Medicare RBRVS is adopted by reference as part of these Rules. The Medicare RBRVS is distributed by the Office of the Federal Register and is also available on the Internet at [www.cms.hhs.gov/medicare](http://www.cms.hhs.gov/medicare). Whenever a different guideline or procedure is not set forth in these Rules, the most current effective Medicare guidelines and procedures shall be followed.
- (3) When extraordinary services resulting from severe head injuries, major burns, and severe neurological injuries or any injury requiring an extended period of intensive care are required, a greater fee may be allowed up to 150% of the professional service fees normally allowed under these Rules. Such cases shall be billed with modifier 21 or 22 (for CPT coded procedures) and shall contain a detailed written description of the extraordinary service rendered and the need therefore. This provision does not apply to In-patient Hospital Care facility fees which are specifically addressed in the In-patient Hospital Fee Schedule Rules, 0800-2-19-.01 et seq.
- (4) Billing for provider services shall be submitted on the forms approved by the Division: UB-92 and HFCA-1500, or their official replacement forms.
- (5) A carrier shall not make a payment for a service unless all required review activities pertaining to that service are completed.
- (6) A carrier's payment shall reflect any adjustments in the bill made through the carrier's utilization review program.
  - (a) A carrier must provide an explanation of medical benefits to a health care provider whenever the carrier's reimbursement differs from the amount billed by the provider.
  - (b) A provider shall not attempt to collect from the injured employee, employer, or carrier any amounts properly reduced by the carrier pursuant to this rule.
- (7) A carrier shall date stamp medical bills and reports upon receipt and shall pay an undisputed and properly submitted bill within thirty-one (31) calendar days of receipt. Any carrier that fails to pay an undisputed and properly submitted bill within thirty-one 31 calendar days of receipt shall be assessed a civil penalty of 2.08% monthly (25% annual percentage rate ("APR")). The 2.08% monthly civil penalty (25% APR) shall be compounded monthly and shall be payable to the provider at the time of reimbursement.
- (8) When a carrier disputes a bill or portion thereof, the carrier shall pay the undisputed portion of the bill within thirty-one (31) calendar days of receipt of a properly submitted bill. Any carrier not paying an undisputed portion of the bill within thirty-one (31) calendar days of receipt shall be

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assessed a civil penalty of 2.08% monthly (25% APR) on the undisputed portion of the bill. The 2.08% monthly civil penalty (25% APR) shall be compounded monthly and shall be payable to the provider at the time of reimbursement.

- (9) Any provider not receiving timely payment of the undisputed portion of the provider's bill may institute a collection action in a court having proper jurisdiction over such matters to obtain payment of the bill, together with the interest civil penalty of 25% APR. Such providers, if they prevail, shall also be entitled to reasonable costs and attorney fees incurred in such collection actions to be paid by the carrier or self-insured employer.
- (10) Billings not submitted on the proper form, as prescribed in these Rules, the In-patient Hospital Fee Schedule Rules, and the Medical Fee Schedule Rules, may be returned to the provider for correction and resubmission. If a carrier returns such billings, it must do so within 20 calendar days of receipt of the bill. The number of days between the date the carrier returns the billing to the provider and the date the carrier receives the corrected billing, shall not apply toward the thirty-one (31) calendar days within which the carrier is required to make payment.
- (11) Payments to providers for initial examinations and treatment authorized by the carrier or a self-insured employer shall be paid by that carrier or self-insured employer and shall not later be subject to reimbursement by the employee or another medical insurance program, even if the injury or condition for which the employee was sent to the provider is later determined non-compensable under the Act.

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

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

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

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

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

- (1) Nothing in this rule shall preclude the recovery of payment already made for services and bills which may later be found to have been medically paid at an amount which exceeds the maximum allowable payment. This also includes payments reimbursed to an employee pursuant to 0800-2-17-.11 above.
- (2) A carrier may recover a payment to a provider, whether by an employee or a carrier, if the carrier requests the provider for the recovery of the payment, with a statement of reasons for the request, within one year of the date of payment.
- (3) Within thirty-one (31) calendar days of receipt of the carrier's request for recovery of the payment, the provider shall do either of the following:
  - (a) If in agreement with the request, refund the payment to the carrier.

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- (b) If not in agreement with the request, supply the carrier with a written detailed statement of the reasons for its disagreement, along with a refund of the portion, if any, of the payment that the provider agrees should be refunded.
- (4) If the carrier does not accept the reason for disagreement supplied by the provider, the carrier may file a request for Administrative Review, within thirty-one (31) calendar days of receipt of the provider's statement of disagreement. The request for review shall be filed with the Medical Director for a recommendation by the Medical Care and Cost Containment Committee (MCCCC). The carrier shall supply a copy to the provider.
- (5) If, within 62 calendar days of the carrier's request for recovery of a payment, the carrier does not receive either a full refund of the payment or a statement of disagreement, then, at the option of the carrier, the carrier may do either or both of the following:
  - (a) File a request for Administrative Review as outlined above, of which the carrier shall supply a copy to the provider.
  - (b) Reduce the payable amount on the provider's subsequent bills (in the case in question or any other case) to the extent of the request for recovery of payment.
- (6) If, within thirty-one (31) calendar days of a recommendation from the MCCCC, a provider does not pay in full any refund recommended, the carrier may reduce the payable amount on the provider's subsequent bills to the extent of the request for recovery of payment, plus an additional 25% per annum. The carrier may, at its discretion, pursue recovery of such refund in a court of law with proper jurisdiction pursuant to T.C.A. § 50-6-226.

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

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

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

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

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

### **0800-2-17-.14 MISSED APPOINTMENT**

A provider shall not receive payment for a missed appointment unless the appointment was arranged by the Division, carrier or the employer. If the carrier or employer fails to cancel the appointment not less than one (1) business day prior to the time of the appointment, the provider may bill the carrier for the missed appointment using procedure code 99199 with a maximum fee of BR.

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

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

- (1) Except for inpatient hospital care, a provider shall furnish the carrier with a narrative medical report for the initial visit, all information pertinent to the compensable injury, illness, or occupational disease if requested within thirty (30) days after examination or treatment of the injured employee, and a progress report for every 60 days of continuous treatment for the same compensable injury, illness or occupational disease.
- (2) If the provider continues to treat an injured or ill employee for the same compensable injury, illness or occupational disease at intervals which exceed 60 calendar days, then the provider shall provide a progress report following each treatment that is at intervals exceeding 60 calendar days.

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- (3) The narrative medical report of the initial visit and the progress report shall include all of the following information:
  - (a) Subjective complaints and objective findings, including interpretation of diagnostic tests.
  - (b) For the narrative medical report of the initial visit, the history of the injury, and for the progress report(s), significant history since the last submission of a progress report.
  - (c) The diagnosis.
  - (d) As of the date of the narrative medical report or progress report, the projected treatment plan, including the type, frequency, and estimated length of treatment.
  - (e) Physical limitations.
  - (f) Expected work restrictions and length of time if applicable.
- (4) Cost of the narrative medical reports required by 0800-2-17-.15(1) and (2) shall be reimbursed at the following rate: Initial and Subsequent Reports – Not to exceed \$10.00 for reports twenty (20) pages or less in length, and twenty-five (25) cents per page after the first twenty pages. Under no circumstances shall a provider bill for more than one report per visit. Initial reports shall be billed using procedure code WC101, subsequent reports shall be billed using procedure code WC102, and final reports shall be billed using procedure code WC103.
- (5) A medical provider shall not charge any fee for completing a medical report form required by the Division.

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

### 0800-2-17-.16 ADDITIONAL REPORTS

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

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

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

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

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

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

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

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

### 0800-2-17-.19 PREAUTHORIZATION

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

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

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

#### (1) Carrier's Dispute of a Bill

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

#### (2) Provider's Request for Reconsideration of Bill

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

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

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

(4) Disputes

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

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

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

## PUBLIC NECESSITY RULES

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

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

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

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

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

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

### 0800-2-17-.22 UTILIZATION REVIEW

- (1) Scope of this part:

Requirements contained in this part shall pertain to utilization review activity as defined by T.C.A. § 50-6-124 (Repl. 1999) with respect to services by a provider for health care or health related services furnished as a result of a compensable injury, illness or occupational disease arising out of and in the course of employment. These Rules are intended to supplement and do not in any way displace the Division's Utilization Review Rules, Chapter 0800-2-6.
- (2) Carrier's Utilization Review Program
  - (a) The carrier shall have a utilization review program.
  - (b) Utilization review shall be conducted in a reasonable manner and in accordance with this rule.

## PUBLIC NECESSITY RULES

- (c) Under the utilization review program, the carrier shall do all of the following:
  - 1. Perform ongoing utilization review of medical bills to identify over-utilization of services and improper billing;
  - 2. Determine the accuracy of the procedure coding. If the carrier determines, based upon review of the bill and any related material which describes the procedure performed, that the procedure is incorrectly or incompletely coded, the carrier may recode the procedure, but shall notify the provider of the reasons for the recoding within 30 days of receipt of the bill;
  - 3. Reduce the bill to the maximum allowable payment for that procedure;
  - 4. Refer to the Division's Medical Director all providers whose billing practices indicate over-utilization.
  - 5. A carrier may have another certified entity perform utilization review activities on its behalf.
- (d) The utilization review program, whether operated by the carrier or an entity on behalf of the carrier, shall be certified by the Tennessee Department of Commerce and Insurance as prescribed in the Division's Rule 0800-2-6-.02.
- (e) The carrier shall provide the Division with the name, address, and license number (and a copy of the contract agreement between the carrier and other entity if applicable) of the entity responsible for conducting the carrier's utilization review program.
- (f) The carrier is responsible for notifying the Division when changing reviewing entities.
- (g) For purposes of this rule, a carrier which has another entity perform utilization review activities on its behalf maintains full responsibility for compliance with this rule.
- (h) Under the carrier's utilization review program, the carrier shall make determinations concerning a compensable injury, illness or occupational disease through one of the following approaches:
  - 1. Review by licensed, registered, or certified health care professionals.
  - 2. The application of criteria developed by licensed, registered, or certified health care professionals.
  - 3. A combination of approaches in subdivisions (1) and (2) of this Subsection according to the type of covered injury or illness.
- (i) Licensed, registered, or certified health care professionals shall be involved in determining the carrier's response to a request by a provider for reconsideration of its bill.
- (j) These licensed, registered, or certified health care professionals shall have suitable occupational injury or disease expertise, or both, to render an informed clinical judgment on the medical appropriateness of the services provided.

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

## PUBLIC NECESSITY RULES

### **0800-2-17-.23 RULE REVIEW**

The Division encourages participation in the development of and changes to the Medical Cost Containment Program Rules, the Medical Fee Schedule Rules and the In-patient Hospital Fee Schedule Rules by all groups, associations, and the public. Any such group, association or other party desiring input into or changes made to these Rules and associated schedules must make their recommendations, in writing, to the Commissioner. After analysis, the Division may incorporate such recommended changes into Rules after appropriate consideration and public comment. The Medical Fee Schedule Rules, Medical Cost Containment Program Rules and In-Patient Hospital Fee Schedule Rules shall be reviewed by the Commissioner, in consultation with the Medical Care and Cost Containment Committee and the Advisory Council on Workers' Compensation July 2006 and on an annual basis thereafter. When appropriate, the Commissioner may revise the Fee Schedule Rules as necessary and appropriate.

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

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

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

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

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

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

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

The public necessity rules set out herein were properly filed in the Department of State on the 15th day of June, 2005, and will be effective from the day of filing for a period of 165 days. These public necessity rules will remain in effect through the 27th day of November, 2005. (06-14)

PUBLIC NECESSITY RULES

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

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

**STATEMENT OF NECESSITY REQUIRING PUBLIC NECESSITY RULES**

The Commissioner of the Tennessee Department of Labor and Workforce Development ("Commissioner") makes this statement pursuant to Tenn. Code Ann. §§ 4-5-209 and 50-6-204(i)(5) (Supp. 2004). The Commissioner hereby promulgates the following public necessity rules establishing a Medical Fee Schedule as part of the comprehensive medical fee schedule and related system applicable to all medical treatment under the Workers' Compensation Law as administered by the Workers' Compensation Division of the Tennessee Department of Labor and Workforce Development.

Tennessee Code Annotated § 50-6-204(i)(1) (Supp. 2004), mandates the Commissioner establish a comprehensive medical fee schedule and related system which includes, but is not limited to, procedures for review of charges, enforcement procedures and appeal hearings, to implement the fee schedule. In addition, the General Assembly specifically authorized the Commissioner to promulgate these rules, if appropriate, as public necessity rules. Tenn. Code Ann. § 50-6-204(i)(5) (Supp. 2004). The General Assembly also mandated these rules must take effect on July 1, 2005. To insure compliance with the General Assembly's directive that the rules establishing a Medical Fee Schedule take effect on July 1, 2005, the Commissioner is therefore required to implement these rules within a prescribed period of time which precludes utilization of the other rulemaking procedures for the promulgation of permanent rules.

James Neeley, Commissioner  
Tennessee Department of Labor & Workforce Development

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

**NEW RULES**

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## PUBLIC NECESSITY RULES

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

- (1) The Medical Fee Schedule of the Tennessee Division of Workers' Compensation ("TDWC") is a Medicare-based system, but with multiple conversion factors. Only one geographical practice index is recognized in Tennessee under Medicare, therefore these Medical Fee Schedule rates apply state-wide. The Medical Fee Schedule is based upon the Centers for Medicare and Medicaid Services ("CMS") (formerly the Health Care Financing Administration's) ("HCFA") Medicare Resource Based Relative Value Scale ("RBRVS"), utilizing CMS' national relative value units and Tennessee specific conversion factors adopted by the Tennessee Division of Workers' Compensation. Anyone using this schedule must consult and be familiar with the Division's Medical Cost Containment Program rules, 0800-2-17-.01 et seq., the In-patient Hospital Fee Schedule rules, 0800-2-19.01 et seq., the most current American Medical Association ("AMA") CPT Codes, Health Care Financing Administration Common Procedure Coding System ("HCPCS"), American Society of Anesthesiologists ("ASA") Relative Value Guide, and the most current effective Medicare procedures and guidelines.
- (2) This Medical Fee Schedule must be used in conjunction with Medical Cost Containment Program Rules and the In-patient Hospital Fee Schedule Rules. The definitions set out in those rules, as well as the other general provisions, including but not limited to those regarding prompt payment of provider's bills, are adopted by reference as if set forth fully herein and those Rules must be used in conjunction with these Medical Fee Schedule Rules.
- (3) The Medical Fee Schedule Rules are effective July 1, 2005 and apply to all services provided on or after July 1, 2005. The most current versions of the American Medical Association's CPT and the Medicare RBRVS shall automatically be applicable and are adopted by these Rules by reference upon their effective dates. Fees shall be calculated using the edition of the CPT and RBRVS effective on the date of service.

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

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

- (1) Format

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

- (2) Reimbursement

- (a) Unless otherwise indicated herein, the most current Medicare procedures and guidelines are hereby adopted and incorporated as part of these Rules as if fully set out herein and effective upon adoption and implementation by the CMS. Whenever there is no specific fee or methodology for reimbursement set forth in these Rules for a service, diagnostic procedure, equipment, etc., then the amount of reimbursement shall be at 100% of the most current effective CMS' Medicare allowable amount. The most current effective Medicare guidelines and procedures shall be followed in arriving at the correct amount. For purposes

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of these Rules, the Medicare amount may be adjusted upward annually based upon the annual Medicare Economic Index adjustment, but this amount shall never fall below the effective 2005 Medicare amount. Whenever there is no applicable Medicare code or method of reimbursement, the service, equipment, diagnostic procedure, etc. shall be reimbursed at the lesser of the usual and customary amount, or the prevailing charge amount, and shall be billed By Report (“BR”).

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

1. The provider’s usual charge;
2. The fee calculated according to the TDWC Fee Schedule Rules (includes 100% of Medicare if no other specific fee or methodology is set forth in these Rules);
3. The MCO/PPO or any other contracted price;
4. In no event shall reimbursement be in excess of these TDWC Fee Schedules, unless otherwise provided in the Division’s rules. Reimbursement in excess of the TDWC Medical Fee Schedule may result in civil penalties, at the Commissioner’s discretion, of \$10,000.00 per violation for each violation assessed severally against the provider accepting such fee and the carrier or employer paying the excessive fee, should a pattern or practice of such activity be found. At the Commissioner’s discretion, such provider may also be reported to the appropriate certifying board or other appropriate authority, and may be subject to exclusion from participating further in providing care under the Tennessee Workers’ Compensation Act (“Act”).

(3) Fee Schedule Calculations

The TDWC Medical Fee Schedule amount can be calculated for any specific CPT code by multiplying the national “transitioned nonfacility total relative value units” (“RVUs”) by the conversion factor applicable to that CPT. Certain areas listed below do not have a conversion factor and the maximum reimbursement amount allowed is the usual and customary amount, as indicated. Other areas not listed below, such as dentistry, have a maximum reimbursement amount of 100% of the Medicare allowable amount calculated in accordance with then current effective Medicare guidelines and methodology.

(4) Conversion Factors—based on the CMS’ 2005 Tennessee unit amount of 37.8975

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

	<u>Conversion Factor</u>	<u>As a percent of TN Medicare Rate</u>
Anesthesiology.....	Usual and Customary Amount	
Chiropractic Care.....	\$49.27	130%
General Surgery.....	\$75.80	200%
Home Health Care.....	100% of LUPA*	
Home Infusion.....	Usual and Customary Amount	

PUBLIC NECESSITY RULES

Gen. Medicine (includes unlisted specialties, Evaluation & Management, etc.)		
Office visits, E&M, etc. CPT codes.....	\$60.64	160%
Emergency care CPT codes.....	\$75.80	200%
Neurosurgery (board-eligible or certified physicians).....	\$104.14	275%
(Non-board eligible physicians paid general surgery rate)		
Orthopedic Surg. (board-eligible or cert. physicians).....	\$104.14	275%
(Non-board eligible physicians paid general surgery rate)		
Pathology.....	Usual and Customary Amount	
Physical and Occupational Therapy		
Independently-owned Facilities-For First 6 visits..	\$56.85	150%
Visits 7-12.....	\$49.27	130%
Visits over 12.....	\$37.90	100%
Physician-affiliated Facilities-For First 6 visits.....	\$49.27	130%
Visits 7-12.....	\$39.79	105%
Visits over 12.....	\$37.90	100%
Radiology .....	\$75.80	200%

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

(5) Forms

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

(6) Violations of Fee Schedules and Medical Cost Containment Rules

The Commissioner, Commissioner's Designee, or an agency member appointed by the Commissioner, shall have the authority to issue civil penalties up to and including \$10,000.00 per violation for violations of the Medical Fee Schedule, In-patient Hospital Fee Schedule or the Medical

## PUBLIC NECESSITY RULES

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

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

### 0800-2-18-.03 GENERAL GUIDELINES

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

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

### 0800-2-18-.04 SURGERY GUIDELINES

- (1) Multiple Procedures: Reimbursement shall be based on 100% of the physician’s usual charge for the major procedure (not to exceed 100% of the TDWC Medical Fee Schedule amount allowable) plus 50% of the physician’s usual charge for the lesser or secondary procedure (s) (not to exceed 50% of the TDWC Medical Fee Schedule allowable).
- (2) Services Rendered by More Than One Physician:
  - (a) Concurrent Care: One attending physician shall be in charge of the care of the injured employee. However, if the nature of the injury requires the concurrent services of two or more specialists for treatment, then each physician shall be entitled to the listed fee for services rendered.
  - (b) Surgical Assistant: A physician who assists at surgery may be reimbursed as a surgical assistant. To identify surgical assistant services provided by physicians, Modifier 80 or 81 shall be added to the surgical procedure code which is billed. A physician serving as a surgical assistant must submit a copy of the operative report to substantiate the services rendered. Reimbursement is limited to the lesser of the surgical assistant’s usual charge or 20% of

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the maximum allowable Medical Fee Schedule amount. Duly licensed physician assistants may serve as surgical assistants as deemed appropriate by the physician, and if so, the licensed physician assistants' reimbursement shall not exceed the physician assistant fee due for the procedure as calculated pursuant to Medicare guidelines, not the conversion factors contained in the workers' compensation Medical Fee Schedule.

- (c) Two Surgeons: For reporting see the most current CPT. Each surgeon must submit an operative report documenting the specific surgical procedure(s) provided. Each surgeon must submit an individual bill for the services rendered. Reimbursement must not be made to either surgeon until the carrier has received each surgeon's individual operative report and bill. Reimbursement to both surgeons shall not exceed 150% of the maximum allowable Fee Schedule amount of the first surgeon and shall be allocated between the surgeons as agreed by them.
- (3) When a surgical fee is chargeable, no office visit charge shall be allowed for the day on which this surgical fee is earned, except if surgery is performed on the same day as the physician's first examination. All exceptions require use of the appropriate modifiers and shall be filed BR.
- (4) Certain of the listed procedures in the Medical Fee Schedule are commonly carried out as an integral part of a total service and, as such, do not warrant a separate charge.
- (5) Lacerations ordinarily require no aftercare except removal of sutures. The removal is considered a routine part of an office or hospital visit and shall not be billed separately unless such sutures are removed by a provider different from the provider administering the sutures.

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

### 0800-2-18-.05 ANESTHESIA GUIDELINES

- (1) General Information and Instructions.
  - (a) The current ASA Relative Value Guide, by the American Society of Anesthesiologists will be used to determine reimbursement for anesthesia codes that do not appear in the RBRVS. These values are to be used only when the anesthesia is personally administered by an Anesthesiologist or Certified Registered Nurse Anesthetist ("CRNA") who remains in constant attendance during the procedure, for the sole purpose of rendering such anesthesia service. To order the Relative Value Guide, write to the American Society of Anesthesiologists, 520 N Northwest Highway; Park Ridge, IL 60068-2573, or call (847) 825-5586.
  - (b) When anesthesia is administered by a CRNA not under the medical direction of an anesthesiologist, reimbursement shall be 90% of the provider's usual and customary charge. No payment will be made to the surgeon supervising the CRNA.
  - (c) When anesthesia is administered personally by an anesthesiologist or administered by a care team involving an anesthesiologist and CRNA, reimbursement shall not exceed 100% of the provider's usual and customary charge.
- (2) Anesthesia Values

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

### (3) Total Anesthesia Value

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

### (4) Billing

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

### (5) Reimbursement

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

### (6) Medical Direction Provided by Anesthesiologists

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

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### (7) Anesthesia by Surgeon

#### (a) Local Anesthesia

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

#### (b) Regional or General Anesthesia

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

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

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

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

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

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

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

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

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

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

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### 0800-2-18-.06 INJECTIONS GUIDELINES

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

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

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

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

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

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

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

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

- (1) Charges for chiropractic services shall not exceed 130% of the participating fees prescribed in the Medicare RBRVS System fee schedule. The number of approved visits shall be limited pursuant to any restrictions in T.C.A. § 50-6-204. The same procedures for certification applicable to physical therapy and occupational therapy services under Rule 0800-2-18-.09(5) below apply to chiropractic services (such as UR review after 12 visits), except that the thirty (30) day time period therein shall not apply to chiropractic services.
- (2) For chiropractic services, an office visit shall not be billed on the same day as a manipulation is billed.
- (3) If allowable payment for chiropractic services is not paid by employers or insurers for chiropractic services provided to employees who have suffered a compensable work-related injury under the Workers' Compensation Law within thirty-one (31) days from the date of receipt by the employer

## PUBLIC NECESSITY RULES

or insurer of the bill for chiropractic services provided to such an employee, interest at the rate of 25% per annum of the payment allowed pursuant to these rules, compounded monthly, may be charged and paid as set forth in Rule 0800-2-11-.10 of the Medical Cost Containment Program Rules.

- (4) There shall be no fee allowable for any modalities performed in excess of four (4) modalities per day per employee. The Medicare definition of modality is applicable.
- (5) There shall be no charge for either hot packs or cold packs provided to an employee who has suffered a compensable work-related injury under the Workers' Compensation Law.

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

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

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

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- (5) Whenever physical therapy and/or occupational therapy services exceed twelve (12) sessions/visits or a period over thirty (30) days, whichever comes first, then such treatment shall be reviewed pursuant to the carrier's utilization review program in accordance with the procedures set forth in 0800-2-6 of the Division's Utilization Review rules before further physical therapy and/or occupational therapy services may be certified for payment by the carrier. Such certification shall be completed within two (2) business days of any request for certification to assure no interruption in delivery of needed services. Failure to properly certify such services as prescribed herein shall result in the forfeiture of any payment for uncertified services. The initial utilization review of physical therapy and/or occupational therapy services shall, if necessary and appropriate, certify an appropriate number of sessions/visits. If necessary, further subsequent utilization review shall be conducted to certify additional physical therapy and/or occupational therapy services as is appropriate.

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

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

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

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

## PUBLIC NECESSITY RULES

- (v) instruction manual and/or audio tape.
  - 2. Supplies submitted for reimbursement must be itemized. In unusual circumstances where additional supplies are necessary, use modifier 22 and “BR”
  - 3. Limited to 30 days trial period.
- (b) Purchase:
- 1. Prior to the completion of the 30-day trial period, the prescribing doctor must submit a report documenting the medical justification for the continued use of the unit. The report should identify the following:
    - (i) Describe the condition and diagnosis that necessitates the use of a TENs unit.
    - (ii) Does the patient have any other implants which would affect the performance of the TENs unit or the implanted unit?
    - (iii) Was the TENs unit effective for pain control during the trial period?
    - (iv) Was the patient instructed on the proper use of the TENS unit during the trial period?
    - (v) How often does the patient use the TENS unit?
  - 2. The purchase price should include the items below if not already included with the rental:
    - (i) lead wires;
    - (ii) two (2) rechargeable batteries; and
    - (iii) a battery charger.
  - 3. Only the first month’s rental price shall be credited to purchase price.
  - 4. Provider shall indicate TENs manufacturer, model name, and serial number.
- (4) Continuous and Passive Motion (Use Code D0540)

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

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

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

Implants, orthotics and prosthetics should be coded according to the HCFA Common Procedures Coding System (HCPCS). Copies may be obtained from the American Orthotic and Prosthetic Association, 1650

## PUBLIC NECESSITY RULES

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

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

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

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

- (1) The provider's usual charge;
- (2) A negotiated contract amount; or
- (3) The fees established by the formula for brand-name and generic pharmaceuticals as described in subsection (5) of this section.
- (4) Prescribed Medication Services
  - (a) "Drug" has the meaning set out in T. C. A. § 63-10-204.
  - (b) Medicine or drugs may only be dispensed by a currently licensed pharmacist or a dispensing practitioner.
  - (c) Carriers may contract with pharmacy benefit managers to process and administer claims for reimbursement of pharmacy services and review the relatedness and appropriateness of prescribed services. Carriers and pharmacists may also negotiate alternative reimbursement schedules and amounts, so long as the reimbursement amount does not exceed the fee schedule amount set out in these Rules.
  - (d) For the purposes of these TWCD Medical Fee Schedule Rules, medicines are defined as drugs prescribed by an authorized health care provider and include only generic drugs or single-source patented drugs for which there is no generic equivalent, unless the authorized health care provider writes that the brand name is medically necessary and includes on the prescription "dispense as written."
- (5) Reimbursement
  - (a) The pharmaceutical reimbursement formula for prescribed drugs (medicines by pharmacists and dispensing practitioners) is the lesser of:  
  
Average Wholesale Price\* ("AWP") + \$5.10 filling fee, the provider's usual charge, or a negotiated contractual amount.

\* The Commissioner may at any time adopt and implement a different base price other than AWP (such as average sales price), should medical reimbursement standards and/or local or other practices warrant, at the Commissioner's discretion.

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- (b) Reimbursement to pharmacists must not exceed the amount calculated by the pharmaceutical reimbursement formula for prescribed drugs. A generic drug must be substituted for any brand name drug unless: 1) there is no pharmaceutical and bioequivalent drug available, or 2) the prescribing physician indicates that substitutions are prohibited by including the words "Dispense as Written", or "No Substitution Allowed" in the prescriber's own handwriting, along with a statement that the brand name drug is medically necessary. A prescribing physician may also prohibit substitution of generic drugs by oral or electronic communication to the pharmacist so long as the same content is conveyed that is required in a written prescription. A lower cost, therapeutically equivalent drug may be substituted for a prescribed drug if the requirements set out in Title 63, Chapter 10, Part 2 of Tennessee Code Annotated are all met.
1. A bill or receipt for a prescription drug shall include all of the following:
    - (i) When a brand name drug with a generic equivalent is dispensed, the brand name and the generic name shall be included unless the prescriber indicates "do not label."
    - (ii) If the drug has no brand name, the generic name, and the manufacturer's name or the supplier's name, shall be included, unless the prescriber indicates "do not label."
    - (iii) The strength, unless the prescriber indicates "do not label."
    - (iv) The quantity dispensed.
    - (v) The dosage.
    - (vi) The name, address, and federal tax ID# of the pharmacy.
    - (vii) The prescription number, if available.
    - (viii) The date dispensed.
    - (ix) The name of the prescriber.
    - (x) The name of the patient.
    - (xi) The price for which the drug was sold to the purchaser.
    - (xii) The National Drug Code Number ("NDC Number").
  2. The AWP shall be determined from the appropriate monthly publication. The monthly publication that shall be used for calculation shall be the same as the date of service. When an AWP is changed during the month, the provider shall still use the AWP from the monthly publication. The publications to be used are:
    - (i) Primary reference. Price Alert from First Data Bank.
    - (ii) Secondary reference (for drugs NOT found in PriceAlert). Red Book from Medical Economics.

## PUBLIC NECESSITY RULES

3. Dietary supplements such as minerals and vitamins shall not be reimbursable unless a specific compensable dietary deficiency has been clinically established in the injured employee as a result of the work-related injury.
4. A compounding fee not to exceed Twenty-five Dollars (\$25.00) per compound prescription may be charged if two (2) or more prescriptive drugs require compound preparation when sold by a hospital, pharmacy, or provider of service other than a physician.
5. If allowable payment for prescriptive drugs is not paid by employers or carriers for prescriptions provided to employees who have suffered a compensable work-related injury under the Workers' Compensation Law within thirty-one (31) days from the date of receipt by the employer or insurer of the bill for prescriptive drugs provided to such an employee, interest at the rate of 2.08% /month of the payment allowed pursuant to these rules may be charged by a hospital, pharmacy, or provider of such service as set forth in Rule 0800-2-11-.10 of the Medical Cost Containment Program Rules.
6. If a workers' compensation claimant chooses a brand-name medicine when a generic medicine is available and allowed by the prescriber, the claimant shall pay the difference in price between the brand-name and generic medicine and shall not be eligible to subsequently recover this difference in cost from the employer or carrier.

### (6) "Patent" or "Proprietary Preparations"

- (a) "Patent" or "Proprietary preparations," frequently called "over-the-counter drugs," are sometimes prescribed for a work-related injury or illness instead of a generic drug.
- (b) Generic substitution as discussed in (4)(b) above applies also to "over-the-counter" preparations.
- (c) Pharmacists must bill and be reimbursed their usual and customary charge for the "over-the-counter" drug(s).
- (d) The reimbursement formula does not apply to the "over-the-counter" drugs and no filling fee may be reimbursed.

### (7) Dispensing Practitioner

- (a) Dispensing practitioners shall be reimbursed the same as pharmacists for prescribed drugs (medicines), except such practitioners shall not receive a filling fee.
- (b) "Patent" or "proprietary preparations" frequently called "over-the-counter drugs," dispensed by a physician(s) from their office(s) to a patient during an office visit should be billed as follows:
  1. Procedure Code 99070 must be used to bill for the "proprietary preparation" and the name of the preparation, dosage and package size must be listed as the descriptor.
  2. An invoice indicating the cost of the "proprietary preparation" must be submitted to the carrier with the HCFA 1500 Form.
  3. Reimbursement is limited to the lesser of the provider's charge or 20 percent above the actual cost of the item.

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

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

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

Based upon the lesser of the submitted charge or the prevailing reimbursement rate for ambulances within the geographic locality. These charges shall not exceed the prevailing charges in that locality for comparable services under comparable circumstances and commensurate with the services actually performed. Ambulance services shall be paid on a two (2) part basis, the first level being the level of care, the second being a mileage allowance. The services rendered are independent of the type of call received.

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

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

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

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

## PUBLIC NECESSITY RULES

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

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

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

The public necessity rules set out herein were properly filed in the Department of State on the 15th day of June, 2005, and will be effective from the day of filing for a period of 165 days. These public necessity rules will remain in effect through the 27th day of November, 2005. (06-15)

PUBLIC NECESSITY RULES

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

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

**STATEMENT OF NECESSITY REQUIRING PUBLIC NECESSITY RULES**

The Commissioner of the Tennessee Department of Labor and Workforce Development ("Commissioner") makes this statement pursuant to Tenn. Code Ann. §§ 4-5-209 and 50-6-204(i)(5) (Supp. 2004). The Commissioner hereby promulgates the following public necessity rules establishing an In-patient Hospital Fee Schedule as part of the comprehensive medical fee schedule and related system applicable to all medical treatment under the Workers' Compensation Law as administered by the Workers' Compensation Division of the Tennessee Department of Labor and Workforce Development.

Tennessee Code Annotated § 50-6-204(i)(1) (Supp. 2004), mandates that the Commissioner establish a comprehensive medical fee schedule and related system which includes, but is not limited to, procedures for review of charges, enforcement procedures and appeal hearings, to implement the fee schedule. In addition, the General Assembly specifically authorized the Commissioner to promulgate these rules, if appropriate, as public necessity rules. Tenn. Code Ann. § 50-6-204(i)(5) (Supp. 2004). The General Assembly also mandated that these rules must take effect on July 1, 2005. To insure compliance with the General Assembly's directive that the rules establishing an In-Patient Hospital Fee Schedule take effect on July 1, 2005, the Commissioner is therefore required to implement these rules within a prescribed period of time which precludes utilization of the other rulemaking procedures for the promulgation of permanent rules.

James Neeley, Commissioner  
Tennessee Department of Labor &  
Workforce Development

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

**NEW RULES**

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**0800-2-19-.01 GENERAL RULES**

- (1) This In-patient Hospital Fee Schedule shall be effective July 1, 2005 and is applicable for all inpatient services as defined herein, and includes medical, surgical, rehabilitation, and/or psychiatric services rendered in a hospital to injured workers under the Tennessee Workers' Compensation Act. Maximum fees for outpatient hospital services are not addressed in this In-patient Hospital Fee Schedule, but are contained in the Medical Fee Schedule Rules, 0800-2-18-.01 et seq. This In-patient Hospital Fee Schedule is established pursuant to Tenn. Code Ann. § 50-6-204 (Supp. 2004) is effective July 1, 2005, and must be used in conjunction with the Medical Cost Contain-

## PUBLIC NECESSITY RULES

ment Program Rules, 0800-2-17-.01 et seq. and the Medical Fee Schedule Rules, 0800-2-18-.01 et seq. as the definitions and general provisions set forth in those rules are incorporated as if set forth fully herein.

### (2) General Information

- (a) Reimbursements shall be determined for services rendered in accordance with this fee schedule and shall be considered to be inclusive unless otherwise noted.
- (b) The most current Medicare procedures and guidelines are hereby adopted and incorporated as part of these Rules as if fully set out herein and shall be effective upon adoption and implementation by the CMS. Whenever there is no specific fee or methodology for reimbursement set forth in these Rules for a service, diagnostic procedure, equipment, etc., then the amount of reimbursement shall be at 100% of the 2005 CMS' Medicare amount and the most current effective Medicare guidelines and procedures shall be followed in arriving at the correct amount. The Medicare amount may, at the Commissioner's discretion, be adjusted upward annually based upon CMS' annual Medicare Economic Index adjustment, but this amount shall never fall below the effective 2005 Medicare amount. Whenever there is no applicable Medicare code, the service, equipment, diagnostic procedure, etc. shall be reimbursed at the lesser of the usual and customary or the prevailing charge amount and be billed By Report.
- (c) Reimbursement for a compensable workers' compensation claim shall be the lesser of the hospital's usual and customary charges, the prevailing charge amount, or the maximum amount allowed under this Inpatient Hospital Fee Schedule.
- (d) Inpatient hospitals shall be grouped into the following separate peer groupings:

Peer Group	1	Hospitals
Peer Group	2	Rehabilitation Hospitals
Peer Group	3	Psychiatric Hospitals
- (e) For each inpatient claim submitted, the provider shall assign a Medicare Diagnosis Related Group ("DRG") code which appropriately reflects the patient's primary cause of hospitalization.
- (f) The inpatient hospital fee schedule shall become effective July 1, 2005 and shall be reviewed annually and may be updated annually.
- (g) Ongoing analysis will be conducted as to the projected savings of this schedule, as well as any impact on patient services.
- (h) Preauthorization is required for specific inpatient services.

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

### 0800-2-19-.02 DEFINITIONS

- (1) "Administrator" means the chief administrative officer of the Division of Workers' Compensation of the Tennessee Department of Labor and Workforce Development.

## PUBLIC NECESSITY RULES

- (2) "Allowed Charges" or "Allowable Charges" shall mean charges reviewed and approved under an appropriate audit and utilization review by the carrier as prescribed in the Division's Rules, or as determined by the Commissioner or the Commissioner's designee after consultation with the Division's Medical Director.
- (3) "Commissioner" means the Commissioner of the Tennessee Department of Labor and Workforce Development.
- (4) "Division" means the Division of Workers' Compensation of the Tennessee Department of Labor and Workforce Development.
- (5) DRG – Medicare classifications of diagnosis in which patients demonstrate similar resource consumption and length of stay patterns.
- (6) In-patient Services - Services rendered to a person who is formally admitted to a hospital and whose length of stay exceeds 23 hours.
- (7) Institutional Services - All non-physician services rendered within the institution by an agent of the institution.
- (8) Length of Stay ("LOS") - Number of days of admission where patient appears on midnight census. Last day of stay shall count as an admission day if it is medically necessary for the patient to remain in the hospital beyond 12:00 noon.
- (9) Medical Admission - Any hospital admission where the primary services rendered are not surgical, psychiatric, or rehabilitative in nature.
- (10) Stop-Loss Payment ("SLP") - An independent method of payment for an unusually costly or lengthy stay.
- (11) Stop-Loss Reimbursement Factor ("SLRF") - A factor established by the Division to be used as a multiplier to establish a reimbursement amount when total hospital charges have exceeded specific stop-loss thresholds.
- (12) Stop-Loss Threshold ("SLT") - Threshold of total charges established by the Division, beyond which reimbursement is calculated by multiplying the applicable Stop-Loss Reimbursement Factor times the total charges identifying that particular threshold.
- (13) Surgical Admission - Any hospital admission where there is an operating room charge, the patient has a surgical procedure code, or the patient has a surgical DRG as defined by the CMS.
- (14) Transfers Between Facilities - To move or remove a patient from one facility to another for a purpose related to obtaining or continuing medical care. May or may not involve a change in the admittance status of the patient, i.e. patient transported from one facility to another to obtain specific care, diagnostic testing, or other medical services not available in facility in which patient has been admitted. Includes costs related to transportation of patient to obtain medical care.
- (15) "Trauma Admission" - means any hospital admission in which the patient has a diagnosis code of 800 to 959.99.

## PUBLIC NECESSITY RULES

- (16) "Usual and customary charge" means a particular provider's average charge for a procedure to all payment sources, and includes itemized charges previously billed separately which are included in the package for that procedure as defined by this rule.
- (17) Workers' Compensation Standard Per Diem Amount ("SPDA") - A standardized per diem amount established for the reimbursement of hospitals for services rendered.

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

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

- (1) This section defines the reimbursement procedures and calculations for inpatient health care services by all hospitals. Hospital reimbursement is divided into two (2) groups based on type of admission (surgical or non-surgical (medical)) and length of stay (less than eight (8) days/over seven (7) days). Rehabilitation and Psychiatric hospitals are grouped separately.
- (2) General Information
- (a) For each inpatient claim submitted, the provider shall assign a Diagnosis Related Group (DRG) code which appropriately reflects the patient's primary cause for hospitalization to determine average length of stay and for tracking purposes. Hospitals within each peer group are subject to a maximum amount per inpatient day.
- (b) The maximum per diem rates to be used in calculating the reimbursement rate is as follows:
- |    |                                |   |                                                                                                                                                                                                                                                               |
|----|--------------------------------|---|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. | Peer Group                     | 1 | \$1,800.00 Surgical adm for the first seven (7) days;<br>1,500.00 per day thereafter (surgical adm.)<br>Includes Intensive Care (ICU) & Critical Care (CCU)<br>1,500.00 Medical adm. for first seven (7) days;<br>1,250.000 per day thereafter (medical adm.) |
| 2. | Peer Group<br>(Rehabilitation) | 2 | 1,000.00 For the first seven (7) days;<br>800.00 per day thereafter                                                                                                                                                                                           |
| 3. | Peer Group                     | 3 | 700.00 Psychiatric Hospitals (applicable to<br>chemical dependency as well.)                                                                                                                                                                                  |
- (c) All trauma care at any licensed Level 1 Trauma Center shall be reimbursed at a maximum rate of \$3,000.00 per day for each day of patient stay.
- (d) Surgical implants shall be reimbursed separately and in addition to the per diem hospital charges.
1. Reimbursement for trauma inpatient hospital services shall be limited to the lesser of the maximum allowable as calculated by the appropriate per diem rate, or the hospital's billed charges minus any non-covered charges.
2. Non-covered charges are: convenience items, charges for services not related to the work injury/illness services that were not certified by the payer or their representative as medically necessary.

## PUBLIC NECESSITY RULES

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

## PUBLIC NECESSITY RULES

- (a) Stop-loss is an independent reimbursement factor established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker.
- (b) Explanation
1. To be eligible for stop loss payment, the total Allowed Charges for a hospital admission must exceed the hospital maximum payment, as determined by the hospital maximum payment rate per day, by at least \$15,000.
  2. This stop-loss threshold is established to ensure compensation for unusually extensive services required during an admission.
  3. Once the allowed charges reach the stop-loss threshold, reimbursement for all additional charges shall be made based on a stop-loss payment factor of 80%.
  4. The additional charges are multiplied by the Stop-Loss Reimbursement Factor (SLRF) and added to the maximum allowable payment.

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

(d) Example: DRG 222: Knee Procedures W/O CC  
Hospital Peer Group: 1 –Surgical admission  
Maximum rate per day: \$1,800 for first 7 days; 1,500 for 2 additional days  
Number Billed Days: 9  
Total Billed Charges: \$37,600.00  
Maximum allowable payment for  
Normal DRG stay \$15,600  
Versus: billed charges \$37,600  
Amount Payable Before Stop-Loss,  
Lower of Charge vs. Maximum Allowable..... \$15,600  
Total difference, charges over and above maximum payments \$22,000  
Difference over and above \$15,000 Stop-loss is \$7,000.00  
Payable under Stop-loss (80% of 7,000.00)..... \$5,600.00  
Total payment  
due hospital: \$21,200.00 (15,600+5,600)

(5) Billing for Inpatient Admissions

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

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

### 0800-2-19-.04. PREAUTHORIZATION.

(1) Procedures For Requesting Preauthorization

- (a) The insurance carrier shall be liable for the reasonable and necessary medical costs relating to the health care treatments and services listed in subparagraph (g) of this Rule required to treat a compensable injury, when any of the following situations occur:

## PUBLIC NECESSITY RULES

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

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

## PUBLIC NECESSITY RULES

### 0800-2-19-.05 OTHER SERVICES

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

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

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

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

## PUBLIC NECESSITY RULES

for a hearing within fifteen (15) calendar days of the date of issuance of a Notice of Violation shall result in the decision of the Commissioner, Commissioner's Designee, or an agency member appointed by the Commissioner becoming a final order and not subject to further review.

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

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

The public necessity rules set out herein were properly filed in the Department of State on the 15th day of June, 2005, and will be effective from the day of filing for a period of 165 days. These public necessity rules will remain in effect through the 27th day of November, 2005. (06-16)

PUBLIC NECESSITY RULES

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

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

**STATEMENT OF NECESSITY REQUIRING PUBLIC NECESSITY RULES**

The Commissioner of the Tennessee Department of Labor and Workforce Development ("Commissioner") makes this statement pursuant to Tenn. Code Ann. § 4-5-209(a)(4) and Public Chapter 962, § 24 (2004). The Commissioner hereby promulgates the following public necessity rules establishing a Medical Impairment Rating Registry Program applicable to all claims where a dispute exists with regard to the degree of medical impairment under the Workers' Compensation Law as administered by the Workers' Compensation Division of the Tennessee Department of Labor and Workforce Development.

Public Chapter 962, § 24 (2004) mandates the Commissioner establish by rule, in accordance with the Uniform Administrative Procedures Act, title 4, chapter 5, an independent medical examiners' registry. The Commissioner shall establish qualifications for the independent medical examiners, including continuing education and peer review requirements, with the advice of the Tennessee Medical Association and the Workers' Compensation Advisory Council. These rules include, but are not limited to, qualifications and procedures for submission of an application for inclusion on the registry, procedures for the review and maintenance of the registry, and procedures for assignment that ensures that the composition of such panels is random. These rules are required to take effect July 1, 2005. The Commissioner is authorized to use public necessity rules under Tenn. Code Ann. § 4-5-209(a)(4) as appropriate in order to have such rules in effect no later than July 1, 2005. Public Chapter 962, § 24 (2004). To insure compliance with the General Assembly's directive that the rules establishing an independent medical examiners' registry take effect on July 1, 2005, the Commissioner is therefore required to implement these rules within a prescribed period of time which precludes utilization of the other rulemaking procedures for the promulgation of permanent rules.

James Neeley, Commissioner  
Tennessee Department of Labor &  
Workforce Development

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

**NEW RULES**

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## PUBLIC NECESSITY RULES

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

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

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

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

- (1) Purpose. The purpose of the Medical Impairment Rating Registry Program is to establish a resource to resolve conflicting opinions regarding permanent impairment ratings given for on-the-job injuries. In order to ensure high-quality independent medical impairment evaluations, the Department establishes these Rules for parties and physicians participating under the Act's independent medical examiner evaluation process. MIR Registry physicians shall agree to provide evaluations in a manner consistent with the standard of care in their community and in compliance with these Rules, as well as to issue opinions based upon the applicable edition of the AMA Guides to the Evaluation of

Permanent Impairment or other appropriate method pursuant to the Act. These Rules are effective July 1, 2005 and are established pursuant Public Chapter 962, § 24 (2004).

- (2) Scope. The MIR Registry is available to any party who disputes an impairment rating of a physician in a Workers' Compensation claim for injuries that occur on or after July 1, 2005. Other potential issues such as causation, apportionment, appropriateness of treatment, work restrictions, and job modifications shall not be considered or addressed under this MIR Registry Program. Requests for evaluations shall be submitted by paper or electronic application to the Program Coordinator pursuant to the Rules.

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

## PUBLIC NECESSITY RULES

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

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

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

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

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

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

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

- (1) Appointment to the MIR Registry shall be for a two (2) year term, except as otherwise set forth in these Rules. Physicians may seek renewal appointments by the same process as the initial application described herein. The Division reserves the right to charge physicians a non-refundable application fee upon appointment, renewal, or reinstatement to the MIR Registry. The Commissioner or the Commissioner's designee, upon the advice of the Medical Director shall have the sole and exclusive authority to approve or reject applications for inclusion in the MIR Registry.
- (2) Physicians seeking appointment to the MIR Registry shall complete an "Application for Appointment to the MIR Registry," available upon request from the Program Coordinator or on-line at [www.state.tn.us/labor-wfd/mainforms.html](http://www.state.tn.us/labor-wfd/mainforms.html), certify to and, upon approval of the application, comply with the following conditions:
  - (a) Unless otherwise approved by the Program Coordinator, conduct all MIR evaluations based on the guidelines in the applicable edition of the AMA Guides and submit the original "MIR Impairment Rating Report" with all attachments to the Program Coordinator. In cases not

## PUBLIC NECESSITY RULES

covered by the applicable AMA Guides, any impairment rating allowed under the Act shall be appropriate;

- (b) Decline the Program Coordinator's request to conduct an evaluation only on the basis of good cause shown, as determined by the Program Coordinator. Consideration will be given to a physician's schedule and other previously arranged or emergency obligations;
- (c) Comply with the MIR Registry's Rules;
- (d) While on the MIR Registry, agree to maintain an active and unrestricted license to practice medicine or osteopathy in Tennessee and to immediately notify the Program Coordinator of any change in the status of the license, including any restrictions placed upon the license;
- (e) While on the MIR Registry, agree to maintain all board certifications listed on the application and to immediately notify the Program Coordinator of any change in their status;
- (f) Conduct MIR evaluations in an objective and impartial manner, and shall:
  - 1. Conduct these evaluations only in a professional medical office suitable for medical or psychiatric evaluations where the primary use of the site is for medical services; not residential, commercial, educational, legal, or retail in nature. Exceptions will be made only on the basis of good cause shown, as determined by the Program Coordinator.
  - 2. Comply with all local, state and federal laws, regulations, and other requirements with regard to business operations, including specific requirements for the provision of medical services.
  - 3. Not conduct a physical examination on a claimant of the opposite sex without a witness of the same sex as the claimant present.
- (g) Not refer any MIR Registry claimant to another physician for any treatment or testing nor suggest referral or treatment;
- (h) Not become the treating physician for the claimant regarding the work-related injury;
- (i) Not evaluate an MIR Registry claimant without prior consent of the Program Coordinator if a conflict of interest exists. A conflict of interest includes, but is not limited to, instances where the physician has treated or evaluated the claimant for the subject injury or has appeared on a panel of doctors made available to the claimant at the time of injury or subsequent to the injury in the course of medical treatment. If an employer provides a claimant with the name of a group of physicians rather than individual physician names, the entire group of physicians shall be considered to have a conflict of interest for purposes of the MIR Registry Program;
- (j) Not employ invasive diagnostic procedures, except venipuncture for obtaining a blood sample, without prior approval of the Program Coordinator;

## PUBLIC NECESSITY RULES

- (k) Not substitute, or allow to be substituted, anyone else, including any other physician, physician assistant, nurse practitioner, physical therapist or staff member, as the physician to conduct the evaluation without prior written permission from the Program Coordinator;
  - (l) No later than thirty (30) calendar days after the cancellation of an evaluation, refund to the paying party part or all of the fee paid by that party, as may be required by the Rules, the Commissioner or the Commissioner's designee; and
  - (m) For each MIR Registry case assigned, address only the issue of permanent impairment rating and make appropriate findings.
- (3) Physicians denied appointment to the MIR Registry on their initial application may seek reconsideration of their application by submitting a request for reconsideration stating the grounds for such reconsideration to the Program Coordinator within fifteen (15) calendar days of the issuance of the Notice of Denial of their application. The Commissioner or the Commissioner's designee may affirm or reverse the initial determination upon reconsideration of the initial decision. The Commissioner or the Commissioner's designee shall issue a Notice of Final Determination which shall be the final decision.

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

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

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

Program Coordinator, shall be used in all cases to request an MIR three-physician listing. The Commissioner requires the request designate:

- (a) All body part(s) or medical condition(s) to be evaluated, including whether mental impairment shall be evaluated;
- (b) The names of all physicians that have previously evaluated, treated, or are currently evaluating or treating the claimant for the work-related injury at employer and/or employee expense;

## PUBLIC NECESSITY RULES

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

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Coordinator, within these ten (10) calendar days, and at the same time provide to the Program Coordinator the name that it wishes to strike. In that situation, the Program Coordinator will randomly select one physician from the remaining two, and that physician shall perform the evaluation. The Program Coordinator shall inform the parties of the name of the selected physician in writing.

- (c) If a selected physician is unable to perform the evaluation, the Program Coordinator shall provide one replacement name to the original listing using the same criteria and process set forth above, and present that revised listing to the parties and each shall again strike one name according to the above procedures. Additionally, if a physician is removed from the three-physician listing for any reason other than having been struck by one of the parties, the Program Coordinator will issue one replacement physician name.
- (7) Appointment date.
- (a) Within three (3) business days of providing or receiving notice of the physician selection, the Program Coordinator shall call the MIR Registry physician to schedule the evaluation, and shall immediately notify both parties, and the Workers' Compensation Specialist if currently assigned, of the date and time of the evaluation. Only after this notification should the employer or insurance carrier contact the MIR Registry physician and only to arrange for payment and for medical records submission required by these Rules.
- (8) Submission of Medical Records.
- (a) The employer's representative shall concurrently provide to the MIR registry physician and the claimant a complete copy of all pertinent medical records pertaining to the subject injury, postmarked or hand-delivered at least ten (10) calendar days prior to the evaluation or as otherwise arranged by the Program Coordinator with the MIR physician. If deemed necessary by the Program Coordinator, the claimant shall promptly sign a "MIR Waiver and Consent" permitting the release of information to the MIR physician. The form shall include the release of all existing medical reports relevant to the subject injury including all previous impairment rating reports, the actual images of all pertinent imaging studies, the reports of all imaging studies and diagnostic tests, all hospital admission "history and physical examination" documents, all hospital discharge summaries, and all operation reports.
  - (b) The employer's representative shall be responsible for promptly sending a copy of the consent form to all treating and evaluating physicians or other healthcare providers, diagnostic centers, and hospitals involved in the care of the claimant requiring the form to ensure that this information will be forwarded to the MIR physician prior to the date of the scheduled evaluation. If the employer's representative fails to adhere to these time limits, the claimant may submit all medical records he/she has in his/her possession no later than five (5) calendar days prior to the evaluation or as otherwise arranged by the Program Coordinator with the MIR registry physician.
  - (c) In cases involving untimely medical record submission by either party, the Program Coordinator at his/her sole discretion, may elect to reschedule the evaluation to allow the physician adequate time for record review. Otherwise, the physician shall perform the evaluation and shall produce an "MIR Impairment Rating Report" utilizing the information properly made available to the physician.

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- (9) Form/Content of Medical Records Package.
  - (a) The medical file shall include a dated cover sheet listing the claimant's name, MIR Registry physician's name, MIR Registry case number, date and time of the appointment, and the state file number. The medical file shall be in chronological order, by provider, and tabbed by year. It shall include a written summary by the treating physician with the range of dates of treatment. Medical records not meeting these requirements shall be resubmitted in the correct format within three (3) calendar days of notification by the Program Coordinator.
  - (b) Medical bills, adjustor notes, surveillance tapes, denials, vocational rehabilitation reports, non-treating case manager records or commentaries to the MIR Registry physician shall not be submitted without prior permission of the Program Coordinator. Medical depositions may be submitted as part of the medical records package only by written agreement of the parties.
- (10) Supplemental medical records shall be prepared in the same manner described above, and shall be mailed or hand-delivered by any party concurrently to the MIR Registry physician and the other party no later than five (5) calendar days prior to the date of the evaluation, or as otherwise arranged by the Program Coordinator.
- (11) Claimants can bring an adult friend or family member to the evaluation to provide comfort and reassurance. However, the accompanying person cannot be the claimant's attorney, paralegal, or other legal representative or any other personnel employed by the claimant's attorney or legal representative. The guest may be asked to leave the evaluation at the discretion of the MIR Registry physician. Any forms that the MIR physician requests to be completed should be completed by the claimant only. If the claimant needs assistance in completing these forms for any reason, the claimant should notify the MIR Registry physician prior to the evaluation so that assistance can be provided by the MIR Registry physician's staff.
- (12) The claimant shall notify the Program Coordinator of the necessity for a language interpreter concurrently with his/her notification of the chosen physician's name. The employer shall be responsible for arranging for the services of and paying for such language interpreter. The language interpreter shall be impartial and independent, and have no professional or personal affiliation with any party to the claim or to the MIR Registry physician.
- (13) When a claimant is required to travel outside a radius of fifteen (15) miles from the claimant's residence or workplace, then such claimant shall be reimbursed by the employer for reasonable travel expenses as defined in the Act.

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

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

- (1) A physician performing evaluations under these Rules shall be prepaid by the employer a total evaluation fee for each evaluation performed, as outlined below:
  - (a) Completed reports received and accepted by the Program Coordinator within thirty (30) calendar days of scheduling the appointment.....1,000.00
  - (b) Completed reports received and accepted by the Program Coordinator between thirty-one (31) and forty-five (45) calendar days of the scheduling the appointment .....\$850.00

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- (c) Completed reports received and accepted by the Program Coordinator between forty-six (46) and sixty (60) calendar days of the scheduling of the appointment . . . . . \$500.00
  - (d) Completed reports received and accepted by the Program Coordinator later than sixty (60) calendar days of scheduling the appointment . . . . . No fee paid
- (2) The evaluation fee includes normal record review, the evaluation, and production of a standard "MIR Impairment Rating Report." If the record review is unusually extensive and requires substantially longer than an hour for review, the physician may contact the Program Coordinator to request additional payment. This request should be made no later than three (3) calendar days prior to the scheduled date of the evaluation. The Program Coordinator, in consultation with the Medical Director, will determine if additional time and fees are appropriate. If denied, the MIR registry physician shall complete the evaluation to the best of his/her ability. If additional evaluation charges are approved, the Program Coordinator shall notify the employer of the approved review charges. The physician shall bill for the additional time at the pro-rata rate of \$500.00 per hour. All non-routine test(s) for an impairment rating essential under the applicable edition of the AMA Guides to the Evaluation of Permanent Impairment shall have been performed prior to the evaluation. Routine tests necessary for a complete evaluation, such as range of motion or spirometry tests, should be performed by the MIR Registry physician as part of the evaluation at no additional cost. The MIR Registry physician shall notify the Program Coordinator prior to performing any essential test that is non-routine or requires special facilities or equipment, and such test was not previously performed, or was previously performed but the findings are not usable at the time of the evaluation. The Program Coordinator, upon the advice of the Medical Director, will determine whether the test will be approved. If approved, the employer shall be responsible for paying for the essential test.
- (3) Late fees and penalties. Failure of the employer to timely submit the evaluation fee, as determined by the Program Coordinator, shall allow the physician to charge the employer an additional \$100.00 late fee for the evaluation. If the evaluation fee and/or late fee remains unpaid fifteen (15) calendar days following the date of the evaluation, an additional \$250.00 penalty is authorized. If any portion of a fee or penalty remains unpaid after an additional thirty (30) calendar day period, an additional \$500.00 penalty is authorized, and again for each additional thirty (30) calendar day period, or portion thereof, that it remains unpaid until all fees and/or penalties are fully paid. At the request of a MIR Registry physician, the Division may assist the MIR Registry physician in collecting monies due under this Rule.
- (4) Cancellations. To be considered timely, notice of a party's desire to cancel an evaluation appointment shall be given to the Program Coordinator at least three (3) business days prior to the date of the evaluation. An evaluation may be canceled or rescheduled only after obtaining the consent of the Program Coordinator. The Program Coordinator shall decide whether an evaluation may be rescheduled within ten (10) calendar days of a request to cancel.
- (a) If the request to cancel is not timely, the MIR registry physician shall be entitled to collect/retain a \$300.00 cancellation penalty fee. If the evaluation is rescheduled, the MIR Registry physician is entitled to the entire evaluation fee
- (for the rescheduled evaluation) in addition to this fee. The employer may be entitled to offset the cancellation fee(s) against any future settlement if the claimant cancels untimely or without good cause as determined by the Program Coordinator.

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1. If the claimant fails to appear for the evaluation with good cause as determined by the Program Coordinator the employer will not be entitled to offset the cancellation penalty fee against any future settlement.
2. If the claimant fails to appear for the evaluation without good cause as determined by the Program Coordinator, the MIR Registry physician will perform a “paper only” evaluation by reviewing the existing medical record file and shall establish an impairment rating based upon the physician’s opinion of the evidence presented. The physician shall be entitled to the entire fee.
  - (b) If the request to cancel is timely and the evaluation is not rescheduled, the MIR Registry physician shall be entitled to collect and/or retain a \$250.00 cancellation penalty fee.
  - (c) If the request to cancel is timely and the evaluation is rescheduled, the MIR Registry physician shall be entitled to collect and/or retain a \$150.00 cancellation penalty fee in addition to the rescheduled MIR fee.

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

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

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

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

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

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

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- (3) A party who seeks the presence of the MIR physician as a witness at a proceeding for any purpose, by subpoena, deposition or otherwise, shall be responsible for payment for those services to the MIR physician. Deposition fees shall be in accordance with applicable state rules and laws.

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

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

- (1) The MIR Registry physician's responsibilities prior to the evaluation are to:
  - (a) Review all materials provided by the parties subject to these Rules; and,
  - (b) Review the purpose of the evaluation and the impairment questions to be answered in the evaluation report.
- (2) The MIR Registry physician's responsibilities following the evaluation are to:
  - (a) Consider all medical evidence obtained in the evaluation and provided by the parties subject to the Rules;
  - (b) Complete an "MIR Impairment Rating Report";
  - (c) Notify the Program Coordinator when the report has been completed;
  - (d) Send that complete report with all required attachments to the Program Coordinator only, via overnight delivery. The Program Coordinator will acknowledge, to the physician, receipt of the report.
- (3) No physician-patient relationship is created between the MIR physician and the claimant through the MIR Registry evaluation. The sole purpose of the evaluation is to establish an impairment rating and not to recommend future treatment or to provide a diagnosis or other medical advice.

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

### **0800-2-20-.11 REQUIREMENTS FOR THE "MIR IMPAIRMENT RATING REPORT."**

- (1) After conducting the evaluation, the MIR physician shall produce the "MIR Impairment Rating Report". The format, available by using the Program's electronic access, available upon request from the Program Coordinator or available online at [www.state.tn.us/labor-wfd/mainforms.html](http://www.state.tn.us/labor-wfd/mainforms.html), or a materially substantial equivalent approved by the Program Coordinator shall be used in all cases to detail the evaluation's results. The MIR physician shall first review the determination by the attending physician that the claimant has reached Maximum Medical Improvement (MMI).
- (2) If, after reviewing the records, taking a history from the claimant and performing the evaluation, the MIR Registry physician concurs with the attending doctor's determination of MMI, the report shall, at a minimum, contain the following:
  - (a) A brief description and overview of the claimant's medical history as it relates to the subject injury, including reviewing and recapping all previous treatments.

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- (b) A statement of concurrence with the attending doctor's determination of MMI;
  - (c) Pertinent details of the physical or psychiatric evaluation performed (both positive and negative findings);
  - (d) Results of any pertinent diagnostic tests performed (both positive and negative findings). Include copies of these tests with the report;
  - (e) An impairment rating consistent with the findings and utilizing a standard method as outlined in the applicable AMA Guides, calculated as a total to the whole person if appropriate. In cases not covered by the AMA Guides, an impairment rating by any appropriate method used and accepted by the medical community is allowed, however, a statement that the AMA Guides fails to cover the case as well as a statement of the system on which the rating was based shall be included;
  - (f) The rationale for the rating based on reasonable medical certainty, supported by specific references to the clinical findings, especially objective findings and supporting documentation including the specific rating system, sections, tables, figures, and AMA Guides page numbers, when appropriate, to clearly show how the rating was derived; and
  - (g) A true or electronic signature and date by the MIR physician performing the evaluation certifying to the following:
    - 1. "It is my opinion, both within and to a reasonable degree of medical certainty that, based upon all information available to me at the time of the MIR impairment evaluation and by utilizing the relevant AMA Guides or other appropriate method as noted above, that the claimant has the permanent impairment so described in this report. I certify that the opinion furnished is my own, that this document accurately reflects my opinion, and that I am aware that my signature attests to its truthfulness. I further certify that my statement of qualifications to serve on the MIR Registry is both current and completely accurate."
- (3) If, after reviewing the records, taking a history from the claimant and performing the evaluation, the MIR physician does not concur with the attending doctor's determination of MMI, a report shall be completed similar to the one outlined above which documents and certifies to, in sufficient detail, the rationale for disagreeing and, if possible to determine, the expected date of full or partial recovery. The physician is still entitled to collect/retain the appropriate MIR fee.
- (4) Services rendered by an MIR Registry physician shall conclude upon the Program Coordinator's acceptance of the final "MIR Impairment Rating Report." An MIR report is final and accepted for the purpose of these Rules when it includes the requested determination regarding final medical impairment rating and any necessary worksheets, as determined by the Program Coordinator. Once the report has been accepted the

Program Coordinator will distribute copies of the report to the other parties and the Workers' Compensation Specialist, if one is currently assigned. After acceptance of the "MIR Impairment Rating Report" the medical records file, including the final "MIR Impairment Rating Report," shall be stored and/or disposed of by the MIR registry physician in a manner used for similar health records containing private information and within a time frame consistent with the Tennessee Board of Medical Examiners' rules.

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

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### **0800-2-20-.12 PEER REVIEW.**

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

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

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

- (1) Written complaints regarding any MIR Registry physician shall be submitted to the Program Coordinator. The Commissioner or the Commissioner's designee, upon the advice of the Medical Director, may remove a physician from the MIR Registry permanently or temporarily by placing a physician on inactive status based upon any of the following grounds:
  - (a) Misrepresentation on the "Application for Appointment to the MIR Registry" as determined by the Program Coordinator;
  - (b) Failure to timely report a conflict of interest in a case assignment, as determined by the Program Coordinator;
  - (c) Refusal or substantial failure to comply with the provisions of these Rules, including, but not limited to, repeated failure to determine impairment ratings correctly using the AMA Guides, as determined by the Medical Director;
  - (d) Failure to maintain the requirements of the Rules, as determined by the Program Coordinator; or
  - (e) Any other reason for the good of the Registry as determined solely and exclusively by the Commissioner or the Commissioner's designee.
- (2) Upon receipt of a complaint regarding a MIR Registry physician, the Program Coordinator shall send written notice of the complaint to such physician, stating the grounds of the complaint, and notifying the physician that he or she is at risk of being removed from the MIR Registry.
  - (a) The physician shall have thirty (30) calendar days from the date the Notice of Complaint is issued to the physician in which to respond in writing to the complaint(s), and may submit any responsive supporting documentation to the Program Coordinator for consideration. Failure of the physician to submit a timely response to the Notice of Complaint may result in removal of the physician from the MIR Registry without further notice or recourse.
  - (b) The Commissioner or the Commissioner's designee, in consultation with the Medical Director, shall consider the complaint(s) and any response(s) from the physician in reaching a decision as to whether the physician shall be removed from the MIR Registry, and if removed, whether the removal will be permanent or temporary.
  - (c) Upon reaching a determination on the complaint(s), the Commissioner or the Commissioner's designee shall issue a written Notice of Determination and set forth the basis for the decision

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in such Notice. The determination set forth shall become final fifteen (15) days after issuance of the Notice of Determination, unless a timely request for reconsideration is received.

- (d) A MIR Registry physician may seek reconsideration of an adverse decision from the Commissioner or the Commissioner's designee by submitting a request for reconsideration stating the grounds for such reconsideration to the Program Coordinator within fifteen (15) calendar days of the issuance of the Notice of Determination. The Commissioner or the Commissioner's designee may affirm, modify or reverse the initial determination upon reconsideration of the initial decision. The Commissioner or the Commissioner's designee shall issue a Notice of Determination upon Reconsideration which shall be the final decision.
  - (e) MIR Registry physicians shall remain active on the MIR Registry pending a final decision on any complaint(s).
- (3) A physician who has been removed from the MIR Registry by the Commissioner or the Commissioner's designee may apply for reinstatement six (6) months after the date of removal by submitting a written request to the Program Coordinator.

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

### **0800-2-20-.14 OTHER PENALTIES.**

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

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

### **0800-2-20-.15 TIME LIMITS.**

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

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

### **0800-2-20-.16 CLAIMANT COOPERATION.**

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

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

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

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

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

The public necessity rules set out herein were properly filed in the Department of State on the 15th day of June, 2005, and will be effective from the day of filing for a period of 165 days. These public necessity rules will remain in effect through the 27th day of November, 2005. (06-20)

## **RULEMAKING HEARINGS**

### **TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION - 0620 BUREAU OF TENNCARE**

There will be a hearing before the Commissioner to consider the promulgation of amendments of rules pursuant to Tennessee Code Annotated, 71-5-105 and 71-5-109. The hearing will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, Tennessee Code Annotated, Section 4-5-204 and will take place in the Nashville Public Library Auditorium, 1<sup>st</sup> Floor, 615 Church Street, Nashville, Tennessee 37219 at 9:30 a.m. C.D.T. on the 16<sup>th</sup> day August 2005.

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

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

### **SUBSTANCE OF PROPOSED RULES**

Subparagraphs (r), (u), and (v) of paragraph (1) of rule 1200-13-1-.03 Amount, Duration, and Scope of Assistance is deleted in their entirety and replaced with new subparagraphs which shall read as follows:

- (r) Intermediate Care Facility services for individuals age 65 or older in institutions for tuberculosis will be covered for those who require institutional health services below the level of care rendered in skilled nursing facilities. Effective August 1, 2005, no reimbursement shall be made for days when the patient is not physically present in the facility.
- (u) Intermediate Care facility services for individuals age 65 or older in institutions for mental diseases will be covered for those who require institutional health services below the level of care rendered in skilled nursing facilities. Effective August 1, 2005, no reimbursement shall be made for days when the patient is not physically present in the facility. However, this policy shall not apply to Intermediate Care Facility services for the Mentally Retarded (ICFs/MR).
- (v) Intermediate Care Facility services other than services in an institution for tuberculosis or mental diseases will be covered. Effective August 1, 2005, no reimbursement shall be made for days when the patient is not physically in the facility.

Subparagraph (b) of paragraph (4) of rule 1200-13-1-.06 Provider Reimbursement is amended by adding part 3. which shall read as follows:

## RULEMAKING HEARINGS

3. Effective August 1, 2005, no reimbursement shall be made for days when the patient is not physically present in the Level I nursing facility.

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

The notice of rulemaking set out herein was properly filed in the Department of State on the 30th day of June, 2005. (06-68)

## RULEMAKING HEARINGS

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

There will be a hearing before the Commissioner to consider the promulgation of amendments of rules pursuant to Tennessee Code Annotated, 71-5-105 and 71-5-109. The hearing will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, Tennessee Code Annotated, Section 4-5-204 and will take place in the Nashville Public Library Auditorium, 1<sup>st</sup> Floor, 615 Church Street, Nashville, Tennessee 37219 at 9:30 a.m. C.D.T. on the 16<sup>th</sup> day August 2005.

Any individuals with disabilities who wish to participate in these proceedings (to review these filings) should contact the Department of Finance and Administration, Bureau of TennCare, to discuss any auxiliary aids or services needed to facilitate such participation. Such initial contact may be made no less than ten (10) days prior to the scheduled meeting date (the date the party intends to review such filings) to allow time for the Bureau of TennCare to determine how it may reasonably provide such aid or service. Initial contact may be made with the Bureau of TennCare's ADA Coordinator by mail at the Bureau of TennCare, 310 Great Circle Road, Nashville, Tennessee 37243 or by telephone at (615) 741-0155 or 1-800-342-3145.

For a copy of this notice of rulemaking hearing, contact George Woods at the Bureau of TennCare, 310 Great Circle Road, Nashville, Tennessee 37243 or call (615) 741-0145.

#### SUBSTANCE OF PROPOSED RULE

Paragraph (6) of rule 1200-13-1-.10 Criteria for Medicaid Reimbursement of Care in Nursing Facilities is deleted in its entirety and subsequent paragraph renumbered accordingly.

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

The notice of rulemaking set out herein was properly filed in the Department of State on the 30th day of June, 2005. (06-67)

## RULEMAKING HEARINGS

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

There will be a hearing before the Commissioner to consider the promulgation of amendments of rules pursuant to Tennessee Code Annotated, 71-5-105 and 71-5-109. The hearing will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, Tennessee Code Annotated, Section 4-5-204 and will take place in the Nashville Public Library Auditorium, 1<sup>st</sup> Floor, 615 Church Street, Nashville, Tennessee 37219 at 9:30 a.m. C.D.T. on the 16<sup>th</sup> day August 2005.

Any individuals with disabilities who wish to participate in these proceedings (to review these filings) should contact the Department of Finance and Administration, Bureau of TennCare, to discuss any auxiliary aids or services needed to facilitate such participation. Such initial contact may be made no less than ten (10) days prior to the scheduled meeting date (the date the party intends to review such filings) to allow time for the Bureau of TennCare to determine how it may reasonably provide such aid or service. Initial contact may be made with the Bureau of TennCare's ADA Coordinator by mail at the Bureau of TennCare, 310 Great Circle Road, Nashville, Tennessee 37243 or by telephone at (615) 741-0155 or 1-800-342-3145.

For a copy of this notice of rulemaking hearing, contact George Woods at the Bureau of TennCare, 310 Great Circle Road, Nashville, Tennessee 37243 or call (615) 741-0145.

### **SUBSTANCE OF PROPOSED RULES**

Rule 1200-13-13-.01 Definitions is amended by adding new paragraphs (69) and (101) and renumbering current paragraph (69) as (70) and current paragraph (101) as (102) and renumbering subsequent paragraphs accordingly so as amended new paragraphs (69) and (101) shall read as follows:

(69) OPEN MEDICAID CATEGORIES shall mean those Medicaid eligibility categories for which enrollment has not been closed pursuant to authority granted by CMS as part of the TennCare demonstration project.

(101) TENNCARE MEDICAID ELIGIBILITY REFORMS shall mean the amendments to the TennCare demonstration project approved by CMS on March 24, 2005, to close enrollment into TennCare Medicaid for non-pregnant adults age twenty-one (21) or older who qualify as Medically Needy under Tennessee's Title XIX State Plan for Medical Assistance and to terminate coverage for currently enrolled non-pregnant Medically Needy adults age twenty-one (21) or older at the expiration of their current eligibility periods.

Rule 1200-13-13-.02 Eligibility paragraph (4) is amended by adding subparagraph (c) which shall read as follows:

- (c) The individual who is eligible as a non-pregnant Medically Needy adult in accordance with Rule 1240-2-1-.03 of the Department of Human Services is found to meet the following criteria:
1. S/he is aged twenty-one (21) or older,
  2. S/he has completed his/her twelve (12) month period of eligibility for TennCare, and
  3. S/he has not been determined eligible in an open Medicaid category.

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Rule 1200-13-13-.02 Eligibility is amended by adding paragraph (7) which shall read as follows:

(7) Disenrollment Related to TennCare Medicaid Eligibility Reforms

Prior to the disenrollment of adult non-pregnant Medically Needy TennCare enrollees based on coverage terminations resulting from TennCare Medicaid Eligibility Reforms, Medicaid eligibility shall be reviewed in accordance with the following.

(a) Ex Parte Review

DHS will conduct an ex parte review of eligibility for open Medicaid categories for all non-pregnant adult Medically Needy enrollees in eligibility groups due to be terminated as part of the TennCare Medicaid eligibility reforms. Such ex parte review shall be conducted in accordance with federal requirements as set forth by CMS in the Special Terms and Conditions of the TennCare demonstration project.

(b) Request for Information

1. At least thirty (30) days prior to the expiration of their current eligibility period, the Bureau of TennCare will send a Request for Information to all non-pregnant adult Medically Needy enrollees in eligibility groups being terminated pursuant to the TennCare Medicaid eligibility reforms. The Request for Information will include a form to be completed with information needed to determine eligibility for open Medicaid categories as well as a list of the types of proof needed to verify certain information.
2. Enrollees will be given thirty (30) days inclusive of mail time from the date of the Request for Information to return the completed form to TDHS and to provide TDHS with the necessary verifications to determine eligibility for open Medicaid categories.
3. Enrollees with a health, mental health, or learning problem or a disability will be given the opportunity to request assistance in responding to the Request for Information. Enrollees with Limited English Proficiency will have the opportunity to request translation assistance for responding to the Request for Information.
4. Enrollees will be given an opportunity until the date of termination to request one extension for good cause of the thirty (30) day timeframe for responding to the Request for Information. The good cause extension is intended to allow a limited avenue for possible relief for certain enrollees who face significant unforeseen circumstances, or who, as a result of a health, mental health, or learning problem, or a disability, or limited English proficiency are unable to respond timely, as an alternative to imposing a standard with no exceptions whatsoever. The good cause exception does not confer an entitlement upon enrollees and the application of this exception will be within the discretion of TDHS. Only one thirty (30) day good cause extension can be granted to each enrollee. Good cause is determined by TDHS eligibility staff. Good cause is not requested nor determined through filing an appeal. Requests for an extension of the 30-day timeframe to respond to the Request for Information must be initiated by the enrollee. However, the enrollee may receive assistance in initiating such request. TDHS will not accept a request for extension of the thirty (30) day timeframe submitted by a family member, advocate, provider, or CMHC acting on the enrollee's behalf without the involvement and knowledge of the enrollee, for example, to allow time for such entity to locate the enrollee if his/her whereabouts is unknown. All requests

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for good cause extension must be made prior to termination of Medicaid eligibility. A good cause extension will be granted if TDHS determines that a health, mental health or learning problem or disability or limited English proficiency prevented an enrollee from understanding or responding timely to the Request for Information. Except in the aforementioned circumstances, a good cause extension will only be granted if such request is submitted in writing to TDHS prior to termination of Medicaid eligibility and TDHS determines that serious personal circumstances such as illness or death prevent an enrollee from responding to the Request for Information for an extended period of time. Proof of the serious personal circumstances is required with the submission of the written request in order for a good cause extension to be granted. Good cause extensions will be granted at the sole discretion of TDHS and if granted shall provide the enrollee with an additional thirty (30) days inclusive of mail time from the date of TDHS's decision to grant the good cause extension. TDHS will send enrollees a letter granting or denying the request for good cause extensions. TDHS's decisions with respect to good cause extensions shall not be appealable.

5. If an enrollee provides some but not all of the necessary information to TDHS to determine his/her eligibility for open Medicaid categories during the thirty (30) day period following the Request for Information, TDHS will send the enrollee a Verification Request. The Verification Request will provide the enrollee with ten (10) days inclusive of mail time to submit any missing information as identified in the Verification Request. Enrollees will not have the opportunity to request an extension for good cause of the ten (10) day timeframe for responding to the Verification Request.
6. Enrollees who respond to the Request for Information within the thirty (30) day period or within any extension of such period granted by TDHS shall retain their eligibility for TennCare Medicaid (subject to any changes in covered services generally applicable to enrollees in their Medicaid category) while TDHS reviews their eligibility for open Medicaid categories.
7. TDHS shall review all information and verifications provided within the requisite time period by an enrollee pursuant to the Request for Information and/or the Verification Request to determine whether the enrollee is eligible for any open Medicaid categories. If TDHS makes a determination that the enrollee is eligible for an open Medicaid category, TDHS will so notify the enrollee and the enrollee will be enrolled in the appropriate TennCare Medicaid category. Once the enrollee is enrolled in the appropriate TennCare Medicaid category, his/her eligibility as a non-pregnant Medically Needy adult shall then be terminated without additional notice. If TDHS makes a determination that the enrollee is not eligible for any open Medicaid categories or if an enrollee does not respond to the Request for Information within the requisite thirty (30) day time period or any extension of such period granted by TDHS, the TennCare Bureau will send the enrollee a twenty (20) day advance Termination Notice.
8. Enrollees who respond to the Request for Information or the Verification Request after the requisite time period specified in those notices or after any extension of such time period granted by TDHS but before the date of termination shall retain their eligibility for TennCare Medicaid (subject to any changes in covered services generally applicable to enrollees in their Medicaid category) while TDHS reviews their eligibility for open Medicaid categories. If TDHS makes a determination that the enrollee is eligible for an open Medicaid category, TDHS will so notify the enrollee and the enrollee will be enrolled in the appropriate TennCare Medicaid category. Once the enrollee is enrolled

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in the appropriate TennCare Medicaid category, his/her eligibility as a non-pregnant Medically Needy adult shall then be terminated without additional notice. If TDHS makes a determination that the enrollee is not eligible for any open Medicaid categories, the TennCare Bureau will send the enrollee a twenty (20) day advance Termination Notice.

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

### (c) Termination Notice

1. The TennCare Bureau will send Termination Notices to all non-pregnant adult Medically Needy enrollees being terminated pursuant to the TennCare Medicaid eligibility reforms who are not determined to be eligible for open Medicaid categories pursuant to the Ex Parte Review or Request for Information processes described in this subsection.
2. Termination Notices will be sent twenty (20) days in advance of the date upon which the coverage will be terminated.
3. Termination Notices will provide enrollees with forty (40) days from the date of the notice to appeal valid factual disputes related to the disenrollment and will inform enrollees how they may request a hearing.
4. Enrollees with a health, mental health, or learning problem or a disability will be given the opportunity to request additional assistance for their appeal. Enrollees with Limited English Proficiency will have the opportunity to request translation assistance for their appeal.
5. Enrollees will not have the opportunity to request an extension for good cause of the forty (40) day timeframe in which to request a hearing.

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

The notice of rulemaking set out herein was properly filed in the Department of State on the 22nd day of June, 2005. (06-26)

## RULEMAKING HEARINGS

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

There will be a hearing before the Commissioner to consider the promulgation of amendments of rules pursuant to Tennessee Code Annotated, 71-5-105 and 71-5-109. The hearing will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, Tennessee Code Annotated, Section 4-5-204 and will take place in the Nashville Public Library Auditorium, 1<sup>st</sup> Floor, 615 Church Street, Nashville, Tennessee 37219 at 9:30 a.m. C.D.T. on the 16<sup>th</sup> day of August 2005.

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

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

### SUBSTANCE OF PROPOSED RULE

Rule 1200-13-13-.04 Covered Services is amended by adding a new paragraph (8) and renumbering the present paragraph (8) as (9) and subsequent paragraphs renumbered according so as amended the new paragraph (8) shall read as follows:

- (8) Effective August 1, 2005, the covered benefits for TennCare Medicaid will be as follows:
  - (a) TennCare managed care contractors shall cover, at a minimum, the following services and benefits subject to any applicable limitations described herein effective August 1, 2005. Any and all medically necessary services may require prior authorization or approval by the managed care contractor, except where prohibited by law. In accordance with the *John B. Court Order*, MCCs may not deny medically necessary EPSDT services due to lack of prior authorization. As stated elsewhere in these rules, managed care organizations shall not require prior authorization or approval for services rendered in the event of an emergency need of the enrollee. Such emergency services may be reviewed on the basis of medical necessity or other MCO administrator requirements, but cannot be denied solely because the provider did not obtain prior authorization or approval from the enrollee's managed care organization. Managed care contractors shall not impose any service limitations that are more restrictive than those described herein; however, this provision shall not limit the managed care contractor's ability to establish procedures for the determination of medical necessity. Services for which there is no federal financial participation (FFP) are not covered.
  - (b) Physical Health and Mental Health Services

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SERVICE	BENEFIT
1. Chiropractic Services	<p>Under age 21: Covered as medically necessary.</p> <p>Age 21 and older: Covered when determined cost effective by the MCO.</p>
2. Community Health Services	<p>Under age 21: Covered as medically necessary.</p> <p>Age 21 and older: As medically necessary, except that effective August 1, 2005, Methadone Clinic services for adults age 21 and older are not covered, even if medically necessary. This includes services that have been prior authorized and/or initiated, but not completed as of August 1, 2005.</p>
3. Convalescent Care	<p>Under age 21: Upon receipt of proof that an enrollee has incurred medically necessary expenses related to convalescent care, TennCare shall pay for up to and including the one-hundredth (100<sup>th</sup>) day of confinement during any calendar year for convalescent facility(ies) room, board, and general nursing care, provided: (A) a physician recommends confinement for convalescence; (B) the enrollee is under the continuous care of a physician during the entire period of confinement, and (C) the confinement is required for other than custodial care.</p> <p>Age 21 and older: Effective August 1, 2005, not covered, even if medically necessary. This includes services that have been prior authorized and/or initiated, but not completed as of August 1, 2005.</p>

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SERVICE	BENEFIT
4. Dental Services	<p>Under age 21: Preventive, diagnostic, and treatment services. Orthodontic services must be prior approved and are limited to individuals under age 21 diagnosed with: (1) a severe handicapping malocclusion or another developmental anomaly or injury resulting in severe malalignment or severe handicapping malocclusion of teeth, documented by at least 28 points on the Salzmann Scale, or any other method that is approved by TennCare, or (2) following repair of an enrollee's cleft palate. Orthodontic treatment will not be authorized for cosmetic purposes. Orthodontic treatment will only be paid for by TennCare as long as the individual remains eligible. If the orthodontic treatment plan is approved prior to the enrollee obtaining 20 ½ years of age, and treatment is initiated prior to the enrollee obtaining 21 years of age, such treatment may continue as long as the enrollee remains eligible.</p> <p>Age 21 and older: Effective August 1, 2005, not covered, even if medically necessary. This includes services which have been prior authorized and/or initiated, but not completed as of August 1, 2005, except for orthodontic treatment as specified above.</p>
5. Durable Medical Equipment	As medically necessary.
6. Emergency Air and Ground Transportation	As medically necessary.
7. EPSDT Services	<p>Under age 21: Covered as medically necessary.</p> <p>Screening, interperiodic screening, diagnostic and follow-up treatment services as medically necessary in accordance with federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989 for enrollees under age 21. Except for Dental services, screens shall be in accordance with the periodicity schedule set forth in the latest "American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care" and all components of the screens must be consistent with the latest "American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care." Dental screens shall be in accordance with the latest periodicity schedule set forth by either the American Academy of Pediatric Dentistry or the American Academy of Pediatrics and all components of the screens must be consistent with the latest recommendations by the American Academy of Pediatric Dentistry or the American Academy of Pediatrics.</p> <p>Age 21 and older: Not covered.</p>

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SERVICE	BENEFIT
8. Home Health Care	<p>Under age 21: As medically necessary.</p> <p>Age 21 and older: As medically necessary, all home health care as delivered by a licensed Home Health Agency, as defined by 42 CFR §440.70.</p> <p>A home health visit includes any of the following: Skilled Nursing, Physical Therapy, Occupational Therapy, Speech Pathology and Audiology Services, and Home Health Aide. Full-time nursing services are not covered for adults 21 years of age and older, except as part of home respiratory therapy services for ventilator-dependent enrollees. (See item 34 in the chart.)</p>
9. Hospice Care	As medically necessary. Must be provided by an organization certified pursuant to Medicare Hospice requirements.
10. Inpatient and Outpatient Substance Abuse Benefits	<p>Under age 21: As medically necessary.</p> <p>Age 21 and older: As medically necessary, except that effective August 1, 2005, Methadone Clinic services for adults age 21 and older are not covered even if medically necessary. This includes services that have been prior authorized and/or initiated, but not completed as of August 1, 2005. Covered substance abuse treatment services are limited to ten (10) days detox, with a \$30,000 limit in lifetime medically necessary benefits. This limit on covered services does not apply to persons who are Severely and/or Persistently Mentally Ill.</p>
11. Inpatient Hospital Services	As medically necessary. MCO may conduct concurrent and retrospective reviews.
12. Inpatient Rehabilitation Facilities	<p>Under age 21: As medically necessary.</p> <p>Age 21 and older: Inpatient Rehabilitation Facilities services may be covered when determined to be a cost effective alternative by the MCO.</p>
13. Lab and X-ray Services	As medically necessary.
14. Medical Supplies	As medically necessary.

RULEMAKING HEARINGS

SERVICE	BENEFIT
15. Non-Emergency Ambulance Transportation	As medically necessary.
16. Non-Emergency Transportation	<p>As necessary to get an enrollee to and from covered services, for enrollees not having access to transportation. MCOs may require advance notice of the need in order to timely arrange transportation.</p> <p>The travel to access primary care and dental services must meet the requirements of the waiver terms and conditions. The availability of specialty services is related to travel distance should meet the usual and customary standards for the community. However, in the event the MCO is unable to negotiate such an arrangement for an enrollee transportation must be provided regardless of whether or not the enrollee has access to transportation. If the enrollee is a child, transportation must be provided for the child and an accompanying adult. However, transportation for a child shall not be denied pursuant to any policy which poses a blanket restriction due to enrollee's age or lack of parental accompaniment. (Note: Tennessee recognizes the "mature minor exception" to permission for medical treatment.) Any decision to deny transportation of a child due to an enrollee's age or lack of parental accompaniment must be made on a case-by-case basis and must be based on the individual facts surrounding the request. As with any denial, all notices and actions must be in accordance with the appeal process.</p> <p>The provision of transportation to and from dental services shall remain with the MCO.</p>
17. Occupational Therapy	<p>Under age 21: Covered as medically necessary.</p> <p>Age 21 and older: Covered as medically necessary, by a Licensed Occupational Therapist, to restore, improve, or stabilize impaired functions.</p>

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SERVICE	BENEFIT
18. Organ Transplant and Donor Organ Procurement	<p>Under age 21: Covered as medically necessary. Experimental or investigational transplants are not covered.</p> <p>Age 21 and older: All medically necessary and non-investigational/experimental organ transplants are covered. These include, but may not be limited to:</p> <ul style="list-style-type: none"> <li>Bone Marrow/Stem Cell</li> <li>Cornea</li> <li>Heart</li> <li>Heart/Lung</li> <li>Kidney</li> <li>Kidney/Pancreas</li> <li>Liver</li> <li>Lung</li> <li>Pancreas</li> <li>Small bowel/Multi-visceral</li> </ul>
19. Outpatient Hospital Services	As medically necessary.
20. Outpatient Mental Health Services (including physician services)	As medically necessary.

RULEMAKING HEARINGS

SERVICE	BENEFIT
<p>21. Pharmacy Services (obtained directly from an ambulatory retail pharmacy setting, outpatient hospital pharmacy, mail order pharmacy or those administered to a long term care facility resident (nursing facility))</p>	<p>As medically necessary, subject to the limitations set out below. Certain drugs (known as DESI, LTE, IRS drugs) are excluded from coverage, or as provided herein at 1200-13-13-.04(7) and 1200-13-13-.10.</p> <p>The following limitations (A) – (D) are effective as of August 1, 2005.</p> <p>(A) Pharmacy services for all children and for individuals receiving TennCare-reimbursed services in a Nursing Facility or Intermediate Care Facility for the Mentally Retarded, or a Home and Community Based Services waiver have no quantity limits on the number of prescriptions per month.</p> <p>(B) Subject to (A) above, pharmacy services for Categorically Needy adults age 21 and older and pregnant women who are eligible in the Medically Needy category are limited to five (5) prescriptions and/or refills per enrollee per month, of which no more than two (2) of the five (5) can be brand name drugs. As of August 1, 2005, additional drugs for individuals in (B) shall not be covered even if medically necessary. This includes drugs which have been prior authorized but not received as of August 1, 2005, and/or drugs for which the initial prescription but not all applicable refills, or the interim supply, but not the balance thereof, has been received as of August 1, 2005.</p> <p>Prescriptions shall be counted beginning on the first of each calendar month. Each prescription or refill counts as one (1). A prescription or refill can be no more than a 30-day supply. The Bureau of TennCare shall maintain a “Pharmacy Short List” of pharmacy services which shall not count against such pharmacy limit. The Pharmacy Short List may be modified at the discretion of the Bureau of TennCare. The most current version of the Pharmacy Short List will be made available to enrollees via the internet on the TennCare website and upon request by mail through the DHS Family Assistance Centers. Only drugs that are specified on the version of the Pharmacy Short List that is current as of the date of service shall not count against applicable pharmacy limits. TennCare will not cover drugs on the Pharmacy Short List for enrollees whose pharmacy services are not covered.</p> <p>Unless specified on the version of the Pharmacy Short List which is current as of the date of pharmacy service, pharmacy services in excess of five (5) prescriptions and/or refills per enrollee per month or two (2) brand name drugs per enrollee per month are non-covered services.</p>

RULEMAKING HEARINGS

SERVICE	BENEFIT
22. Physical Therapy	<p>Under age 21: Covered as medically necessary.</p> <p>Age 21 and older: Covered as medically necessary, by a Licensed Physical Therapist, to restore, improve, or stabilize impaired functions.</p>
23. Physician Inpatient Services	As medically necessary.
24. Physician Outpatient Services/ Community Health Clinics/Other Clinic Services	<p>Under age 21: As medically necessary.</p> <p>Age 21 and older: As medically necessary, except that effective August 1, 2005, Methadone Clinic services for adults age 21 and older are not covered, even if medically necessary. This includes services that have been prior authorized and/or initiated, but not completed as of August 1, 2005.</p>
25. Private Duty Nursing	<p>Under age 21: Covered as medically necessary when prescribed by an attending physician for treatment and services rendered by a registered nurse (R.N.) or a licensed practical nurse (L.P.N. who is not an immediate relative.</p> <p>Age 21 and older: Effective August 1, 2005, not covered even if medically necessary. This includes services which have been prior authorized and/or initiated, but not completed as of August 1, 2005.</p>
26. Psychiatric Inpatient Services	As medically necessary.
27. Psychiatric Physician Inpatient Services	As medically necessary.
28. Psychiatric Rehabilitation Services	As medically necessary.

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SERVICE	BENEFIT
29. Reconstructive Breast Surgery	Covered in accordance with Tenn. Code Ann. § 56-7-2507 which requires coverage of all stages of reconstructive breast surgery on a diseased breast as a result of a mastectomy as well as any surgical procedure on the non-diseased breast deemed necessary to establish symmetry between the two breasts in the manner chosen by the physician. The surgical procedure performed on a non-diseased breast to establish symmetry with the diseased breast will only be covered if the surgical procedure performed on a non-diseased breast occurs within five (5) years of the date the reconstructive breast surgery was performed on a diseased breast.
30. Renal Dialysis Services	As medically necessary, for the first ninety (90) days prior to being covered by Medicare.
31. Sitter Services	<p>Under age 21: As medically necessary, a sitter who is not a relative may be used where an enrollee is confined to a hospital as a bed patient and certification is made by a network physician that R.N. or L.P.N. is needed and neither is available.</p> <p>Age 21 and older: As of August 1, 2005, not covered even if medically necessary. This includes services that have been prior authorized and/or initiated, but not completed as of August 1, 2005.</p>
32. Speech Therapy	<p>Under age 21: Covered as medically necessary.</p> <p>Age 21 and older: Covered as medically necessary, by a Licensed Speech Therapist to restore speech (as long as there is continued medical progress) after a loss or impairment.</p>
33. 24-Hour Psychiatric Residential Treatment	As medically necessary.

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SERVICE	BENEFIT
34. Ventilator Services	<p>Under 21: As medically necessary.</p> <p>Age 21 and older. Medically necessary home and community-based respiratory therapy services provided outside an institutional setting for ventilator-dependent enrollees, to include nursing services when necessary to prevent institutionalization. Prior approval required.</p>
35. Vision Services	<p>Under 21: Preventive, diagnostic, and treatment services (including eyeglasses) are covered as medically necessary</p> <p>Age 21 and older: Medical eye care, meaning evaluation and management of abnormal conditions, diseases, and disorders of the eye (not including evaluation and treatment of refractive state), will be covered. Routine, periodic assessment, evaluation, or screening of normal eyes and examinations for the purpose of prescribing, fitting, or changing eyeglasses and/or contact lenses will not be covered.</p>

(c) Pharmacy

TennCare is permitted under the terms and conditions of the demonstration project approved by the federal government to restrict coverage of prescription and non-prescription drugs to a TennCare-approved list of drugs known as a drug formulary. TennCare must make this list of covered drugs available to the public. Through the use of a formulary, the following drugs or classes of drugs, or their medical uses, shall be excluded from coverage or otherwise restricted by TennCare as described in Section 1927 of the Social Security Act [42 U.S.C. §1396r-8]:

1. Agents for weight loss or weight gain.
2. Agents to promote fertility or for the treatment of impotence or infertility or for the reversal of sterilization.
3. Agents for cosmetic purposes or hair growth.
4. Agents for symptomatic relief of coughs and colds.

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5. Agents to promote smoking cessation.
6. Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.
7. Nonprescription drugs.
8. Covered outpatient drugs, which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.

TennCare shall not cover drugs considered by the FDA to be Less Than Effective (LTE) and DESI drugs, or drugs considered to be Identical, Related and Similar (IRS) to DESI and LTE drugs or any other pharmacy services for which federal financial participation (FFP) is not available. The exclusion of drugs for which no FFP is available extends to all TennCare enrollees regardless of the enrollee's age. TennCare shall not cover experimental or investigational drugs, which have not received final approval from the FDA.

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

The notice of rulemaking set out herein was properly filed in the Department of State on the 30th day of June, 2005. (06-69)

## RULEMAKING HEARINGS

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

There will be a hearing before the Commissioner to consider the promulgation of amendments of rules pursuant to Tennessee Code Annotated, 71-5-105 and 71-5-109. The hearing will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, Tennessee Code Annotated, Section 4-5-204 and will take place in the Nashville Public Library Auditorium, 1<sup>st</sup> Floor, 615 Church Street, Nashville, Tennessee 37219 at 9:30 a.m. C.D.T. on the 16<sup>th</sup> day of August, 2005.

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

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

### SUBSTANCE OF PROPOSED RULE

Rule 1200-13-13-.05 Enrollee Cost Sharing is deleted in its entirety and replaced with the following new language to read as follows:

#### **1200-13-13-.05 ENROLLEE COST SHARING.**

- (1) TennCare Medicaid enrollees do not have cost sharing responsibilities for TennCare coverage and covered services, except that effective August 1, 2005, TennCare Medicaid adults (age 21 and older) who receive pharmacy services will have nominal copays for these services. The copays will be \$3.00 (three dollars) for each branded drug and \$0 (zero dollars) for each covered generic drug. Generic drugs which exceed the limit of five (5) prescriptions or refills per enrollee per month are not covered. Family planning drugs and emergency services are exempt from copay. There is no Out-of-Pocket Maximum on copays.
- (2) The following adult groups are exempt from copay:
  - (a) Individuals receiving hospice services who provide verbal notification of such to the pharmacy provider at the point of service;
  - (b) Individuals who are pregnant who provide verbal notification of such to the pharmacy provider at the point of service; and
  - (c) Individuals who are receiving services in a Nursing Facility, an Intermediate Care Facility for the Mentally Retarded, or a Home and Community Based Services waiver.

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

The notice of rulemaking set out herein was properly filed in the Department of State on the 30th day of June, 2005. (06-70)

## RULEMAKING HEARINGS

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

There will be a hearing before the Commissioner to consider the promulgation of amendments of rules pursuant to Tennessee Code Annotated, 71-5-105 and 71-5-109. The hearing will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, Tennessee Code Annotated, Section 4-5-204 and will take place in the Nashville Public Library Auditorium, 1<sup>st</sup> Floor, 615 Church Street, Nashville, Tennessee 37219 at 9:30 a.m. C.D.T. on the 16<sup>th</sup> day August 2005.

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

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

### SUBSTANCE OF PROPOSED RULE

Rule 1200-13-13-.10 Exclusion is deleted in its entirety and replaced with a new rule 1200-13-13-.10 which shall read as follows:

#### **1200-13-13-.10 EXCLUSIONS.**

- (1) General exclusions. The following items and services shall not be considered covered services by TennCare:
  - (a) Items and services that are not considered medically necessary, as defined in these rules.
  - (b) Provision of medical assistance which is outside the scope of benefits as defined in these rules.
  - (c) Provision of services to persons who are not enrolled in TennCare on the date the services are delivered.
  - (d) Services for which there is no Federal Financial Participation (FFP).
  - (e) Services provided outside the geographic borders of Tennessee, including transportation to return to Tennessee to receive medical care except in the following circumstances:
    1. Emergency medical services are needed because of an emergency medical condition;
    2. Non-emergency urgent care services are requested because the recipient's health would be endangered if he were required to travel, but only upon the explicit prior authorization of the MCC;

## RULEMAKING HEARINGS

3. The covered medical service would not be readily available within Tennessee if the enrollee was physically located in Tennessee at the time of need. Covered services are explicitly authorized by the enrollee's TennCare MCC; or
  4. The out-of-state provider is participating in the enrollee's MCC network.
- (f) Investigative or experimental services or procedures including, but not limited to:
1. Drug or device lacks FDA approval except when medically necessary as defined by TennCare, or
  2. Drug or device lacks approval of facility's Institutional Review Board, or
  3. Requested treatment is the subject of Phase I or Phase II clinical trials or the investigational arm of Phase III clinical trials, or
  4. Prevailing opinion among experts is that further study is required to determine safety, efficacy, or long-term clinical outcomes of requested service.
- (g) Services which are delivered in connection with, or required by, an item or service not covered by TennCare, including the transportation to receive such non-covered services.
- (h) The reversal and/or treatment of associated complications of any medical procedure when such procedure is itself excluded from coverage, pursuant to any provision of this section except subsection (c), except for emergency services to treat a complication to the extent that these emergency services are covered for the individual enrollee.
- (i) Items or services furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury.
- (j) Non-emergency services (other than prescription drugs for dual eligibles, until January 1, 2006) that are ordered or furnished by an out-of-network provider and which have not been approved by the enrollee's MCC for out-of-network care.
- (k) Services that are free to the public, with the exception of services delivered in the schools pursuant to the Individuals with Disabilities in Education Act (IDEA).
- (l) Items or services ordered, prescribed, administered, supplied, or provided by an individual or entity that has been excluded from participation in the Medicaid program under the authority of the United States Department of Health and Human Services or the Bureau of TennCare.
- (m) Items or services ordered, prescribed, administered, supplied, or provided by an individual or entity that is no longer licensed by their licensing board.
- (n) Items or services outside the scope and/or authority of a provider's specialty and/or area of practice.
- (o) Items or services to the extent that Medicare or a third party payer is legally responsible to pay or would have been legally responsible to pay except for the enrollee's or the treating provider's failure to comply with the requirements for coverage of such services.

## RULEMAKING HEARINGS

- (2) Specific exclusions. The following services, products, and supplies are specifically excluded from coverage under the TennCare Section 1115(a) waiver program and the TennCare Section 1915(b) waiver program. Some of these services may be covered outside TennCare under a Home and Community Based Services waiver when provided as part of an approved plan of care, in accordance with Rules 1200-13-1-.25, 1200-13-1-.26, and 1200-13-1-.27.
- (a) Services, products, and supplies that are specifically excluded from coverage except for children under EPSDT
1. Audiological therapy or training; prescribing, fitting, or changing hearing aids
  2. Augmentative communication devices
  3. Chiropractor's services
  4. Convalescent care
  5. Ear plugs, except for children with tympanostomy tubes ordered by an ENT doctor
  6. Electrically powered adjustable hospital beds, including variable height beds
  7. Floor standers
  8. Food supplements, except as medically necessary for treatment of metabolic disorders in children under age 21 and as required for PKU treatment by Tennessee law
  9. Hearing aids
  10. Maintenance services (physical, occupational, and speech therapy) unless required to prevent regression or deterioration of a child's condition. Services without which the child's condition would remain unchanged are not considered maintenance services.
  11. Methadone clinic services
  12. Orthodontic services, except under the conditions described elsewhere in these rules.
  13. Purchase, repair, or replacement of materials or equipment when the reason for the purchase, repair, or replacement is the result of enrollee abuse
  14. Purchase, repair, or replacement of materials or equipment that has been stolen or destroyed except when the following documentation is provided:
    - (i) Explanation of continuing medical necessity for the item, and
    - (ii) Explanation that the item was stolen or destroyed, and
    - (iii) Copy of police, fire department, or insurance report if applicable

## RULEMAKING HEARINGS

15. Radial keratotomy
  16. Reimbursement to a provider or enrollee for the replacement of a rented durable medical equipment (DME) item that is stolen or destroyed
  17. Repair of DME items not covered by TennCare
  18. Repair of DME items covered under the provider's or manufacturer's warranty
  19. Repair of a rented DME item
  20. Sitter services
  21. Speech, language, and hearing services to address speech problems caused by mental, psychoneurotic, or personality disorders
  22. Standing tables
- (b) Services, products, and supplies that are specifically excluded from coverage under the TennCare program.
1. Alcoholic beverages
  2. Animal therapy including, but not limited to:
    - (i) Dolphin therapy
    - (ii) Equine therapy
    - (iii) Hippo therapy
    - (iv) Pet therapy
  3. Art therapy
  4. Autopsy
  5. Bariatric surgery including, but not limited to, gastric stapling, intestinal bypass surgery, banding, and body remodeling
  6. Bathtub equipment and supplies including, but not limited to:
    - (i) Action Bath Hydro Massage, or similar devices
    - (ii) Aero massage, or similar devices
    - (iii) Aqua Whirl, or similar devices
    - (iv) Bed baths
    - (v) Century Bed Baths

## RULEMAKING HEARINGS

- (vi) Eaton E-Z baths
  - (vii) Nolan Bath Chairs, or similar devices
  - (viii) Paraffin baths
  - (ix) Sauna baths
  - (x) Sitz baths, or similar devices
7. Beds and bedding equipment such as:
- (i) Adjust-a-Beds, or similar devices
  - (ii) Air flotation beds, powered
  - (iii) Air fluidized beds (including Clinitron beds)
  - (iv) Bead beds, or similar devices
  - (v) Bed boards
  - (vi) Bedding and bed casings
  - (vii) Hospital beds, unless specifically documented by the treating physician to handle a specific condition that requires repositioning that cannot be accomplished by the use of a conventional bed\_
  - (viii) Lounge beds
  - (ix) Ortho-prone beds
  - (x) Oscillating beds
  - (xi) Pillows, hypoallergenic
  - (xii) Springbase beds
  - (xiii) Vail beds
  - (xiv) Vasculating beds
  - (xv) Waterbeds
8. Bioenergetic therapy
9. Biofeedback
10. Body adornment and enhancement services including, but not limited to:
- (i) Body piercing, or removal of body piercing

## RULEMAKING HEARINGS

- (ii) Breast augmentation
  - (iii) Breast capsulectomy
  - (iv) Breast implant removal
  - (v) Ear piercing, or repair of ear piercing
  - (vi) Hair transplantation, and agents for hair growth
  - (vii) Tattoos or removal of tattoos
  - (viii) Tongue splitting or repair of tongue splitting
  - (ix) Wigs or hairpieces
11. Breathing equipment such as:
- (i) Intrapulmonary Percussive Ventilators (IPVs)
  - (ii) Spirometers
  - (iii) Vaporizers
12. Carbon dioxide therapy
13. Care facilities or services, the primary purpose of which is non-medical, including, but not limited to:
- (i) Day care
  - (ii) Evening care centers
  - (iii) Respite care
  - (iv) Rest cures
  - (v) Social or diversion services
14. Carotid body tumor, excision of, as treatment for asthma
15. Chelation therapy, except for the treatment of heavy metal poisoning or secondary hemochromatosis in selected settings. Chelation therapy for treatment of arteriosclerosis or autism is not covered. Chelation therapy for asymptomatic individuals is not covered. In the case of lead poisoning, the lead levels must be extremely high. For children, a minimum level of 45 ug/dl is recommended. Because chelation therapy and its after-effects must be continuously monitored for possible adverse reactions, chelation therapy is covered only in inpatient or outpatient hospital settings, renal dialysis facilities, and skilled nursing facilities. It is not covered in an office setting, an ambulatory surgical center, or a home setting.

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16. Clothing, including adaptive clothing, with the exception of mastectomy bras
17. Cold therapy devices
18. Comfort and convenience items including, but not limited to:
  - (i) Arch supports
  - (ii) Corn plasters
  - (iii) Garter belts
  - (iv) Incontinence products (diapers/liners/underpads) for persons younger than 3 years of age
  - (v) Incontinence products other than disposable diapers, including pull-up pants, for persons 3 years of age and older
  - (vi) Non-prescription ointments
  - (vii) Support stockings other than Jobst supports
19. Computers, personal, and peripherals including, but not limited to printers, modems, monitors, scanners, and software, including their use in conjunction with an Augmentative Communication Device
20. Cosmetic dentistry, cosmetic oral surgery, and cosmetic orthodontic services
21. Cosmetic prosthetic devices
22. Cosmetic surgery or surgical procedures primarily for the purpose of changing the appearance of any part of the body to improve appearance of self-esteem, including scar revision. The following services are not considered cosmetic services:
  - (i) Reconstructive surgery to correct the results of an injury or disease
  - (ii) Surgery to treat congenital defects (such as cleft lip and cleft palate) to restore normal bodily function
  - (iii) Surgery to reconstruct a breast after mastectomy that was done to treat a disease, or as a continuation of a staged reconstructive procedure
  - (iv) In accordance with Tennessee law, surgery of the non-diseased breast following mastectomy and reconstruction to create symmetrical appearance
  - (v) Surgery for the improvement of the functioning of a malformed body member
  - (vi) Reduction mammoplasty, except that reduction mammoplasty will only be deemed medically necessary if the minimum amount of breast material to be removed is equal to or greater than 22nd percentile of the Schnur Sliding Scale based on the individual's body surface area.

## RULEMAKING HEARINGS

23. Cushions, pads, and mattresses including, but not limited to:
  - (i) Aquamatic K Pads
  - (ii) Elbow protectors
  - (iii) Heat and massage foam cushion pads
  - (iv) Heating pads
  - (v) Heel protectors
  - (vi) Lamb's wool pads
  - (vii) Steam packs
24. Dance therapy
25. Dental implant services including implant supported prosthesis
26. Dental services for adults age 21 and older
27. Educational services including, but not limited to:
  - (i) Academic performance testing
  - (ii) Educational tests and training programs
  - (iii) Habilitation
  - (iv) Job training
  - (v) Lamaze classes
  - (vi) Lovaas therapy
  - (vii) Picture illustrations
  - (viii) Remedial education
  - (ix) Sign language instruction
  - (x) Special education
28. Encounter groups or workshops
29. Environmental modifications including, but not limited to:
  - (i) Air cleaners or purifiers
  - (ii) Air conditioners, central or unit

## RULEMAKING HEARINGS

- (iii) Dehumidifiers
  - (iv) Humidifiers, central or room
  - (v) Micronaire environmentals, and similar devices
  - (vi) Pollen extractors
  - (vii) Portable room heaters
  - (viii) Vacuum systems for dust filtering
  - (ix) Water purifiers
  - (x) Water softeners
30. Exercise equipment including, but not limited to:
- (i) Exercise equipment
  - (ii) Exercycles (including cardiac use)
  - (iii) Functional electrical stimulation
  - (iv) Gravitronic traction devices
  - (v) Gravity guidance inversion boots
  - (vi) Parallel bars
  - (vii) Pulse tachometers
  - (viii) Tilt tables
  - (ix) Training balls
  - (x) Treadmill exercisers
  - (xi) Weighted quad boots
31. Footwear and orthotics, including all forms and types of shoes and shoe inserts, except for the following:
- (i) Therapeutic shoes for treatment or prevention of foot complications associated with diabetes mellitus, as required by Tennessee law
  - (ii) Shoes that are an integrated part of a leg brace.
32. Grooming services including, but not limited to:
- (i) Barber services

## RULEMAKING HEARINGS

- (ii) Beauty services
  - (iii) Electrolysis
  - (iv) Hairpieces or wigs
  - (v) Manicures
  - (vi) Pedicures
33. Hair analysis
34. Home improvements and furnishings including, but not limited to:
- (i) Decks
  - (ii) Electric powered recliners, elevator seats, and lift chairs
  - (iii) Elevators
  - (iv) Enlarged doorways
  - (v) Environmental accessibility modifications such as grab bars and ramps
  - (vi) Fences
  - (vii) Furniture, indoor or outdoor
  - (viii) Handrails
  - (ix) Meals, home delivered
  - (x) Minor home modifications
  - (xi) Overbed tables
  - (xii) Plexiglass
  - (xiii) Plumbing repairs
  - (xiv) Porch gliders
  - (xv) Rollabout chairs
  - (xvi) Room additions and room expansions
  - (xvii) Stair glides
  - (xviii) Telephone alert systems
  - (xix) Telephone arms

## RULEMAKING HEARINGS

- (xx) Telephone service in home
  - (xxi) Televisions
  - (xxii) Tilt tables
  - (xxiii) Toilet trainers
35. Homemaker services not performed by a licensed home health agency
  36. Hospital inpatient items that are not directly related to the treatment of an injury or illness (such as radios, TVs, movies, telephones, massage, guest beds, haircuts, hair styling, guest trays, etc.)
  37. Hotel charges, unless pre-approved in conjunction with a transplant or as part of a non-emergency transportation service
  38. Hypnosis or hypnotherapy
  39. Icterus index
  40. Infant/child car seats, except that adaptive car seats may be covered for a person with disabilities such as severe cerebral palsy, spina bifida, muscular dystrophy, and similar disorders who meets all of the following conditions:
    - (i) Cannot sit upright unassisted, and
    - (ii) Infant/child care seats are too small or do not provide adequate support, and
    - (iii) Safe automobile transport is not otherwise possible.
  41. Infertility or impotence services including, but not limited to:
    - (i) Artificial insemination services
    - (ii) Purchase of donor sperm and any charges for the storage of sperm
    - (iii) Purchase of donor eggs, and any charges associated with care of the donor required for donor egg retrievals or transfers of gestational carriers
    - (iv) Cryopreservation and storage of cryopreserved embryos
    - (v) Services associated with a gestational carrier program (surrogate parenting) for the recipient or the gestational carrier
    - (vi) Fertility drugs
    - (vii) Home ovulation prediction kits
    - (viii) Services for couples in which one of the partners has had a previous sterilization procedure, with or without reversal

## RULEMAKING HEARINGS

- (ix) Reversal of sterilization procedures
  - (x) Any other service or procedure intended to create a pregnancy
  - (xi) Testing and/or treatment, including therapy, supplies, and counseling, for frigidity or impotence
42. Lamps such as:
- (i) Heating lamps
  - (ii) Lava lamps
  - (iii) Sunlamps
  - (iv) Ultraviolet lamps
43. Lifts including, but not limited to:
- (i) Automobile van lifts
  - (ii) Burke bed elevators
  - (iii) Cheney safety bath lifts
  - (iv) Electric powered recliner and elevating seats
  - (v) Elevators
  - (vi) Hoyer lifts, except when:
    - (I) The enrollee's condition is such that periodic movement is necessary to effect improvement or to arrest or retard deterioration; and
    - (II) Transfer between bed and chair, wheelchair, or commode requires the assistance of more than one person; and
    - (III) Without the use of a lift, the enrollee would be confined to bed; and
    - (IV) Medical records contain documentation which supports medical necessity.
  - (vii) Lift chairs
  - (viii) Liko maneuvering lift or Liko ceiling track lift systems, except when:
    - (I) Enrollee's condition is such that periodic movement is necessary to effect improvement or to arrest or retard development; and
    - (II) Transfer between bed and chair, wheelchair, or commode requires the assistance of more than one person; and

## RULEMAKING HEARINGS

- (III) Without the use of a lift, the enrollee would be confined to bed; and
  - (IV) Medical records contain information which supports medical necessity; and
  - (V) Structural modification to the dwelling is minor, limited primarily to installment of equipment, and does not involve major renovation (e.g., moving walls, enlarging passageways, strengthening ceilings and supports).
  - (ix) Stairway lifts, stair glides
  - (x) Wheel-O-Vators
44. Ligation of mammary arteries, unilateral or bilateral
45. Megavitamin therapy
46. Medical supplies, over-the-counter, including, but not limited to:
- (i) Alcohol, rubbing
  - (ii) Antiseptics
  - (iii) Band-aids
  - (iv) Bandages
  - (v) Cotton balls
  - (vi) Cotton swabs
  - (vii) Creams, medicated, over-the-counter
  - (viii) Dressings
  - (ix) Eyewash
  - (x) Gauze
  - (xi) Peroxide
  - (xii) Q-tips
  - (xiii) Tape
  - (xiv) Wound dressing material for home use
47. Motor vehicle parts and services including, but not limited to:
- (i) Automobile controls

## RULEMAKING HEARINGS

- (ii) Automobile repairs or modifications
- 48. Music therapy
- 49. Nail analysis
- 50. Naturopathic services
- 51. Necropsy
- 52. Nerve stimulators, except for vagus nerve stimulators after conventional therapy has failed in treating partial onset of seizures
- 53. Nutritional supplements and vitamins, over-the-counter, except for prenatal vitamins and folic acid for pregnant women
- 54. Organ and tissue transplants that have been determined experimental or investigational
- 55. Organ donor services provided in connection with organ or tissue transplants, including, but not limited to:
  - (i) Transplants from a donor who is a living TennCare enrollee and the transplant is to a non-TennCare enrollee
  - (ii) Donor services other than the direct services related to organ procurement (such as, hospitalization, physician services, anesthesia)
  - (iii) Hotels, meals, or similar items provided outside the hospital setting for the donor
  - (iv) Any costs incurred by the next of kin of the donor
  - (v) Any services provided outside of any “bundled rates” after the donor is discharged from the hospital
- 56. Oxygen, except when provided under the order of a physician and administered under the direction of a physician
- 57. Oxygen, preset system (flow rate not adjustable)
- 58. Certain pharmacy items, including:
  - (i) Agents to promote smoking cessation
  - (ii) Agents to promote hair growth
  - (iii) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or his designee

## RULEMAKING HEARINGS

- (iv) DESI, LTE, and IRS drugs
  - (v) Over-the-counter drugs for which there is no prescription
  - (vi) Prescriptions filled that exceed the quantity limits established through prior authorization\_
- 59. Play therapy
  - 60. Primal therapy
  - 61. Psychodrama
  - 62. Psychogenic sexual dysfunction or transformation services
  - 63. Purging
  - 64. Recertification of patients in Level 1 and Level II Nursing Facilities
  - 65. Recreational therapy
  - 66. Religious counseling
  - 67. Retreats for mental disorders
  - 68. Rolfing
  - 69. Routine health services which may be required by an employer; or by a facility where an individual lives, goes to school, or works; or by travel plans
    - (i) Drug screenings
    - (ii) Employment and pre-employment physicals
    - (iii) Fitness to duty examinations
    - (iv) Immunizations related to travel or work
    - (v) Insurance physicals
    - (vi) Job related illness or injury covered by workman's compensation
  - 70. Sensitivity training or workshops
  - 71. Sensory integration therapy and equipment used in sensory integration therapy including, but not limited to:
    - (i) Ankle weights
    - (ii) Floor mats

## RULEMAKING HEARINGS

- (iii) Mini-trampolines
  - (iv) Poof chairs
  - (v) Sensory balls
  - (vi) Sky chairs
  - (vii) Suspension swings
  - (viii) Trampolines
  - (ix) Therapy balls
  - (x) Weighted blankets or weighted vests
72. Sensory stimulation services
73. Services provided by immediate relatives, i.e., a spouse, parent, grandparent, step-parent, child, grandchild, brother, sister, half brother, half sister, a spouse's parents or stepparents, or members of the recipient's household
74. Sex change or transformation surgery
75. Sexual dysfunction or inadequacy services and medicine, including drugs for erectile dysfunctions and penile implant devices
76. Speech devices including:
- (i) Phone mirror handivoice
  - (ii) Speech software
  - (iii) Speech teaching machines
77. Sphygmomanometers (blood pressure cuffs)
78. Stethoscopes
79. Supports
- (i) Cervical pillows
  - (ii) Orthotrac pneumatic vests
80. Thermograms
81. Thermography
82. Time involved in completing necessary forms, claims, or reports

## RULEMAKING HEARINGS

83. Tinnitus maskers
84. Toy equipment such as:
  - (i) Flash switches (for toys)
85. Transportation costs such as:
  - (i) Transportation to a provider who is outside the geographical access standards that the MCC is required to meet when a network provider is available within such geographical access standards
  - (ii) Use of a private vehicle when transportation services have been offered through the MCC
86. Transsexual surgery
87. Vision services for persons 21 years of age and older that are not needed to treat a systemic disease process including, but not limited to:
  - (i) Eyeglasses, sunglasses, and/or contact lenses for persons aged 21 and older, including eye examinations for the purpose of prescribing, fitting, or changing eyeglasses, sunglasses, and/or contact lenses; procedures performed to determine the refractive state of the eye(s).
  - (ii) LASIK
  - (iii) Orthoptics
  - (iv) Vision perception training
  - (v) Vision therapy
88. Vitamins, except for prescription prenatal vitamins for prenatal patients, fluoride vitamins for children, and folic acid for prenatal patients
89. Weight loss or weight gain and physical fitness programs including, but not limited to:
  - (i) Dietary programs of weight loss programs, including, but not limited to, Optifast, Nutrisystem, and other similar programs or exercise programs. Food supplements will not be authorized for use in weight loss programs or for weight gain.
  - (ii) Health clubs, membership fees (e.g., YMCA)
  - (iii) Marathons, activity and entry fees
  - (iv) Swimming pools
90. Wheelchairs, specialized, such as:

## RULEMAKING HEARINGS

- (i) Amigo motorized wheelchairs, or similar devices
  - (ii) Rollabout chairs
  - (iii) Scooters
  - (iv) Standing wheelchairs
- 91 Whirlpools and whirlpool equipment such as:
- (i) Action bath hydro massage
  - (ii) Aero massage
  - (iii) Aqua whirl
  - (iv) Aquasage pump, or similar devices
  - (v) Hand-D-Jets, or similar devices
  - (vi) Jacuzzis, or similar devices
  - (vii) Turbojets
  - (viii) Whirlpool bath equipment
  - (ix) Whirlpool pumps

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

The notice of rulemaking set out herein was properly filed in the Department of State on the 30th day of June, 2005. (06-71)

## RULEMAKING HEARINGS

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

There will be a hearing before the Commissioner to consider the promulgation of amendments of rules pursuant to Tennessee Code Annotated, 71-5-105 and 71-5-109. The hearing will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, Tennessee Code Annotated, Section 4-5-204 and will take place in the Nashville Public Library Auditorium, 1<sup>st</sup> Floor, 615 Church Street, Nashville, Tennessee 37219 at 9:30 a.m. C.D.T. on the 16<sup>th</sup> day August 2005.

Any individuals with disabilities who wish to participate in these proceedings (to review these filings) should contact the Department of Finance and Administration, Bureau of TennCare, to discuss any auxiliary aids or services needed to facilitate such participation. Such initial contact may be made no less than ten (10) days prior to the scheduled meeting date (the date the party intends to review such filings) to allow time for the Bureau of TennCare to determine how it may reasonably provide such aid or service. Initial contact may be made with the Bureau of TennCare's ADA Coordinator by mail at the Bureau of TennCare, 310 Great Circle Road, Nashville, Tennessee 37243 or by telephone at (615) 741-0155 or 1-800-342-3145.

For a copy of this notice of rulemaking hearing, contact George Woods at the Bureau of TennCare, 310 Great Circle Road, Nashville, Tennessee 37243 or call (615) 741-0145.

### SUBSTANCE OF PROPOSED RULES

Rule 1200-13-14-.01 Definitions is amended by adding new paragraphs (69) and (106) and renumbering current paragraph (69) as (70) and (106) as (107) and renumbering subsequent paragraphs accordingly so as amended new paragraphs (69) and (106) shall read as follows:

(69) OPEN MEDICAID CATEGORIES shall mean those Medicaid eligibility categories for which enrollment has not been closed pursuant to authority granted by CMS as part of the TennCare demonstration project.

(106) TENNCARE STANDARD ELIGIBILITY REFORMS shall mean the amendments to the TennCare demonstration project approved by CMS on March 24, 2005, to terminate coverage for adults aged 19 and older in TennCare Standard eligibility groups.

Rule 1200-13-14-.02 Eligibility paragraph (3) is amended by adding subparagraph (h) which shall read as follows:

(h) Effective July 6, 2005, all TennCare Standard eligibility groups for adults aged nineteen (19) and older are terminated, notwithstanding anything else in these rules to the contrary.

Rule 1200-13-14-.02 Eligibility paragraph (4) is amended by adding subparagraph (a) which shall read as follows:

(a) Effective July 6, 2005, all TennCare Standard eligibility groups for adults aged nineteen (19) and older are terminated, notwithstanding anything else in these rules to the contrary.

Rule 1200-13-14-.02 Eligibility paragraph (5) is amended by adding subparagraph (t) which shall read as follows:

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- (t) The individual who is eligible for TennCare Standard in accordance with paragraphs (3) and (4) of this section is found to meet the following criteria:
  - 1. S/he is aged nineteen (19) or older,
  - 2. His/her eligibility category has been terminated from TennCare, and
  - 3. S/he has not been determined eligible in an open Medicaid category.

Rule 1200-13-14-.02 Eligibility is amended by deleting paragraph (7) in its entirety and renumbering subsequent paragraphs accordingly.

Rule 1200-13-14-.02 Eligibility is amended by adding a new renumbered paragraph (9) which shall read as follows:

### (9) Disenrollment Related to TennCare Standard Eligibility Reforms

Prior to the disenrollment of TennCare Standard enrollees based on coverage terminations resulting from TennCare Standard Eligibility Reforms, Medicaid eligibility shall be reviewed in accordance with the following.

#### (a) Ex Parte Review

TDHS will conduct an ex parte review of eligibility for open Medicaid categories for all TennCare Standard enrollees in eligibility groups due to be terminated as part of the TennCare Standard eligibility reforms. Such ex parte review shall be conducted in accordance with federal requirements as set forth by CMS in the Special Terms and Conditions of the TennCare demonstration project.

#### (b) Request for Information

- 1. At least thirty (30) days prior to the expiration of their current eligibility period, the Bureau of TennCare will send a Request for Information to all TennCare Standard enrollees in eligibility groups being terminated pursuant to the TennCare Standard eligibility reforms. The Request for Information will include a form to be completed with information needed to determine eligibility for open Medicaid categories as well as a list of the types of proof needed to verify certain information.
- 2. Enrollees will be given thirty (30) days inclusive of mail time from the date of the Request for Information to return the completed form to TDHS and provide TDHS with the necessary verifications to determine eligibility for open Medicaid categories.
- 3. Enrollees with a health, mental health, or learning problem or a disability will be given the opportunity to request assistance in responding to the Request for Information. Enrollees with Limited English Proficiency will have the opportunity to request translation assistance for responding to the Request for Information.
- 4. Enrollees will be given an opportunity until the date of termination to request one extension for good cause of the thirty (30) day timeframe for responding to the Request for Information. The good cause extension is intended to allow a limited avenue for possible relief for certain enrollees who face significant unforeseen circumstances, or

## RULEMAKING HEARINGS

who, as a result of a health, mental health, or learning problem, or disability, or limited English proficiency are unable to respond timely, as an alternative to imposing a standard with no exceptions whatsoever. The good cause exception does not confer an entitlement upon enrollees and the application of this exception will be within the discretion of TDHS. Only one 30-day good cause extension can be granted to each enrollee. Good cause is determined by TDHS eligibility staff. Good cause is not requested nor determined through filing an appeal. Requests for an extension of the thirty (30) day timeframe to respond to the Request for Information must be initiated by the enrollee. However, the enrollee may receive assistance in initiating such request. TDHS will not accept a request for extension of the thirty (30) day timeframe submitted by a family member, advocate, provider, or CMHC acting on the enrollee's behalf without the involvement and knowledge of the enrollee, for example, to allow time for such entity to locate the enrollee if his/her whereabouts are unknown. All requests for good cause extension must be made prior to termination of TennCare eligibility. A good cause extension will be granted if TDHS determines that a health, mental health or learning problem, or disability, or limited English proficiency prevented an enrollee from understanding or responding timely to the Request for Information. Except in the aforementioned circumstances, a good cause extension will only be granted if such request is submitted in writing to DHS prior to termination of TennCare eligibility and TDHS determines that serious personal circumstances such as illness or death prevent an enrollee from responding to the Request for Information for an extended period of time. Proof of the serious personal circumstances is required with the submission of the written request in order for a good cause extension to be granted. Good cause extensions will be granted at the sole discretion of TDHS and if granted shall provide the enrollee with an additional thirty (30) days inclusive of mail time from the date of TDHS's decision to grant the good cause extension. TDHS will send enrollees a letter granting or denying the request for good cause extensions. TDHS's decisions with respect to good cause extensions shall not be appealable.

5. If an enrollee provides some but not all of the necessary information to TDHS to determine his/her eligibility for open Medicaid categories during the thirty (30) day period following the Request for Information, TDHS will send the enrollee a Verification Request. The Verification Request will provide the enrollee with ten (10) days inclusive of mail time to submit any missing information as identified in the Verification Request. Enrollees will not have the opportunity to request an extension for good cause of the ten (10) day timeframe for responding to the Verification Request.
6. Enrollees who respond to the Request for Information within the thirty (30) day period or within any extension of such period granted by TDHS shall retain their eligibility for TennCare Standard (subject to any changes in covered services generally applicable to enrollees in their TennCare Standard category) while TDHS reviews their eligibility for open Medicaid categories.
7. TDHS shall review all information and verifications provided within the requisite time period by an enrollee pursuant to the Request for Information and/or the Verification Request to determine whether the enrollee is eligible for any open Medicaid categories. If TDHS makes a determination that the enrollee is eligible for an open Medicaid category, TDHS will so notify the enrollee and the enrollee will be enrolled in appropriate TennCare Medicaid category. Once the enrollee is enrolled in TennCare Medicaid, his/her TennCare Standard eligibility shall then be terminated without additional notice. If TDHS makes a determination that the enrollee is not eligible for any open Medicaid

## RULEMAKING HEARINGS

categories or if an enrollee does not respond to the Request for Information within the requisite thirty (30) day time period or any extension of such period granted by TDHS, the TennCare Bureau will send the enrollee a twenty (20) day advance Termination Notice.

8. TDHS shall, pursuant to the rules, policies and procedures of TDHS and the Bureau of TennCare applicable to new applicants for TennCare coverage, review all information and verifications provided by an enrollee after the thirty (30) day period following the Request for Information or after any extension of such period granted by TDHS, but the enrollee shall not be entitled to retain eligibility for TennCare Standard pending this review. If the individual is subsequently determined to be eligible for an open Medicaid category, s/he shall be granted retroactive coverage to the date of application, or in the case of spend down eligibility for Medically Needy pregnant women and children, to the latter of (a) the date of his or her application or (b) the date spenddown eligibility is met.

### (c) Termination Notice

1. The TennCare Bureau will send Termination Notices to all TennCare Standard enrollees being terminated pursuant to the TennCare Standard eligibility reforms who are not determined to be eligible for open Medicaid categories pursuant to the Ex Parte Review or Request for Information processes described in this subsection.
2. Termination Notices will be sent twenty (20) days in advance of the date upon which the coverage will be terminated.
3. Termination Notices will provide enrollees with forty (40) days from the date of the notice to appeal valid factual disputes related to the disenrollment and inform enrollees how they may request a hearing.
4. Enrollees with a health, mental health, or learning problem or a disability will be given the opportunity to request additional assistance for their appeal. Enrollees with Limited English Proficiency will have the opportunity to request translation assistance for their appeal.
5. Enrollees will not have the opportunity to request an extension for good cause of the forty (40) day timeframe in which to request a hearing.

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Rule 1200-13-14-.05 Enrollee Cost Sharing paragraph (1) subparagraph (b) is amended by revising the first two columns in the “Percentage of Poverty” section from “0%-100%” and “101%-149%” to “0%-99%” and “100%-149%” respectively so as amended subparagraph (b) shall read as follows:

- (b) Effective January 1, 2002, the Bureau will update its Premium Sliding Scale Schedule monthly income brackets used for the determination of enrollee cost sharing to reflect the most current poverty levels as published by the Centers for Medicare and Medicaid Services. The Premium Sliding Scale effective January 1, 2002, follows:

Individual Monthly Premium	\$0	\$20.00	\$35.00	\$100.00	\$150.00
Family Monthly Premium	\$0	\$40.00	\$70.00	\$250.00	\$375.00
Percentage of Poverty	0% - 99%	100% - 149%	150% - 199%	200% - 249%	250% - 299%
Individual Monthly Premium	\$200.00	\$250.00	\$350.00	\$450.00	\$550.00
Family Monthly Premium	\$500.00	\$625.00	\$875.00	\$1,125.00	\$1,375.00
Percentage of Poverty	300% - 349%	350% - 399%	400% - 499%	500% - 599%	600% - Over

Rule 1200-13-14-.05 Enrollee Cost Sharing paragraph (3) is amended by adding the phrase “is equal to or” between the words “income” and “exceeds” in the first sentence and by deleting references to deductibles and 2% copayments which are no longer applicable so as amended paragraph (3) shall read as follows:

- (3) In accordance with the following schedules, families and individuals who enroll in TennCare who are not Medicaid-eligible and whose income is equal to or exceeds 100% of the poverty level shall pay-copayments for services other than preventive services.

Rule 1200-13-14-.05 Enrollee Cost Sharing paragraph (3) subparagraph (a) is amended by revising the first two Poverty Levels in the chart from “0%-100%” and “101%-199%” to “0%-99%” and “100%-199%” respectively and by deleting the reference to the TennCare deductible so as amended subparagraph (a) shall read as follows:

- (a) Effective January 1, 2000, or at such date thereafter as the change is approved by the Health Care Financing Administration and can be implemented, the annual TennCare Maximum Out-of-Pocket Expenditures described below shall apply for both uninsured and uninsurable designations, based on the poverty level.

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**TENNCARE MAXIMUM ANNUAL OUT-OF-POCKET EXPENDITURES.**

POVERTY LEVELS	Individual Maximum Annual Out-of-Pocket	Family Maximum Annual Out-of-Pocket
0% - 99%	\$ 0.00	\$ 0.00
100% - 199%	\$ 1,000.00	\$ 2,000.00
200% and above	\$ 2,000.00	\$ 4,000.00

Managed care organizations participating in the TennCare program shall be specifically prohibited from waiving, or discouraging TennCare enrollees from paying, the amounts described in this provision.

Rule 1200-13-14-.05 Enrollee Cost Sharing paragraph (3) subparagraph (b) is amended by revising the first two Poverty Levels in the chart from “0%-100%” and “101%-199%” to “0%-99%” and “100%-199%” respectively so as amended subparagraph (b) shall read as follows:

- (b) Effective January 1, 2000, or at such date thereafter as the change is approved by the CMS and can be implemented, the following TennCare copayment schedule shall apply for both Uninsured and Uninsurable designations, based on the poverty level. Effective August 1, 2002 the poverty levels will be those as used by TDHS.

**TENNCARE COPAYMENT AMOUNTS.**

POVERTY LEVELS	COPAYMENT AMOUNTS
0% - 99%	\$ 0.00
100% - 199%	\$ 25.00 for hospital emergency room (waived if admitted) \$ 5.00 for primary care provider and Community Mental Health Agency services other than preventive care \$ 15.00 for physician specialists \$ 5.00 for prescription or refill \$ 100.00 per inpatient hospital admission

RULEMAKING HEARINGS

200% and above	\$ 50.00 for hospital emergency room (waived if admitted) \$ 10.00 for primary care provider and Community Mental Health Agency services other than preventive care \$ 25.00 for physician specialists \$ 10.00 for prescription or refill \$ 200.00 per inpatient hospital admission
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Managed care organizations participating in the TennCare program shall be specifically prohibited from waiving, or discouraging TennCare enrollees from paying, the amounts described in this provision.

Rule 1200-13-14-.05 Enrollee Cost Sharing paragraph (4) subparagraph (a) is amended by revising the first two column in the "Percentage of Poverty" section from "0%-100%" and "101%-149%" to "0%-99%" and "100%-149%" respectively so as amended subparagraph (a) shall read as follows:

- (a) The following premiums were effective January 1, 2002 as approved by the Centers for Medicare and Medicaid Services, and apply to the TennCare Standard enrollees who are classified as uninsured or medically eligible.

Individual Monthly Premium	\$0	\$20.00	\$35.00	\$100.00	\$150.00
Family Monthly Premium	\$0	\$40.00	\$70.00	\$250.00	\$375.00
Percentage of Poverty	0% - 99%	100% - 149%	150% - 199%	200% - 249%	250% - 299%
Individual Monthly Premium	\$200.00	\$250.00	\$350.00	\$450.00	\$550.00
Family Monthly Premium	\$500.00	\$625.00	\$875.00	\$1,125.00	\$1,375.00
Percentage of Poverty	300% - 349%	350% - 399%	400% - 499%	500% - 599%	600% - Over

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

The notice of rulemaking set out herein was properly filed in the Department of State on the 22nd day of June, 2005. (06-27)

## RULEMAKING HEARINGS

### TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION = 0620 BUREAU OF TENNCARE

There will be a hearing before the Commissioner to consider the promulgation of amendments of rules pursuant to Tennessee Code Annotated, 71-5-105 and 71-5-109. The hearing will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, Tennessee Code Annotated, Section 4-5-204 and will take place in the Nashville Public Library Auditorium, 1<sup>st</sup> Floor, 615 Church Street, Nashville, Tennessee 37219 at 9:30 a.m. C.D.T. on the 16<sup>th</sup> day of August 2005.

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

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

### SUBSTANCE OF PROPOSED RULE

Rule 1200-13-14-.04 Covered Services is amended by adding a new paragraph (11) and renumbering the present paragraph (11) as (12) and subsequent paragraphs renumbered according so as amended the new paragraph (11) shall read as follows:

(11) Effective August 1, 2005, the covered benefits for TennCare Standard will be as follows:

- (a) TennCare managed care contractors shall cover, at a minimum, the following services and benefits subject to any applicable limitations described herein effective August 1, 2005. Any and all medically necessary services may require prior authorization or approval by the managed care contractor, except where prohibited by law. In accordance with the *John B. Court Order*, MCCs may not deny medically necessary services for children under age 21 due to lack of prior authorization. As stated elsewhere in these rules, managed care organizations shall not require prior authorization or approval for services rendered in the event of an emergency need of the enrollee. Such emergency services may be reviewed on the basis of medical necessity or other MCO administrator requirements, but cannot be denied solely because the provider did not obtain prior authorization or approval from the enrollee's managed care organization. Managed care contractors shall not impose any service limitations that are more restrictive than those described herein; however, this provision shall not limit the managed care contractor's ability to establish procedures for the determination of medical necessity. Services for which there is no federal financial participation (FFP) are not covered.
- (b) Physical Health and Mental Health Services

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SERVICE	BENEFIT
1. Chiropractic Services	<p>Under age 21: Covered as medically necessary.</p> <p>Age 21 and older: Covered when determined cost effective by the MCO.</p>
2. Community Health Services	<p>Under age 21: Covered as medically necessary.</p> <p>Age 21 and older: As medically necessary, except that effective August 1, 2005, Methadone Clinic services for adults age 21 and older are not covered, even if medically necessary. This includes services that have been prior authorized and/or initiated, but not completed as of August 1, 2005.</p>
3. Convalescent Care	<p>Under age 21: Upon receipt of proof that an enrollee has incurred medically necessary expenses related to convalescent care, TennCare shall pay for up to and including the one-hundredth (100<sup>th</sup>) day of confinement during any calendar year for convalescent facility(ies) room, board, and general nursing care, provided: (A) a physician recommends confinement for convalescence; (B) the enrollee is under the continuous care of a physician during the entire period of confinement, and (C) the confinement is required for other than custodial care.</p> <p>Age 21 and older: Effective August 1, 2005, not covered, even if medically necessary. This includes services that have been prior authorized and/or initiated, but not completed as of August 1, 2005.</p>
4. Dental Services	<p>Under age 21: Preventive, diagnostic, and treatment services. Orthodontic services must be prior approved and are limited to individuals under age 21 diagnosed with: (1) a severe handicapping malocclusion or another developmental anomaly or injury resulting in severe malalignment or severe handicapping malocclusion of teeth, documented by at least 28 points on the Salzmann Scale, or any other method that is approved by TennCare, or (2) following repair of an enrollee's cleft palate. Orthodontic treatment will not be authorized for cosmetic purposes. Orthodontic treatment will only be paid for by TennCare as long as the individual remains eligible. If the orthodontic treatment plan is approved prior to the enrollee obtaining 20 ½ years of age, and treatment is initiated prior to the enrollee obtaining 21 years of age, such treatment may continue as long as the enrollee remains eligible.</p> <p>Age 21 and older: Effective August 1, 2005, not covered, even if medically necessary. This includes services which have been prior authorized and/or initiated, but not completed as of August 1, 2005, except for orthodontic treatment as specified above.</p>
5. Durable Medical Equipment	<p>As medically necessary.</p>

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SERVICE	BENEFIT
6. Emergency Air and Ground Transportation	As medically necessary.
7. Screening, Inter-periodic Screening, Diagnostic and Follow-up Treatment Services for Children under age 21	<p>Under age 21: Covered as medically necessary.</p> <p>Screening, interperiodic screening, diagnostic and follow-up treatment services as medically necessary. Except for Dental services, screens shall be in accordance with the periodicity schedule set forth in the latest “American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care” and all components of the screens must be consistent with the latest “American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care.” Dental screens shall be in accordance with the latest periodicity schedule set forth by either the American Academy of Pediatric Dentistry or the American Academy of Pediatrics and all components of the screens must be consistent with the latest recommendations by the American Academy of Pediatric Dentistry or the American Academy of Pediatrics.</p> <p>Age 21 and older: Not covered.</p>
8. Home Health Care	<p>Under age 21: As medically necessary.</p> <p>Age 21 and older: As medically necessary, all home health care as delivered by a licensed Home Health Agency, as defined by 42 CFR §440.70.</p> <p>A home health visit includes any of the following: Skilled Nursing, Physical Therapy, Occupational Therapy, Speech Pathology and Audiology Services, and Home Health Aide. Full-time nursing services are not covered for adults 21 years of age and older, except as part of home respiratory therapy services for ventilator-dependent enrollees. (See item 34 in the chart.)</p>
9. Hospice Care	As medically necessary. Must be provided by an organization certified pursuant to Medicare Hospice requirements.
10. Inpatient and Outpatient Substance Abuse Benefits	<p>Under age 21: As medically necessary.</p> <p>Age 21 and older: As medically necessary, except that effective August 1, 2005, Methadone Clinic services for adults age 21 and older are not covered even if medically necessary. This includes services that have been prior authorized and/or initiated, but not completed as of August 1, 2005. Covered substance abuse treatment services are limited to ten (10) days detox, with a \$30,000 limit in lifetime medically necessary benefits. This limit on covered services does not apply to persons who are Severely and/or Persistently Mentally Ill.</p>

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SERVICE	BENEFIT
11. Inpatient Hospital Services	As medically necessary. MCO may conduct concurrent and retrospective reviews.
12. Inpatient Rehabilitation Facilities	Under age 21: As medically necessary. Age 21 and older: Inpatient Rehabilitation Facilities services may be covered when determined to be a cost effective alternative by the MCO.
13. Lab and X-ray Services	As medically necessary.
14. Medical Supplies	As medically necessary.
15. Non-Emergency Ambulance Transportation	As medically necessary.
16. Non-Emergency Transportation	<p>As necessary to get an enrollee to and from covered services, for enrollees not having access to transportation. MCOs may require advance notice of the need in order to timely arrange transportation.</p> <p>The travel to access primary care and dental services must meet the requirements of the waiver terms and conditions. The availability of specialty services is related to travel distance should meet the usual and customary standards for the community. However, in the event the MCO is unable to negotiate such an arrangement for an enrollee transportation must be provided regardless of whether or not the enrollee has access to transportation. If the enrollee is a child, transportation must be provided for the child and an accompanying adult. However, transportation for a child shall not be denied pursuant to any policy which poses a blanket restriction due to enrollee's age or lack of parental accompaniment. (Note: Tennessee recognizes the "mature minor exception" to permission for medical treatment.) Any decision to deny transportation of a child due to an enrollee's age or lack of parental accompaniment must be made on a case-by-case basis and must be based on the individual facts surrounding the request. As with any denial, all notices and actions must be in accordance with the appeal process.</p> <p>The provision of transportation to and from dental services shall remain with the MCO.</p>

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SERVICE	BENEFIT
17. Occupational Therapy	<p>Under age 21: Covered as medically necessary.</p> <p>Age 21 and older: Covered as medically necessary, by a Licensed Occupational Therapist, to restore, improve, or stabilize impaired functions.</p>
18. Organ Transplant and Donor Organ Procurement	<p>Under age 21: Covered as medically necessary. Experimental or investigational transplants are not covered.</p> <p>Age 21 and older: All medically necessary and non-investigational/experimental organ transplants are covered. These include, but may not be limited to:</p> <ul style="list-style-type: none"> <li>Bone Marrow/Stem Cell</li> <li>Cornea</li> <li>Heart</li> <li>Heart/Lung</li> <li>Kidney</li> <li>Kidney/Pancreas</li> <li>Liver</li> <li>Lung</li> <li>Pancreas</li> <li>Small bowel/Multi-visceral</li> </ul>
19. Outpatient Hospital Services	As medically necessary.
20. Outpatient Mental Health Services (including physician services)	As medically necessary.

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SERVICE	BENEFIT
<p>21. Pharmacy Services (obtained directly from an ambulatory retail pharmacy setting, outpatient hospital pharmacy, mail order pharmacy or those administered to a long term care facility resident (nursing facility))</p>	<p>As medically necessary, subject to the limitations set out below. Certain drugs (known as DESI, LTE, IRS drugs) are excluded from coverage, or as provided herein at 1200-13-14-.04(7) and 1200-13-14-.10.</p> <p>The following limitations (A) – (B) are effective as of August 1, 2005.</p> <p>(A) Pharmacy services for individuals receiving TennCare-reimbursed services in a Nursing Facility or Intermediate Care Facility for the Mentally Retarded, or a Home and Community Based Services waiver have no quantity limits on the number of prescriptions per month.</p> <p>(B) Pharmacy services for all TennCare Standard adults age 21 and older, other than those included in Group (A) above, are non-covered, effective August 1, 2005, even if medically necessary. This includes drugs which have been prior authorized but not received as of August 1, 2005, and/or drugs for which the initial prescription but not all applicable refills, or the interim supply but not the balance thereof, have been received as of August 1, 2005.</p> <p>TennCare is responsible for the provision and payment of pharmacy benefits to individuals who are enrolled in the TennCare Program in the category of TennCare Medicaid/Medicare dual eligible. However, this does not include pharmaceuticals administered in a doctor's office or administered by other vendors under contract with the MCO.</p>
<p>22. Physical Therapy</p>	<p>Under age 21: Covered as medically necessary.</p> <p>Age 21 and older: Covered as medically necessary, by a Licensed Physical Therapist, to restore, improve, or stabilize impaired functions.</p>
<p>23. Physician Inpatient Services</p>	<p>As medically necessary.</p>
<p>24. Physician Outpatient Services/ Community Health Clinics/Other Clinic Services</p>	<p>Under age 21: As medically necessary.</p> <p>Age 21 and older: As medically necessary, except that effective August 1, 2005, Methadone Clinic services for adults age 21 and older are not covered, even if medically necessary. This includes services that have been prior authorized and/or initiated, but not completed as of August 1, 2005.</p>

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SERVICE	BENEFIT
25. Private Duty Nursing	<p>Under age 21: Covered as medically necessary when prescribed by an attending physician for treatment and services rendered by a registered nurse (R.N.) or a licensed practical nurse (L.P.N. who is not an immediate relative.</p> <p>Age 21 and older: Effective August 1, 2005, not covered even if medically necessary. This includes services which have been prior authorized and/or initiated, but not completed as of August 1, 2005.</p>
26. Psychiatric Inpatient Services	As medically necessary.
27. Psychiatric Physician Inpatient Services	As medically necessary.
28. Psychiatric Rehabilitation Services	As medically necessary.
29. Reconstructive Breast Surgery	Covered in accordance with Tenn. Code Ann. § 56-7-2507 which requires coverage of all stages of reconstructive breast surgery on a diseased breast as a result of a mastectomy as well as any surgical procedure on the non-diseased breast deemed necessary to establish symmetry between the two breasts in the manner chosen by the physician. The surgical procedure performed on a non-diseased breast to establish symmetry with the diseased breast will only be covered if the surgical procedure performed on a non-diseased breast occurs within five (5) years of the date the reconstructive breast surgery was performed on a diseased breast.
30. Renal Dialysis Services	As medically necessary, for the first ninety (90) days prior to being covered by Medicare.
31. Sitter Services	<p>Under age 21: As medically necessary, a sitter who is not a relative may be used where an enrollee is confined to a hospital as a bed patient and certification is made by a network physician that R.N. or L.P.N. is needed and neither is available.</p> <p>Age 21 and older: As of August 1, 2005, not covered even if medically necessary. This includes services that have been prior authorized and/or initiated, but not completed as of August 1, 2005.</p>

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SERVICE	BENEFIT
32. Speech Therapy	<p>Under age 21: Covered as medically necessary.</p> <p>Age 21 and older: Covered as medically necessary, by a Licensed Speech Therapist to restore speech (as long as there is continued medical progress) after a loss or impairment.</p>
33. 24-Hour Psychiatric Residential Treatment	As medically necessary.
34. Ventilator Services	<p>Under 21: As medically necessary.</p> <p>Age 21 and older. Medically necessary home and community-based respiratory therapy services provided outside an institutional setting for ventilator-dependent enrollees, to include nursing services when necessary to prevent institutionalization. Prior approval required.</p>
35. Vision Services	<p>Under 21: Preventive, diagnostic, and treatment services (including eyeglasses) are covered as medically necessary</p> <p>Age 21 and older: Medical eye care, meaning evaluation and management of abnormal conditions, diseases, and disorders of the eye (not including evaluation and treatment of refractive state), will be covered. Routine, periodic assessment, evaluation, or screening of normal eyes and examinations for the purpose of prescribing, fitting, or changing eyeglasses and/or contact lenses will not be covered.</p>

(c) Pharmacy

TennCare is permitted under the terms and conditions of the demonstration project approved by the federal government to restrict coverage of prescription and non-prescription drugs to a TennCare-approved list of drugs known as a drug formulary. TennCare must make this list of covered drugs available to the public. Through the use of a formulary, the following drugs or classes of drugs, or their medical uses, shall be excluded from coverage or otherwise restricted by TennCare as described in Section 1927 of the Social Security Act [42 U.S.C. §1396r-8]:

1. Agents for weight loss or weight gain.
2. Agents to promote fertility or for the treatment of impotence or infertility or for the reversal of sterilization.

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3. Agents for cosmetic purposes or hair growth.
4. Agents for symptomatic relief of coughs and colds.
5. Agents to promote smoking cessation.
6. Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.
7. Nonprescription drugs.
8. Covered outpatient drugs, which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.

TennCare shall not cover drugs considered by the FDA to be Less Than Effective (LTE) and DESI drugs, or drugs considered to be Identical, Related and Similar (IRS) to DESI and LTE drugs or any other pharmacy services for which federal financial participation (FFP) is not available. The exclusion of drugs for which no FFP is available extends to all TennCare enrollees regardless of the enrollee's age. TennCare shall not cover experimental or investigational drugs, which have not received final approval from the FDA.

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

The notice of rulemaking set out herein was properly filed in the Department of State on the 30th day of June, 2005. (06-72)

## RULEMAKING HEARINGS

### TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION – 0620 BUREAU OF TENNCARE

There will be a hearing before the Commissioner to consider the promulgation of amendments of rules pursuant to Tennessee Code Annotated, 71-5-105 and 71-5-109. The hearing will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, Tennessee Code Annotated, Section 4-5-204 and will take place in the Nashville Public Library Auditorium, 1<sup>st</sup> Floor, 615 Church Street, Nashville, Tennessee 37219 at 9:30 a.m. C.D.T. on the 16<sup>th</sup> day August 2005.

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

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

### SUBSTANCE OF PROPOSED RULES

Subparagraph (a) of paragraph (3) of rule 1200-13-14-.05 Enrollee Cost Sharing is amended by adding the sentence "Effective August 1, 2005, there is no Out of Pocket Maximum for enrollee copays" at the end of the subparagraph so as amended the last paragraph in subparagraph (a) shall read as follows:

Managed care organizations participating in the TennCare program shall be specifically prohibited from waiving, or discouraging TennCare enrollees from paying, the amounts described in this provision. Effective August 1, 2005, there is no Out of Pocket Maximum for enrollee copays.

Subparagraph (a), (b), (d), (e), and (f) of paragraph (7) of rule 1200-13-14-.05 Enrollee Cost Sharing is amended by adding the sentence "Effective August 1, 2005, there is no Out-of-Pocket Maximum for enrollee copays" at the end of each subparagraph so as amended the subparagraphs shall read as follows:

- (a) For enrollees in families with incomes equal to or above two hundred (200%) percent of the poverty level, the annual out-of-pocket maximum is two thousand (\$2,000) dollars per individual and four thousand (\$4,000) dollars per family. Effective August 1, 2005, there is no Out-of-Pocket Maximum for enrollee copays.
- (b) For enrollees in families with incomes below two hundred (200%) percent of the poverty level, the annual out-of-pocket maximum is one thousand (\$1,000) dollars per individual and two thousand (\$2,000) dollars per family. Effective August 1, 2005, there is no Out-of-Pocket Maximum for enrollee copays.
- (d) Effective August 1, 2002, the poverty levels for out-of-pocket maximum will be the poverty levels used by the Tennessee Department of Human Services. Effective August 1, 2005, there is no Out-of-Pocket Maximum for enrollee copays.

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- (e) Effective January 1, 2003, included in the annual out-of-pocket maximums are monthly out-of-pocket maximums for pharmacy services only. The monthly out-of-pocket maximum for pharmacy services for all TennCare Standard enrollees is one hundred-fifty (\$150.00) dollars per enrollee per month. Effective August 1, 2005, there is no Out-of-Pocket Maximum for enrollee copays.
- (f) TennCare Standard enrollees are responsible for requesting a review of his/her out-of-pocket expenditures by TennCare if s/he believes s/he has reached, or is close to reaching, his/her out-of-pocket maximum. Effective August 1, 2005, there is no Out-of-Pocket Maximum for enrollee copays.

Subparagraphs (l) and (m) of paragraph (7) of rule 1200-13-14-.05 Enrollee Cost Sharing is deleted in their entirety and replaced with new subparagraphs (l) and (m) which shall read as follows:

- (l) Pharmacy and Psychiatric Pharmacy Copayments
  - 1. Effective August 1, 2005, all TennCare Standard enrollees with incomes at or above poverty who receive pharmacy services will have nominal copayments on these services. The copays will be \$3.00 for each branded drug and \$0 for each covered generic drug. Generic drugs which exceed the limit of five (5) prescriptions or refills per enrollee per month are not covered. Family planning drugs and emergency services are exempt from copay.
  - 2. The following groups (adults and children) are exempt from copay:
    - (i) Individuals receiving hospice services who provide verbal notification of such to the provider at the point of service;
    - (ii) Individuals who are pregnant who provide verbal notification of such to the provider at the point of service; and
    - (iii) Individuals who are receiving services in a Nursing Facility, an Intermediate Care Facility for the Mentally Retarded, or a Home and Community Based Services waiver.
- (m) Effective August 1, 2005, there is no maximum out-of-pocket maximum on pharmacy services.
- (n) The three (3) day supply requirements of the Grier Revised Consent Decree do not affect the pharmacy copay requirements. Every prescription for all TennCare Standard enrollees will require a copayment as described herein. In the event the three (3) day supply represents less than a full prescription, the entire copayment will be required.

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

The notice of rulemaking set out herein was properly filed in the Department of State on the 30th day of June, 2005. (06-73)

## RULEMAKING HEARINGS

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

There will be a hearing before the Commissioner to consider the promulgation of amendments of rules pursuant to Tennessee Code Annotated, 71-5-105 and 71-5-109. The hearing will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, Tennessee Code Annotated, Section 4-5-204 and will take place in the Nashville Public Library Auditorium, 1st Floor, 615 Church Street, Nashville, Tennessee 37219 at 9:30 a.m. C.D.T. on the 16th day August 2005.

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

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

### SUBSTANCE OF PROPOSED RULE

Rule 1200-13-14-.10 Exclusion is deleted in its entirety and replaced with a new rule 1200-13-14-.10 which shall read as follows:

#### **1200-13-14-.10 EXCLUSIONS.**

- (1) General exclusions. The following items and services shall not be considered covered services by TennCare:
  - (a) Items and services that are not considered medically necessary, as defined in these rules.
  - (b) Provision of medical assistance which is outside the scope of benefits as defined in these rules.
  - (c) Provision of services to persons who are not enrolled in TennCare on the date the services are delivered.
  - (d) Services for which there is no Federal Financial Participation (FFP).
  - (e) Services provided outside the geographic borders of Tennessee, including transportation to return to Tennessee to receive medical care except in the following circumstances:
    1. Emergency medical services are needed because of an emergency medical condition;
    2. Non-emergency urgent care services are requested because the recipient's health would be endangered if he were required to travel, but only upon the explicit prior authorization of the MCC;

## RULEMAKING HEARINGS

3. The covered medical service would not be readily available within Tennessee if the enrollee was physically located in Tennessee at the time of need. Covered services are explicitly authorized by the enrollee's TennCare MCC; or
  4. The out-of-state provider is participating in the enrollee's MCC network.
- (f) Investigative or experimental services or procedures including, but not limited to:
1. Drug or device lacks FDA approval except when medically necessary as defined by TennCare, or
  2. Drug or device lacks approval of facility's Institutional Review Board, or
  3. Requested treatment is the subject of Phase I or Phase II clinical trials or the investigational arm of Phase III clinical trials, or
  4. Prevailing opinion among experts is that further study is required to determine safety, efficacy, or long-term clinical outcomes of requested service.
- (g) Services which are delivered in connection with, or required by, an item or service not covered by TennCare, including the transportation to receive such non-covered services.
- (h) The reversal and/or treatment of associated complications of any medical procedure when such procedure is itself excluded from coverage, pursuant to any provision of this section except subsection (c), except for emergency services to treat a complication to the extent that these emergency services are covered for the individual enrollee.
- (i) Items or services furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury.
- (j) Non-emergency services (other than prescription drugs for dual eligibles, until January 1, 2006) that are ordered or furnished by an out-of-network provider and which have not been approved by the enrollee's MCC for out-of-network care.
- (k) Services that are free to the public, with the exception of services delivered in the schools pursuant to the Individuals with Disabilities in Education Act (IDEA).
- (l) Items or services ordered, prescribed, administered, supplied, or provided by an individual or entity that has been excluded from participation in the Medicaid program under the authority of the United States Department of Health and Human Services or the Bureau of TennCare.
- (m) Items or services ordered, prescribed, administered, supplied, or provided by an individual or entity that is no longer licensed by their licensing board.
- (n) Items or services outside the scope and/or authority of a provider's specialty and/or area of practice.
- (o) Items or services to the extent that Medicare or a third party payer is legally responsible to pay or would have been legally responsible to pay except for the enrollee's or the treating provider's failure to comply with the requirements for coverage of such services.

## RULEMAKING HEARINGS

- (2) Specific exclusions. The following services, products, and supplies are specifically excluded from coverage under the TennCare Section 1115(a) waiver program and the TennCare Section 1915(b) waiver program. Some of these services may be covered outside TennCare under a Home and Community Based Services waiver when provided as part of an approved plan of care, in accordance with Rules 1200-13-1-.25, 1200-13-1-.26, and 1200-13-1-.27.
- (a) Services, products, and supplies that are specifically excluded from coverage except as medically necessary for children under the age of 21
1. Audiological therapy or training; prescribing, fitting, or changing hearing aids
  2. Augmentative communication devices
  3. Chiropractor's services
  4. Convalescent care
  5. Ear plugs, except for children with tympanostomy tubes ordered by an ENT doctor
  6. Electrically powered adjustable hospital beds, including variable height beds
  7. Floor standers
  8. Food supplements, except as medically necessary for treatment of metabolic disorders in children under age 21 and as required for PKU treatment by Tennessee law
  9. Hearing aids
  10. Maintenance services (physical, occupational, and speech therapy) unless required to prevent regression or deterioration of a child's condition. Services without which the child's condition would remain unchanged are not considered maintenance services.
  11. Methadone clinic services
  12. Orthodontic services, except under the conditions described elsewhere in these rules.
  13. Purchase, repair, or replacement of materials or equipment when the reason for the purchase, repair, or replacement is the result of enrollee abuse
  14. Purchase, repair, or replacement of materials or equipment that has been stolen or destroyed except when the following documentation is provided:
    - (i) Explanation of continuing medical necessity for the item, and
    - (ii) Explanation that the item was stolen or destroyed, and
    - (iii) Copy of police, fire department, or insurance report if applicable
  15. Radial keratotomy

## RULEMAKING HEARINGS

16. Reimbursement to a provider or enrollee for the replacement of a rented durable medical equipment (DME) item that is stolen or destroyed
  17. Repair of DME items not covered by TennCare
  18. Repair of DME items covered under the provider's or manufacturer's warranty
  19. Repair of a rented DME item
  20. Sitter services
  21. Speech, language, and hearing services to address speech problems caused by mental, psychoneurotic, or personality disorders
  22. Standing tables
- (b) Services, products, and supplies that are specifically excluded from coverage under the TennCare program.
1. Alcoholic beverages
  2. Animal therapy including, but not limited to:
    - (i) Dolphin therapy
    - (ii) Equine therapy
    - (iii) Hippo therapy
    - (iv) Pet therapy
  3. Art therapy
  4. Autopsy
  5. Bariatric surgery including, but not limited to, gastric stapling, intestinal bypass surgery, banding, and body remodeling
  6. Bathtub equipment and supplies including, but not limited to:
    - (i) Action Bath Hydro Massage, or similar devices
    - (ii) Aero massage, or similar devices
    - (iii) Aqua Whirl, or similar devices
    - (iv) Bed baths
    - (v) Century Bed Baths
    - (vi) Eaton E-Z baths
    - (vii) Nolan Bath Chairs, or similar devices

## RULEMAKING HEARINGS

- (viii) Paraffin baths
  - (ix) Sauna baths
  - (x) Sitz baths, or similar devices
7. Beds and bedding equipment such as:
- (i) Adjust-a-Beds, or similar devices
  - (ii) Air flotation beds, powered
  - (iii) Air fluidized beds (including Clinitron beds)
  - (iv) Bead beds, or similar devices
  - (v) Bed boards
  - (vi) Bedding and bed casings
  - (vii) Hospital beds, unless specifically documented by the treating physician to handle a specific condition that requires repositioning that cannot be accomplished by the use of a conventional bed
  - (viii) Lounge beds
  - (ix) Ortho-prone beds
  - (x) Oscillating beds
  - (xi) Pillows, hypoallergenic
  - (xii) Springbase beds
  - (xiii) Vail beds
  - (xiv) Vasculating beds
  - (xv) Waterbeds
8. Bioenergetic therapy
9. Biofeedback
10. Body adornment and enhancement services including, but not limited to:
- (i) Body piercing, or removal of body piercing
  - (ii) Breast augmentation
  - (iii) Breast capsulectomy
  - (iv) Breast implant removal

## RULEMAKING HEARINGS

- (v) Ear piercing, or repair of ear piercing
  - (vi) Hair transplantation, and agents for hair growth
  - (vii) Tattoos or removal of tattoos
  - (viii) Tongue splitting or repair of tongue splitting
  - (ix) Wigs or hairpieces
11. Breathing equipment such as:
- (i) Intrapulmonary Percussive Ventilators (IPVs)
  - (ii) Spirometers
  - (iii) Vaporizers
12. Carbon dioxide therapy
13. Care facilities or services, the primary purpose of which is non-medical, including, but not limited to:
- (i) Day care
  - (ii) Evening care centers
  - (iii) Respite care
  - (iv) Rest cures
  - (v) Social or diversion services
14. Carotid body tumor, excision of, as treatment for asthma
15. Chelation therapy, except for the treatment of heavy metal poisoning or secondary hemochromatosis in selected settings. Chelation therapy for treatment of arteriosclerosis or autism is not covered. Chelation therapy for asymptomatic individuals is not covered. In the case of lead poisoning, the lead levels must be extremely high. For children, a minimum level of 45 ug/dl is recommended. Because chelation therapy and its after-effects must be continuously monitored for possible adverse reactions, chelation therapy is covered only in inpatient or outpatient hospital settings, renal dialysis facilities, and skilled nursing facilities. It is not covered in an office setting, an ambulatory surgical center, or a home setting.
16. Clothing, including adaptive clothing, with the exception of mastectomy bras
17. Cold therapy devices
18. Comfort and convenience items including, but not limited to:
- (i) Arch supports

## RULEMAKING HEARINGS

- (ii) Corn plasters
  - (iii) Garter belts
  - (iv) Incontinence products (diapers/liners/underpads) for persons younger than 3 years of age
  - (v) Incontinence products other than disposable diapers, including pull-up pants, for persons 3 years of age and older
  - (vi) Non-prescription ointments
  - (vii) Support stockings other than Jobst supports
19. Computers, personal, and peripherals including, but not limited to printers, modems, monitors, scanners, and software, including their use in conjunction with an Augmentative Communication Device
20. Cosmetic dentistry, cosmetic oral surgery, and cosmetic orthodontic services
21. Cosmetic prosthetic devices
22. Cosmetic surgery or surgical procedures primarily for the purpose of changing the appearance of any part of the body to improve appearance of self-esteem, including scar revision. The following services are not considered cosmetic services:
- (i) Reconstructive surgery to correct the results of an injury or disease
  - (ii) Surgery to treat congenital defects (such as cleft lip and cleft palate) to restore normal bodily function
  - (iii) Surgery to reconstruct a breast after mastectomy that was done to treat a disease, or as a continuation of a staged reconstructive procedure
  - (iv) In accordance with Tennessee law, surgery of the non-diseased breast following mastectomy and reconstruction to create symmetrical appearance
  - (v) Surgery for the improvement of the functioning of a malformed body member
  - (vi) Reduction mammoplasty, except that reduction mammoplasty will only be deemed medically necessary if the minimum amount of breast material to be removed is equal to or greater than the 22nd percentile of the Schnur Sliding Scale based on the individual's body surface area.
23. Cushions, pads, and mattresses including, but not limited to:
- (i) Aquamatic K Pads
  - (ii) Elbow protectors
  - (iii) Heat and massage foam cushion pads
  - (iv) Heating pads

## RULEMAKING HEARINGS

- (v) Heel protectors
  - (vi) Lamb's wool pads
  - (vii) Steam packs
24. Dance therapy
25. Dental implant services including implant supported prosthesis
26. Dental services for adults age 21 and older
27. Educational services including, but not limited to:
- (i) Academic performance testing
  - (ii) Educational tests and training programs
  - (iii) Habilitation
  - (iv) Job training
  - (v) Lamaze classes
  - (vi) Lova as therapy
  - (vii) Picture illustrations
  - (viii) Remedial education
  - (ix) Sign language instruction
  - (x) Special education
28. Encounter groups or workshops
29. Environmental modifications including, but not limited to:
- (i) Air cleaners or purifiers
  - (ii) Air conditioners, central or unit
  - (iii) Dehumidifiers
  - (iv) Humidifiers, central or room
  - (v) Micronaire environmentals, and similar devices
  - (vi) Pollen extractors
  - (vii) Portable room heaters
  - (viii) Vacuum systems for dust filtering

## RULEMAKING HEARINGS

- (ix) Water purifiers
  - (x) Water softeners
30. Exercise equipment including, but not limited to:
- (i) Exercise equipment
  - (ii) Exercycles (including cardiac use)
  - (iii) Functional electrical stimulation
  - (iv) Gravitronic traction devices
  - (v) Gravity guidance inversion boots
  - (vi) Parallel bars
  - (vii) Pulse tachometers
  - (viii) Tilt tables
  - (ix) Training balls
  - (x) Treadmill exercisers
  - (xi) Weighted quad boots
31. Footwear and orthotics, including all forms and types of shoes and shoe inserts, except for the following:
- (i) Therapeutic shoes for treatment or prevention of foot complications associated with diabetes mellitus, as required by Tennessee law
  - (ii) Shoes that are an integrated part of a leg brace.
32. Grooming services including, but not limited to:
- (i) Barber services
  - (ii) Beauty services
  - (iii) Electrolysis
  - (iv) Hairpieces or wigs
  - (v) Manicures
  - (vi) Pedicures
33. Hair analysis
34. Home improvements and furnishings including, but not limited to:

## RULEMAKING HEARINGS

- (i) Decks
  - (ii) Electric powered recliners, elevator seats, and lift chairs
  - (iii) Elevators
  - (iv) Enlarged doorways
  - (v) Environmental accessibility modifications such as grab bars and ramps
  - (vi) Fences
  - (vii) Furniture, indoor or outdoor
  - (viii) Handrails
  - (ix) Meals, home delivered
  - (x) Minor home modifications
  - (xi) Overbed tables
  - (xii) Plexiglass
  - (xiii) Plumbing repairs
  - (xiv) Porch gliders
  - (xv) Rollabout chairs
  - (xvi) Room additions and room expansions
  - (xvii) Stair glides
  - (xviii) Telephone alert systems
  - (xix) Telephone arms
  - (xx) Telephone service in home
  - (xxi) Televisions
  - (xxii) Tilt tables
  - (xxiii) Toilet trainers
35. Homemaker services not performed by a licensed home health agency
36. Hospital inpatient items that are not directly related to the treatment of an injury or illness (such as radios, TVs, movies, telephones, massage, guest beds, haircuts, hair styling, guest trays, etc.)

## RULEMAKING HEARINGS

37. Hotel charges, unless pre-approved in conjunction with a transplant or as part of a non-emergency transportation service
38. Hypnosis or hypnotherapy
39. Icterus index
40. Infant/child car seats, except that adaptive car seats may be covered for a person with disabilities such as severe cerebral palsy, spina bifida, muscular dystrophy, and similar disorders who meets all of the following conditions:
  - (i) Cannot sit upright unassisted, and
  - (ii) Infant/child care seats are too small or do not provide adequate support, and
  - (iii) Safe automobile transport is not otherwise possible.
41. Infertility or impotence services including, but not limited to:
  - (i) Artificial insemination services
  - (ii) Purchase of donor sperm and any charges for the storage of sperm
  - (iii) Purchase of donor eggs, and any charges associated with care of the donor required for donor egg retrievals or transfers of gestational carriers
  - (iv) Cryopreservation and storage of cryopreserved embryos
  - (v) Services associated with a gestational carrier program (surrogate parenting) for the recipient or the gestational carrier
  - (vi) Fertility drugs
  - (vii) Home ovulation prediction kits
  - (viii) Services for couples in which one of the partners has had a previous sterilization procedure, with or without reversal
  - (ix) Reversal of sterilization procedures
  - (x) Any other service or procedure intended to create a pregnancy
  - (xi) Testing and/or treatment, including therapy, supplies, and counseling, for frigidity or impotence
42. Lamps such as:
  - (i) Heating lamps
  - (ii) Lava lamps
  - (iii) Sunlamps

## RULEMAKING HEARINGS

- (iv) Ultraviolet lamps
- 43. Lifts including, but not limited to:
  - (i) Automobile van lifts
  - (ii) Burke bed elevators
  - (iii) Cheney safety bath lifts
  - (iv) Electric powered recliner and elevating seats
  - (v) Elevators
  - (vi) Hoyer lifts, except when:
    - (I) The enrollee's condition is such that periodic movement is necessary to effect improvement or to arrest or retard deterioration; and
    - (II) Transfer between bed and chair, wheelchair, or commode requires the assistance of more than one person; and
    - (III) Without the use of a lift, the enrollee would be confined to bed; and
    - (IV) Medical records contain documentation which supports medical necessity.
  - (vii) Lift chairs
  - (viii) Liko maneuvering lift or Liko ceiling track lift systems, except when:
    - (I) Enrollee's condition is such that periodic movement is necessary to effect improvement or to arrest or retard development; and
    - (II) Transfer between bed and chair, wheelchair, or commode requires the assistance of more than one person; and
    - (III) Without the use of a lift, the enrollee would be confined to bed; and
    - (IV) Medical records contain information which supports medical necessity; and
    - (V) Structural modification to the dwelling is minor, limited primarily to installment of equipment, and does not involve major renovation (e.g., moving walls, enlarging assageways, strengthening ceilings and supports
  - (ix) Stairway lifts, stair glides
  - (x) Wheel-O-Vators
- 44. Ligation of mammary arteries, unilateral or bilateral
- 45. Megavitamin therapy

## RULEMAKING HEARINGS

46. Medical supplies, over-the-counter, including, but not limited to:
  - (i) Alcohol, rubbing
  - (ii) Antiseptics
  - (iii) Band-aids
  - (iv) Bandages
  - (v) Cotton balls
  - (vi) Cotton swabs
  - (vii) Creams, medicated, over-the-counter
  - (viii) Dressings
  - (ix) Eyewash
  - (x) Gauze
  - (xi) Peroxide
  - (xii) Q-tips
  - (xiii) Tape
  - (xiv) Wound dressing material for home use
47. Motor vehicle parts and services including, but not limited to:
  - (i) Automobile controls
  - (ii) Automobile repairs or modifications
48. Music therapy
49. Nail analysis
50. Naturopathic services
51. Necropsy
52. Nerve stimulators, except for vagus nerve stimulators after conventional therapy has failed in treating partial onset of seizures
53. Nutritional supplements and vitamins, over-the-counter, except for prenatal vitamins and folic acid for pregnant women
54. Organ and tissue transplants that have been determined experimental or investigational

## RULEMAKING HEARINGS

55. Organ donor services provided in connection with organ or tissue transplants, including, but not limited to:
  - (i) Transplants from a donor who is a living TennCare enrollee and the transplant is to a non-TennCare enrollee
  - (ii) Donor services other than the direct services related to organ procurement (such as, hospitalization, physician services, anesthesia)
  - (iii) Hotels, meals, or similar items provided outside the hospital setting for the donor
  - (iv) Any costs incurred by the next of kin of the donor
  - (v) Any services provided outside of any “bundled rates” after the donor is discharged from the hospital
56. Oxygen, except when provided under the order of a physician and administered under the direction of a physician
57. Oxygen, preset system (flow rate not adjustable)
58. Certain pharmacy items, including:
  - (i) Agents to promote smoking cessation
  - (ii) Agents to promote hair growth
  - (iii) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or his designee
  - (iv) DESI, LTE, and IRS drugs
  - (v) Over-the-counter drugs for which there is no prescription
  - (vi) Prescriptions filled that exceed the quantity limits established through prior authorization\_
59. Play therapy
60. Primal therapy
61. Psychodrama
62. Psychogenic sexual dysfunction or transformation services
63. Purging
64. Recertification of patients in Level 1 and Level II Nursing Facilities
65. Recreational therapy
66. Religious counseling

## RULEMAKING HEARINGS

67. Retreats for mental disorders
68. Rolfing
69. Routine health services which may be required by an employer; or by a facility where an individual lives, goes to school, or works; or by travel plans
  - (i) Drug screenings
  - (ii) Employment and pre-employment physicals
  - (iii) Fitness to duty examinations
  - (iv) Immunizations related to travel or work
  - (v) Insurance physicals
  - (vi) Job related illness or injury covered by workman's compensation
70. Sensitivity training or workshops
71. Sensory integration therapy and equipment used in sensory integration therapy including, but not limited to:
  - (i) Ankle weights
  - (ii) Floor mats
  - (iii) Mini-trampolines
  - (iv) Poof chairs
  - (v) Sensory balls
  - (vi) Sky chairs
  - (vii) Suspension swings
  - (viii) Trampolines
  - (ix) Therapy balls
  - (x) Weighted blankets or weighted vests
72. Sensory stimulation services
73. Services provided by immediate relatives, i.e., a spouse, parent, grandparent, step-parent, child, grandchild, brother, sister, half brother, half sister, a spouse's parents or stepparents, or members of the recipient's household
74. Sex change or transformation surgery

## RULEMAKING HEARINGS

75. Sexual dysfunction or inadequacy services and medicine, including drugs for erectile dysfunctions and penile implant devices
76. Speech devices including:
  - (i) Phone mirror handivoice
  - (ii) Speech software
  - (iii) Speech teaching machines
77. Sphygmomanometers (blood pressure cuffs)
78. Stethoscopes
79. Supports
  - (i) Cervical pillows
  - (ii) Orthotrac pneumatic vests
80. Thermograms
81. Thermography
82. Time involved in completing necessary forms, claims, or reports
83. Tinnitus maskers
84. Toy equipment such as:
  - (i) Flash switches (for toys)
85. Transportation costs such as:
  - (i) Transportation to a provider who is outside the geographical access standards that the MCC is required to meet when a network provider is available within such geographical access standards
  - (ii) Use of a private vehicle when transportation services have been offered through the MCC
86. Transsexual surgery
87. Vision services for persons 21 years of age and older that are not needed to treat a systemic disease process including, but not limited to:
  - (i) Eyeglasses, sunglasses, and/or contact lenses for persons aged 21 and older, including eye examinations for the purpose of prescribing, fitting, or changing eyeglasses, sunglasses, and/or contact lenses; procedures performed to determine the refractive state of the eye(s).
  - (ii) LASIK

## RULEMAKING HEARINGS

- (iii) Orthoptics
  - (iv) Vision perception training
  - (v) Vision therapy
88. Vitamins, except for prescription prenatal vitamins for prenatal patients, fluoride vitamins for children, and folic acid for prenatal patients
89. Weight loss or weight gain and physical fitness programs including, but not limited to:
- (i) Dietary programs of weight loss programs, including, but not limited to, Optifast, Nutrisystem, and other similar programs or exercise programs. Food supplements will not be authorized for use in weight loss programs or for weight gain.
  - (ii) Health clubs, membership fees (e.g., YMCA)
  - (iii) Marathons, activity and entry fees
  - (iv) Swimming pools
90. Wheelchairs, specialized, such as:
- (i) Amigo motorized wheelchairs, or similar devices
  - (ii) Rollabout chairs
  - (iii) Scooters
  - (iv) Standing wheelchairs
91. Whirlpools and whirlpool equipment such as:
- (i) Action bath hydro massage
  - (ii) Aero massage
  - (iii) Aqua whirl
  - (iv) Aquasage pump, or similar devices
  - (v) Hand-D-Jets, or similar devices
  - (vi) Jacuzzis, or similar devices
  - (vii) Turbojets
  - (viii) Whirlpool bath equipment
  - (ix) Whirlpool pumps

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

## RULEMAKING HEARINGS

The notice of rulemaking set out herein was properly filed in the Department of State on the 30th day of June, 2005. (06-74)

## RULEMAKING HEARINGS

### **TENNESSEE DEPARTMENT OF HEALTH - 1200 BUREAU OF HEALTH LICENSURE AND REGULATION DIVISION OF EMERGENCY MEDICAL SERVICES**

There will be a hearing before the Division of Emergency Medical Services to consider the promulgation of amendments of rules pursuant to T.C.A. §§68-140-504, 68-140-508, 68-140-509, 68-140-517, and 68-140-518. The hearing will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, Tennessee Code Annotated, Section 4-5-204 and will take place in the Magnolia Room of the Cordell Hull Building, Ground Floor, located at 425 Fifth Avenue North, Nashville, Tennessee at 9:00 a.m., Central Standard Time, on the 31<sup>st</sup> day of August, 2005.

Any individuals with disabilities who wish to participate in these proceedings or review these filings should contact the Department of Health, Division of Emergency Medical Services to discuss any auxiliary aids or services needed to facilitate such participation. Such initial contact may be made no less than ten (10) days prior to the scheduled meeting date or the date the party plans to review such filings, to allow time for the Division of Emergency Medical Services to determine how it may reasonably provide such aid or service. Initial contact may be made with Richard F. Land, Director of Ambulance Service Licensure and Regulation, Division of Emergency Medical Services, Cordell Hull Building, First Floor, 425 Fifth Avenue, North, Nashville, TN 37247-0701, 615-741-2584.

For a copy of the entire text of the notice of rulemaking, contact Richard F. Land, Director of Ambulance Service Licensure and Regulation, Division of Emergency Medical Services, Cordell Hull Building, First Floor, 425 Fifth Avenue, North, Nashville, TN 37247-0701, 615-741-2584.

### **SUBSTANCE OF PROPOSED RULES**

#### **AMENDMENTS OF RULE**

Rule 1200-12-1-.04 Emergency Medical Technician is amended by deleting the existing language of subparagraph (2)(c) in its entirety and substituting the following language, and renumbering the subparagraphs appropriately, so that as amended the paragraph shall read:

- (2) EMT Paramedic Requirements
  - (a) Must meet all the Emergency Medical Technician licensure requirements in paragraph (1).
  - (b) Must successfully complete an EMT Paramedic course accredited or recognized by the Division of Emergency Medical Services of the Tennessee Department of Health.
  - (c) Must successfully complete an EMS Board approved Emergency Medical Technician Paramedic level course, including completion of all examinations within one (1) year of completion of training.
    - I. Written Examination
      - (i) Achieve a passing score on a Board approved examination with a minimum score as established by the Board.

## RULEMAKING HEARINGS

- (ii) Applicants who fail to pass the examination shall be eligible to reapply for examination.
2. Practical Examination
- (i) An EMS Board approved practical examination must be successfully completed by all applicants.
  - (ii) Applicants who fail to pass the practical examination shall be eligible to reapply for examination.
- (d) Must submit an Application for Licensure form as provided by the Division of Emergency Medical Services.
- (e) Must remit the appropriate licensure and application fees, if applicable, as determined under rule 1200-12-1-.06.

Subparagraphs (a) and (b) of paragraph (7) of rule 1200-12-1-.04 Emergency Medical Technician are amended by deleting the existing language in its entirety and substituting the following language and renumbering the subparagraphs appropriately, so that as amended the paragraph shall read:

(7) Reinstatement of a lapsed license

(a) Emergency Medical Technician

1. When the license has lapsed for one (1) year or less, an individual may reinstate the license by meeting and completing all applicable license and license renewal standards, successfully completing the EMT license written examination (attaining a minimum score as established by the Board) and submitting all applicable fees.
2. When the license has lapsed for more than one (1) year, but less than two (2) years an individual may reinstate the license by completion of an EMS Board approved refresher course; achieving a passing score on a Board approved examination with a minimum score as established by the Board and successfully completing an EMS Board approved practical examination and submitting all applicable fees.
3. When the license has lapsed for two (2) year or more, an individual must complete the EMT course in its entirety and comply with license requirements in effect under paragraph (1).

(b) The EMT-Paramedic

1. When the license has lapsed for one (1) year or less, an individual may reinstate the license by meeting and completing all applicable license and license renewal standards, successfully completing the Board approved EMT-P license written examinations, attaining a minimum score as established by the Board, and submitting all applicable fees.
2. When the license has lapsed for more than one (1) year, but less than two (2) years an individual may reinstate the license by completion of an EMS Board approved

## RULEMAKING HEARINGS

EMT-P refresher course; achieving a passing score on a Board approved Paramedic written examination with a minimum score as established by the Board and successfully completing an EMS Board approved EMT-P practical examination and submitting all applicable fees.

3. When the license has lapsed for more than two (2) years, an individual must complete the EMT-Paramedic course in its entirety and comply with license requirements.

Paragraphs (8) and (9) of rule 1200-12-1-.04 Emergency Medical Technician are amended by deleting the existing captions and language in their entirety and substituting the following language, adding a new paragraph (9) and renumbering the existing paragraph (9) appropriately as paragraph (10) , so that as amended the paragraphs shall read:

- (8) Out-of-state requirements for License. Any EMT or EMT-Paramedic who holds current certification/license from another state or country and who has successfully completed an approved U.S. Department of Transportation EMT or EMT-Paramedic course or equivalent curriculum may apply for Tennessee EMT or EMT-Paramedic license by complying with the following:
  - (a) conform to all license requirements for Tennessee Emergency Medical Technicians or EMT-Paramedics; and
  - (b) submit appropriate documentation of extended skills training conducted by an authorized instructor of a Tennessee Accredited EMS Training Institutions; or documentation of extended skills training from an authorized training agency of another state or country; and
  - (c) successful completion of any EMS Board approved written and practical examinations.
  - (d) submit the appropriate application forms and fees, if applicable, to the Division of Emergency Medical Services.
- (9) Out-of-state requirements for License of federal or ex-federal employees. Any EMT or EMT-Paramedic who has successfully completed an approved U.S. Department of Transportation EMT Basic or EMT Paramedic course while employed with the federal government and who holds current certification from National Registry of Emergency Medical Technicians for the Emergency Medical Technician-Basic or Emergency Medical Technician– Paramedic may apply for Tennessee EMT or EMT-Paramedic license by complying with the following:
  - (a) conform to all license requirements for Tennessee Emergency Medical Technicians or EMT-Paramedics; and
  - (b) submit appropriate documentation of extended skills training conducted by an authorized instructor of a Tennessee Accredited EMS Training Institution; or documentation of extended skills training from a federally approved training agency; and
  - (c) submit the appropriate application forms and fees, if applicable, to the Division of Emergency Medical Services.
- (10) Personnel licensed by the Department, upon a change of name or address shall notify the Division of Emergency Medical Services in writing within thirty (30) days of such change. Notifications for renewal or disciplinary action shall be posted to the address listed on file with the Division and, unless returned by the post office, shall constitute effective notice for renewal or action upon

RULEMAKING HEARINGS

license status. Return by the post office shall be interpreted as a willful violation for failure to retain a current address on file.

**Authority:** T.C.A. §§ 4-5-202, 4-5-204, 68-140-504, 68-140-508, 68-140-509, and 68-140-518.

Subparagraph (a) of paragraph (4) of rule 1200-12-1-.06 Schedule of Fees is amended by adding a new license fee for Emergency Medical Technician – Paramedic Critical Care as a new part, so that as amended the subparagraph shall read:

- (4) Emergency Medical Services Personnel Fees – Personnel applying for licensure, certification, authorization, renewal, or reinstatement shall remit application processing and license fees as follows.

- (a) Fees for licensed personnel

	Application	License
1. Emergency Medical Technican –Basic	\$50.00	\$75.00
2. Emergency Medical Technican –Basic -IV	\$70.00	\$80.00
3. Emergency Medical Tech. – Paramedic	\$75.00	\$100.00
4. Emergency Medical Tech. Paramedic Critical Care – Initial Application for Endorsement	\$75.00	
5. Initial Instructor Authorization	\$35.00	

**Authority:** T.C.A. §§ 4-5-202, 4-5-204, 68-140-504, 68-140-506, 68-39-508, and 68-140-517.

The notice of rulemaking set out herein was properly filed in the Department of State on the 29th day of June, 2005. (06-60)

RULEMAKING HEARINGS

**THE TENNESSEE DEPARTMENT OF HEALTH - 1200  
DIVISION OF EMERGENCY MEDICAL SERVICES**

There will be a hearing before the Division of Emergency Medical Services to consider the promulgation of amendments of rules pursuant to T.C.A. §§ 68-140-504, 68-140-506, 68-140-508, and 68-140-509. The hearing will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, Tennessee Code Annotated, Section 4-5-204 and will take place in the Magnolia Room of the Cordell Hull Building, Ground Floor, located at 425 Fifth Avenue North, Nashville, Tennessee at 11:00 a.m., Central Daylight Time, on the 31<sup>st</sup> day of August, 2005.

Any individuals with disabilities who wish to participate in these proceedings or review these filings should contact the Department of Health, Division of Emergency Medical Services to discuss any auxiliary aids or services needed to facilitate such participation. Such initial contact may be made no less than ten (10) days prior to the scheduled meeting date or the date the party plans to review such filings, to allow time for the Division of Emergency Medical Services to determine how it may reasonably provide such aid or service. Initial contact may be made with Richard F. Land, Director of Ambulance Service Licensure and Regulation, Division of Emergency Medical Services, Cordell Hull Building, First Floor, 425 Fifth Avenue, North, Nashville, TN 37247-0701, 615-741-2584.

For a copy of the entire text of the notice of rulemaking, contact Richard F. Land, Director of Ambulance Service Licensure and Regulation, Division of Emergency Medical Services, Cordell Hull Building, First Floor, 425 Fifth Avenue, North, Nashville, TN 37247-0701, 615-741-2584.

**SUBSTANCE OF PROPOSED RULES**

**NEW RULE**

**CHAPTER 1200-12-4  
EMERGENCY MEDICAL TECHNICIAN OR EMERGENCY MEDICAL TECHNICIAN-PARAMEDIC IN  
HOSPITAL EMERGENCY SERVICES**

**TABLE OF CONTENTS**

1200-12-4-.01 Responsibilities in Hospital Emergency Services      1200-12-4-.02 Each hospital to maintain evidence of training

1200-12-4-.01 Responsibilities of the Emergency Medical Technician (EMT) or Emergency Medical Technician-Paramedic (EMT-P) when providing patient care while functioning in Hospital Emergency Services under nursing supervision.

- (1) Emergency Medical Technicians and Emergency Medical Technician-Paramedics shall be permitted to perform extended skills or procedures when such treatment is conducted under authorized medical control and nursing supervision and within the scope of practice as identified in 1200-12-1-.04 Paragraph (3).
- (2) All individuals who are employed in this capacity shall demonstrate continued training and competence in order to perform their professional duties.

## RULEMAKING HEARINGS

1200-12-4-.02 Each hospital employing an Emergency Medical Technician or EMT-Paramedic in hospital emergency services will maintain evidence of the continued competence of such individuals, including records of any in-service training or continuing education.

**Authority:** *T.C.A. §§ 4-5-202, 4-5-204, 68-140-504, 68-140-508, and 68-140-509.*

The notice of rulemaking set out herein was properly filed in the Department of State on the 29th day of June, 2005. (06-61)

## RULEMAKING HEARINGS

### THE TENNESSEE DEPARTMENT OF HEALTH - 1200 DIVISION OF EMERGENCY MEDICAL SERVICES

There will be a hearing before the Division of Emergency Medical Services to consider the promulgation of amendments of rules pursuant to T.C.A. §§ 68-140-504, 68-140-506, 68-140-508, 68-140-509, and 68-140-517. The hearing will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, Tennessee Code Annotated, Section 4-5-204 and will take place in the Magnolia Room of the Cordell Hull Building, Ground Floor, located at 425 Fifth Avenue North, Nashville, Tennessee at 10:00 a.m., Central Daylight Time, on the 31<sup>st</sup> day of August, 2005.

Any individuals with disabilities who wish to participate in these proceedings or review these filings should contact the Department of Health, Division of Emergency Medical Services to discuss any auxiliary aids or services needed to facilitate such participation. Such initial contact may be made no less than ten (10) days prior to the scheduled meeting date or the date the party plans to review such filings, to allow time for the Division of Emergency Medical Services to determine how it may reasonably provide such aid or service. Initial contact may be made with Richard F. Land, Director of Ambulance Service Licensure and Regulation, Division of Emergency Medical Services, Cordell Hull Building, First Floor, 425 Fifth Avenue, North, Nashville, TN 37247-0701, 615-741-2584.

For a copy of the entire text of the notice of rulemaking, contact Richard F. Land, Director of Ambulance Service Licensure and Regulation, Division of Emergency Medical Services, Cordell Hull Building, First Floor, 425 Fifth Avenue, North, Nashville, TN 37247-0701, 615-741-2584.

### SUBSTANCE OF PROPOSED RULES

#### NEW RULES

#### 1200-12-5 CRITICAL CARE PARAMEDIC

#### TABLE OF CONTENTS

1200-12-5-.01	Preamble and Endorsement	1200-12-5-.03	Critical Care Paramedic Requirements.
1200-12-5-.02	Scope of Practice for Critical Care Paramedic.	1200-12-5-.04	Critical Care Paramedic Training Programs.

**1200-12-5-.01 PREAMBLE:** To provide for the on-going care of a critically injured or ill patient during an inter-facility transport and other special situations, the Tennessee Emergency Medical Services Board authorizes endorsement of EMT-Paramedics with additional training to perform special critical care. The Emergency Medical Technician-Paramedic Critical Care shall be a person who is licensed as a Tennessee Emergency Medical Technician Paramedic and has successfully completed a critical care paramedic course recognized by the Division of Emergency Medical Services, Tennessee Department of Health or comparable training and education, and received endorsement from the training institution and the department, and who is licensed to practice advanced emergency medical care upon the order or under the supervision of a physician or authorized registered nurse.

**1200-12-5-.02 SCOPE OF PRACTICE FOR CRITICAL CARE PARAMEDIC:** An experienced Paramedic who has received additional training and possesses the following skills can conduct care for critically ill patients of all ages through the ability to:

## RULEMAKING HEARINGS

- (1) Provide patient care during transport and in special situations with such devices as are approved by the EMS Board.
- (2) Access existing and manage invasive lines such as but not limited to: Parenteral Internal Central Catheters (PICC), Hickman catheters, Portacaths, central, and arterial lines.
- (3) Initiate and manage ventilators.
- (4) Manage care of tracheostomy tubes.
- (5) Initiate and manage surgical airways.
- (6) Provide care for cardiac patients, with but not limited to, cardiac interventions and advanced therapeutic devices.
- (7) Perform and interpret 12-lead electrocardiograms.

**1200-12-5-.03 CRITICAL CARE PARAMEDIC REQUIREMENTS.** All persons desiring endorsement of their Paramedic license as a Critical Care Paramedic pursuant to T.C.A Title 68, Chapter 140, Part 5 must comply with the following requirements and standards:

- (1) Emergency Medical Technician Paramedic Critical Care Paramedic endorsement requirements:
  - (a) Must meet all the Emergency Medical Technician Paramedic requirements in 1200-12-1-.04(2) and must be currently licensed as paramedic in good standing in Tennessee and submit an application and fees to the Division for modification of the license by endorsement demonstrating:
    1. Successful completion of a Board approved Critical Care Paramedic Program; and,
    2. Successful completion with a passing score as established by the Board on an approved endorsement examination.
      - (i) After the third attempt to complete the exam an individual must show remediation from the critical care program before they may take the examination again.
      - (ii) After six unsuccessful attempts in less than two years, the individual must repeat the entire training before attempting examination.
  - (b) Endorsement must be obtained within two years of completion of an approved course.
- (2) Individuals completing a Critical Care Paramedic Course prior to effective date of this rule may make application for endorsement. Individuals must show documentation of completion of a Critical Care Paramedic Course and must complete a qualifying examination as outlined in (1) (a) 2. Individuals will have two (2) years to complete the examination requirements before being required to repeat the course.
- (3) Emergency Medical Technician Paramedic Critical Care or such students during training in an approved Critical Care Program may utilize procedures under medical control as identified (above in .02, Scope of Practice).

## RULEMAKING HEARINGS

- (4) Continued endorsement is contingent on renewal of Emergency Medical Technician Paramedic license and meeting the following requirements:
  - (a) Shall demonstrate a minimum of ten (10) additional continuing education contact hours in critical care topics within a two year period in order to perform their professional duties.
  - (b) Continued competence activities may include but are not limited to continuing education, in-service, and attendance and participation in other approved critical care programs.

### **1200-12-5-.04 EMERGENCY MEDICAL TECHNICIAN- PARAMEDIC -CRITICAL CARE PARAMEDIC TRAINING PROGRAMS.**

- (1) Definitions. Within this Rule, the following terms shall apply:
  - (a) Approval: Means the process of training program approval used to assure compliance with the requirements of the Tennessee Emergency Medical Services Board and the policies of the Division of Emergency Medical Services.
  - (b) Approved Program: Means a training program approved by the Tennessee Emergency Medical Services Board.
  - (c) Contract or Agreement: Means a written agreement between the training program and the cooperating agency.
- (2) All programs offered by facilities, institutions, or agencies desiring to qualify applicants for EMT-P Critical Care endorsement shall conform to the standards approved by the Tennessee Emergency Medical Services Board and such rules as shall be promulgated by the Department.
  - (a) Purpose of Approval
    - 1. To insure the safety and quality of practice by the Emergency Medical Technician Paramedic - Critical Care (EMT-P CC) by setting standards for each program preparing the critical care provider.
    - 2. To insure graduates of approved programs eligibility for endorsement.
- (3) Approval shall be categorized, and awarded or revoked in accordance with the following criteria.
  - (a) Initial approval is granted a new program that has not been in operation long enough to complete its first class but demonstrates its eligibility for full approval. The program shall be reviewed after one year or when the first students complete the program.
  - (b) Full approval is granted a program that has met the requirements that are set forth by the EMS Board and the policies of the Division of EMS.
  - (c) Conditional approval may be accorded a program which has failed to maintain minimum standards and has been notified that it must meet the requirements within a specified time period.

## RULEMAKING HEARINGS

- (d) Approval shall be denied for cause or may be revoked or conditioned for failure to comply with the standards established by the board.
  - (e) Renewal of approval. Renewal shall be based on recommendations of the Division to the Board utilizing surveys, site visits, conferences, review of documentation instructor student ratio, instructor qualifications and related evidence of continuing compliance with the regulations of the Board and policies of the Division. If deficiencies are not corrected within the specified time, and until such action is approved by the board, the program shall not convene a subsequent class.
- (4) Philosophy, Purpose, Capabilities and Organization
- (a) All facilities, institutions, or agencies seeking initial and continuing approval shall have a written statement of the educational philosophy and purpose of the program.
  - (b) Capabilities:
    - 1. The facilities, institutions, or agencies shall maintain liaison with a hospital which is capable of supporting Critical Care Paramedic Clinical training; and,
    - 2. The institution shall ensure the financial support, equipment, facilities, and leadership which will provide for a sound educational program; and,
    - 3. The institution shall ensure student competency in knowledge and experience and shall endorse participants for eligibility to complete endorsement examinations.
  - (c) Organization:
    - 1. The facilities, institutions, or agencies shall demonstrate effective organization and shall be administered in ways conducive to the management of program.
    - 2. An accurate, comprehensive record system shall be maintained for all phases of the program and shall be available for inspection during survey visits.
- (5) Faculty: The faculty shall be experienced in the field area for course content, such as, but not limited to, critical care professionals, attorneys, and Registered Respiratory Therapists.
- (6) Medical Director
- (a) Each program shall have a licensed physician who serves as the medical advisor.
- (7) Student admission:
- (a) Each student must hold a current license as a Paramedic in Tennessee with a minimum of two years experience as an Advanced Care Provider; and,
  - (b) Must hold current certification in an Advanced Cardiac Life Support, Pediatric Advanced Life Support, and an advanced Trauma Care course.
- (8) Training Facilities

## RULEMAKING HEARINGS

- (a) Classrooms, Laboratories, Offices. Facilities, institutions, or agencies shall provide adequate teaching facilities and laboratories and clinical areas sufficient for instruction.
  - (b) Clinical Facilities: The clinical facilities must provide for student learning experiences as identified in the Board approved curriculum.
- (9) Curriculum Review: A copy of the complete curriculum, statements of course objectives, copies of course outlines, class schedules, schedules of supervised clinical experience, and teaching plans shall be on file and available for review and inspections by an authorized representative of the EMS Division with other information as follows:
- (a) Evidence of student competency in achieving the performance for educational objectives of the program shall be kept on file.
  - (b) Procedures for evaluation of teaching effectiveness and instruction shall be established by the program.
- (10) Only students from Tennessee approved programs or having completed an equivalent curriculum in other states, as determined by the board or the Division shall be eligible for State endorsement.

**Authority:** T.C.A. § 4-5-202, 4-5-204, 68-140-504, 68-140-506, 68-140-508, and 68-140-517.

The notice of rulemaking set out herein was properly filed in the Department of State on the 29th day of June, 2005. (06-62)

## RULEMAKING HEARINGS

### THE TENNESSEE WILDLIFE RESOURCES COMMISSION - 0660

There will be a hearing before the Tennessee Wildlife Resources Commission to consider the promulgation of rules, amendments of rules, or repeals of rules pursuant to Tennessee Code Annotated, Section 70-1-206. The hearing will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, Tennessee Code Annotated, Section 4-5-204 and will take place in the Region II Conference Room of the Tennessee Wildlife Resources Agency, Ray Bell Region II Building, 5105 Edmondson Pike, Nashville, Tennessee, at 9:00 a.m., local time, on the 18th day of August, 2005.

Any individuals with disabilities who wish to participate in these proceedings (to review these filings) should contact the Tennessee Wildlife Resources Agency to discuss any auxiliary aids or services needed to facilitate such participation. Such initial contact may be made no less than ten (10) days prior to the scheduled meeting date (the date the party intends to review such filings), to allow time for the Tennessee Wildlife Resources Agency to determine how it may reasonably provide such aid or service. Initial contact may be made with the Tennessee Wildlife Resources Agency ADA Coordinator, Carolyn Wilson, Room 229, Tennessee Wildlife Resources Agency Building, Ellington Agricultural Center, Nashville, Tennessee 37204, telephone number (615)781-6594.

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

### SUBSTANCE OF PROPOSED RULES

#### AMENDMENT

Rule 1660-1-8-.03 Permit Requirements - Wildlife Management areas, Refuges and Other Agency Controlled Lands, Paragraph (1)(b) is amended by deleting it in its entirety and inserting the following language so it shall read:

- (b) Hunt applicants or participants must be seventeen (17) years of age or over for hunting turkey, deer, bear and hog, except that youths, ages 6-16, may apply and participate if they are accompanied on the hunt by an adult, twenty-one (21) years of age or older. Youths under sixteen (16) years of age are exempt from purchasing an area hunt permit on all wildlife management areas and refuges when hunting any species except big game, but they must be accompanied on the hunt by an adult who possesses a valid hunt permit.

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

Rule 1660-1-8-.03 Permit Requirements - Wildlife Management areas, Refuges and Other Agency Controlled Lands, Paragraph (3) is amended by deleting it in its entirety and inserting the following language so it shall read:

- (3) Before any person, except those under 16 years of age hunting small game and waterfowl, may hunt on a wildlife management area or refuge, he must possess a permit as outlined below.
  - (a) A WMA Small Game permit is required on the following wildlife management areas and refuges:

## RULEMAKING HEARINGS

AEDC	Cypress Pond	Natchez Trace
Alpine Mountain	Eagle Creek	New Hope
Arnold Hollow	Eagle Lake Refuge	Nolichucky
Bark Camp Barrens	Ernest Rice Sr.	North Chickamauga Creek
Barkley Units I & II	Foothills	Oak Ridge
Bean Switch Refuge	Forks of the River	Obion River
Bear Hollow Mountain	Haley-Jaqueth	Old Hickory (Unit I)
Beaver Dam Creek	Harmon Creek	Old Hickory Lock 5 Refuge
Big Sandy (including Gin Creek)	Haynes Bottom	Pea Ridge
Black Bayou Refuge	Henderson Island Refuge	Percy Priest (Units I & II)
Bogota	Hick Hill	Perryville
Bridgestone/Firestone Centennial	Hickory Flat	Prentice Cooper
Wilderness	Hiwassee Refuge	Rankin
Browntown	Holly Fork	Royal Blue
Buffalo Springs	Hop-In Refuge	Shelby Forest
Camden Units I & II	Jackson Swamp	Shelton Ferry
Catoosa	Jarrell Switch Refuge	Sundquist
Cheatham	John Tully	Tellico Lake
Cheatham Lake	Kingston Refuge	Tie Camp
Chickamauga (Candies Creek, Johnson Bottoms, Rogers Creek, Yellow Creek Units)	Kyker Bottoms Refuge	Watts Bar (Long Island Unit)
Chuck Swan	Kyles Ford	West Sandy
Cold Creek	Laurel Hill	White Lake Refuge
Cordell Hull	Lick Creek	White Oak
Cordell Hull Refuge	Lick Creek Bottoms	Williamsport
Cove Creek	Maness Swamp Refuge	Wolf River
C. M. Gooch	Maple Springs	Woods Reservoir Refuge
	Mingo Swamp	Yanahli
	Moss Island	Yuchi Refuge at Smith Bend
	MTSU	

## RULEMAKING HEARINGS

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

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

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

## RULEMAKING HEARINGS

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

AEDC	Fall Creek Fall State Park	Nolichucky
Alpine Mountain	Foothills	North Chickamauga Creek
Arnold Hollow	Forks of the River	Oak Ridge
Bark Camp Barrens	Gallatin Steam Plant	Obion River
Barkley Units I & II	Harmon Creek	Old Hickory (Unit I)
Bear Hollow Mountain	Haynes Bottom	Old Hickory Lock 5 Refuge
Bean Switch Refuge	Henderson Island Refuge	Pea Ridge
Beaver Dam Creek	Hick Hill	Percy Priest (Units I & II)
Big Sandy (including Gin Creek)	Hickory Flat	Perryville
Bogota	Hiwassee Refuge	Prentice Cooper
Bridgestone/Firestone Centennial	Holly Fork	President's Island
Wilderness	Hop-In Refuge	Rankin
Browntown	International Paper	Royal Blue
Buffalo Springs	Jackson Swamp	Shelby Forest
C. M. Gooch	Jarrell Switch Refuge	Shelton Ferry
Camden Units I & II	John Tully	Sundquist
Catoosa	Kingston Refuge	Tellico Lake
Cheatham	Kyles Ford	Tie Camp WMA
Cheatham Lake	Laurel Hill	Tigrett
Cherokee	Lick Creek	Watts Bar (Long Island Unit)
Chickamauga (Candies Creek,	Lick Creek Bottoms	West Sandy
Johnson Bottoms, Rogers Creek,	Lovell Field	White Lake Refuge
Yellow Creek Units)	Maness Swamp Refuge	White Oak
Chuck Swan	Maple Springs	WilliamSPORT
Cold Creek	Mingo Swamp	Wolf River
Cordell Hull	Moss Island	Woods Reservoir Refuge
Cordell Hull Refuge	MTSU	Yanahli
Cove Creek	Natchez Trace	Yuchi Refuge at Smith Bend
Cypress Pond	Nathan B. Forrest State Historical	
Eagle Creek	Area	
Eagle Lake Refuge	New Hope	
Ernest Rice Sr.		

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

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

Rule 1660-1-8-.05(1)(b) Permit Applications and Drawings, is amended by deleting it in its entirety and by substituting instead the following new paragraph:

- (b) Applicants may submit only one application, except youths six (6) through sixteen (16) years of age may apply for one additional young sportsman hunt on management areas. If an individual's name (except youths applying for one additional young sportsman hunt

## RULEMAKING HEARINGS

as noted above) appears on more than one application, that individual will be rejected, his permit fee forfeited, and will be subject to prosecution

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

Rule 1660-1-8-.05(1)(c) Permit Applications and Drawings, is amended by deleting it in its entirety and by substituting instead the following new paragraph:

- (c) For quota big game hunts on wildlife management areas, applicants must be at least six (6) years of age prior to the date of the hunt.

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

The notice of rulemaking set out herein was properly filed in the Department of State on the 30th day of June, 2005. (06-33)

## WILDLIFE PROCLAMATIONS

### TENNESSEE WILDLIFE RESOURCES COMMISSION - 1660

#### PROCLAMATION 05-16 IMPORTATION OF CERVID CARCASSES AND PARTS

Pursuant to the authority granted by Tennessee Code Annotated, Section 70-1-206 and 70-4-107, the Tennessee Wildlife Resources Commission hereby proclaims carcass importation restrictions effective August 1, 2005:

The following U.S. states, portions of states, and Canadian provinces are proclaimed to be CWD positive and are therefore regulated by rule 1660-1-15:

Colorado	Oklahoma*
Illinois (that portion north of Interstate 80)	South Dakota
Kansas*	Utah
Minnesota*	Wisconsin
Montana*	Wyoming
Nebraska	
New Mexico	Alberta*
New York	Saskatchewan

\* States and provinces where CWD has been found in captive cervids only.

Proclamation No. 05-16, received and recorded this 28th day of June, 2005. (06-36)

WILDLIFE PROCLAMATIONS

**TENNESSEE WILDLIFE RESOURCES COMMISSION - 1660**

**PROCLAMATION 05-17**

**PROCLAIMING KYLES FORD WILDLIFE MANAGEMENT AREA**

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

Kyles Ford Wildlife Management Area – Those lands and waters located in eastern Hancock County northeast of Sneedville, lying in the Clinch River or adjacent drainages, owned or leased by the Tennessee Wildlife Resources Agency.

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

Proclamation No. 05-17 received and recorded this 27th day of June, 2005. (06-36)

WILDLIFE PROCLAMATIONS

**TENNESSEE WILDLIFE RESOURCES COMMISSION - 1660**

**PROCLAMATION 05-18  
AMENDMENT TO PROCLAMATION 05-13  
STATEWIDE BIG GAME HUNTING SEASONS AND BAG LIMITS  
(EXCLUSIVE OF WILDLIFE MANAGEMENT AREAS AND REFUGES)**

Pursuant to the authority granted by Title 70, Tennessee Code Annotated, and Sections 70-4-107 and 70-4-119, thereof, the Tennessee Wildlife Resources Commission hereby proclaims the following amendments to Proclamation 05-13 dealing with statewide big game seasons and bag limits.

Amend Section II. Feral Hog Seasons (No hunting with dogs allowed except where indicated.)

In the following counties dogs may be used for feral hog hunting on the dates indicated by inserting the wording, "Polk (East of Hwy. 411 & North of Hwy. 64)", following Monroe for the Oct. 10-17, 2005 Gun-Muzzleloader-Archery hunt to read as follows:

Monroe, Polk (East of Hwy. 411 & North of Hwy. 64)

Gun-Muzzleloader-Archery  
(Dogs Permitted)

Oct. 10-17, 2005  
No limit-Either Sex

Proclamation 05-18 received and recorded this 30th day of June, 2005. (06-66)



### CERTIFICATE OF APPROVAL

As provided by T.C.A., Title 4, Chapter 5, I hereby certify that to the best of my knowledge, this issue of the Tennessee Administrative Register contains all documents required to be published that were filed with the Department of State in the period beginning June 1, 2005 and ending June 30, 2005.

**RILEY C. DARNELL**  
Secretary of State