



This Quick Guide is intended to be a user-friendly reference to help identify services and products covered under the TennCare program. The Quick Guide is neither an exhaustive discussion of TennCare program benefits, nor is it a legal document. Additional information about allowable benefits can be found in the TennCare Rules, TennCare MCO CRAs<sup>1</sup>, and/or the TennCare Policy Statements listed with each item.

**All** services and products covered by TennCare **must** be medically necessary; therefore, if a service or product is listed as “covered”, it means that it will only be covered if it is medically necessary. Some items listed will only be covered for certain groups (i.e., persons under age 21 or persons enrolled in CHOICES), as indicated in the description. Services and products not listed are not necessarily excluded from TennCare coverage and may be allowed under certain circumstances.

**Exception to Excluded Benefits: Cost Effective Alternatives (CEAs)** – Each Managed Care Contractor (MCC) has the sole discretion to authorize CEAs, as approved by the Centers for Medicare and Medicaid Services (CMS), in order to provide appropriate, medically necessary care. CEAs can be found throughout this document, and additional information can be found in TennCare Policy Statement BEN 08-001 on the TennCare website. Questions about CEAs may be directed to the TennCare Office of Policy at (615) 507-6480.

**A “●” next to an item means that more detail is available in the TennCare Rules.**

<sup>1</sup> Managed Care Organization Contractor Risk Agreement (MCO CRA). Note: MCO is a type of MCC; other MCCs include the Dental Benefits Manager (DBM) and Pharmacy Benefits Manager (PBM).

**Abortion** – Abortions and services associated with the abortion procedure are covered only if the pregnancy is the result of an act of rape or incest; or in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death if the abortion is not performed. A “Certification of Medical Necessity for Abortion” is required.

[MCO CRAs, Sec. 2.7.8.]

**Adaptive Devices, Non-medical, such as reactors, buttonhole adaptive devices, etc.—**

- **CHOICES members:** Covered. For additional information see *Assistive Technology*.
- **Non-CHOICES members:** Not Covered, and may only be approved as a CEA at the sole discretionary authority of the MCC.

[Policy BEN 08-001]

● **Adult Care Home** – Covered for CHOICES members only; the costs of room and board are not included. As defined by the CHOICES program, an Adult Care Home is a state-licensed, community-based residential alternative (CBRA) that offers 24-hour residential care and support in a single family residence to no more than five elderly or disabled adults who meet the Nursing Facility (NF) level of care. Pursuant to state law, licensure is currently limited to Critical Adult Care homes for persons who are ventilator-dependent or adults with traumatic brain injury.

[Rules 1200-13-01-.02 & 1200-13-01-.05]

● **Adult Day Care** –

- **CHOICES members:** Covered for CHOICES members who are age 21 and older only. Limited to 2080 hours per calendar year per member.
- **Non-CHOICES members:** Not Covered for non-CHOICES adults; however, it may be approved as a CEA at the sole discretionary authority of the MCC.

[Rules 1200-13-01-.02 & 1200-13-01-.05; Policy BEN 08-001]

**Air Cleaners, Purifiers, or HEPA Filters** – Covered for children under age 21 only.

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Alcoholic Beverages** – Not Covered

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Alcohol or Drug Treatment Services** – See *Inpatient and Outpatient Substance Abuse Benefits*.

**Ambulance** – See *Emergency Air & Ground Ambulance Transportation; Non-Emergency Ambulance Transportation; and Non-Emergency Transportation*.

● **Animal Therapy** – Not Covered

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Appetite Suppression and Other Weight Reduction Drugs** – See *Pharmacy*.

**Applied Behavioral Analysis (ABA)** – a widely used strategy for addressing behavior problems among patients with disorders such as mental retardation and traumatic brain injury. It considers environmental factors that appear to trigger unwanted behavior, the behaviors themselves, and consequences that either increase or decrease future occurrences of that behavior. A treatment program using a behavioral technique known as operant conditioning is then carried out to address the specific challenging behavior.

ABA as described above is a Covered TennCare benefit.

ABA is Not Covered when used primarily as an educational intervention, not a medical service, in highly structured intensive programs to improve the cognitive and social skills of children with autism (e.g., Lovaas therapy).

[See: *TennCare Medical Necessity Guidelines: Procedure: Applied Behavioral Analysis (Orig. Date: 01/10/06 / Revised 07/08/09)*, Available on the Bureau of TennCare's website at

<http://www.tn.gov/assets/entities/tenncare/attachments/apcard.pdf> ]

**Art Therapy** – Not Covered

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Assisted Care Living Facility (ACLF) Services** – Covered for CHOICES members only; the costs of room and board are not included.

Defined by CHOICES as a Community-Based Residential Alternative (CBRA) to NF care. ACLF services are provided in a home-like environment and include personal care, daily meals, homemaker, and other supportive services or health care including medication oversight (to the extent permitted under State law).

[Rules 1200-13-01-.02 & 1200-13-01-.05]

● **Assistive Technology** – Covered for CHOICES members only with a limit of \$900 per calendar year, per member. To include: assistive devices, adaptive aids, controls, or appliances that enable a member to increase the ability to perform Activities of Daily Living (ADLs) or to perceive or control his environment. See *Adaptive Devices*.

[Rules 1200-13-01-.02 & 1200-13-01-.05]

● **Attendant Care** – Covered for CHOICES members only who, due to age and/or physical disabilities, need more extensive assistance than provided through intermittent Personal Care Visits (i.e. more than 4 hours per visit or visits occurring less than 4 hours apart.. For members who do not require homemaker services, coverage is limited to 1080 hours per calendar year, per member. For members who require homemaker services, coverage is limited to 1400 hours per calendar year, per member. To include: hands-on assistance with activities of daily living, safety monitoring, and supervision..

Not Covered for CHOICES members: 1) living in an ACLF, Adult Care Home, Residential Home for the Aged, or other group residential setting; 2) receiving CBRA (including Companion Care) or Short-Term NF services; or 3) while receiving Adult Day Care Services.

[Rules 1200-13-01-.02 & 1200-13-01-.05]

**Audiological Therapy or Training** - Covered for children under age 21 only.

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Audiometry** – See *Preventive Services*

**Augmentative Communication Devices** – Covered for children under age 21 only.

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Autopsy** – Not Covered

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Bariatric Surgery** – Defined as surgery to induce weight loss. Covered as medically necessary.

[Rules 1200-13-13-.04 & 1200-13-14-.04]

● **Bathtub Equipment and Supplies** – Not Covered

[Rules 1200-13-13-.10 & 1200-13-14-.10]

● **Beds and Bedding Equipment** –

- **Under age 21:** Covered
- **Age 21 and over:** Not Covered, **unless** the member has both severely impaired mobility **and** any stage pressure ulcer on the trunk or pelvis combined with at least one of the following: impaired nutritional status, incontinence, altered sensory perception, or compromised circulatory status.

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Bed Baths and Sitz Baths** – Covered for children under age 21 only

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Bioenergetic Therapy** – Not Covered

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Biofeedback** – Covered for children under age 21 only

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Blood Pressure Cuffs** – See *Sphygmomanometers*

● **Body Adornment and Enhancement Services** – Not Covered

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Breast Surgery** – See *Reconstructive Breast Surgery*

● **Breathing Equipment** – Not Covered, **except** for peak flow meter spirometers, which are covered for medical management of asthma.

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Bypass Surgery** – See *Bariatric Surgery*

**Carbon Dioxide Therapy** – Not Covered

[Rules 1200-13-13-.10 & 1200-13-14-.10]

● **Care Facilities or Services, the primary purpose of which is non-medical** – Not Covered, **except** for respite care when it is a component of Mental Health Crisis Services benefits or Hospice Care benefits.

[Rules 1200-13-13-.04, 1200-13-13-.10, 1200-13-14-.04, & 1200-13-14-.10]

**Carotid Body Tumor, Excision of, as Treatment for Asthma** – Not Covered

[Rules 1200-13-13-.10 & 1200-13-14-.10]

● **Chelation Therapy** – Not Covered, **except** for the treatment of heavy metal poisoning or secondary hemochromatosis in selected settings.

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Chiropractic Services** –

- **Under age 21:** Covered
- **Age 21 and older:** Not Covered, but may be approved as a CEA at the sole discretionary authority of the MCC.

[Rules 1200-13-13-.04, 1200-13-13-.10, 1200-13-14-.04, & 1200-13-14-.10; Policy BEN 08-001]

**Clothing**, including adaptive clothing – Not Covered

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Cold Therapy Devices** – Not Covered

[Rules 1200-13-13-.10 & 1200-13-14-.10]

- **Comfort and Convenience Items** – Not Covered, including diapers/liners/underpads for enrollees younger than 3 years of age, **except** for surgical weight and thrombo-embolic deterrent support stockings, which are Covered in limited situations, as medically necessary.

[Rules 1200-13-13-.10 & 1200-13-14-.10]

- **Community-Based Residential Alternatives (CBRAs)** – Covered only for CHOICES members. CBRAs are defined by CHOICES as residential services that offer a cost-effective, community-based alternative to NF care for individuals who are elderly and/or have physical disabilities. CBRAs include, but are not limited to ACLFs, Adult Care Homes, and Companion Care. Coverage does NOT include room and board.

[Rules 1200-13-01-.02 & 1200-13-01-.05]

**Community Health Services** – Covered

[Rules 1200-13-13-.04 & 1200-13-14-.04]

**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 – Not Covered

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Convalescent Care** – Not Covered

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Correctional Facilities** – See *Penal Institutions***Cosmetic Dentistry, Cosmetic Oral Surgery, and Cosmetic Orthodontic Services** – Not Covered

[Rules 1200-13-13-.10 & 1200-13-14-.10]

- **Cosmetic Surgery or Surgical Procedure** which is primarily for the purpose of changing the appearance of any part of the body to improve appearance or self-esteem, including scar revision – Not Covered

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Counseling and Risk Factor Reduction Services** – See *Preventive Services*

- **Cushions, Pads, and Mattresses** – Covered for children under age 21 only.

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Dance Therapy** – Not Covered

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Dental Services** –

- **Under age 21:** Covered: Preventive, diagnostic, and treatment services, as medically necessary. Dental services under EPSDT (TennCare Kids) include dental screens provided in accordance with the state's periodicity schedule and at other intervals as medically necessary. Coverage for orthodontic services will only be provided for members up to age 21 and will be discontinued on the member's 21<sup>st</sup> birthday. Orthodontic treatment will not be authorized for cosmetic purposes.

The MCO is responsible for the provision of transportation to and from covered dental services, as well as the medical and anesthesia services related to the covered dental services.

- **Age 21 and older:** Not Covered, **except** when an adult enrollee presents to a hospital Emergency Department with a dental problem, the EMTALA screening and treatment of any emergency medical condition identified in the screening are covered services. Dental services to treat the origin of the emergency medical condition are NOT covered.

Dental services for adults may be approved as a CEA at the sole discretionary authority of the MCC.

[Rules 1200-13-13-.04, 1200-13-13-.10, 1200-13-14-.04, & 1200-13-14-.10; Policies BEN 08-001, BEN 06-002, & PRO 05-001]

**Diagnostic Tests** conducted solely to evaluate the need for a service excluded from coverage under TennCare rules – Not Covered, **except** for children under age 21

[Rules 1200-13-13-.04, 1200-13-13-.10, 1200-13-14-.04, & 1200-13-14-.10]

**Dialysis Services** – See *Renal Dialysis Clinic Services*

**Diapers** – See *Comfort and Convenience Items; and also Incontinence Products*

**Donor Organ Procurement** – See *Organ and Tissue Transplant and Donor Organ/Tissue Procurement Services & Organ and Tissue Donor Services*

- **Durable Medical Equipment (DME)** – Covered. DME is defined as equipment that can stand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of an illness or injury, is appropriate for and used in the patient’s home, and is related to the patient’s physical disorder.

[Rules 1200-13-13-.01, 1200-13-13-.04, 1200-13-14-.01, & 1200-13-14-.04]

**Repair of DME Items Not Covered by TennCare** – Covered for children under age 21 only

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Repair of DME Items** covered under the provider’s or manufacturer’s warranty – Covered for children under age 21 only

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Repair of a Rented DME Item** – Covered for children under age 21 only

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Reimbursement to a provider or an enrollee for the replacement of rented DME** that is stolen or destroyed – Covered for children under age 21 only

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Ear Plugs** – Covered for children under age 21 only

[Rules 1200-13-13-.10 & 1200-13-14-.10]

- **Educational Services** – Not Covered

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Emergency Medical Services** – Covered

[Rules 1200-13-13-.04 & 1200-13-14-.04]

**Emergency Air & Ground Ambulance Transportation** – Covered

[Rules 1200-13-13-.04 & 1200-13-14-.04]

**Employment Physicals** – See *Routine Health Services*

**Encounter Groups or Workshops** – Not Covered

[Rules 1200-13-13-.10 & 1200-13-14-.10]

- **Environmental Modifications** – Not Covered

[Rules 1200-13-13-.10 & 1200-13-14-.10]

- **EPSDT Services [TennCare Kids]** – Covered for individuals under age 21 only. Includes screening and interperiodic screening (screenings that take place between regular checkups and are covered if a parent or caregiver suspects there may be a problem) covered in accordance with federal regulations. Diagnostic and follow-up treatment services covered as medically necessary in accordance with federal regulations.

[Rules 1200-13-13-.04]

**Erectile Dysfunction Medication(s)** – Not Covered, when specifically for the treatment of male impotence. Certain sildenafil citrate and tadalafil medications are covered for the treatment of severe Pulmonary Arterial Hypertension (PAH). Compounds containing sildenafil citrate and tadalafil are covered only for the treatment of PAH and only when the individual cannot take a commercially available product.

[Rules 1200-13-13-.10 & 1200-13-14-.10; Policy BEN 06-001]

● **Exercise Equipment** – Not Covered

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Eyeglasses** – See *Vision Services*

**Family Planning Services** – See *Preventive Services*

**Fitness to Duty Examinations** – See *Routine Health Services*

**Floor Standers** – Not Covered, **except** for children under age 21

[Rules 1200-13-13-.10 & 1200-13-14-.10]

● **Food and Food Products** (distinct from food supplements or substitutes, as defined in Rules 1200-13-13-.10 & 1200-13-14-.10) – Not Covered

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Food Supplements and Substitutes Including Formulas** –

- **Under age 21:** Covered as medically necessary.
- **Age 21 and older:** Not Covered, except that parenteral nutrition formulas, enteral nutrition formulas for tube feedings and phenylalanine-free formulas (not foods) used to treat PKU, as required by *Tennessee Code Annotated § 56-7-2505*, are covered for adults. In addition, oral liquid nutrition may be covered when medically necessary for adults with swallowing or breathing disorders who are severely underweight (BMI < 15 kg/m<sup>2</sup>) and physically incapable of otherwise consuming a sufficient intake of food to meet basic nutritional requirements.

[Rules 1200-13-13-.10 & 1200-13-14-.10; T.C.A. § 56-7-2505]

**Footwear (Podiatric Appliances), for prevention of complications associated with diabetes.** Covered as required by the *Tennessee Annotated Code § 56-7-2605*.

[T.C.A. § 56-7-2605]

**Gastric Stapling** – See *Bariatric Surgery*

● **Grooming Services** – Not Covered

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Hair Analysis** – Not Covered

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Hair Growth Agents** – Not Covered

[Rules 1200-13-13-.04, 1200-13-13-.10, 1200-13-14-.04, & 1200-13-14-.10]

● **Home and Community Based Services (HCBS) Long-Term Care Benefits under CHOICES** – In addition to the medical and behavioral health services TennCare enrollees receive, the following services may be available to CHOICES members only. Some limits apply; see individual services for details.

- Adult Day Care
- Assistive Technology
- Attendant Care
- Community-Based Residential Alternatives (CBRAs)
- Home-Delivered Meals
- In-Home Respite Care
- Inpatient Respite Care
- Minor Home Modifications
- Personal Care Visits
- Personal Emergency Response System (PERS)
- Pest Control
- Short-Term NF Care

[Scope: Rule 1200-13-01-.02; Limitations: 1200-13-01-.05; MCO CRAs, Sec.2.6.1.5.4.]

● **HCBS Long-Term Care Benefits under TennCare's three 1915(c) waivers for individuals with intellectual disabilities** – Home and community-based alternatives to institutional care. Covered by the Bureau outside the TennCare managed care program for persons who qualify.

[Rules 1200-13-01-.25, 1200-13-01-.28, & 1200-13-01-.29]

**Hearing Services, including the prescribing, fitting, or changing of hearing aids** – Covered for children under age 21 only

*[Rules 1200-13-13-.10 & 1200-13-14-.10]*

- **Home-Delivered Meals** – For the purposes of the CHOICES Program, nutritionally well-balanced meals that provide at least one-third but no more than two-thirds of the current daily RDA and that will be served in the CHOICES member’s home. Covered for CHOICES members receiving HCBS, with a limit of one (1) meal per day, per member.

*[Rules 1200-13-01-.02 & 1200-13-01-.05]*

- **Home Health Care Services**–

- **Under age 21:** Covered with prior approval.
- **Age 21 and older:** Covered with prior approval and certain limitations. All home health care services must be delivered by a licensed Home Health Agency as defined by 42 CFR §440.70. A home health visit includes any of the following: Skilled Nursing, Physical Therapy, Occupational Therapy, Speech Pathology and Audiology Services, and Home Health Aide.

*[Rules 1200-13-13-.04 & 1200-13-14-.04; Limitations: 1200-13-13-.01 & 1200-13-14-.01; Prior Authorization Requirements: 1200-13-13-.04(6) & 1200-13-14-.04(6)]*

- **Home Modifications and Items for Use in the Home** – Covered for CHOICES members only, with limitations.

*[Rules 1200-13-01-.05, 1200-13-13-.10, & 1200-13-14-.10]*

- **Homemaker Services** – Covered for CHOICES members only. Provided only as part of Personal Care Visits and Attendant Care services for members who also require hands-on assistance with ADLs. Defined by CHOICES as general household activities and chores that are covered only when members are unable to perform such activities and there are no other caregivers or household members available to perform such activities for them.

*[Rules 1200-13-01-.02, 1200-13-01-.05, 1200-13-13-.10, & 1200-13-14-.10]*

- **Hospice Care** – Covered. To be provided to enrollees living at home or in a NF. Hospice care must be provided by an organization certified pursuant to Medicare Hospice requirements. For those enrollees living in a NF who elect the hospice benefit, their room and board expenses at the NF are part of the hospice benefit.

*[Rules 1200-13-13-.04 & 1200-13-14-.04; Policy BEN 07-001]*

- **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.] – Not Covered

*[Rules 1200-13-13-.10 & 1200-13-14-.10]*

- **Hotel Accommodations** – Not Covered, **except:**

- When pre-approved in conjunction with a transplant or as a part of a non-emergency transportation service; OR
- When approved as a CEA at the sole discretionary authority of the MCC for persons receiving frequent treatment at a distant location to avoid the rigors of excessive travel. If not approved as a CEA, this service is not provided.

*[Rules 1200-13-13-.10 & 1200-13-14-.10; Policy BEN 08-001]*

- **Humidifiers (central or room) and Dehumidifiers** – Covered for children under age 21 only

*[Rules 1200-13-13-.10 & 1200-13-14-.10]*

- **Hypnosis or Hypnotherapy** – Not Covered

*[Rules 1200-13-13-.10 & 1200-13-14-.10]*

- **Hysterectomy** – Covered pursuant to applicable state and federal regulations, with informed consent. The “Acknowledgement of Hysterectomy Form” form is required. A hysterectomy is not covered if the sole purpose or primary purpose is to render the individual incapable of reproduction, or if it is performed for the purpose of cancer prophylaxis.

*[MCO CRAs, Sec. 2.7.8.]*

**Icterus Index – Not Covered**

[Rules 1200-13-13-.10 & 1200-13-14-.10]

● **Illness Management and Recovery** – Covered as a component of Psychiatric Rehabilitation. Refers to a series of weekly sessions with trained mental health practitioners for the purpose of assisting individuals in developing personal strategies for coping with mental illness and promoting recovery.

[MCO CRAs, Attachment I]

**Immunizations** – See *Preventive Services*

**Impotence** – See *Infertility or Impotence Services*

**Incontinence Products** – Covered. **Note:** Diapers/liners/underpads are not covered for enrollees younger than 3 years of age.

[Rules 1200-13-13-.04, 1200-13-13-.10, 1200-13-14-.04, & 1200-13-14-.10]

**Infant/Child Car Seats** – Not Covered, **except** for adaptive car seats which 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:

- Cannot sit upright unassisted; and
- Infant/child car seats are too small or do not provide adequate support; and
- Safe automobile transport is not otherwise possible.

[Rules 1200-13-13-.10 & 1200-13-14-.10]

● **Infertility or Impotence Services** – Services (or agents) for the treatment of infertility or impotence or for the reversal of sterilization – Not Covered

[Rules 1200-13-13-.04, 1200-13-14-.10, 1200-13-14-.04, & 1200-13-14-.10]

● **In-Home Respite Care** – Covered for CHOICES members only, with a limit of 216 hours per calendar year, per member. Not Covered when the member is receiving CBRA facility services or Short-Term NF Care.

Defined as: Services provided to CHOICES members unable to care for themselves, furnished on a short-term basis in the CHOICES member's place

of residence, because of the absence or need for relief of those persons normally providing the care.

[Rules 1200-13-01-.02 & 1200-13-01-.05]

**Inpatient Hospital Services** – Covered. Preadmission and concurrent reviews are allowed.

[Rules 1200-13-13-.04 & 1200-13-14-.04]

**Inpatient and Outpatient Substance Abuse Benefits** – Covered

[Rules 1200-13-13-.04 & 1200-13-14-.04]

**Inpatient Rehabilitation Facility Services:**

- **Under age 21:** See *Inpatient Hospital Services*.
- **Age 21 and older:** Not Covered, but may be approved as a CEA at the sole discretionary authority of the MCC.

[Rules 1200-13-13-.04, 1200-13-13-.10, 1200-13-14-.04, & 1200-13-14-.10; Policy BEN 08-001]

● **Inpatient Respite Care** – Covered for CHOICES members only with a limit of 9 days per calendar year, per member.

Defined by CHOICES as: services provided to CHOICES members unable to care for themselves, furnished on a short-term basis in a licensed NF or licensed CBRA, because of the absence or need for relief of those persons normally providing the care.

[Rules 1200-13-01-.02 & 1200-13-01-.05]

**Insurance Physicals** – See *Routine Health Services*

**Intermediate Care Facility Services for Individuals with Intellectual Disabilities (ICFs/IID) Services** – Covered. **Note:** An “ICF/IID” is a licensed facility approved for Medicaid reimbursement that provides specialized services for individuals with intellectual disabilities or related conditions and that complies with current federal standards and certification requirements.

[Rules 1200-13-01-.01 & 1200-13-01-.30]

**Investigational Services** – See *Experimental or Investigational Services*

**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 – Not Covered

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**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 U.S. Department of Health and Human Services or the Bureau of TennCare - Not Covered.

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Items or Services Ordered, Prescribed, Administered, Supplied, or Provided by an Individual or Entity that is Not Licensed by the Appropriate Licensing Board** – Not Covered

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Items or Services Outside the Scope and/or Authority of a Provider's Specialty and/or Area of Practice** – Not Covered

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Items or Services to the Extent That Medicare or a Third Party 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 – Not Covered

[Rules 1200-13-13-.10 & 1200-13-14-.10; Policy CON 09-001]

**Jail** – See *Penal Institutions*

**Lab and X-Ray Services** – Covered

[Rules 1200-13-13-.04 & 1200-13-14-.04]

● **Lamps** – Not Covered

[Rules 1200-13-13-.10 & 1200-13-14-.10]

● **Lifts** – Not Covered

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Ligation of Mammary Arteries, unilateral or bilateral** – Not Covered

[Rules 1200-13-13-.10 & 1200-13-14-.10]

● **Long-Term Services and Supports**

See *Nursing Facility Services, Intermediate Care Facility Services for Individuals with Intellectual Disabilities; HCBS Benefits under CHOICES; and HCBS Benefits under TennCare's three 1915(c) waivers for individuals with intellectual disabilities.*

[Rule 1200-13-01]

**Mammography Services** – See *Preventive Services*

**Medical Supplies**—Supplies that are deemed medically necessary and appropriate, and are prescribed for use in the diagnosis and treatment of medical conditions. Defined as a Home Health Service in 42 CFR 440.70.

Covered **only when provided** by or through a licensed home health agency, by or through a licensed medical vendor supplier, or by or through a licensed pharmacist, when not included as medically necessary medical supplies as part of institutional services.

[Rules 1200-13-13-.04 & 1200-13-14-.04; 42 CFR 440.70)]

● **Medical Supplies, Over-the-Counter** (e.g., rubbing alcohol, Q-tips or cotton swabs, and peroxide)–

➤ **Under Age 21:** Covered.

➤ **Age 21 and older:** Not Covered, but may be approved as a CEA at the sole discretionary authority of the MCC.

[Rules 1200-13-13-.10 & 1200-13-14-.10; Policy BEN 08-001]

**Megavitamin Therapy** – Not Covered

[Rules 1200-13-13-.10 & 1200-13-14-.10]

● **Mental Health Case Management** – Covered

[Rules 1200-13-13-.04 & 1200-13-14-.04; MCO CRAs, Attachment I]

● **Mental Health Crisis Services** – Covered

[Rules 1200-13-13-.04 & 1200-13-14-.04; MCO CRAs, Attachment I]

**Methadone Clinic Services**—Covered for children under age 21 only

[Rules 1200-13-13-.04, 1200-13-13-.10, 1200-13-14-.04, & 1200-13-14-.10]

**Motor Vehicle Parts and Services** – Not Covered, including, but not limited to, automobile controls and automobile repairs or modifications

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Music Therapy** – Not Covered

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Nail Analysis** – Not Covered

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Naturopathic Services** – Not Covered

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Necropsy** – Not Covered

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Nerve Stimulators** – See *Vagus Nerve Stimulators*.

**Newborn Services** – Covered

[Rules 1200-13-13-.04 & 1200-13-14-.04]

● **Non-Emergency Ambulance Transportation** – Covered

[Rules 1200-13-13-.04 & 1200-13-14-.04]

● **Non-Emergency Services That Are Ordered or Furnished by an Out-Of-Network Provider** and that have not been approved by the enrollee’s MCC for out-of-network care – Not Covered, **except** if the enrollee is dually eligible for TennCare and Medicare. In-network care that has been provided by an out-of-network provider, may be covered for dual eligible enrollees, if authorized by the MCO.

[Rules 1200-13-13-.10 & 1200-13-14-.10]

● **Non-Emergency Transportation** – Covered as necessary for enrollees lacking accessible transportation for TennCare-covered services. The travel to access primary care and dental services must meet the requirements of the TennCare waiver terms and conditions. The availability of specialty services, as 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 the enrollee has access to transportation.

If the enrollee is a minor child, transportation must be provided for the minor child and an accompanying adult. However, transportation for a minor child shall not be denied pursuant to any policy that poses a blanket restriction due to enrollee’s age or lack of parental accompaniment. Tennessee recognizes the “mature minor exception” to permission for medical treatment.

[Rules 1200-13-13-.04 & 1200-13-14-.04]

● **Nursing Facility Services** – Covered under the CHOICES program:

- Level 1 services
- Level 2 services
- Services for CHOICES members who qualify for Enhanced Respiratory Care Reimbursement.

[Rule 1200-13-01-.05]

**Nursing Services** – See *Private Duty Nursing*

**Nutritional Supplements and Vitamins, Over-the-Counter** –

- **Under age 21:** Covered.
- **Age 21 and older:** Not Covered, **except** for prenatal vitamins for pregnant women and folic acid for women of childbearing age.

For other individuals age 21 and older, these items may be approved as CEAs at the sole discretionary authority of the MCCs.

[Rules 1200-13-13-.10 & 1200-13-14-.10; Policy BEN 08-001]

**Occupational Therapy–**

- **Under age 21:** Covered when provided by a Licensed Occupational Therapist, to restore, improve, stabilize, or ameliorate impaired functions.
- **Age 21 and older:** Covered when provided by a Licensed Occupational Therapist, to restore, improve, or stabilize impaired functions.

[Rules 1200-13-13-.04 & 1200-13-14-.04]

**Organ and Tissue Transplant and Donor Organ/Tissue Procurement Services–**

- **Under age 21:** Covered.
- **Age 21 and older:** Covered when Medicare allows such coverage.

**Note:** Experimental or investigational transplants are **not** covered for either population.

[Rules 1200-13-13-.04, 1200-13-13-.10, 1200-13-14-.04, & 1200-13-14-.10]

- **Organ and Tissue Donor Services,** provided in connection with organ or tissue transplants – Not Covered

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Orthodontics – See Dental Services****Orthotics:** See Durable Medical Equipment (DME)

- **Out-of-State Services –** Not Covered, **except** for:

- Emergency situations;
- When the MCC has given prior authorization; or
- The out-of-state provider is participating in the enrollee’s MCC network.

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Outpatient Hospital Services –** Covered

[Rules 1200-13-13-.04 & 1200-13-14-.04]

**Outpatient Mental Health Services (including Physician Services) –** Covered

[Rules 1200-13-13-.04 & 1200-13-14-.04]

**Outpatient Substance Abuse Treatment Benefits –** See *Inpatient and Outpatient Substance Abuse Benefits*

**Oxygen –** Not Covered, **except** when provided under the order of a physician and administered under the direction of a physician.

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Oxygen, Preset System** [flow rate not adjustable] – Not Covered

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Peer Recovery Services –** Covered as a component of Psychiatric Rehabilitation. “Peer recovery” is a service model that allows persons who have experienced, or who are still experiencing, a mental illness and/or substance abuse disorder to provide support to individuals who are dealing with similar experiences.

[Policy BEN 11-002; MCO CRAs, Attachment I]

**Penal Institutions –** Medical services for inmates confined in a local, state, or federal prison, jail, or other penal or correctional facility, including a furlough from such facility – Not Covered

[Rules 1200-13-13-.10 & 1200-13-14-.10]

- **Personal Care Visits –** Covered for CHOICES members only, with limitations. Services are provided through intermittent visits of limited duration, not to exceed 4 hours per visit and 2 visits per day with no less than 4 hours between visits. Personal Care Visits include hands-on assistance and related tasks to individuals who, due to age and/or physical disability, need help with performing Activities of Daily Living (ADLs). Personal Care Visits may also include Homemaker Services for individuals who need assistance with Instrumental Activities of Daily Living (IADLs).

Not Covered for CHOICES members: 1) living in an ACLF, Adult Care Home, Residential Home for the Aged, or other group residential setting; 2) receiving CBRA (including Companion Care) or Short-Term NF services; or 3) while receiving Adult Day Care Services.

[Rule 1200-13-01-.02 & 1200-13-01-.05]

- **Personal Emergency Response System (PERS)** – Covered for CHOICES members only. **Note:** Not covered for CHOICES members who are living in a CBRA facility or receiving Short-Term NF services.

Defined as: an electronic device that enables certain CHOICES members at high risk of institutionalization to summon help in an emergency.

[Rule 1200-13-01-.02 & 1200-13-01-.05]

- **Pest Control** – Covered for CHOICES members only, with a limit of 9 treatment visits per calendar year, per member. **Note:** Not covered for CHOICES members living in CBRA facilities or receiving Short-Term NF services.

Defined by the CHOICES program as: the use of sprays, poisons, and traps, as appropriate, in the CHOICES member's place of residence to regulate or eliminate the intrusion of household pests into the household environment thereby removing an environmental issue that could be detrimental to a frail, elderly or disabled member's health and physical well-being.

[Rule 1200-13-01-.02 & 1200-13-01-.05]

#### Pharmacy—

- **Enrollees under age 21:** Covered, **except** certain drugs known as DESI, LTE, or IRS, which are not covered. No limit on the number of prescriptions per month.
- **Enrollees age 21 and older:** Covered—subject to limitations described below—**except** certain drugs known as DESI, LTE, or IRS, which are not covered:

#### Pharmacy (cont.)--

- No Limits:
  1. Individuals who meet the NF LOC and are receiving NF or HCBS through the CHOICES Program (CHOICES 1 or CHOICES 2), or are enrolled in PACE
  2. Individuals who were enrolled in CHOICES 1 or 2, or PACE, under the NF LOC criteria effective on June 30, 2012, and remained

enrolled in services (CHOICES 1 and 2 Carryover Group, and PACE Carryover Group)

3. Individuals receiving services in an ICF/IID or through an HCBS IID waiver
  - Limit of five (5) prescriptions/refills per month. No more than two (2) of which can be brand name drugs:
    1. Individuals enrolled in TennCare Medicaid who do not meet NF LOC
    2. Individuals enrolled in TennCare Standard, including Standard Spend Down (SSD)

**Note:** The Bureau maintains a list of drugs (the Automatic Exception List) that do not count against the limit. The Bureau also maintains a list of drugs (the Prescriber Attestation List) that enrollees may receive—even if they have reached a benefit limit—if the prescriber attests that the need for these drugs is urgent.

- **Dual Eligibles, Enrollees with Both Medicare and TennCare:** Individuals who are dually eligible for—and enrolled in—both Medicare and TennCare will receive their pharmacy services through Medicare Part D.
- **Enrollees Receiving Hospice Services:** Drugs used for the relief of pain and symptom control related to the enrollee's terminal illness are covered as part of the hospice benefit. Pharmacy services for conditions unrelated to the illness are covered. Hospice patients receiving TennCare-reimbursed room and board in an NF are not subject to limits on the number of prescriptions per month. Pharmacy services for patients receiving hospice services at home or in a residential hospice are subject to the limitations described above.

**Pharmacy, Items Not Covered for Individuals Age 21 and Older.** The following items are Covered for children under age 21, as medically necessary, unless otherwise noted:

- Agents when used for cosmetic purposes or for hair growth
- Agents when used for anorexia or weight loss

- Agents when used to promote fertility
- Agents when used for the symptomatic relief of cough and colds
- Covered outpatient drugs for 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
- Non-prescription drugs
- Generic buprenorphine, Subutex (buprenorphine), and Suboxone (buprenorphine/naloxone) in dosage amounts that exceed sixteen milligrams (16 mg) per day for a period of up to six months (which for a pregnant enrollee shall not begin until the enrollee is no longer pregnant), or eight milligrams (8 mg) per day at the end of a six-month period
- Sedative hypnotic medications in dosage amounts that exceed fourteen (14) pills per month for sedative hypnotic formulations in pill form such as Ambien and Lunesta; one hundred forty milliliters (140 ml) per month of chloral hydrate; or one (1) bottle every sixty (60) days of Zolpimist

[Rules 1200-13-13-.04, 1200-13-13-.10, 1200-13-14-.04, & 1200-13-14-.10]

#### Physical Therapy–

- **Under age 21:** Covered when provided by a Licensed Physical Therapist, to restore, improve, stabilize, or ameliorate impaired functions.
- **Age 21 and older:** Covered when provided by a Licensed Physical Therapist, to restore, improve, or stabilize impaired functions.

[Rules 1200-13-13-.04 & 1200-13-14-.04]

#### Physician Inpatient Services – Covered

[Rules 1200-13-13-.04 & 1200-13-14-.04]

- **Physician Outpatient Services** – Covered, **except** for Methadone Clinic Services for persons age 21 and older.

[Rules 1200-13-13-.04 & 1200-13-14-.04]

#### Play Therapy – Not Covered

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Power Operated Vehicles (POVs)** – Three or four-wheeled motorized scooters that are operated by a tiller. *See Scooters.*

#### Prenatal Care – See Preventive Services

- **Preventive Services** – Covered, to include office visits, counseling and risk factor reduction intervention, family planning services, prenatal care, administration and interpretation of health risk assessment, immunizations, hearing screens including audiometry, vision, initial hospitalization and assessment for newborns, mental health case management services, and mammography screenings.

[Rule 1200-13-14-.04(5)]

- **Preventive Services that Meet Medical Necessity Criteria** – Covered, including but not limited to: prenatal and maternity care delivered in accordance with the American College of Obstetrics and Gynecology; family planning services; and health education services for TennCare-eligible children under age 21.

[Rule 1200-13-16-.05]

#### Preventive, Diagnostic, and Treatment Services for Persons Under Age 21:

Includes screening and interperiodic screening (screenings that take place between regular checkups and are covered if a parent of caregiver suspects there may be a problem) covered in accordance with federal regulations. Diagnostic and follow-up treatment services covered as medically necessary in accordance with federal regulations. *See also EPSDT (TennCare Kids).*

[Rule 1200-13-14-.04]

#### Primal Therapy – Not Covered

[Rules 1200-13-13-.10 & 1200-13-14-.10]

● **Private Duty Nursing Services–**

- **Under age 21:** Covered in accordance with EPSDT requirements.
- **Age 21 and older:** Covered, but only when medically necessary to support the use of ventilator equipment or other life-sustaining medical technology, when constant nursing supervision, visual assessment, and monitoring of both equipment and patient are required. **Note:** Must be prescribed by an attending physician for treatment and services rendered by a registered nurse (RN) or a licensed practical nurse (LPN), who is not an immediate relative. Requires prior authorization by the MCO.

[Rules 1200-13-13-.04 & 1200-13-14-.04; Limitations: 1200-13-13-.01 & 1200-13-14-.01; Prior Authorization Requirements: 1200-13-13-.04(6) & 1200-13-14-.04(7) & MCO CRAs, Sec. 2.6.1.3.]

**Prosthetic Devices**, used to serve a medical purpose related to the member’s physical disorder—including artificial limbs and eyes. *See Durable Medical Equipment (DME)*

**Prosthetic Devices, Cosmetic – Not Covered**

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Prosthetic Devices, High Tech**, for active lifestyles rather than standard prosthetic devices – Not Covered, but may be approved as a CEA at the sole discretionary authority of the MCC. If not approved as a CEA, these items are not provided.

[Policy BEN 08-001]

**Provision of Medical Assistance Which is Outside the Scope of Benefits as Defined by the Rules and Regulations of the TennCare Program – Not Covered**

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Provision of Services to Persons Who Are Not Enrolled in TennCare, Either On The Date The Services Are Delivered, or Retroactively to the Date the Services are Delivered – Not Covered, except** for limited special appeal provisions pertaining to children who are placed in Youth Development

Centers (YDC) as defined in the *Grier Revised Consent Decree*, Section C.15.f, and pursuant to the DCS Interagency Agreement.

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Psychiatric Inpatient Facility Services – Covered.** Preadmission and concurrent reviews are allowed.

[Rules 1200-13-13-.04 & 1200-13-14-.04]

**Psychiatric Pharmacy Services – See Pharmacy Services**

**Psychiatric Physician Inpatient Services – Covered**

[Rules 1200-13-13-.04 & 1200-13-14-.04]

**Psychiatric Physician Outpatient Services – See Outpatient Mental Health Services**

● **Psychiatric Rehabilitation Services – Covered**

[Rules 1200-13-13-.04 & 1200-13-14-.04; MCO CRAs, Attachment I]

**Psychiatric Residential Treatment Services – Covered**

[Rules 1200-13-13-.04 & 1200-13-14-.04]

**Psychodrama – Not Covered**

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Psychogenic Sexual Dysfunction or Transformation Services – Not Covered**

[Rules 1200-13-13-.10 & 1200-13-14-.10]

● **Psychosocial Rehabilitation–** Covered as a component of Psychiatric Rehabilitation. “Psychosocial rehabilitation” services utilize a comprehensive approach to work with the whole person for the purpose of improving an individual’s functioning, promoting management of illness(es), and facilitating recovery.

[MCO CRAs, Attachment I]

**Purging – Not Covered**

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Purchase, Repair, or Replacement of Materials or Equipment** when the reason for the purchase, repair, or replacement is the result of enrollee abuse – Covered for children under age 21 only.

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Purchase, Repair, or Replacement of Materials or Equipment** that has been stolen or destroyed—

- **Under age 21:** Covered
- **Age 21 and older:** Not Covered, **except** when the following documentation is provided:
  - An explanation of continuing medical necessity for the item; and
  - An explanation that the item was stolen or destroyed; and
  - A copy of a police, fire department, or insurance report, if applicable.

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Radial Keratotomy** – Covered for children under age 21 only

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Recertification of Patients in Level I or Level II Nursing Facilities** – Not Covered

[Rules 1200-13-13-.10 & 1200-13-14-.10]

- **Reconstructive Breast Surgery** – Covered, in accordance with *Tennessee Code Annotated § 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 in the manner chosen by the physician.

[Rules 1200-13-13-.04 & 1200-13-14-.04; TCA § 56-7-2507]

**Recreational Therapy** – Not Covered

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Rehabilitation Services** –

- **Under age 21:** See *Inpatient Rehabilitation Facility Services; Occupational Therapy; Physical Therapy; and Speech Therapy.*
- **Age 21 and older:** See *Occupational Therapy; Physical Therapy; and Speech Therapy*

[Rules 1200-13-13-.04 & 1200-13-14-.04]

**Religious Counseling** – Not Covered

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Renal Dialysis Clinic Services** – Covered. Generally limited to the beginning 90-day period prior to the enrollee's becoming eligible for the Medicare program.

[Rules 1200-13-13-.04 & 1200-13-14-.04]

**Retreats for Mental Disorders** – Not Covered

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Rolfing**– Not Covered

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**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 – Not Covered.

May include, but is not limited to, the following:

- Drug screenings
- Employment or pre-employment physicals
- Immunizations related to work or travel
- Fitness to duty examinations
- Insurance physicals
- Job-related illness or injury covered by worker's compensation

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Scooters (sometimes referred to as a “Power-Operated Vehicles” or “POVs”)** – Not Covered, but may be approved as a CEA at the sole discretionary authority of the MCC.

*See also “Powered Operated Vehicles” and “Wheelchairs”.*

*[Rules 1200-13-13-.10 & 1200-13-14-.10; Policy BEN 08-001]*

**Sensitivity Training or Workshops** – Not Covered

*[Rules 1200-13-13-.10 & 1200-13-14-.10]*

● **Sensory Integration Therapy and Equipment** used in Sensory Integration Therapy – Not Covered

*[Rules 1200-13-13-.10 & 1200-13-14-.10]*

**Sensory Stimulation Services** – Not Covered

*[Rules 1200-13-13-.10 & 1200-13-14-.10]*

**Services for Which There Is No Federal Financial Participation (FFP)** – Not Covered

*[Rules 1200-13-13-.04, 1200-13-13-.10, 1200-13-14-.04, & 1200-13-14-.10]*

● **Services Provided by Immediate Relatives**, i.e., spouses, parents, grandparents, step-parents, children, grandchildren, brothers, sisters, half-brothers, half-sisters, parents’ spouses, or members of the enrollee’s household – Not Covered for non-CHOICES enrollees.

Covered only for those CHOICES members participating in Consumer Direction, with limitations. The hiring of consumer-directed workers who are neighbors, friends and family members, excluding spouses, is allowed. However, family members may not be reimbursed for services that they would otherwise have provided without pay.

*[Rules 1200-13-13-.10, 1200-13-14-.10, & 1200-13-01-.05]*

**Services Provided Outside the United States or Its Territories**– Not Covered

*[Rules 1200-13-13-.10 & 1200-13-14-.10]*

**Services That Are Free To The Public** – Not Covered, with the exception of services delivered in the schools pursuant to the Individuals with Disabilities Education Act (IDEA)

*[Rules 1200-13-13-.10 & 1200-13-14-.10]*

● **Services That Are Delivered In Connection With, or Required by, an Item or Service Not Covered by TennCare**, including transportation to receive such non-covered services – Not Covered, **except** when treatment of conditions resulting from the provision of non-covered services may be Covered, if medically necessary

*[Rules 1200-13-13-.10 & 1200-13-14-.10]*

**Sex Change or Transformation Surgery** – Not Covered

*[Rules 1200-13-13-.10 & 1200-13-14-.10]*

**Sexual Dysfunction or Inadequacy Services and Medicine**, including drugs for erectile dysfunction and penile implant devices – Not Covered

*[Rules 1200-13-13-.10 & 1200-13-14-.10]*

● **Short-Term Nursing Facility Care** – Covered for CHOICES members only. As defined by the CHOICES Program: the provision of NF care for up to 90 days to a CHOICES member who was receiving HCBS upon admission and who requires temporary placement in an NF when such member is reasonably expected to be discharged and to resume HCBS participation within no more than 90 days.

*[Rule 1200-13-01-.02 & 1200-13-01-.05]*

**Sitter Services** – Not Covered

*[Rules 1200-13-13-.10 & 1200-13-14-.10]*

**Specialized Mental Health Crisis Services** – *See Mental Health Crisis Services*

**Specialized Outpatient and Symptom Management Services** – *See Outpatient Mental Health Services*

**Speech, Language, and Hearing Services to Address Speech Problems** caused by mental, psychoneurotic, or personality disorders– Covered for children under age 21 only.

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Speech Devices** Including:

- Phone mirror handivoice
- Speech software
- Speech teaching machines

Not Covered

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Speech Therapy–**

- **Under age 21:** Covered when provided by a Licensed Speech Therapist, to restore, improve, stabilize, or ameliorate impaired functions.
- **Age 21 and older:** Covered as medically necessary, as long as there is continued medical progress, certified/verified/attested to by a Licensed Speech Therapist, to restore speech after a loss or impairment.

[Rules 1200-13-13-.04 & 1200-13-14-.04]

**Sphygmomanometers** [blood pressure cuffs] – Not Covered

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Standing Tables** – Covered for children under age 21 only.

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Steel Crowns, Prophylactic Use of Stainless** – Not Covered

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Stem Cell Transplants** – See *Organ and Tissue Transplant Services; and Donor Organ/Tissue Procurement Services*

- **Sterilizations** – Covered for individuals age 21 and older only, pursuant to applicable state and federal regulations, who are not institutionalized, who are mentally competent, and who give informed consent on the approved “Sterilization Consent Form” no less than 30 calendar days (or no less than

72 hours in the case of premature delivery or emergency abdominal surgery), but not more than 180 calendar days before the date of sterilization.

[MCO CRAs, Sec. 2.7.8.]

**Sterilization Reversals** – See *Infertility or Impotence Services*

**Stethoscopes** – Not Covered

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Substance Abuse Benefits** – See *Inpatient and Outpatient Substance Abuse Benefits*

- **Supported Employment** – Covered as a component of Psychiatric Rehabilitation. “Supported employment” consists of services to assist individuals to choose, prepare for, obtain, and maintain gainful employment that is based on individuals’ preferences, strengths, and experiences.

[MCO CRAs, Attachment I]

- **Supported Housing Services** – Covered as a component of Psychiatric Rehabilitation. “Supported housing services” refers to services rendered at facilities that are staffed twenty-four (24) hours a day, seven (7) days a week with associated mental health staff supports for priority enrollees who require treatment services and supports in a highly structured setting.

[MCO CRAs, Attachment I]

**Supports:**

- Cervical pillows
- Orthotrac pneumatic vests

Not Covered

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Thermograms** – Not Covered

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Thermography – Not Covered**

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Time Involved in Completing Necessary Forms, Claims, or Reports – Not Covered**

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Tinnitus Maskers – Not Covered**

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Toy Equipment** such as flash switches [for toys] – Not Covered

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Transportation** – See *Emergency Air & Ground Transportation; Non-Emergency Ambulance Transportation; and Non-Emergency Transportation For information on transportation services related to the CHOICES Program, see Rule 1200-13-01-.05.*

**Transportation, Costs associated with:**

- Transportation to a provider located outside the geographical area established in the access standards that the MCC is required to meet, when a network provider is available within the designated geographical area; or, in the case of Medicare beneficiaries, transportation to Medicare providers who are outside the designated geographical area, when there are Medicare providers available within the area as defined in the geographical access standards.
- Mileage reimbursement, car rental fees, or other reimbursement for use of a private vehicle unless prior authorized by the MCC in lieu of contracted transportation services
- Transportation back to Tennessee from vacation or other travel out-of-state in order to access non-emergency covered services (unless authorized by the MCC)
- Any non-emergency out-of-state transportation, including airfare, which has not been prior authorized by the MCC. This includes the costs of transportation to obtain out-of-state care that has been authorized by

the MCC. Out-of-state transportation must be prior authorized independently of out-of-state care.

**Not Covered**

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Transsexual Surgery – Not Covered**

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Vagus Nerve Stimulators** -- Not Covered, **except** after conventional therapy has failed in treating partial onset of seizures.

[Rules 1200-13-13-.10 & 1200-13-14-.10]

**Vision Services–**

- **Under age 21:** Preventive, diagnostic, and treatment services (including eyeglasses) – Covered
- **Age 21 and older:** The following vision services are covered for individuals age 21 and older:
  - Medical eye care—meaning evaluation and management of abnormal conditions, diseases, and disorders (not including evaluation and treatment of the refractive state)
  - One pair of cataract glasses or lenses is covered for adults following cataract surgery.

The following services are Not Covered for adults age 21 and older:

- Eyeglasses, sunglasses, and/or contact lenses, 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] (**Note:** May be approved as a CEA at the sole discretionary authority of the MCC.)
- LASIK
- Orthoptics
- Vision perception training

- Vision therapy

*[Rules 1200-13-13-.04, 1200-13-13-.10, 1200-13-14-.04, & 1200-13-14-.10; Policy BEN 08-001]*

**Weight Loss or Weight Gain and Physical Fitness Programs** including, but not limited to:

- Dietary programs or 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.
- Health clubs, membership fees [e.g., YMCA]
- Marathons, activity and entry fees
- Swimming pools

Not Covered, but may be approved as a CEA for the treatment of obesity for enrollees of any age, at the sole discretionary authority of the MCC.

*[Rules 1200-13-13-.10 & 1200-13-14-.10; Policy BEN 08-001]*

**Wheelchairs**— Covered as medically necessary, including powered wheelchairs, meaning 4-wheeled, battery-operated vehicles that provide back support and that are steered by an electronic device or joystick that controls direction and turning.

The following items are Not Covered:

- Wheelchairs defined by CMS as power operated vehicles (POVs), namely, scooters and devices with 3 or 4 wheels that have tiller steering and limited seat modification capabilities (i.e., provide little or no back support), but may be approved as a CEA at the sole discretionary authority of the MCC. If not approved as a CEA, the item is not provided.
- Standing wheelchairs
- Stair-climbing wheelchairs
- Recreational wheelchairs

*[Rules 1200-13-13-.10 & 1200-13-14-.10; Policy BEN 08-001]*

- **Whirlpools and Whirlpool Equipment** – Not Covered

*[Rules 1200-13-13-.10 & 1200-13-14-.10]*

**Workers' Compensation** – Treatment of job-related illnesses or injuries covered by workers' compensation. Not Covered.

*[Rules 1200-13-13-.10 & 1200-13-14-.10]*