

G.O.C. STAFF RULE ABSTRACT

DEPARTMENT: Environment and Conservation

DIVISION: Air Pollution Control

SUBJECT: Emission Inventory Requirements

STATUTORY AUTHORITY: No federal or state law mandates adoption of this rule, but states are required to collect emissions inventory data pursuant to 40 CFR 51 Subpart A.

EFFECTIVE DATES: February 12, 2018 through June 30, 2018

FISCAL IMPACT: None

STAFF RULE ABSTRACT: This rulemaking hearing rule amends Chapter 1200-03-10 Required Sampling, Recording, and Reporting by adding a new Rule 1200-03-10-.05 (Emissions Inventory Requirements). The new rule is needed to address an inefficiency in Tennessee's Title V permitting process. The federal regulations in 40 C.F.R. Part 51, Subpart A require Tennessee to collect emissions inventory data from all facilities that meet the emission thresholds specified by the rule. Because Tennessee's current rules do not require the collection of emissions inventory data, the Technical Secretary must annually issue demand letters to obtain the required information. Once this amendment becomes effective, the demand letters from the Technical Secretary will no longer be necessary. The rule will require electricity generating units (EGUs) subject to federal emission inventory requirements to submit inventories by July 1 of each calendar year in a format issued by the Technical Secretary. The rule would require other emission sources (non-EGUs) subject to federal emission inventory requirements to submit inventories by June 1 of each calendar year in a format issued by the Technical Secretary. This rule also includes language referencing the department's electronic reporting requirements and certification. This reference is required for the

department to submit emissions inventory data received electronically to fulfill federal requirements. An electronic submittal process will be less burdensome for the regulated community.

Public Hearing Comments

One copy of a document containing responses to comments made at the public hearing must accompany the filing pursuant to T.C.A. § 4-5-222. Agencies shall include only their responses to public hearing comments, which can be summarized. No letters of inquiry from parties questioning the rule will be accepted. When no comments are received at the public hearing, the agency need only draft a memorandum stating such and include it with the Rulemaking Hearing Rule filing. Minutes of the meeting will not be accepted. Transcripts are not acceptable.

There were no comments received during the public comment period or during the public hearing on June 13, 2017.

Regulatory Flexibility Addendum

- (1) The type or types of small business and an identification and estimate of the number of small businesses subject to the proposed rule that would bear the cost of, or directly benefit from the proposed rule.

In general, this proposed rule affects large emission sources (at least 100 tons/year of emissions of a listed pollutant), which are not owned or operated by small businesses.

Because federal regulations require the collection of emissions inventory data from facilities that emit at least 0.5 tons/year of lead, it is possible that small businesses involved in metal fabrication, welding, and other industries could be required to submit emissions inventory data. However, no facilities are currently submitting emission inventory data to the Division of Air Pollution Control for lead emissions only. Furthermore, sources that emit more than 0.5 tons/year of lead are subject to other existing requirements, such as ambient monitoring, which reduce the incentive for facilities to emit more than 0.5 tons/year of lead.

Considering the available information, the Division of Air Pollution Control believes that small businesses will not bear the cost of, and will not directly benefit from, this proposed rule.

- (2) The projected reporting, recordkeeping, and other administrative costs required for compliance with the proposed rule, including the type of professional skills necessary for preparation of the report or record.

Because this proposed rule generally affects large emissions sources, the Division anticipates that there would be minimal reporting, recordkeeping, and other administrative costs to small businesses for compliance with the proposed rule.

- (3) A statement of the probable effect on impacted small businesses and consumers.

Because this proposed rule generally affects large emissions sources, the Division expects that the proposed rule would have minimal effect on small businesses and consumers.

- (4) A description of any less burdensome, less intrusive or less costly alternative methods of achieving the purpose and objectives of the proposed rule that may exist, and to what extent the alternative means might be less burdensome to small business.

Because the collection of emissions inventory data is federally mandated, there are no known less burdensome, less intrusive, or less costly alternative methods. The Division of Air Pollution Control believes that this proposed rule, which sets a yearly deadline for the submittal of emissions inventory data, will ultimately be less burdensome on sources than the existing procedure (i.e., the Division's annual issuance of demand letters for the emissions inventory data, which may establish different deadlines from one year to another).

- (5) A comparison of the proposed rule with any federal or state counterparts.

40 CFR 51 Subpart A (§§ 51.1-51.50) requires States to inventory emission sources located on nontribal lands and report this information to EPA. This proposed rule gives the Division the mechanism to obtain that required emissions inventory data.

- (6) Analysis of the effect of the possible exemption of small businesses from all or any part of the requirements contained in the proposed rule.

Because federal regulations mandate the collection of emissions inventories, no exemptions are proposed for small businesses. However, because this proposed rule generally affects large emissions sources, the Division anticipates that the rule will have minimal effect on small businesses.

Impact on Local Governments

Pursuant to T.C.A. §§ 4-5-220 and 4-5-228 "any rule proposed to be promulgated shall state in a simple declarative sentence, without additional comments on the merits of the policy of the rules or regulation, whether the rule or regulation may have a projected impact on local governments." (See Public Chapter Number 1070 (<http://state.tn.us/sos/acts/106/pub/pc1070.pdf>) of the 2010 Session of the General Assembly)

The Air Pollution Control Board anticipates that these amended rules will not have a financial impact on local governments.

Additional Information Required by Joint Government Operations Committee

All agencies, upon filing a rule, must also submit the following pursuant to T.C.A. § 4-5-226(i)(1).

- (A)** A brief summary of the rule and a description of all relevant changes in previous regulations effectuated by such rule;

The Air Pollution Control Board is amending Chapter 1200-03-10 Required Sampling, Recording, and Reporting by adding a new Rule 1200-03-10-.05 (Emissions Inventory Requirements). The new rule is needed to address an inefficiency in Tennessee's Title V permitting process. The federal regulations in 40 C.F.R. Part 51, Subpart A require Tennessee to collect emissions inventory data from all facilities that meet the emission thresholds specified by the rule. Because Tennessee's current rules do not require the collection of emissions inventory data, the Technical Secretary must annually issue demand letters to obtain the required information. Once this amendment becomes effective, the demand letters from the Technical Secretary will no longer be necessary. The rule will require electricity generating units (EGUs) subject to federal emission inventory requirements to submit inventories by July 1 of each calendar year in a format issued by the Technical Secretary. The rule would require other emission sources (non-EGUs) subject to federal emission inventory requirements to submit inventories by June 1 of each calendar year in a format issued by the Technical Secretary. This rule also includes language referencing the department's electronic reporting requirements and certification. This reference is required for the department to submit emissions inventory data received electronically to fulfill federal requirements. An electronic submittal process will be less burdensome for the regulated community.

- (B)** A citation to and brief description of any federal law or regulation or any state law or regulation mandating promulgation of such rule or establishing guidelines relevant thereto;

No federal or state law mandates adoption of this rule, but states are required to collect emissions inventory data pursuant to 40 CFR 51 Subpart A.

- (C)** Identification of persons, organizations, corporations or governmental entities most directly affected by this rule, and whether those persons, organizations, corporations or governmental entities urge adoption or rejection of this rule;

Any stationary source that emits more than 100 tons/year of particulate matter, sulfur dioxide, volatile organic compounds, nitrogen oxides, carbon monoxide, or ammonia, or any stationary source that emits more than 0.5 tons/year of lead. None of these entities have urged adoption or rejection of the rule.

- (D)** Identification of any opinions of the attorney general and reporter or any judicial ruling that directly relates to the rule or the necessity to promulgate the rule;

The Air Pollution Control Board is not aware of any opinions that directly relate to the rulemaking.

- (E)** An estimate of the probable increase or decrease in state and local government revenues and expenditures, if any, resulting from the promulgation of this rule, and assumptions and reasoning upon which the estimate is based. An agency shall not state that the fiscal impact is minimal if the fiscal impact is more than two percent (2%) of the agency's annual budget or five hundred thousand dollars (\$500,000), whichever is less;

No change in state and local government revenues and expenditures is expected to result from this rule.

- (F)** Identification of the appropriate agency representative or representatives, possessing substantial knowledge and understanding of the rule;

Travis Blake
Division of Air Pollution Control
William R. Snodgrass Tennessee Tower
312 Rosa L. Parks Avenue, 15th Floor
Nashville, Tennessee 37243
travis.blake@tn.gov

- (G)** Identification of the appropriate agency representative or representatives who will explain the rule at a scheduled meeting of the committees;

Lucian Geise
Senior Counsel for Legislative Affairs
Office of General Counsel

- (H) Office address, telephone number, and email address of the agency representative or representatives who will explain the rule at a scheduled meeting of the committees; and

Office of General Counsel
Tennessee Department of Environment and Conservation
William R. Snodgrass Tennessee Tower
312 Rosa L. Parks Avenue, 2nd Floor
Nashville, Tennessee 37243
(615) 532-0108
Lucian.Geise@tn.gov

- (I) Any additional information relevant to the rule proposed for continuation that the committee requests.

The Tennessee Air Pollution Control Board is not aware of any additional relevant information.

**Department of State
Division of Publications**

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Nashville, TN 37243
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Email: publications.information@tn.gov

For Department of State Use Only

Sequence Number: 11-11-17
Rule ID(s): 6647
File Date: 11/14/17
Effective Date: 02/12/18

Rulemaking Hearing Rule(s) Filing Form

Rulemaking Hearing Rules are rules filed after and as a result of a rulemaking hearing (Tenn. Code Ann. § 4-5-205).

Pursuant to Tenn. Code Ann. § 4-5-229, any new fee or fee increase promulgated by state agency rule shall take effect on July 1, following the expiration of the ninety (90) day period as provided in § 4-5-207. This section shall not apply to rules that implement new fees or fee increases that are promulgated as emergency rules pursuant to § 4-5-208(a) and to subsequent rules that make permanent such emergency rules, as amended during the rulemaking process. In addition, this section shall not apply to state agencies that did not, during the preceding two (2) fiscal years, collect fees in an amount sufficient to pay the cost of operating the board, commission or entity in accordance with § 4-29-121(b).

Agency/Board/Commission:	Environment & Conservation
Division:	Air Pollution Control
Contact Person:	Travis Blake
Address:	William R. Snodgrass Tennessee Tower 312 Rosa L. Parks Avenue, 15th Floor Nashville, Tennessee
Zip:	37243
Phone:	(615) 532-0617
Email:	travis.blake@tn.gov

Revision Type (check all that apply):

- Amendment
 New
 Repeal

Rule(s) (ALL chapters and rules contained in filing must be listed here. If needed, copy and paste additional tables to accommodate multiple chapters. Please make sure that **ALL** new rule and repealed rule numbers are listed in the chart below. Please enter only **ONE** Rule Number/Rule Title per row)

Chapter Number	Chapter Title
1200-03-10	Required Sampling, Recording, and Reporting
Rule Number	Rule Title
1200-03-10-.05	Emissions Inventory Requirements

(Place substance of rules and other info here. Please be sure to include a detailed explanation of the changes being made to the listed rule(s). Statutory authority must be given for each rule change. For information on formatting rules go to http://sos.tn.gov/sites/default/files/forms/Rulemaking_Guidelines_August2014.pdf)

Chapter 1200-03-10
Required Sampling, Recording, and Reporting

New Rule

Add the following to the table of contents to Chapter 1200-03-10 Required Sampling, Recording, and Reporting::

1200-03-10-.05 Emissions Inventory Requirements

Authority: T.C.A. §§ 68-201-101 et seq. and 4-5-201 et seq.

Add a new rule to Chapter 1200-03-10 Required Sampling, Recording, and Reporting to read as follows:

1200-03-10-.05 Emissions Inventory Requirements

- (1) Stationary sources that exceed the emission thresholds specified in 40 CFR 51 Subpart A shall submit emissions inventories of the pollutants listed in § 51.15(a)(1), as follows:
 - (a) Electricity generating units (EGUs), as defined in subpart (9)(d)2(i) of Rule 1200-03-26-.02, shall submit emissions inventories no later than July 1 of each calendar year, in accordance with § 51.30 and Table 1 to Appendix A of 40 C.F.R. 51 Subpart A.
 - (b) All other stationary sources shall submit emissions inventories no later than June 1 of each calendar year, in accordance with § 51.30 and Table 1 to Appendix A of 40 C.F.R. 51 Subpart A.
- (2) Emissions inventories shall be submitted and certified in accordance with forms and guidance issued by the Technical Secretary.
- (3) The Technical Secretary may make the forms issued pursuant to paragraph (2) of this rule available electronically. If an emission inventory is submitted electronically, then the submission shall be in accordance with the requirements of Chapter 0400-01-40.

Authority: T.C.A. §§ 68-201-101 et seq. and 4-5-201 et seq.

* If a roll-call vote was necessary, the vote by the Agency on these rulemaking hearing rules was as follows:

Board Member	Aye	No	Abstain	Absent	Signature (if required)
Dr. Ronne Adkins Commissioner's Designee, Dept. of Environment and Conservation				X	
Dr. John Benitez Licensed Physician with experience in health effects of air pollutants				X	
Karen Cisler Environmental Interests	X				
Dr. Wayne T. Davis Conservation Interests				X	
Dr. Joshua S. Fu Involved with Institution of Higher Learning on air pollution evaluation and control				X	
Stephen Gossett Working for Industry with technical experience	X				
Dr. Shawn A. Hawkins Working in field related to Agriculture or Conservation	X				
Richard Holland Working for Industry with technical experience	X				
Caitlin Roberts Jennings Small Generator of Air Pollution representing Automotive Interests	X				
Chris Moore Working in management in Private Manufacturing				X	
Amy Spann, PE Registered Professional Engineer	X				
Larry Waters County Mayor	X				
Jimmy West Commissioner's Designee, Dept. of Economic and Community Development	X				
Vacant Working in Municipal Government					

I certify that this is an accurate and complete copy of rulemaking hearing rules, lawfully promulgated and adopted by the Air Pollution Control Board on 07/12/2017, and is in compliance with the provisions of T.C.A. § 4-5-222.

I further certify the following:

Notice of Rulemaking Hearing filed with the Department of State on: 04/11/17

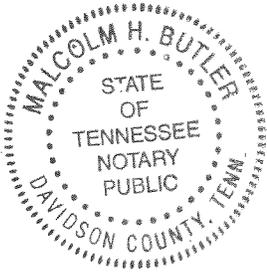
Rulemaking Hearing(s) Conducted on: (add more dates). 06/13/17

Date: July 17, 2017

Signature: Michelle W. Owenby

Name of Officer: Michelle W. Owenby

Title of Officer: Technical Secretary



Subscribed and sworn to before me on: July 17, 2017

Notary Public Signature: Malcolm H. Butler

My commission expires on: September 7, 2020

Agency/Board/Commission: _____

Rule Chapter Number(s): _____

All rulemaking hearing rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

Herbert H. Slatery III
Herbert H. Slatery III
Attorney General and Reporter

11/3/2017
Date

Department of State Use Only

Filed with the Department of State on: 11/14/17

Effective on: 02/12/18

Tre Hargett
Tre Hargett
Secretary of State

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PUBLICATIONS

G.O.C. STAFF RULE ABSTRACT

DEPARTMENT: Labor and Workforce Development

DIVISION: Occupational Safety and Health

SUBJECT: Occupational Safety and Health Standards

STATUTORY AUTHORITY: Under the statutory authority of 29 U.S.C. § 667, Tennessee has an approved state plan that provides for the development and enforcement of occupational safety and health standards. In accordance with the plan, when a federal occupational safety and health standard is promulgated under 29 U.S.C. § 655 Tennessee generally adopts the federal standard relating to the same issue. When a federal standard is not adopted, it is referenced as an exception in the rules. The statutory authority for promulgation of the rules by the Commissioner of Labor and Workforce Development is T.C.A. § 50-3-201.

EFFECTIVE DATES: February 4, 2018 through June 30, 2018

FISCAL IMPACT: None

STAFF RULE ABSTRACT: Rules 0800-01-01-.06, 0800-01-06-.02, 0800-01-07-.01 and 0800-01-07-.02 are amended by this proposed rule in order to adopt and reference the latest occupational safety and health standards and exceptions, if any, in the applicable parts of Title 29, Code of Federal Regulations when published in the Federal Register. Since the last amendments to the rules there have been no substantive changes to the Occupational Safety and Health Standards.

Regulatory Flexibility Addendum

Pursuant to T.C.A. §§ 4-5-401 through 4-5-404, prior to initiating the rule making process as described in T.C.A. § 4-5-202(a)(3) and T.C.A. § 4-5-202(a), all agencies shall conduct a review of whether a proposed rule or rule affects small businesses.

An economic impact statement regarding the amendments in this rule proposal is not required under the provisions of the Regulatory Flexibility Act of 2007. As stated in Section 6 of Public Chapter 464, "This part shall not apply to rules that are adopted on an emergency or public necessity basis under Title 4, Chapter 5, Part 2, that are federally mandated, or that substantially codify existing state or federal law." Under the statutory authority of 29 U.S.C. § 667, Tennessee has an approved state plan that provides for the development and enforcement of occupational safety and health standards. In accordance with the Tennessee Occupational Safety and Health State Plan, when a federal occupational safety and health standard is promulgated under 29 U.S.C. § 655 Tennessee generally adopts the federal standard relating to the same issue. The plan specifies that the state of Tennessee will adopt the federal standards or an equivalent state requirement within six (6) months of the standard's promulgation by federal OSHA. In addition, T.C.A. §50-3-201 authorizes the Commissioner of Labor and Workforce Development to adopt either state or federal occupational safety and health standards.

Impact on Local Governments

Pursuant to T.C.A. §§ 4-5-220 and 4-5-228 “any rule proposed to be promulgated shall state in a simple declarative sentence, without additional comments on the merits of the policy of the rules or regulation, whether the rule or regulation may have a projected impact on local governments.” (See Public Chapter Number 1070 (<http://state.tn.us/sos/acts/106/pub/pc1070.pdf>) of the 2010 Session of the General Assembly)

This rule does not have a projected impact on local governments.

Additional Information Required by Joint Government Operations Committee

All agencies, upon filing a rule, must also submit the following pursuant to T.C.A. § 4-5-226(i)(1).

- (A) A brief summary of the rule and a description of all relevant changes in previous regulations effectuated by such rule;

Rules 0800-01-01-.06, 0800-01-06-.02, 0800-01-07-.01 and 0800-01-07-.02 are amended in order to adopt and reference the latest occupational safety and health standards and exceptions, if any, in the applicable parts of Title 29, Code of Federal Regulations when published in the Federal Register. Since the last amendments to the rules there have been no substantive changes to the Occupational Safety and Health Standards.

- (B) A citation to and brief description of any federal law or regulation or any state law or regulation mandating promulgation of such rule or establishing guidelines relevant thereto;

Under the statutory authority of 29 U.S.C. § 667, Tennessee has an approved state plan that provides for the development and enforcement of occupational safety and health standards. In accordance with the plan, when a federal occupational safety and health standard is promulgated under 29 U.S.C. § 655 Tennessee generally adopts the federal standard relating to the same issue. When a federal standard is not adopted, it is referenced as an exception in the rules. The statutory authority for promulgation of the rules by the Commissioner of Labor and Workforce Development is T.C.A. § 50-3-201.

- (C) Identification of persons, organizations, corporations or governmental entities most directly affected by this rule, and whether those persons, organizations, corporations or governmental entities urge adoption or rejection of this rule;

All persons subject to T.C.A. §§ 50-3-101 *et seq.* are directly affected by the rules in Chapters 0800-01-01, 0800-01-06 and 0800-01-07. These rules provide for the effective administration and enforcement of the occupational safety and health standards required by the state plan. Employees and employers including governmental entities in the state must comply with the rules promulgated pursuant to federal and state law. It appears that there are no objections to the proposed amendments to the rules since no inquiries have been made.

- (D) Identification of any opinions of the attorney general and reporter or any judicial ruling that directly relates to the rule;

There have been no Attorney General opinions or judicial rulings relevant to these rules.

- (E) An estimate of the probable increase or decrease in state and local government revenues and expenditures, if any, resulting from the promulgation of this rule, and assumptions and reasoning upon which the estimate is based. An agency shall not state that the fiscal impact is minimal if the fiscal impact is more than two percent (2%) of the agency's annual budget or five hundred thousand dollars (\$500,000), whichever is less;

There are no anticipated increases or decreases in state and local government revenues and expenditures resulting from promulgation of the proposed rules and amendments to the existing rules.

- (F) Identification of the appropriate agency representative or representatives, possessing substantial knowledge and understanding of the rule;

- (G) Identification of the appropriate agency representative or representatives who will explain the rule at a scheduled meeting of the committees;

Larry Hunt, Manager, Standards & Procedures, Division of Occupational Safety and Health, is the agency representative most knowledgeable about these rules.

- (H)** Office address, telephone number, and email address of the agency representative or representatives who will explain the rule at a scheduled meeting of the committees; and

Tennessee Department of Labor and Workforce Development
Division of Occupational Safety and Health
220 French Landing Drive
Nashville, TN 37243-1002
(615) 741-7036
email: larry.hunt@tn.gov

- (I)** Any additional information relevant to the rule proposed for continuation that the committee requests.

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For Department of State Use Only

Sequence Number: 11-04-17
 Rule ID(s): 6639-6641
 File Date: 11/6/17
 Effective Date: 2/4/18

Proposed Rule(s) Filing Form

Proposed rules are submitted pursuant to T.C.A. §§ 4-5-202, 4-5-207 in lieu of a rulemaking hearing. It is the intent of the Agency to promulgate these rules without a rulemaking hearing unless a petition requesting such hearing is filed within sixty (60) days of the first day of the month subsequent to the filing of the proposed rule with the Secretary of State. To be effective, the petition must be filed with the Agency and 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. The agency shall forward such petition to the Secretary of State.

Agency/Board/Commission:	Department of Labor and Workforce Development
Division:	Division of Occupational Safety and Health
Contact Person:	Larry Hunt
Address:	220 French Landing Drive
Zip:	37243-1002
Phone:	(615) 741-7036
Email:	Larry.Hunt@tn.gov

Revision Type (check all that apply):

- Amendment
 New
 Repeal

Rule(s) Revised (ALL chapters and rules contained in filing must be listed here. If needed, copy and paste additional tables to accommodate multiple chapters. Please enter only ONE Rule Number/Rule Title per row)

Chapter Number	Chapter Title
0800-01-01	Occupational Safety and Health Standards for General Industry
Rule Number	Rule Title
0800-01-01-.06	Adoption and Citation of Federal Standards

Chapter Number	Chapter Title
0800-01-06	Occupational Safety and Health Standards for Construction
Rule Number	Rule Title
0800-01-06-.02	Adoption and Citation of Federal Standards

Chapter Number	Chapter Title
0800-01-07	Occupational Safety and Health Standards for Agriculture
Rule Number	Rule Title
0800-01-07-.01	Adoption and Citation of Federal Standards
0800-01-07-.02	Exceptions to Adoption of Federal Standards

Proposed Amendments with Changes Red-Lined

Chapter 0800-01-01

Rule 0800-01-01-.06 Amended

Paragraph (2) of Rule 0800-01-01-.06 Adoption and Citation of Federal Standards is amended by changing the date from "July 1, 2017" to "January 1, 2018".

Existing Rule:

- (2) The Commissioner of Labor and Workforce Development adopts the federal occupational safety and health standards codified in Title 29, Code of Federal Regulations, Part 1910, as of ~~July 1, 2017~~ except as provided in Rule 0800-01-01-.07 of this chapter.

Proposed Amended Rule:

- (2) The Commissioner of Labor and Workforce Development adopts the federal occupational safety and health standards codified in Title 29, Code of Federal Regulations, Part 1910, as of January 1, 2018 except as provided in Rule 0800-01-01-.07 of this chapter.

Authority: T.C.A. §§ 4-3-1411 and 50-3-201.

Chapter 0800-01-06

Rule 0800-01-06-.02 Amended

Paragraph (2) of Rule 0800-01-06-.02 Adoption and Citation of Federal Standards is amended by changing the date from "July 1, 2017" to "January 1, 2018".

Existing Rule:

- (2) The Commissioner of Labor and Workforce Development adopts the federal occupational safety and health standards codified in Title 29, Code of Federal Regulations, Part 1926, as of ~~July 1, 2017~~ except as provided in Rule 0800-01-06-.03 of this chapter.

Proposed Amended Rule:

- (2) The Commissioner of Labor and Workforce Development adopts the federal occupational safety and health standards codified in Title 29, Code of Federal Regulations, Part 1926, as of January 1, 2018 except as provided in Rule 0800-01-06-.03 of this chapter.

Authority: T.C.A. §§ 4-3-1411, 50-3-103 and 50-3-201.

Chapter 0800-01-07

Rule 0800-01-07-.01 Amended

Paragraph (2) of Rule 0800-01-07-.01 Adoption and Citation of Federal Standards is amended by changing the date from "July 1, 2017" to "January 1, 2018".

Existing Rule:

- (2) The Commissioner of Labor and Workforce Development adopts the federal occupational safety and health standards codified in Title 29, Code of Federal Regulations, Part 1928, as of ~~July 1, 2017~~ except as provided in Rule 0800-01-07-.02 of this chapter.

Proposed Amended Rule:

- (2) The Commissioner of Labor and Workforce Development adopts the federal occupational safety and health standards codified in Title 29, Code of Federal Regulations, Part 1928, as of January 1, 2018 except as provided in Rule 0800-01-07-.02 of this chapter.

Authority: T.C.A. §§4-3-1411 and 50-3-201.

Rule 0800-01-07-.02 Amended

Paragraph (1) of Rule 0800-01-07-.02 Exceptions to Adoption of Federal Standards in 29 CFR Part 1928 is amended by changing the date from "July 1, 2017" to "January 1, 2018".

Existing Rule:

- (1) As of ~~July 1, 2017~~, there are no exceptions.

Proposed Amended Rule:

- (1) As of January 1, 2018, there are no exceptions.

Authority: T.C.A. §§4-3-1411 and 50-3-201.

* If a roll-call vote was necessary, the vote by the Agency on these rules was as follows:

Board Member	Aye	No	Abstain	Absent	Signature (if required)

I certify that this is an accurate and complete copy of proposed rules, lawfully promulgated and adopted by the (board/commission/other authority) on 9/8/17 (date as mm/dd/yyyy), and is in compliance with the provisions of T.C.A. § 4-5-222. The Secretary of State is hereby instructed that, in the absence of a petition for proposed rules being filed under the conditions set out herein and in the locations described, he is to treat the proposed rules as being placed on file in his office as rules at the expiration of sixty (60) days of the first day of the month subsequent to the filing of the proposed rule with the Secretary of State.

Date: 9/8/17

Signature: Burns Phillips

Name of Officer: Burns Phillips

Title of Officer: Commissioner of Labor and Workforce Development



Subscribed and sworn to before me on: 9-8-17

Notary Public Signature: Desiree W. Felts

My commission expires on: March 17, 2021

All proposed rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

Herbert H. Slattery III
 Herbert H. Slattery III
 Attorney General and Reporter
10/21/2017
 Date

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 PUBLICATIONS

Filed with the Department of State on: 11/6/17

Effective on: 2/4/18

Tre Hargett
 Tre Hargett
 Secretary of State

G.O.C. STAFF RULE ABSTRACT

DEPARTMENT: Commerce and Insurance

DIVISION: Securities

SUBJECT: Securities Registration and Exemptions

STATUTORY AUTHORITY: Tennessee Code Annotated, Section 48-1-101 *et seq.*

EFFECTIVE DATES: February 28, 2018 through June 30, 2018

FISCAL IMPACT: This rule will not affect state or local government revenues and expenditures.

STAFF RULE ABSTRACT: This proposed amendment clarifies what the Division requires for notice filings for written compensatory benefit plans exempt from federal registration requirements pursuant to SEC Rule 701 (17 C.F.R. 230.701).

Regulatory Flexibility Addendum

Pursuant to T.C.A. §§ 4-5-401 through 4-5-404, prior to initiating the rule making process, all agencies shall conduct a review of whether a proposed rule or rule affects small business.

This rule amendment will not affect small businesses.

Impact on Local Governments

Pursuant to T.C.A. §§ 4-5-220 and 4-5-228 “any rule proposed to be promulgated shall state in a simple declarative sentence, without additional comments on the merits of the policy of the rules or regulation, whether the rule or regulation may have a projected impact on local governments.” (See Public Chapter Number 1070 (<http://state.tn.us/sos/acts/106/pub/pc1070.pdf>) of the 2010 Session of the General Assembly)

This rule amendment will not affect local governments.

Additional Information Required by Joint Government Operations Committee

All agencies, upon filing a rule, must also submit the following pursuant to T.C.A. § 4-5-226(i)(1).

- (A) A brief summary of the rule and a description of all relevant changes in previous regulations effectuated by such rule;

This proposed amendment clarifies what the Division requires for notice filings for written compensatory benefit plans exempt from federal registration requirements pursuant to SEC Rule 701 (17 C.F.R. 230.701).

- (B) A citation to and brief description of any federal law or regulation or any state law or regulation mandating promulgation of such rule or establishing guidelines relevant thereto;

This rule is authorized by various provisions of the Tennessee Securities Act of 1980 (T.C.A. §§ 48-1-101 *et seq.*), particularly T.C.A. § 48-1-116, which provides that the Commissioner "may from time to time make, promulgate, amend, and rescind such rules, forms, and orders as are necessary to carry out this part" and T.C.A. § 48-1-103(b)(9), the corresponding statutory provision on exempt employee plans. Additionally, the National Securities Market Improvement Act of 1996 authorizes the states to collect notice filings for securities offerings that are exempt from federal registration, including certain employee compensatory plans exempt from federal registration pursuant to SEC Rule 701 (17 C.F.R. 230.701).

- (C) Identification of persons, organizations, corporations or governmental entities most directly affected by this rule, and whether those persons, organizations, corporations or governmental entities urge adoption or rejection of this rule;

This rule amendment affects only companies that wish to offer their employees written compensatory benefit plans that are exempt from federal registration requirements pursuant to SEC Rule 701 (17 C.F.R. 230.701).

- (D) Identification of any opinions of the attorney general and reporter or any judicial ruling that directly relates to the rule or the necessity to promulgate the rule;

There are no known opinions of the attorney general or any judicial rulings that directly relate to this rule.

- (E) An estimate of the probable increase or decrease in state and local government revenues and expenditures, if any, resulting from the promulgation of this rule, and assumptions and reasoning upon which the estimate is based. An agency shall not state that the fiscal impact is minimal if the fiscal impact is more than two percent (2%) of the agency's annual budget or five hundred thousand dollars (\$500,000), whichever is less;

This rule will not affect state or local government revenues and expenditures.

- (F) Identification of the appropriate agency representative or representatives, possessing substantial knowledge and understanding of the rule;

Frank Borger-Gilligan, Assistant Commissioner;
Elizabeth Bowling, Direct of Registration for the Securities Division;
Kaycee Wolf, Chief Counsel for Insurance, Securities, and TennCare Oversight

- (G) Identification of the appropriate agency representative or representatives who will explain the rule at a scheduled meeting of the committees;

Kelsey J. Bridges, Assistant General Counsel for Securities

- (H) Office address, telephone number, and email address of the agency representative or representatives who will explain the rule at a scheduled meeting of the committees; and

500 James Robertson Parkway, Legal Division, 8th Floor, Nashville, TN 37243; (615) 350-7984;
Kelsey.j.bridges@tn.gov

(l) Any additional information relevant to the rule proposed for continuation that the committee requests.

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**Department of State
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Sequence Number: 11-23-17
Rule ID(s): 6655
File Date: 11/30/17
Effective Date: 2/28/18

Proposed Rule(s) Filing Form

Proposed rules are submitted pursuant to Tenn. Code Ann. §§ 4-5-202, 4-5-207, and 4-5-229 in lieu of a rulemaking hearing. It is the intent of the Agency to promulgate these rules without a rulemaking hearing unless a petition requesting such hearing is filed within ninety (90) days of the filing of the proposed rule with the Secretary of State. To be effective, the petition must be filed with the Agency and be signed by ten (10) persons who will be affected by the amendments, or submitted by a municipality which will be affected by the amendments, or an association of ten (10) or more members, or any standing committee of the General Assembly. The agency shall forward such petition to the Secretary of State.

Pursuant to Tenn. Code Ann. § 4-5-229, any new fee or fee increase promulgated by state agency rule shall take effect on July 1, following the expiration of the ninety (90) day period as provided in § 4-5-207. This section shall not apply to rules that implement new fees or fee increases that are promulgated as emergency rules pursuant to § 4-5-208(a) and to subsequent rules that make permanent such emergency rules, as amended during the rulemaking process. In addition, this section shall not apply to state agencies that did not, during the preceding two (2) fiscal years, collect fees in an amount sufficient to pay the cost of operating the board, commission or entity in accordance with § 4-29-121(b).

Agency/Board/Commission:	Commerce and Insurance
Division:	Securities
Contact Person:	Kelsey J. Bridges
Address:	500 James Robertson Parkway
Zip:	37243
Phone:	615-350-7984
Email:	Kelsey.j.bridges@tn.gov

Revision Type (check all that apply):

- Amendment
 New
 Repeal

Rule(s) (ALL chapters and rules contained in filing must be listed here. If needed, copy and paste additional tables to accommodate multiple chapters. Please make sure that ALL new rule and repealed rule numbers are listed in the chart below. Please enter only ONE Rule Number/Rule Title per row)

Chapter Number	Chapter Title
0780-04-02	Securities Registration and Exemptions
Rule Number	Rule Title
0780-04-02-.13	Notice Filings for Exempt Employee Plans

Chapter Number	Chapter Title
Rule Number	Rule Title

0780-04-02-13 NOTICE FILINGS FOR EXEMPT EMPLOYEE PLANS.

~~(1)~~ All issuers who wish to offer to sell securities from, in, or into this state in reliance on the ~~an~~ exemption afforded to written employee compensatory benefit plans under T.C.A. § 48-1-103(b)(9)(A)(iii) ~~sales of securities in an employee stock purchase/option plan~~ must file with the commissioner no later than fifteen (15) days after the first sale, as defined under T.C.A. § 48-1-102(19)(A), from, in, or into Tennessee:

~~(1)(a)~~ A completed and properly executed Form IN-1461, ~~One (1) copy of the form entitled~~ "Notice of Sale of Securities Pursuant to Employee Stock Purchase/Option Plan Exemption", as provided by the Division;

~~(2)(b)~~ A completed and properly executed consent to service of process on Form U-2, or in such other format acceptable to the Division, as provided under T.C.A. § 48-1-124(e) ~~A Form U-2 Uniform Consent to Service of Process~~;

~~(3)(c)~~ A completed and properly executed Form U-2A, if applicable ~~If the issuer is a corporation, a Form U-2A Uniform Form of Corporate Resolution~~;

~~(4)(d)~~ ~~A non-refundable~~ The filing fee as provided under T.C.A. § 48-1-103(b)(9)(A)(iii)(c) ~~in the amount of five hundred dollars (\$500)~~; and

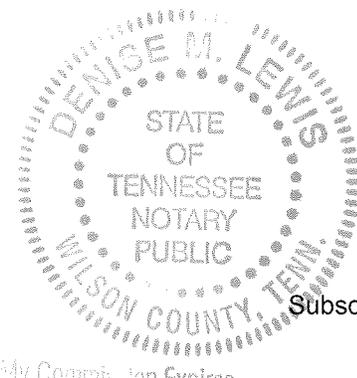
~~(5)(e)~~ A statement ~~specifying~~ ~~noting~~ the date of the first sale, if any, of such securities ~~security~~ from, in, or into this state.

Authority: T.C.A. §§ 48-1-103(b)(9), 48-1-115, 48-1-116, and 48-1-124, ~~and Public Acts of 2001, Chapter 278~~.

* If a roll-call vote was necessary, the vote by the Agency on these rules was as follows:

Board Member	Aye	No	Abstain	Absent	Signature (if required)

I certify that this is an accurate and complete copy of proposed rules, lawfully promulgated and adopted by the Commissioner on 5/19/17 (date as mm/dd/yyyy), and in compliance with the provisions of T.C.A. § 4-5-222. The Secretary of State is hereby instructed that, in the absence of a petition for proposed rules being filed under the conditions set out herein and in the locations described, he is to treat the proposed rules as being placed on file in his office as rules at the expiration of ninety (90) days of the filing of the proposed rule with the Secretary of State.



Date: 5/19/17

Signature: Julie Mix McPeak

Name of Officer: Julie Mix McPeak

Title of Officer: Commissioner of the Department of Commerce and Insurance

Subscribed and sworn to before me on: Denise M Lewis

Notary Public Signature: 5/19/17

My commission expires on: 1/15/20

Agency/Board/Commission: Commerce and Insurance

Rule Chapter Number(s): 0780-04-02

All proposed rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

Herbert H. Slatery III
Herbert H. Slatery III
Attorney General and Reporter

11/21/2017 Date

Department of State Use Only

Filed with the Department of State on: 11/30/17

Effective on: 2/29/18

Tre Hargett
Tre Hargett
Secretary of State

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REGISTRATIONS

G.O.C. STAFF RULE ABSTRACT

DEPARTMENT: Agriculture

DIVISION: Consumer and Industry Services

SUBJECT: Plant Sales and Distribution; Quarantines

STATUTORY AUTHORITY: Tennessee Code Annotated, Sections 43-6-104 and 43-6-106

EFFECTIVE DATES: February 4, 2018 through June 30, 2018

FISCAL IMPACT: Minimal

STAFF RULE ABSTRACT: This rulemaking hearing rule provides for a new quarantine against boxwood blight to prevent the spread of the disease. The rule also amends general packing requirements for the shipment of plants in commerce, and the removal of five counties from the Thousand Cankers Disease quarantine.

Public Hearing Comments

The Department of Agriculture held a public hearing on September 12, 2017. Jay Miller served as hearing officer for the rulemaking hearing, regarding chapters 0080-06-01 Plant Sales and Distribution; 0080-06-07 Boxwood Blight Quarantine; and 0080-06-11 Thousand Cankers Disease Quarantine. Oral comments from the hearing and written comments from constituents are summarized below along with the Department's response.

Comment:

Jeff Ray of Nashville Nursery and Landscape Supply, Inc. in Nashville, Tennessee commented that boxwood blight is a serious and legitimate concern in the nursery and plant industries. He and others requested specific guidance to address the disease for all segments of the landscape supply and distribution chain, including the length of time materials are required to be quarantined to ensure boxwood blight is not present. He also commented that the rule needed additional clarification on the responsibilities of sectors within the industry (e.g. growers, distributors, landscapers, and property owners) in order to contain boxwood blight.

Response:

The Department appreciates Mr. Ray's comments and agrees that boxwood blight is a serious concern for Tennessee plant industries. As boxwood blight spreads in the United States, the Department anticipates more information will be learned about how the disease spreads, what measures are most effective in containing it, and what actions are best suited for material found to be infected (e.g. burning, burial, or bagged disposal), etc. Inasmuch as more information and education may likely occur as this disease progresses, the Department is hesitant to promulgate in rule particular containment practices as requirements if they may quickly be outdated. Instead, the Department has published more specific disease information and suggested best practices at its website: <https://www.tn.gov/agriculture/article/ag-businesses-other-pests>, and intends for this rule to focus on more elemental requirements for containment of the disease, i.e. phytosanitary inspection, involvement in cleanliness programs, and pre-notification of shipments from outside Tennessee. When and if infections are found in Tennessee, the Department is equipped under this rule to issue orders specific to the particular circumstances of those occurrences. In that way, the Department anticipates being able to respond to situations in a minimally intrusive fashion that still protects the public health and welfare from spread of this disease. While the Department cannot predict outcomes for all possible situations in which boxwood blight might be observed, it is likely that departmental response will include stop-movement and destruction of material that is infected or exposed to infection if it is capable of spreading the disease, and sanitation of all exposed equipment, etc. The Department is not persuaded that that holding all boxwood materials in quarantine for a prescribed time will be effective in managing risks of the disease, because host plants may be asymptomatic, and is concerned that such weightier requirements will unduly burden private business without significant public benefit.

As written the basic requirements of this rule are: for shipment of boxwood plants from out-of-state or from any quarantined area in Tennessee, the movement must be reported to the Department by any nursery or plant dealer, etc. in Tennessee who receives the shipment; and the shipment must be accompanied by a phytosanitary inspection certificate and a cleanliness program compliance agreement. If a firm in Tennessee receives violative material, the firm is not subject to penalty for violation of the quarantine unless it imported the material or failed to report its receipt; however, the firm will be subject to stop movement and destruction orders issued for the material. The firm may also be quarantined for containment of the disease.

Comment:

Danny Roller of Rock Island, Tennessee complimented the cross section of industry representatives present at the hearing and appreciated the varied perspective of plant retailers, wholesalers, and producers.

Response:

The Department appreciates Mr. Roller's comments. The Department continually strives for good communication with all of its stakeholders regarding how regulatory requirements affect them and how the public safety may best be protected.

Comment:

Frank Collier of Pleasant Cove Nursery in Rock Island, Tennessee voiced a concern that, in response to Tennessee's quarantine against out-of-state shipments of boxwood plants, other states may institute tougher quarantines against Tennessee for similar shipments into their states. Mr. Collier suggested that for shipment of regulated articles into Tennessee, the rule should require a phytosanitary certificate and cleanliness program agreement—not simply one or the other. Mr. Collier also recommended the rule require notification to the Department before any boxwood plants are shipped into the state—although Mr. Collier admits it may be impractical for the Department to inspect all boxwood shipments coming into the state. Mr. Collier also asked that the rule require boxwoods imported into the state not be sprayed with fungicide within 30 days prior to shipment, so that boxwood blight symptoms are not masked upon entry into Tennessee. Mr. Collier indicated that as a grower, he is already beginning to drop production of various varieties of boxwood believed to be more susceptible to boxwood blight. He and others stressed the need to educate stakeholders on how the disease is spread and what can be done to curtail its progression. Mr. Collier would urge rejection of this quarantine rule if it does not include a phytosanitary inspection requirement and notification of shipments. Mr. Collier and others urged firm participation in cleanliness programs. He indicated that other states are already instituting similar restrictions on boxwood movement, including Maryland, Virginia, and Oregon. Finally, Mr. Collier voiced concerns over how a Tennessee firm can verify the out-of-state producer's compliance with Tennessee requirements prior to shipping boxwoods into Tennessee.

Response:

The Department appreciates Mr. Collier's comments, and agrees that boxwood blight is a serious concern affecting the plant industry that will require coordinated efforts in regulation, outreach, and education in order to address the disease. The Department is hopeful that this rule may serve a pivotal part in that process.

With respect to Mr. Collier's concerns for quarantine warfare among the states, whether a sister state promulgates weightier restrictions in response to a Tennessee quarantine or shipment restriction is always a concern for the Department before promulgating a quarantine rule of this kind. Consequently, this rule is drafted to be as minimally intrusive as possible for affected parties. As noted in previous responses, the rule requires inspection, compliance agreement practices, and pre-notification of shipment. The rule has not taken up more restrictive requirements such as automatic 30-day quarantines for observation, etc. It is the Department's hope that other states will value this approach for their producers that ship product into Tennessee while also serving to protect spread of the boxwood blight disease. The Department is encouraged that other states are reported to be taking up similar measures.

With respect to Mr. Collier's suggestion to make inspection and compliance agreements both applicable requirements and his suggestion to require notification of shipments into Tennessee, the Department finds the suggestions well-taken and has amended the rules accordingly. Inasmuch as enforcement of the pre-notification requirement is difficult among out-of-state shippers and with the limited resources of the Department, the rule includes the notification requirement only among firms licensed by the Department. This requirement will be more enforceable than as against out-of-state firms and will still apply to the vast majority of out-of-state shipments of boxwood plants into Tennessee.

With respect to Mr. Collier's concern for liability of Tennessee firms that receive violative product and his suggestion for a 30-day holding period of all received boxwood plants (for observation and for non-spray of fungicides), the Department makes the same response as detailed above for Mr. Ray's comments.

Comment:

David Bates of Bates Nursery and Garden Center in Nashville, Tennessee commented that firms in the plant industry are already changing their production and supply of boxwoods based on concerns with Boxwood Blight. Mr. Bates stressed the importance of knowing what was required for out-of-state shippers so that in-state recipients can be compliant with this rule. Mr. Bates and others in attendance indicated difficulty understanding the rule. These persons asked for greater clarity and specificity on what requirements were for shipping and receiving boxwood plants in the state and what the ramifications were for violating those requirements. On this point, Mr. Bates expressed concern that if boxwood blight was found on his premises, a resulting stop-movement order or quarantine of his business could include other species of plants besides boxwood. Mr. Bates requested clarity on how to avoid such a situation. Mr. Bates recommended automatic quarantine of out-of-state shipments and shipments from uncertified growers for 30 days prior to sale or movement.

Response:

The Department appreciates Mr. Bates' comments. With respect to his concerns regarding rule clarity, the Department finds Mr. Bates' comments well-taken and has amended the rule accordingly. Subsequent revision of the rule focused on using more plain language, removing redundant or unnecessary definitions, words, and phrases, shortening sentences, removing loquacious qualifiers (e.g. "otherwise in compliance"), and using more specific definitions (e.g. "certificate" is more clearly defined as a "phytosanitary certificate," etc.). The Department continually strives to revise all of its rules to be clearer and more easily understood by affected parties, while also not creating loopholes in protection of the public health and welfare.

With respect to the remainder of Mr. Bates' comments, the Department makes the same response as detailed above for Mr. Ray's comments.

Comment:

Steve Bennett of Riverbend Nurseries in Thompson Station, Tennessee commented on the importance of knowing how boxwood blight is spread and that if it is waterborne, the recycling of irrigation water at a nursery is a major concern for spread of the disease. Bennett, and others, indicated a need for greater clarity on whether and how infected plants will be required to be destroyed so that firms can be prepared for burning, burying, bagging and disposition, etc.

Response:

The Department appreciates Mr. Bennett's comments and makes the same response as detailed above for Mr. Ray's comments.

Comment:

No member of the public in attendance voiced a concern that the rule was unnecessary to protect the public health, safety, or welfare. No member of the public voiced a concern that the rule was arbitrary or unreasonable. No member of the public voiced a concern that the rule would adversely or unnecessarily impact business or individuals.

Response:

The Department appreciates all comments made in this rulemaking process and is encouraged that no member of the public found the rule to be unnecessary, arbitrary, or adversely impactful.

Regulatory Flexibility Addendum

Pursuant to T.C.A. §§ 4-5-401 through 4-5-404, prior to initiating the rule making process, all agencies shall conduct a review of whether a proposed rule or rule affects small business.

- (1) Type or types of small business subject to the proposed rule that would bear the cost of and/or directly benefit from the proposed rule:

Businesses subject to the proposed rule include those businesses engaged in the sale, distribution, or receipt of boxwood or Sarcococca plants or plant material. Affected firms include greenhouses, nurseries, plant dealers, landscapers, florists, and wild plant collectors.
- (2) Identification and estimate of the number of small businesses subject to the proposed rule:

Approximately 265 greenhouses, 564 nurseries, 1969 plant dealers, 593 landscapers, 305 florists, and 15 wild plant collectors are licensed with the department.
- (3) Projected reporting, recordkeeping and other administrative costs required for compliance with the proposed rule, including the type of professional skills necessary for preparation of the report or record:

Reporting, recordkeeping, and other administrative costs are minimally affected by this rule where firms are required to report receipt of out-of-state boxwood and Sarcococca plants to the Department. The Department has not established required reporting means and would accept email, phone, or other convenient notification from affected firms.
- (4) Statement of the probable effect on impacted small businesses and consumers:

This rule protects Tennessee from receiving material infected with boxwood blight from out-of-state suppliers and removes five counties (Campbell, Claiborne, Grainger, Monroe, and Scott) from the Thousand Cankers Disease quarantine. Removal from the quarantine allows less restrictive movement of some firewood and other materials from or through these counties.
- (5) Description of any less burdensome, less intrusive or less costly alternative methods of achieving the purpose and/or objectives of the proposed rule that may exist, and to what extent such alternative means might be less burdensome to small business:

No less burdensome methods for achieving this purpose are possible.
- (6) Comparison of the proposed rule with any federal or state counterparts:

USDA does not currently consider boxwood blight to be an actionable pest. However, several other states are reported to take up or to consider similar restrictions on movement of boxwood and Sarcococca plants and plant material.
- (7) Analysis of the effect of the possible exemption of small businesses from all or any part of the requirements contained in the proposed rule.

Exemption of small businesses from this rule may expose the state to greater risks associated with movement of boxwood and Sarcococca plants and plant material.

Impact on Local Governments

Pursuant to T.C.A. §§ 4-5-220 and 4-5-228 "any rule proposed to be promulgated shall state in a simple declarative sentence, without additional comments on the merits of the policy of the rules or regulation, whether the rule or regulation may have a projected impact on local governments." (See Public Chapter Number 1070 (<http://publications.tnsosfiles.com/acts/106/pub/pc1070.pdf>) of the 2010 Session of the General Assembly)

No impact is expected on local governments.

Additional Information Required by Joint Government Operations Committee

All agencies, upon filing a rule, must also submit the following pursuant to T.C.A. § 4-5-226(i)(1).

- (A)** A brief summary of the rule and a description of all relevant changes in previous regulations effectuated by such rule;

The rule entails a new quarantine against boxwood blight to prevent spread of the disease. The rule also entails amendments to general packing requirements for shipment of plants in commerce and removal of five counties from the Thousand Cankers Disease quarantine.

- (B)** A citation to and brief description of any federal law or regulation or any state law or regulation mandating promulgation of such rule or establishing guidelines relevant thereto;

Under T.C.A. §§ 43-6-104 and 43-6-106, the commissioner of agriculture is authorized to promulgate rules necessary to prevent dissemination of plant diseases in the state, to establish quarantines restricting movement of plants and plant material within the state, and to promulgate rules regarding the distribution of plants.

- (C)** Identification of persons, organizations, corporations or governmental entities most directly affected by this rule, and whether those persons, organizations, corporations or governmental entities urge adoption or rejection of this rule;

Businesses subject to the proposed rule include greenhouses, nurseries, plant dealers, landscapers, florists, and wild plant collectors. At public hearing, one nurseryman urged rejection of the rule as previously written because the rule did not require phytosanitary inspection or pre-notification of imported boxwood plants. Upon review, the Department has amended the rule to include these measures.

- (D)** Identification of any opinions of the attorney general and reporter or any judicial ruling that directly relates to the rule or the necessity to promulgate the rule;

There are no known attorney general opinions or court decisions in this state that directly relate to the rule.

- (E)** An estimate of the probable increase or decrease in state and local government revenues and expenditures, if any, resulting from the promulgation of this rule, and assumptions and reasoning upon which the estimate is based. An agency shall not state that the fiscal impact is minimal if the fiscal impact is more than two percent (2%) of the agency's annual budget or five hundred thousand dollars (\$500,000), whichever is less;

The estimated increase in departmental expenditures resulting from this rule is minimal.

- (F)** Identification of the appropriate agency representative or representatives, possessing substantial knowledge and understanding of the rule;

David Waddell, Administrative Director, Tennessee Department of Agriculture, Division of Consumer & Industry Services

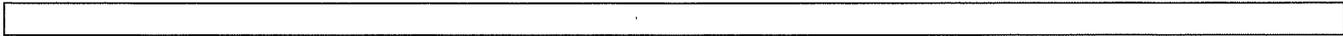
- (G)** Identification of the appropriate agency representative or representatives who will explain the rule at a scheduled meeting of the committees;

David Waddell, Administrative Director, Tennessee Department of Agriculture, Division of Consumer & Industry Services

- (H)** Office address, telephone number, and email address of the agency representative or representatives who will explain the rule at a scheduled meeting of the committees; and

436 Hogan Road, Nashville, Tennessee 37220; (615) 837-5331; david.waddell@tn.gov

- (I)** Any additional information relevant to the rule proposed for continuation that the committee requests.



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Sequence Number: 11-05-17
Rule ID(s): 6642-6644
File Date: 11/6/17
Effective Date: 2/4/18

Rulemaking Hearing Rule(s) Filing Form

Rulemaking Hearing Rules are rules filed after and as a result of a rulemaking hearing (Tenn. Code Ann. § 4-5-205).

Pursuant to Tenn. Code Ann. § 4-5-229, any new fee or fee increase promulgated by state agency rule shall take effect on July 1, following the expiration of the ninety (90) day period as provided in § 4-5-207. This section shall not apply to rules that implement new fees or fee increases that are promulgated as emergency rules pursuant to § 4-5-208(a) and to subsequent rules that make permanent such emergency rules, as amended during the rulemaking process. In addition, this section shall not apply to state agencies that did not, during the preceding two (2) fiscal years, collect fees in an amount sufficient to pay the cost of operating the board, commission or entity in accordance with § 4-29-121(b).

Agency/Board/Commission:	Department of Agriculture
Division:	Consumer & Industry Services
Contact Person:	Jay Miller
Address:	P.O. Box 40627, Nashville, Tennessee
Zip:	37204
Phone:	(615) 837-5341
Email:	jay.miller@tn.gov

Revision Type (check all that apply):

- Amendment
 New
 Repeal

Rule(s) (ALL chapters and rules contained in filing must be listed here. If needed, copy and paste additional tables to accommodate multiple chapters. Please make sure that **ALL** new rule and repealed rule numbers are listed in the chart below. Please enter only **ONE** Rule Number/Rule Title per row)

Chapter Number	Chapter Title
0080-06-01	Plant Sales and Distribution
Rule Number	Rule Title
0080-06-01-.03	License, Certificate, and Packing Requirements

Chapter Number	Chapter Title
0080-06-07	Boxwood Blight Quarantine
Rule Number	Rule Title
0080-06-07-.01	Declaration of Quarantine
0080-06-07-.02	Definitions
0080-06-07-.03	Quarantine Areas
0080-06-07-.04	Conditions for Movement of Regulated Articles
0080-06-07-.05	Inspections
0080-06-07-.06	Violations
0080-06-07-.07	Cleanliness Program Agreements
0080-06-07-.08	Stop Movement Orders

Chapter Number	Chapter Title
0080-06-11	Thousand Cankers Disease Quarantine

Rule Number	Rule Title
0080-06-11-.04	Quarantine Areas
0080-06-11-.05	Repealed
0080-06-11-.07	Repealed

New

Chapter 0080-06-07
Boxwood Blight Quarantine

0080-06-07-.01 Declaration of Quarantine.

- (1) Boxwood blight, also known as box blight and boxwood leaf drop, is a plant disease that may affect all Buxus and Sarcococca species of plants. The disease is caused by the fungus Calonectria pseudonaviculatum. It has been observed in the United States and is known to spread rapidly in warm and humid conditions. Symptoms include leaf spots, stem lesions, and premature leaf drop. Fungicides applied to affected plants do not cure the disease but only mask these symptoms. The disease is often fatal to infected plants. Boxwood blight does not require a wound entry to infect a host plant. Consequently, the disease may spread easily and rapidly. Given the ease of contagion and risk of unknowingly moving infected plant material, boxwood blight poses a significant risk to Tennessee landscapes and commercial plant industries in the state. Therefore, a quarantine against boxwood blight is necessary to protect the agricultural, horticultural, silvicultural, and other interests of the state.
- (2) The department hereby establishes a quarantine to restrict movement of all plants and regulated articles under this chapter as capable of supporting dissemination of boxwood blight.

Authority: T.C.A. §§ 4-3-203, 43-6-104, and 43-6-106.

0080-06-07-.02 Definitions.

- (1) Terms in this chapter share those meanings of terms set forth in the Tennessee Plant Pest Act, T.C.A. §43-6-101, et seq.
- (2) When used in this chapter, unless the context requires otherwise:
- (a) Act means the Tennessee Plant Pest Act, compiled at T.C.A. §43-6-101, et seq.;
- (b) Boxwood plant means any plant of a species within the Buxus genus and includes any part of the plant in any form;
- (c) Boxwood blight means any plant disease or symptom of disease caused by the fungus Calonectria pseudonaviculatum;
- (d) Cleanliness program agreement means a voluntary compliance agreement between a duly authorized federal or state regulatory official and a person for the growth, holding, or movement of regulated articles in accordance with principles of a cleanliness program recognized by the issuing official for the prevention of spreading boxwood blight;
- (e) Infected, infested, diseased, or words of similar import mean infected with boxwood blight or so exposed to the disease that infection can reasonably be expected to occur;
- (f) Move, distribute, ship, transport, or words of similar import mean to relocate, to offer to relocate, or to cause the relocation of an item from one real property to another;
- (g) Person means an individual, partnership, corporation, or any other form of legal entity;
- (h) Phytosanitary certificate means a certificate of phytosanitary inspection prepared by a duly authorized federal or state regulatory official that affirms a regulated article has been inspected

and found to be apparently free of boxwood blight;

- (i) Quarantine area means a defined area from where the movement of regulated articles is prohibited except in accordance with this chapter;
- (j) Regulated article means any item or material determined by the department to pose a material risk for spreading boxwood blight. Regulated articles include:
 - 1. Boxwood plants and any material containing boxwood plants, e.g. compost, mulch, soil, or waste;
 - 2. Sarcococca plants and any material containing Sarcococca plants, e.g. compost, mulch, soil, or waste; and,
 - 3. Any equipment, shipping material, compost, mulch, soil, or waste exposed to boxwood or Sarcococca plants.
- (k) Sarcococca plant means any plant of a species within the Sarcococca genus and includes any part of the plant in any form;
- (l) Stop movement order means a written directive issued by a duly authorized federal or state regulatory official to prohibit or limit the movement of regulated articles.

Authority: T.C.A. §§ 4-3-203, 43-6-104, and 43-6-106.

0080-06-07-.03 Quarantine Areas.

- (1) Designated quarantine areas. [RESERVED]
- (2) Temporary quarantine of non-designated areas.
 - (a) The department may temporarily quarantine any non-designated area upon written notice to its owner or upon general publication if:
 - 1. Boxwood blight is observed within the area;
 - 2. Significant symptoms or indicators of boxwood blight are observed within the area;
 - 3. Infected plants or regulated articles are shipped into the area; or,
 - 4. Any plants or regulated articles shipped into the area share a common container, vessel, producer, or shipper with plants or articles found to be infected.
 - (b) The department may lift the temporary quarantine of a non-designated area if after due inspection boxwood blight is not observed within the area and there exists no reasonable cause to continue the quarantine.

Authority: T.C.A. §§ 4-3-203, 43-6-104, and 43-6-106.

0080-06-07-.04 Conditions for Movement of Regulated Articles.

- (1) A person shall not ship any boxwood plant, Sarcococca plant, or other regulated article into the state unless:
 - (a) The shipment is plainly marked with the name and address of the sender and the recipient; and,

- (b) The shipment is accompanied by a phytosanitary certificate and cleanliness program agreement issued for the plant or article; or is accompanied by written authorization from the department for movement of the plant or article, e.g. for research, destruction, or emergency purposes.
- (2) A person shall not ship any boxwood plant, Sarcococca plant, or other regulated article from a quarantine area unless the shipment is accompanied by a phytosanitary certificate and cleanliness program agreement; or is accompanied by written authorization from the department.
- (3) A person shall not ship any boxwood plant, Sarcococca plant, or other regulated article through a quarantine area in route to its destination unless:
- (a) No items are loaded on to or off of the shipment within the quarantine area; or,
- (b) After the shipment is loaded or unloaded within the quarantine area, all items being moved out of the quarantine area are accompanied by cleanliness program agreements and newly issued phytosanitary certificates.
- (4) Each boxwood plant, Sarcococca plant, or other regulated article moved not in conformity with this chapter—or moved contrary to the phytosanitary certificate, cleanliness program agreement, or authorization for which its movement was permitted—shall constitute a separate violation of this chapter.
- (5) Any person licensed by the department as a greenhouse, nursery, plant dealer, florist, landscaper, or wild plant collector shall notify the department within three days of importing or receiving any boxwood or Sarcococca plant from an origin outside the state. The person shall include in the notification the species, number, location, and date of plants received. To comply with this requirement a person may notify the department of anticipated shipments of boxwood or Sarcococca plants prior to their actual import.

Authority: T.C.A. §§ 4-3-203, 43-6-104, and 43-6-106.

0080-06-07-.05 Inspections.

- (1) Scope of inspections. The department may enter any property or location during normal business hours where the department has reason to believe that boxwood plants, Sarcococca plants, or other regulated articles are being grown or kept. The department may enter such place for the purposes of inspecting any plant or regulated article as necessary for the prevention of spreading boxwood blight or for the purposes of examining and copying records necessary to determine compliance with this chapter.
- (2) The department may conduct inspections of persons under this chapter as often as the department deems necessary for the prevention of spreading boxwood blight.

Authority: T.C.A. §§ 4-3-203, 43-6-104, and 43-6-106.

0080-06-07-.06 Violations.

- (1) A person is responsible for violations of the Act or this chapter when committed by either the person or his agent.
- (2) Each violation of the Act, this chapter, or departmental orders issued under this chapter is grounds for issuance of stop movement orders; denial or revocation of any license issued by the department; actions for injunction; and imposition of civil penalties or criminal charges against the violator.

Authority: T.C.A. §§ 4-3-203, 43-6-104, and 43-6-106.

0080-06-07-.07 Cleanliness Program Agreements.

- (1) Any breach of a cleanliness program agreement shall constitute a separate violation of this chapter.
- (2) Revocation of any license issued by the department shall be grounds for immediate rescission of any cleanliness program agreement to which the licensee or the department is a party.

Authority: T.C.A. §§ 4-3-203, 43-6-104, and 43-6-106.

0080-06-07-.08 Stop Movement Orders.

- (1) The department may issue a stop movement order for any boxwood plant, Sarcococca plant, or other regulated article that is: moved in violation of the Act or this chapter; found to be infected; or found to be capable of spreading boxwood blight.
- (2) The department may lift a stop movement order when the item that is subject to the order is treated, returned, or destroyed as directed by the department at the owner's or possessor's expense. If the item is not treated or returned as ordered by the department within 10 days of the stop movement order being issued, the department may order the item destroyed at the owner's expense.
- (3) Any person aggrieved by an order of the department issued under the Act or this chapter, may petition the department for review of the order under T.C.A. §43-6-105 and the Uniform Administrative Procedures Act. Petitions for review of a departmental order must be submitted to the department in writing within 10 days of the order being issued. If no petition is filed with the department within the 10 day period, the department's order shall become final and will not be subject to review.

Authority: T.C.A. §§ 4-3-203, 43-6-104, and 43-6-106.

Amendments

Chapter 0080-06-01
Plant Sales and Distribution

Paragraph 0080-06-01-.03(1) is amended by deleting the paragraph in its entirety and substituting instead the following language so that as amended the paragraph shall read:

0080-06-01-.03 License, Certificate, and Packing Requirements.

- (1) No plant shall be sold, offered for sale, or transported. A person shall not sell, offer for sale, or transport a plant in the state commerce unless the plant or its shipment is accompanied by a copy of a valid license or certificate or license from a duly authorized federal or state regulatory official is affixed to the plant, its shipment, or its invoice, affirming the plant is apparently free of pests, pest plants, and disease.

Authority: T.C.A. §§ 4-3-203, 43-6-104, and 43-6-106.

Chapter 0080-06-11
Thousand Cankers Disease Quarantine

Chapter 0080-06-11 Thousand Cankers Disease is amended by re-titling the chapter "Thousand Cankers Disease Quarantine".

Authority: T.C.A. §§ 4-3-203, 43-6-104, and 43-6-106.

Rule 0080-06-11-.04 Quarantined Areas is amended by deleting the rule in its entirety and substituting instead the following language so that as amended the rule shall read:

0080-06-11-.04 Quarantine Areas.

- (1) ~~The following areas in Tennessee are designated as Designated quarantined areas: Anderson, Blount, Jefferson, Knox, Loudon, Morgan, Rhea, Roane, Sevier, and Union counties are designated quarantine areas.~~
- ~~(a) — Anderson County — The entire county.~~
 - ~~(b) — Blount County — The entire county.~~
 - ~~(c) — Knox County — The entire county.~~
 - ~~(d) — Union County — The entire county.~~
 - ~~(e) — Other counties where the thousand cankers disease is found by the commissioner, or counties determined by the commissioner to be at high risk for the presence of thousand cankers disease. Such counties shall be conspicuously posted on the department's website at <http://state.tn.us/agriculture/regulatory/plants.html>.~~
- (2) Temporary quarantine of non-designated areas.
- (a) The department may temporarily quarantine any non-designated area upon written notice to its owner or upon general publication if:
 - 1. Thousand Cankers Disease is observed within the area;
 - 2. Significant symptoms or indicators of Thousand Cankers Disease are observed within the area;
 - 3. Infected plants or regulated articles are shipped into the area; or,
 - 4. Any plants or regulated articles shipped into the area share a common container, vessel, producer, or shipper with plants or articles found to be infected.
 - (b) The department may lift the temporary quarantine of a non-designated area if after due inspection Thousand Cankers Disease is not observed within the area and there exists no reasonable cause to continue its quarantine.

Authority: T.C.A. §§ 4-3-203, 43-6-104, and 43-6-106.

Repeal

Chapter 0080-06-11
Thousand Cankers Disease Quarantine

Rule 0080-06-11-.05 Regulated Buffer Areas is repealed in its entirety.

~~0080-06-11-.05 Regulated Buffer Areas.~~

- ~~(1) — The following counties in Tennessee are designated as regulated buffer areas:~~
- ~~(a) — Campbell County — the entire county.~~
 - ~~(b) — Claiborne County — the entire county.~~

- ~~(c) — Grainger County — the entire county.~~
- ~~(d) — Jefferson County — the entire county.~~
- ~~(e) — Loudon County — the entire county.~~
- ~~(f) — Monroe County — the entire county.~~
- ~~(g) — Morgan County — the entire county.~~
- ~~(h) — Roane County — the entire county.~~
- ~~(i) — Scott County — the entire county.~~
- ~~(j) — Sevier County — the entire county.~~
- ~~(k) — Other counties in Tennessee whose boundary touches the boundary of a county that has been quarantined for Thousand Cankers Disease. Such counties shall be conspicuously posted on the department's website at <http://state.tn.us/agriculture/regulatory/plants.html>.~~

Authority: T.C.A. §§ 4-3-203, 43-6-104, and 43-6-106.

Rule 0080-06-11-.07 Movement of Regulated Articles from Regulated Buffer Areas is repealed in its entirety.

~~0080-06-11-.07 Movement of Regulated Articles from Regulated Buffer Areas.~~

- ~~(1) — Regulated articles may be moved from and through a regulated buffer area only if moved:

 - ~~(a) — With a certificate or limited permit issued and attached in accordance with this chapter.~~
 - ~~(b) — Without a certificate or limited permit only when:

 - ~~1. — The regulated article originates outside the quarantined or other regulated buffer area and is moved through the regulated buffer area under the following conditions:

 - ~~(i) — The points of origin and destination are indicated on a document accompanying the regulated article; and~~
 - ~~(ii) — The regulated article is moved directly through the regulated buffer area without stopping (except for refueling or for traffic conditions, such as traffic lights or stop signs), or has been stored, packed, or handled at locations approved by the commissioner as not posing a risk of infestation by Thousand Cankers Disease; and~~
 - ~~(iii) — The article has not been combined or commingled with other articles so as to lose its individual identity; or~~~~
 - ~~2. — The regulated article is moved directly to a quarantined area or directly to another regulated buffer area.~~~~~~

Authority: T.C.A. §§ 4-3-203, 43-6-104, and 43-6-106.

* If a roll-call vote was necessary, the vote by the Agency on these rulemaking hearing rules was as follows:

Board Member	Aye	No	Abstain	Absent	Signature (if required)

I certify that this is an accurate and complete copy of rulemaking hearing rules, lawfully promulgated and adopted by the Department of Agriculture (board/commission/ other authority) on 10/13/2017 (mm/dd/yyyy), and is in compliance with the provisions of T.C.A. § 4-5-222.

I further certify the following:

Notice of Rulemaking Hearing filed with the Department of State on: 07/17/17

Rulemaking Hearing(s) Conducted on: (add more dates). 09/12/17

Date: Oct. 13, 2017

Signature: [Handwritten Signature]

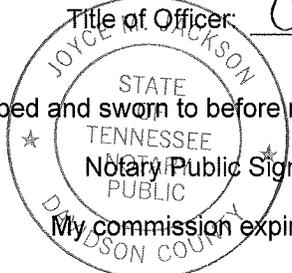
Name of Officer: Jai Templeton

Title of Officer: Commissioner

Subscribed and sworn to before me on: Oct. 13, 2017

Notary Public Signature: [Handwritten Signature]

My commission expires on: July 5, 2021



Agency/Board/Commission: _____

Rule Chapter Number(s): _____

All emergency rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

[Handwritten Signature]

Herbert H. Slatery III
Attorney General and Reporter

10/31/2017
Date

Department of State Use Only

Filed with the Department of State on: 11/6/17

Effective on: 2/4/18

[Handwritten Signature]

Tre Hargett
Secretary of State

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PUBLICATIONS

G.O.C. STAFF RULE ABSTRACT

AGENCY: Alcoholic Beverage Commission

SUBJECT: Rules for Manager Permits - Reduction of Permit Fee and Annual Training Requirement for Managers

STATUTORY AUTHORITY: Tenn. Code Ann. Sections 57-3-816 and 57-3-221 require a manager permit for any individual in actual control of the alcohol, wine or beer operations of a retailer.

EFFECTIVE DATES: February 19, 2018, through June 30, 2018

FISCAL IMPACT: Based on the proposed fee reduction for 5-year manager permits, the ABC expects to see a decrease in current services revenue of \$413,250 in FY22.

STAFF RULE ABSTRACT: This rulemaking hearing rule clarifies who must obtain a manager permit for a retail package store and a retail food store pursuant to the passage of the "wine in grocery store" legislation. The rule also reduces the manager permit fee from \$200 to \$50. The rule also reduces the annual training requirement for managers from 2 hours to 1 hour.

Public Hearing Comments

One copy of a document containing responses to comments made at the public hearing must accompany the filing pursuant to T.C.A. § 4-5-222. Agencies shall include only their responses to public hearing comments, which can be summarized. No letters of inquiry from parties questioning the rule will be accepted. When no comments are received at the public hearing, the agency need only draft a memorandum stating such and include it with the Rulemaking Hearing Rule filing. Minutes of the meeting will not be accepted. Transcripts are not acceptable

There were no public comments on these particular rule amendments.

Regulatory Flexibility Addendum

Pursuant to T.C.A. §§ 4-5-401 through 4-5-404, prior to initiating the rule making process, all agencies shall conduct a review of whether a proposed rule or rule affects small business.

(Insert statement here)

These rules would benefit small businesses by reducing the manager permit fee and the training requirement for managers at retail food stores and retail package stores. Small business owners expressed concerns to the ABC that this manager permit fee and the training requirements represented an excessive business burden imposed on the industry.

As a result, we evaluated the rules and determined that the manager permit fee was set at the statutory maximum at the very beginning of the implementation of WIGS. We also determined the annual training requirement to be excessive in comparison to other permit training requirements.

These rules reduce the fee to be more consistent with other permit fees at the ABC, instead of 4 times higher than other permit fees. Moreover, these rules reduce the training requirement in a way that will require business owners to spend less time in training, rather than running their business on an annual basis. The ABC believes the same quality training may be accomplished in half the time.

An exact number of such small businesses affected is impossible to estimate at this time, but is expected to be substantial and significant. There are no less burdensome, intrusive, or costly method for effectuating such purpose and requirements. There are no state or federal counterparts for which this rule can be effectively compared to. The exemption of small businesses from this rule would be detrimental to the small businesses of this state and would be contrary to statute.

Impact on Local Governments

Pursuant to T.C.A. §§ 4-5-220 and 4-5-228 "any rule proposed to be promulgated shall state in a simple declarative sentence, without additional comments on the merits of the policy of the rules or regulation, whether the rule or regulation may have a projected impact on local governments." (See Public Chapter Number 1070 (<http://state.tn.us/sos/acts/106/pub/pc1070.pdf>) of the 2010 Session of the General Assembly)

(Insert statement here)

These rules will not impact local government.

Additional Information Required by Joint Government Operations Committee

All agencies, upon filing a rule, must also submit the following pursuant to T.C.A. § 4-5-226(i)(1).

- (A) A brief summary of the rule and a description of all relevant changes in previous regulations effectuated by such rule;

This rule clarifies who must obtain a manager permit for a retail package store and a retail food store pursuant to the passage of the "wine in grocery store" legislation. The rule also reduces the manager permit fee from \$200 to \$50. Finally, the rule reduces the annual training requirement for managers from 2 hours to 1 hour.

- (B) A citation to and brief description of any federal law or regulation or any state law or regulation mandating promulgation of such rule or establishing guidelines relevant thereto;

Tenn. Code Ann. Sections 57-3-816 and 57-3-221 require a manager permit for any individual in actual control of the alcohol, wine or beer operations of a retailer.

- (C) Identification of persons, organizations, corporations or governmental entities most directly affected by this rule, and whether those persons, organizations, corporations or governmental entities urge adoption or rejection of this rule;

Retail food store owners and employees, retail package store owners and employees, and trainers would most likely be impacted by this rule. Because these rules reduce a fee and reduce the length of the training, these stakeholders would likely urge adoption of the rule.

- (D) Identification of any opinions of the attorney general and reporter or any judicial ruling that directly relates to the rule or the necessity to promulgate the rule;

N/A

- (E) An estimate of the probable increase or decrease in state and local government revenues and expenditures, if any, resulting from the promulgation of this rule, and assumptions and reasoning upon which the estimate is based. An agency shall not state that the fiscal impact is minimal if the fiscal impact is more than two percent (2%) of the agency's annual budget or five hundred thousand dollars (\$500,000), whichever is less;

Based on the proposed fee reduction for 5-year manager permits, the TABC expects to see a decrease in current services revenue of \$413,250 in FY22.

- (F) Identification of the appropriate agency representative or representatives, possessing substantial knowledge and understanding of the rule;

Clay Byrd, Executive Director; Zack Blair, Assistant Director

- (G) Identification of the appropriate agency representative or representatives who will explain the rule at a scheduled meeting of the committees;

Clay Byrd, Executive Director

- (H) Office address, telephone number, and email address of the agency representative or representatives who will explain the rule at a scheduled meeting of the committees; and

Clay Byrd, Executive Director, 500 James Robertson Parkway, 3rd floor, Nashville, TN, 37243; 615-741-7620
Clay.Byrd@tn.gov

- (I) Any additional information relevant to the rule proposed for continuation that the committee requests.

A vast majority of the statutory provisions governing the WIGs legislation took effect on July 1, 2016. This effective date prompted an industry meeting/public forum for stakeholder comment on July 7th 2016, in which

industry members expressed concerns over ambiguities imbedded within the comprehensive framework of the new law. Through communication and collaboration, the TABC published guidance to settle the industry's concerns in an expeditious manner. (see links below), and These rules represent the promulgation of that guidance. <http://www.tn.gov/abc/topic/frequently-asked-questions>

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For Department of State Use Only

Sequence Number: 11-14-17
Rule ID(s): 6648
File Date: 11/21/17
Effective Date: 2/19/18

Rulemaking Hearing Rule(s) Filing Form

Rulemaking Hearing Rules are rules filed after and as a result of a rulemaking hearing (Tenn. Code Ann. § 4-5-205).

Pursuant to Tenn. Code Ann. § 4-5-229, any new fee or fee increase promulgated by state agency rule shall take effect on July 1, following the expiration of the ninety (90) day period as provided in § 4-5-207. This section shall not apply to rules that implement new fees or fee increases that are promulgated as emergency rules pursuant to § 4-5-208(a) and to subsequent rules that make permanent such emergency rules, as amended during the rulemaking process. In addition, this section shall not apply to state agencies that did not, during the preceding two (2) fiscal years, collect fees in an amount sufficient to pay the cost of operating the board, commission or entity in accordance with § 4-29-121(b).

Agency/Board/Commission:	Tennessee Alcoholic Beverage Commission
Division:	
Contact Person:	Clay Byrd, Executive Director
Address:	500 James Robertson Pkwy, 3 rd Floor, Nashville, TN
Zip:	37243
Phone:	615-741-7620
Email:	Clay.Byrd@tn.gov

Revision Type (check all that apply):

- Amendment
 New
 Repeal

Rule(s) (ALL chapters and rules contained in filing must be listed here. If needed, copy and paste additional tables to accommodate multiple chapters. Please make sure that **ALL** new rule and repealed rule numbers are listed in the chart below. Please enter only **ONE** Rule Number/Rule Title per row)

Chapter Number	Chapter Title
0100-13	Rules for Manager Permits
Rule Number	Rule Title
0100-13-.01	Manager Permits
0100-13-.02	Obtaining a Manager Permit

RULES OF THE TENNESSEE ALCOHOLIC BEVERAGE COMMISSION

CHAPTER 0100-13 RULES FOR MANAGER PERMITS

TABLE OF CONTENTS

0100-13-.01 Manager Permits

0100-13-.02 Obtaining a Manager Permit

0100-13-.01 Manager Permits

- (1) A manager permit shall be required of any individual operating, supervising, or managing a retail package store licensed pursuant to T.C.A. § 57-3-204 and any individual (e.g. a designated manager) in actual control of the wine operation at a retail food store licensed pursuant to T.C.A. § 57-3-801 et seq.
- (2) Notwithstanding the provisions of 0100-06-.05(1) above, any individual may be issued both an off-premise retail employee permit and an on-premise server permit if that individual has completed and submitted the appropriate applications. Further, that person must qualify for and meet all the requirements to obtain each permit.
- (3) An individual licensed as a sole proprietorship pursuant to T.C.A. §§ 57-3-204 or 57-3-801 et seq., shall be authorized to engage in the activities outlined herein without the requirement of a manager permit.
- (4) A manager permit may be suspended or revoked by the Commission for any violation of Title 57 of the Tennessee Code or the rules and regulations of the Commission committed by the holder of the manager permit or by any person operating under the supervision of the holder of the manager permit. A manager permit may also be suspended or revoked if the permittee no longer meets the requirements for the issuance of the manager permit pursuant to T.C.A. § 57-3-221.

Authority: T.C.A. §§ 57-1-209, 57-3-104, 57-3-221, and 57-3-812. Administrative History:

0100-13-.02 Obtaining a Manager Permit

- (1) Any individual seeking a manager permit shall complete the application form established by the Commission, along with a completed declaration of citizenship (Form AB-0116) and any other information that the Tennessee Alcoholic Beverage Commission may request.
- (2) Any applicant for a manager permit shall pay the permit fee to the Commission prior to being issued the permit. This permit fee is \$50.00 pursuant to T.C.A. § 57-3-221(c).
- (3) Any individual who either has a manager permit or is seeking a manager permit shall annually attend:
 - (a) Either a responsible beer vendor training program pursuant to Chapter 0100-08 or a responsible wine vendor training program pursuant to Chapter 0100-12; and
 - (b) A one (1) hour course taught by the Commission or by an entity authorized by the Commission, at such place and time as may be specified by the Commission. Such one (1) hour course may cover any material deemed appropriate by the Commission and may include, but not necessarily be limited to, a review of recent changes in the law, a review of certain statutes, rules, and regulations as decided upon by the Commission, and an opportunity for a question and answer session.
- (4) Any individual applying for a manager permit shall attend, and provide proof of attendance to, the training program and the training course required by paragraph (3) of this rule prior to the issuance of a manager permit to such individual. Any such training shall be valid for only one (1) year, and any such training attended more than one (1) year from the date of application for a manager permit shall not be sufficient to satisfy the requirements of this rule.

Authority: T.C.A. §§ 57-3-104 and 57-3-221.

* If a roll-call vote was necessary, the vote by the Agency on these rulemaking hearing rules was as follows:

Board Member	Aye	No	Abstain	Absent	Signature (if required)
Bryan Kaegi	✓				<i>Bryan Kaegi</i>
Richard Skiles	✓				<i>Richard Skiles</i>
John A. Jones	✓				<i>John A. Jones</i>

I certify that this is an accurate and complete copy of rulemaking hearing rules, lawfully promulgated and adopted by the Tennessee Alcoholic Beverage Commission (board/commission/ other authority) on 05/23/2017 (mm/dd/yyyy), and is in compliance with the provisions of T.C.A. § 4-5-222.

I further certify the following:

Notice of Rulemaking Hearing filed with the Department of State on: 01/17/17

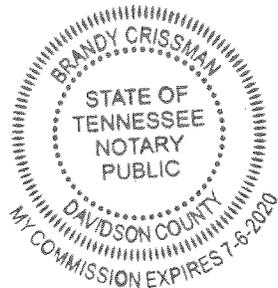
Rulemaking Hearing(s) Conducted on: (add more dates). 03/14/2017

Date: 5-23-17

Signature: *Clay Byrd*

Name of Officer: Clay Byrd

Title of Officer: Executive Director, TABC



Subscribed and sworn to before me on: May 23, 2017

Notary Public Signature: *Brandy Crissman*

My commission expires on: 7-6-2020

Agency/Board/Commission: _____

Rule Chapter Number(s): _____

All rulemaking hearing rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

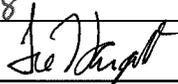
Herbert H. Slatery III
Herbert H. Slatery III
Attorney General and Reporter

11/3/2017
Date

Department of State Use Only

Filed with the Department of State on: 11/21/17

Effective on: 2/19/18



Tre Hargett
Secretary of State

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G.O.C. STAFF RULE ABSTRACT

DEPARTMENT: Commerce and Insurance, Board of Cosmetology and Barber Examiners

DIVISION: Regulatory Boards

SUBJECT: Equipment and Location Requirements for Barber Shops; Fees; Residential Barber Services

STATUTORY AUTHORITY: 2017 Public Chapter No. 102 mandates the promulgation of these rules and sets forth relevant guidelines. Specifically, the law creates a residential barber certificate that permits barbers to provide residential services.

EFFECTIVE DATES: February 19, 2018 through June 30, 2018

FISCAL IMPACT: The promulgation of these rules is expected to increase state government revenues by a minimal amount. Because the number of barbers interested in obtaining a residential barber certificate is unknown, the accounting department for the Tennessee Department of Commerce and Insurance is unable to provide a more specific estimate.

STAFF RULE ABSTRACT: These proposed rules establish the equipment requirements and fees for residential barber certificates. The equipment requirements are related to health and safety. There are no relevant changes in previous regulations effectuated by these rules.

Regulatory Flexibility Addendum

Pursuant to T.C.A. §§ 4-5-401 through 4-5-404, prior to initiating the rule making process, all agencies shall conduct a review of whether a proposed rule or rule affects small business.

1. The type or types of small business and an identification and estimate of the number of small businesses subject to the proposed rule that would bear the cost of, or directly benefit from the proposed rule;

There are approximately 1,995 licensed barber shops in the state of Tennessee. The vast majority of these shops are considered small businesses. There are also approximately 4,990 licensed master barbers in the state of Tennessee. These rules would allow master barbers to provide residential barbering services, which was previously not allowed under the law. As such, master barbers would directly benefit from these rules. Consumers would benefit because there would be more convenient access to the services provided by master barbers.

Because barber shops employ master barbers, the number of barber shops could potentially decrease if master barbers decide to leave barber shops and provide residential services as their primary source of income. Residential barbering requires much less overhead, so this option could be attractive as opposed to working in a barber shop. New small businesses will likely be created to connect consumers with residential barbers electronically.

Because 2017 Public Chapter No. 102 is only applicable to master barbers and cosmetologists are not permitted to provide residential services, it is possible that cosmetologists would lose clientele thereby impacting cosmetology shops. Cosmetologists could lose clientele because many of the services offered by master barbers are also offered by cosmetologists. There are approximately 7,129 licensed full cosmetology shops in the state of Tennessee. It is unlikely that barber shops or cosmetology shops would benefit from residential barbering services being offered, so it is possible that shop owners would not support these rules. However, these rules are required pursuant to 2017 Public Chapter No. 102. There is no way to project the overall impact of these rules at this time.

2. The projected reporting, recordkeeping and other administrative costs required for compliance with the proposed rule, including the type of professional skills necessary for preparation of the report or record;

These rules do not have projected reporting, recordkeeping, or other administrative costs. There are fees required for issuance and renewal of the certificate as well as equipment inspections; such fees are necessary to offset the estimated costs of administering this program.

3. A statement of the probable effect on impacted small businesses and consumers;

See response to question #1.

4. A description of any less burdensome, less intrusive or less costly alternative methods of achieving the purpose and objectives of the proposed rule that may exist, and to what extent the alternative means might be less burdensome to small business;

There are no less burdensome, less intrusive or less costly methods of achieving the purpose of these proposed rules.

5. A comparison of the proposed rule with any federal or state counterparts; and

These rules are required pursuant to 2017 Public Chapter No. 102, and are not comparable with any known federal or state counterparts.

6. Analysis of the effect of the possible exemption of small businesses from all or any part of the requirements contained in the proposed rule.

Exempting small businesses from these rules would not be beneficial, as these rules allow master barbers to provide services that they were not previously allowed to provide under current law.

Impact on Local Governments

Pursuant to T.C.A. §§ 4-5-220 and 4-5-228 "any rule proposed to be promulgated shall state in a simple declarative sentence, without additional comments on the merits of the policy of the rules or regulation, whether the rule or regulation may have a projected impact on local governments." (See Public Chapter Number 1070 (<http://state.tn.us/sos/acts/106/pub/pc1070.pdf>) of the 2010 Session of the General Assembly)

These rules are not expected to have an impact on local governments.

Additional Information Required by Joint Government Operations Committee

All agencies, upon filing a rule, must also submit the following pursuant to T.C.A. § 4-5-226(i)(1).

- (A)** A brief summary of the rule and a description of all relevant changes in previous regulations effectuated by such rule;

These rules establish the equipment requirements and fees for residential barber certificates. The equipment requirements are related to health and safety. There are no relevant changes in previous regulations effectuated by these rules.

- (B)** A citation to and brief description of any federal law or regulation or any state law or regulation mandating promulgation of such rule or establishing guidelines relevant thereto;

2017 Public Chapter No. 102 mandates the promulgation of these rules and sets forth relevant guidelines. Specifically, the law creates a residential barber certificate that permits barbers to provide residential services.

- (C)** Identification of persons, organizations, corporations or governmental entities most directly affected by this rule, and whether those persons, organizations, corporations or governmental entities urge adoption or rejection of this rule;

There are approximately 1,995 licensed barber shops in the state of Tennessee. The vast majority of these shops are considered small businesses. There are also approximately 4,990 licensed master barbers in the state of Tennessee. These rules would allow master barbers to provide residential barbering services, which was previously not allowed under the law. As such, master barbers would directly benefit from these rules. Consumers would benefit because there would be more convenient access to the services provided by master barbers.

Because barber shops employ master barbers, the number of barber shops could potentially decrease if master barbers decide to leave barber shops and provide residential services as their primary source of income. Residential barbering requires much less overhead, so this option could be attractive as opposed to working in a barber shop. New small businesses will likely be created to connect consumers with residential barbers electronically.

Because 2017 Public Chapter No. 102 is only applicable to master barbers and cosmetologists are not permitted to provide residential services, it is possible that cosmetologists would lose clientele thereby impacting cosmetology shops. Cosmetologists could lose clientele because many of the services offered by master barbers are also offered by cosmetologists. There are approximately 7,129 licensed full cosmetology shops in the state of Tennessee. It is unlikely that barber shops or cosmetology shops would benefit from residential barbering services being offered, so it is possible that shop owners would not support these rules. However, these rules are required pursuant to 2017 Public Chapter No. 102. There is no way to project the overall impact of these rules at this time.

- (D)** Identification of any opinions of the attorney general and reporter or any judicial ruling that directly relates to the rule or the necessity to promulgate the rule;

There are no known opinions of the attorney general and reporter or any judicial ruling that directly relate to the rule or the necessity to promulgate the rule.

- (E)** An estimate of the probable increase or decrease in state and local government revenues and expenditures, if any, resulting from the promulgation of this rule, and assumptions and reasoning upon which the estimate is based. An agency shall not state that the fiscal impact is minimal if the fiscal impact is more than two percent (2%) of the agency's annual budget or five hundred thousand dollars (\$500,000), whichever is less;

The promulgation of these rules is expected to increase state government revenues by a minimal amount. Because the number of barbers interested in obtaining a residential barber certificate is unknown, the accounting department for the Tennessee Department of Commerce and Insurance is unable to provide a more specific estimate.

(F) Identification of the appropriate agency representative or representatives, possessing substantial knowledge and understanding of the rule;

Cherrelle Hooper
Assistant General Counsel

Roxana Gumucio
Executive Director

(G) Identification of the appropriate agency representative or representatives who will explain the rule at a scheduled meeting of the committees;

Cherrelle Hooper
Assistant General Counsel

Roxana Gumucio
Executive Director

(H) Office address, telephone number, and email address of the agency representative or representatives who will explain the rule at a scheduled meeting of the committees; and

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(I) Any additional information relevant to the rule proposed for continuation that the committee requests.

None

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Sequence Number: 11-15-17
Rule ID(s): 6649
File Date: 11/21/17
Effective Date: 2/19/18

Proposed Rule(s) Filing Form

Proposed rules are submitted pursuant to Tenn. Code Ann. §§ 4-5-202, 4-5-207, and 4-5-229 in lieu of a rulemaking hearing. It is the intent of the Agency to promulgate these rules without a rulemaking hearing unless a petition requesting such hearing is filed within ninety (90) days of the filing of the proposed rule with the Secretary of State. To be effective, the petition must be filed with the Agency and be signed by ten (10) persons who will be affected by the amendments, or submitted by a municipality which will be affected by the amendments, or an association of ten (10) or more members, or any standing committee of the General Assembly. The agency shall forward such petition to the Secretary of State.

Pursuant to Tenn. Code Ann. § 4-5-229, any new fee or fee increase promulgated by state agency rule shall take effect on July 1, following the expiration of the ninety (90) day period as provided in § 4-5-207. This section shall not apply to rules that implement new fees or fee increases that are promulgated as emergency rules pursuant to § 4-5-208(a) and to subsequent rules that make permanent such emergency rules, as amended during the rulemaking process. In addition, this section shall not apply to state agencies that did not, during the preceding two (2) fiscal years, collect fees in an amount sufficient to pay the cost of operating the board, commission or entity in accordance with § 4-29-121(b).

Agency/Board/Commission:	Tennessee Board of Cosmetology and Barber Examiners
Division:	Regulatory Boards
Contact Person:	Cherelle Hooper, Assistant General Counsel
Address:	500 James Robertson Parkway, Nashville, TN
Zip:	37243
Phone:	615-741-3072
Agency/Board/Commission:	Tennessee Board of Cosmetology and Barber Examiners
Email:	cherelle.hooper@tn.gov

Revision Type (check all that apply):

- Amendment
 New
 Repeal

Rule(s) (ALL chapters and rules contained in filing must be listed here. If needed, copy and paste additional tables to accommodate multiple chapters. Please make sure that ALL new rule and repealed rule numbers are listed in the chart below. Please enter only ONE Rule Number/Rule Title per row)

Chapter Number	Chapter Title
0200-01	Rules of the Barber Board
Rule Number	Rule Title
0200-01-.07	Equipment and Location Requirements for Barber Shops
0200-01-.11	Fees
0200-01-.20	Residential Barber Services

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Rule ID(s): _____
File Date: _____
Effective Date: _____

Proposed Rule(s) Filing Form (Redline)

Proposed rules are submitted pursuant to Tenn. Code Ann. §§ 4-5-202, 4-5-207, and 4-5-229 in lieu of a rulemaking hearing. It is the intent of the Agency to promulgate these rules without a rulemaking hearing unless a petition requesting such hearing is filed within ninety (90) days of the filing of the proposed rule with the Secretary of State. To be effective, the petition must be filed with the Agency and be signed by ten (10) persons who will be affected by the amendments, or submitted by a municipality which will be affected by the amendments, or an association of ten (10) or more members, or any standing committee of the General Assembly. The agency shall forward such petition to the Secretary of State.

Pursuant to Tenn. Code Ann. § 4-5-229, any new fee or fee increase promulgated by state agency rule shall take effect on July 1, following the expiration of the ninety (90) day period as provided in § 4-5-207. This section shall not apply to rules that implement new fees or fee increases that are promulgated as emergency rules pursuant to § 4-5-208(a) and to subsequent rules that make permanent such emergency rules, as amended during the rulemaking process. In addition, this section shall not apply to state agencies that did not, during the preceding two (2) fiscal years, collect fees in an amount sufficient to pay the cost of operating the board, commission or entity in accordance with § 4-29-121(b).

Agency/Board/Commission:	Tennessee Board of Cosmetology and Barber Examiners
Division:	Regulatory Boards
Contact Person:	Cherelle Hooper, Assistant General Counsel
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Zip:	37243
Phone:	615-741-3072
Agency/Board/Commission:	Tennessee Board of Cosmetology and Barber Examiners
Email:	cherelle.hooper@tn.gov

Revision Type (check all that apply):

- Amendment
 New
 Repeal

Rule(s) (ALL chapters and rules contained in filing must be listed here. If needed, copy and paste additional tables to accommodate multiple chapters. Please make sure that ALL new rule and repealed rule numbers are listed in the chart below. Please enter only ONE Rule Number/Rule Title per row)

Chapter Number	Chapter Title
0200-01	Rules of the Barber Board
Rule Number	Rule Title
0200-01-.07	Equipment and Location Requirements for Barber Shops
0200-01-.11	Fees
0200-01-.20	Residential Barber Services

Chapter 0200-01
Board of Barber Examiners
Amendments

Table of Contents Chapter 0200-01 is amended by deleting the phrase "for Barber Shops" in the title of rule 0200-01-.07 and further amended by adding new rule 0200-01-.20 "Residential Barber Services" so that, as amended, the Table of Contents shall read:

0200-01-.01 Requirements for School License	0200-01-.10 Original License Fee
0200-01-.02 Curriculum	0200-01-.11 Fees
0200-01-.03 Transcripts	0200-01-.12 Inspections
0200-01-.04 Applications for Examination	0200-01-.13 License Qualifications
0200-01-.05 Posting of Licenses	0200-01-.14 Teacher Training Programs
0200-01-.06 Expiration of Certificates of Registration	0200-01-.15 Student Kits
0200-01-.07 Equipment and Location Requirements for Barber Shops	0200-01-.16 Demonstrations
0200-01-.08 Educational Equivalent	0200-01-.17 Alcoholic Beverages
0200-01-.09 Examinations	0200-01-.18 Civil Penalties
	0200-01-.19 Mobile Shops
	<u>0200-01-.20 Residential Barber Services</u>

Table of Contents

0200-01-.07 Equipment and Location Requirements, effective January 1, 2018, is amended by adding the following, new appropriately numbered Paragraphs:

- (7) Every barber providing residential barber services pursuant to T.C.A. § 62-3-135 shall have a kit consisting of at least the following materials at all times when providing services in residences:
- (a) One (1) enclosed and labeled container with clean towels separated from other equipment;
 - (b) One (1) enclosed and labeled container solely for soiled towels;
 - (c) One (1) wet surface cape;
 - (d) One (1) cape (not wet surface);
 - (e) Trash bags;
 - (f) One (1) leak tight container for wet sterilizer solution;
 - (g) One (1) bottle of wet sterilizer solution;
 - (h) One (1) aerosol spray disinfectant for clippers;
 - (i) One (1) portable ultra violet sanitizer;
 - (j) One (1) blood spill kit;
 - (k) Extra disposable gloves;
 - (l) One (1) bottle of alcohol;
 - (m) Hand sanitizer;
 - (n) Cotton balls;
 - (o) Cotton swabs;

- (p) One (1) sharps disposal container;
- (q) Neck strips; and
- (r) Portable shampoo bowl, if required under Paragraph (8).

(8) A portable shampoo bowl shall only be required pursuant to subparagraph (7)(r) when a barber is providing services in a residence involving removal of chemicals, including, but not limited to, color, permanents, relaxers and conditioners. If a barber intends to provide such services, the portable shampoo bowl shall be available for inspection prior to the issuance of the residential barber certificate. If a barber decides to provide such services after issuance of the residential barber certificate, the barber shall be obligated to notify the board and obtain a new equipment inspection at the barber's expense.

Authority: T.C.A. §§62-3-109, 62-3-113, 62-3-128, and ~~62-3-128(a)~~, and 62-3-135.

Rule 0200-01-.11 Fees, effective January 1, 2018, is amended by inserting the following language as a new subparagraph (1)(c) following the current subparagraph (1)(b) and renumbering the subsequent subparagraphs accordingly:

(1)

(c) Residential Barber Services

1. Application (Initial and Renewal).....sixty dollars (\$60.00)
2. Certificate of registrationseventy-five dollars (\$75.00)
3. Renewal cardtwenty-five dollars (\$25.00)
4. Inspection of residential barbering kit (subsequent to issuance of residential barber certificate)seventy-five dollars (\$75.00)
5. Penalty for late renewal (permissible for up to one (1) year following expiration of registration)twenty-five dollars (\$25.00)
6. Retirement of license.....twenty-five dollars (\$25.00)

~~(e)~~(d) **Barber Schools or Colleges**

....

~~(d)~~(e) **Barber Instructors**

....

~~(e)~~(f) **Barber Shops**

....

~~(f)~~(g) **New Dual shop licenseone hundred and fifty dollars (\$150.00)**

~~(g)~~(h) **Dual shop license renewal.....one hundred dollars (\$100.00)**

~~(h)~~(i) **Dual shop penalty for late renewal.....fifty dollars (\$50.00) per year.**

~~(i)~~(j) **Certifications to other Jurisdictions**

....

-
- ~~(j)~~(k) Barber instructor assistant certificate of registration.....twenty-five dollars (\$25.00)
 - ~~(k)~~(l) Reciprocity.....one hundred dollars (\$100.00)
 - ~~(h)~~(m) In the event that any check, draft or money order for the payment of a fee to the Board of Cosmetology and Barber Examiners is returned because of insufficient funds, only cash, certified checks or money orders will be accepted for the amount due, plus a penalty fee of twenty dollars (\$20.00).
 - ~~(m)~~(n) Change of ownership in a barber school or shop due to the death of an immediate family member..... no charge.
Application must be accompanied by death certificate or notice.
 - ~~(n)~~(o) Replacement of lost, misplaced or mutilated certificate of registration.....twenty-five dollars (\$25.00).

Authority: T.C.A. §§ 62-3-113, 62-3-128, and 62-3-129, and 62-3-135.

Chapter 0200-01
Board of Barber Examiners
New Rules

The following new rule shall be effective January 1, 2018:

0200-01-20 Residential Barber Services.

- (1) An applicant for a residential barber certificate shall apply to the Board on a form prescribed by the Board accompanied by the application fee set out in 0200-01-11(1)(c).
- (2) Upon approval of the applicant's initial application for a residential barber certificate, the applicant shall undergo an inspection of the applicant's residential barber kit to ensure that the kit complies with the requirements set out by 0200-01-07(7). In the event of any initial or later inspection of a barber's residential kit, payment for the certificate of registration or of the inspection fee must be made before the inspection is completed. No residential services shall be rendered until the barber's residential kit has been approved.
- (3) If a residential barber certificate is not renewed within one (1) year of its expiration, the residential barber certificate shall not be subject to renewal and the master barber shall file a new initial application for a residential barber certificate, including paying for and passing a new residential barber kit inspection.
- (4) The expiration date of an issued or renewed residential barber certificate shall be the same as the expiration date of the applicant's master barber registration and the fees for issuance or renewal shall not be prorated irrespective of the length of such issuance.

Authority: T.C.A. §§ 62-3-113 and 62-3-135.

* If a roll-call vote was necessary, the vote by the Agency on these rules was as follows:

Board Member	Aye	No	Abstain	Absent	Signature (if required)
Kelly Barger				X	
Jimmy Boyd	X				
Anita Charlton				X	
Nina Coppinger				X	
Frank Gambuzza	X				
Brenda Graham	X				
Judy McAllister	X				
Patricia Richmond	X				
Mona Sappenfield				X	
Amy Tanksley	X				
Ron Gillihan	X				
Yvette Granger	X				

I certify that this is an accurate and complete copy of proposed rules, lawfully promulgated and adopted by the Tennessee Board of Cosmetology And Barber Examiners on 06/05/2017, and is in compliance with the provisions of T.C.A. § 4-5-222. The Secretary of State is hereby instructed that, in the absence of a petition for proposed rules being filed under the conditions set out herein and in the locations described, he is to treat the proposed rules as being placed on file in his office as rules at the expiration of ninety (90) days of the filing of the proposed rule with the Secretary of State.



Date: 10/26/17

Signature: *Cherelle Hooper*

Name of Officer: Cherelle Hooper

Title of Officer: Assistant General Counsel

Subscribed and sworn to before me on: October 26, 2017

Notary Public Signature: *Carol L. McGlynn*

My commission expires on: Nov. 5, 2019

All proposed rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

The Board of Cosmetology and Barber Examiners
 0200-01-.07 Equipment and Location Requirements
 0200-01-.11 Fees
 0200-01-.20 Residential Barber Services

Herbert H. Slatery III
 Herbert H. Slatery III
 Attorney General and Reporter

11/8/2017 Date

Department of State Use Only

Filed with the Department of State on: 11/21/17

Effective on: 2/19/18



Tre Hargett
Secretary of State

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REGISTRATIONS

G.O.C. STAFF RULE ABSTRACT

DEPARTMENT: State Board of Education

DIVISION:

SUBJECT: Standards for Child Care Centers and School Age Child Care Programs

STATUTORY AUTHORITY: Tennessee Code Annotated, Section 49-1-302 and Sections 49-1-1101 through 49-1-1109

EFFECTIVE DATES: February 1, 2018 through June 30, 2018

FISCAL IMPACT: This rule will not impact state and local government revenues or expenditures.

STAFF RULE ABSTRACT: All public and private school-administered infant/toddler, preschool, before and after school programs, as well as, approved Montessori programs, TEIS early intervention programs, school-based and community-based Lottery Education Afterschool Programs and 21st Century Community Learning Centers must be in compliance with Standards for Infant/Toddler, Preschool, and School-Age Extended Care Programs, adopted by the State Board and certified by the Department of Education and verified through inspection by the Department's child care program evaluators.

These revisions were made to align the Standards for Child Care Centers and School-Age Child Care Programs Rule with recent changes to the Child Care Development Block Grant Program.

Regulatory Flexibility Addendum

Pursuant to T.C.A. §§ 4-5-401 through 4-5-404, prior to initiating the rule making process as described in T.C.A. § 4-5-202(a)(3) and T.C.A. § 4-5-202(a), all agencies shall conduct a review of whether a proposed rule or rule affects small businesses.

Not Applicable

Impact on Local Governments

Pursuant to T.C.A. §§ 4-5-220 and 4-5-228 "any rule proposed to be promulgated shall state in a simple declarative sentence, without additional comments on the merits of the policy of the rules or regulation, whether the rule or regulation may have a projected impact on local governments." (See Public Chapter Number 1070 (<http://state.tn.us/sos/acts/106/pub/pc1070.pdf>) of the 2010 Session of the General Assembly)

These rules will have no impact on local governments.

Additional Information Required by Joint Government Operations Committee

All agencies, upon filing a rule, must also submit the following pursuant to T.C.A. § 4-5-226(i)(1).

- (A) A brief summary of the rule and a description of all relevant changes in previous regulations effectuated by such rule;

All public and private school-administered infant/toddler, preschool, before and after school programs, as well as, approved Montessori programs, TEIS early intervention programs, school-based and community-based Lottery Education Afterschool Programs and 21st Century Community Learning Centers must be in compliance with Standards for Infant/Toddler, Preschool, and School-Age Extended Care Programs, adopted by the State Board and certified by the Department of Education and verified through inspection by the Department's child care program evaluators.

These revisions were made to align the Standards for Child Care Centers and School-Age Child Care Programs Rule with recent changes to the Child Care Development Block Grant Program.

- (B) A citation to and brief description of any federal law or regulation or any state law or regulation mandating promulgation of such rule or establishing guidelines relevant thereto;

T.C.A. § 49-1-302 requires the state board to set standards for school administered child care programs. In accordance with T.C.A. §§49-1-1101-1109, the Department of Education is mandated to inspect and approve all programs subject to the state board's jurisdiction pursuant to T.C.A. §49-1-302(l).

- (C) Identification of persons, organizations, corporations or governmental entities most directly affected by this rule, and whether those persons, organizations, corporations or governmental entities urge adoption or rejection of this rule;

School administered child care programs across the state are most directly affected by this rule. Montessori schools and the Montessori Alliance of Tennessee urged rejection of this rule because they claim that it prevents Montessori schools from providing the comprehensive system of Montessori Education that parents have chosen for their children. Specific concerns include the definition for mixed age group, the ratios and proposed group size. The rule was adjusted between readings to account for some of their concerns. The State Board of Education urges adoption of this rule.

- (D) Identification of any opinions of the attorney general and reporter or any judicial ruling that directly relates to the rule;

N/A

- (E) An estimate of the probable increase or decrease in state and local government revenues and expenditures, if any, resulting from the promulgation of this rule, and assumptions and reasoning upon which the estimate is based. An agency shall not state that the fiscal impact is minimal if the fiscal impact is more than two percent (2%) of the agency's annual budget or five hundred thousand dollars (\$500,000), whichever is less;

This rule will not impact state and local government revenues or expenditures.

- (F) Identification of the appropriate agency representative or representatives, possessing substantial knowledge and understanding of the rule;

Elizabeth Taylor
Elizabeth.Taylor@tn.gov

Nathan James
Nathan.James@tn.gov

- (G) Identification of the appropriate agency representative or representatives who will explain the rule at a scheduled meeting of the committees;

Elizabeth Taylor
Elizabeth.Taylor@tn.gov

Nathan James
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- (H) Office address, telephone number, and email address of the agency representative or representatives who will explain the rule at a scheduled meeting of the committees; and

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(615)-532-3528

- (I) Any additional information relevant to the rule proposed for continuation that the committee requests.

N/A

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Sequence Number: 11-03-17
 Rule ID(s): 6638
 File Date: 11/2/17
 Effective Date: 2/1/18

Proposed Rule(s) Filing Form

Proposed rules are submitted pursuant to T.C.A. §§ 4-5-202, 4-5-207 in lieu of a rulemaking hearing. It is the intent of the Agency to promulgate these rules without a rulemaking hearing unless a petition requesting such hearing is filed within sixty (60) days of the first day of the month subsequent to the filing of the proposed rule with the Secretary of State. To be effective, the petition must be filed with the Agency and 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. The agency shall forward such petition to the Secretary of State.

Agency/Board/Commission:	Tennessee State Board of Education
Division:	
Contact Person:	Elizabeth Taylor
Address:	710 James Robertson Pkwy 1 st floor
Zip:	37243
Phone:	615-253-5707
Email:	Elizabeth.Taylor@tn.gov

Revision Type (check all that apply):

- Amendment
 New
 Repeal

Rule(s) Revised (ALL chapters and rules contained in filing must be listed here. If needed, copy and paste additional tables to accommodate multiple chapters. Please enter only ONE Rule Number/Rule Title per row)

Chapter Number	Chapter Title
0520-12-01	Standards for Child Care Centers and School Age Child Care Programs
Rule Number	Rule Title
0520-12-01-.01	Introduction
0520-12-01-.02	Definitions
0520-12-01-.03	Basis for Certification of Approval
0520-12-01-.04	Procedures for Obtaining a Certificate of Approval
0520-12-01-.05	Ownership, Organization, and Administration
0520-12-01-.06	Supervision
0520-12-01-.07	Staff
0520-12-01-.08	Equipment for Children
0520-12-01-.09	Program
0520-12-01-.10	Health and Safety
0520-12-01-.11	Food
0520-12-01-.12	Physical Facilities

0520-12-01-.13	Transportation
0520-12-01-.14	Care of Children with Special Needs
0520-12-01-.15	Afterschool Programs Serving Adolescents
0520-12-01-.16	Civil Penalties

**RULES
OF
THE STATE BOARD OF EDUCATION
OFFICE OF THE COMMISSIONER**

**CHAPTER 0520-12-01
STANDARDS FOR SCHOOL ADMINISTERED CHILD CARE PROGRAMS CENTERS AND
SCHOOL-AGE CHILD CARE PROGRAMS**

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0520-12-01-.02 Definitions	0520-12-01-.11 Food
0520-12-01-.03 Basis for Certification of Approval <u>Program Approval</u>	0520-12-01-.12 Physical Facilities
0520-12-01-.04 Repealed <u>Procedures for Obtaining a Certificate of</u>	0520-12-01-.13 <u>Transportation</u>
	<u>Approval</u> 0520-12-01-.14 <u>Care of Children with</u>
<u>Special Needs</u> <u>Transportation</u>	
0520-12-01-.05 <u>Ownership, Program Organization, and Administration</u>	0520-12-01-.15 <u>Afterschool Programs Serving</u>
<u>Adolescents</u> <u>Care of Children with Special Needs</u>	
0520-12-01-.06 <u>Supervision Program Operation</u>	0520-12-01-.16 <u>School-Age Before and After</u>
<u>School Programs</u> <u>Civil Penalties</u>	
0520-12-01-.07 <u>Staff</u>	0520-12-01-.16 <u>Civil Penalties</u>
0520-12-01-.08 Repealed <u>Equipment for Children</u>	
0520-12-01-.09 <u>Program</u>	

0520-12-01-.01 INTRODUCTION.

Pursuant to T.C.A. § 49-1-302, these ~~Scope of Rules.~~ These rules are applicable to the following programs and are subject to monitoring by the Department of Education:

(a1) ~~Public~~ ; ~~public, school~~ -administered early childhood education ~~infant/toddler, prekindergarten, and/or school-age care programs; programs;~~

(b2) ~~Programs administered by approved Montessori schools and private church-related schools as defined in T.C.A. § 49-50-801; programs operated by private schools as defined by T.C.A. § 49-6-3001(c)(3);~~

(c3) ~~Child care provided~~ (A)(iii); Lottery Education Afterschool Programs (LEAPs) as mandated by church affiliated schools as defined by § 49-50-801;

(d4) State approved Montessori school programs;

(e5) Before or after school child care programs operated pursuant to §§ 49-2-203(b)(11) and the T.C.A. § 49-6-707;

(f6) ~~Programs~~ programs providing center-based early intervention services through Tennessee Early Intervention Services; and

(g7) Child care provided in federally regulated programs including Title I preschools ~~school-administered Head Start, monitored by the Department of Education pursuant to T.C.A. § 49-1-302(l), providing child care services to children ages six (6) weeks through minority.~~ In addition, any before or after school program, 21st Century Community Learning Centers

~~(21st CCLC), and all school administered head start and even start programs, community based Voluntary Pre-K programs, may be subject to these rules.~~

- ~~(1) Purpose of Child Care Certification of Approval. The primary purpose of school-administered child care certification of approval is the protection of children. These minimum requirements seek to maintain adequate health, safety, and supervision of children while in a group setting. The secondary purpose of certification is to promote developmentally appropriate care.~~
- ~~(2) Criteria for Approval. The state board of education's regulations of school-administered child care programs are based on the following criteria:
 - ~~(a) The safety, welfare and best interests of the children in the care of the program;~~
 - ~~(b) The capability, training and character of the persons providing or supervising the care to the children;~~
 - ~~(c) The quality of methods of care and instruction provided for the children;~~
 - ~~(d) The suitability of the facilities provided for the care of the children; and~~
 - ~~(e) The adequacy of the methods of administration and the management of the child care program, the program's personnel policies, and the financing of the program.~~~~

Authority: T.C.A. §§ 4-5-201 et seq., 49-1-201(c)(24), 49-1-302(l), 49-1-1101 through 49-1-1109, 49-2203(b)(11), 49-5-413 and 49-6-707. **-Administrative History:** Original rule filed September 26, 1990; effective December 29, 1990. -Amendment filed April 30, 2002; effective July 14, 2002. Amendment repealing and replacing rule filed March 15, 2010; effective August 29, 2010.

0520-12-01-.02 DEFINITIONS. For purposes of this chapter, the following definitions are applicable:

For purposes of this Chapter the following definitions are applicable:

- (1) Administrative Hearing. -A hearing that is held under the Uniform Administrative Procedures Act at T.C.A. § 4-5-101, et seq. rather than a court of law.- The purpose of the hearing is to allow an agency the opportunity to challenge enforcement actions taken by the Department of Education (Department).
- (2) Adolescence. -The period of physical and psychological development from the onset of puberty to maturity.

Approval. -A preschool, school-age care or child care program is in accordance with the provisions of the law and the requirements (rules) of the State Board of Education. Approval is not transferable from one location to another or from one agency to another. The approval may be revoked at any time upon ninety (90) days' notice to the agency; or if the health, safety, or welfare of the children in care imperatively requires it, may be suspended immediately.

~~(3) Annual Certificate of Approval. Certificate issued by the Department of Education to programs that have satisfactorily completed the temporary certificate of approval time period and is reissued on an annual basis as long as the program meets the standards of the Department of Education and the rules of this Chapter.~~

~~(4) Approved Capacity. The designated maximum number of children permitted in a facility as determined by the Department based upon usable space, age of children, adult: child ratios, and group size. Capacity shall be designated on the certificate Annual Certificate of Approval.~~

~~Auxiliary Staff. Full and part-time employees of the program who provide non-caregiving services.~~

~~Caregiver or Care Provider. (See Teacher).~~

~~Certificate of Approval. (5) A written form of approval issued by the Department of Education to agencies/programs providing care to children. Issuance of a Certificate of Approval is not an endorsement of child care methods or of the agency's operational philosophy. A Certificate of Approval is not transferable from one location to another or from one school and /or system to another.~~

~~Certified Childcare Professional (C.C.P.). An early childhood educational credential granted by the National Child Care Association.~~

~~Chemical Restraint. A medication that is prescribed to restrict a student's freedom of movement for the control of extreme violent physical behavior. Chemical restraints are medications used in addition to, or in replacement of, a student's regular drug regimen to control extreme violent physical behavior.~~

~~Child. A person under eighteen (18) years of age.~~

~~(6) Child's Age. The age of child on August 15 of any given year, except for infants/toddlers, whose age is based on calendar year.~~

~~(7) Child Development Associate (C.D.A.). An early childhood education credential granted by the National Council for Professional Recognition.~~

~~Child Care. The provision of supervision, protection, and at a minimum, the basic needs of a child or children for more than three (3) hours a day, but less than twenty-four (24) hours a day.~~

~~(8) Child Care Advisory Council. A ten (10) member council established by T.C.A. § 49-1-302 to advise the State Board of Education Child Care Advisory Council. A director of a local school system, a representative of a private, church-related school organization as defined by T.C.A. § 49-50-801, a representative from an institution of higher education, a parent of a child in a child care program, a coordinator of child care programs, a representative of the Department of Education, a representative of the Child Care Services of Department of Human Services and four other members appointed by the State Board of Education to advise in the establishment of child care standards and regulations and to act as a hearing tribunal for appeals from actions of the State Department of Education regarding the certificate of approval issued to child care programs.~~

~~(9) Child Care Program. Any Any place or facility operated by any public or private school which provides care for children in a before or after-school-based program operated by a local board of education pursuant to T.C.A. § 49-2-203(b)(11), a public school administered early childhood education programs; program, a church-affiliated program operated pursuant to T.C.A. § 49-50-801,~~

~~or federally funded early childhood education program such as a Title I program, a school administered Head Start, or an even start program, state approved Montessori school programs, programs operated by a private schoolsschool as defined by T.C.A. § 49-6-3001(c)(3); child care provided by church affiliated schools as defined by § 49-50-801; state approved Montessori school programs; before or after school child care programs operated pursuant to §§ 49-2-203(b)(11) and a LEAPS (Lottery Education Afterschool Program) as mandated by T.C.A. § 49-6-707; programs providing center-based or an early intervention services program funded through the Tennessee Early Intervention Services; child care provided in federally regulated programs including Title I preschools, 21st Century Community Learning Centers and all school administered head start and even start programs.~~

(10) Civil Penalty. A penalty placed upon a program for each violation of a statute, rule, or order pertaining to such person or entity in an amount ranging from fifty dollars (\$50.00) to one thousand dollars (\$1,000.00). Each day of continued violation constitutes a separate violation as indicated by T.C.A. § 49-1-1107(c)(1).

(11) Commissioner.—The executive head of the Department of Education, appointed by the Governor.

(12) Conventional Care.—Child care services provided between the hours of 6:00 a.m. and 6:00 p.m., Monday through Friday.

(13) Day Care. ~~Synonymous with definition of child care, above.~~

Department (TDOE).—The Tennessee Department of Education and its representatives.

(14) Developmentally Appropriate. Practices which use the knowledge of child development to identify the range of appropriate behaviors, activities, and materials for specific age groups. —This knowledge is used in conjunction with an understanding about children's growth patterns, strengths, interests, and experiences to design the most appropriate learning environment. —A developmentally appropriate curriculum provides for all areas of a child's development, physical, emotional, social, and cognitive, through an integrated approach. —For children from birth to five (5) years of age, the Tennessee Early Learning Development Standards is adopted by the State Board of Education for guidance in appropriate learning expectations.

(15) Director.—The person with overall responsibility for the child care program.

(16) Group. A specific number of children comprising an age range, assigned to specific staff in an assigned space, which that is divided from the space of other groups by a recognizable barrier.

(17) Home School. The provision of full-time educational services, as recognized by the Department of Education, to a child by the child's parent in the child's primary residence. Any early childhood program attached to a home school program falls under the jurisdiction of the Department of Human Services (DHS).

Emergency Situation.—A child's behavior places the child or others at risk of violence or injury if no intervention occurs.

Extended Isolation.—Isolation which lasts longer than one (1) minute per year of the child's age.

~~Extended Restraint. Physical holding restraint lasting longer than five (5) minutes. Field Trip. A trip that is not part of the regular curriculum which is off the general premises and beyond reasonable walking distance.~~

~~Group. A specific number of children comprising an age range, assigned to specific staff in an assigned space, which is divided from the space of other groups by a recognizable barrier.~~

~~Home School. The provision of full-time educational services, as recognized by the Department of Education, to a child by the child's parent in the child's primary residence. Any early childhood program attached to a home school program falls under the jurisdiction of DHS (Department of Human Services).~~

(18) Infant.—A child who is six (6) weeks through twelve (12) ~~fifteen (15)~~ months of age.

∑

~~Kindergarten. A school or class that prepares children for first grade and is part of a public or private school system. Kindergarten programs in the public school system must comply with the Minimum Kindergarten Program Law pursuant to T.C.A. § 49-6-201. To enter kindergarten, a child must be five years old by August 15th.~~

~~(19) Kindergarten. A school or class that prepares children for first grade and is part of a public or private school system. Kindergarten programs in the public school system must comply with the Minimum Kindergarten Program Law pursuant to T.C.A. § 49-6-201. To enter kindergarten, a child must be five (5) years old by August 15.~~

~~(20)32 Law. Statutory or regulatory provisions affecting the operation of an early child-welfare agency early childhood program including, but not limited to, the law as contained in T.C.A. § 49-1-302(l) and T.C.A. §§ 49-1-1101 through 49-1-1109, and Chapter 0520-12-01 of the State Board Rules, and these rules.~~

~~Meal. Meat or meat substitute, vegetable and/or fruit, bread or bread product, and fluid milk.~~

~~Mechanical Restraint. The application of a mechanical device, material, or equipment attached or adjacent to the student's body, including ambulatory restraints, which the student cannot easily remove and that restrict freedom of movement or normal access to the student's body. Mechanical restraint does not include the use of restraints for medical immobilization, adaptive support, or medical protection.~~

~~Mixed Age Grouping. Mixed age group can also be referred to "heterogeneous or multi-age". A group of children with varying ages that are combined to maximize the educational benefits in a non-traditional classroom. All mixed age group classrooms shall not exceed the maximum group size and, must maintain adult: child ratios, and must show an equal distribution of children between the ages at all times. For 3-6 year old classrooms, 30% of students must be school-age.~~

~~(21) Mixed Age Grouping. Mixed age group can also be referred to "heterogeneous or multi-age". A group of children with varying ages that are combined to maximize the educational benefits in a non-traditional classroom. All mixed age group classrooms shall not exceed the maximum group size and must maintain adult: child ratios.~~

(22) Non-school, Community-based Organization Program.— An infant/toddler, preschool or school age before and after school program operated through contract with the Department of Education and under the certifying authority of the Department of Education.

~~Noxious Substance. A substance released in proximity to the child's face or sensitive area of the body for the purpose of limiting a child's freedom of movement or action, including but not limited to Mace and other defense sprays.~~

~~Off-site Activity. Any activity which occurs away from the general premises of the child care program's facility and beyond reasonable walking distance.~~

(23) Off-site Activity. Any activity which occurs away from the general premises of the child care program's facility.

(24)

Parent. A biological, legal, or adoptive parent, guardian, or legal or physical custodian who has primary responsibility for a child.

~~Physical Holding Restraint. The use of body contact by school personnel with a student to restrict freedom of movement or normal access to the student's body.~~

~~The term "safe-hold" includes any technique through which an adult attempts to immobilize a violent child by wrapping their limbs around the child. The term does not include holds administered for the sole purpose of providing comfort or security to a distressed child.~~

~~The term "serious self-inflicted injury" includes, but is not limited to, violent outbursts in which a child throws himself/herself against a wall, is hitting or cutting himself/herself, etc.~~

~~Plan of Corrective Action (POCA). Required when one or more violations are found that require documented progress of the correction and specific steps to move into compliance.~~

~~Pre-kindergarten. A class or program proceeding prior to kindergarten for children that are four (4) years old by August 15.~~

(25) Pre-kindergarten. A class or program prior to kindergarten for children that are four (4) years old by August 15.

(26) Preschool Child. A program providing child care services to children who are six (6) weeks through five (5) years of age and not in kindergarten, including children who are more specifically defined under this subchapter as an "infant" or a "toddler".

(27) "infant" or a "toddler".

Program. Any public or private school-administered preschool/infant/toddler, pre-kindergarten, ~~preschool~~ and/or school-age care program, including community based programs funded by Voluntary Pre-K, Pre-K, Lottery Education Afterschool Programs (LEAPs), and 21st Century Community Learning Center (21st CCLC) programs that serve a minimum of one ~~one~~ (1) child, is subject to the jurisdiction of the Office of School-based Support Services. Exception: fee based and 21st CCLC funded before and after care programs that operate less than three ~~three~~ (3) hours per day or less than fifteen ~~fifteen~~ (15) hours per week.

(28)

Related.- Any children of the following relationships by marriage, blood, or adoption; children, step-children, grandchildren, siblings, step-siblings, nieces, and nephews of the primary caregiver.—The term "related" includes any "grand" or "great" relationship (e.g. great niece, great grandchild, etc.) within the relationships indicated.

(29) School-age Child. A child who is five (5) years of age to seventeen (17) years of age, by August 15, and currently enrolled in kindergarten through twelfth (12th) grade.

~~Safety Plan.- A plan that is placed on a program as a result of a violation of Chapter 0520-12-01. A safety plan may require, but is not limited to, the exclusion or restriction of any individuals from access to children, the closure or restriction of any part of the program, the modification or elimination of services, the re-inspection of the program, the training of management, staff, or volunteers.~~

~~Satellite/Umbrella Program.- A satellite and/or umbrella program is an alternative education school which serves to oversee the homeschooling of children to fulfill government educational requirements. TDOE does not recognize satellite or umbrella~~

~~School-administered.- A program that is run by a public or private school and is housed in conjunction with an elementary, middle, or high school T.C.A. § 49-6-301.~~

(30) School-administered. A program that is serving five (5) or more school-age children and is run by a public or private school and is housed in conjunction with an elementary, middle, or high school T.C.A. § 49-6-301.

(31)

~~Snack.- A fluid drink and two (2) of the following components, provided, however, that a fluid drink shall not be required if a fluid drink is chosen as one of these components:~~

~~Vegetables or fruits~~

~~Bread or Bread Alternative~~

~~Meat or meat alternates, or~~

~~Fluid Milk~~

~~Staff.- Full and part-time teachers, employees, or unpaid volunteers of the program.~~

~~Substitute.- Paid or unpaid persons who are replacements for regular staff.~~

(50) ~~Supervision.- For the purposes of this Chapter, when children are not within the direct sight and sound of an adult, the term "supervision" means the following requirements:~~

(a) ~~Children six (6) weeks of age through age two (2) years of age: the adult shall be able to hear the child at all times, shall be able to see the child with a quick glance, and must be able to physically respond immediately.~~

(b) ~~Children three (3) years of age to five (5) years of age shall be safely protected by an adult in close proximity and not distracted by other tasks.~~

~~Children six (6) weeks of age to five (5) years of age during mealtime. An adult must be in the direct sight and sound of child/children while the child/children are eating.~~

~~(c) — Children, who are in kindergarten five (5) years of age through nine (9) years of age, shall be protected by an adult who adjusts restrictions appropriately for different age groups and abilities.~~

~~(d) — Children ten (10) years of age through thirteen (13) years of age: The adult shall know the whereabouts and activities of the children at all times and must be able to physically respond immediately.~~

~~(e) — Children fourteen (14) years of age to eighteen (18) years of age: The adults shall know the whereabouts and activities of the children, provide age appropriate guidance, and must be able to physically respond immediately.~~

~~(f) — Mixed Age Groups. When children ages ten (10) years or above are grouped with children under ten (10) years of age, the minimum supervision requirements must be in accordance with the supervision required for the age group of the youngest child in the group.~~

~~Helper devices such as mirrors, electronic sound monitors, etc. may be used as appropriate to meet these requirements.~~

(32) Teacher. The person, persons, entity or entities directly responsible for providing for the supervision, protection, and basic needs of the child.

(33) Temporary Certificate of Approval. —A certificate permit issued by the Department to a new child care program allowing and authorizing the program to begin child care operations while the program attempts to attain full compliance with all applicable regulations. —The temporary approval is valid, unless suspended, in accordance with T.C.A. § 49-1-1103(c)(2)(C), for ninety days (90) or until the Department grants or denies the application for annual certificate of approval.

(34) Toddler. —A child who is twelve (12) months through twenty-three (23) months of age.

(35) Umbrella Program.— An umbrella program that oversees the homeschooling of children to fulfill government educational requirements. TDOE does not recognize umbrella early childhood programs as school-administered.

(36) Volunteer. —A person who provides services for a child care center without payment and who is used to supplement the regular staff or substitutes. The volunteer shall not be used to meet classroom adult: child ratios. —The names, addresses, telephone numbers, and dates of service for all volunteers shall be recorded in the staff personnel records of the program.

Youth.—A person who is ten (10) years of age through seventeen (17) years of age.

Authority: T.C.A. §§ 4-5-201 et seq., 49-1-201(c)(24), 49-2-203(b)(11), 49-2-203(b)(11)(B), 49-1-302(l), 49-1-1102, 49-6-101 and 49-6-707. **Administrative History:** Original rule filed September 26, 1990; effective December 29, 1990. Amendment filed April 30, 2002; effective July 14, 2002. Amendment repealing and replacing rule filed March 15, 2010; effective August 29, 2010. Emergency rule filed August 30, 2010; effective through February 26, 2011. Amendment filed December 21, 2010; effective March 21,

2010. Emergency rule filed August 30, 2010 and to have been effective through February 26, 2011 expired; on February 27, 2011 the rule reverted to its previous status.

~~CHILD CARE CENTERS AND SCHOOL-AGE~~

0520-12-01-.03 PROGRAM03 BASIS FOR CERTIFICATION OF APPROVAL.

(1) All persons or entities operating a child care program must be certified by the Department of Education (Department).

(2) A school-administered child care program seeking approval shall submit an application to the Department of Education that contains the following information:

(a) Satisfactory evidence that

The safety, welfare and best interests of the the facility that is proposed for children in the care of children has received fire safety and environmental safety approval, that the applicant the program;

The capability, training and character of the personnel who will persons providing or supervising the care for the children are capable to the children and the use of such judgment by a teacher in the performance of any of the teacher's duties as would be reasonably necessary to prevent injury, harm or the threat of harm to any child in care;

The quality of the methods of care and instruction provided for the children and that the applicant has the ability and intent to comply with the certificate of approval law and regulations;;

(b) Three (3) satisfactory references

(a) The suitability of the facilities provided for the care of the children; and

The adequacy of the methods of administration and the management of the program director;

, the program's personnel policies, and the financing of the program.

(3) The program must be maintained in compliance with the certification criteria listed in paragraph

(2) above and any other certification criteria throughout the year.

Falsification of Records/Information. Includes but is not limited to falsified or forged records, documents, and/or concealment of services or children from monitoring by the Department. Falsification of any information required for Certification of Approval shall be grounds for suspension, denial, or revocation of the Certificate of Approval.

Specifications of the Certificate of Approval

All programs shall be operated within approved capacity, the hours of operation, specific age ranges, services offered, and at the address designated on the certificate; and

All programs shall operate within the restrictions stated on the certificate.

Authority: T.C.A. §§ 4-5-201 et seq., 49-1-201(c) (24), 49-1-302 et seq., 49-1-1101 through 49-1-1109, 49-2-203(b) (11) and 49-6-707. Administrative History: Original rule filed September 26, 1990; effective December 29, 1990. Amendment filed April 30, 2002; effective July 14, 2002. Amendment repealing and replacing rule filed March 15, 2010; effective August 29, 2010.

~~0520-12-01-.04 PROCEDURES FOR OBTAINING A CERTIFICATE OF APPROVAL.~~

~~The Department of Education offers consultation and instruction sessions to before and after school child care, as described in T.C.A. § 49-2-203(b)(11); school-administered early childhood education programs; Voluntary Pre-Kindergarten (VPK) programs; school~~Verification that the program director's qualifications meet the requirements of Chapter 0520-12-01-.07;

~~(d) Verification that all program staff have successfully completed a criminal history background check as required by T.C.A. § 49-5-413; and. See Rule 0520-12-01-.07(4)~~

~~(e) Verification of enrollment of at least five (5) school-aged children enrolled in kindergarten through grade twelve (12).~~

~~(1) administered Head Start; approved Montessori programs; infant/toddler, preschool or school age programs administered by private schools; church related schools, as defined in T.C.A. § 49-50-801; Lottery Education Afterschool Programs (LEAPS); and center-based Tennessee Early Intervention System programs. 21st Century Community Learning Centers (21st CCLC) programs and fee based after school programs may be subject to these rules. A child care program evaluator is available to serve schools in each major region of the state, east, middle, and west. The department will offer instruction in the certification process to schools announcing interest in developing infant/toddler, pre-kindergarten, and/or school-age child care programs.~~

~~When a public or private school is planning to offer an infant/toddler, pre-kindergarten, and/or school-age care program, the Office of School-based Support Services must be contacted to start the certification process.~~

~~Any program found in operation without oversight from the department of education, will be found to be running an illegal operation, and will be turned over to local authorizes as indicated by T.C.A. § 49-1-1105(a).~~

~~Upon satisfaction of the following minimum requirements, a temporary approval may be issued if:~~

~~(a);~~

~~Verification of three (3) satisfactory references for the director;~~

~~Verification that physical facilities have received fire safety and environmental approval;~~

~~Verification that all staff have successfully completed a criminal history background check and has a negative criminal history as required by T.C.A. § 49-5-413;~~

~~Verification. (3) Upon receipt and approval of an application by the department shall conduct an~~Department, after appropriate on-site inspection to ensure, the site is suitable for child care activities and does

not endanger the welfare or safety of children. Upon satisfaction of the on-site inspection by the department, the program shall be provided a temporary certificate of approval.

~~(6) Denial or Restriction of Temporary Certificate of Approval.~~

~~The temporary certificate of approval must remain in effect, unless suspended, for a period of ninety (90) days, or until such time as the Department grants or denies the annual certificate of approval, whichever is later.~~

~~During the temporary certificate of approval period, the program must attain and maintain compliance with all applicable regulations. The failure to obtain and maintain compliance during this period may result in the denial of the certificate of approval.~~

~~(4) Within ninety (90) days of the issuance of the temporary certificate, the Department shall determine if the applicant has complied with all regulations and requirements necessary to receive an annual certificate of approval. During the temporary certificate of approval period:~~

~~(a) The Department shall perform a minimum of two (2) visits to the program at least one (1) of which shall be unannounced;~~
~~Evaluation Process for Annual Certificate of Approval.~~

~~The temporary certificate of approval is issued to authorize the program to begin infant/toddler, pre-kindergarten or preschool and/or school-age care operations while the program attempts to attain full compliance with all other applicable regulations.~~

~~The Department shall perform a minimum of two (2) visits to the program during the temporary certificate of approval period, at least one (1) of which shall be unannounced.~~

~~(b) The Department shall perform at least one (1) observation of the teachers' interaction with children during the temporary certificate of approval period; and.~~

~~(c) During the temporary certificate of approval period, the program must provide verification, including any required supporting documentation as directed by the Department, of compliance with all applicable regulations. The failure to obtain and maintain compliance with all applicable regulations during the period of temporary approval may result in the revocation of the temporary certificate of approval.~~

~~Department, of compliance with all applicable regulations and further, that the applicant otherwise meets, or has continued to meet, all the requirements set forth in paragraph (4) above.~~

~~(a) During the temporary certificate of approval period, the Department shall determine whether an annual or restricted certificate of approval shall be issued to the program.~~

~~(5) On or before the expiration of the temporary certificate of approval, the Department shall:~~

~~(a) Issue an annual certificate of approval to a program that has satisfied the requirements for the ninety (90) day temporary approval;~~

~~If the Department determines that any of the requirements set forth in this Chapter have not been, or cannot be, satisfactorily met then it may deny the issuance of a certificate of approval.~~

- ~~(b) If the Department determines that the conditions of the program's facility, the methods of care or other circumstances warrant, it may issue a restricted temporary license certificate that limits a program's authority in one (1) or more areas of operation if the Department determines that the conditions of the facility, the methods of care or other circumstances warrant it; or that permits operation of the program, but limits the program's authority in one (1) or more areas of operation.~~
- ~~(c) Deny the annual certificate of approval if the Department determines that any of the requirements set forth in this Chapter have not been, or cannot be, satisfactorily met.~~
- ~~(b) —~~
- ~~(6) A certificate of approval is not transferable from one location to another or from one agency to another.~~
- ~~(7) The certificate of approval may be revoked at any time upon ninety (90) days' notice to the agency. If the health, safety, or welfare of the children in care imperatively requires it, the certificate of approval shall be revoked. Issuance of a Certificate of Approval. The Department shall issue a Certificate of Approval if the Department determines that the program:~~

~~Has fully complied with all laws and regulations governing the specific program; and~~

~~Has demonstrated a reasonable probability that the program can maintain compliance with all regulations during the certification of approval period.~~

~~Upon issuance of the annual Certificate, immediately.~~

~~of Approval, the program must maintain compliance with all applicable regulations and restrictions on the Certificate of~~

~~Approval, if any, throughout the certification period. —~~

~~Renewal and Re-Evaluation.~~

~~Programs currently certified as approved by the Department must submit an updated annual report prior to October 1, in accordance with T.C.A. § 49-1-1108(c).(8) To renew an annual certificate of approval, approved programs shall submit an annual report to the department prior to October 1. Any entity not completing the annual report by October 1, shall be notified and if a report is not submitted the certificate of approval shall be suspended.~~

~~(a) The report shall include:~~

~~_____ 1.(a) Current enrollment figures;~~

~~_____ 2.(b) Identification information;~~

~~3.(c) A description of the services to be offered to children and parents and reasons these services are needed at the proposed location;~~

~~4.(d) Certified program must demonstrate compliance with Ages of children to be served;~~

~~5.(e) Hours of operation;~~

- 6.(f) A description of meal provision or preparation;
- 7.(g) Admission requirements set forth in paragraphs (4) and enrollment procedures;~~(6).~~
- 8.(h) Provision for emergency medical care; and
- 9.(i) Transportation Plan; and
- 10.(j) ~~Upon demonstration~~ Demonstration of compliance with all laws and regulations governing the program.
- (b) If, after being approved, a child care provider wishes to change the scope or type of service offered to children and families, an amended report shall be filed with the Department for approval prior to implementation.
- ~~(9) A program that submits a satisfactory annual report and demonstrates and if the program has demonstrated a reasonable probability that the program can maintain compliance with all laws and regulations during the annual certification~~ Certification period, ~~the Department shall be issued~~ issue a new annual certificate of approval by the Ddepartment Certificate of Approval.
- ~~(c) If the Department determines that any of the requirements set forth in Chapter 0520-12-01 have not been, or cannot be, satisfactorily met, then it may deny the issuance of the new annual Certificate of Approval.~~
- ~~(d) If the Department determines that the conditions of the applicant's facility, its methods of care or other circumstances warrant, it may issue a restricted annual Certificate of Approval that permits operation of a program, but limits the program's authority in one (1) or more areas of operation.~~
- (10) Throughout the temporary certification period and during the annual re-evaluation period, immediate access to all areas of the child care facility shall be granted to all Department representatives and other inspection authorities (i.e., fire safety, sanitation, health, Department of Children's Service, etc.) during operating hours.
- (11) Any program found in operation without oversight from the department of education, will be found to be running an illegal operation, and will be turned over reported to local authorizes as indicated by T.C.A. § 49-1-1105(a).
- (12) If the Department determines, as a result of its inspections or investigations or those of other local, state or federal agencies or officials, or through any other means, that a plan is necessary to insure the safety of the children in the care of the program the Department may require the program to implement a safety plan. The safety plan may require, but is not limited to, the exclusion or restriction of any individuals from access to children, the closure or restriction of any part of the program, the modification or elimination of services, the re-inspection of the program, the training of management, staff, or volunteers. such a safety plan.

Authority: T.C.A. §§ 4-5-201 et seq., 49-1-201(c) (24), 49-1-302(l), 49-1-1101 et seq. through 49-1-1109, 49-2-203(b) (11), and 49-5-413. **Administrative History:** Original rule filed September 26, 1990; effective

December 29, 1990. Amendment filed April 30, 2002; effective July 14, 2002. Amendment repealing and replacing rule filed March 15, 2010; effective August 29, 2010.

0520-12-01-.04 PROCEDURES FOR OBTAINING A CERTIFICATE OF APPROVAL.

Repeal REPEALED.

Authority: T.C.A. §§ 4-5-201 et seq., 49-1-201(c)(24), 49-1-302(l), 49-1-1101 et seq. through 49-1-1109, 49-2-203(b)(11), and 49-5-413. **Administrative History:** Original rule filed September 26, 1990; effective December 29, 1990. Amendment filed April 30, 2002; effective July 14, 2002. Amendment repealing and replacing rule filed March 15, 2010; effective August 29, 2010.

0520-12-01-.05 PROGRAM OWNERSHIP, ORGANIZATION, AND ADMINISTRATION.

(1) Each program shall have an adequate budget for the financial support of the program. Adequate financing of the center's operation shall be maintained throughout the year.

~~_____ (1) Statement of Purpose and Need.~~

~~(a) An applicant for approval to operate a school-administered infant/toddler program, prekindergarten/preschool, school-age care, center-based TEIS early intervention services, or school-administered or community organization administered LEAPS, Voluntary Pre-K, and 21st Century Community Learning Center programs must submit, on or before October 1, a written statement to the Department of Education governing the following areas:~~

~~A description of the services to be offered to children and parents and reasons these services are needed at the proposed location;~~

~~Ages of children to be served;~~

~~Hours of operation;~~

~~A description of meal provision or preparation;~~

~~1. Admission requirements and enrollment procedures; and~~

~~_____ Provision for emergency medical care; and.~~

~~2. Transportation Pplan.~~

~~(b) If, after being approved, a child care provider wishes to change the scope or type of service offered to children and families, an amended statement shall be filed with the Department for approval prior to implementation.~~

~~_____ (2) Organizational Structure.~~

~~(a) The organization of every program shall be such that legal and administrative responsibility is clearly defined and available upon request.~~

~~(b) Every program shall have an on-site director.~~

~~(c) Following the issuance of an initial approval, program may operate without an on-site director for a period of no more than sixty (60) days total within the annual approval year. A qualified person, as determined by the Department, shall be in charge in the interim.~~

~~(3) Finances.~~

~~(a) In order to ensure the appropriate continuity of care for children the program management must provide a reasonable plan with a proposed budget for the financial support of the program. The proposal must demonstrate a reasonable plan for the financial support of the program which would assure adequate staffing, equipment and safe operation. Adequate financing of the center's operation shall be maintained throughout the year. _____~~

~~(a)~~

Proposed budgets and other relevant financial records shall be available to the Department of Education upon request.

~~(b) If any program is the subject of any bankruptcy or receivership petition or order, or any other action that may affect the financial status or operational status of the program, including but not limited to foreclosure notices, liens, etc. or, if any program is the subject of any local, state or federal regulatory action, such as but not limited to, the fire safety, health, environmental zoning or local, state or federal grant compliance status or tax enforcement proceedings, the program's management shall immediately notify the Department and shall provide current documentation of the status of the program, including copies of necessary administrative and/or court legal documents applicable to that status.~~

~~(2) Insurance.~~

General liability, automobile liability and medical payment insurance coverage shall be maintained on the operations of the program's facilities and on the vehicles owned, operated or leased by the program and as follows:

~~(a) General liability coverage on the operations of the program's facilities shall be maintained in a minimum amount of five hundred thousand dollars (\$500,000) per occurrence and five hundred thousand dollars (\$500,000) general aggregate coverage.~~

~~(b) Medical payment coverage shall be maintained in the minimum amount of five thousand dollars (\$5,000) for injuries to children resulting from the operation of the program.~~

~~(c) Automobile coverage for programs that transport children:~~

~~1. Automobile liability coverage shall be maintained in a minimum amount of five hundred thousand dollars (\$500,000) combined single limit of liability.~~

~~2. Medical payment coverage shall be maintained in the minimum amount of five thousand dollars (\$5,000) for injuries to children being transported in vehicles owned, operated or leased by the program.~~

- (d) The requirements of this paragraph shall not apply to a program that is under the direct management of a self-insured administrative department of the state, a county or a municipality or any combination of those three (3) or that has, or whose parent entity has a self-insurance program that provides, as determined by the Department, the coverage and the liability limits required by these rules.
- (e) Documentation that the necessary insurance is in effect, or that the administrative department or other entity is self-insured, shall be maintained in the records of the program and shall be available for review by the Department.

(3) Enrollment Restrictions.

~~Enrollment of children under six (6) weeks of age is prohibited.~~

~~Children shall not be in care for more than twelve (12) hours in a twenty four (24) hour period except in special circumstances (e.g., acute illness of or injury to parents, severe weather conditions, natural disaster, and unusual work hours). In such cases every effort shall be made to minimize the amount of time spent in the program by exploring and documenting alternatives (i.e., part time care, care with a relative, etc.)~~

~~(a) Individualized plans for the care of a child in excess of twelve (12) hours due to special circumstances shall be signed by the parent and the director/administrator and must be approved by the Department. Plans shall be updated annually.~~

- (a) ~~A~~The program shall is not enrollpermitted to admit a child into care until the parent or /guardian has supplied the program with a completed application, Tennessee Department of Health Official official immunization immunizations record (for children over two (2) months of age), and a health history. Exception: After an initial eligibility determination, children who are homeless and/or children in state custody may receive care prior to providing all required documentation by the department. Care without documentation of immunizations must not exceed two (2) weeks. Program must have a written plan for obtaining records for children who are homeless and/or in state custody.

~~All children physically present in the program's facility or the program's assigned area within the facility shall be counted in the adult: child ratio and group size, and shall have all required records on file before care is provided.~~

~~The program shall maintain documentation that the parent was offered an on-site visit of the program to review the facility and and the parent had an the opportunity to review the program's policies and procedures prior to the child being enrolled into the program. Exception: On-site visit is not required for children of homeless families.~~

~~Requirements for Communication with Parents.~~

~~(a) A copy of the program's policies, procedures, and the Department's Summary of Certification requirements shall be supplied to the parent upon admission of the child. The program's policies shall include:~~

~~1. _____ Criteria for the dis-enrollment of children (Expulsion Policy).~~

~~2. Specific criteria concerning the release of children to anyone whose behavior may place the children at immediate risk.~~

~~Behavior management techniques~~

~~Late fees~~

~~Hours of Operation~~

~~Rates~~

~~Inclement weather~~

~~Emergency policy~~

~~Smoke-free environment~~

~~Meal Service Policy~~

~~—~~

~~11. _____ Transportation Plan~~

~~The program shall require the parent to sign for receipt of the policies and Summary of Certification Requirement, and the signed receipt shall be maintained by the program in the child's file.~~

~~Parents shall be permitted to see the professional credential(s) of staff upon request.~~

~~Each center shall implement a plan for regular and ongoing communication with parents. This plan shall include but not be limited to communication concerning curriculum, changes in personnel, or planned changes affecting children's routine care. Documentation shall be maintained for the most recent quarter.~~

~~(b) _____ During operating hours, parents shall be permitted access to their children. Programs shall develop a policy and implementation plan regarding non-custodial parent access and/or denial of access to children. The policy and implementation plan shall be provided to all parents. (The policy may be included in the parent handbook.)~~

~~(c) _____ Parents shall give written permission in advance of the child's removal from the premises, including prior notification and consent for each off-site activity, except in cases of emergencies or investigative procedures conducted pursuant to the child protective services laws or other applicable laws.~~

~~(d) Children shall be signed in and out of the program by the custodial parent or attendance recorded by the appropriate staff person. School-age students may sign themselves into the program. Program staff shall verify parental authorization and the identity of any person to whom a child is released.~~

~~(e) An abuse prevention awareness program for parents shall be offered at least once a year. The program shall include a child abuse prevention component, approved by the Department of Education, with information on the detection, reporting, and prevention of child abuse in child care centers and in the home.~~

Notifying Parents of Violations

~~1. Within the Certification year, after issuing two (2) formal notices of violations in compliance with rules, a notice of Probation, or after issuing any type of legal enforcement order, the Department may, in its discretion, require the program to notify parents and funding sources of the circumstances. Such notification shall be a letter prepared by the Department to be provided to each parent or posted in the program with parents' signatures indicating they have seen the letter.~~

The Department may, at its discretion, notify parents and funding sources of any decision affecting the program rendered by the State Board of Education Child Care Advisory Council serving in the role of Hearing Board for appeals or by any court.

General Record Requirements.

All records required by this Chapter shall be maintained in an organized manner on-site at the program and shall be immediately available to the Department upon request.

~~(a) A child's records shall be kept for one (1) year following the child's leaving the agency; provided, however, that the health record shall be returned to the child's parent upon request when the child leaves the agency. Records of children enrolled in prekindergarten programs may be made part of the child's cumulative file.~~

~~(b) Staff records shall be maintained for at least one (1) year following the separation of the staff from the program.~~

Children's Records.

~~(c) General Requirements for Children's Records shall include:~~

~~1. A current information form, which shall be updated annually and as changes occur, and which shall include:~~

~~(i) The child's name and date of birth;~~

~~(ii) Name of parent(s);~~

~~(iii) Child's and parents' home address (or addresses) and phone numbers;~~

~~(iv) Parents' business addresses, phone numbers, and approximate work hours;~~

~~(v) Any special needs or relevant history of the child or the child's family; and~~

~~(vi) The name and address (home and business or school) of a responsible person to contact in an emergency if parent(s) cannot be located promptly.~~

~~2. Name, address, and telephone number of a physician to call in case of an emergency;~~

~~3. Written consent of parent(s) regarding emergency medical care.~~

~~4. A written plan stating to whom the child shall be released.~~

~~5. Written transportation agreement between parent and the program regarding daily transportation between home and the program and the program and school. If parents have a third party transportation arrangement, verification and details of the arrangement shall be maintained in the child's file.~~

~~6. A copy of the child's health history provided by the child's parent or other caretaker, which need not be signed or certified by a health care provider, shall be on file in the program and shall be available to appropriate staff.~~

~~7. Daily attendance records for each child to include time in and time out.~~

~~8. Prior written permission of parent for each off-site activity.~~

~~9. Immunization Record.~~

The program shall maintain a written record in the child's file, as set forth in subparagraphs (b) _____ and (c), verifying that the child has been immunized according to current Department of Health guidelines.

(b) _____

Exceptions to this immunization record requirement may be made only if:

1. _____ The child's physician or the health department provides a signed and dated statement, giving a medical reason why the child should not be given a specified immunization; or
2. _____ The child's parent provides a signed written statement that such immunizations conflict with his/her religious tenets and practices; or.
3. _____ Care for children of homeless families and/or children in state custody is needed before documentation of immunizations can be confirmed. Care without documentation of immunizations must not exceed two (2) weeks. Program must have a written plan for obtaining records for children who are homeless and/or in state custody.

(c) _____ Programs may not deny enrollment to students based on citizenship status. (Plyler v. Doe, 457 U.S. 202, 1982).

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~~10. Reports of Incidents, Accidents, Injuries and Fatalities.~~

~~(i) Incidents, accidents and injuries shall be reported to the parent as soon as possible, but no later than the child's release to the parent or authorized representative.~~

~~(ii) Incidents, accidents and injuries to children shall be documented immediately as follows:~~

~~(I) Date and time of occurrence;~~

~~(II) Description of circumstances; and~~

~~(III) Action(s) taken by the agency program.~~

~~(iii) Documentation of incidents, accidents and injuries to children shall be filed in the child's record no later than one (1) business day immediately following the occurrence.~~

~~(iv) The Department shall be notified of any child fatality at the program no later than one (1) calendar day immediately following the death.~~

~~(b) Preschool Children's Record Requirements.~~

~~1. Additional information for infants, toddlers and all non-verbal children shall be recorded and shared with parents daily as follows: the time and amount of feeding, any incidence of excessive spitting up, toileting and/or times of diaper changes, sleep patterns, and developmental progress.~~

~~2. Before a child under the age of thirty (30) months of age is accepted for care, the parent shall provide proof of a physical examination within three (3) months prior to admission, signed or stamped by a physician or health care provider. This record must be kept on file at the program.~~

~~3. The records of any child who is five (5) years old in an agency which lacks approved kindergarten status for purposes of T.C.A. § 49-6-201 shall include a signed acknowledgment by the child's~~

~~parents that recognizes that the child's attendance does not satisfy the mandatory kindergarten prerequisite for the child's enrollment in first (1st) grade. The statement of acknowledgment shall be signed by the parent and maintained in the child's file.~~

~~(c) — School-age Children's Record Requirements.~~

~~1. The information form for school-age children shall list the name, address, and phone number of the school the child attends.~~

~~2. If the school-age program is not located within the school in which the child is enrolled, the program shall have on file a statement from the parent (or the school) that the child's immunizations are current and that his/her health record is on file at the specified school which the child attends.~~

~~3. The records of any child who is five (5) years old in a center which lacks approved kindergarten status for purposes of T.C.A. § 49-6-201 shall include a signed acknowledgment of the child's parents that recognizes that the child's attendance does not satisfy the mandatory kindergarten prerequisite for the child's enrollment in first grade. The statement of acknowledgment shall be signed by the parent and maintained in the child's file.~~

~~(d) — Immigrant children. Schools may request information but may not deny enrollment to undocumented immigrant children regardless of their immigrant status. Plyler v. Doe, 457 U.S. 202 (1982).~~

~~(9) — Staff Record Requirements Shall Include:~~

~~(a) — Name, birth date, social security number, (used by the employer for Federal/State tax purposes), address, and telephone number of all staff members, including volunteers, and a contact for each staff member in an emergency;~~

~~(b) — Educational background and educational experiences, including dates and places of diplomas received, and conferences, courses, and workshops attended in the preceding year;~~

~~Documentation, signed by the examining licensed physician, licensed psychologist, licensed clinician, Nurse Practitioner or Physician's Assistant, verifying that the staff person is capable of safely and appropriately providing care for children in a group setting.~~

~~(d) — Enrollment of children under six (6) weeks of age is prohibited.~~

~~(e) — The program shall maintain documentation that the parent was offered an on-site visit of the program to review the facility and the opportunity to review the program's policies and procedures prior to the child being enrolled into the program. Exception: On-site visit is not required for children of homeless families.~~

~~(c) — The documentation shall be on file within ten (10) calendar days of employment or starting to work;~~

~~(d) — An updated statement of each staff member's physical health shall be obtained every third (3rd) year, or more often if deemed necessary by the Department;~~

~~(e) — At least three (3) references from non-relatives, either written or with documented interviews of each reference on each staff member;~~

~~(f) — Written, verified record of employment history;~~

- ~~(g) Documentation of annual performance reviews;~~
- ~~(h) Date of employment and date of separation from the program;~~
 - ~~_____ Daily attendance (including time in/out) of staff;~~
- ~~(i) Signed and completed criminal history disclosure form;~~
- ~~(j) Verification of criminal background check results;~~
- ~~(k) Verification of Vulnerable Persons Registry results;~~
- ~~(l) Documentation of trainings to include all pre-service training hours;~~
- ~~(m) Driver records shall additionally contain:~~
 - ~~1. Copy of driver's license showing proper endorsement;~~
 - ~~2. Verification of a passed drug screen; and~~
 - ~~3. Verification of Cardiopulmonary Resuscitation (CPR) and First Aid certifications;~~
- ~~(n) Volunteer Records. Records of volunteers shall be maintained on-site at the program and must include names, addresses, telephone numbers and dates of service of all volunteers.~~
- ~~(10) Right to Privacy/Confidentiality.~~

~~_____ The program staff shall not disclose or knowingly permit the use by other persons of any information concerning a child or family except as required by law, regulation or court order, or as may be necessary to be disclosed to public authorities in the performance of their duties and which may be necessary for health, safety, or welfare of any child enrolled Exception: On-site visit is not required for children of homeless families in the program or the child's family.~~

- ~~(4) Each program shall implement a plan for regular and ongoing communication with parents. This plan shall include but not be limited to communication concerning curriculum, changes in personnel, or planned changes affecting children's routine care.~~
 - ~~(a) Parents or guardians shall be provided a parent handbook outlining the program's policies, procedures, and the requirements of this Chapter upon admission of the child. The program's parent handbook shall include, at a minimum:~~

~~(11) Posting of Certificate of Approval and Other Required Documentation.~~

During

- ~~_____ 1. Criteria for the dis-enrollment of children (expulsion policy);~~
- ~~_____ 2. Specific criteria concerning the release of children to anyone whose behavior may place the children at immediate risk;~~

3. hoursBehavior management techniques;
 4. Rates and late fee policy;
 5. Hours of operation;
 6. Emergency plan and inclement weather policy;
 7. the current Certificate of Approval to operate the Smoke free environment; and
 8. Meal sService pPolicy.
- (b) The program shall require the parent to sign for receipt of the policies and summary of the requirements of this Chapter, and the signed receipt shall be maintained by the program in the child's filebe posted near the main entrance in a conspicuous location.
- (c) Parents shall be permitted to see the professional credential(s) of program staff upon request.

~~The Department of Human Services toll-free complaint number shall be posted in a conspicuous location.~~

~~The Department of Children's Services' child abuse number shall be posted near the main entrance in a conspicuous location and at each telephone.~~

~~A copy of all current applicable Department Certification rules shall be maintained in a central space and available to all staff and parents.~~

~~No smoking signs shall be posted in a conspicuous manner.~~

~~The program shall post any other materials as directed by the Department.~~

- (d) An abuse prevention awareness program for parents shall be offered at least once a year. The program shall include a child abuse prevention component, approved by the Department of Education, with information on the detection, reporting, and prevention of child abuse in child care centers and in the home.
- (e) After issuing two (2) formal notices of violations in compliance with rules, a Notice of Probation, or after issuing any type of legal enforcement order, the Department may, in its discretion, require the program to notify parents and funding sources of the circumstances. to be provided to each parent or posted in the program with parents' signatures indicating they have seen the letter.
- (f) The Department may, at its discretion, notify parents and funding sources of any decision affecting the program rendered by the State Board of Education Child Care Advisory Council serving in the role of Hearing Board for appeals or by any court.

(5) Release of Children

- (a) Parents shall give written permission in advance of the child's removal from the premises, including prior notification and consent for each off-site activity, except in cases of emergencies or investigative procedures conducted pursuant to the child protective services laws or other applicable laws.
- (b) Children shall be signed in and out of the program by the custodial parent. Students transported to the program pursuant to 0520-12-01-.13 may be signed in and out of attendance recorded by the appropriate staff person. School-age students may sign themselves into the program. Program staff shall verify parental authorization and the identity of any person to whom a child is released.
- (c) Children shall only be released to a responsible designated person in accordance with the child release plan required by these rules. The program shall verify the identity of the authorized person by requiring presentation of a photo identification. The person to whom the child is released must sign the child out of the program.
- ~~The person to whom the child is released must sign the child out of the program.~~
- (d) Children should not be released to anyone whose behavior, as deemed by a reasonable person, may place him/her in imminent risk. Immediately call 911, the local law enforcement agency or other emergency services number prior to the release of children. If the person, displaying risky behavior, is not the parent, the program shall not release the child and the parent shall be called immediately.
- (e) During operating hours, parents shall be permitted access to their children. Programs shall develop a policy and implementation plan regarding non-custodial parent access and/or denial of access to children. The policy and implementation plan shall be provided to all parents. (The policy may be included in the parent handbook.)

- (a) Children should not be released to anyone whose behavior, as deemed by a reasonable person, may place him/her in imminent risk. Immediately call 911, the local law enforcement agency or other emergency services number prior to the release of children to a parent. If the person, displaying risky behavior, is not the parent, the program shall not release the child and the parent shall be called immediately.

(f) Programs shall develop a policy and implementation plan regarding non-custodial parent access and/or denial of access to children. The policy and implementation plan shall be provided to all parents. (The policy may be included in the parent handbook.)

- (f) A parent shall be notified before the child leaves the premises except in emergency circumstances, except that an authorized investigator with the Department of Children's Services or local law enforcement may take a child off the premises of the program if he/she has obtained custody of the child as follows:
1. Voluntary placement agreement with the parent;
 2. Court order;
 3. Emergency assumption of custody under T.C.A. § 37-1-113 without parental permission;

4. If the child's parent or legal guardian is present and approves; or
 5. In conjunction with investigative procedures under the child abuse laws.
- (6) Incidents, accidents and injuries shall be reported to the parent as soon as possible, but no later than the child's release to the parent or authorized representative.
- (a) Incidents, accidents and injuries to children shall be documented immediately as follows:
 1. Date and time of occurrence;
 2. Description of circumstances; and
 3. Action(s) taken by the program.
 - (b) Documentation of incidents, accidents and injuries to children shall be filed in the child's record no later than one (1) business day immediately following the occurrence.
 - (c) The Department shall be notified of any child fatality at the program no later than one (1) calendar day immediately following the death.
- (7) All programs must comply with the following record requirements for children and staff:
- (a) All records shall be maintained in an organized manner and shall be immediately available to the Department upon request.
 - (b) Children's Records shall include:
 1. A current information form, which shall be updated annually and as changes occur, and which shall include:
 - (i) The child's name and date of birth;
 - (ii) Name of parent(s);
 - (iii) Child's and parents' home address (or addresses) and phone numbers;
 - (iv) Parents' business addresses, phone numbers, and approximate work hours;
 - (v) Any special needs or relevant history of the child or the child's family; and
 - (vi) The name and address (home and business or school) of a responsible person to contact in an emergency if parent(s) cannot be located promptly.
 2. Name, address, and telephone number of a physician to call in case of an emergency.

3. Written consent of parent(s) regarding emergency medical care.
 4. A written plan stating to whom the child shall be released.
 5. Written transportation agreement between parent and the program regarding daily transportation between home and the program and the program and school. If parents have a third party transportation arrangement, verification and details of the arrangement shall be maintained in the child's file.
 6. A copy of the child's health history provided by the child's parent or other caretaker, which need not be signed or certified by a health care provider, shall be on file in the program and shall be available to appropriate staff.
 7. Daily attendance records for each child to include time in and time out.
 8. Prior written permission of parent for each off-site activity.
 9. Immunization Record.
- (c) A child's records shall be kept for one (1) year following the child's leaving the agency; provided, however, that the health record shall be returned to the child's parent upon request when the child leaves the agency. -Records of children enrolled in pre-kindergarten programs may be made part of the child's cumulative file.
- (d) Additional information for infants, toddlers and all non-verbal children shall be recorded and shared with parents daily as follows:- the time and amount of feeding, any incidence of excessive spitting up, toileting and/or times of diaper changes, sleep patterns, and developmental progress. Before a child under the age of thirty (30) months of age is accepted for care, the parent shall provide proof of a physical examination within three (3) months prior to admission, signed or stamped by a physician or health care provider. -This record must be kept on file at the program.
- (e) School-age children's records shall include:
1. An information form that list the name, address, and phone number of the school the child attends;
 2. If the school-age program is not located within the school in which the child is enrolled, the program shall have on file a statement from the parent (or the school) that the child's immunizations are current and that his/her health record is on file at the specified school which the child attends;
 3. The records of any child who is five (5) years old in a center which lacks approved kindergarten status for purposes of T.C.A. § 49-6-201 shall include a signed acknowledgment from the child's parents that recognizes that the child's attendance does not satisfy the mandatory kindergarten prerequisite for the child's enrollment in first grade. The statement of acknowledgment shall be maintained in the child's file; and

4. Written authorization from a physician for the self-administration of medication for the current school year, if applicable.

(f) Staff records shall include:

1. Name, birth date, social security number, (used by the employer for Federal/State tax purposes), address, and telephone number of all staff members and a contact for each staff member in an emergency;

2. Educational background and educational experiences, including dates and places of diplomas received, and conferences, courses, and workshops attended in the preceding year.;

3. Documentation, signed by the examining licensed physician, licensed psychologist, licensed clinician, Nurse Practitioner or Physician's Assistant, verifying that the staff person is capable of safely and appropriately providing care for children in a group setting.- The documentation shall be on file within ten (10) calendar days of employment or starting to work. An updated statement of each staff member's physical health shall be obtained every third (3rd) year, or more often if deemed necessary by the Department;

4. At least three (3) references from non-relatives, either written or with documented interviews of each reference on each staff member;

5. Written, verified record of employment history;

6. Documentation of annual performance reviews;

7. Daily attendance (including time in/out) of staff;

8. Signed and completed criminal history disclosure form;

9. Verification of criminal background check and Vulnerable Persons Registry results;

10. Documentation of trainings to include all pre-service training hours; and

11. Date of employment and date of separation from the program.

12. Driver records shall additionally contain:

(i) Copy of driver's license showing proper endorsement;

(ii) Verification of a passed drug screen; and

(iii) Verification of Cardiopulmonary Resuscitation (CPR) and First Aid certifications.;

(g) Staff records shall be maintained for at least one (1) year following the separation of the staff from the program.

- (h) Records of volunteers shall be maintained and must include names, addresses, telephone numbers and dates of service of all volunteers.
- (i) Records of substitutes shall be maintained and include the names, addresses, telephone numbers and dates of service of all substitutes.
- (8) The program staff shall not disclose or knowingly permit the use by other persons of any information concerning a child or family except as required by law, regulation or court order, or as may be necessary to be disclosed to public authorities in the performance of their duties and which may be necessary for health, safety, or welfare of any child enrolled in the program or the child's family.
- (9) Programs shall meet the following requirements for the posting of documentation:
 - (a) During the hours of operation, the current certificate of approval shall be posted near the main entrance in a conspicuous location.
 - (b) The Department of Human Services' toll-free complaint number shall be posted in a conspicuous location.
 - (c) The Department of Children's Services' child abuse number shall be posted near the main entrance in a conspicuous location and at each telephone.
 - (d) A copy of these sState bBoard rules shall be maintained in a central space and available to all staff and parents.
 - (e) No smoking signs shall be posted in a conspicuous manner.
 - (f) The program shall post any other materials as directed by the Department.

Authority: T.C.A. §§ 4-5-201 et seq., 37-1-403(a)(8) 49-1-302(l), 49-1-1101 through 49-1-1109, 49-62101, 49-6-2105, 49-6-2107, 49-6-2108, 49-2-2110, 49-6-2114, 49-6-2116, 55-9-602 et seq., 55-50-301 et seq. and 55-50-401 et seq. **Administrative History:** Original rule filed September 26, 1990; effective December 29, 1990. Amendment filed April 30, 2002; effective July 14, 2002. Amendment repealing and replacing rule filed March 15, 2010; effective August 29, 2010.

0520-12-01-.06 PROGRAM OPERATIONSUPERVISION.

Program Responsibility for the Children's Supervision:

~~The management of the program shall maintain a system that enables all children in the program's care to receive a level of supervision of their status and activities that is appropriate to their age and their development, physical and mental status so as to ensure their health and safety and that allows program personnel to know the whereabouts of each child.~~ (1) Each program shall maintain a system that enables all children in the program's care to receive a level of supervision that is appropriate to their age and their development, physical and mental status so as to ensure their health and safety and that allows program personnel to know the whereabouts of each child.

- (a) This system shall include a mandatory visual inspection of all areas of the building and grounds immediately prior to closing the program for the day in order to ensure that no children have been unintentionally left in any part of the program's facilities or in any vehicles that the program uses to transport children.
 - (b) Children six (6) weeks of age through two (2) years of age: the adult must be able to hear the child at all times, must be able to see the child at a quick glance, and must be able to physically respond immediately.
 - (c) Children three (3) years through five (5) years of age shall be safely protected by an adult in close proximity and not distracted by other tasks and must be able to physically respond immediately.
 - (d) Children six (6) weeks of age to five (5) years of age during mealtime: An adult must be in the direct sight and sound of child/children while the child/children are eating.
 - (e) Children six (6) weeks of age to five (5) years of age during mealtime: An adult must be in the direct sight and sound of child/children while the child/children are eating.
- Children who are in kindergarten, five (5) years of age, by ~~September 30th~~ August 15th through nine (9) years of age shall be protected by an adult who adjusts restrictions appropriately for different ages and abilities and must be able to physically respond immediately.
- (f) Children ten (10) years of age through thirteen (13) years of age: The adult shall know the whereabouts and activities of the child/children at all times and must be able to physically respond immediately. Youth/children shall have the opportunity to develop independence.
 - (g) Children fourteen (14) years of age to eighteen (18) years of age: The adult shall know the whereabouts and activities of the children, provide age appropriate guidance and must be able to physically respond as needed.

~~Staff shall position themselves strategically for adequate supervision and quick response.~~

~~Staff shall be aware of the dynamics (interactions) and activities of the entire group even when dealing with only part of the group at a time.~~

~~Children fourteen (14) years of age to eighteen (18) years of age: The adult shall know the whereabouts and activities of the children, provide age appropriate guidance and must be able to physically respond as needed.~~

~~Mixed-age Groups. When children ages ten (10) and above are grouped with children under ten (10) years of age, the minimum supervision requirements must be in accordance with the supervision required for the age group of the youngest child in the group.~~

- ~~(h) Mixed-age Groups. When children ages ten (10) and above are grouped with children under ten (10) years of age, the minimum supervision requirements must be in accordance with the supervision required for the age group of the youngest child in the group.~~

- (i) Staff shall position themselves strategically for adequate supervision and quick response.

~~(j) Staff shall be aware of the dynamics (interactions) and activities of the entire group even when dealing with only part of the group at a time.~~

~~(k) Helper devices such as mirrors, electronic sound monitors, etc. may be used as appropriate to meet these requirements.~~

~~(l) Teachers shall monitor children's toileting and be aware of their activities while respecting the privacy needs of the child.~~

~~(g) Helper devices such as mirrors, electronic sound monitors, etc. may be used as appropriate to meet these requirements.~~

~~Teachers shall monitor children's toileting and be aware of their activities while respecting the privacy needs of the child.~~

~~When more than twelve (12) children are present on the premises, but a second (2nd) adult is not required by the Adult: Child ratio rules, contained in this Chapter, a second (2nd) adult shall be physically available on the premises.~~

~~(m) The program shall maintain a plan, approved by the Department's child care program evaluator, that enables a teacher in an emergency situation to call a second (2nd) adult who can respond quickly while maintaining as much supervision of the children in care as is possible under the circumstances.~~

~~(2) Each enrolled child shall be in a defined group based on their age and assigned to that group with a specific teacher.~~

~~All children for whom care is provided at any one time shall be included in the program's enrollment, square footage allowance, and approved capacity.~~

~~Auxiliary staff may be used as emergency substitutes if their qualifications permit, but not while performing auxiliary duties.~~

~~If meals are served, any person responsible for preparing meals and washing the dishes shall not be included in the Adult: Child ratio while preparing meals or washing dishes.~~

~~When more than twelve (12) school-age children in first (1st) grade and above are present, a separate group, a separate space, and a separate program type shall be provided for them.~~

~~Assignment of Children to Groups:~~

~~Based on their age by August 15th, Each child must be on roll in a defined group and assigned to that group with a specific teacher.~~

~~(a) Maximum group size requirements shall be maintained at all times when children are indoors with the exceptions of meals served in common dining rooms, napping in common nap rooms, or outdoors on the playground.~~

(b) ~~When infants are cared for in a center with older children, they shall not be grouped with children older than thirty (30) months of age and a separate area shall be provided for them.~~

(c) ~~In order to assure the continuity of care for children thirty (30) months of age to five (5) years of age and their teachers, the children shall be kept with the same group throughout the day and shall not be moved, shuffled, or promoted to a new group until required based upon the developmental needs of the child; provided however, that:~~

~~1. For children, groups, excluding infants and toddlers, may be combined for short periods for a special activity, e.g. special assembly, visiting performers, or community helpers, etc., of no more than thirty (30) minutes duration per day as long as adult: child ratios are met.~~

~~For children, groups, excluding infants and toddlers, may be combined for short periods for a special activity, e.g. special assembly, visiting performers, or community helpers, etc., of no more than thirty (30) minutes duration per day as long as adult: child ratios are met.~~

(3) ~~Each program shall adhere to the maximum group size and adult: child ratios required by this chapter.~~

~~(a) The adult: child ratios shall be maintained by the program while the children are indoors and on the playground. Groups, excluding infants and toddlers, may be combined, for up to one (1) hour at the beginning of the day and for up to one (1) hour at the end of the day as set forth in the Adult: Child Ratio Chart 3.~~

~~(e) Each group must have a "home base" with enough space for the entire group.~~

~~Required Adult: Child Ratios:~~

~~The adult: child ratios shall be maintained by the program while the children are indoors and on the playground.~~

~~(b) The maximum group size and adult: child ratio shall be based on the age of the child on August 15th.~~

~~(c) All children physically present in the program's facility or the program's assigned area within the facility shall be counted in the adult: child ratio and group size.~~

~~(d) Any number of children in excess of the adult: child ratio requires a second qualified adult teacher; provided, however, that the maximum group size shall not be exceeded.~~

~~(e) When more than twelve (12) children are present on the premises, but a second (2nd)-adult is not required by the adult: child ratio rules contained in this Chapter, a second (2nd)-adult shall be physically available on the premises.~~

~~Adult: Child~~

~~Any number of children in excess of the adult: child ratio requires a second qualified adult teacher; provided, however, that the maximum group size shall not be exceeded.~~

Adult: Child Ratio Charts

Adult: Child Adult: Child Adult: Child Adult: Child Adult: Child Adult: Child Chart 1 – Single Age Grouping and Adult: Child Ratio Chart**

Chart 1: Singleratio rules, contained in this Chapter, a second (2nd) adult shall be physically available on the premises.

(f) If meals are served, any person responsible for preparing meals and washing the dishes shall not be included in the adult: child ratio while preparing meals or washing dishes.

(4) Programs must meet the following group size and adult: child ratios:

(a) Maximum group size and adult: child ratio for single-age grouping:

Age	Group Size	Adult: Child Ratio
Infant (6wks – 11m)	8	1: 4
One (1) year old Toddler (11m-23m)	12	1: 6
Two (2) years old	14	1: 7
Three (3) years old	18	1: 9
Four (4) years old	20	1: 13
VPK, 619, PDGLEA Pre-K	2020	1:101:10

(b) Maximum group size and adult: child ratio for multi-age grouping:

Age	Group Size	Adult: Child Ratio
Infant – 18 months	8	1: 4
18 – 36 months	16	1: 8
3 – 6 years old*	24	1: 13

*Not including first grade children.

Age	Group Size				Maximum Group Size and Adult: Child Ratio					
Single-Age Grouping	8	12	14	16	Infant – 18 months	820				1: 4No-Max
18 – 36 infants:	16				1: 84					

6-wks. - 12 months									
Toddlers (12-mos. - 23-mos.)		1:6							
3 - 62 years old (24 mos. - 35 mos.)	24		1:13						
3-years					1:9				
4-years						1:13			
School-age before/after care (kindergarten-12-years)							1:20		
School-age before/after care (13-17-years)							1:30		

- (c) For children six (6) weeks through two (2) years, class assignment shall be based on the developmental needs of the child.
- (de) For children three (3) years through pre-kindergarten, class assignment shall be determined on the child's age on August 15th.
- (ef) Group sizes or class assignments and adult: child ratios may not be adjusted based on a change to a child's age during the school year. Schools shall not change a classroom status mid-year.- i.e. from single-age to multi-age due to a child's age.
- (fg) For children three (3) years through pre-kindergarten (excluding LEA pre-k to include VPK, IDEA 619, etc.) -if the director of schools finds through evaluation and testing, at the request of the parent or legal guardian, that a child who has a birthdate from August 16-September 30 and is sufficiently mature emotionally and academically, then the child may be permitted to enter such classroom.
- (g) Maximum group size and adult: child ratio during arrival and departure (1 hour prior to and end of the school day) excluding infants and toddlers:

<u>Age</u>	<u>Group Size</u>	<u>Adult: Child Ratio</u>
<u>Including 3 year olds</u>	<u>15</u>	<u>1: 10</u>
<u>Including 4 year olds</u>	<u>20</u>	<u>1: 12</u>

**The pre-kindergarten classes implemented in accordance with State Board of Education rule 0520-01-03-.05 (5).05 may never exceed twenty (20) children.

Chart 2 - Multi-Age Grouping and Adult: Child Ratio Chart***

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Maximum Group Size and Adult: Child Ratio								
Multi- Age Group occupy ing	8	1	1	2	2	2	No	
Infants: 6 weeks - 18 months	1							
Toddlers: 18 - 36 months		1						
3 - 6 years (Kin derg arte							-1:10	

n only }							
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<u>MAXIMUM GROUP SIZE AND ADULT: CHILD RATIO</u>		
<u>This chart is based on the age of child by August 15th</u>		
<u>Age</u>	<u>Maximum Group Size</u>	<u>Adult: Child Ratio</u>
<u>Infants</u> <u>6 wks-18 months</u>	<u>8</u>	<u>1:4</u>
<u>Toddlers</u> <u>18-36 months</u>	<u>16</u>	<u>1:8</u>
<u>3-6 year</u>	<u>24</u>	<u>1:13</u>
<u>K-12 years</u> <u>Before/after care</u>	<u>No max</u>	<u>1:20</u>
<u>13-17 years</u> <u>Before/after care</u>	<u>No max</u>	<u>1:30</u>

All mixed age group classrooms shall not exceed the maximum group size, shall maintain ratios, and must show an enrollment of 30% school-age.

<u>MAXIMUM GROUP SIZE AND ADULT: CHILD RATIO</u>		
<u>This chart is based on the age of child by August 15th</u>		
<u>Age</u>	<u>Maximum Group Size</u>	<u>Adult: Child Ratio</u>
<u>Infants</u> <u>6 wks-18 months</u>	<u>8</u>	<u>1:4</u>
<u>Toddlers</u> <u>18-36 months</u>	<u>16</u>	<u>1:8</u>
<u>3-6 year</u>	<u>24</u>	<u>1:13</u>
<u>K-12 years</u> <u>Before/after care</u>	<u>No max</u>	<u>1:20</u>
<u>13-17 years</u> <u>Before/after care</u>	<u>No max</u>	<u>1:30</u>

Chart 3- Allowable group size during arrival and departure (1 hour prior to and end of the school day) i.e. children grouped in cafeteria prior to school starting.

<u>MAXIMUM GROUP SIZE AND ADULT: CHILD RATIO</u>		
<u>Age</u>	<u>Maximum Group Size</u>	<u>Adult: Child Ratio</u>

<u>Including 3 year olds</u>	<u>15</u>	<u>1:10</u>
<u>Including 4 year olds</u>	<u>20</u>	<u>1:12</u>

Maximum group size and Adult: Child Ratio		
Multi-age grouping	15	20
Including 3-year olds	1:10	
Including 4-year olds		1:12

(hd) Maximum group size and adult: child ratio during before and after school programs for birth through five:

Age	Group Size	Adult: Child Ratio
Infant – 36 months	Ratio and Group size remains the same	
3-4 year olds	<u>22</u>	<u>1:13</u>
4-5 year olds	<u>24</u>	<u>1:16</u>

Group size and class assignment shall be determined based on a child's age on August 15. Group sizes, class assignments and adult: child ratios may not be adjusted based on a change to a child's age during the school year.

Naptime Supervision

(a) At(5) During naptime and during nighttime care, after the children have settled down, adult: child ratios may be relaxed so long as the children are adequately protected and all of the following requirements are met:

(a)

At least one (1) adult shall be awake and supervising the children in each nap room or /sleeping area;

(b)

Infant/toddler ratios shall be maintained; and

(c)

The adult: child ratio for children ages three (3) years and thirty-one (31) months and above can be fifty percent (50%) of the required ratio if there are enough adults on the premises so that the adult: child ratio required for children when they are awake shall be met immediately in an emergency.

(d)

Maximum group size limits do not apply as long as the appropriate adult: child ratio is met at the fifty percent (50%) level.

(6) Each program shall have a written playground supervision plan that includes:

~~Safe Sleep Practices:~~

~~Infants shall be positioned on their backs when placed in a crib for sleeping.~~

~~In order to avoid the risk of smothering, soft bedding for infants is prohibited.~~

~~Infants shall not be wrapped tightly or swaddled in blankets for sleeping.~~

~~Infants shall be touched by a teacher every fifteen (15) minutes in order to check breathing and body temperature.~~

~~Pillows shall be prohibited for infants.~~

~~If a child appears not to be breathing, the program must immediately begin CPR and call for emergency medical assistance.~~

~~Before any teacher can assume duties of any type in an infant room they must be oriented in the foregoing SIDS procedures.~~

~~(d) Nap Room Lighting. The areas where infants sleep shall be lit in a manner which allows the teacher to quickly, at a glance, verify that the child's head is uncovered, that the child is breathing, and otherwise visually verify the child's condition.~~

~~Playground Supervision:~~

~~The same adult: child ratios are applicable for the playground as in the classrooms.~~

~~A playground supervision plan shall be written and implemented which includes:~~

~~(a) Arrival and departure procedures;~~

~~(b) Supervision assignments of staff to assure that all areas of the playground can be seen so that all children can remain within sight of the teachers;~~

~~(c) Identification of which staff will merely supervise in their assigned zone while other staff, if any, interact with children as play facilitators;~~

~~(d) Emergency plans specific to a variety of circumstances, such as, child injury, weather evacuation, toileting and other personal care needs of children or staff, etc.; and~~

~~(e) A communication link among playground supervisors and a designated staff person, if available, inside the program's facility.~~

(7) Programs shall meet the following requirements for off-site activities and swimming:

(a) _____

~~Supervision During Off-Site Activities.~~

~~Preschool Children. The required number of adults displayed in adult: child ratio for preschool children shall in charts 1 and 2 must be doubled during off-site visits.~~

~~(b) For children in kindergarten through thirteen (13) years of age the following requirements shall be met:~~

~~1. The number of trained teachers required to be present on off-site activities shall be at a minimum, equivalent to the number that would be required in the classroom; additional adults to meet the following off-site ratios in chart below may be teachers, volunteers and/or unpaid staff.~~

~~School-age Children (Kindergarten – 13 years of age).~~

~~The number of trained teachers required to be present on off-site activities shall be at a minimum, equivalent to the number that would be required in the classroom; additional adults to meet the following off-site ratios in chart 4 may be teachers, volunteers and/or unpaid staff.~~

<u>Number of children</u>	<u>Trained Teachers</u>	<u>Additional Adults</u>	<u>Total Adults Required</u>
<u>1 – 20</u>	<u>1</u>	<u>1</u>	<u>2</u>
<u>21 – 30</u>	<u>2</u>	<u>1</u>	<u>3</u>
<u>31 – 40</u>	<u>2</u>	<u>2</u>	<u>4</u>
<u>41 – 50</u>	<u>3</u>	<u>2</u>	<u>5</u>

~~1.~~

~~2. Chart 4 – Off Site Activities for School-age Children~~

~~School-age Children (14 to 18 years of age). The number of trained teachers required to be present on off-site activities shall yield an adult: child ratio of 1:20, additional adults to meet this ratio may be teachers, volunteers and/or unpaid staff.~~

~~(c) For children age fourteen (14) to eighteen (18), the number of trained teachers required to be present on off-site activities shall yield an adult: child ratio of 1:20, additional adults to meet this ratio may be teachers, volunteers and/or unpaid staff.~~

~~(d) A minimum of two (2) adults is required for any off-site activity.~~

~~(e) Programs shallThe program must maintain a system utilizing an off-site attendance roll which tracks the whereabouts of each child while off the premises.~~

~~(f) TheSupervision While Swimming. When children are swimming, the Adult: Child ratios in Chart 5 and the following requirements shall be met when children are swimming:;~~

~~1. The following adult: child ratios shall be followed:~~

~~(a) Chart 5 – Swimming Adult: Child Ratio Chart~~

Age-Group	Adult: Child Ratio
Infant/Infants (6wks-12 months)	1:1
Thirteen/Toddlers/Twos (13) – thirty-five (-35) months)	1:2
Three (3) years old/Year Olds	1:4
Four (4) years old/Year Olds	1:6
Five (5) years old/Year Olds	1:8
Kindergarten – thirteen (School-Age (K-13) years)	1:10
Fourteen (14) – eighteen (-to-18) years	1:20

2. ~~Group~~ Although group swimming for infants and toddlers is not prohibited, it is not recommended.
3. At least one (1) adult present shall have a current certificate in advanced aquatic lifesaving skills. This person must supervise from above the level of the swimmers, preferably from an elevated lifeguard chair or otherwise from the pool deck.
4. The lifeguard may not be included in the required adult: child ~~Adult: Child~~ ratio while performing lifeguard duties.
5. Remaining teachers should supervise both in and out of the water.

~~Transportation Supervision. Supervision for transportation of children shall comply with rules in 0520-12-01-.13(2).~~

Authority: T.C.A. §§ 4-5-201 et seq., 49-1-302(l), 49-1-1101 through 49-1-1109, 49-5-413, 49-6-2101, 496-2105, 49-6-2107, 49-6-2108, 49-2-2110, 49-6-2114, 49-6-2116, 49-6-3001, 55-9-602 et. seq., 55-50-301 et seq., 37-1-403(a)(8), 55-50-401 et. seq. and 71-3-507(g) and (h). **Administrative History:** Original rule filed September 26, 1990; effective December 29, 1990. Amendment filed April 30, 2002; effective July 14, 2002. Amendment repealing and replacing rule filed March 15, 2010; effective August 29, 2010.

0520-12-01-.07 STAFF.

- (1) Responsibility for Staff.
 - (a) The board, owner, applicant, or other designated agent of the program shall be responsible for selecting individuals qualified and of suitable character to work with children.
 - (b) The director, with the guidance of the board or owner of the program, shall be responsible for staff and program and the day-to-day operation of the program.
 - (c) Each location where children are kept shall have an on-site director.

~~(d) To be designated as such, the on-site director of a program in operation up to twelve (12) hours a day shall be physically present in the program's facilities daily at least half of the total hours of operation. If a program operates more than one (1) shift, the on-site director shall be physically present at least one (1) shift.~~

~~(e) To be designated as the director or person in charge (on a daily basis) of a multi-site program, he/she shall be employed full time in that capacity.~~

~~(f) An assistant director or other staff member shall be designated to be in charge in the absence of the director and all staff shall be notified of this designation.~~

~~(g) Management shall evaluate all staff in the performance of their duties. Teachers shall be evaluated for knowledge and understanding of growth and development patterns of children and understanding of appropriate activities for children as well as those with special needs. The Tennessee Frameworks for Evaluation process for licensed, prekindergarten teachers (certified in early childhood education) shall be accepted as the performance evaluation requirements of this subsection.~~

(1) All programs shall be staffed with a director and enough teachers and staff to meet the required adult: child ratios.

(2) Every staff person, including auxiliary staff, substitutes, volunteers, and practicum students, shall be physically, mentally, and emotionally capable of using the appropriate judgment for the care of children, and otherwise performing his/her duties satisfactorily. A person who has a physical, mental, or emotional condition which is in any way potentially harmful to children shall not be present with the children.

General Staff Qualifications.

Every staff person, including auxiliary staff, substitutes, volunteers, and practicum students, shall be physically, mentally, and emotionally capable of using the appropriate judgment for the care of children, and otherwise performing his/her duties satisfactorily.

A person who has a physical, mental, or emotional condition which is in any way potentially harmful to children shall not be present with the children.

(3) Every staff person, both paid and unpaid, who is under the age of twenty-one (21) years must be supervised by an adult while in the presence of children. Exception: Before and after school care programs.

(4) At least one (1) adult available on the premises at all times during program operating hours shall must be able to read and write English.

(5) Prior to assuming duties, each new employee shall receive two (2) hours of orientation, and be able to explain the program philosophy, emergency procedures, policies regarding discipline of children, policies regarding the reporting of child abuse, and policies for receiving and dismissing children.:

(6) Within the first two (2) weeks on the job, each employee, including directors, teachers, substitutes, volunteers, and practicum students, shall receive annual instruction in:

~~Program philosophy;~~

~~Job description;~~

~~Emergency procedures;~~

~~Policies regarding discipline of children;~~

~~Policies regarding the reporting of child abuse; and~~

~~Policies for receiving and dismissing children.~~

~~(f) Within the first two (2) weeks on the job, and reviewed annually each employee, where applicable, (including auxiliary staff, such as bus driver, cook, etc.) shall receive annual instruction in:~~

~~(a)1. Child abuse detection, reporting, and prevention;~~

~~(b)2. Parent-center communication;~~

~~(c)3. _____
Disease control and health promotion;~~

~~(d)4. An overview of certificate of approval requirements, Chapter 0520-12-01;~~

~~(e)5. Information on risks of infection to female employees of childbearing age;~~

~~(f)6. Food allergies;~~

~~(g)7. Supervision during high risk activities such as eating and outdoor play;~~

~~(h)8. Meal service and safe food preparation policies;~~

~~(i)9. Shaken baby syndrome;~~

~~(j)10. Abusive and abusive head trauma;~~

~~(k)11. Safe sleep procedures; and~~

~~(l)12. Developmentally appropriate practices.~~

(7) All training shall be documented in the program's records and be available for review by the Department's staff at any time.

(8) The program must maintain written documentation that each employee has read the full set of all applicable rules. In addition, a copy of these rules (0520-12-01) shall be maintained in an area that is readily accessible to all staff.

(9) Each program location where children are present shall have an on-site director. The on-site director, with the guidance of the board or owner of the program, shall be responsible for staff and the day-to-day operation of the program. On-site directors shall meet the following criteria:

(a) The on-site director of a program shall be a full-time employee and shall be physically present in the program's facilities daily at least half of the total hours of operation.

(b) A director shall be at least twenty-one (21) years of age if hired after June 30, 2017 and shall meet at least one (1) of the minimum qualifications listed below:

Multi-Site Personnel.

Multi-Site Coordinator. The multi-site coordinator must meet the same requirements listed below for a single-site program director.

Qualifications of On-Site Director Under a Multi-site Coordinator:

Must be 21 years of age, and

1. At least two (2) years of college training or a department-recognized credential in addition to at least one (1) year of full-time documented work experience with young children in a group setting; or
2. A high school diploma or its equivalent educational credential recognized by the Department in addition to at least two (2) years of full-time (paid or unpaid) documented work experience with young children in a group setting.

(2) Qualifications for Director of a Single Site Program.

Must be 21 years of age and,

The director shall meet at least one (1) of the minimum qualifications listed in the chart below:

<u>If Minimum Education levels:</u>	<u>The Minimum experience required Group Care Experience Required Is:</u>
<u>Graduation from an accredited four-year (4 year) college.</u>	<u>One (1) year of full-time (paid or unpaid) experience in a group setting. Experience may be paid or unpaid. ([2 years school-age care experience = 1 year full-time experience])</u>
<u>Sixty (60) semester hours (two [2] years) of college training, with at least thirty (30) hours of which shall be in business or management, child or youth development, early childhood</u>	<u>Two (2) years of full-time (paid or unpaid) experience in a group setting. Experience may be paid or unpaid. ([2 years school-age care</u>

education or related field.	experience = 1 year full-time experience}]
High school diploma School Diploma (or Department recognized equivalent), and Tennessee Early Childhood Training Alliance (TECTA) certificate for completing thirty (30) clock hours of orientation training, or the equivalent as recognized by the Department.	Four (4) years of full-time (paid or unpaid) experience in a group setting. Experience may be paid or unpaid. (2 years school-age Schoolage care experience = 1 year full-time experience.}]
Has been continuously employed as an on-site program director or child care agency owner since July 1, 2000.	Not applicable. Applicable

(c) Within the first thirty (30) days of employment by a program, a director shall complete an orientation provided by the Department of Education.

(d) In the 2017-18 school year, directors shall complete at least twenty-four (24) hours of professional development. In the 2018-19 school year and beyond, directors shall complete at least thirty (30) hours of professional development.

1. Six (6) hours of the professional development shall be in administration management or supervisory training and six (6) hours shall be in developmentally appropriate literacy practices.

(a) ~~Training Requirements:~~

1. ~~Prior to issuance of the first annual certificate of approval~~Within the first thirty (30) days of employment, directors shall complete an orientation on rules implementation provided by the Department of Education child care program evaluator.

2.

3. ~~During the first year of employment a new director shall:~~

(i) ~~Complete an orientation course within three (3) months of assuming the position; provided, however, that this course shall not be required if the director has:~~

(I) ~~Received specific training meeting the requirements of this part within three (3) years prior to employment; or~~

(II) ~~Earned a Bachelor's degree, an Associate's degree in child development or early childhood education, a CDA credential, or a CCP credential;~~

(ii) ~~Have evidence of receiving at least thirty-six (36) clock hours of Department recognized, competency-based training or one-to-one consulting sessions, at least six (6) hours of which must be in administration, management or supervisory training; or~~

(iii) ~~Earn credit during the year in one (1) academic course in administration, child development, early childhood education, health/safety, inclusion of children with special needs, or other related field.~~

4. ~~After the first (1) year of employment, the director shall:~~

- ~~(i) Earn credit during the year in one (1) academic course in administration, child development, early childhood education, health/safety or other related field; or~~
- ~~(ii) For 2016-17, have evidence of receiving at least eighteen (18) clock hours annually in workshops, competency-based training, or one-to-one consulting sessions:~~
- ~~(I) Six (6) hours shall be in administration management or supervisory training;~~
- ~~(II) Six (6) hours must be in developmentally appropriate literacy development; and~~
- ~~(III) Four (4) hours of the required eighteen (18) hours may be earned by conducting training.~~
- ~~(IV) (iii) For 2017-18, 24 professional development hours are required.~~
- ~~(V) (iv) For 2018-19, 30 professional development hours are required.~~
- ~~(c) If the Principal of a school serves as Director of the program. The Principal qualifications and training are in accordance with T.C.A. § 49-2-203.~~
- (10) Programs may employ an on-site assistant director. An assistant director or other staff member shall be designated to be in charge in the absence of the director and all staff shall be notified of this designation. On-site assistant directors shall meet the following criteria:
 - (a) The on-site assistant director shall be at least twenty-one (21) years of age if hired after June 30, 2017 and shall have at least two (2) years of college training or a Department recognized credential and one (1) year of full-time or two (2) years of part time school-age care documented work experience (paid or un-paid) in a group setting; or
 - ~~(3) Assistant Director Qualifications.~~
 - ~~(a) The on-site assistant director shall have at least two (2) years of college training or a Department recognized credential and one (1) year of full-time or two (2) years of part time school-age care documented work experience (paid or un-paid) in a group setting; or~~
 - (b) The on-site assistant director shall be at least twenty-one (21) years of age and shall have earned a high school diploma or equivalent educational credential recognized by the Department and two (2) years of full-time or four (4) years of part time school-age care documented work experience (paid or unpaid) in a group setting.
 - (c) Within the first thirty (30) days of employment, assistant directors shall complete an orientation provided by the department of education child care program evaluator.
 - (d) In the 2017-18 school year, assistant directors shall complete at least twenty-four (24) hours of professional development. In the 2018-19 school year and beyond, assistant directors shall complete at least thirty (30) hours of professional development.
 - ~~(b) Training requirements:~~
 - ~~1 For 2016-17, 18 hours of professional development is required.~~
 - ~~2 For 2017-18, 24 hours of professional development is required~~

~~3 For 2018-19, 30 hours of professional development is required.~~

~~1. Six (6) hours of the professional development shall be in developmentally appropriate literacy practices.~~

~~(11) All teachers and assistant teachers shall be at least twenty-one (21) years of age if hired after June 30, 2017 and shall meet the following criteria:~~

~~(a) Within the first thirty (30) days of employment, teachers and assistant teachers shall complete two (2) clock hours of pre-service orientation training offered or recognized by the Department. Pending completion of the orientation training, the teacher's employment status with the program is conditional. Up to two (2) hours of training credit may be earned for Child and Adult Care Food Program (CACFP) training or USDA Free and Reduced Price Meal Program training.~~

~~(b) In the 2017-18 school year, teachers and assistant teachers shall complete at least twenty-four (24) hours of professional development. In the 2018-19 school year and beyond, teachers and assistant teachers shall complete at least thirty (30) hours of professional development.~~

~~(c) At least six (6) hours of the required professional development shall be obtained outside of the program. At least six (6) hours of the professional development shall be in developmentally appropriate literacy practices.~~

~~(d) Teachers shall be evaluated for knowledge and understanding of growth and development patterns of children and understanding of appropriate activities for children as well as those with special needs. The Tennessee Frameworks for Evaluation process for licensed, pre-kindergarten (certified in early childhood education) shall be accepted as the performance evaluation requirement of this subsection.~~

~~Teacher Qualifications.~~

~~Each teacher shall be at least twenty-one (21) years of age.~~

~~Each group shall have at least one (1) teacher at all times.~~

~~Training requirements for teachers:~~

~~For 2016-17, 18 hours of professional development is required.~~

~~For 2017-18, 24 hours of professional development is required.~~

~~For 2018-19, 30 hours of professional development is required.~~

~~Training for Teachers During the First (1st) Year of Employment.~~

~~New teachers shall complete, within the first (1st) thirty (30) days of employment with the program, two (2) clock hours of pre-service orientation training offered or recognized by the Department. Pending completion of the orientation training, the teacher's employment status with the program is conditional.~~

~~A maximum of two (2) hours training credit may be credited for Child and Adult Care Food Program (CACFP) training or USDA Free and Reduced Price Meal Program training.~~

~~At least six (6) hours of the required training shall be obtained outside of program.~~ S

~~Up to four (4) hours of training credit annually may be earned by conducting training.~~

~~Six (6) hours must be in developmentally appropriate literacy development
Teachers shall be evaluated for knowledge and understanding of growth and development patterns
of children and understanding of appropriate activities for children as well as those with special
needs.~~

~~New teachers shall additionally complete sixteen (16) hours of Department recognized, competency-based training within the first (1st) year of employment, six (6) hours of which must be completed within the first six (6) months of employment.~~

~~Failure of the teacher to complete the required two (2) hours of pre-service orientation and/or failure to complete the required six (6) hours of training within the first (1st) six (6) months of employment shall require that the employee be removed from duties until completion of the training.~~

~~Exception. Teachers who have been employed in early childhood education programs or child care programs during the last three (3) years, hold a Bachelors or Associates degree in child development or a related field, or who hold a Child Development Associate (CDA) credential or Child Care Professional (CCP) credential as recognized by the Department shall instead comply with the training requirements for experienced teachers required in subparagraph (d) below.~~

~~—— (d) Training for Teachers After First (1st) Year of Employment.~~

~~Experienced teachers shall complete at least twelve (12) clock hours annually of Department recognized, competency-based training.~~

~~A maximum of two (2) hours training credit may be credited for Child and Adult Care Food Program (CACFP) training or USDA Free and Reduced Price Meal Program training.~~

~~At least six (6) hours of the required training shall be obtained outside of program.~~

~~Up to four (4) hours of training credit annually may be earned by conducting training.~~

~~Six (6) hours must be in developmentally appropriate literacy development; and~~

~~Credit for Tennessee Early Childhood Training Alliance Orientation Training Completion of a thirty (30) hour orientation class through the TECTA system shall satisfy the teacher's minimum annual training requirements for two (2) years.~~

~~Substitutes.~~

~~The names, addresses, telephone numbers and dates of service shall be recorded for all substitutes in the staff personnel records of the program.~~

Substitutes shall comply with the same orientation requirements defined by these rules for all program staff.

(12) Substitute teachers shall meet the following criteria:

(a) Substitutes shall comply with the same orientation requirements defined by these rules for all program staff.

(b) Substitutes who have acted as teachers for two hundred (200) or more hours in the previous calendar year shall meet the training requirements contained in the rules for teachers.

(c) _____
Auxiliary staff may be used as emergency substitutes if their qualifications permit, but not while performing auxiliary duties.

(d) Substitutes shall meet the criminal background check requirements and the same requirements as regular staff for the physical examination required by this Chapter. Substitutes providing services:

Meet the criminal background check requirements contained in these rules; and

Meet the same requirements as regular staff for the physical examination required by these rules.

(e) e) Practicum Students. Persons serving temporarily as teachers in field service placements as part of an educational course of study or other curriculum requirement shall not be considered as substitutes for purposes of this paragraph.

(4) (13) A volunteer is a person who provides services for a child care center. Volunteers.

Volunteers may be used to provide services and supplement the required teachers or substitutes without payment and who is used to supplement the regular staff or substitutes. Volunteers shall, but are not be included counted to meet the adult: child ratios. If counted in the adult: child ratios. The on-site director ratio, or provide services for more than twenty (20) hours per calendar week, volunteers shall meet the qualifications for substitutes as set forth in paragraph 0520-12-01-.07(7) above.

Management shall be responsible for and supervise the activities of volunteers to assure to assure the safety of the children.

(14) All child care programs shall require any person employed in a position requiring proximity to children to:

(a) Provide evidence of the following:

1. Department of Health Vulnerable Persons Abuse Registry check;

2. TBI/FBI Fingerprint and Background check;

3. TBI/FBI Sex Offender Registry; and

(b) This evidence shall be obtained by the program prior to employment.

~~(c) The program shall immediately review the report of the background check received from the Tennessee Bureau of Investigation, and shall immediately consult with the Department to resolve any questions relative to the person's status. Upon determination that the person's status prohibits the person from having access to children as described in this Chapter, the program shall immediately exclude such person from access to children. Failure to exclude the person under this part will result in immediate suspension of the program's certificate of approval.~~

~~(d) A new fingerprint sample must be obtained, for all employees, every five (5) years.~~

~~(a) Records for volunteers shall be maintained as required in 0520-12-01-.05.~~

~~(5) Criminal Background and Vulnerable Persons Registry Review Requirements.~~

~~Any individual (employee, director, substitute, volunteer, etc.) that works in a school-administered early childhood or before/after school program, shall have evidence and must show proof the following information is updated every five (5) years:~~

~~1. Department of Health V Person's Registry check;~~

~~2. TBI/FBI Fingerprint and Background check; and~~

~~3. TBI/FBI Sex Offender Registry~~

~~These checks must be obtained prior to employment.~~

~~(a) Individuals Requiring a Fingerprint Criminal Background Review and Abuse (Vulnerable Persons) Registry Check:~~

~~1. Any individual applying to work as a paid employee, a director, substitute, or manager of a program in a position that will require or allow the individual to have contact with children at any time;~~

~~2. Any individual applying for a certificate of approval to operate a program as defined in T.C.A. §§ 49-1-1102 et seq. and who has significant contact with children in the course of the role of operator. For purposes of this subparagraph, an "operator" shall be an individual who is an owner or administrator of a school-administered infant/toddler, preschool and/or school-age care program, pre-kindergarten, school-administered Head Start, approved Montessori, Lottery Afterschool Education Program, TEIS early intervention program.~~

~~(b) Individuals applying to work as a paid employee of a program, administered by a local education agency (LEA) or the State Department of Education, shall have their name, address and social security number submitted to the Department of Children's Services Background Check and the Sex Offender Registry to verify that the person does not appear on any of these registries as required by T.C.A. § 49-10-608.~~

~~The program shall immediately review the report of the background check received from the Tennessee Bureau of Investigation, and shall immediately consult with the Department to resolve any questions relative to the person's status.~~

~~(c) Pending outcome of the criminal background check as described in this paragraph; the outcome of the review of the individual's status on the Department of Health's Vulnerable Persons Registry; and, for LEA and State Department of Education applicants, the outcome of the Department of Children's Services Background Check and the Sex Offender Registry, the~~

applicant for employment or a substitute or volunteer position, or for a director/owner, seeking to be certified to operate a program, shall be conditional and shall be dependent upon the results of these background checks.

(d) ~~(c) Requirements for Submission of a Fingerprint Sample.~~

1. ~~Programs shall utilize an established user agreement between the Tennessee Bureau of Investigation and the local education agency, private school, or community-based organization for the processing of applicant fingerprints.~~

2. ~~Fingerprint Sample. The program shall be responsible for obtaining and submitting the fingerprint sample of any every person that is in proximity to children required by the Chapter in the form and manner as directed by the Tennessee Bureau of Investigation. Failure to exclude the person under this part will result in immediate suspension of the program's certificate of approval. A new fingerprint sample must be obtained, for all employees, every five (5) years.~~

(15) ~~No individual with a prohibited criminal history as defined below may work, substitute or volunteer in a program, be an owner, director or manager of a program who has access to children, have significant contact with children or otherwise have unrestricted access to children in any manner whatsoever. An individual shall be immediately and automatically excluded from a program or any contact whatsoever with children if the individual's criminal history includes:~~

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~~Vulnerable Persons Registry. The program shall be responsible for determining, within the same time periods as set forth in part (d)2 above, the status on the Department of Health's Vulnerable Persons Registry of any individual who is required by subparagraph (a) above to undergo a criminal history background check. Verification of status check shall be maintained in the employee's record pursuant to the requirements set forth in 0520-12-01-.05.~~

~~Department of Children's Services Background Check and the Sex Offender Registry. The LEA or State Department of Education administered program shall be responsible for determining, within the same time periods as set forth in part (d)2 above, the status on the Department of Children's Services Background Check and the Sex Offender Registry of any individual who is required by T.C.A. § 49-10-608 to undergo a criminal history background check. Verification of such status check shall be maintained in the employee's record pursuant to the requirements set forth in 0520-12-01-.05.~~

~~Exclusions Of of Persons from Contact with Children.~~

~~(a) Prohibited Criminal or Abuse or Neglect History.~~

~~No individual with a prohibited criminal history as defined below, regardless of whether such individual is required by these rules to undergo a criminal background check, may work, substitute or volunteer in a program, or be resident, owner, director or manager of a program who has access to children, or be an operator who has significant contact with children or otherwise have unrestricted access to children in any manner whatsoever.~~

~~An individual shall be immediately and automatically excluded from a program or any contact whatsoever with children, as described above, if the individual's criminal history includes:~~

- a) _____ A criminal conviction or a no-contest or guilty plea; or any pending criminal action, including individuals subject to any warrant, indictment or presentment, etc.; or placement in a pretrial diversion; or;
- b) _____ A pending juvenile action or previous juvenile adjudication, which, if an adult, would constitute a criminal offense; and
- c) _____ Any of the circumstances in ~~(a)~~subparts (i) or (bii) above involves any of the following criminal offenses:
 - 1. _____ Any offense (including a lesser included offense) involving the physical, sexual or emotional abuse or gross neglect of a child or involving a threat to the health, safety or welfare of a child;
 - 2. _____ Any offense (including a lesser included offense) involving violence, or the threat of violence against another person; and/or
 - 3. _____ Any offense (including a lesser included offense) involving, the manufacture, sale, distribution or possession of any drug.

(16) 3. _____ An individual shall also be immediately and automatically excluded from the program or from access in any manner whatsoever to the children in the care of the program, if the individual:

- (a) _____ Reveals a prohibited or potentially prohibited criminal history on the criminal history disclosure form; or
- (b) _____ Is listed on the Department of Health's Vulnerable Persons Abuse Registry; or
- (c) _____ Is known to the management of a program as a perpetrator of child abuse or child sexual abuse or to have a prohibited criminal record, who is identified to the program's management by the Department of Children's Services as a validated perpetrator of abuse of a child based upon an investigation conducted by the Department of Children's Services or by the child protective services agency of any other state; or, who at any time is identified by any person or entity to the program's management and is confirmed by the Department as having a prohibited criminal history.

4. _____ ~~Exclusions from driving duties. An individual with a prohibited history as set forth below shall be immediately and automatically excluded from providing driving duties on behalf of the program if the individual:~~

- ~~(i) Has a pending criminal action (including warrants, indictments, presentments, etc.) is completing pretrial diversion, or has been convicted of or pled guilty to any offense involving the use of a motor vehicle while under the influence of any intoxicant, which constitutes a violation of T.C.A. §§ 39-13-213; 55-10-101; 55-10-102 or 55-10-401; or~~
- ~~(ii) Has been convicted of or pled guilty to any felony involving use of a motor vehicle while under the influence of any intoxicant. In such case, the individual shall not be employed or otherwise serve as a driver for a program for a period of five (5) years from the date of the conviction or guilty plea.~~

~~5. Exclusions for Child Neglect. An individual who has been identified by the Department of Children's Services as having neglected a child based on an investigation conducted by the Department of Children's Services, or any child protective services agency of any state, and who has not been criminally charged or convicted or pled guilty as stated above, shall be supervised by another adult while providing care for children.~~

~~The program shall immediately review the report of the background check received from the Tennessee Bureau of Investigation, and shall immediately consult with the Department to resolve any questions relative to the person's status. An individual with a prohibited history as set forth below shall be immediately and automatically excluded from providing driving duties on behalf of the program if the individual:~~

~~(17) An individual with a prohibited history as set forth below shall be immediately and automatically excluded from providing driving duties on behalf of the program if the individual:~~

~~(a) Has a pending criminal action (including warrants, indictments, presentments, etc.) is completing pretrial diversion, or has been convicted of or pled guilty to any offense involving the use of a motor vehicle while under the influence of any intoxicant, which constitutes a violation of T.C.A. §§ 39-13-213; 55-10-101; 55-10-102 or 55-10-401; or~~

~~(b) Has been convicted of or pled guilty to any felony involving use of a motor vehicle while under the influence of any intoxicant. In such case, the individual shall not be employed or otherwise serve as a driver for a program for a period of five (5) years from the date of the conviction or guilty plea.~~

~~(18) An individual who has been identified by the Department of Children's Services as having neglected a child based on an investigation conducted by the Department of Children's Services, or any child protective services agency of any state, and who has not been criminally charged or convicted or pled guilty as stated above, shall be supervised by another adult while providing care for children.~~

~~(19) Any person who is excluded or whose certificate of approval or operator status is denied based upon the results of the criminal history background review or based upon any other determination may request in writing to the Department within ten (10) calendar days of receiving notice of such exclusion or denial, a waiver from these automatic exclusion requirements.~~

~~(a) Requests for a waiver shall state the basis for the request, including any extenuating or mitigating circumstances that would, in the person's opinion, clearly warrant an exemption from the exclusion. Any documentary evidence may also be submitted with the request.~~

~~Upon determination that the person's status prohibits the person from having access to children as described in part 7 of Rule 0520-12-01-07(10)(a), the program shall immediately exclude such person from access to children. Failure to exclude the person under this part will result in immediate suspension of the program's certificate of approval.~~

~~Failure to exclude individuals with a criminal history or abuse or neglect finding. Failure to immediately exclude any individual subject to exclusion or supervision pursuant to this subchapter may result in immediate suspension, denial or revocation of the program's certificate of approval.~~

~~Waivers from Exclusions Due to Criminal or Abuse or Neglect History.~~

~~Any person who is excluded or whose certificate of approval or operator status is denied based upon the results of the criminal history background review or based upon any other determination may request in writing to the Department within ten (10) calendar days of receiving notice of such exclusion or denial, a waiver from these automatic exclusion requirements.~~

~~Excluded individuals may also make a written request for a waiver by letter or directly on the criminal history disclosure form.~~

~~Requests for a waiver shall state the basis for the request, including any extenuating or mitigating circumstances that would, in the person's opinion, clearly warrant an exemption from the exclusion. Any documentary evidence may also be submitted with the request.~~

~~(b) Requests for waivers shall be heard by an advisory committee, composed, at a minimum, of law enforcement personnel, persons experienced in child protective services, persons experienced in child development issues and child care providers issued a certificate of approval by the Department and reviewed by the Department.~~

~~(c) Any person who is excluded from providing care or services to children under any provisions of this subchapter shall remain excluded pending the outcome of any exemption review and appeals.~~

~~(20) Supplemental Background Checks.~~

~~The Department may, at any time, request that the criminal background or status on the Department of Health's Vulnerable Persons Abuse Registry of any individuals having access to children under any of the circumstances set forth in this subchapter be reviewed using the processes described above. All other provisions applicable to any pre-employment, residential or access status of any individual shall apply to any background review conducted pursuant to this paragraph (12).~~

~~(21) The employment status of persons for whom a post-employment criminal background check was conducted, or the status of existing program owners or operators, substitutes or volunteers of a program for whom a criminal background check was conducted after issuance of a certificate of approval or after employment or assuming duties as a volunteer or substitute, and who were not otherwise subject to a pre-status applicant background check and to the exclusionary provisions provided in this subchapter, shall be governed by the provisions of this Chapter subchapter.~~

Authority: T.C.A. §§ 4-5-201 et seq., 49-1-302(l), 49-1-1101 through 49-1-1109, 49-2-203, 49-5-413, 496-300, 49-10-608 and 71-3-507 (g) & (h). **Administrative History:** Original rule filed September 26, 1990; effective December 29, 1990. Amendment filed April 30, 2002; effective July 14, 2002. Amendment repealing and replacing rule filed March 15, 2010; effective August 29, 2010.

0520-12-01-.08 EQUIPMENT FOR CHILDREN.

REPEALED.

~~(1) General.~~

~~(a) Manufacturer's safety instructions shall be followed for the use and/or installation of all indoor and outdoor equipment and appliances. Such instructions shall be retained and communicated to all appropriate staff.~~

- ~~(b) All indoor and outdoor equipment shall be well made and safe. There shall be no dangerous angles, no sharp edges, splinters, nails and nails sticking out, no open S-hooks or pinch points within children's reach.~~

~~Electrical cords on equipment for children shall be inaccessible to the children.~~

~~Damaged equipment shall be repaired or removed from the room or playground immediately.~~

~~Equipment shall be kept clean by washing frequently with soap and water.~~

~~There shall be developmentally appropriate equipment and furnishings for each age group in attendance.~~

~~Individual lockers, separate hooks and shelves or other containers, placed at children's reaching level, shall be provided for the belongings of each child, ages infant-preschool.~~

~~In infant/toddler rooms, equipment and space shall be provided for climbing, crawling, and pulling without the restraint of playpens or cribs.~~

- ~~(c) A place shall be provided for each school-age child's belongings.~~

~~(2) Indoor Play Equipment.~~

~~Pieces of equipment, such as television sets, bookcases, and appliances, shall be secured or supported so that they will not fall or tip over.~~

- ~~(a) Sufficient indoor equipment, materials, and toys shall be available to:~~

- ~~1. Meet active and quiet play needs of all children enrolled;~~
- ~~2. Provide a variety of developmentally appropriate activities so that each child has at least three (3) choices during play time; and~~
- ~~3. Adequately provide for all the activities required in Section 0520-12-01-.09 pProgram.~~

~~Toys, educational and play materials, shall be organized and displayed within children's reach so that they can select and return items independently.~~

- ~~(c) Toys or teaching aids that are small or that have small parts that can be inhaled or swallowed shall be inaccessible to infants and toddlers~~

~~(3) Outdoor Play Equipment.~~

~~There shall be developmentally appropriate outdoor play equipment for children who are in care more than three (3) daylight hours.~~

~~All outdoor play equipment and materials shall be sufficient in amount and variety so that children have an opportunity to participate in a minimum of at least three (3) different types of play using either stationary equipment and/or portable play materials.~~

(a) ~~All outdoor play equipment shall be placed to avoid injury:~~

~~Fall zones shall extend six (6) feet away from the perimeter of climbing equipment and away from retainer structures, fences, and other equipment and out of children's traffic paths.~~

~~Agencies with a playground continually certified as approved since prior to January 1, 2002, shall be permitted to maintain fall zones of at least four (4) feet; provided, however, that any expansion or addition shall comply with the six (6) feet fall zone required by part 1 above.~~

(d) ~~Anchorage of Equipment.~~

~~Supports for climbers, swings, and other heavy equipment that could cause injury if toppled shall be securely anchored to the ground, even if the equipment is designed to be portable.~~

~~Portable equipment shall otherwise be anchored to the ground if the height and weight of the equipment exceeds the height and weight of the smallest child who will use the equipment.~~

(e) ~~An acceptable resilient surfacing material, as recognized by the Department, shall cover fall zones in accordance with the following chart:~~

Resilient Surfacing Material	Minimum Acceptable Depth
Wood chips or Mulch	Six (6) inches
Double Shredded Bark	Six (6) inches
Pea Gravel	Six (6) inches
Medium Gravel	Eight (8) inches
Fine Sand	Eight (8) inches
Course Sand	Eight (8) inches
Artificial (Manufactured) Surface	As recommended by Manufacturer

(4) ~~Naptime and Sleeping Equipment.~~

~~There shall be equipment for napping or sleeping for each preschool child who is in care for six (6) hours or more.~~

~~A quiet rest area and cots or mats shall be available for children who want to rest or nap.
However, no child shall be forced to nap.~~

~~No child shall be forced to stay on a cot or on a mat for an extended period of time.~~

~~All nap/sleep equipment shall be in good condition and comply with the following requirements:~~

~~Individual cots or two-inch (2") mats shall be provided for children ages twelve (12) months to five (5) years.~~

~~Individual beds or cots shall be provided for children sleeping for extended periods of more than two and one half (2-1/2) hours, such as during nighttime care.~~

~~Each child under twelve (12) months shall have an individual, free-standing, crib at least twenty-two inches (22") x thirty-six inches (36") with an open top.~~

1. ~~Mattresses and foam pads shall be covered with safe, waterproof material.~~

~~A clean sheet or towel shall be used to cover whatever the child sleeps on.~~

~~A clean coverlet shall be available to each child.~~

~~Soiled sheets and coverlets shall be replaced immediately.~~

2. ~~For health and safety reasons each crib, cot, bed or mat shall be labeled to assure that each child naps on his own bedding.~~

Authority: —T.C.A. §§ 4-5-201 et seq., 49-1-201(c)(24), 49-1-302(l), 49-1-1101 through 49-1-1109, 49-2203(b)(11), and Executive Order No. 24 (November 11, 1988). *Administrative History:* Original rule filed September 26, 1990; effective December 29, 1990. Amendment filed April 30, 2002; effective July 14, 2002. Amendment repealing and replacing rule filed March 15, 2010; effective August 29, 2010.

Repeal

0520-12-01-.09 PROGRAM.

(1) ~~Schedule and Routines.~~

(a) ~~Routines such as snacks, meals, and rest shall occur at approximately the same time each day.~~

(b) ~~There shall be a balance between child's choice and adult directed activities.~~

(c) ~~There shall be alternating periods of vigorous activity and rest throughout the day.~~

- ~~(d) Special consideration shall be given to providing early morning and late afternoon activities that will help children cope with possible unhappiness over separation from parents and end-of-day fatigue.~~
 - ~~(e) Each teacher shall be responsible for providing consistent care for a specific infant(s)/toddler(s). "Consistent care" includes, but is not limited to, planning, recordkeeping for the child, communication, general interaction with and routine care of the child.~~
 - ~~(f) The teacher(s) shall give individual attention to each child, in addition to the time devoted to diapering and feeding.~~
 - ~~(g) Children shall not be left in restraining devices such as swings, car seats, or high chairs (in excess of thirty (30) minutes). Stimulation shall be provided to children in those settings.~~
 - ~~(h) Opportunities shall be provided for children to interact with one another.~~
 - ~~(i) Opportunities shall be provided for children to be by themselves to play alone or do homework, if they choose, in a small quiet area away from other activities.~~
 - ~~(j) Youth ten (10) years and older shall be encouraged to participate in the planning of their schedules and activities.~~
 - ~~(k) Extended Care. Children shall be given the same opportunities for developmentally appropriate activities during extended care hours as during conventional care hours.~~
- (a) Television, Radio, Videos, and Computers:
- _____
- (b) _____

(Rule 0520-12-01-.09, continued)

~~(c) — Programs, movies, computer games, and music with violent or adult content (including "soap operas") shall not be permitted in children's presence.~~

~~(d) — Programs/movies/computer games shall be developmentally appropriate for the viewers.~~

~~(e) — Parents shall be informed of movie showings and video/computer games and their ratings.~~

~~(f) — Videos, movies, and video/computer games must be previewed by staff for content.~~

~~(g) — If television, video tapes/DVDs, video/computer games, and/or movies are used, they shall be limited to:~~

~~1. Two (2) hours per day, or the length of a movie if more than two (2) hours in case of school-age children.~~

~~2. Extended Care. Television viewing by children during night care between 6 p.m. and 6 a.m. shall be limited to one (1) hour.~~

~~(f) — All programs shall be designed for children's education and/or enjoyment.~~

~~(g) — Up to one (1) additional hour per day, but not more than three (3) days per week, can be added to viewing time for computer use.~~

~~(h) — School-age children and adolescents may use computers for completion of homework or for test prep with no limits on viewing time.~~

~~(i) — Computers, if used, shall be located in view of a teacher for monitoring purposes.~~

~~(j) — Computers which allow internet access by the children shall be equipped with monitoring or filtering software, or an analogous software protection, which limits children's access to inappropriate web sites, e-mail, and instant messages.~~

~~(k) — Other activity choices shall be available to children during television/movie viewing or computer use.~~

~~(3) — Outdoor Play and Playground Routines.~~

~~(a) — An opportunity for outdoor play shall be extended to children of all ages who are in care more than three (3) daylight hours; provided, however, for programs where outdoor play is prohibitive or dangerous, as determined at the discretion of the Department, unoccupied indoor space providing fifty (50) square feet per child is acceptable.~~

~~(b) — Children shall be allowed to experience a variety of weather conditions:~~

(Rule 0520-12-01-.09, continued)

~~1.Children shall be provided an opportunity for outdoor play when the temperature range, after adjustment for wind chill and heat index, is between thirty-two (32) degrees and ninety-five (95) degrees Fahrenheit and not raining;~~

~~2.Children shall be properly dressed and the length of time outside adjusted according to the conditions and the age of the children.~~

~~(c) Teachers shall be alert for signs of dehydration, heat stroke, frostbite, etc., dependent upon the season.~~

~~(d) Each agency shall develop a set of age appropriate playground rules that uses positive language. Rules shall be posted in each play area.~~

~~(4) Reclining Rest Period:~~

~~(a) A reclining rest period of at least one (1) hour shall be provided for all preschool children in care for six (6) hours or more.~~

~~(b) Each child shall be allowed to form his own patterns of sleep.~~

~~(c) A child shall not be left in a crib or on a cot for an unreasonable length of time.~~

~~(5) Behavior Management and Guidance:~~

~~(a) Attention spans and skills of children shall be considered so that teachers do not require children to engage in developmentally inappropriate behavior.~~

~~(b) Discipline shall be reasonable, appropriate, and in terms the children can understand.~~

~~(c) Discipline that is shaming, humiliating, frightening, verbally abusive, or injurious to children shall not be used.~~

~~(d) Discipline shall not be related to food, rest, or toileting.~~

~~(e) Spanking or any other type of corporal punishment is prohibited. ("Corporal punishment" is the infliction of bodily pain as a penalty for behavior of which the punisher disapproves.)~~

~~(f) Teachers shall not focus solely upon unacceptable behavior.~~

~~(g) Praise and encouragement of good behavior shall be used.~~

~~(h) Efforts shall be made to help children develop a feeling of self-worth beginning in infancy and continuing throughout the school-age years.~~

(Rule 0520-12-01-.09, continued)

~~(i) When a child is engaging in unacceptable behavior the teacher shall, prior to disciplining the child, first distract the child's attention and substitute a desirable activity.~~

~~(j) Time out shall be reasonable and developmentally appropriate.~~

~~1. Time out shall take place in an appropriate location based upon the development of the child.~~

~~2. The length of each time out session shall be based on the age of the child and shall not exceed one (1) minute per each year of age of the child; provided, however, that in no event shall any child below the age of thirty six (36) months be placed in time out for more than three (3) minutes, and no child between thirty six (36) months and sixty (60) months of age shall be placed in time out for longer than five (5) minutes.~~

~~Physical Care Toilet Training.~~

~~(6)~~

~~(a) Toilet training shall never be started until a child has been in the program long enough to feel comfortable.~~

~~(b) Toilet training shall not be started until a child is able to understand, to do what is asked of them, and to communicate their need to use the bathroom.~~

~~(c) Children shall not be made to sit on the potty or toilet for more than five (5) minutes.~~

~~(1) Children shall be diapered or cleaned immediately in a safe, sanitary manner.~~

~~Educational activitiesActivities.~~

~~Activities shall be based on developmentally appropriate educational practices.~~

~~(a)~~

~~Infant/Toddler classrooms ages six (6) weeks through t twenty-four (24) months must show evidence that children are provided the opportunity to: (See TNELDS standards for Birth-48 months)~~

~~1. Sit and listen to teacher read aloud to him/her individually and in a group daily.~~

~~2. Engage in interactive play that includes activities such as movement, dance, musical games, and pretend play that encourages the use of both large and small muscles.~~

~~3.~~

~~iii. Engage in meaningful conversationconversation with teachers.~~

~~4.~~

~~Engage in touching, feeling, and identify a variety of known and unknown objects.~~

(Rule 0520-12-01-.09, continued)

5. Explore a variety of culturally diverse books that encourage early literacy skill development and increase children's knowledge about the world around them. in rhythm, rhyming words, predictive texts, etc. These books should represent different genres, i.e. poetry, nonfiction, fiction, informational texts, etc; and.

6. Experience daily tummy time.

(b)

Preschool/Pre-K classrooms ages twenty-four (24) months to five (5) years must show evidence that children are provided the opportunity to: (See TNELDS standards for 48 months to kindergarten)

1. Sit and listen to teacher read aloud to him/her individually and in group daily;

2. Engage in pretend play;

3. Engage with developmentally appropriate educational and open-ended materials, i.e. blocks, clay, sand;

4. Engage in meaningful conversations with peers and teachers;

5. Write, create books, and engage in print rich materials;

6. Engage in with a variety of culturally diverse books and materials that encourage early literacy skills in concepts about print, genres, letter identification, beginning sounds, etc.;

7. Engage in a variety of activities that support number sense, mathematical thinking, and understanding; and numeracy development; and

8. Help with daily classroom and self-care routines.

(c) 3. Children, enrolled in any LEA pre-kindergarten program, must participate in an educational curriculum that is aligned with the Tennessee early learning standards state department of education approved early learning standards and that includes, but not limited to, literacy, writing, math and science skills. (T.C.A. § 49-6-104 (b) (5)).

(d) Staff shall plan ahead for developmentally appropriate activities and; written lesson plans shall be provided for children of each age group.

(e)

There shall be a balance between child's choice and adult-directed activities.

(Rule 0520-12-01-.09, continued)

(f) ~~_____~~ A daily program shall provide opportunities for learning, self-expression, and participation in a variety of creative activities such as art, music, literature, dramatic play, science, and health.

(2) Non-educational program activities

Staff shall be stimulating and plan ahead for developmentally appropriate.

(a) ~~_____~~ Any technology children engage in shall be developmentally appropriate, previewed by staff for content, approved by parents, and shall not exceed two (2) hours per day.

(b) ~~_____~~ There shall be alternating periods of vigorous activity and rest throughout the day.

(c) ~~_____~~ Children shall not be left in restraining devices such as swings, car seats, or high chairs (in excess of thirty (30) minutes). ~~Stimulation shall be provided to children in those settings.~~

(d) ~~_____~~ Opportunities activities; written lesson plans shall be provided for children to interact with one another of each age group.

(e) ~~_____~~ Opportunities shall be provided for children to be by themselves to play alone or do homework, if they choose, in a small quiet area away from other activities.

(f) ~~_____~~ Youth ten (10) years and older shall be encouraged to participate in the planning of their schedules and activities.

(g) ~~_____~~ Indoor physical activities, requiring children to use both large and small muscles, shall be provided for children of each age group.

(h) ~~_____~~ For infants and toddlers, a portion of the day shall include floor time for activities that develop physical, social, language and cognitive skills.

(i) ~~_____~~ ~~Because of the importance of language development and communication skills, infants~~ Infants and toddlers shall have language experiences with adults on a daily basis.

(b) ~~_____~~ (3) ~~_____~~ Personal Safety Curriculum required:

For ages three (3) through school-age, the program curriculum shall include instruction in personal safety.

~~(-as needed but at least once a) -year.~~

The personal safety curriculum shall include a Department-recognized component on the prevention of child abuse, based upon Department curriculum guidelines. ~~The program may choose terminology and instructional methods for this curriculum with a goal of providing clear, effective and appropriate instruction to the children in personal safety, including the prevention of child abuse.~~

(Rule 0520-12-01-.09, continued)

- (b) _____ The personal safety curriculum used by the program shall be made available to the parents and legal guardians for review.
- (c) _____ The record of each enrolled child shall include a copy of the signed notification form acknowledging that parents/legal guardians have been provided an opportunity to review the agency's personal safety curriculum, and have been notified of the sexual abuse/personal safety curriculum for their child.
- (d) _____ If parents/legal guardians have questions regarding the personal safety component of the curriculum, a representative of the program shall meet with the parent/legal guardian to discuss the personal safety component of the curriculum.
- (e) _____ For school-age children, the personal safety curriculum is integrated in the Health and Wellness curriculum during the school day for K-12 students. -The school-age children enrolled in the program shall be provided information on reporting physical, verbal or sexual abuse to the students.
- (f) _____ Children, enrolled in a school-administered pre-kindergarten program, shall participate in an educational curriculum, ~~aligned~~correlated with the Tennessee Early Learning Developmental Standards (TN-ELDS)-as required by T.C.A. § 49-6-104(b)(5).
- (4) An opportunity for outdoor play shall be extended to children of all ages who are in care more than three (3) daylight hours; provided, however, for programs where outdoor play is prohibitive or dangerous, as determined at the discretion of the Department, unoccupied indoor space providing fiftythree (53) square feet per child is acceptable.
- (a) Children shall be provided an opportunity for outdoor play when the temperature range is between thirty-two (32) degrees and ninety-five (95) degrees Fahrenheit and not raining.
- (b) Teachers shall be alert for signs of dehydration, heat stroke, frostbite, etc., dependent upon the season.
- (c) Each agency shall develop a set of age appropriate playground rules that uses positive language. -Rules shall be posted in each play area.
- (5) Programs shall meet the following behavior management criteria:
- (a) Discipline shall be reasonable, appropriate, and in terms the children can understand.
- (b) Discipline that is shaming, humiliating, frightening, verbally abusive, or injurious to children shall not be used.
- (c) Discipline shall not be related to food, rest, or toileting.
- (d) Spanking or any other type of corporal punishment is prohibited.

(Rule 0520-12-01-.09, continued)

- (e) Praise and encouragement of good behavior shall be used.
- (f) Time out shall be reasonable and developmentally appropriate.
 - 1. Time out shall take place in an appropriate location based upon the development of the child.
 - 2. The length of each time out session shall be based on the age of the child and shall not exceed one (1) minute per each year of age of the child; provided, however, that in no event shall any child below the age of thirty-six (36) months be placed in time-out for more than three (3) minutes, and no child between thirty-six (36) months and sixty (60) months of age shall be placed in time-out for longer than five (5) minutes.
- (6) Toilet training shall never be started until a child has been in the program long enough to feel comfortable and is able to communicate their need to use the bathroom. Children shall not be made to sit on the toilet for more than five (5) minutes.
- (7) Children shall not be in care for more than twelve (12) hours in a twenty-four (24) hour period except in special circumstances (e.g., acute illness of or injury to parents, severe weather conditions, natural disaster, and unusual work hours).- In such cases every effort shall be made to minimize the amount of time spent in the program by exploring and documenting alternatives (i.e., part time care, care with a relative, etc.) Individualized plans for the care of a child in excess of twelve (12) hours due to special circumstances shall be signed by the parent and the director/ administrator and must be approved by the Department.- Plans shall be updated annually.
- (8) When more than twelve (12) school-age children in first (1st) grade and above are present, a separate group, a separate space, and a separate program type shall be provided for them.
- (9) Routines such as snacks, meals, and rest shall occur at approximately the same time each day.

Authority: T.C.A. §§ 4-5-201 et seq., 37-1-403, 37-1-601, 37-1-603, 49-1-302 (l), 49-1-1101 through 491-1109 and 49-6-104. **Administrative History:** Original rule filed September 26, 1990; effective December 29, 1990. Amendment filed April 30, 2002; effective July 14, 2002. Amendment repealing and replacing rule filed March 15, 2010; effective August 29, 2010.

0520-12-01-.10 HEALTH AND SAFETY.

- (1) Current and comprehensive first aid information shall be available to all staff who interact with children. A standard first aid kit (for example, one approved by the American Red Cross) shall be available to all staff, and all staff shall be familiar with its contents and use. Each program shall provide periodic training and updates on basic first aid and the use of the first aid kit.

Children's health records shall be maintained as directed under subchapter 0520-12-01-.05.

(Rule 0520-12-01-.09, continued)

~~Each child shall be immunized according to the current Department of Health guidelines unless exempted pursuant to subchapter 0520-12-01-.05(8). Programs serving non-school-age children shall maintain written policies for dis-enrollment of children who fail to comply with Department of Health immunization guidelines in a timely manner.~~

~~Children shall be checked upon arrival and observed for signs of communicable disease during the day.~~

~~A child's temperature should be taken using a non-invasive method unless otherwise prescribed by a physician. Symptomatic children shall be removed from the group until parents are contacted and health issues are resolved.~~

~~Universal precautions, as defined by the Department of Health and required by 0520-01-03.08(2)(g)4, shall be followed when handling or cleaning bodily fluids.~~

~~First Aid.~~

~~A standard first aid kit (for example, one approved by the American Red Cross) shall be available to all staff, and all staff shall be familiar with its contents and use.~~

~~(2) At least one (1) staff member who has current certification or equivalent in first aid from a certifying organization recognized by the Department shall be on duty at all times. The first aid certification course shall be a minimum of three (3) hours and shall be taught by a certified first aid instructor. Extended Care: All staff shall have certification or equivalent in first aid from a certifying organization recognized by the Department.~~

~~(3) At least one (1) staff member on duty shall hold current certification in Infant/Pediatric Cardiopulmonary Resuscitation (CPR) from the American Red Cross, the American Heart Association, or other certifying organization, as recognized by the Department.~~

~~(a) The initial CPR course shall be a minimum of four (4) hours and shall be taught by an individual currently certified, as recognized by the Department, to provide CPR instruction.~~

~~(a) Current and comprehensive first aid information shall be available to all staff who interact with children and the agency shall provide periodic training and updates on basic first aid and the use of the first aid kit.~~

~~(8) Emergency Treatment.~~

~~(a) Cardiopulmonary Resuscitation (CPR) Requirements.~~

(Rule 0520-12-01-.14, continued)

~~1. At least one staff member on duty shall hold current certification in Infant/Pediatric Cardiopulmonary Resuscitation (CPR) from the American Red Cross, the American Heart Association, or other certifying organization, as recognized by the Department.~~

~~2. Extended Care. All staff shall be certified in Infant/Pediatric Cardiopulmonary Resuscitation (CPR) from a certifying organization recognized by the Department.~~

~~(b) The initial CPR course shall be a minimum of four (4) hours and shall be taught by an individual currently certified, as recognized by the Department, to provide CPR instruction.~~

~~(b) When school-age children are present, and/or in a school-age only program, at least one (1) staff member shall hold current certification, pursuant to the requirements listed in subparagraphs (a) and (b) above, in Adult CPR. Extended Care: All staff shall be certified pursuant to the requirements listed in subparagraphs (a) and (b) above, in adult CPR.~~

~~(9) (4) Each Preparation for Emergencies.~~

~~The program, in consultation with appropriate local authorities, shall develop a written plan to protect children in the event of disaster such as, but not limited to, fire, tornado, earthquake, chemical spills, floods, etc. and shall inform parents of the plan.~~

~~(a) The program shall implement these emergency procedures through timely practice drills to meet local regulations and local emergency services plans and shall maintain documentation of drills for one year. Extended Care: At least one (1) of these drills shall be conducted during extended care hours.~~

~~The following emergency telephone numbers shall be posted next to all telephones and be readily available to any staff member:~~

~~Fire Department;~~

~~1. Police Department/Sheriff;~~

~~2. Nearest Hospital Emergency Room;~~

~~3. Child Abuse Hotline;~~

~~4. Local Emergency Management Agency;~~

~~5. Ambulance or Rescue Squad; and~~

~~6. Poison Control Center.~~

~~(d) If 911 or a similar generic number is operable in the community, it shall be posted in addition to the above numbers.~~

~~(e) All home/work contact numbers for parents shall be readily available to all staff.~~

(Rule 0520-12-01-.14, continued)

~~(10) Contagious Conditions:~~

~~(a) Impetigo and diagnosed strep shall be treated appropriately for twenty-four (24) hours prior to readmission of the child to the center.~~

~~(b) Children diagnosed with scabies or lice shall have proof of treatment prior to readmission.~~

~~(c) The program may not provide care and/or isolation for a child with contagious condition unless written instructions are obtained from a licensed physician or certified health care provider.~~

~~(d) Parents of every child enrolled shall be notified immediately if one of the following communicable diseases has been introduced into the program:~~

~~1. Hepatitis A;~~

~~2. Food borne outbreaks (food poisoning);~~

~~3. Salmonella;~~

~~4. Shigella;~~

~~5. Measles, mumps, and/or rubella;~~

~~6. Pertussis;~~

~~7. Polio;~~

~~8. Haemophilus influenza type B;~~

~~9. Meningococcal meningitis;~~

~~10. Chicken Pox; and~~

~~10. Any other illness identified by the state or local Department of Health.~~

~~(e) The program shall report the occurrence of any of the above diseases to the local health department as soon as possible, but no later than the end of the day in which it occurred.~~

~~(11) Notification to Parents of Accidents, Injuries, Illnesses:~~

~~(a) Staff shall make every reasonable attempt to notify parents immediately when a child sustains serious injury/injuries, including but not limited to, massive bleeding, broken bones, head injuries, possible internal injury, etc., to arrange for emergency treatment.~~

~~(b) Staff shall make every reasonable attempt to notify parents immediately when a child shows signs of serious illness, including but not limited to, high temperature, disorientation, coughing,~~

(Rule 0520-12-01-.14, continued)

~~vomiting or diarrhea with blood present, severe difficulty breathing, seizure, etc. to arrange for emergency treatment.~~

~~(c) Accidents, injuries, and every sign of illnesses shall be reported, or a reasonable attempt made to report, to the parent as soon as possible, but no later than the child's release to the parent or authorized representative.~~

~~(d) In no event shall the program delay seeking emergency treatment due to a delay in making contact with the parent.~~

~~(12) Medications.~~

~~(a) All medications, prescription and non-prescription shall be received from the parent by a designated staff person or management level staff person.~~

~~(b) An alternate staff person shall be available to administer medication in the event the designated staff person is absent.~~

~~(c) The staff person designated in subparagraph (a) above shall document verification of the following:~~

~~1. The parent's written authorization to administer medication;~~

~~2. That medicines or drugs are in the original prescription container, are not out of date, and labeled with the child's name;~~

~~3. The specific dosage and times medication is to be administered to the child; and~~

~~4. That the parent has provided the program with instructions on the methods of administration.~~

~~(d) The following documentation of administration shall be maintained in the child's file and a copy provided to the parent:~~

~~1. Times medications administered;~~

~~2. Noticeable side effects; and~~

~~3. Name of staff person administering medication to child.~~

~~(e) The parent shall sign documentation verifying that:~~

~~1. The administration information required by subparagraph (c) above was received; and~~

~~2. Unused medication was returned to the parent.~~

~~(f) Medication shall not be handled by children. Exception: A physician's authorization for the current school year shall be on file for school-age children who must have self-administered self-~~

(Rule 0520-12-01-.14, continued)

~~administered medications. Assistance to school-age children self-administering medication must be in accordance with Guidelines for Use of Health Care Professionals and Health Care Procedures in a School Setting, developed by the Department of Health in accordance with T.C.A. § 49-5-415.~~

~~(g) Medication shall never be administered in bottles or infant feeders unless authorized by a physician.~~

~~(h) Accessibility of Medications.~~

~~1. All medicines, prescription and non-prescription, whether requiring refrigeration or not, shall be stored in a locked compartment or container.~~

~~2. If medicine requiring refrigeration is kept in a refrigerator used for food storage, the medicine shall be put in a leak-proof locked container.~~

~~3. Keys for these compartments shall be inaccessible to children.~~

~~4. Exception for Emergency Administration. Medication requiring emergency administration, as directed by the physician, nurse practitioner or physician's assistant, e.g., "EpiPen", asthma inhaler, etc., may be kept in an unlocked container that is inaccessible to children.~~

~~(5) Smoking is not permitted on the premises of a child care program.~~

~~(6) The consumption or possession of alcohol is not permitted on the premises of a child care program. Unused medication shall be returned to the parent.~~

~~Public school-administered programs shall follow the procedures for student medications defined in the School Health policy, adopted by the Local Education Agency in accordance with 0520-01-01-.08(1).~~

~~Prohibited Practices and Products.~~

~~Smoking.~~

~~Smoking is not permitted.~~

~~Under state law, smoking in child care centers that are not private homes is restricted within a child care facility to areas where children are not permitted access, and parents must be given notice that the facility has a smoking area.~~

~~No smoking signs must be posted conspicuously within the facility as provided by state law.~~

~~Federal law prohibits smoking in any part of a child care facility that is not a private residence if the facility is constructed, operated, or maintained with Federal funds.~~

~~Alcoholic Beverages.~~

~~The consumption or possession of alcohol is not permitted.~~

(Rule 0520-12-01-.14, continued)

~~Illegal or inappropriate activities on the premises, property, or in a vehicle on the facility property or used for transportation of children enrolled in the program or any activity that otherwise places children at risk are prohibited.~~

(7) ~~Firearms shall not be on the premises of a child care program, or in any vehicle used to transport children or in the presence of a child.~~

(8) ~~Kitchen knives and other potentially dangerous utensils or tools shall be secured so that they are not accessible to children.~~

(9) ~~Staff's personal belongings (such as, but not limited to, contents of purses, backpacks, coat pockets, diaper bags, etc.) shall be inaccessible to children at all times.~~

~~Diapering:
(13)~~

~~Children shall be diapered/changed and cleaned immediately when wet or soiled.~~

~~For the protection of children and adults, the Centers for Disease Control guidelines for hand washing and diapering procedures shall be followed.~~

~~The diapering area and/or toilet training area shall be located near a hand washing lavatory and shall be located in a separate area from the food preparation/service area.~~

~~All diapering surfaces must off the floor, nonporous and shall be sanitized using solutions for general cleaning and sanitizing purposes:~~

~~For general cleaning and sanitizing purposes, a fresh solution of one quarter (1/4) cup chlorine bleach to one (1) gallon of water (or one (1) tablespoon bleach to one (1) quart of water) shall be made daily.~~

~~1. Substitutions for the bleach solution required in part 1 above, that above that above that are approved for the child care setting by the Department of Health are permissible.~~

~~The solution required in part 1 above is not appropriate for items associated with food preparation or for items that children frequently place in their mouths, and the Health Department does not permit the use of higher concentrations than these in food preparation areas. Specific jurisdictions may have even more stringent requirements, therefore, the local health department should be consulted.~~

~~A tightly covered container with plastic liner shall be used for diaper disposal and shall be inaccessible to children. This container shall be emptied by closing the liner and disposing of it in an outside receptacle.~~

(Rule 0520-12-01-.14, continued)

(10) The following emergency telephone numbers shall be posted next to all telephones and be readily available to any staff member:

(a) Fire Department;

(b) Police Department/Sheriff;

(c) Nearest Hospital Emergency Room;

(d) Child Abuse Hotline;

(e) Local Emergency Management Agency;

(f) Ambulance or rescue squad;

(g) Poison control center;

(h) 911 or a similar generic number operated in the community; and

(i) Contact numbers for parents.

(11) Programs shall comply with the following rules for the health of children:

(a) All children shall be checked upon arrival and observed for signs of communicable disease during the day.

(b) A child's temperature should be taken using a non-invasive method unless otherwise prescribed by a physician. Symptomatic children shall be removed from the group until parents are contacted and health issues are resolved.

(c) Impetigo and diagnosed strep shall be treated appropriately for twenty-four (24) hours prior to readmission of the child to the center.

(d) Special Needs Children diagnosed with scabies or lice.

If older children are enrolled who lack independent toileting abilities, rules regarding diapering of preschool children shall have proof of treatment prior to readmission apply.

Children shall be changed in a location designated for that purpose and which provides privacy from other children and adults.

School-age children may be diapered on the floor on a nonporous washable surface that adequately protects the floor from contamination.

The floor beneath the diapering surface shall be immediately cleaned after each diapering.

(Rule 0520-12-01-.14, continued)

~~2. The diapering area shall be located near a hand washing lavatory. This area shall be in a separate location from food preparation/service area.~~

~~(14) Naptime Care:~~

~~In order to avoid the spread of airborne diseases, children shall be positioned on mats in a face-to-feet alternating pattern.~~

~~(a) Spacing of cots, cribs, and mats shall allow sufficient space to walk between them.~~

~~(15) Tuberculosis (TB) Screening:~~

~~Tuberculosis (TB) screening prior to on-going contact with children is recommended for any individual who:~~

~~Was born in a country other than the United States, Canada, Western Europe, Australia, New Zealand, and Japan;~~

~~Has a weakened immune system (Human Immunodeficiency Virus (HIV), cancer, taking chemotherapy drugs, etc.); (e) The program may not provide care and/or isolation for a child with contagious condition unless written instructions are obtained from a licensed physician or certified health care provider.~~

~~(f) All children born in countries other than the United States, Canada, Western Europe, Australia, New Zealand, and Japan shall present evidence of a tuberculin skin test performed in the United States at any time after twelve (12) months of age. Any child with a positive tuberculin skin test shall be referred to a physician for evaluation. After the initial evaluation, future periodic screening is not required unless the child develops persistent pulmonary symptoms or there is contact with tuberculosis.~~

~~or~~

~~Has been recently exposed to tuberculosis.~~

~~Any person who has had a cough for three (3) weeks or longer should be evaluated by a physician for tuberculosis.~~

~~Future screening is not required for individuals who have been treated for tuberculosis or latent tuberculosis infection unless persistent pulmonary symptoms develop or there is contact with tuberculosis.~~

~~All children born in countries other than the United States, Canada, Western Europe, Australia, New Zealand, and Japan shall present evidence of a tuberculin skin test performed in the United States at any time after twelve (12) months of age. Any child with a positive tuberculin skin test shall be referred to a physician for evaluation. After the initial evaluation, future periodic~~

(Rule 0520-12-01-.14, continued)

~~screening is not required unless the child develops persistent pulmonary symptoms or there is contact with tuberculosis~~

- ~~(g) Staff shall make every reasonable attempt to notify parents immediately when a child shows signs of serious illness, including but not limited to, high temperature, disorientation, coughing, vomiting or diarrhea with blood present, severe difficulty breathing, seizure, etc. to arrange for emergency treatment.~~
- ~~(h) In no event shall the program delay seeking emergency treatment due to a delay in making contact with the parent.~~
- ~~(i) Parents of every child enrolled shall be notified immediately if one of the following communicable diseases has been introduced into the program:
 - 1. Hepatitis A;
 - 2. Food borne outbreaks (food poisoning);
 - 3. Salmonella;
 - 4. Shigella;
 - 5. Measles, mumps, and/or rubella;
 - 6. Pertussis;
 - 7. Polio;
 - 8. Haemophilus influenza type B;
 - 9. Meningococcal meningitis;
 - 10. Chicken Pox; and
 - 11. Any other illness identified by the state or local Department of Health. Hand, foot and mouth disease (HFMD); and
 - 12. Any other illness identified by the state or local Department of Health.~~
- ~~(j) The program shall report the occurrence of any of the above diseases to the local health department as soon as possible, but no later than the end of the day in which it occurred.~~
- ~~(12) Program staff shall make every reasonable attempt to notify parents immediately when a child sustains serious injury/injuries, including but not limited to, massive bleeding, broken bones, head injuries, possible internal injury, etc., to arrange for emergency treatment.~~

(Rule 0520-12-01-.14, continued)

- (a) Was born in a country other than the United States, Canada, Western Europe, Australia, New Zealand, and Japan;
- (b) Has a weakened immune system (Human Immunodeficiency Virus (HIV), cancer, taking chemotherapy drugs, etc.); or
- (c) Has been recently exposed to tuberculosis.

(14) The administration of medication shall be in compliance with the following:

- (a) All medications, prescription and non-prescription shall be received from the parent by a designated staff person or management level staff person. An alternate staff person shall be available to administer medication in the event the designated staff person is absent.
- (b) The designated staff person shall document verification of the following:
 - 1. The parent's written authorization to administer medication and instructions on the methods of administration;
 - 2. That medicines or drugs are in the original prescription container, are not out of date, and labeled with the child's name; and
 - 3. The specific dosage and times medication is to be administered to the child.

~~Staff Health.~~

~~Staff health records shall be maintained as directed under subchapter 0520-12-01.05(9).~~

- ~~(c) The following documentation of administration shall be maintained in the child's file and a copy provided to the parent:~~
 - 1. ~~A statement~~Times medications administered;
 - 2. Noticeable side effects; and
 - 3. Name of staff person administering medication to child.
- (d) The parent of a child receiving medication~~mental or emotional health~~ shall sign documentation verifying the receipt of documentation of administration required by subparagraph (c) above and that all unused medication was returned to the parent.
- (e) Medication shall not be handled by children. Exception: school-age children with a physician's authorization for the self-administration of a medication. Assistance to school-age children self-administering medication must be in accordance with Guidelines for Use of Health Care Professionals and Health Care Procedures in a School Setting.
- (f) Medication shall never be administered in bottles or infant feeders unless authorized by a physician.

(Rule 0520-12-01-.14, continued)

- (g) All medicines, prescription and non-prescription shall be stored in a locked compartment obtained from a psychiatrist or container.
 - 1. If medicine requiring refrigeration is kept in a refrigerator the medicine shall be put in a leak-proof locked container.
 - 2. Keys for these compartments shall be inaccessible to children.
 - 3. Medication requiring emergency administration, as directed by the physician, nurse practitioner or physician's assistant, e.g., "EpiPen," asthma inhaler, etc., may be kept in an unlocked container that is inaccessible to children.
- (h) Public school-administered programs shall follow the procedures for student medications defined in the School Health policy, adopted by the Local Education Agency.

(15) The following safe sleep practices shall be followed:

- (a) Infants shall be positioned on their backs clinical psychologist when placed in a crib for sleeping.
- (b) A crib shall only have a tight fitting sheet; soft bedding for infants is prohibited.
- (c) Infants shall not be wrapped tightly or swaddled in blankets for sleeping.
- (d) Infants should be dressed lightly for sleep and the room temperature shall be in a range that is comfortable for a lightly clothed adult. Infants may be clothed in sleep sacks that have been approved by the Consumer Product Safety Commission and the Tennessee Department of Health as long as the sleep sack is not handmade, not on the recall list, and children are able to move their arms freely while wearing the sleep sack.
- (e) Infants that fall asleep during tummy time shall be placed in their crib immediately.
- (f) Infants shall be touched by a teacher every fifteen (15) minutes in order to check breathing and body temperature.
- (g) Pillows and blankets shall be prohibited for infants.
- (h) If a child appears not to be breathing, the program must immediately begin CPR and call for emergency medical assistance.
- (i) Before any teacher can assume duties of any type in an infant room they must be oriented in the foregoing SIDS procedures.
- (j) The areas where infants sleep shall be lit in a manner have adequate lighting which allows the teacher to quickly, at a glance, verify that the child's head is uncovered, that the child is breathing, and otherwise visually verify the child's condition.

(Rule 0520-12-01-.14, continued)

- (16) For the protection of children and adults, the Centers for Disease Control guidelines for hand washing and diapering procedures shall be followed.
- (17) Diapering shall comply with the following:
- (a) Children shall be diapered/changed and cleaned immediately when wet or soiled.
 - (b) The diapering area and/or toilet training area shall be located near a hand washing lavatory and shall be located in a separate area from the food preparation/service area.
 - (c) All diapering surfaces must be off the floor, nonporous and shall be sanitized using solutions for general cleaning and sanitizing purposes, i.e.:
 - 1. For general cleaning and sanitizing purposes, a fresh solution of one quarter (1/4) cup chlorine bleach to one (1) gallon of water (or one (1) tablespoon bleach to one (1) quart of water) shall be made daily.
 - 2. Substitutions for the bleach solution required in part 1 above, that are approved for the child care setting deemed necessary by the Department of Health are permissible.
 - 3. The solution required in part 1 above is not appropriate for items associated with food preparation or for items that children frequently place in their mouths, and the Health Department does not permit the use of higher concentrations than these in food preparation areas. – Specific jurisdictions may have even more stringent requirements, therefore, the local health department should be consulted.
 - (d) A tightly covered container with plastic liner shall be used for diaper disposal and shall be inaccessible to children. This container shall be emptied by closing the liner and disposing of it in an outside receptacle.
- (18) Program equipment shall meet the following safety requirements:
- (a) Manufacturer's safety instructions shall be followed for the use and/or installation of all indoor and outdoor equipment and appliances. Such instructions shall be retained and communicated to all appropriate staff.
 - (b) All indoor and outdoor equipment shall be well made and safe. There shall be no dangerous angles, no sharp edges, splinters, nails sticking out, no open S-hooks or pinch points within children's reach.
 - (c) Electrical cords on equipment for children shall be inaccessible to the children.
 - (d) Damaged equipment shall be repaired or removed from the room or playground immediately.
 - (e) Equipment shall be kept clean by washing frequently with soap and water.

(Rule 0520-12-01-.14, continued)

- (f) There shall be developmentally-appropriate equipment and furnishings for each age group in attendance.
 - (g) Individual lockers, separate hooks and shelves or other containers, placed at children's reaching level, shall be provided for the belongings of each child, ages infant - preschool.
 - (h) In infant/toddler rooms, equipment and space shall be provided for climbing, crawling, and pulling without the restraint of playpens or cribs.
 - (i) A place shall be provided for each school-age child's belongings.
 - (j) There shall be equipment for napping or sleeping for each preschool child who is in care for six (6) hours or more.
 - 1. A quiet rest area and cots or mats shall be available for children who want to rest or nap. However, no child shall be forced to nap.
 - 2. No child shall be forced to stay on a cot or on a mat for an extended period of time.
 - 3. In order to avoid the spread of airborne diseases, children shall be positioned on mats in a face-to-feet alternating pattern.
 - 4. Spacing of cots, cribs, and mats shall allow sufficient space to walk between them.
 - 5. All nap/sleep equipment shall be in good condition and comply with the following requirements:
 - (i) Individual cots or two-inch (2") mats shall be provided for children ages twelve (12) months to five (5) years.
 - (ii) Individual beds or cots shall be provided for children sleeping for extended periods of more than two and one half (2-1/2) hours, such as during nighttime care.
 - (iii) Each child under twelve (12) months shall have an individual, free-standing, crib at least twenty-two inches (22") x thirty-six inches (36") with an open top.
- (16) — (iv) Duty to Report Child Abuse and Neglect.
- (a) Duty to Report.
- Mattresses and foam pads shall be covered with safe, waterproof material.
- (v) A clean sheet or towel shall be used to cover whatever the child sleeps on.
 - (vi) A clean coverlet shall be available to each child.

(Rule 0520-12-01-.14, continued)

(vii) Soiled sheets and coverlets shall be replaced immediately.

(viii) Each crib, cot, bed or mat shall be labeled to assure that each child naps on his own bedding.

6. Crib mattress shall not be positioned directly on the floor for napping. Pack 'n plays may be used for naptime.

(19) Every operator, owner, director, teacher, or staff member of, or substitute staff member or volunteer in a program is individually responsible, and is required by T.C.A. §§ 37-1-403 and 37-1-605, to immediately report any reasonable suspicion of child abuse or neglect to the Department of Children's Services, local law enforcement or the judge of the juvenile court in the county of the child's residence.

(a) All agency staff, including non-caregiving staff, shall receive annual training regarding the procedures to report child abuse and neglect.

(b) In determining a reasonable suspicion for purposes of reporting, the program shall limit questioning of the child and may make only the most basic inquiries necessary to determine if any reasonable possibility of abuse or neglect exists.

Determining Suspicion of Abuse/Neglect:

Due to both the immediate risk to children's safety, as well as to the extreme risk of destroying or losing critical evidence, the program and/or individual staff shall not delay reporting possible abuse or neglect in an attempt to conduct an investigation to verify the abuse/neglect allegations.

All agency staff, including non-caregiving staff, shall receive training regarding the procedures to report child abuse and neglect. In determining a reasonable suspicion for purposes of reporting, the program shall limit questioning of the child and may make only the most basic inquiries necessary to determine if any reasonable possibility of abuse or neglect exists.
basic inquiries necessary to determine if any reasonable possibility of abuse or neglect exists. (c)

The program does not have to, and shall not attempt to, validate (or "prove") the allegation prior to making a report, as required by this paragraph (18). A final determination of the validity of the report of abuse or neglect shall be made exclusively by the Department of Children's Services and/or by law enforcement upon the report by the program's staff.

(d) 3. Any statement from a child reasonably indicating abuse/neglect of that child or another child or any evidence of abuse/neglect observed on a child shall be immediately reported by staff to the Department of Children's Services in a manner specified by that department, to local law enforcement or to the judge of the juvenile court in the county of the child's residence.

(e) The following procedures for reporting suspected child abuse or neglect are prohibited:

(Rule 0520-12-01-.14, continued)

1. The program shall not develop or implement policy that inhibits, interferes with or otherwise affects the duty of any staff, including substitutes and volunteers, to report suspected abuse or neglect of a child as required by this Chapter and T.C.A. § 37-1-403 and 605, and shall not otherwise directly or indirectly require staff to report to the program management or seek the approval of program management prior to any individual staff member reporting the suspected abuse or neglect.

~~(b) The telephone numbers of the Department of Children's Services, the local law enforcement or the juvenile judge of the county of the child's residence for staff to call to report suspected abuse and neglect shall be posted in a conspicuous location by each telephone.~~

~~(c) Prohibited Procedures for Reporting Suspected Child Abuse/Neglect/Penalties.~~

~~1. The program shall not develop or implement policy that inhibits, interferes with or otherwise affects the duty of any staff, including substitutes and volunteers, to report suspected abuse or neglect of a child as required by subparagraph (a) above and T.C.A. §§ 37-1-403 and 605, and shall not otherwise directly or indirectly require staff to report to the program management or seek the approval of program management prior to any individual staff member reporting the suspected abuse or neglect.~~

2. A report of suspected child abuse or neglect of a child enrolled in the program by the operator, owner, director, teacher or staff member of, or substitute staff member or volunteer in a program shall not be made to any other entities or persons, including, but not limited to, hospitals, physicians, or educational institutions as an alternative to or substitute for the reporting requirements to the persons or entities specifically listed in subparagraph (a) above this Chapter.

3. The operator, owner, director, teacher, or staff member of, or substitute staff member or volunteer in the program shall not suggest to advise or direct a parent or caretaker of a child enrolled in the program to make a report of suspected child abuse or neglect regarding that parent's or caretaker's own child who is enrolled in the program as a means of fulfilling the duty of the operator, owner, director, teacher or staff member of, or substitute staff member or volunteer in, the program to report child abuse or neglect as required by T.C.A. §§ 37-1-403 and 37-1-05.

4. Any action that does not comply in all respects with these rules Because the statutory requirements of T.C.A. §§ 37-1-403 and 37-1-605 do not authorize the prohibited procedures described in parts 1-3 of this subparagraph (c) to fulfill the statutory duty of any person, and especially the duty of those certified as approved by the Department of Education to care for and protect vulnerable children, to make timely and effective reports of child abuse and neglect to appropriate investigative agencies, and because the prohibited procedures described in parts 1-3 of this subparagraph (c) are unreliable procedures to ensure that the appropriate authorities are to timely and satisfactorily investigate suspected child abuse or neglect, any action that does not comply in all respects with subparagraph (a)

(Rule 0520-12-01-.14, continued)

above, will not fulfill the statutory duty to report child abuse or neglect and the certification of approval requirements of this Chapter.

- (f) Failure to make the reports required by this Chapter or the use of the prohibited methods as an attempt to fulfill the duty to report suspected child abuse or neglect, for children in the care of the program are, by themselves, grounds for suspension, denial or revocation of the program's certificate of approval.
- (g) If the facts established by a preponderance of the evidence indicate that there has not been strict compliance with the requirements of this Chapter or that the prohibited procedures been utilized as an alternative means of fulfilling the requirements, these circumstances shall create a rebuttable presumption for the Administrative Law Judge and the Child Care Advisory Council Review Board that the duty to report child abuse or neglect has not been fulfilled, and this ground for suspension, denial, or revocation of the program's certificate of approval by the Department of Education shall be sustained unless such presumption is rebutted by a preponderance of the evidence.
- (h) Every operator, owner, director, teacher or staff member of, or substitute staff member or volunteer in a program certified as approved by the Department of Education shall fully cooperate with all agencies involved in the investigation of child abuse or neglect.

~~Failure to Report Properly Is Grounds for Suspension, Denial or Revocation of the Program's Certificate of Approval.~~

~~Failure to make the reports required by subparagraph (a) above or the use of the prohibited methods described in parts 1-3 of this subparagraph (c) as an attempt to fulfill the duty to report suspected child abuse or neglect, for children in the care of the program are, by themselves, grounds for suspension, denial or revocation of the program's certificate of approval.~~

~~If the facts establish by a preponderance of the evidence that there has not been strict compliance with the requirements of subparagraph (a) above or that the prohibited procedures described in parts 1-3 of this subparagraph (c) have been utilized as an alternative means of fulfilling the requirements of subparagraph (a) above, these circumstances shall create a rebuttable presumption for the Administrative Law Judge and the Child Care Advisory Council Review Board that the duty to report child abuse or neglect has not been fulfilled, and this ground for suspension, denial, or revocation of the program's certificate of approval by the Department of Education shall be sustained unless such presumption is rebutted by a preponderance of the evidence.~~

~~Agency Duties During Investigations of Child Abuse and Neglect: Custodial Authority of Children.~~

~~Every operator, owner, director, teacher or staff member of, or substitute staff member or volunteer in a program certified as approved by the Department of Education shall fully cooperate with all agencies involved in the investigation of child abuse or neglect.~~

1.2, The program shall provide access to records of children and staff.

(Rule 0520-12-01-.14, continued)

2. The program shall allow appropriate investigators to interview children and staff.

3. The program shall not interfere with a child abuse and neglect investigation.

4. The program shall protect the child by requesting the investigator's identification.

5. The program shall maintain confidentiality of the investigation and shall not disclose the investigation or details of the investigation except as required to carry out procedures for the protection of children or as otherwise directed by the Department of Children's Services, law enforcement or the Department of Education.

(i) Upon notification of a pending abuse/neglect investigation of any program staff member or resident of a home-based program, the program shall enter into a safety plan Safety Plan with the Department regarding the individual's access to the program and the children in the care of the program.

~~(d) All agency staff, including non-caregiving staff, shall receive training regarding the procedures to report child abuse and neglect.~~

~~(19) A parent shall be notified before the child leaves the premises except in emergency circumstances, except that an authorized investigator with the Department of Children's Services or local law enforcement may take a child off the premises of the program if he/she has obtained custody of the child as follows:~~

~~(a) Voluntary placement agreement with the parent;~~

~~(b) Court order;~~

~~(c) Emergency assumption of custody under T.C.A. § 37-1-113 without parental permission;~~

~~(d) If the child's parent or legal guardian is present and approves; or~~

~~(e) In conjunction with investigative procedures under the child abuse laws.~~

Authority: T.C.A. §§ 4-5-201 et seq., 49-1-302(l), 49-1-1101 through 49-1-1109, 49-5-415, 49-6-5001 and 5002, 37-1-113, 37-1-401 et seq., 37-1-601 et seq. and 20 U.S.C. § 6081. **Administrative History:** Original rule filed April 30, 2002; effective July 14, 2002. Amendment repealing and replacing rule filed March 15, 2010; effective August 29, 2010. Amendment filed June 18, 2013; effective November 28, 2013.

0520-12-01-.11 FOOD.

(1) Nutritional Needs.

(Rule 0520-12-01-.14, continued)

If the program provides meals, the program shall provide developmentally appropriate meals, snacks, and drinks for each child that are of sufficient proportions and nutritional value to meet each child's health needs in accordance with the following minimum requirements:

- (a) For children in the agency at least four (4) hours, one (1) snack shall be provided, unless the four (4) hour period covers a normal meal hour, in which case a meal shall be served. However, if the child is fed their meal at home or in school, the child shall be served two (2) snacks in lieu of a meal.
- (b) Children in care five (5) to six (6) hours shall be provided- one (1) meal and one (1) or two (2) snacks.- However, if the child is fed their meal at home or in school, the child shall be served two (2) snacks in lieu of a meal.
- (c) Children in care seven (7) to ten (10) hours shall be provided one (1) meal and one (1) or two (2) snacks.
- (d) Children in care for longer than ten (10) hours shall be provided two (2) complete meals and one (1) or two (2) snacks.
- (e) A meal shall be ~~provided~~ deferred to children who arrive before 7:00 a.m. and who have not had breakfast at home.
- (f) Foods high in sugar and/or fat content but containing low nutritional value, shall not be served.
- (g) All special needs diets shall be prepared as prescribed by a physician or by the written instructions of the parent.
- (h) In order for parents to be aware of the food their children are receiving, the week's menus shall be planned and posted by the first day of each week and remain posted throughout the week. These menus shall be followed, although reasonable substitutions are permissible, if the substituted food contains the same nutrients. Any change shall be documented in advance of the meal.
- (i) Food shall not be forced on or withheld from children.
- (j) Programs must establish a feeding schedule for infants.
- (k) Bottled breast milk, infant bottles, and formula shall not be heated in a microwave.
- (l) Bottles shall not be propped, and a child shall not be given a bottle while lying flat. Infants must be held while bottle feeding.
- 1. _____

~~2. Extended Care. For children in extended night care, meal and snack service will not apply while children are asleep, but snacks will be offered if the child awakens and indicates hunger.~~

(Rule 0520-12-01-.14, continued)

~~(b) — Appropriate foods shall be encouraged; highly inappropriate foods, e.g., foods high in sugar and/or fat content but containing low nutritional value, shall not be served.~~

~~(c) — Powdered milks shall be used only in a cooked food product.~~

~~(d) — All special needs diets shall be prepared as prescribed by a physician or by the written instructions of the parent.~~

~~(e) — In order for parents to be aware of the food their children are receiving, the week's menus shall be planned and posted by the first day of each week and remain posted throughout the week.~~

~~1. — These menus shall be followed, although reasonable substitutions are permissible, if the substituted food contains the same nutrients. Any change shall be documented in advance of the meal.~~

~~2. — Any change shall be documented in advance of the meal.~~

~~(f) — Food shall not be forced on or withheld from children.~~

~~(g) — Food as Behavior Management.~~

~~1. — Foods served as part of the meal/supplement pattern shall not be used as reward; nor shall food be used or withheld as a form of discipline.~~

~~2. — Desserts and sweets must not be used as rewards or a form of discipline.~~

~~(h) — New foods shall be introduced to infants and toddlers one at a time over a five (5) to seven (7) day period with parent's approval.~~

~~(i) — The feeding schedule for infants shall be in accordance with the child's need rather than according to the hour.~~

~~(j) — Staff shall support parent's decision to continue breast-feeding.~~

~~(k) — Parents and teachers shall work together when weaning an infant to insure consistency in the weaning process. Weaning shall be delayed until after an infant adjusts to group care.~~

~~(m) — Children shall not be permitted to carry a bottle with them throughout the day.~~

~~(2) — The following rules shall be followed for meal service:~~

~~(a) — (2) — Meal Service.~~

(Rule 0520-12-01-.14, continued)

Teachers and children shall wash their hands with soap and water.

(b) High chairs and tables on which food is prepared and served shall be washed with soap and water and sanitized prior to and after snacks and meals.

(c) Floors under tables and high chairs on which food is served shall be swept and/or vacuumed after each meal and cleaned as needed.

(d) Solid foods (including cereal) shall not be given in bottles or with infant feeders to children with normal eating abilities unless authorized by a physician. Violation of this rule may result in suspension, revocation or denial of the agency's ability under its certificate of approval to provide infant care.

~~Dishes and Utensils.~~

~~Napkins, individual forks and/or spoons shall be provided for children who feed themselves.~~

~~Individual dishes as necessary for the type of feeding shall be provided.~~

~~Routine food service dishes, utensils, and bottles shall be break-resistant.~~

~~Due to the extreme risk of choking, solid foods (including cereal) shall not be given in bottles or with infant feeders to children with normal eating abilities unless authorized by a physician. Violation of this rule may result in suspension, revocation or denial of the agency's ability under its certificate of approval to provide infant care.~~

(e) To avoid choking, foods shall be appropriately sized for the eating and chewing abilities of children. ~~Special attention should be given when serving raw fruits and vegetables and prepackaged meats and cheeses, such as hotdogs, pepperonis, and cheese cubes.~~

(f) At mealtime, children shall be seated at appropriately sized tables and chairs, and adults shall supervise them ~~in accordance with subsection 0520-12-01-.06(1)(d).~~

(3) The following guidelines shall be followed for formula and food brought from home:

(a) Formula and Food Brought from Home:

All formulas and food brought from home shall be labeled with the child's name.

(b) Milk shall be placed immediately in the refrigerator.

(c) Once milk has been warmed, it shall not be re-warmed or returned to the refrigerator.

(d) For optimum digestion, formula is to be served at body temperature.

(e) Frozen breast milk shall be dated when expressed.

(Rule 0520-12-01-.14, continued)

- (f) ~~_____~~ All formulas remaining in bottles after feeding shall be discarded.
- (g) ~~_____~~ Previously opened baby food jars shall not be accepted in the center. If food is fed directly from the jar by the teacher, the jar shall be used for only one feeding.
- (e) ~~_____~~ Microwaves, Bottle Warmers, and Crock Pots. In order to prevent scald and splash burns:
 - 1. ~~Microwave ovens, bottle warming devices, and crock pots, including cords, shall not be accessible to preschool children.~~
 - 2. ~~School-age children shall use microwaves only under direct supervision.~~
 - 3. ~~Children shall never be held while removing a bottle from a crock pot or warming device.~~
 - 4. ~~The "splash zone" area immediately surrounding microwaves, crock pots and warming devices shall be kept inaccessible to children at all times.~~
 - 5. ~~All crock pots, bottle warmers and other warming devices shall be maintained at the device's lowest available temperature setting.~~
 - ~~_____~~ ~~Crock pots and bottle warming devices shall be secured in such a manner as to prevent them from tipping over, splashing and spilling.~~
- 6. ~~_____~~
 - 7. ~~_____~~ Bottled breast milk, infant bottles, and formula shall not be heated in a microwave oven.
 - 8. ~~_____~~ To prevent scalding, liquid and solid foods heated in a microwave oven shall be checked for "hot spots" prior to serving.
- (f) ~~_____~~ Previously opened baby food jars shall not be accepted in the center. If food is fed directly from the jar by the teacher, the jar shall be used for only one feeding.
- (4) ~~_____~~ Microwaves, bottle warmers, and crock pots shall be only used by adults and shall not be accessible to children. All devices shall be used on the lowest setting.
- (5) ~~_____~~ Infants shall be held while being fed as long as they are unable to sit in a high chair, an infant seat, or at the table.
- (6) ~~_____~~ Children~~To avoid the risk of serious injury or choking, children shall always be restrained in the high chair manufacturer's restraint device while sitting in a high chair. _____Children who are too small or are too large to be restrained using the manufacturer's restraint device shall not be placed in a high chair.~~
- (7) ~~_____~~ When children are capable of using a high chair, they shall be allowed to do so and to experiment with food, with feeding themselves, and to eat with fingers or spoon.

(Rule 0520-12-01-.14, continued)

- ~~(g) Bottles shall not be propped, and a child shall not be given a bottle while lying flat.~~
- ~~(h) When children are capable of using a high chair, they shall be allowed to do so and to experiment with food, with feeding themselves, and to eat with fingers or spoon.~~

(8) Children shall never be left without adult supervision while eating.

(9) The following rules for food storage shall be followed:

(a) Food Storage.

Potentially hazardous foods requiring cold storage shall be maintained at forty-five (45) degrees Fahrenheit (F) or below, and accurate thermometers for measurement of the food temperature shall be kept in the refrigerators where such food is stored.

(b) Potentially hazardous food requiring hot storage shall be maintained at an internal temperature of one-hundred forty (140) degrees F or above.

(c) Frozen foods shall be maintained at a temperature of zero (0) degrees F or below.

(d) Thermometers shall be placed in all freezers and all other cold storage equipment.

(e) All dry food supplies shall be stored in closed containers. These foods shall be stored in a manner to prevent possible contamination and to allow for proper cleaning of the storage area. Containers of food shall be stored at a minimum of six (6) inches above the floor or on movable dollies.

(f) All food shall be protected from contamination during storage, preparation, transportation, and serving.

(g) No poisonous or toxic materials except those required for sanitization purposes may be used or stored in a food-service area of a facility.

(10) The following rules for food sanitation shall be followed:

(a) Food Sanitation.

~~Home-canned food and raw milk are prohibited.~~

Raw fruits and vegetables shall be washed before use.

(b) Utensils shall be thoroughly cleaned and sanitized after each use. Single-service utensils shall be made from non-toxic materials and shall be discarded following use.

(Rule 0520-12-01-.14, continued)

~~(c) Milk and food shall not be placed on the table longer than fifteen (15) minutes prior to the beginning of the meal to avoid contamination and spoilage.~~

~~(a) _____~~

~~(b) All eating and drinking utensils shall be thoroughly cleaned and sanitized after each use with the exception of single-service utensils which shall be discarded following use.~~

~~(c) Single-service articles shall be made from non-toxic materials and shall be stored, handled, and dispensed in a sanitary manner.~~

~~(d) All utensils and food-contact surfaces or equipment used in the preparation, transportation, service, display, or storage of potentially hazardous food shall be cleaned and sanitized prior to and after each use.~~

~~(e) Milk and food shall not be placed on the table longer than fifteen (15) minutes prior to the beginning of the meal to avoid contamination and spoilage.~~

Authority: T.C.A. §§ 4-5-201 et seq., 49-1-302(l), and 49-1-1101 through 49-1-1109. **Administrative History:** Original rule filed April 30, 2002; effective July 14, 2002. Amendment repealing and replacing rule filed March 15, 2010; effective August 29, 2010.

0520-12-01-.12 PHYSICAL FACILITIES.

~~_____ (1) Physical facilities shall maintain compliance with all applicable health and safety codes throughout the certification year and shall additionally comply with any updated standards issued by the Fire Marshal and the Department of Health.~~

~~_____ Inspections and Compliance with Fire, Health and Safety Standards.~~

~~All facilities shall annually pass an inspection verifying compliance with all applicable state and local fire and environmental requirements.~~

~~The following facilities, in addition to meeting the requirements set forth in subparagraph~~

~~(a) above, shall pass inspection by the State Fire Marshal's Division of the Tennessee Department of Commerce and Insurance and the Food and General Sanitation Division of the Tennessee Department of Health:~~

~~Facilities that have never been awarded a certificate of approval or a DHS child care license;~~

~~Facilities that have not previously been approved by the State Fire Marshal;~~

~~Facilities that have relocated; and/or~~

~~Existing facilities with renovations, new construction, additions to, and/or changes in occupancy.~~

~~(2) Neither a temporary nor an annual license shall be issued unless all of the following requirements are met:~~

(Rule 0520-12-01-.14, continued)

~~The physical facility meets all requirements set forth in paragraph (1) above;~~

~~The physical facility (indoor and outdoor) present no apparent hazards; and~~

~~The physical facilities are otherwise deemed appropriate by the Department for the safe care of children.~~

~~Requests for inspections are made by the Department's child care program evaluator, but it is the responsibility of the applicant to obtain verification of the inspections and the approvals.~~

~~Building Plans: Plans for new construction must be drawn by a registered architect or engineer and submitted to the fire prevention division of the Department of Commerce & Insurance and to the local health department when required by such departments and in accordance with the respective departments' procedures.~~

~~Continuing compliance. Physical facilities shall maintain compliance with all applicable codes as set forth in paragraph (1) above, throughout the certification year and shall additionally comply with any updated standards issued by the fire safety section of the Department of Commerce and Insurance and the food and general sanitation section of the Department of Health.~~

(2) All facilities shall have a means of communications via phone.

(3) The maximum number of children who may be present inside a physical space (e.g., the program's "certificated capacity") shall be determined in accordance with the minimum square footages set forth in this paragraph; provided, however, the Department may, in its discretion as determined reasonably necessary to maintain the health and safety of the children in care, restrict the program's certificated capacity below the maximum which is set forth in these rules.

(a) A minimum of thirty (30) square feet of usable indoor space shall be provided for each child.

(b) Career and technical child care classes shall have separate space for the group of young children, with thirty (30) square feet per child of usable space, apart from the classroom space for students.

(c) For the purposes of calculating square footage requirements, any area used as restrooms, halls, kitchen, or office space, and any space used by cribs or large pieces of furniture, shall not be considered "usable play space" and shall not be counted toward the program's certificated space.

(d) Rooms with sufficient floor space, as defined by the requirements set forth in these rules, may be divided and used for more than one (1) group; provided, however, that each area is adequately equipped and arranged and that each group shall have the security of a stable classroom space.

~~Annual inspection. All facilities shall be inspected and approved annually by either state codes enforcement officers or authorized local fire safety inspectors and by environmentalists. Exception: Public and private schools are inspected based on a schedule established by the fire marshal and/or fire officials of partnering jurisdictions.~~

(Rule 0520-12-01-.14, continued)

~~The program shall not be located in a building used for purposes which would be hazardous to the children or would prohibit outdoor play unless the program is an inner city program which has requested and has been granted an exception from the Department pursuant to the requirements for "Outdoor Play" found in paragraph 0520-12-01-.09 of this Chapter.~~

~~Telephones and Other Communication Devices.~~

~~There shall be a working telephone in the center.~~

~~If answering machines/voice mail must be used, they shall be monitored at thirty (30) minute intervals (except when staff and children are off premises) so that emergency messages can be received.~~

~~Parents shall be informed that answering machines/voicemail are used.~~

~~Licensed Capacity of Physical Space.~~

~~The maximum number of children who may be present inside a physical space (e.g., the program's "certificated capacity") shall be determined in accordance with the minimum square footages set forth in this paragraph; provided, however, the Department may, in its discretion as determined reasonably necessary to maintain the health and safety of the children in care, restrict the program's certificated capacity below the maximum which is set forth in these rules.~~

~~The maximum number of children who may be present inside a physical space (e.g., the program's "certificated capacity") shall be determined in accordance with the minimum square footages set forth in this paragraph; provided, however, the Department may, in its discretion as determined reasonably necessary to maintain the health and safety of the children in care, restrict the program's certificated capacity below the maximum which is set forth in these rules.~~

~~A minimum of thirty (30) square feet of usable indoor play space shall be provided for each child.~~

~~(a) — Each nap room shall contain a minimum of thirty (30) square feet of floor space per child.~~

~~(b) — Teen parenting career and technical classes (formerly known as "vocational") shall have separate space for the group of young children with thirty (30) square feet of usable play space per child apart from the classroom space for the students.~~

~~Occupational/career and technical child care classes shall have separate space for the group of young children, with thirty (30) square feet per child of usable space, apart from the classroom space for students. The designated separate space may be located in the same room and divided by movable barriers less than four (4) feet in height.~~

~~(c) — For the purposes of calculating square footage requirements, any area used as restrooms, halls, kitchen, or office space, and any space used by cribs or large pieces of furniture, shall not be considered "usable play space" and shall not be counted toward the program's certificated space.~~

(Rule 0520-12-01-.14, continued)

~~(d) Rooms with sufficient floor space, as defined by the requirements set forth in these rules, may be divided and used for more than one (1) group; provided, however, that each area is adequately equipped and arranged and that each group shall have the security of a stable classroom space.~~

~~(4) All indoor areas shall be clean and safe.~~

~~(a) The indoor play/care areas shall be free of hazardous items that could be accessible to children.~~

~~(b) Indoor play equipment shall meet the following guidelines:~~

~~1. Pieces of equipment, such as television sets, bookcases, and appliances, shall be secured or supported so that they will not fall or tip over.~~

~~(3) Outdoor Play Area.~~

~~(b) Pieces of equipment, such as television sets, bookcases, and appliances, shall be secured or supported so that they will not fall or tip over.~~

~~2. Sufficient indoor equipment, materials, and toys shall be available to meet active and quiet play needs of all children enrolled and to provide a variety of developmentally appropriate activities so that each child has at least three (3) choices during play time.~~

~~3. Toys, educational and play materials, shall be organized and displayed within children's reach so that they can select and return items independently.~~

~~4. Toys or teaching aids that are small or that have small parts that can be inhaled or swallowed shall be inaccessible to infants and toddlers.~~

~~(5) Outdoor play areas shall contain a minimum of fifty (50) square feet of usable play space for each child using the area at one time.~~

~~(a) Agencies Initially Certificated After January 1, 2002. The outdoor play area must be enclosed by a fence or barricade at least four (4) feet in height. The Provided, however, the Department may in at its discretion grant a waiver from this provision when the Department determines that the lack of such fence or barricade poses no apparent or potential risk to children.~~

~~(b) Outdoor play equipment shall meet the following guidelines:~~

~~1. There shall be developmentally appropriate outdoor play equipment for children who are in care more than three (3) daylight hours.~~

~~2. All outdoor play equipment and materials shall be sufficient in amount and variety so that children have an opportunity to participate in a minimum of at least three~~

(Rule 0520-12-01-.14, continued)

(3) different types of play using either stationary equipment and/or portable play materials.

3. All outdoor play equipment shall be placed to avoid injury:

(i) Fall zones shall extend six (6) feet away from the perimeter of climbing equipment and away from retainer structures, fences, and other equipment and out of children's traffic paths.

(ii) Agencies with a playground continually certified as approved since prior to January 1, 2002, shall be permitted to maintain fall zones of at least four (4) feet; provided, however, that any expansion or addition shall comply with the six (6) feet fall zone required by part 4(i) above.

4. Supports for climbers, swings, and other heavy equipment that could cause injury if toppled shall be securely anchored to the ground, even if the equipment is designed to be portable.

5. Portable equipment shall otherwise be anchored to the ground if the height and weight of the equipment exceeds the height and weight of the smallest child who will use the equipment.

6. An acceptable resilient surfacing material, as recognized by the Department, shall cover fall zones in accordance with the following:

<u>Resilient Surfacing Material</u>	<u>Minimum Acceptable Depth</u>
<u>Wood chips or mulch</u>	<u>Six (6) inches</u>
<u>Double shredded bark</u>	<u>Six (6) inches</u>
<u>Pea gravel</u>	<u>Six (6) inches</u>
<u>Medium gravel</u>	<u>Eight (8) inches</u>
<u>Fine sand</u>	<u>Eight (8) inches</u>
<u>Course sand</u>	<u>Eight (8) inches</u>
<u>Artificial (manufactured) surface</u>	<u>Manufacturer recommendation</u>

(c) The areas where children play or are cared for shall be properly maintained:

A written playground maintenance plan shall be prepared by the program to address routine, remedial, and preventive maintenance and to designate who is responsible for each maintenance need. The outdoor areas where children play or are cared for shall be properly maintained and a written playground maintenance plan shall be prepared by the program to address routine, remedial, and preventive maintenance and to designate who is responsible for each maintenance need.

(Rule 0520-12-01-.14, continued)

~~(d) A pre-play/care inspection of the outdoor play area shall be completed by the program before children play outdoors.~~

~~(e) The outdoor play/care areas shall be free of hazardous items that could be accessible to children.~~

~~1. The play/care areas shall be free of hazardous items or materials unless adequately protected by storage, inaccessibility, proper supervision, or other safety procedures.~~

~~2. These areas shall present no conditions which are hazardous to children.~~

~~(f) OutdoorAll such areas shall be free of all animal wastes.~~

~~(6) Drinking water from individual single service cups or an approved drinking fountain shall be provided in all occupied rooms.~~

~~Equipment Hazards:~~

~~Cords on window blinds shall be inaccessible to children.~~

~~Electrical cords on equipment shall be inaccessible to children.~~

~~All indoor and outdoor areas shall be kept safe by the absence of, or the immediate removal or repair of, any object, fixture, equipment, or substance in the facility or grounds that could potentially cause injury to a child.~~

~~General Sanitation and Safety of Building and Grounds:~~

~~(a) Water Supply:~~

~~The drinking water supply serving child care facilities shall be from a source approved by the health authority having jurisdiction.~~

~~Drinking water from individual single service cups or an approved drinking fountain shall be provided in all occupied rooms.~~

~~(7) All garbage shall be removed from the building daily and all garbage storage receptacles shall be outside and kept closed with tight-fitting lids. The area surrounding the garbage containers shall be kept clean.~~

~~(8) The building shall be kept clean and maintained in good repair, without unsafe cracks, leaks or unsatisfactory plumbing.~~

~~(b) Sewage and Waste Disposal:~~

~~1. Connection to a public storage disposal system shall be made where possible. The use of a private sewage disposal system shall have the approval of the local health department and it shall be operating satisfactorily.~~

(Rule 0520-12-01-.14, continued)

~~2. All garbage shall be removed from the building daily.~~

~~— All garbage storage receptacles shall be outside and kept closed with tight-fitting lids.~~

~~3. —~~

~~4. The area surrounding the garbage containers shall be kept clean.~~

~~(c) Building, Grounds and Pools.~~

~~1. The building shall be kept clean and maintained in good repair, without unsafe cracks, leaks or unsatisfactory plumbing.~~

~~(9) Adequate natural and/or artificial lighting shall be provided throughout the facility.~~

~~(10) All rooms used by children shall be maintained at a temperature of between sixty-eight (68) to seventy-eight (78) degrees Fahrenheit by means of heating, cooling or ventilation sources approved for use.~~

~~(11) Stoves, hot radiators, steam and hot water pipes, fans, or other heat generating equipment shall be adequately protected by screens, guards, insulation, or suitable measures that will protect children from coming in contact with them.~~

~~(12) Broken glass, trash, and debris shall be kept removed from the building and grounds.~~

~~(13) Swimming pools and/or wading pools shall be fenced and shall not be used without prior approval by the Department of Health.~~

~~(14) Grounds, tire swings and containers shall have adequate drainage to prevent standing water that can breed mosquitoes and other insects.~~

~~2. —~~

~~3. Building and grounds shall be kept free of unprotected ponds, wells, cisterns, refrigerators or similar hazards.~~

~~4. Swimming pools shall be fenced to prevent entry of children without adult supervision.~~

~~9. Swimming pools and/or wading pools shall not be used without prior approval by the Health Department.~~

~~10. Grounds, tire swings and containers shall have adequate drainage to prevent standing water that can breed mosquitoes and other insects.~~

~~(15) If animals or birds are kept in classrooms as pets, they shall be caged away from the food storage and preparation or service area, and cages kept clean.~~

~~— Turtles shall not be kept as pets due to the risk of salmonella.~~

(Rule 0520-12-01-.14, continued)

Authority: T.C.A. §§ 4-5-201 et seq., 49-1-202, 49-1-302(l), and 49-1-1101 through 49-1-1109.
Administrative History: Original rule filed April 30, 2002; effective July 14, 2002. Amendment filed September 6, 2007; effective January 28, 2008. Amendment repealing and replacing rule filed March 15, 2010; effective August 29, 2010.

0520-12-01-.13 TRANSPORTATION.

(1) If a program provides transportation or contracts for transportation, the program's management shall be fully responsible for all transportation of children, including between home and program (if different facility from school), to and from school, and on field trips.

(2) Transportation services shall be operated in compliance with all state laws, regarding school transportation and all rules and regulations, promulgated by State Board of Education regarding school transportation and school buses. (1) Management Responsibility.

~~If a program provides transportation or contracts for transportation, the program's management shall be fully responsible for all transportation of children, including between home and program (if different facility from school), to and from school, and on field trips.~~

~~(a) Program management is responsible for operating transportation services in compliance with:~~

- ~~1. All State laws, regarding school transportation, T.C.A. §§ 49-6-2102 through 49-6-2115 & T.C.A. §§ 49-6-2117 through 49-6-2118;~~

~~All rules and regulations, promulgated by State Board of Education, Chapter 052001-05 regarding school transportation and school buses.~~

~~Fifteen (15) passenger vans are prohibited.~~

(3) Vehicles used to transport children and which are owned or operated by, contracted for or which are otherwise under the direction or control of the school-administered program, shall carry automobile liability insurance coverage for each vehicle used for that purpose in the minimum amounts required by T.C.A. § 49-6-2111 and defined in State Board of Education Pupil Transportation Rule 0520-01-05-.01(2).

(a) Automobile insurance coverage for non-school community-based organizations which transport children shall comply with the following:

1. Automobile liability coverage shall be maintained in a minimum amount of five hundred thousand dollars (\$500,000) combined single limit of liability.
2. Medical payment coverage shall be maintained in the minimum amount of five thousand dollars (\$5,000) for injuries to children being transported in vehicles

(Rule 0520-12-01-.14, continued)

owned, operated or leased by the non-school community-based organization's program.

(4) Vehicles used to transport children must be in compliance with the Federal Motor Vehicle Safety Standards as defined by Title 49 part 571 of the Code of Federal Regulations and the Tennessee Minimum School Bus Standards, adopted by the State Board of Education as required by Rule 0520-01-05-.02.

(5) Fifteen (15) passenger vans are prohibited.

~~Unless the certification label states the fifteen (15) passenger van is a "school bus", the National Traffic and Motor Vehicle Safety Act, 49 USC § 30112, prohibits the use of a fifteen (15) passenger van to transport students to and from school or a school-related activity. The fifteen (15) passenger van is defined as any vehicle that seats ten (10) to fifteen (15) passengers, not including the driver.~~

Fifteen (15) passenger vans are prohibited.

(6) Children may be transported in passenger vehicles, however, children of all ages but must be in compliance with passenger restraint laws, T.C.A. § 55-9-602 at all times in passenger vehicles, and must be transported in rear seats.

(a) Any child under one (1) year of age or any child weighing twenty pounds (20 lbs.) or less shall be properly secured in a child passenger restraint system in a rear facing position. times in passenger vehicles, and must be transported in rear seats (vehicles weighing less than ten thousand (10,000) pounds).

~~(i) Any child under one (1) year of age or any child weighing less than twenty pounds (20 lbs.) or less shall be properly secured in a child passenger restraint system in a rear facing position.~~

(b) Any child, one (1) through three (3) years of age, weighing greater than twenty pounds (20 lbs.) shall be properly secured in a child passenger restraint system in a forward facing position.

(c) ~~iii)~~ Any child, four (4) through eight (8) years of age and measuring less than four feet, nine (4'9") inches in height shall be properly secured in a child seat or a belt-positioning booster seat.

(d) Any child, nine (9) through twelve (12) years of age, measuring four feet, nine inches (4'9") or more in height, shall be properly secured in a passenger motor vehicle using a seat belt system in the rear seat of the vehicle.

(e) Any child, thirteen (13) through fifteen (15) years of age, shall be properly secured in a passenger motor vehicle using a seat belt system.

(7) Federally approved child care restraint systems must be provided and utilized during the transport of any child three (3) years of age or and-under on a school bus.

(Rule 0520-12-01-.14, continued)

- (8) No child shall be allowed to ride on the floor of a vehicle, and no child shall be placed with another child in the same restraint device.
- (9) All school buses shall be inspected in compliance with the Rules and Regulations for School Bus Inspection, Chapter 1340-03-03, promulgated by and regulated by the Tennessee Department of Safety.
- (10) All persons hired for the position of "school bus driver" shall:
- (a) Be issued a commercial driver's license (CDL) by the Tennessee Department of Safety;
 - (b) Have an "S" endorsement ~~if Bus drivers employed by a public school or /school system; shall have an "S" endorsement.~~
 - (c) Have a "P" endorsement and completion of school bus driver training ~~if(ii) Bus drivers employed by a nonpublic school or a non-school, community based organization; shall have a "P" endorsement and completion of school bus driver training.~~
 - (d) ~~Know~~Knows and understands the school system's or private school's policies and procedures concerning transportation and to bus driver's responsibilities and duties;
 - (e) ~~Have~~Has no criminal offense or criminal record of a violation of any of the following:
 - 1. Driving under the influence of an intoxicant as prohibited by T.C.A. § 55-10-401;
 - 2. Vehicular assault as prohibited by T.C.A. § 39-13-106;
 - 3. Vehicular homicide as prohibited by T.C.A. § 39-13-213(a)(2);
 - 4. Aggravated vehicular homicide as prohibited by T.C.A. § 39-13-218; or
 - 5. Manufacture, delivery, sale or possession of a controlled substance as prohibited by T.C.A. § 39-17-417;
 - (f) ~~Complete~~Completed the annual physical and mental examinations of school bus drivers as required by T.C.A. § 49-6-2108;
 - (g) Complete the annual training for school bus drivers presented by the Tennessee Department of Safety ~~(school. School bus driver training is not required for drivers of passenger vehicles only); and-~~
 - (h) ~~Complete~~Completed CPR and First Aid certifications.

(Rule 0520-12-01-.14, continued)

(11) Drivers of any passenger vehicle, used to transport children, shall possess a current, valid driver's license and endorsement required by the Tennessee Department of Safety for transporting children in the applicable type of vehicle.

(12) Seating capacity on a school bus shall be in compliance with T.C.A. § 49-6-2110 (a), requiring a minimum of thirteen ~~(13)~~ linear inches of seat space for each student.

(13) Vehicles used for transporting children shall:

(a) Have a clearly visible identifying sign. Exceptions: Vehicles used exclusively for the occasional field trip; vehicles used exclusively for the limited provision of emergency transportation, e.g., vehicle used when regular vehicle has a mechanical breakdown; and The Department may waive the vehicle identification requirements for programs under the direction or control of a public agency.

~~(i) have a clearly visible identifying sign.~~

~~1. Exceptions to vehicle identification, i.e. signage:~~

~~(i) Vehicles used exclusively for the occasional field trip;~~

~~(ii) Vehicles used exclusively for the limited provision of emergency transportation, e.g., vehicle used when regular vehicle has a mechanical breakdown; and~~

~~(iii) The Department may waive the vehicle identification requirements for programs under the direction or control of a public agency.~~

~~(l) Develop transportation routes (school bus routes) in compliance with T.C.A. § 49-6-2105 to ensure no child is on a school bus more than one and one-half (1-½) hours in the morning and one and one-half (1-½) hours in the afternoon.~~

(b) Have a vehicle used to transport children shall have fire extinguishers, emergency reflective triangles, a first aid kit, and a blood-borne pathogenic clean-up kit, and an adult familiar with the use of this equipment on board. Emergency exiting procedures shall be practiced by all staff responsible for transporting children on a regular basis. (Not applicable to occasional transportation by volunteers). All items must be secured.

(14) Transportation routes shall be (school bus routes) in compliance with T.C.A. § 49-6-2105 to ensure no child is on a school bus more than one and one-half (1-½) hours in the morning and one and one-half (1-½) hours in the afternoon.

(15) Firearms are prohibited in vehicles used to transport children.

(16) Supervision of children in vehicles shall meet the following requirements:

(a) An adult must be in the vehicle whenever a child is in the vehicle.

(Rule 0520-12-01-.14, continued)

(b) An adult must be seated behind the steering wheel if the motor is running and children are being loaded and/or are on board.

(c) Transportation of children with special needs shall be in compliance with the Individual Education Plan (IEP) for each child.

(d) Adult Monitor Requirements. Children During during Transportation.

~~An adult must be in the vehicle whenever a child is in the vehicle.~~

~~(a)~~

~~(b) An adult must be seated behind the steering wheel if the motor is running and children are being loaded and/or are on board.~~

~~(c) Transportation of children with special needs shall be in compliance with the Individual Education Plan (IEP) for each child. Bus drivers who do not return to a central depot shall stipulate that all buses will be checked at the end of every run to make sure that no person remains on the bus as defined in T.C.A. § 49-6-2114.~~

~~(d) Adult Monitor Requirements.~~

1. An adult monitor, in addition to the driver, is required on the vehicle for the transportation children ages six (6) weeks through Pre-K.

2. An adult monitor shall not be seated in the front passenger seat, but shall be seated in the vehicle in a position which will allow:

(i) Each child to be seen with a quick glance;

(ii) Each child to be heard at all times;

(iii) Each child's activities to be observed; and

(iv) The monitor to respond immediately should there be an emergency.

(17)

~~Responsibility for Loading, Unloading and Tracking Each Child.~~

Passenger Log:

A passenger log shall be used to track each child during transportation.

(a) The first and last name of each child received for transport shall be recorded on the passenger log. A sibling group shall not be listed as a single group entry, for example, "Smith children".

(Rule 0520-12-01-.14, continued)

~~(b) The driver of the vehicle or the monitor shall be designated by management as the person responsible for completing the log.~~

~~(c) As each child is loaded onto the vehicle the time the child was placed on the vehicle shall be recorded on the passenger log.~~

~~(d) The passenger log shall be updated immediately upon the child being released from the vehicle. The time the child was released shall be recorded and initialed by the person responsible for completing the log.~~

~~(e) Loading Procedures:~~

~~1. As each child is loaded onto the vehicle the time the child was placed on the vehicle shall be recorded on the passenger log.~~

~~(f) Unloading Procedures:~~

~~1. The individual designated by the program as responsible for the log shall update it immediately upon the child being released from the vehicle. The designated staff member shall update the log by:~~

~~(i) Recording the time the child was released; and~~

~~(18) All drivers shall comply with the following:~~

~~(a) Bus drivers who do not return to a central depot shall check at the end of every run to make sure that no person remains on the bus as defined in T.C.A. § 49-6-2114. Immediately upon unloading the last child the driver shall:~~

~~Initialing next to the time of release.~~

~~When Pre-Kindergarten children are transported on the return route, the school bus driver must not leave a Pre-K child at the child's home or bus stop unless the parent or other authorized person is present. If the parent or other authorized person is not present, the Pre-K student is not to exit the bus and the school bus driver is to follow the process/policy developed by the school system in collaboration with the Department of Children's Services and/or the police or sheriff's office.~~

~~Confirming that Every Child is Off the Vehicle.~~

~~Driver Responsibilities. Immediately upon unloading the last child and to ensure that all children have been unloaded the driver shall:~~

~~1. Physically walk through the vehicle;~~

~~2. Inspect all seat surfaces, under all seats and in all compartments or recesses in the vehicle's interior;~~

(Rule 0520-12-01-.14, continued)

3. Sign the log, with the driver's full name, indicating the children are all unloaded.

(b) If a child is expected for transport (based on the roster) but is not present at the location, the driver may not leave the location without checking with a designated member of staff and the center. If the designated member of staff is not present in the loading area and there is not an additional adult on the vehicle, all children will accompany the driver into the facility to verify the whereabouts of the child.

(c) When Pre-Kindergarten children are transported on the return route, the school bus driver must not leave a Pre-K child at the child's home or bus stop unless the parent or other authorized person is present. If the parent or other authorized person is not present, the Pre-K student is not to exit the bus and the school bus driver is to follow the process/policy developed by the school system in collaboration with the Department of Children's Services and/or the police or sheriff's office.

(19) All programs providing transportation for child care shall provide a written statement to the Department—
Transportation plan for all programs.

All programs providing transportation for child care shall provide a written statement to the Department:

(a) Stating the type(s) of transportation offered, e.g. transportation to and/or from school, transportation to and/or from child care program, transportation to and/or from child's home, etc.;

(b) Listing and describing the vehicles that will be used for the transportation of children;

(c) Describing any contracts, agreements or arrangements with any third-(3rd)-parties for the provision of transportation services, with copies of such contracts or agreements or arrangements available upon the Department's request;

(d) Describing the agency's policy, procedures and staff training plans for maintaining compliance with responsibilities for loading and unloading and tracking each child;

(e) Describing the agency's management plan for ensuring all transportation staff properly perform their duties in accordance with the licensing rules and agency policies and procedures;

(f) Describing the agency's policy, procedures and staff transportation training plans for maintaining compliance with transportation rules and state law; and

(g) Describing the agency's policy, procedures and staff training plans for the emergency evacuation of the vehicle.

(20) —(b) Non-school, community-based organization vehicles shall meet the following organization's vehicle requirements; and inspections.

(Rule 0520-12-01-.14, continued)

- (a) ~~Department of Safety Inspections.~~ Annually, all non-school, community-based organization's vehicles that are designed by the vehicle manufacturer to carry ten (10) or more passengers ~~shall~~ must be inspected in accordance with the schedule established by the Department of Safety. Any maintenance or repair to the vehicles disclosed by the inspections shall be the sole responsibility of the ~~non-school~~ non-school, community-based organization.
- (b) The non-school, community-based organization's vehicle may have a stop arm in accordance with T.C.A. § 55-8-151(d) if the bus driver has completed annual school bus driver training provided by the Department of Safety.
- (c) The non-school, community-based organization's vehicle with a stop arm is required to be distinctly marked "Youth Bus" on the front and rear thereof in letters not less than six inches (6") in height and legibly written.
- (d) No vehicle which does not pass the inspections required in part (a) shall be used by the non-school, community-based organization to provide transportation services until necessary repairs, as determined by Department of Safety, have been made.
- (e) ~~Non-school, community-based organization vehicles shall receive~~ Receive regular inspections and maintenance by a certified mechanic in accordance with the maintenance schedule recommended by the vehicle manufacturer.
- (f) ~~Vehicle~~ Have the following vehicle equipment shall be certified as inspected at least every four thousand (4,000) miles, if not covered by and/or otherwise serviced in accordance with the manufacturer's maintenance schedule, including: brakes; steering; oil levels; coolant; brake, windshield-washer and transmission fluids; hoses and belts; and tires.
- (g) The following equipment shall be maintained in the vehicle and stored in a manner which is not readily accessible to children: fire extinguisher; emergency reflective triangles; first aid kit; blood-borne pathogenic clean-up kit; and seat-belt cutter or similar device designed to immediately release the vehicle's child restraint system(s) in an emergency.
- (h) The bus driver or transportation monitor assigned to the vehicle shall be familiar with the location and use of all equipment required under part (g) ~~subparagraph 5~~.
- (i) The non-school, community-based organization shall maintain documentation that the following daily inspections have been performed and any necessary repairs completed or other appropriate action taken before transporting children.
1. A visual inspection of the vehicle's tires for wear and adequate pressure;
 2. A visual inspection for working headlights and taillights (brake lights and back-up lights), signals, mirrors, wiper blades and dash gauges;

(Rule 0520-12-01-.14, continued)

~~_____3. An inspection of properly functioning child and driver safety restraints;~~

~~An inspection of properly functioning child and driver safety restraints;~~

~~_____4. An inspection for properly functioning doors and windows;~~

~~5. An inspection for the presence of safety equipment required by these rules or any other provisions of law or regulations, and repair or replacement as necessary based upon visual evidence of the need to do so;~~

~~6. A determination that the vehicle has adequate fuel; and~~

~~7. An inspection for, and cleaning of, debris from the vehicle's interior.~~

~~(j) Emergency exiting procedures shall be practiced on a regular basis by all staff responsible for transporting children.~~

~~(k) Any vehicle, contracted by a non-school community-based organization for the purposes of transporting children in a program administered by a non-school, community-based organization, shall be a for hire commercial passenger vehicle properly registered with the Federal Motor Carrier Safety Administration.~~

~~7. Emergency exiting procedures shall be practiced on a regular basis by all staff responsible for transporting children.~~

~~_____ (5) Non-school community-based organizations contracting for transportation services.~~

~~Any vehicle, contracted for the purposes of transporting children in a program administered by a non-school, community-based organization, shall be a for hire commercial passenger vehicle properly registered with the Federal Motor Carrier Safety Administration.~~

~~(l) The contracted vehicle shall have a commercial license plate (tag) and shall have minimum levels of liability insurance as defined by the Federal Motor Carrier Safety Administration rule § 387.33.~~

~~(a) _____
The contracted vehicle shall have a commercial license plate (tag).~~

~~(b) _____
The contracted vehicle shall have minimum levels of liability insurance as defined by the Federal Motor Carrier Safety Administration rule § 387.33.~~

~~1. Any vehicle with seating capacity of sixteen (16) passengers or more shall have five million dollars (\$5,000,000) liability coverage.~~

~~2. Any vehicle with seating capacity of fifteen (15) passengers or less shall have one and one half million dollars (\$1,500,000) liability coverage.~~

(Rule 0520-12-01-.14, continued)

Authority:— T.C.A. §§ 4-5-201 et seq., 49-1-302(l), 49-6-2101 through 49-6-2117, 55-8-151, 55-9-602, 55-10-401 and 55-50-101 et seq. **Administrative History:**— Original rule filed April 30, 2002; effective July 14, 2002. —Amendment repealing and replacing rule filed March 15, 2010; effective August 29, 2010. Emergency rule filed August 30, 2010; effective through February 26, 2011.— Repeal and new rule filed December 21, 2010; effective through March 21, 2011. Emergency rule filed August 30, 2010 and to have been effective through February 26, 2011 expired; on February 27, 2011 the rule reverted to its previous status.— Repeal and new rule filed December 21, 2010; effective through March 21, 2011.— Amendment filed September 29, 2011; effective February 28, 2012.

0520-12-01-.14 CARE OF CHILDREN WITH SPECIAL NEEDS.

~~(1) In addition to the preceding rules, if children with special needs are cared for in the center, the following rules shall be met:~~

~~When children with special needs are enrolled, all reasonable and appropriate efforts shall be made to provide those children equal opportunity to participate in the same program activities as their peers.~~

When children with special needs are enrolled in a child care program, all reasonable and appropriate efforts shall be made to provide those children equal opportunity to participate in the same program activities as their peers.

(2) Parents or other appropriate individual identified by the parent shall provide information and, as appropriate, training to teachers regarding special needs/techniques/emergency measures, as utilized in the child's home to ensure the child's well-being.

(3) Adaptations to the environment shall be directed toward normalizing the lifestyle of the child with a disability by helping him/her become independent and develop self-help skills.

(4) Behavior management techniques or program activities which would tend to demean or isolate the child are prohibited.

(5) The program shall inform parents of any specialized services available from the program, and if the program is aware of any specialized services available through third parties, shall additionally inform the parent of such services.

(6) Efforts to provide specialized service (e.g., speech/hearing therapy, physical therapy, psychological evaluation, or services for mentally-retarded/intellectual disability) either directly or by referral, shall be conducted only with written permission by the parent in accordance with the Individual Family Service Plan (IFSP) or Individual Education Plan (IEP) and documented in the child's record. Any information exchange regarding these services that is shared with or received from third parties shall also be documented.

(7) The program shall have written individualized emergency plans for each child with a disability who requires more assistance in emergencies than other children of the same age or in the same group. The program shall maintain documentation that the Emergency Plan is practiced monthly.

(Rule 0520-12-01-.14, continued)

~~(8) Each non-verbal child's daily activities, including, as applicable to the individual child, the time and amount of feeding, elimination, times of diaper changes, sleep patterns, and developmental progress, shall be recorded and shared with the parent(s) daily.~~

~~(1) Emergency Plans:~~

~~(a) The program shall have written individualized emergency plans for each child with a disability who requires more assistance in emergencies than other children of the same age or in the same group. The program shall maintain documentation that the Emergency Plan is practiced monthly.~~

~~(b) The program shall maintain documentation that the Emergency Plan is practiced monthly.~~

~~(8) Each non-verbal child's daily activities, including, as applicable to the individual child, the time and amount of feeding, elimination, times of diaper changes, sleep patterns, and developmental progress, shall be recorded and shared with the parent(s) daily.~~

~~(9) Diapering of schoolSchool-age childrenChildren with special needs shall be completed as follows:~~

~~(a) Children shall be changed in a location designated for that purpose and which provides privacy from other children and adults.~~

~~(b) School-age children may be diapered on the floor on a nonporous washable, surface that adequately protects the floor from contamination.~~

~~(c) required by Rule 0520-12-01-. The floor beneath the diapering surface shall be immediately cleaned after each diapering.~~

~~(d) The diapering area shall be located near a hand washing lavatory. This area shall be in a separate location from food preparation/service area.~~

~~(10) Isolation and physical restraint (14).~~

~~Physical-Restraint shall be in accordance with T.C.A. §§ 49-10-1301 through-1305; and rules promulgated by State Board of Education in accordance with T.C.A. § 49-10-1306.~~

~~(a) A student receiving special education services, as defined by T.C.A. § 49-10-102(4), may be or isolated, only if such restraint or isolation is provided for in the individual education program, except that such student may be restrained only or isolated in emergency situations and only if such isolation or restraint is provided in the student's IEP in emergency situations, if necessary to assure the physical safety of the student or others nearby.~~

~~(b) If school personnel impose restraints or isolation in an emergency situation, the school shall immediately contact the appropriate school personnel designated to authorize isolationprincipal or restraint, the principal's designee. The student's principal or principal's~~

(Rule 0520-12-01-.14, continued)

~~designee shall see and evaluate the student's condition within a reasonable time after the intervention and the student's parent or guardian shall be notified, orally or by written or printed communication, the same day the isolation or restraint was used.~~

- (c) If the student's individualized education program does not provide for the use of isolation or restraint for the behavior precipitating such action or if school personnel are required to use isolation or restraint longer than five (5) minutes, then an individual education program meeting shall be convened within ten (10) days following the use of such isolation or restraint. If the behavior precipitating such action also warrants a change of placement, the child will have all rights provided under applicable state and federal law.
- (d) School personnel who must isolate or restrain a student receiving special education services, as defined by T.C.A. § 49-10-102(4), whether or not such isolation or restraint was in an emergency situation or provided for in the student's individual education program, shall report the incident to the appropriate school personnel designated to authorize isolation principal or restrain the principal's designee who shall record the use of such isolation or restraint and the facts surrounding such use. A copy of such record shall be made available at individual education program meetings and upon the request of the student's parent or legal guardian.
- (e) If the appropriate school personnel designated to authorize isolation principal or principal's designee or any person having knowledge of the isolation or restraint, have reason to believe that such isolation or restraint was unreasonable, unsafe, or unwarranted, and such isolation or restraint caused injury to the student, the incident shall be reported pursuant to T.C.A. § 37-1-403.
- (f) School personnel shall remain in the physical presence of any restrained student and shall continuously observe a student who is in isolation or being restrained to monitor the health and well-being of such student.
- (g) Administering a chemical restraint to a student receiving special education services, as defined by T.C.A. § 49-10-102(4), is prohibited, provided that nothing in this subsection shall prohibit the administration of a chemical restraint when administered for therapeutic purposes under the direction of a physician and with the child's parent or guardian's consent to administer such chemical restraint.
- (h) Administering a noxious substance to a student receiving special education services, as defined by T.C.A. § 49-10-102(4), is prohibited.
- (i) Use of any mechanical restraint on any student receiving special education services, as defined by T.C.A. § 49-10-102(4), is prohibited.
- (j) Any form of life threatening restraint, including restraint that restricts the flow of air into a person's lungs, whether by chest compression or any other means, to a student receiving special education services, as defined by § 49-10-102(4), is prohibited.

(Rule 0520-12-01-.14, continued)

(k) _____ The use of isolation or physical holding restraint as a means of coercion, punishment, convenience or retaliation on any student receiving special education services, as defined by T.C.A. § 49-10-102(4), is prohibited.

(l) _____ The use of physical holding restraint in the following circumstances is not prohibited:

1. _____ The brief holding by an adult in order to calm or comfort;

2. _____ The minimum contact necessary to physically escort a student from one area to another;

3. _____ Assisting a student in completing a task or response if the student does not resist, or resistance is minimal in intensity or duration; or

4. _____ Holding a student for a brief time in order to prevent any impulsive behavior that threatens the student's immediate safety.

5. _____ The program is not required to notify the student's parent or guardian pursuant to ~~Section 10(b) above to this Chapter~~ in any of the circumstances listed in this subdivision (lj).

(m) _____ The use of a locked door, or use of any physical structure that substantially accomplishes the intent of locking a student in a room or structure, to isolate or seclude a student, is prohibited.

~~(e) _____ Local education agencies shall develop policies and procedures, in accordance with 0520-01-09-.23, governing:~~

~~1. _____ Personnel authorized to use isolation and restraint;~~

~~2. _____ Training requirements; and~~

~~3. _____ Incident reporting procedures.~~

~~(f) _____ Notwithstanding any provision of this section, actions undertaken by school personnel to break up a fight or to take a weapon from a student are not prohibited; however, these acts shall be reported.~~

Authority:- T.C.A. §§ 4-5-201 et seq., 37-1-403, 49-1-302(l), 49-1-1101 through 49-1-1109, 49-10-102, 49-10-1301 through 1306.- **Administrative History:-** Original rule filed March 1, 2005; effective July 29, 2005. Amendment repealing and replacing rule filed March 15, 2010; effective August 29, 2010.

0520-12-01-.15 SCHOOL AGE BEFORE AND AFTER SCHOOL PROGRAMS—SERVING ADOLESCENTS (YOUTH WHO ARE IN THE PERIOD OF PHYSICAL AND PSYCHOLOGICAL DEVELOPMENT FROM THE ONSET OF PUBERTY TO MATURITY).

(1) _____ All beforeOrganization and after school programsAdministration.

(Rule 0520-12-01-.14, continued)

Program shall have an adequate budget.

(2) Records shall be kept on all adolescents enrolled in ~~each~~the program.

~~(a) Staff records shall be maintained for each employee: educational background, reference checks, FBI check, in-service training, physical exams and reviews.~~

~~(b) (3) Each Program volunteers shall complete criminal history background checks and appropriate in-service training.~~

The program shall post their ~~annual certificate~~Certificate of ~~approval~~Approval and provide parents with a copy of the policies and procedures.

(4) Parents shall have access to all areas of the program when ~~the student~~their adolescent is present.

(5) If the program provides transportation, the transportation shall be in accordance with the rules of this Chapter~~with 0520-12-01-.13~~.

(6) Staff Qualifications:

(a) Each program shall have a ~~The director is~~responsible for the day to day operations, including staff and program.

~~A person shall be designated to serve as acting director when the director is absent.~~

~~(a) Staff shall be in compliance with 0520-12-01-.07 (9)-(12) Criminal Background and Vulnerable Persons Registry Review Requirements.~~

(Rule 0520-12-01-.16, continued)

~~(b) Staff shall have knowledge of adolescent behavior and development.~~

~~(c) Staff shall be physically, mentally and emotionally stable.~~

~~All new employees shall have orientation and child abuse prevention training before working with the adolescents.~~

~~1. _____~~

~~The director shall have at least a high school diploma and four (4) years' experience working with adolescents.~~

~~2. Directors shall have eighteen (18) hours in-service training each year.~~

~~3. _____~~

~~A person shall be designated to serve as acting director when the director is absent.~~

~~(b) All teachers staff shall be a minimum of eighteen (18) years of age and one teacher staff member in each group shall have a high school diploma.~~

~~1. All staff~~

~~Directors shall have twelve (12) ~~eighteen (18)~~ hours of in-service training each year.~~

~~(c) All staff shall be physically, mentally and emotionally stable and shall have knowledge of adolescent behavior and development. teachers twelve (12) hours.~~

~~(d) All new employees shall have orientation and child abuse prevention training before working with the adolescents.~~

~~(e) Staff shall be in compliance with all criminal history background checks required under 0520-12-01-.07.~~

~~(f) Program volunteers shall complete criminal history background checks and appropriate in-service training.~~

~~(g) Staff records shall be maintained for each employee with the following Supervision and Grouping of Children:~~

~~: educational background, reference checks, TBI check, in-service training, physical exams and reviews.~~

~~(7) Each grouping of children group shall have adult supervision and shall meet the following minimum staffing requirements:-~~

~~(a) _____~~

~~Minimum staffing requirements per group of adolescents (adult: adolescent ratio) is 1:30.~~

Age	Max. Group Size	Adult: Child Ratio
K—twelve (12) years	No-Max	1:20
Thirteen (13) years or older	No-Max	1:30

STANDARDS FOR CHILD CARE CENTERS AND SCHOOL-ADMINISTERED AGE CHAPTER
0520-12-01 CHILD CARE PROGRAMS CHAPTER

(Rule 0520-12-01-.16, continued)

Elementary School	No Max	1:20
Middle School	No Max	1:30
High School	No Max	1:30

(b) _____
Swimming and field trips require ratios be doubled.

(8) _____
Equipment:

All program equipment shall be in good condition and kept clean.

(4) ~~Program, Schedule and Routines:~~

(a) ~~Snacks and meals (if full day program) shall be scheduled regularly.~~

(9) Students Adolescents shall have time for self-directed activities, as well as, adult-directed activities.

(a) Students Adolescents shall have choices regarding activities and an opportunity to help plan activities.

(b) _____ Parents shall be informed of any TV or movies or computer games to be shown.

(c) _____ Staff shall monitor computer use.

(d) _____ Sports and physical activity shall be offered, weather permitting.

(e) Students shall have opportunities for learning, self-expression, and enrichment activities each day.

(f) Students shall receive child abuse awareness and personal safety information.

(10) _____
Behavior Management and Guidance:

Teachers shall be knowledgeable of developmentally appropriate adolescent behavior.

(a) _____ Discipline shall be in accordance with rules and policy adopted by the program to define program objectives, student expectations, behavioral code, and discipline procedures. The rules and policy shall be made available to all participants in an accessible document such as a student handbook.

(b) _____ No corporal punishment is allowed.

(c) _____ Good behavior shall be praised and encouraged.

(11) Programs
(5) ~~Educational Activities:~~

STANDARDS FOR CHILD CARE CENTERS AND SCHOOL-ADMINISTERED AGE CHAPTER
0520-12-01 CHILD CARE PROGRAMS CHAPTER

(Rule 0520-12-01-.16, continued)

(a) Adolescents shall comply with the following rules have opportunities for health learning, self-expression, and enrichment activities each day.

Adolescents shall receive child abuse awareness and personal safety information, such as "Safe at Last" curriculum if not made available through their school curriculum.

(6) (a) Students Health and Safety, Adolescent Health.

Adolescents shall have immunizations in accordance with this Chapter.

~~0520-01-03-08.~~ (b) Instructions for any student's adolescent's special health needs shall be documented.

(c) Parents shall be notified if their student adolescent is hurt or becomes ill.

(d) All parents shall be notified of any communicable diseases.

(e) Use of medications shall be in accordance with school system's policy for the administration of medications and health care procedures as defined by T.C.A. § 49-5415 50-1602 and State Board of Education guidelines.

(f) Smoking and the possession or consumption of alcohol is ~~There is to be no smoking.~~

Staff Health.

prohibited.

(g) Staff shall have documentation they are physically and mentally able to work with children.

(h) Safety.

There shall be a staff member present at all times who has current certification in CPR and first aid training.

(i) A first aid kit must be on the premises as well as a first aid chart.

(j) There shall be no firearms on the premises.

(k) There shall be an Emergency Management Plan, a written plan to protect students in event of disaster, such as fire, tornado, earthquake, chemical spills, floods, etc.

(12) Food, Nutritional Needs.

Adolescents Snacks and meals (if full day program) shall be scheduled regularly.

(a) Students will receive meals and snacks based on the amount of time spent in the program.

~~(Rule 0520-12-01-.16, continued)~~

~~(b)~~ Menus shall be posted.

~~(c)~~ Special diets and instructions shall be provided in writing.

~~(13) Physical Facilities.~~

Programs shall be in buildings that are not hazardous or dangerous to children.

~~(a)~~ All facilities shall have annual fire and health inspections.

~~(b)~~ All programs shall have a working telephone.

~~(c)~~ Programs shall have thirty (30) square feet of usable space per adolescent.

~~(d)~~ Outdoor recreation/sports area shall have fifty (50) square feet per student.

~~(14) Care of Adolescents with Special Needs.~~

Programs serving ~~students~~adolescents with ~~disabilities~~special needs shall follow the rules defined in ~~this Chapter. 052012-01-.14.~~

~~(a)~~ Adaptations shall be directed towards helping the ~~student~~adolescent become independent and developing self-help skills.

~~(b)~~ Specialized services provided shall be documented and information shared with appropriate parties.

Authority: T.C.A. §§ 49-1-302(l), 49-1-1101 through -49-1-1109, 49-6-707. **Administrative History:** Original rule filed March 15, 2010; effective August 29, 2010.

0520-12-01-.16 CIVIL PENALTIES.

~~(1)~~ Pursuant to T.C.A. § 49-1-1107(c)(2) the following are the minimum and maximum civil penalties that may be assessed against a child care program authorized pursuant to T.C.A. § 49-1-1101, et seq.

~~(2)~~ The department shall assess the civil penalty in an order which states the reasons for the assessment of the civil penalty, the factors used to determine its assessment and the amount of the penalty.- The order may not be imposed solely upon the recommendation of an agent of the department.- All orders shall be reviewed by the department's legal staff before being imposed.

~~(3)~~ Prior to the department's assessment of a civil penalty, a program determined by an agent of the department to be in violation of these rules may be prescribed a plan of corrective action. Failure to follow a plan of corrective action as prescribed by the department may result in the assessment of a civil penalty.

~~(4)~~ Definitions.

~~(a)~~ "Negligence" is the failure of a child care program, owner, staff, auxiliary staff, director or other employees to comply with the duties or standards imposed by these rules, federal,

(Rule 0520-12-01-16, continued)

state and local laws, or the standards of care generally required of school-administered child care programs.

(b) "Intentional disregard" is the knowing forbearance of a child care program, owner, staff, auxiliary staff, director or other employees to comply with the duties or standards imposed by these rules, federal, state and local laws, or the standards of care generally required of school-administered child care programs.

(c) "Plan of corrective action" is a plan which provides a schedule for the completion of work to bring a program into compliance with these rules, federal, state and local laws, or the standards of care required of school-administered child care programs. The plan must include specific strategies to be implemented in program design during the completion of the work. The plan must ensure that children will not be placed in danger due to the program area which is not in compliance and it must ensure that children will not be placed in danger by the work being done to bring the area into compliance.

(5) Civil Penalties Schedule.

(a) Major Violations.

1. For any violation of a law or regulation that, due to negligence or intentional disregard of a law or regulation, results in serious injury to, or death of, a child, the Department may assess a civil penalty in a range from seven hundred fifty dollars (\$750.00) up to one thousand dollars (\$1,000.00). The Department shall determine the amount of the penalty based upon the extent of the injury to the child and whether the injury or death of the child was the result of negligence or intentional disregard of the law or regulation. Consideration of the program's history of prior violations shall also be a factor in the determination of the amount of the civil penalty.

2. For any violation of a law or regulation that, due to negligence or intentional disregard of a law or regulation, results in an injury to a child, the Department may assess a civil penalty in a range from three hundred dollars (\$300.00) up to five hundred dollars (\$500.00). The Department shall determine the amount of the penalty based upon the extent of the injury and whether the injury to the child was the result of negligence or intentional disregard of the regulation. Consideration of the program's history of prior violations shall also be a factor in the determination of the amount of the civil penalty.

3. For violations of the following categories of regulations the Department may impose a civil penalty of two hundred dollars (\$200.00) for the first violation, three hundred dollars (\$300.00) for the second violation, and four hundred dollars (\$400.00) for the third and any subsequent such violation:

(i) Failure to follow any regulation related to organization, ownership and administration of a program pursuant to Section 0520-12-01-06 of these rules;

(ii) Failure to follow any regulation related to health and safety pursuant to Section 0520-12-01-10 of these rules;

STANDARDS FOR CHILD CARE CENTERS AND SCHOOL ADMINISTERED AGE CHAPTER
0520-12-01 CHILD CARE PROGRAMS CHAPTER

(Rule 0520-12-01-.16, continued)

- (iii) Failure to follow any regulation related to food, nutritional needs and meal service pursuant to Section 0520-12-01-.11 of these rules;
- (iv) Failure to follow any regulation related to maintenance of equipment pursuant to Section 0520-12-01-.08 of these rules;
- (v) Failure to follow any regulation related to maintenance of physical facilities pursuant to Section 0520-12-01-.12 of these rules;
- (vi) Failure to follow any regulation related to adult: child ratios pursuant to Section 0520-12-01-.06 of these rules;
- (vii) Failure to follow any regulation related to supervision of children pursuant to Section 0520-12-01-.06 of these rules;
- (viii) Failure to follow any regulation related to dispensing or storing medications pursuant to Section 0520-12-01-.10 of these rules;
- (ix) Failure to follow any regulation related to care of children with special needs pursuant to Section 0520-12-01-.14 of these rules;
- (x) Failure to follow any regulation related to program staff pursuant to Section 0520-12-01-.07 of these rules;
- (xi) Failure to properly store hazardous items such as, but not limited to, cleaning products, pesticides, hazardous chemicals, or other poisonous items pursuant to Section 0520-12-01-.10 of these rules;
- (xii) Failure to properly remove or secure firearms within the physical facility and under the ownership or control of the program, or its staff or other persons permitted access to the children, or failure to prevent exposure of children in the program's care to firearms which are under the control of the program, or its staff, or other persons who have been permitted by the program to have access to the children pursuant to Section 0520-12-01-.10 of these rules; or
- (xiii) Failure to follow or failure to complete a plan of corrective action.

(b) Minor Violations.

1. A minor violation shall be any violation of a law or regulation not described as a major violation in part (a).
2. Each minor violation may require the program to complete a corrective action plan and may subject the program subject the program to the proscription of a corrective action plan by the Department or to a civil penalty of fifty dollars (\$50.00).
3. The existence of six (6) or more minor violations of any type in any period of twelve (12) months shall constitute a major violation and may be subject to a civil penalty imposed by the Department of two hundred dollars (\$200.00) in addition to the

STANDARDS FOR CHILD CARE CENTERS AND SCHOOL-ADMINISTERED AGE CHAPTER
0520-12-01 CHILD CARE PROGRAMS CHAPTER

(Rule 0520-12-01-.16, continued)

penalty for each minor violation. -Three (3) or more minor violations of the same regulation in any period of twelve (12) months shall constitute a major violation and may be subject to a civil penalty imposed by the Department of two hundred dollars (\$200.00) in addition to the penalty for each minor violation.

~~(5) Upon timely notice of a request for an appeal pursuant to T.C.A. § 49-1-1107(c)(5), the Department shall appoint a hearing officer to conduct the appeal proceedings before the council. The hearing officer shall have the authority of an Administrative Law Judge of the~~

~~(6) Department of State and shall conduct the appeal process pursuant to the rules of procedure for hearing contested cases as provided in Chapter 1360-04-01 of the Rules and Regulations of the Tennessee Department of State.~~

(6) Upon timely notice of a request for an appeal pursuant to T.C.A. § 49-1-1107(c)(5), the Department shall appoint a hearing officer to conduct the appeal proceedings before the council. The hearing officer shall have the authority of an Administrative Law Judge of the Department of State and shall conduct the appeal process pursuant to the rules of procedure for hearing contested cases as provided by the Tennessee Secretary of State.

Authority: T.C.A. §§ 49-1-302 and 49-1-1107(c)(2). **Administrative History:**- Original rule filed March 15, 2010; effective August 29, 2010.

* If a roll-call vote was necessary, the vote by the Agency on these rules was as follows:

Board Member	Aye	No	Abstain	Absent	Signature (if required)
Chancey	X				
Cook	X				
Edwards	X				
Ferguson				X	
Hartgrove	X				
Kim	X				
Rolston	X				
Tucker	X				

I certify that this is an accurate and complete copy of proposed rules, lawfully promulgated and adopted by the Tennessee State Board of Education (board/commission/other authority) on 05/24/2017 (date as mm/dd/yyyy), and is in compliance with the provisions of T.C.A. § 4-5-222. The Secretary of State is hereby instructed that, in the absence of a petition for proposed rules being filed under the conditions set out herein and in the locations described, he is to treat the proposed rules as being placed on file in his office as rules at the expiration of sixty (60) days of the first day of the month subsequent to the filing of the proposed rule with the Secretary of State.

Date: 10/23/17

Signature: [Handwritten Signature]

Name of Officer: Elizabeth Taylor

Title of Officer: General Counsel

Subscribed and sworn to before me on: 10-23-17

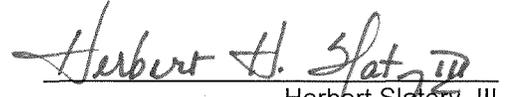
Notary Public Signature: [Handwritten Signature]

My commission expires on: 3-8-21



State Board of Education Rules Chapter 0520-12-01 – Standards for Child Care Centers and School Age Child Care Programs
Rules 0520-12-01-.01 through 0520-12-01-.16

All proposed rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.


Herbert Slatery, III
Attorney General and Reporter
10/21/2017 Date

Department of State Use Only

Filed with the Department of State on: 11/2/17

Effective on: 2/1/18


Tre Hargett
Secretary of State

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G.O.C. STAFF RULE ABSTRACT

DEPARTMENT: Labor and Workforce Development

DIVISION: Bureau of Workers' Compensation

SUBJECT: Workers' Compensation Appeals Board

STATUTORY AUTHORITY: Tennessee Code Annotated, Sections 50-6-217 and 50-6-218

EFFECTIVE DATES: February 5, 2018 through June 30, 2018

FISCAL IMPACT: Minimal

STAFF RULE ABSTRACT: These rules establish the guidelines and procedures for appealing a determination from the Court of Workers' Compensation Claims to the Workers' Compensation Appeals Board.

Public Hearing Comments

One copy of a document containing responses to comments made at the public hearing must accompany the filing pursuant to T.C.A. § 4-5-222. Agencies shall include only their responses to public hearing comments, which can be summarized. No letters of inquiry from parties questioning the rule will be accepted. When no comments are received at the public hearing, the agency need only draft a memorandum stating such and include it with the Rulemaking Hearing Rule filing. Minutes of the meeting will not be accepted. Transcripts are not acceptable.

PUBLIC COMMENTS AND RESPONSES

Comment: In 0800-02-22-.02 Appeal of an Interlocutory Order, paragraph 1, sentence 3 should reference a "joint" statement of the evidence.

Response: The bureau disagrees. This sentence as drafted has a provision for a joint statement of the evidence.

Comment: In 0800-02-22-.02(1) and .03(1), there is no means to resolve a dispute concerning the contents of the record, only a dispute regarding the joint statement of the evidence.

Response: The bureau agrees with the comment and changes were made to address this comment.

Regulatory Flexibility Addendum

Pursuant to T.C.A. §§ 4-5-401 through 4-5-404, prior to initiating the rulemaking process as described in T.C.A. § 4-5-202(a)(3) and T.C.A. § 4-5-202(a), all agencies shall conduct a review of whether a proposed rule or rule affects small businesses.

1. The type or types of small business and an identification and estimate of the number of small businesses subject to the proposed rule that would bear the cost of, or directly benefit from the proposed rule: The amended rules will affect small employers that fall under the Tennessee Workers' Compensation Laws, which would be employers with at least five employees, or for those in the construction industry at least one employee. There should be no additional costs associated with these rule changes.
2. The projected reporting, recordkeeping and other administrative costs required for compliance with the proposed rule, including the type of professional skills necessary for preparation of the report or record. There is no additional record keeping requirement or administrative cost associated with these rule changes.
3. A statement of the probable effect on impacted small businesses and consumers: These rules should not have any impact on consumers or small businesses.
4. A description of any less burdensome, less intrusive or less costly alternative methods of achieving the purpose and objectives of the proposed rule that may exist, and to what extent the alternative means might be less burdensome to small business: There are no less burdensome methods to achieve the purposes and objectives of these rules.
5. Comparison of the proposed rule with any federal or state counterparts: None.
6. Analysis of the effect of the possible exemption of small businesses from all or any part of the requirements contained in the proposed rule: Exempting small businesses could frustrate the small business owners' access to the services provided by the Bureau of Workers' Compensation and timely medical treatment for injured workers, which would be counter-productive.

Impact on Local Governments

Pursuant to T.C.A. §§ 4-5-220 and 4-5-228 "any rule proposed to be promulgated shall state in a simple declarative sentence, without additional comments on the merits of the policy of the rules or regulation, whether the rule or regulation may have a projected impact on local governments." (See Public Chapter Number 1070 (<http://state.tn.us/sos/acts/106/pub/pc1070.pdf>) of the 2010 Session of the General Assembly)

These proposed rules will have little, if any, impact on local governments.

Additional Information Required by Joint Government Operations Committee

All agencies, upon filing a rule, must also submit the following pursuant to T.C.A. § 4-5-226(i)(1).

- (A) A brief summary of the rule and a description of all relevant changes in previous regulations effectuated by such rule;

These rules establish the guidelines and procedures for appealing a determination from the Court of Workers' Compensation Claims to the Workers' Compensation Appeals Board.

- (B) A citation to and brief description of any federal law or regulation or any state law or regulation mandating promulgation of such rule or establishing guidelines relevant thereto;

T.C.A. § 50-6-217 and 50-6-218 establish the Workers' Compensation Appeals Board and provide guidelines for the Appeals Board.

- (C) Identification of persons, organizations, corporations or governmental entities most directly affected by this rule, and whether those persons, organizations, corporations or governmental entities urge adoption or rejection of this rule;

All parties to a workers' compensation claim will be affected by the adoption or rejection of these rules.

- (D) Identification of any opinions of the attorney general and reporter or any judicial ruling that directly relates to the rule;

None

- (E) An estimate of the probable increase or decrease in state and local government revenues and expenditures, if any, resulting from the promulgation of this rule, and assumptions and reasoning upon which the estimate is based. An agency shall not state that the fiscal impact is minimal if the fiscal impact is more than two percent (2%) of the agency's annual budget or five hundred thousand dollars (\$500,000), whichever is less;

The overall effect will have little fiscal impact upon state or local government.

- (F) Identification of the appropriate agency representative or representatives, possessing substantial knowledge and understanding of the rule;

Troy Haley, Legislative Liaison and Director of Administrative Legal Services

- (G) Identification of the appropriate agency representative or representatives who will explain the rule at a scheduled meeting of the committees;

Troy Haley, Legislative Liaison and Director of Administrative Legal Services

- (H) Office address, telephone number, and email address of the agency representative or representatives who will explain the rule at a scheduled meeting of the committees; and

Tennessee Bureau of Workers' Compensation
220 French Landing Drive, 1-B
Nashville, TN 37243
(615) 532-0179
Attn: Troy Haley (troy.haley@tn.gov)

- (I) Any additional information relevant to the rule proposed for continuation that the committee requests.

None

**Department of State
Division of Publications**

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Nashville, TN 37243
Phone: 615-741-2650
Fax: 615-741-5133
Email: register.information@tn.gov

For Department of State Use Only

Sequence Number: 11-08-17
Rule ID(s): 6645
File Date: 11/7/17
Effective Date: 2/5/18

Rulemaking Hearing Rule(s) Filing Form

Hearings will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, T.C.A. § 4-5-204. For questions and copies of the notice, contact the person listed below.

Agency/Board/Commission:	Tennessee Department of Labor and Workforce Development
Division:	Bureau of Workers' Compensation
Contact Person:	Troy Haley
Address:	220 French Landing Drive 1-B
Phone:	615-532-0179
Email:	troy.haley@tn.gov

Any Individuals with disabilities who wish to participate in these proceedings (to review these filings) and may require aid to facilitate such participation should contact the following at least 10 days prior to the hearing:

ADA Contact:	Troy Haley
Address:	220 French Landing Drive 1-B
Phone:	615-532-0179
Email:	troy.haley@tn.gov

Revision Type (check all that apply):

- Amendment
 New
 Repeal

Rule(s) (ALL chapters and rules contained in filing must be listed. If needed, copy and paste additional tables to accommodate more than one chapter. Please enter only **ONE** Rule Number/Rule Title per row.)

Chapter Number	Chapter Title
0800-02-22	Workers' Compensation Appeals Board
Rule Number	Rule Title
0800-02-22-.01	Filing of Notice of Appeal
0800-02-22-.02	Appeal of an Interlocutory Order
0800-02-22-.03	Appeal of a Compensation Order
0800-02-22-.04	Oral Argument; Costs on Appeal; Settlement During Appeal
0800-02-22-.05	Appeal of Workers' Compensation Cases Filed Against the State

Chapter 0800-22-01 Workers' Compensation Appeals Board is amended by deleting the prior rule and replacing it with the following:

0800-02-22-.01 Filing of Notice of Appeal

**RULES
OF THE
TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT**

**CHAPTER 0800-02-22
WORKERS' COMPENSATION APPEALS BOARD**

TABLE OF CONTENTS

0800-02-22-.01	Filing of Notice of Appeal	0800-02-22-.05	Appeal of Workers' Compensation Cases Filed Against the State
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0800-02-22-.04	Oral Argument; Costs on Appeal; Settlement During Appeal		

0800-02-22-.01 FILING OF NOTICE OF APPEAL.

- (1) Any party may appeal any order of a workers' compensation judge by filing a notice of appeal, on a form approved by the Division Bureau, with the clerk of the court of workers' compensation claims, in accordance with Rule 0800-02-21-.02(14). Pursuant to Tennessee Code Annotated section 50-6-217(a)(2), the notice of appeal must be filed:
 - (a) Within seven (7) business days of the date an interlocutory order was entered filed by the workers' compensation judge; or
 - (b) Within thirty (30) calendar days of the date a compensation order was entered filed by the workers' compensation judge.
- (2) The appealing party shall serve a copy of the Notice of Appeal upon the opposing party or parties by any means as set forth in Rule 0800-02-21-.09.
- (3) Any notice of appeal that is not received by the clerk of the court of workers' compensation claims within the time provided by paragraph (1) shall be dismissed.
- (4) ~~A notice of appeal of a compensation order that is not timely filed will not toll the time limit for filing an appeal to the Supreme Court pursuant to Tennessee Code Annotated section 50-6-225(a)(1) and Rule 4(a) of the Tennessee Rules of Appellate Procedure. Upon the filing of a notice of appeal, the court of workers' compensation claims no longer has jurisdiction over the case, absent a remand, until a decision is filed by the appeals board; except, after a notice of appeal has been filed, the court of workers' compensation claims retains jurisdiction to rule on motions in accordance with these rules or any applicable rule of the Tennessee Rules of Civil Procedure.~~

Authority: T.C.A. §§ 4-3-1409; 50-6-217; 50-6-225; 50-6-233; and 50-6-237. **Administrative History:** Original rule filed April 1, 2014; effective June 30, 2014. Repeal and new rule filed June 22, 2015; effective September 20, 2015.

0800-02-22-.02 APPEAL OF AN INTERLOCUTORY ORDER.

- (1) ~~If the appellant elects to file a position statement in support of an interlocutory appeal, the appellant shall file such position statement with the clerk of the court of workers' compensation claims within five (5) business days of the expiration of the time to file a transcript or statement of the evidence, specifying the issues presented for review and including any argument in support thereof. A party opposing the appeal shall file a response, if any, with the clerk of the court of workers' compensation claims within five (5) business days of the filing of the appellant's position statement. The parties to an appeal have the responsibility to ensure a complete record on appeal. A party or parties may have a transcript of any hearing pertinent to the appeal prepared by a licensed court reporter and filed with the clerk of the court of workers' compensation claims within ten (10) business days~~

of the filing of the notice of appeal. Alternatively, the parties may file a joint statement of the evidence within ten (10) business days of the filing of the notice of appeal. The joint statement of the evidence must be approved by the workers' compensation judge before the record is submitted to the workers' compensation appeals board. Should there be a dispute between the parties regarding the contents of a joint statement of the evidence or the contents of the record on appeal, the parties shall file a motion with the court of workers' compensation claims within ten (10) business days of the filing of the notice of appeal asking the trial court to resolve any such disputes. If necessary, the appeals board may direct that a supplemental record be submitted to the appeals board.

~~(2) The parties, having the responsibility to ensure a complete record on appeal, may have a transcript prepared by a licensed court reporter and file it with the clerk of the court of workers' compensation claims within ten (10) calendar days of the filing of the notice of appeal. Alternatively, the parties may file a statement of the evidence within ten (10) calendar days of the filing of the notice of appeal. The statement of the evidence must be~~

(Rule 0800-02-22-.02, continued)

approved by the judge before the record is submitted to the clerk of the appeals board. The clerk of the workers' compensation appeals board shall docket the appeal upon receipt of the record from the clerk of the court of workers' compensation claims and send a docketing notice to all parties. The appellant shall file a brief or position statement with the clerk of the court of workers' compensation claims within ten (10) business days of the expiration of the time to file a transcript or statement of the evidence, or within ten (10) business days of the date the trial court enters an order resolving any dispute concerning the contents of the record or a joint statement of the evidence, whichever is later. The brief shall specify the issues presented for review and include any argument in support thereof. A party opposing the appeal shall file a brief in response with the clerk of the court of workers' compensation claims within ten (10) business days of the filing of the appellant's brief or the expiration of the time for the filing of the appellant's brief, whichever is earlier. Briefs shall comply with the Practices and Procedures of the Workers' Compensation Appeals Board.

- (3) ~~Within seven (7) business days of the receipt of the record on appeal by the clerk of the workers' compensation appeals board, the appeals board shall review the record and enter an order affirming, reversing, or modifying and remanding the interlocutory order of the workers' compensation judge. The order of the workers' compensation appeals board shall not be subject to further appeal. The clerk of the workers' compensation appeals board shall docket the appeal upon receipt of the record from the clerk of the court of workers' compensation claims and send a docketing notice to all parties.~~
- (a) ~~If the appeals board affirms an interlocutory order awarding temporary disability or medical benefits, the employer shall begin making payments of benefits within five (5) business days from the date the order affirming the interlocutory order is issued by the appeals board. Failure to begin benefit payments within five (5) business days may result in the assessment of a civil penalty pursuant to Tennessee Code Annotated section 50-6-118.~~
- (b) ~~Following the issuance of a decision affirming, reversing, or modifying and remanding an interlocutory order of temporary disability benefits, the claim shall continue in the manner provided by Tennessee Code Annotated section 50-6-239 and by these rules.~~
- (4) ~~If the appeals board affirms an interlocutory order awarding temporary disability or medical benefits, the employer shall begin making payments of benefits within five (5) business days from the date the decision affirming the interlocutory order is filed by the appeals board. Failure to begin benefit payments within five (5) business days may result in the assessment of a civil penalty pursuant to Tennessee Code Annotated section 50-6-118.~~
- (5) ~~Upon the filing of a decision on an interlocutory appeal, the clerk of the workers' compensation appeals board shall forward a copy of the decision to the parties by regular or electronic mail and to the clerk of the court of workers' compensation claims.~~
- (6) ~~Following the filing of a decision affirming, reversing, and/or modifying and remanding an interlocutory order, the claim shall continue in the manner provided by Tennessee Code Annotated section 50-6-239 and by these rules.~~

Authority: T.C.A. §§ 4-3-1409; 50-6-118; 50-6-217; 50-6-225; 50-6-233; and 50-6-237. **Administrative History:** Original rule filed April 1, 2014; effective June 30, 2014. Repeal and new rule filed June 22, 2015; effective September 20, 2015.

0800-02-22-.03 APPEAL OF A COMPENSATION ORDER.

- (1) ~~Upon the filing of a notice of appeal of a compensation order, within fifteen (15) calendar days, the party that filed the notice of appeal shall file with the clerk of the court of workers' compensation claims a copy of the transcript of the proceedings before the workers' compensation court or shall file notice that no transcript will be provided. The appealing party shall serve a copy of this transcript or notice upon the opposing party or parties. The party may file a statement of the evidence in lieu of a transcript.~~

- ~~(2) Upon receipt of the transcript of the proceedings, statement of the evidence, or notice that no transcript will be filed, the clerk of the court of workers' compensation claims shall forward a copy of the notice of appeal and the transcript or statement of the evidence, if any, or notice that no transcript will be filed, to the workers' compensation judge that issued the order.~~
- ~~(3) Within ten (10) business days after receiving a copy of the notice of appeal and the transcript, or statement of the evidence, if any, or the notice that no transcript will be provided, the workers' compensation judge shall review the record in its entirety to ensure that it is complete and that it accurately reflects the proceedings at the hearing, and shall compile the contents of the record and forward the record to the clerk of the court of workers' compensation claims.~~
- ~~(4) If a transcript or statement of the evidence is not timely filed, the workers' compensation judge may certify the record or proceedings if the judge believes that the record provides an accurate reflection of the proceedings that occurred at trial. If the judge determines that the record cannot be certified, the workers' compensation judge shall issue an order compelling the party who filed the notice of appeal to file a transcript, a statement of the evidence, or take such other action as is necessary for the trial judge to certify the record.~~
- (1) The parties to an appeal have the responsibility to ensure a complete record on appeal. A party or parties may have a transcript of any hearing pertinent to the appeal prepared by a licensed court reporter and filed with the clerk of the court of workers' compensation claims within fifteen (15) calendar days of the filing of the notice of appeal. Alternatively, the parties may file a joint statement of the evidence within fifteen (15) calendar days of the filing of the notice of appeal, or a notice that no transcript or statement of the evidence will be filed. A joint statement of the evidence must be approved by the workers' compensation judge before the record is submitted to the workers' compensation appeals board. Should there be a dispute between the parties regarding the contents of a joint statement of the evidence or the contents of the record on appeal, the parties shall file a motion with the court of workers' compensation claims within fifteen (15) business days of the filing of the notice of appeal asking the trial court to resolve any such disputes. If necessary, the appeals board may direct that a supplemental record be submitted to the appeals board.
- (2) The clerk of the workers' compensation appeals board shall docket the appeal upon receipt of the record from the clerk of the court of workers' compensation claims and send a docketing notice to all parties.
- (3) The appellant shall file a brief within fifteen (15) calendar days after the issuance of the docketing notice with the clerk of the appeals board. Any opposing party shall have fifteen (15) calendar days after the filing of the appellant's brief or the expiration of the time for the filing of the appellant's brief, whichever is earlier, to file a brief with the clerk of the appeals board. No reply brief shall be filed unless the appellee raises an issue or issues on appeal not previously addressed in the appellant's brief. Under such circumstances, the appellant may file a reply brief addressing only the issue or issues not previously addressed. Briefs shall comply with the Practices and Procedures of the Workers' Compensation Appeals Board.
- (4) Upon the filing of a decision on a compensation appeal, the clerk of the workers' compensation appeals board shall forward a copy of the decision to the parties by regular or electronic mail and to the clerk of the court of workers' compensation claims.

(Rule 0800-02-22-.03, continued)

- (5) ~~Upon receipt of the record, the clerk of the workers' compensation appeals board shall docket the appeal and shall send a docketing notice to all parties. The clerk of the appeals board shall forward the record to the appeals board for review.~~
- (6) ~~The party who filed the notice of appeal shall have fifteen (15) calendar days after the issuance of the docketing notice provided in paragraph (5) to submit a brief to the appeals board for consideration. Any opposing party shall have fifteen (15) calendar days after the filing of the appellant's brief to file a brief in response. No reply briefs shall be filed. Briefs shall comply with the Practice and Procedure Guidelines of the Workers' Compensation Appeals Board.~~
- (7) ~~Within forty-five (45) calendar days after the period for the filing of briefs ends, the board shall issue its decision affirming, reversing or modifying the order of the workers' compensation judge and shall remand the case for further proceedings.~~
- (a) ~~If the appeals board reverses or modifies and remands the case following an appeal of a compensation order, the clerk of the court of workers' compensation claims shall send a docketing notice to the parties, by regular or electronic mail, setting forth the procedure for preparing for and scheduling any hearing, if necessary. The clerk shall also return the record to the previously assigned judge, unless otherwise directed by the Chief Judge.~~
- (b) ~~If the appeals board affirms and certifies a compensation order as final, the time for filing an appeal to the supreme court pursuant to Tennessee Code Annotated section 50-6-225 shall begin to run on the date the order is certified as final by the appeals board. If no further appeal is filed, the compensation order shall become final and binding in thirty (30) calendar days after the decision of the appeals board is filed and any benefits provided through the compensation order shall be paid within five (5) business days after the compensation order becomes final.~~
- (8) ~~Immediately upon the issuance of a decision on any appeal, the clerk of the workers' compensation appeals board shall forward a copy of the decision to the parties by regular or electronic mail and to the clerk of the court of workers' compensation claims.~~

Authority: T.C.A. §§ 4-3-1409; 50-6-217; 50-6-225; 50-6-233; and 50-6-237. **Administrative History:** Original rule filed April 1, 2014; effective June 30, 2014. Repeal and new rule filed June 22, 2015; effective September 20, 2015.

0800-02-22-.04 ORAL ARGUMENT, COSTS ON APPEAL, SETTLEMENT DURING APPEAL.

- (1) ~~The appeals board shall base its decision on a review of the record and the briefs or responses of the parties, if any. Evidence not contained in the record submitted to the clerk of the workers' compensation appeals board shall not be considered on appeal. No oral argument shall be allowed unless otherwise directed by the workers' compensation appeals board either upon its own motion or upon motion of a party. Any motion for oral argument filed by a party must state with specificity the reason or reasons the decision-making process would be aided by oral argument. Oral argument may be conducted telephonically, by video conference, or in person, at the direction of the appeals board.~~
- (2) ~~No request to rehear or reconsider the decision of the appeals board may be filed by any party.~~
- (3) ~~Costs on appeal may be assessed as ordered by the appeals board.~~
- (4) ~~If the parties agree to settle the claim following the filing of the notice of appeal, the parties shall file a joint motion requesting the appeal be held in abeyance and the case be remanded~~

(Rule 0800-02-22-.04, continued)

~~to the workers' compensation judge to consider approval of the settlement. If the settlement is approved within thirty (30) calendar days of the filing of the order remanding the case, the parties shall file a joint motion seeking to dismiss the appeal. The motion shall provide for the assessment of costs on appeal and shall be accompanied by a copy of the order approving the settlement. If the proposed settlement is not approved within thirty (30) calendar days of the filing of the order remanding the case, the appeal shall proceed in accordance with any further order of the appeals board.~~

- ~~(5) Once a notice of appeal has been filed with the state supreme court, the appeals board no longer has jurisdiction to rule on any issue. The clerk of the appeals board may not accept for filing any motion or other paper sought to be filed by any party following the filing of a notice of appeal to the state supreme court, unless and until the case is remanded to the workers' compensation trial court.~~
- ~~(6) When it appears to the appeals board that an appeal was frivolous or taken solely for delay, the appeals board may, either upon motion of a party or of its own motion, award expenses, including reasonable attorney's fees, incurred by the appellee as a result of the appeal.~~
- (1) The appeals board shall base its decision on the record on appeal and the arguments of the parties. Evidence not contained in the record on appeal shall not be considered. Oral argument shall be allowed only upon motion of a party or by order of the appeals board. Any motion for oral argument filed by a party must state with specificity the reason or reasons the decision-making process would be aided by oral argument. Oral argument may be conducted telephonically, by video conference, or in person, at the direction of the appeals board.
- (2) No request to rehear or reconsider the decision of the appeals board will be granted.
- (3) Costs on appeal may be assessed as ordered by the appeals board. If an appeal is dismissed, costs shall be taxed against the appellant unless otherwise agreed by the parties or ordered by the appeals board; if a judgment or order is affirmed, costs shall be taxed against the appellant unless otherwise ordered; if a judgment or order is reversed, costs shall be taxed against the appellee unless otherwise ordered; if a judgment is affirmed or reversed in part, or is vacated or modified, costs shall be allowed as ordered by the appeals board. Costs on appeal may include filing fees and costs associated with ensuring a complete record on appeal, among other necessary and reasonable costs.
- (4) If the parties agree to settle the claim following the filing of the notice of appeal, the parties shall file a joint motion requesting the appeal be held in abeyance and the case be remanded to the workers' compensation judge to consider approval of the settlement. If the settlement is approved within thirty (30) calendar days of the filing of the order remanding the case, the parties shall file a joint motion seeking to dismiss the appeal. The motion shall provide for the assessment of costs on appeal and shall be accompanied by a copy of the order approving the settlement. If the proposed settlement is not approved within thirty (30) calendar days of the filing of the order remanding the case, the appeal shall proceed in accordance with any further order of the appeals board.
- (5) Once a notice of appeal has been filed with the state supreme court, the appeals board no longer has jurisdiction to rule on any issue absent a remand.
- (6) When it appears to the appeals board that an appeal was frivolous or taken solely for delay, the appeals board may, either upon motion of a party or of its own motion, award expenses, including reasonable attorney's fees, incurred by the appellee as a result of the appeal.

Authority: T.C.A. §§ 4-3-1409; 50-6-217; 50-6-225; 50-6-233; and 50-6-237. **Administrative History:**

(Rule 0800-02-22-.04, continued)

Original rule filed June 22, 2015; effective September 20, 2015.

0800-02-22-.05 APPEAL OF WORKERS' COMPENSATION CASES FILED AGAINST THE STATE.

The workers' compensation appeals board is without jurisdiction to consider an appeal of any decision of the claims commission either awarding or denying workers' compensation benefits to a state employee.

Authority: T.C.A. §§ 4-3-1409, 9-8-307, 9-8-402; 50-6-217; 50-6-233; and 50-6-237.

Administrative

History: *Original rule filed June 22, 2015; effective September 20, 2015.*

* If a roll-call vote was necessary, the vote by the Agency on these rules was as follows:

Board Member	Aye	No	Abstain	Absent	Signature (if required)

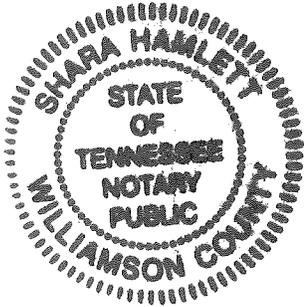
I certify that this is an accurate and complete copy of rulemaking hearing rules, lawfully promulgated and adopted by the Tennessee Bureau of Workers' Compensation on 9/8/2017 and is in compliance with the provisions of T.C.A. § 4-5-222.

I further certify the following:

Notice of Rulemaking Hearing filed with the Department of State on June 12, 2017.

Rulemaking Hearing Conducted on August 16, 2017.

Date: September 8, 2017
 Signature: Abbie Hudgens
 Name of Officer: Abbie Hudgens
 Title of Officer: Administrator, Bureau of Workers' Compensation
 Subscribed and sworn to before me on: September 8, 2017
 Notary Public Signature: [Signature]
 My commission expires on: 2/19/20



All proposed rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

Herbert H. Slatery III
 Herbert H. Slatery III
 Attorney General and Reporter
 Date 10/31/2017

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Filed with the Department of State on: 11/7/17
 Effective on: 2/5/18

[Signature]
 Tre Hargett
 Secretary of State

G.O.C. STAFF RULE ABSTRACT

DEPARTMENT: Labor and Workforce Development

DIVISION: Bureau of Workers' Compensation

SUBJECT: Workers' Compensation Medical Treatment Guidelines

STATUTORY AUTHORITY: None

EFFECTIVE DATES: February 5, 2018 through June 30, 2018

FISCAL IMPACT: None

STAFF RULE ABSTRACT: The change to the rule will allow the Administrator to seek the evaluation of the adopted guideline and drug formulary, and any updates, by the bureau Medical Director and Medical Advisory Committee for recommendation by the committee.

Regulatory Flexibility Addendum

Pursuant to T.C.A. §§ 4-5-401 through 4-5-404, prior to initiating the rule making process as described in T.C.A. § 4-5-202(a)(3) and T.C.A. § 4-5-202(a), all agencies shall conduct a review of whether a proposed rule or rule affects small businesses.

1. The type or types of small business and an identification and estimate of the number of small businesses subject to the proposed rule that would bear the cost of, or directly benefit from the proposed rule: The rule will affect small employers that fall under the Tennessee Workers' Compensation Laws, which would be employers with at least five employees, or for those in the construction industry at least one employee. There should be no additional costs associated with these rule changes.
2. The projected reporting, recordkeeping and other administrative costs required for compliance with the proposed rule, including the type of professional skills necessary for preparation of the report or record: There is no additional record keeping requirement or administrative cost associated with these rule changes.
3. A statement of the probable effect on impacted small businesses and consumers: These rules should not have any impact on consumers or small businesses.
4. A description of any less burdensome, less intrusive or less costly alternative methods of achieving the purpose and objectives of the proposed rule that may exist, and to what extent the alternative means might be less burdensome to small business: There are no less burdensome methods to achieve the purposes and objectives of these rules.
5. Comparison of the proposed rule with any federal or state counterparts: None.
6. Analysis of the effect of the possible exemption of small businesses from all or any part of the requirements contained in the proposed rule: None.

Impact on Local Governments

Pursuant to T.C.A. §§ 4-5-220 and 4-5-228 "any rule proposed to be promulgated shall state in a simple declarative sentence, without additional comments on the merits of the policy of the rules or regulation, whether the rule or regulation may have a projected impact on local governments." (See Public Chapter Number 1070 (<http://state.tn.us/sos/acts/106/pub/pc1070.pdf>) of the 2010 Session of the General Assembly)

This proposed rule will have little, if any, impact on these entities.

Additional Information Required by Joint Government Operations Committee

All agencies, upon filing a rule, must also submit the following pursuant to T.C.A. § 4-5-226(i)(1).

- (A)** A brief summary of the rule and a description of all relevant changes in previous regulations effectuated by such rule;

The change to the rule will allow the Administrator to seek the evaluation of the adopted guideline and drug formulary, and any updates, by the bureau Medical Director and Medical Advisory Committee for recommendation by the committee.

- (B)** A citation to and brief description of any federal law or regulation or any state law or regulation mandating promulgation of such rule or establishing guidelines relevant thereto;

This change is made for the purpose of clarifying the input of the bureau Medical Director and Medical Advisory Committee to the Administrator regarding updates to the treatment guidelines and drug formulary.

- (C)** Identification of persons, organizations, corporations or governmental entities most directly affected by this rule, and whether those persons, organizations, corporations or governmental entities urge adoption or rejection of this rule;

Medical providers and patients may be affected by the medical treatment guidelines and drug formulary. No entity has urged adoption or rejection of these rules.

Identification of any opinions of the attorney general and reporter or any judicial ruling that directly relates to the rule;

None

- (D)** An estimate of the probable increase or decrease in state and local government revenues and expenditures, if any, resulting from the promulgation of this rule, and assumptions and reasoning upon which the estimate is based. An agency shall not state that the fiscal impact is minimal if the fiscal impact is more than two percent (2%) of the agency's annual budget or five hundred thousand dollars (\$500,000), whichever is less;

The effect of the rule change will be negligible.

- (E)** Identification of the appropriate agency representative or representatives, possessing substantial knowledge and understanding of the rule;

Troy Haley, Director of Administrative Legal Services and Legislative Liaison

- (F)** Identification of the appropriate agency representative or representatives who will explain the rule at a scheduled meeting of the committees;

Troy Haley, Director of Administrative Legal Services and Legislative Liaison

- (G)** Office address, telephone number, and email address of the agency representative or representatives who will explain the rule at a scheduled meeting of the committees; and

Tennessee Bureau of Workers' Compensation
220 French Landing Drive
Floor 1-B
(615) 532-0179
troy.haley@tn.gov

- (H)** Any additional information relevant to the rule proposed for continuation that the committee requests.

None

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For Department of State Use Only

Sequence Number: 11-09-17
Rule ID(s): 6646
File Date: 11/7/17
Effective Date: 2/5/18

Proposed Rule(s) Filing Form

Proposed rules are submitted pursuant to T.C.A. §§ 4-5-202, 4-5-207 in lieu of a rulemaking hearing. It is the intent of the Agency to promulgate these rules without a rulemaking hearing unless a petition requesting such hearing is filed within sixty (60) days of the first day of the month subsequent to the filing of the proposed rule with the Secretary of State. To be effective, the petition must be filed with the Agency and 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. The agency shall forward such petition to the Secretary of State.

Agency/Board/Commission:	Department of Labor and Workforce Development
Division:	Bureau of Workers' Compensation
Contact Person:	Troy Haley
Address:	220 French Landing Drive Side 1-B, Nashville, Tennessee
Zip:	37243
Phone:	(615) 532-0179
Email:	troy.haley@tn.gov

Revision Type (check all that apply):

- Amendment
 New
 Repeal

Rule(s) Revised (ALL chapters and rules contained in filing must be listed here. If needed, copy and paste additional tables to accommodate multiple chapters. Please enter only ONE Rule Number/Rule Title per row)

Chapter Number	Chapter Title
0800-02-25	Workers' Compensation Medical Treatment Guidelines
Rule Number	Rule Title
0800-02-25-.03	Treatment Guidelines
0800-02-25-.04	Drug Formulary

(Place substance of rules and other info here. Statutory authority must be given for each rule change. For information on formatting rules go to <http://state.tn.us/sos/rules/1360/1360.htm>)

Amendments

Chapter 0800-02-25 Workers' Compensation Medical Treatment Guidelines

Rule 0800-02-25-.03(6) is amended by deleting subdivision (6) and substituting the following:

~~(6) As new information becomes available, the Administrator may direct the Medical Director to publish or post on the Division's website, advisory or explanatory updates or bulletins to the guidelines. Print copies will be made available by request to the Medical Director. The Medical Advisory Committee may be consulted at the Administrator's discretion.~~

(6) As the Work Loss Data Institute releases updated guidelines or other information pertinent to the interpretation or application of any such guidelines, the Medical Director, in consultation with the Medical Advisory Committee, shall review all such updates or other information, on a semi-annual or annual basis as deemed appropriate by the Medical Director, and report to the Administrator the impact, if any, of such updates on the continuing viability of the guidelines for use in Tennessee. The Administrator will include any such pertinent information and/or recommendations in the Bureau's annual report to the general assembly.

Authority: T.C.A. §§ 50-6-122, 50-6-124, 50-6-125, 50-6-126, 50-6-233.

Rule 0800-02-25-.04(2) is amended by adding the following language:

(2) The Bureau adopts the ODG Drug Formulary as found in Drug Appendix A published and updated by the Work Loss Data Institute. When the Work Loss Data Institute releases an updated ODG Drug Formulary, or amends any element of the current ODG Drug Formulary, the Medical Director, in consultation with the Medical Advisory Committee, shall review all such updates and amendments on a semi-annual or annual basis as deemed appropriate by the Medical Director, and report to the Administrator the impact, if any, of such updates or amendments on the continuing viability of the ODG Drug Formulary for use in Tennessee. The Administrator will include any such pertinent information and/or recommendations in the Bureau's annual report to the general assembly.

Authority: T.C.A. §§ 50-6-122, 50-6-124, 50-6-125, 50-6-126, 50-6-233.

* If a roll-call vote was necessary, the vote by the Agency on these rules was as follows:

Board Member	Aye	No	Abstain	Absent	Signature (if required)

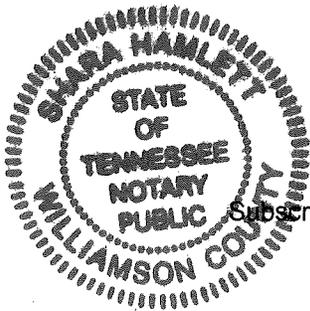
I certify that this is an accurate and complete copy of proposed rules, lawfully promulgated and adopted by the (board/commission/other authority) on 10/13/17 (date as mm/dd/yyyy), and is in compliance with the provisions of T.C.A. § 4-5-222. The Secretary of State is hereby instructed that, in the absence of a petition for proposed rules being filed under the conditions set out herein and in the locations described, he is to treat the proposed rules as being placed on file in his office as rules at the expiration of sixty (60) days of the first day of the month subsequent to the filing of the proposed rule with the Secretary of State.

Date: 10/13/17

Signature: Abbie Hudgens

Name of Officer: Abbie Hudgens

Title of Officer: Administrator, Bureau of Workers' Compensation



Subscribed and sworn to before me on: October 13, 2017

Notary Public Signature: Shara Hamlett

My commission expires on: 2/19/20

All proposed rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

Herbert H. Slatery III
 Herbert H. Slatery III
 Attorney General and Reporter
10/31/2017
 Date

Department of State Use Only

Filed with the Department of State on: 11/7/17

Effective on: 2/5/18

Tre Hargett
 Tre Hargett
 Secretary of State

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G.O.C. STAFF RULE ABSTRACT

DEPARTMENT: Labor and Workforce Development

DIVISION: Bureau of Workers' Compensation

SUBJECT: Inpatient Hospital Fee Schedule

STATUTORY AUTHORITY: Tennessee Code Annotated, Section 50-6-204

EFFECTIVE DATES: February 25, 2018 through June 30, 2018

FISCAL IMPACT: Minimal

STAFF RULE ABSTRACT: These rules together with the Medical Fee Schedule and Rules for Medical Payments establish a comprehensive medical fee schedule, procedures for review of bills and enforcement of procedures.

Public Hearing Comments

One copy of a document containing responses to comments made at the public hearing must accompany the filing pursuant to T.C.A § 4-5-222. Agencies shall include only their responses to public hearing comments, which can be summarized. No letters of inquiry from parties questioning the rule will be accepted. When no comments are received at the public hearing, the agency need only draft a memorandum stating such and include it with the Rulemaking Hearing Rule filing. Minutes of the meeting will not be accepted. Transcripts are not acceptable.

PUBLIC COMMENTS AND RESPONSES

Comment (D. Fulton, Esq.): Should utilization review be required in all hospitalizations, even if the employer/carrier does not want to contest the treatment?

Response: Yes. Rule 0800-02-19-.01 (f) provides that prospective admission utilization review is required for non-emergent or non-urgent inpatient services, and emergency and urgent admissions require utilization review to begin within one business day of the admission. This language is consistent with the statutory language in TCA § 50-6-124(b). No further language is necessary.

Comment/Response (Bureau of WC): The following clarifying edits were made:

In 0800-02-19-.02 (1): Removed "Tennessee Department of Labor and Workforce Development or the".

In 0800-02-19-.03 (2) (f) line 3: After CPT added @.

In 0800-02-19-.01 (1): Added at the end of the paragraph: "if a waiver is granted by the Bureau."

Regulatory Flexibility Addendum

Pursuant to T.C.A. §§ 4-5-401 through 4-5-404, prior to initiating the rulemaking process as described in T.C.A. § 4-5-202(a)(3) and T.C.A. § 4-5-202(a), all agencies shall conduct a review of whether a proposed rule or rule affects small businesses.

1. The type or types of small business and an identification and estimate of the number of small businesses subject to the proposed rule that would bear the cost of, or directly benefit from the proposed rule: The amended rules will affect small employers that fall under the Tennessee Workers' Compensation Laws, which would be employers with at least five employees, or for those in the construction industry at least one employee. There should be no additional costs associated with these rule changes.
2. The projected reporting, recordkeeping and other administrative costs required for compliance with the proposed rule, including the type of professional skills necessary for preparation of the report or record. There is no additional record keeping requirement or administrative cost associated with these rule changes.
3. A statement of the probable effect on impacted small businesses and consumers: These rules should not have any impact on consumers or small businesses.
4. A description of any less burdensome, less intrusive or less costly alternative methods of achieving the purpose and objectives of the proposed rule that may exist, and to what extent the alternative means might be less burdensome to small business: There are no less burdensome methods to achieve the purposes and objectives of these rules.
5. Comparison of the proposed rule with any federal or state counterparts: None.
6. Analysis of the effect of the possible exemption of small businesses from all or any part of the requirements contained in the proposed rule: Exempting small businesses could frustrate the small business owners' access to the services provided by the Bureau of Workers' Compensation and timely medical treatment for injured workers, which would be counter-productive.

Impact on Local Governments

Pursuant to T.C.A. §§ 4-5-220 and 4-5-228 “any rule proposed to be promulgated shall state in a simple declarative sentence, without additional comments on the merits of the policy of the rules or regulation, whether the rule or regulation may have a projected impact on local governments.” (See Public Chapter Number 1070 (<http://state.tn.us/sos/acts/106/pub/pc1070.pdf>) of the 2010 Session of the General Assembly)

These proposed rules will have little, if any, impact on local governments.

Additional Information Required by Joint Government Operations Committee

All agencies, upon filing a rule, must also submit the following pursuant to T.C.A. § 4-5-226(i)(1).

- (A) A brief summary of the rule and a description of all relevant changes in previous regulations effectuated by such rule;

These rules together with the Medical Fee Schedule and Rules for Medical Payments establish a comprehensive medical fee schedule, procedures for review of bills and enforcement procedures.

- (B) A citation to and brief description of any federal law or regulation or any state law or regulation mandating promulgation of such rule or establishing guidelines relevant thereto;

T.C.A. § 50-6-204 provides that the Bureau administrator is authorized to establish by rule a comprehensive medical fee schedule and will review it annually and make revisions as necessary.

- (C) Identification of persons, organizations, corporations or governmental entities most directly affected by this rule, and whether those persons, organizations, corporations or governmental entities urge adoption or rejection of this rule;

All parties to a workers' compensation claim will be affected by the adoption or rejection of these rules.

- (D) Identification of any opinions of the attorney general and reporter or any judicial ruling that directly relates to the rule;

None

- (E) An estimate of the probable increase or decrease in state and local government revenues and expenditures, if any, resulting from the promulgation of this rule, and assumptions and reasoning upon which the estimate is based. An agency shall not state that the fiscal impact is minimal if the fiscal impact is more than two percent (2%) of the agency's annual budget or five hundred thousand dollars (\$500,000), whichever is less;

The overall effect will have little fiscal impact upon state or local government.

- (F) Identification of the appropriate agency representative or representatives, possessing substantial knowledge and understanding of the rule;

Troy Haley, Legislative Liaison and Director of Administrative Legal Services

- (G) Identification of the appropriate agency representative or representatives who will explain the rule at a scheduled meeting of the committees;

Troy Haley, Legislative Liaison and Director of Administrative Legal Services

- (H) Office address, telephone number, and email address of the agency representative or representatives who will explain the rule at a scheduled meeting of the committees; and

Tennessee Bureau of Workers' Compensation
220 French Landing Drive Floor 1-B
Nashville, TN 37243
(615) 532-0179 troy.haley@tn.gov

- (I) Any additional information relevant to the rule proposed for continuation that the committee requests.

None

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For Department of State Use Only

Sequence Number: 11-16-17
Rule ID(s): 6650
File Date: 11/27/17
Effective Date: 2/25/18

Rulemaking Hearing Rule(s) Filing Form

Rulemaking Hearing Rules are rules filed after and as a result of a rulemaking hearing (Tenn. Code Ann. § 4-5-205).

Pursuant to Tenn. Code Ann. § 4-5-229, any new fee or fee increase promulgated by state agency rule shall take effect on July 1, following the expiration of the ninety (90) day period as provided in § 4-5-207. This section shall not apply to rules that implement new fees or fee increases that are promulgated as emergency rules pursuant to § 4-5-208(a) and to subsequent rules that make permanent such emergency rules, as amended during the rulemaking process. In addition, this section shall not apply to state agencies that did not, during the preceding two (2) fiscal years, collect fees in an amount sufficient to pay the cost of operating the board, commission or entity in accordance with § 4-29-121(b).

Agency/Board/Commission:	Tennessee Department of Labor and Workforce Development
Division:	Bureau of Workers' Compensation
Contact Person:	Troy Haley
Address:	220 French Landing Drive 1-B, Nashville, TN 37243
Phone:	615-532-0179
Email:	troy.haley@tn.gov

Revision Type (check all that apply):

- Amendment
 New
 Repeal

Rule(s) (ALL chapters and rules contained in filing must be listed. If needed, copy and paste additional tables to accommodate more than one chapter. Please enter only **ONE** Rule Number/Rule Title per row.)

Chapter Number	Chapter Title
0800-02-19	Inpatient Hospital Fee Schedule
Rule Number	Rule Title
0800-02-19-.01	General Rules
0800-02-19-.02	Definitions
0800-02-19-.03	Special Ground Rules – Inpatient Hospital Services
0800-02-19-.04	Pre-admission Utilization Review
0800-02-19-.05	Other Services
0800-02-19-.06	Penalties for Violations of Fee Schedules

RULES
TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE
DEVELOPMENT DIVISION OF WORKERS' COMPENSATION

CHAPTER 0800-02-19
IN-PATIENT HOSPITAL FEE

SCHEDULE TABLE OF CONTENTS

0800-02-19-.01	General Rules	0800-02-19-.04	Pre-admission Utilization Review
0800-02-19-.02	Definitions	0800-02-19-.05	Other Services
0800-02-19-.03	Special Ground Rules – Inpatient Hospital Services	0800-02-19-.06	Penalties for Violations of Fee Schedules

0800-02-19-.01 GENERAL RULES.

- (1) These In-patient Hospital Fee Schedule Rules ~~shall become effective May 1, 2006 and~~ are applicable to all in-patient services as defined herein. These include medical, surgical, rehabilitation, and/or psychiatric services rendered in a hospital to injured or ill workers claiming medical benefits pursuant to the Tennessee Workers' Compensation Act. Maximum fees for outpatient hospital services are not addressed in these In-patient Hospital Fee Schedule Rules, but are addressed in Rule 0800-02-18-.07 of the Medical Fee Schedule Rules, Chapter 0800-02-18-.01 et seq. These In-patient Hospital Fee Schedule Rules are established pursuant to Tenn. Code Ann. § 50-6-204 ~~(Repl. 2005)~~. They must be used in conjunction with the Medical Cost Containment Program Rules for Medical Payments, Chapter 0800-02-17-.01 et seq., and the Medical Fee Schedule Rules, Chapter 0800-02-18-.01 et seq., as the definitions and provisions set forth in those rules are incorporated as if set forth fully herein. Providers rendering medically appropriate care outside of the state of Tennessee to an injured employee pursuant to the Tennessee Workers' Compensation Act may be paid in accordance with the medical fee schedule, law, and rules governing in the jurisdiction where such medically appropriate care is provided, if a waiver is granted by the Bureau.
- (2) General Information
- (a) Reimbursements shall be determined for services rendered in accordance with these Fee Schedule Rules and shall be considered to be inclusive unless otherwise expressly noted in these Rules.
- (b) The most ~~recent~~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. All such Medicare procedures and guidelines are applicable unless these Rules set forth a different procedure or guideline. Whenever there is no specific maximum fee or methodology for reimbursement set forth in these Rules for a service, diagnostic procedure, equipment, etc., then the maximum amount of reimbursement shall be 100% of the most ~~recent~~current and ~~and~~ effective Medicare allowable amount and the most ~~current~~recent effective Medicare guidelines and procedures shall be followed in arriving at the correct amount. Whenever there is no applicable Medicare code, the service, equipment, diagnostic procedure, etc. shall be reimbursed up to a maximum of the usual and customary amount, as defined in Rule 0800-02-17-.03~~(80)~~ of the Medical Cost Containment Rules. All Medicare rules shall be applied that are effective on the date of service or the date of discharge in accordance with Medicare guidelines.
- (c) Reimbursement for a compensable workers' compensation claim shall be the lesser of the hospital's usual and customary charges or the maximum amount allowed under this In-patient Hospital Fee Schedule.

(d) In-patient hospitals shall be grouped into the following separate peer groupings:

1. Peer Group 1 Hospitals
2. Peer Group 2 Rehabilitation Hospitals
3. Peer Group 3 Psychiatric Hospitals
4. Peer Group 4 Designated Level 1 Trauma Centers.

(e) For each inpatient claim submitted, the provider shall assign a Medicare Diagnosis Related Group ("MS-DRG") code which appropriately reflects the patient's primary cause of hospitalization.

~~This In-patient Hospital Fee Schedule shall become effective May 1, 2006, shall be reviewed annually, and may be updated annually.~~

~~Ongoing analysis will be conducted as to the projected savings of this schedule, as well as any impact on patient services.~~

(f) ~~Prospective admission utilization review is required for non-emergent, non-urgent inpatient services, and Emergency and or urgent admissions require utilization review to begin within one (1) business day of the admission.~~

Authority: T.C.A. §§ 50-6-125, 50-6-128, 50-6-204 and 50-6-205 (Repl. 2005). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006.

0800-02-19-02 DEFINITIONS.

(1) "Administrator" means the chief administrative officer of the ~~Bureau~~Division of Workers' Compensation of the Tennessee Department of Labor and Workforce Development or the Administrator's designee.

(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 ~~Bureau~~Division's Rules, or as determined by the Administrator or the Administrator's designee after consultation with the ~~Bureau~~Division's Medical Director.

~~"Commissioner" means the Commissioner of the Tennessee Department of Labor and Workforce Development.~~

(3) "~~Bureau~~Division" means the Tennessee BureauDivision of Workers' Compensation, ~~of the Tennessee Department of Labor and Workforce Development.~~

(4) "MS-DRG" – Medicare classifications of diagnosis in which patients demonstrate similar resource consumption and length of stay patterns.

~~(4)(5) "Hospital" is the same as the definition for as defined by Medicare.~~

(6) "In-patient Services" - services rendered to a person who is formally admitted to a hospital and whose length of stay exceeds 23 hours as defined by Medicare:

(a) Is expected to include at least two midnights, or;

(b) The medical record supports the admitting physician's determination that the patient requires inpatient care despite the lack of a two midnight length of stay, or;

(c) The procedure/treatment is included on the "in-patient only" list.

- (5)(7) Institutional Services - all non-physician services rendered within the institution by an agent of the institution.
- (6)(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 as defined by Medicare.
- (9) Medical Admission - any hospital admission where the primary services rendered are not surgical, or in a psychiatric, or rehabilitation hospital, ~~ve in nature, or in a specially designated psychiatric or rehabilitation unit within an acute care hospital.~~
- (7)(10) Stop-Loss Payment ("SLP") - an independent method of payment for an unusually costly or lengthy stay.
- (8)(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.
- (9)(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.
- (10)(13) Surgical Admission - any hospital admission where ~~there is an operating room charge, the patient has a surgical procedure or ICD-9 code, or the patient has an assigned surgical MS-DRG as defined by the Medicare~~ CMS.
- (11)(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. This 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. This 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.
- (a) Any level 1 trauma center hospital admission in which the patient has an ICD-9 diagnosis code of 800 to 959.99, or ICD-10 code that is (or includes) S00.00XA through S99.99XX, T07, T14 to T32, T79 and the claim includes an ICU revenue code of 020x or a CCU revenue code of 021x, or
- (b) Any level 1 trauma center hospital admission for any diagnosis with a trauma response revenue code of 068x and/or type of admission code, "5."
- Note: this includes all hospital days that qualify as an inpatient day as defined under inpatient services.
- (12)(15)
- (13)(16) "Usual and customary charge" means eighty percent (80%) of a specific provider's average charges to all payers for the same procedure.
- (14) (17) "Utilization Review" for workers' compensation claims means evaluation of the necessity, appropriateness, efficiency and quality of medical care services provided to an injured or disabled employee based on medically accepted standards and an objective evaluation of the medical care services provided; provided, that "utilization review" does not include the establishment of approved payment levels or a review of medical charges or fees.
- (18) 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. §§ 50-6-102, 50-6-125, 50-6-128, 50-6-204, 50-6-205 (Repl. 2005), 50-6-233, and Public Chapters 282 & 289 (2013). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendment filed June 12, 2009; effective August 26, 2009. Amendment filed December 26, 2013; effective March 26, 2014.

0800-02-19-.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 four (42) groups based on type of admission
 - (a) Peer Groups:

- 1. Peer Group 1-surgical or non-surgical (medical),
- 2. Peer Group 2-rehabilitation;
- 3. Peer Group 3-psychiatric,
- 4. Peer Group 4-trauma, level 1 and:

(b) Length of stay (less than eight (8) days/over seven (7) days).—Rehabilitation and Psychiatric hospitals are grouped separately.

- (2) General Information, Payments

For each inpatient claim submitted, the provider shall assign a Diagnosis Related Group (MS-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 be paid the maximum amount per inpatient day, unless a contracted rate is less. An additional payment will be due if the total bill for the hospitalization exceeds the stop loss threshold as defined below.

- (a) The maximum per diem rates to be used in calculating the reimbursement rate is as follows:

1. Peer Group 1 \$~~1,800~~2,235.00 (surgical admission) daily for the first seven (7) days;
~~1,500~~1935.00 per day thereafter (surgical admission) per day for the 8th day and thereafter;
 NOTE: these rates include Intensive Care (ICU) & Critical Care (CCU) if not a trauma admission as described above.

~~\$1,500~~1840.00 (medical admission) daily for first seven (7) days;
~~1,250~~1590.00 per day thereafter (medical admission.) NOTE: These rates include Intensive Care (ICU) & Critical Care (CCU)

2. Peer Group 2 \$~~1,000~~1090.00 For the first seven (7) days and ~~800~~890.00 per day thereafter (Rehabilitation)

3. Peer Group 3 \$~~700~~790.00 per day.—Psychiatric Hospitals (applicable to (Psychiatric) chemical dependency as well.)

(Trauma level 1) 4. Peer Group 4 ~~\$3740 daily, see (c) below.~~

All trauma care at any licensed Level 1 Trauma Center only shall be reimbursed at a maximum rate of ~~\$3,000~~\$4,500.00 per day for each day of the patient's admission as defined in 0800-02-18- .02 (16).
~~3,740.00 per day for each day of patient stay.~~

- (b) Surgical implants shall be reimbursed separately and in addition to the per diem hospital charges.
- (c) 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.

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.

- (d) Additional reimbursement may be made in addition to the per diem for implantables (i.e. rods, pins, plates and joint replacements, etc.). ~~Maximum reimbursement for implantables for which charges are \$100.00 or less per item shall be limited to eighty percent (80%) of billed charges. Maximum reimbursement for implantables for which charges are over \$100.00 is limited to a maximum of the hospital's cost plus fifteen percent (15%) - capped at one thousand dollars - of the invoice amount, up to a maximum of invoice plus (\$1,000.00) - of the invoice amount. This is applicable per item, and is not cumulative. Implantables shall be billed using the appropriate HCPCS codes, when available. Billing for implantables which have an invoice amount over \$100.00 shall be accompanied by an invoice if requested by the payer.~~
- (e) 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 applicable CPT®/HCPCS.

1. Durable Medical Equipment
2. Orthotics and Prosthetics
3. Implantables
4. Ambulance Services
5. Take home medications and supplies
6. Radiology Services
7. Pathology Services

- (f) The items listed in subsection (e) (d)(4) shall be reimbursed according to the ~~Medical Cost Containment Program Rules for Medical Payments (Chapter 0800-02-17) and Medical Fee Schedule Rules (Chapter 0800-02-18)~~ payment limits. Refer to the maximum rates set forth in Rule 0800-02-18(4) for practitioner fees. Items not listed in the Rules shall be reimbursed at the usual and customary rate as defined in Rule 0800-02-17(80), unless otherwise indicated herein.
- (g) Per diem rates are all inclusive (with the exception of those items listed in subsection (e) (d)(4) above).

- (h) 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.
- (h)(i) Payments for implantables shall be made only to the facility and not to a supplier or distributor.

(3) Reimbursement Calculations

(a) Explanation

1. Each admission is assigned an appropriate MS-DRG.
2. The applicable Standard Per Diem Amount ("SPDA") is multiplied by the length of stay ("LOS") for that admission plus items paid under (e) above:
Formula: $LOS \times SPDA + (\text{other items listed under in (e) above}) = WCRA$
3. The Workers' Compensation Reimbursement Amount ("WCRA") is the total amount of reimbursement to be made for that particular admission and may include a stop loss payment ("SLP") as calculated below.

(b) ~~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

(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. This stop-loss threshold is established to ensure compensation for unusually extensive services required during an admission.

(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~~20,750 for Non-Trauma Admissions and ~~\$30,004~~5,750 for Trauma Admissions. ~~Amounts for items set forth in rule 0800-02-19-.03(d)(4.), such as implantables, radiology, pathology services, DME, etc., shall not be included in determining the total Allowed Charges for stop-loss calculations. This does not include amounts for items set forth in rule 0800-02-19-.03, such as implantables, DME, etc., which shall not be included in determining the total Allowed Charges for stop-loss calculations.~~
2. 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%.
3. The additional charges are multiplied by the Stop-Loss Reimbursement Factor (SLRF) and added to the maximum allowable payment.

(c) Formula: $(LOS) \times (SPDA) + (\text{Items listed under (2)(e) in this section}) + (\text{Additional Charges} \times \text{SLRF}) = \text{WCRA}$
 Formula: $(\text{Additional Charges} \times \text{SLRF}) + \text{Maximum Allowable Payment} = \text{WCRA}$

(d) Example: DRG 222: Knee Procedures W/O CC

Hospital Peer Group: 1 — Surgical admission
 Maximum rate per day: \$1,800~~2235~~ for first 7 days; 1,500~~1935~~ for 2-
 additional days Number Billed Days: 9
 Total Billed Charges _____ \$120,000.00
 (after subtracting amounts for implants, radiology, etc.): _____
 \$53,650~~80,000.00~~

Maximum allowable per diem payment for Surgical Admission Normal DRG stay
 _____ \$15,600~~19,515.00~~

Total difference, charges over and above maximum payments _____
 \$38,050~~60,485.00~~ (if this amount is \$20,750.00~~15,000~~ or less, then stop-loss is not
 applicable)

Difference over and above \$15,000 ~~20,750.00~~ Stop-loss is _____
 \$23,050~~39,735.00~~
 Payable under Stop-loss (80% of \$23,050.00~~39,735.00~~) _____
 \$18,440.00~~31,788.00~~

Amounts due hospital for implants, radiology, etc. _____
 \$10,000.00~~3,525.00~~

Maximum fee schedule amount: _____ \$15,600.00 ~~19,515.00~~ + 18,440.00 ~~31,788.00~~ +
 3,525.00 ~~10,000~~ = \$37,565.00~~61,303.00~~

Proper reimbursement would be the lesser of billed charges, maximum fee schedule
 amount, or other contracted or negotiated rate

(5) Billing for In-patient Admissions

(a) All bills for in-patient institutional services should be submitted on the standard
 billing UB-92 form or any revision to that form approved for use by the Medicare CMS.

Authority: T.C.A. §§ 50-6-125, 50-6-128, 50-6-204 and 50-6-205 (Repl. 2005). **Administrative History:**
 Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed
 November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April
 19, 2006. Amendment filed June 12, 2009; effective August 26, 2009. Amendments filed March 12, 2012;
 to have been effective June 10, 2012. The Government Operations Committee filed a stay on May 7,
 2012; new effective date August 9, 2012.

0800-02-19-.04 PRE-ADMISSION UTILIZATION REVIEW.

Utilization review shall be performed when mandated by and in accordance with Chapter 0800-02-06.

Authority: T.C.A. §§ 50-6-124, 50-6-125, 50-6-128, 50-6-204 and 50-6-205 (Repl. 2005).
Administrative History: Public necessity rule filed June 5, 2005; effective through November 27, 2005.
 Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed
 February 3, 2006; effective April 19, 2006. Amendment filed June 12, 2009; effective August 26, 2009.

0800-02-19-.05 OTHER SERVICES.

- (1) Pharmacy Services
 - (a) Pharmaceutical services rendered as part of in-patient care are considered inclusive within the In-patient Fee Schedule and shall not be reimbursed separately.
 - (b) All retail pharmaceutical services rendered shall be reimbursed in accordance with the Pharmacy Schedule Guidelines, Rule 0800-02-18-.12.
- (2) Professional Services
 - (a) All non-institutional professional and technical services will be reimbursed in accordance with the Bureau Division's Medical Cost Containment Program Rules for Medical Payments 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 and -50-6-205 (Repl. 2005).

Administrative History: Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendment filed June 12, 2009; effective August 26, 2009.

0800-02-19-.06 PENALTIES FOR VIOLATIONS OF FEE SCHEDULES.

- (4) Except when a waiver is granted by the Bureau, 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 for Medical Payments, 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 Administrator's discretion, be subject to civil penalties of one thousand (\$1000) dollars up to 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 Administrator, the Administrator's Designee, or an agency member appointed by the Administrator, 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. Other violations of the Rules for Medical Payments, Medical Fee Schedule Rules, or the In-patient Hospital Fee Schedule Rules may subject the alleged violator(s) to a civil penalty of not less than one hundred dollars (\$100.00) nor more than one thousand dollars (\$1,000.00) per violation, at the discretion of the Administrator, the Administrator's Designee, or an agency member appointed by the Administrator. Any provider reimbursed or carrier paying an amount which is in excess of these Rules shall have a period of ninety (90) calendar days from the time of receipt/payment of such excessive payment in which to refund/recover the overpayment amount. Overpayments refunded/recovered within this time period shall not constitute a violation under these Rules. At the discretion of the Administrator, the Administrator's Designee, or an agency member appointed by the Administrator, 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 violations 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 Administrator, Administrator's Designee, or an agency member appointed by the Administrator.

- (2) Any provider reimbursed or carrier paying an amount which is in excess of these Rules shall have a period of one hundred eighty (180)~~ninety (90)~~ calendar days from the time of receipt/payment of such excessive payment in which to refund/recover the overpayment amount. Overpayments refunded/recovered within this time period shall not constitute a violation under these Rules.
- (3) 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, the notice of assessment of civil penalties. All rights, duties, obligations, and procedures applicable under the Uniform Administrative Procedures Act, Tenn. Code Ann. § 4-5-101 et seq., are applicable under these Rules, including, but not limited to, the right to judicial review of any final departmental decision.
- (4) The request for a hearing shall be made to the ~~Division~~ Bureau 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.
- (5) Any request for a hearing shall be filed with the ~~Division~~ Bureau 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 a Notice of Violation shall result in the decision of the Administrator, Administrator's Designee, or an agency member appointed by the Administrator becoming a final order and not subject to further review.
- (6) ~~The Commissioner, Commissioner's Designee, or an agency member appointed by the Commissioner~~ Administrator or the Administrator's Designee shall have the authority to hear the matter as a contested case and determine if any civil penalty assessed should have been assessed. All procedural aspects set forth in the ~~Division's~~ Bureau's Penalty Program Rules, Chapter 0800-02-13, shall apply and be followed in any such contested case hearing.
- (7) Upon receipt of a timely filed request for a hearing, the ~~Commissioner~~ Administrator shall issue a Notice of Hearing to all interested parties.

Authority: T.C.A. §§ 50-6-102, 50-6-125, 50-6-128, 50-6-204, 50-6-205, 50-6-233 (Repl. 2005), and Public Chapters 282 & 289 (2013). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendment filed June 12, 2009; effective August 26, 2009. Amendment filed December 26, 2013; effective March 26, 2014.

* If a roll-call vote was necessary, the vote by the Agency on these rules was as follows:

Board Member	Aye	No	Abstain	Absent	Signature (if required)

I certify that this is an accurate and complete copy of rulemaking hearing rules, lawfully promulgated and adopted by the Tennessee Bureau of Workers' Compensation on 8/22/17 and is in compliance with the provisions of T.C.A. § 4-5-222.

I further certify the following:

Notice of Rulemaking Hearing filed with the Department of State on April 13, 2017.

Rulemaking Hearing Conducted on June 8, 2017.

Date: August 22, 2017

Signature: Abbie Hudgens

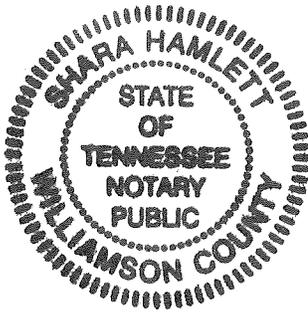
Name of Officer: Abbie Hudgens

Title of Officer: Administrator, Bureau of Workers' Compensation

Subscribed and sworn to before me on: August 22, 2017

Notary Public Signature: [Signature]

My commission expires on: 2/19/20



All proposed rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

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 SECRETARY OF STATE
 PUBLICATION

Herbert H. Slatery III

Herbert H. Slatery III
 Attorney General and Reporter

Date 10/23/2017

Department of State Use Only

Filed with the Department of State on: 11/27/17

Effective on: 2/25/18

[Signature]

Tre Hargett
 Secretary of State

G.O.C. STAFF RULE ABSTRACT

DEPARTMENT: Labor and Workforce Development

DIVISION: Bureau of Workers' Compensation

SUBJECT: Medical Fee Schedule

STATUTORY AUTHORITY: Tennessee Code Annotated, Section 50-6-204

EFFECTIVE DATES: February 25, 2018 through June 30, 2018

FISCAL IMPACT: Minimal

STAFF RULE ABSTRACT: These rules together with the Inpatient Hospital Fee Schedule and Rules for Medical Payments establish a comprehensive medical fee schedule, procedures for review of bills and enforcement procedures.

Public Hearing Comments

One copy of a document containing responses to comments made at the public hearing must accompany the filing pursuant to T.C.A § 4-5-222. Agencies shall include only their responses to public hearing comments, which can be summarized. No letters of inquiry from parties questioning the rule will be accepted. When no comments are received at the public hearing, the agency need only draft a memorandum stating such and include it with the Rulemaking Hearing Rule filing. Minutes of the meeting will not be accepted. Transcripts are not acceptable.

PUBLIC COMMENTS AND RESPONSES

Comment (Concentra): In 0800-02-18-.02, it is suggested that the Bureau update to the most current Medicare conversion factor and begin to apply the Medicare Economic Index (MEI) adjustment each year to the conversion factor rate.

Response: The Bureau disagrees with this comment. This would increase cost to the workers' compensation system. The Bureau analyzes reimbursement rates and does not feel that the present conversion factor difference with Medicare affects access or delivery of services to injured workers.

Comment (Concentra): In 0800-02-18-.01(3) the new rules add the Medicare multiple procedure discount rule. Since regulations are already present that limit the utilization review of physical therapy procedures codes, the application of the Medicare multiple discount rule is essentially applying redundant utilization and payment limitation rules.

Response: The Bureau agrees in part, and the rule has been amended to add the following language at the end of 0800-02-18-.09(3): "with no additional reductions such as those to the relative value units (RVU's)."

Comment (TASCA): In 0800-02-18-.07(1)(b), it is suggested that the Bureau use the Medicare-issued OPPS payment rate file as the basis for establishing freestanding ASC payment rates annually and that C-APC payment methodology bundling conversions are not applicable in conjunction with this rate table as established by Medicare.

Response: The Bureau disagrees. The suggested changes are a significant departure from the current rule, would require cost and impact analysis and may be considered by the administrator when reviewing the medical fee schedules on an annual basis, pursuant to TCA § 50-6-204(i)(3).

Comment (Abercrombie Radiology): In 0800-02-18-.02(4), it is suggested that the Bureau change the TN specific conversion percentage for radiology services from 200% of Medicare RVUs to 200% of the Medicare OPPS rate for technical component services.

Response: The Bureau disagrees with the comment. The comment does not account for who is responsible for the cost of the machines, rent, etc. Other physicians receive differing payments depending on location from Medicare (office-based surgery, etc.). The suggested change would create an inequity peculiar to radiology.

Comment (NCDPD): In 0800-02-17.03(75), 0800-02-17-.10(4), and 0800-02-18-.02(1)(a) it is recommended that the NCPDP Workers' Compensation/Property & Casualty Universal Claim Form (WC/PC UCF) be adopted as a standard form.

Response: The Bureau agrees and has made the following change in 0800-02-17-.03 (75) and 17-.10 (4), 18-.02 (a): "and the NCPDP WC/PC UCF for pharmacies."

Comment (eHealth Systems): There is concern about added burdens for Medicare and HIPAA EOB forms.

Response: The Bureau disagrees with the comment. There is no change in the language from the prior rules.

Comment (eHealth Systems): In 0800-02-18-.12 (1) (e) (3) (IV) the word "other" should be added before "provider of service."

Response: The Bureau agrees in part. Adding "other" may be confusing. The Bureau has edited the rule to provide that only the language "hospital or pharmacy" remain.

Comment (BWC): In 0800-02-18-.12, the word "should" needs to be replaced with "shall."

Response: The Bureau has made this change.

Comment/Response (BWC): The Bureau recommends and has made the following clarifying changes:

0800-02-18-.01 (1) add to the end, "upon waiver granted by the Bureau."

0800-02-18-.01 (3) add to the end, "except where exceptions are specified in these rules."

0800-02-18-.03 (3) add to the end, "except when a waiver has been granted by the Bureau."

0800-02-18-.06 first line remove period before the CPT code. Remove "I" at the end of the line.

0800-02-18-.09 (3) line 3-4, add the phrase "with no additional reductions such as those to the relative value units (RVUs)".

Regulatory Flexibility Addendum

Pursuant to T.C.A. §§ 4-5-401 through 4-5-404, prior to initiating the rulemaking process as described in T.C.A. § 4-5-202(a)(3) and T.C.A. § 4-5-202(a), all agencies shall conduct a review of whether a proposed rule or rule affects small businesses.

1. The type or types of small business and an identification and estimate of the number of small businesses subject to the proposed rule that would bear the cost of, or directly benefit from the proposed rule: The amended rules will affect small employers that fall under the Tennessee Workers' Compensation Laws, which would be employers with at least five employees, or for those in the construction industry at least one employee. There should be no additional costs associated with these rule changes.
2. The projected reporting, recordkeeping and other administrative costs required for compliance with the proposed rule, including the type of professional skills necessary for preparation of the report or record. There is no additional record keeping requirement or administrative cost associated with these rule changes.
3. A statement of the probable effect on impacted small businesses and consumers: These rules should not have any impact on consumers or small businesses.
4. A description of any less burdensome, less intrusive or less costly alternative methods of achieving the purpose and objectives of the proposed rule that may exist, and to what extent the alternative means might be less burdensome to small business: There are no less burdensome methods to achieve the purposes and objectives of these rules.
5. Comparison of the proposed rule with any federal or state counterparts: None.
6. Analysis of the effect of the possible exemption of small businesses from all or any part of the requirements contained in the proposed rule: Exempting small businesses could frustrate the small business owners' access to the services provided by the Bureau of Workers' Compensation and timely medical treatment for injured workers, which would be counter-productive.

Impact on Local Governments

Pursuant to T.C.A. §§ 4-5-220 and 4-5-228 "any rule proposed to be promulgated shall state in a simple declarative sentence, without additional comments on the merits of the policy of the rules or regulation, whether the rule or regulation may have a projected impact on local governments." (See Public Chapter Number 1070 (<http://state.tn.us/sos/acts/106/pub/pc1070.pdf>) of the 2010 Session of the General Assembly)

These proposed rules will have little, if any, impact on local governments.

Additional Information Required by Joint Government Operations Committee

All agencies, upon filing a rule, must also submit the following pursuant to T.C.A. § 4-5-226(i)(1).

- (A) A brief summary of the rule and a description of all relevant changes in previous regulations effectuated by such rule;

These rules together with the Inpatient Hospital Fee Schedule and Rules for Medical Payments establish a comprehensive medical fee schedule, procedures for review of bills and enforcement procedures.

- (B) A citation to and brief description of any federal law or regulation or any state law or regulation mandating promulgation of such rule or establishing guidelines relevant thereto;

T.C.A. § 50-6-204 provides that the Bureau administrator is authorized to establish by rule a comprehensive medical fee schedule and will review it annually and make revisions as necessary.

- (C) Identification of persons, organizations, corporations or governmental entities most directly affected by this rule, and whether those persons, organizations, corporations or governmental entities urge adoption or rejection of this rule;

All parties to a workers' compensation claim will be affected by the adoption or rejection of these rules.

- (D) Identification of any opinions of the attorney general and reporter or any judicial ruling that directly relates to the rule;

None

- (E) An estimate of the probable increase or decrease in state and local government revenues and expenditures, if any, resulting from the promulgation of this rule, and assumptions and reasoning upon which the estimate is based. An agency shall not state that the fiscal impact is minimal if the fiscal impact is more than two percent (2%) of the agency's annual budget or five hundred thousand dollars (\$500,000), whichever is less;

The overall effect will have little fiscal impact upon state or local government.

- (F) Identification of the appropriate agency representative or representatives, possessing substantial knowledge and understanding of the rule;

Troy Haley, Legislative Liaison and Director of Administrative Legal Services

- (G) Identification of the appropriate agency representative or representatives who will explain the rule at a scheduled meeting of the committees;

Troy Haley, Legislative Liaison and Director of Administrative Legal Services

- (H) Office address, telephone number, and email address of the agency representative or representatives who will explain the rule at a scheduled meeting of the committees; and

Tennessee Bureau of Workers' Compensation
220 French Landing Drive, Floor 1-B
Nashville, TN 37243
(615) 532-0179 troy.haley@tn.gov

(H) Any additional information relevant to the rule proposed for continuation that the committee requests.

None

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 312 Rosa L. Parks, 8th Floor Snodgrass/TN Tower
 Nashville, TN 37243
 Phone: 615.741.2650
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For Department of State Use Only

Sequence Number: 11-17-17
 Rule ID(s): 6651
 File Date: 11/27/17
 Effective Date: 2/25/18

Rulemaking Hearing Rule(s) Filing Form

Rulemaking Hearing Rules are rules filed after and as a result of a rulemaking hearing (Tenn. Code Ann. § 4-5-205).

Pursuant to Tenn. Code Ann. § 4-5-229, any new fee or fee increase promulgated by state agency rule shall take effect on July 1, following the expiration of the ninety (90) day period as provided in § 4-5-207. This section shall not apply to rules that implement new fees or fee increases that are promulgated as emergency rules pursuant to § 4-5-208(a) and to subsequent rules that make permanent such emergency rules, as amended during the rulemaking process. In addition, this section shall not apply to state agencies that did not, during the preceding two (2) fiscal years, collect fees in an amount sufficient to pay the cost of operating the board, commission or entity in accordance with § 4-29-121(b).

Agency/Board/Commission:	Tennessee Department of Labor and Workforce Development
Division:	Bureau of Workers' Compensation
Contact Person:	Troy Haley
Address:	220 French Landing Drive 1-B, Nashville, TN 37243
Phone:	615-532-0179
Email:	troy.haley@tn.gov

Revision Type (check all that apply):

- Amendment
- New
- Repeal

Chapter Number	Chapter Title
0800-02-18	Medical Fee Schedule
Rule Number	Rule Title
0800-02-18-.01	Medicare-Basis for System, Applicability, Effective Date, and Coding References
0800-02-18-.02	General Information and Instructions for Use
0800-02-18-.03	General Guidelines
0800-02-18-.04	Surgical Guidelines
0800-02-18-.05	Anesthesia Guidelines
0800-02-18-.06	Injections Guidelines
0800-02-18-.07	Ambulatory Surgical Centers and Outpatient Hospital Care (Including Emergency Room Facility Charges)
0800-02-18-.08	Chiropractic Services Guidelines
0800-02-18-.09	Outpatient Physical and Occupational Therapy Guidelines
0800-02-18-.10	Durable Medical Equipment and Implantables
0800-02-18-.11	Orthotics and Prosthetics Guidelines
0800-02-18-.12	Pharmacy Schedule Guidelines
0800-02-18-.13	Ambulance Services Guidelines
0800-02-18-.14	Clinical Psychological Service Guidelines
0800-02-18-.15	Penalties for Violations of Fee Schedule

Rule 0800-02-18 is hereby amended by deleting the prior rule and replacing it with the following:

0800-02-18-.01 Medicare-Basis for System, Applicability, Effective Date, and Coding References.

- (1) The Medical Fee Schedule of the Tennessee Bureau of Workers' Compensation (Bureau) is a Medicare-based system, but with multiple medical specialty Tennessee Specific conversion percentages. These Medical Fee Schedule Rules apply to all injured employees claiming benefits under the Tennessee Workers' Compensation Act. The Medical Fee Schedule is based upon the Centers for Medicare and Medicaid Services ("CMS") (formerly the Health Care Financing Administration) ("HCFA") Medicare Resource Based Relative Value Scale ("RBRVS") system, utilizing the CMS' relative value units ("RVUs") which must be adjusted for the Tennessee Geographic Practice Index ("GPCI") and the Tennessee conversion percentages adopted by the Tennessee Bureau of Workers' Compensation in these Rules. These Medical Fee Schedule Rules must be used in conjunction with the current American Medical Association's (AMA) CPT® Code Guide, CMS Common Procedure Coding System ("HCPCS"), the current and effective Resource Based Relative Value Scale (RBRVS), as developed by the AMA and CMS, the American Society of Anesthesiologists (ASA) Relative Value Guide, the National Correct Coding Initiative edits (NCCI) and current effective Medicare procedures and guidelines, unless specifically exempted in these rules. Providers rendering medically appropriate care outside of the state of Tennessee to an injured employee pursuant to the Tennessee Workers' Compensation Act may be paid in accordance with the medical fee schedule, law, and rules governing in the jurisdiction where such medically appropriate care is provided, upon waiver granted by the Bureau.
- (2) These Medical Fee Schedule Rules must also be used in conjunction with Rules for Medical Payments, Chapter 0800-02-17, and the In-patient Hospital Fee Schedule Rules, Chapter 0800-02-19. The definitions set out in those rules, as well as the other general provisions, including but not limited to those regarding electronic billing and prompt payment of provider's bills, are adopted by reference as if set forth fully herein.
- (3) These Medical Fee Schedule Rules apply to all services provided after the effective date of these rules. The most recent 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

Medical Fee Schedule

Chapter Number		Chapter Title
0800-02-18		Medical Fee Schedule
Rule Number		Rule Title
0800-02-18-.01	Medicare-Basis for System, Effective Date and Coding References	0800-02-18-.08 Chiropractic Services Guidelines
0800-02-18-.02	General Information and Instructions Use	0800-02-18-.09 Physical and Occupational Therapy Guidelines
0800-02-18-.03	General Guidelines	0800-02-18-.10 Durable Medical Equipment and Guidelines
0800-02-18-.04	Surgery Guidelines	0800-02-18-.11 Orthotics and Prosthetics Guidelines
0800-02-18-.05	Anesthesia Guidelines	0800-02-18-.12 Pharmacy Schedule Guidelines
0800-02-18-.06	Injections Guidelines	0800-02-18-.13 Ambulance Services Guidelines
0800-02-18-.07	Ambulatory Surgical Centers and Outpatient Hospital Care (Including Emergency Room Facility Charges)	0800-02-18-.14 Clinical Psychological Service
		0800-02-18-.15 Penalties for Violations of Fee Schedule

(Place substance of rules and other info here. Statutory authority must be given for each rule change. For information on formatting rules go to <http://state.tn.us/sos/rules/1360/1360.htm>)

0800-02-18-.01 MEDICARE-BASIS FOR SYSTEM, APPLICABILITY, EFFECTIVE DATE AND CODING REFERENCES.

- (1) The Medical Fee Schedule of the Tennessee ~~Bureau~~Division of Workers' Compensation (~~Bureau~~"~~TBD~~WC") is a Medicare-based system, but with multiple medical specialty Tennessee Specific conversion percentagesfactors. These Medical Fee Schedule Rules apply to all injured employees claiming benefits under the Tennessee Workers' Compensation Act. 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") system, utilizing the CMS' relative value units ("RVUs") which must be adjusted for the Tennessee Geographic Practice Index ("GPCI") and the Tennessee specific conversion percentagesfactors adopted by the Tennessee ~~Bureau~~Division of Workers' Compensation in these Rules. These Medical Fee Schedule Rules must be used in conjunction with the current American Medical Association's ("AMA's") CPT® Code Guide, ~~the Health Care Financing Administration CMS Common Procedure Coding System ("HCPCS"), the current and effective Resource Based Relative Value Scale AMA's Medicare (RBRVS), as developed by the AMA and CMS. The Physicians' Guide,~~ the American Society of Anesthesiologists ("ASA") Relative Value Guide, the National Correct Coding Initiative edits (NCCI) and current effective Medicare procedures and guidelines, unless specifically exempted in these rules. Providers rendering medically appropriate care outside of the state of Tennessee to an injured employee pursuant to the Tennessee Workers' Compensation Act may be paid in accordance with the medical fee schedule, law, and rules governing in the jurisdiction where such medically appropriate care is provided, upon waiver granted by the Bureau.
- (2) These Medical Fee Schedule Rules must also be used in conjunction with Rules for Medical Payments~~Medical Cost Containment Program Rules~~, Chapter 0800-02-17, and the In-patient Hospital Fee Schedule Rules, Chapter 0800-02-19. The definitions set out in those rules, as well as the other general provisions, including but not limited to those regarding electronic billing and prompt payment of provider's bills, are adopted by reference as if set forth fully herein.
- (3) These Medical Fee Schedule Rules ~~are effective May 1, 2006 and apply to all services provided after the effective date of these rules on or after May 1, 2006. The most recent~~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, including rules concerning “families” of procedures, add-on codes, status indicators, and multiple procedure discounts in all places of service, except where exceptions are specified in these rules.

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendment filed December 20, 2007; effective March 4, 2008.

0800-02-18-.02 GENERAL INFORMATION AND INSTRUCTIONS FOR USE.

(1) Format

- (a) These Rules address and consist of the following sections: General Guidelines, 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 consult and use the section(s) containing the procedure(s) they perform, or the service(s) they render, together with the appropriate sections of the ~~Medical Cost Containment Program Rules for mMedical pPayments~~, and the In-patient Hospital Fee Schedule Rules, if applicable, and the NCPDP WC/WP UCF for pharmacies.

(2) Reimbursement

- (a) Unless otherwise indicated herein, the most recent ~~current~~, effective 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 maximum amount of reimbursement shall be 100% of the ~~current effective CMS' Medicare allowable amount, in effect on the date of service.~~ The ~~current effective Medicare guidelines and procedures, in effect at the date of service,~~ shall be followed in arriving at the correct amount. For purposes of these Rules, the base Medicare amount may be adjusted ~~upward annually at the discretion of the Administrator~~ based upon the ~~annual Medicare Economic Index adjustment~~. Whenever there is no applicable Medicare code or method of reimbursement, the service, equipment, diagnostic procedure, etc. shall be reimbursed at the usual and customary amount as defined in the ~~Medical Cost Containment Program Rules for Medical Payments at 0800-2-17-.03(80)~~.
- (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 Medical 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. Except when a waiver is granted by the Bureau, in no event shall reimbursement be in excess of these TDWC Fee Schedule Rules that are in force on the date of

service unless otherwise provided in T.C.A 50-6-204 or in the Bureau/Division's rules. Reimbursement in excess of the TDWC Medical Fee Schedule Rules may result in civil penalties, at the Administrator's discretion, of from \$50.00 (fifty dollars) of up to \$510,000.00 (fiveone thousand dollars-) 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. It is recognized that providers must bill all payers at the same amount and simply billing an amount which exceeds the Fee Schedule Rules does not constitute a violation. It is acceptance and retention of an amount in excess of this Fee Schedule Rules for longer than one hundred eighty (180)(90) calendar days that constitutes a violation by a provider. At the Administrator's discretion, multiple violations such provider may also be reported to the appropriate certifying board or other appropriate authority, and may be subject the provider to exclusion from participating further in providing care under in the program of the Tennessee Workers' Compensation Act ("Act"). Any provider reimbursed or carrier paying an amount which is in excess of the maximum amount allowed under these Rules shall have a period of one hundred eighty (180)(90) calendar days from the time of receipt or /payment of such excessive payment in which to refund/recover the overpayment amount. If such -amount -is refunded or /recovered within this ninetyone hundred eighty (180)(90) calendar day time period, the overpayment shall not be considered a violation of these Rules by the provider or employer /carrier and shall not be the basis for a penalty against the provider receiving or employer carrier paying the excessive payment.

5. The "lesser of" comparison among (1i) the provider's usual charge, (2ii) the maximum allowable amount pursuant to these Rules, or (3iii) any other contracted amount. (4)(iv) These comparisons ~~should~~ shall be determined based on the entire bill or an amount due for a particular service, rather than on a line-by-line basis.

(3) Fee Schedule Calculations

The Medical Fee Schedule maximum reimbursement amount for professional services is calculated for any specific CPT@™ code by multiplying the Medicare CMS relative value units ("RVUs") with the by Medicare CMS' Tennessee specific Geographic Practice Cost Index ("GPCI") to establish the total Tennessee specific RVUs. That figure is then multiplied by the appropriate conversion factor to establish the base payment amount. ~~specific RVUs, then multiplying the~~ This base payment amount adjusted Tennessee total RVUs is multiplied by the appropriate Medical Fee Schedule Tennessee specific conversion percentage factor. Whether one uses the facility or non-facility RVUs is determined using the ~~current,~~ effective Medicare guidelines on the date of service and is dependent upon the location at which the service is provided. Certain specialty areas listed below do not have a specific conversion factor and the maximum reimbursement amount allowed is the usual and customary amount (defined in the Medical Cost Containment Rules for Medical Payments at 0800-2-17-13(80)), as indicated. For areas not listed, the maximum allowable amount is 100% of the Tennessee specific Medicare allowable amount calculated in accordance with Medicare guidelines and methodology effective on the date of service, except where a waiver has been granted by the bureau.

- (4) Practitioner fees shall be based on the Medical Fee Schedule conversion factor of 33.9764, which shall be used in conjunction with the effective most current Medicare RVUs on the date of service, as adjusted above. The Administrator Division may designate another baseline Medical Fee Schedule conversion factor at any time, through the rulemaking process. The Tennessee--Sspecific eConversion pPercentage factors listed below should be applied to the appropriate service category in order to calculate the correct appropriate charge or billing amount (Anesthesia by units, see Rule 0800-02-18-.05):

<u>Service Category by Medical Specialty</u>	<u>TN Specific Conversion %</u>
--	---------------------------------

Anesthesiology.....	\$75.00 per unit
Orthopaedics and Neurosurgery*	275%
General Surgery.....	200%
Radiology.....	200%
Pathology.....	200%
Physical/Occupational Therapy.....	130%
Chiropractic.....	130%

General Medicine
(including Evaluation & Management)..... 160% All

Evaluation and Management (E/M) codes are paid at 160% (not specialty dependent). This percentage is not applicable to PA and NP charges, who shall be paid at the standard Medicare rates. See 0800-02-18-.04(2)(c) for rates for surgery involving a PA or NP.

Emergency Care.....200%

Home Health Services (episodic and not "LUPA" adjustment)... 100% of Medicare

DDentistry.....100% using ADA dental codes.

Oral Surgery follows the surgery percentage when using CPT® codes.

* Board certified or Board eligible Orthopaedists and Neurosurgeons may use the modifier "ON" on the appropriate billing HCFA 1500 form when submitting surgical charges. If the modifier or another indicator is not placed on the form, then the Tennessee Department of Health's database may be consulted in order to determine the provider's specialty.

(5) Forms

- (a) The following forms (or their official replacements) should be used for provider billing:
The effective current version of the CMS 1500 and UB 92 04 or the electronic equivalents.
- (b) Bills for reimbursement shall be sent directly to the employerparty responsible for reimbursement. In most instances, this is the Insurance Carrier or the Self-Insured Employer. Insurance Carriers and/or Employers shall furnish this billing information to the Providers, and such information must be accurate and updated, within thirty (30) calendar days of anysixty change to the billing address of the responsible party, either mail, e-mail or electronic submission.

(6) Violations of Fee Schedule Rules and Medical Cost Containment Rules for Medical Payments

- (a) The Administrator, Administrator's Designee, or an agency member appointed by the Administrator, shall have the authority to issue civil penalties from \$50.00 (fifty dollars) up to \$105,000.00 (onefifty thousand dollars) per violation for violations of the Medical Fee Schedule Rules, In-patient Hospital Fee Schedule Rules or the

~~Rules for Medical Payments Medical 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 Administrator, Administrator’s Designee, or an agency member appointed by the Administrator pursuant to the Uniform Administrative Procedures Act, Tenn. Code Ann. § 4-5-101 et seq., if a written request is submitted to the ~~Bureau~~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. §§ ~~50-6-102, 50-6-204, 50-6-205, 50-6-226, 50-6-233~~ (Repl. 2005), ~~and Public Chapters 282 & 289~~ (2013). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Emergency rules filed April 27, 2006; effective through October 9, 2006. Amendment ~~filed~~ January 8, 2007; effective March 24, 2007. Amendments filed December 20, 2007; effective March 4, 2008. Amendments filed June 12, 2009; effective August 26, 2009. Emergency rule filed September 2, 2011; effective through February 29, 2012. Withdrawal of emergency rule 0800-02-18(4) filed November 8, 2011 by the Department of Labor and Workforce Development; withdrawal effective November 8, 2011. Amendments filed March 12, 2012; to have been effective June 10, 2012. The Government Operations Committee filed a stay on May 7, 2012; new effective date August 9, 2012. Amendment filed December 26, 2013; effective March 26, 2014.

0800-02-18-.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 effective~~ editions of the AMA’s CPT® Guide and Medicare RBRVS in effect on the date of service: The Physicians’ Guide applies 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. ~~CPT-3 Codes of current dental terminology prescribed by the~~ American Dental Association, including the terminology updates and revisions 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® and the Medicare RBRVS: The Physicians’ Guide, the following Medical Fee Schedule Rule Guidelines also apply. For a Tennessee claim, whenever a conflict exists between these Medical Fee Schedule Rules and any other state fee schedule, rule or regulation, these Rules shall govern, except when a waiver has been granted by the Bureau.
- (3)(4) For free standing or in-office laboratory, pathology and toxicology procedures including urine drug screens (UDS), these services shall be reimbursed at the pathology percentage when there is a G codes or applicable cross-walk CPT® code.—See 0800-02-18-.02(4). For any urine drug screens, the laboratory requisition must specify exactly which drugs are to be tested and why. The billing code(s) submitted shall be those recognized by Medicare as appropriate for the date of service. The frequency of urine drug screens should be in accord with the most recent version of the Department of Health Tennessee Chronic Pain Guidelines, Clinical Practice Guidelines for the Outpatient Management of Chronic Non-Malignant Pain.

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006.

0800-02-18-.04 SURGERY GUIDELINES.

- (1) Multiple Procedures: Maximum reimbursement shall be based on 100% of the appropriate Medical Fee Schedule amount for the major procedure plus each additional appropriately coded secondary and/or multiple multiple procedures according to MedicareCMS guidelines (including endoscopy and other applicable "families) and CPT® CCI edits. plus 50% of the lesser or secondary procedure(s). The major procedure shall be determined to be the procedure with the highest Medicare reimbursement.
- (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 the maximum allowable Medical Fee Schedule amount.
 - (b)(c) ~~Appropriately licensed Physician Assistants and Advance Practice Nurses (Nurse Practitioners) uly licensed physician assistants may serve as surgical assistants as deemed appropriate by the physician, and if so, that assistants' reimbursement shall not exceed 100% of the Pphysician Aassistant fee or Advance Practice Nurse feethat would be due under Medicare guidelines, without regard to for conversion factors or percentages applicable to their supervising physician specialty contained in these workers' compensation Medical Fee Schedule.~~
 - (d) 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 employercarrier has received each surgeon's individual operative report and bill. Reimbursement to both surgeons shall be in accord with Medicare guidelines 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.
 - (e)(e) The need for a surgical assistant, assisting surgeon, co-surgeon, second surgeon or team surgery will follow Medicare status indicators. The payment amount will depend on the specialty as designated in 0800-02-18-.02(4) and 0800-02-18-.04(2).
- (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, in accord with Medicare guidelines. —All exceptions require use of the appropriate modifiers.
- (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, commonly known as a global fee. 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 and 50-6-233 (Repl. 2005). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed

November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendment filed March 12, 2012; to have been effective June 10, 2012. The Government Operations Committee filed a stay on May 7, 2012; new effective date August 9, 2012.

0800-02-18-.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, maximum reimbursement shall be 90% of the maximum allowable fee for anesthesiologists under these Medical Fee Schedule Rules. No additional payment will be made to any physician supervising the CRNA.
- (c) Whenever anesthesia services are provided by an anesthesiologist or other physician and a CRNA, reimbursement shall never exceed 100% of the maximum amount an anesthesiologist or physician would have been allowed under these Medical Fee Schedule Rules had the anesthesiologist or physician alone performed these services.

(2) Anesthesia Values

- (a) Each anesthesia service contains two value components which make up the charge and determine reimbursement: a Basic Value and a Time Value, and physical status modifiers and qualifying circumstance codes that may be appropriately added according to Medicare guidelines.
- (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

- (a) 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, and physical status modifiers and qualifying circumstance codes that may be appropriately added according to Medicare guidelines. The TAV is calculated for the purpose of determining reimbursement.

(4) Billing

- (a) 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, or its presently accepted equivalent. The total time in minutes must be entered in Element 24 G of the HCFA 1500 Form. Include the appropriate modifiers.

(5) Reimbursement

- (a) Reimbursement for anesthesia services shall not exceed the maximum allowable Medical Fee Schedule amount of \$75.00 per unit.

(6) Medical Direction Provided by Anesthesiologists

- (a) 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 an appropriately documented extreme emergency situations. Total reimbursement for the nurse anesthetist and the anesthesiologist shall not exceed the maximum amount allowable under the Medical Fee Schedule Rules had the anesthesiologist alone performed the services.

(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. payment is included in the surgical procedure reimbursement, according to Medicare guidelines. To identify the anesthesia service, list the CPT surgical procedure code and add Modifier 47.~~

- ~~(i) Reimbursement shall not exceed the maximum amount allowable under these Medical Fee Schedule Rules of \$75.00 per unit.~~

~~(ii)~~

~~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 by report. -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.
- (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 and 50-6-233 (Repl. 2005). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendments filed December 20, 2007; effective March 4, 2008.

0800-02-18-.06 INJECTIONS GUIDELINES.

Reimbursement for injection(s) (such as J codes) includes allowance for CPT® code ~~9078296372~~. n 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"). Follow the Medicare guidelines in effect for the date of service for both single and multiple use vials of injectable medications for both medications and procedures. Immunization codes (vaccines and toxoid) should be reimbursed for both the medication and the procedure, reported separately with number of units administered.

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006.

0800-02-18-.07 AMBULATORY SURGICAL CENTERS AND OUTPATIENT HOSPITAL CARE (INCLUDING EMERGENCY ROOM FACILITY CHARGES).

- (1) ~~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.~~
 - (a) For the purpose of the Medical Fee Schedule Rules, "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.

- (b) The CMS has implemented the Outpatient Prospective Payment System ("OPPS") under Medicare for reimbursement for hospital outpatient services at most hospitals. All services paid under the new OPPS 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. Current APC Medicare allowable payment amounts and guidelines are available online at: <http://www.cms.hhs.gov/HospitalOutpatientPPS>. The payment rate for each APC group is the basis for determining the maximum total payment to which an ASC or hospital outpatient procedure or center will be entitled, including add-ons, hospital outpatient procedures, multiple procedure discounts and status indicators, according to current CMS guidelines.
- (c) Under the Medical Fee Schedule Rules, the OPPS reimbursement system shall be used for reimbursement for all outpatient services, wherever they are performed, in a free-standing ASC or hospital setting. The most current, effective Medicare APC rates shall be used as the basis for facility fees charged for outpatient services and shall be reimbursed at a maximum of 150% of current value for such services. Depending on the services provided, ASCs and hospitals may be paid for more than one APC for an encounter. When multiple surgical procedures are performed during the same surgical session, maximum reimbursement shall be based on 100% of the appropriate Medical Fee Schedule amount for the major procedure plus 50% of the lesser or secondary procedure(s); provided, that the major procedure shall be determined to be the procedure with the highest Medicare reimbursement. Only separate and distinct surgical procedures shall be billed. Medicare guidelines shall be consulted and used in determining separate and distinct surgical procedures and the order of payment.
- (d) If a claim contains services that result in an APC payment but also contains packaged services, separate payment of the packaged services is not made since the payment is included in the APC. However, charges related to the packaged services are used in setting outlier calculations.
- (e) Reimbursement for all outpatient services is based on the Medicare Ambulatory Payment Classification ("APC") national unadjusted base rates, which can be obtained from the Centers for Medicare and Medicaid Services. There are no adjustments for wage-price indices and these are not hospital-specific APC rate calculations. Reimbursements for Critical Access Hospitals ("CAH") are not based on CAH methodology but on the national unadjusted APC base rates as described in the preceding sentence.
- (f) Status indicators used under Medicare should be interpreted using Medicare guidelines with the exception of status indicator "C," which Medicare does not reimburse for outpatient services, but requires inpatient treatment. Under these Rules, these procedures listed with status indicator "C" performed on an outpatient basis shall be reimbursed, but with the maximum amount being usual & customary, which is 80% of the billed charges, as defined in the Bureau's Rules for Medical Payments, Division's Rule 0800-2-17-03(80).
- (g) All other outpatient hospital care in all ASCs and all hospitals, 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 services and shall be reimbursed at a maximum rate of 150% of the current value of Medicare reimbursement for outpatient hospital care.
- (h) ~~Facility services do not include (the following services may be billed and reimbursed separately from the facility fees, if allowed under current Medicare guidelines, with the exception of implantables, which at the discretion of the facility shall be billed and reimbursed separately in all cases and in all settings unless they are billed and~~

~~reimbursed as part of a package or bundled charge):~~

~~(h) All of the following services are to be reimbursed according to in accordance with the Medicare status indicators effective on the date of service or according to the Medicare guidelines concerning hospital outpatient diagnostic services rates, in effect on the date of service.~~

~~1. Physician services, including pathologists, radiologists and anesthesiologists and CRNAs.~~

~~2. Laboratory Services (including pathology)~~

~~3.2. Radiology services (professional and/or technical components may only be separately reimbursed when not included in APC)~~

~~4.3. Diagnostic procedures not related to the surgical procedure~~

~~5.4. Prosthetic devices~~

~~6.5. Ambulance services~~

~~7.6. Orthotics~~

~~8.7. Implantables~~

~~9.8. DME for use in the patient's home~~

~~CRNA or Anesthesia Physician Services (suspension of CRNA is included in the facility fee)~~

~~10.9. Take home medications~~

~~11.10. Take home supplies~~

~~(i) 1. For cases involving implantation of medical devices (implantables), regardless of the current Medicare status indicators, payment shall be made only to the facility. the facility shall at their discretion for each individual patient case, choose to bill and shall subsequently be reimbursed at either:~~

~~1. 150% of the entire Medicare OPPS payment as described above; or~~

~~2. 150% of the non-device portion of the APC within the Medicare OPPS payment and separately bill and be reimbursed for implantable medical devices as described under Rule 0800-02-18-10.~~

~~2. For DME, orthotics and prosthetics used in the patient's home that is supplied by the facility, payment shall be made only to the facility (at the rates specified in 0800-02-18-10 and 0800-02-18-11), and not to any other separate entity for these services. No extra payment shall be made for these services if according to CMS regulations and status indicators when those particular services are included in the APC payment.~~

~~(j) The listed services and supplies in subsection (1)(h) above shall be reimbursed according to the Medical Fee Schedule Rules, or at the usual and customary amount, as defined in these Rules, for items/services not specifically addressed in the Medical Fee Schedule Rules.~~

~~1. There may be emergency cases or other occasions in which the patient was scheduled for outpatient surgery and it becomes necessary to admit the patient. All hospitals with ambulatory patients who stay longer than 23 hours past ambulatory surgery or other diagnostic procedures and are formally admitted to the hospital as an inpatient will be paid in accordance with according to the In-patient Hospital Fee Schedule Rules, 0800-02-19. All ASCs shall be paid pursuant to this Rule 0800-02-18-07 regardless of the patient's length of stay. Medicare hospital criteria shall apply to~~

these cases.

- (k) 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, according to Medicare guidelines. Pre-admission lab and radiology are not included in the facility fee.
- (l) Facility fees for surgical procedures not listed shall be reimbursed by report BR with a maximum of the usual and customary rate as defined in the Division's Rule 0800-02-17-.03(80).
- (m) There may be emergency cases or other occasions in which the patient was scheduled for outpatient surgery and it becomes necessary to admit the patient. All hospitals with ambulatory patients who stay longer than 23 hours past ambulatory surgery or other diagnostic procedures and are formally admitted to the hospital as an inpatient will be paid in accordance with ~~according to~~ the In-patient Hospital Fee Schedule Rules, 0800-02-19. ~~All ASCs shall be paid pursuant to this Rule 0800-02-18-.07 regardless of the patient's length of stay. Medicare hospital criteria shall apply to~~ these cases.

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Emergency rules filed April 27, 2006; effective through October 9, 2006. Amendment filed January 8, 2007; effective March 24, 2007. Amendment filed December 20, 2007; effective March 4, 2008. Amendments filed June 12, 2009; effective August 26, 2009. Amendments filed March 12, 2012; to have been effective June 10, 2012. The Government Operations Committee filed a stay on May 7, 2012; new effective date August 9, 2012.

0800-02-18-.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 Tenn. Code Ann. § 50-6-204. The same procedures for utilization review applicable to physical therapy and occupational therapy services under Rule 0800-02-18-.09(5) below apply to chiropractic services.
- (2) For chiropractic services, an office visit (E/M code) may only be billed on the same day as a manipulation when it is the patient's initial visit with that provider. During the course of treatment, the chiropractor may bill a second E/M code if the patient does not adequately respond to the initial treatment regimen, and a documented significant change is made in the treatment recommendations.
- ~~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) calendar days from the date of receipt by the employer or insurer of the bill for chiropractic services provided to such an employee, interest at the rate of 245% per annum of the payment allowed pursuant to these rules, compounded monthly, may be charged and paid as set forth in Rule 0800-2-17-.10 of the Medical Cost Containment Program Rules.~~
- (3) 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) 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.

- (4)(5) If the Bureau's adopted treatment guidelines allow for exceptions such as but not limited to the number of modalities or visits, then the guidelines may be used.

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendment filed June 12, 2009; effective August 26, 2009. Amendment filed March 12, 2012; to have been effective June 10, 2012. The Government Operations Committee filed a stay on May 7, 2012; new effective date August 9, 2012.

0800-02-18-.09 OUTPATIENT PHYSICAL AND OCCUPATIONAL THERAPY GUIDELINES.

- (1) Reimbursement for all physical and occupational therapy services shall not exceed one hundred thirty percent (130%) of the maximum allowable fees prescribed in the Medicare RBRVS fee schedule, no matter where the services are performed, except home health services.
- (2) For physical therapy and/or occupational therapy, there shall be no reimbursement 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 or therapeutic procedures performed in excess of four (4) modalities, therapeutic procedures, or combination thereof per day per employee, with no additional reductions such as those to the relative value units (RVUs). The definitions of modality and therapeutic procedures from the most recent American Medical Association's Current Procedural Terminology (CPT®), 2005 edition are applicable.
- (4) ~~For any procedure for which an appropriate Medicare code is not available, such as a Functional Capacity Evaluations, or work hardening, the four unit (time measurement) maximum may not apply as long as the documentation supports the extra units, usual and customary charge, as defined in Rule 0800-2-17-.03(80), shall be the maximum amount reimbursable for such services. The current most recent Medicare CPT® codes available for Functional Capacity Evaluations are not appropriate for use under the Tennessee Workers' Compensation Medical Fee Schedule, thus, usual and customary is the proper reimbursement methodology for these procedures.~~
- (4)(5) For Work Hardening/Conditioning Programs using the approved CPT® codes shall be billed at Usual and Customary hourly charges for a maximum of 6 hours per day or 60 hour maximum and are subject to utilization review prior approval. Payment is 80% of the billed charges.
- (5)(6) Whenever physical therapy and/or occupational therapy services exceed twelve (12) visits, such treatment may shall be reviewed pursuant to the carrier/employer's utilization review program in accordance with the procedures set forth in Chapter 0800-02-06 of the Division's Utilization Review rules before further physical therapy and/or occupational therapy services may be certified for payment by the employer/carrier. Such certification shall be completed within the timeframes set forth in Chapter 0800-02-06 to assure no interruption in delivery of needed services. Failure by a provider to properly certify such services as prescribed herein shall may result in the forfeiture of any payment for uncertified services. Failure by an employer or utilization review organization/agent to conduct utilization review in accordance with this Chapter 0800-02-18 and Chapter 0800-02-06 shall result in no more than twelve (12) additional visits being deemed certified. The initial utilization review of physical therapy and/or occupational therapy services shall, if necessary and appropriate, certify an appropriate number of visits. If necessary, further subsequent utilization review shall may be conducted to certify additional physical therapy and/or occupational therapy services as is appropriate; provided, that further certifications are not required to be in increments of twelve (12) visits.

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Emergency rules filed April 27, 2006; effective through October 9, 2006. Amendment filed January 8, 2007; effective March 24, 2007. Amendments filed December 20, 2007; effective March 4, 2008. Amendment filed June 12, 2009; effective August 26, 2009. Amendment filed March 12, 2012; to have been effective June 10, 2012. The Government Operations Committee filed a stay on May 7, 2012; new effective date August 9, 2012.

0800-02-18-.10 DURABLE MEDICAL EQUIPMENT AND IMPLANTABLES GUIDELINES.

(1) Reimbursement for durable medical equipment and implants for which billed charges are \$100.00 or less shall be limited to eighty (80%) of billed charges. Durable medical equipment and implants for which billed charges exceed \$100.00 shall be reimbursed at a maximum amount of the supplier or manufacturer's invoice amount, plus the lesser of 15% of invoice or \$1,000.00, and coded using the HCPCS codes. These calculations are per item and are not cumulative. Charges for durable medical equipment and implants are in addition to, and shall be billed separately from, all facility and professional service fees. Codes to be used are found in the HCPCS. Charges should be submitted on a HCFA-1500 form or, for hospital reimbursements, a UB-04 form.

(1) Reimbursement for durable medical equipment and implantables for which billed charges:

(a) are \$100.00 or less shall be limited to eighty (80%) of billed charges; Durable medical equipment and implantables for which billed charges

(b) exceed \$100.00 shall be reimbursed at a maximum amount of the supplier or manufacturer's invoice amount, plus the lesser of 15% of invoice or \$1,000.00, and coded using the HCPCS codes. These calculations are per item and are not cumulative. Charges for durable medical equipment and implantables are in addition to, and shall be billed separately from, all facility and professional service fees.

(c) This Rule shall not apply to durable medical equipment and medical supplies, other than implantables, with applicable Medicare allowable amounts. Such durable medical equipment and medical supplies, including home DMEs, infusion and oxygen services, other than implantables, shall be reimbursed at the lesser of the billed charges or 100% of the applicable Medicare allowable amount.

(2) 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.

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(3) Rental/Purchase. Rental fees are applicable in instances of short-term utilization (30-60 days). The maximum allowable rental fee for DME is 100% of the Tennessee Medicare allowable amount. 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".

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(4) 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.

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Not.

(a) Rentals

(+) 1. Include the following supplies:

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(+) (i) lead wires;

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(+)(i) (ii) two (2) rechargeable batteries;

- (III)(II) (iii) battery charger;
- (IV)(III) (iv) electrodes; and
- (V)(IV) (v) instruction manual and/or audio tape.

(ii) 2. Supplies submitted for reimbursement must be itemized. In unusual circumstances where additional supplies are necessary, use modifier 22 and "BR"

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(iii)(ii) 3. Limited to 30 days trial period.

2. (b) Purchase:

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(i)(iii) 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) (i) Describe the condition and diagnosis that necessitates the use of a TENS unit.

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(II)(I) (ii) Does the patient have any other implants which would affect the performance of the TENS unit or the implanted unit?

(III)(II) (iii) Was the TENS unit effective for pain control during the trial period?

(IV)(III) (iv) Was the patient instructed on the proper use of the TENS unit during the trial period?

(V)(IV) (v) How often does the patient use the TENS unit?

(VI)(iv) 2. The purchase price should include the items below if not already included with the rental: (i) lead wires;

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(VII)(I) (ii) two (2) rechargeable batteries; and

(VIII)(II) (iii) a battery charger.

(ii)(v) 3. Only the first month's rental price shall be credited to purchase price.

(iii) 4. The provider shall indicate TENS manufacturer, model name, and serial number.

(iv) —

(5) Continuous and Passive Motion and Other External Exercise/Treatment Devices (Use see Medicare CMS Code)

3.2. (a) Use of this unit in excess of the days recommended by the Bureau's adopted treatment guidelines requires documentation of medical necessity by the doctor. Only one (1) set of soft goods will be allowed for purchase.

(2) (b) The use of cold compression therapy units and other external exercise/treatment devices in excess of 7 days (or the length of use recommended by the Bureau's adopted treatment guidelines) requires documentation of the device's use and medical necessity and may be subject to utilization review. This Rule 0800-02-18-10 shall not apply to durable medical equipment and medical supplies (other than implants) with applicable Medicare allowable amounts. Such durable medical equipment and

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medical supplies (other than implants) shall be reimbursed at the lesser of the billed charges or 100% of the applicable Medicare allowable amount.

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendment filed December 20, 2007; effective March 4, 2008. Amendments filed June 12, 2009; effective August 26, 2009. Amendment filed March 12, 2012; to have been effective June 10, 2012. The Government Operations Committee filed a stay on May 7, 2012; new effective date August 9, 2012.

0800-02-18-.11 ORTHOTICS AND PROSTHETICS GUIDELINES.

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, 330 John Carlyle Street, Suite 200, Alexandria, VA 22314, (571) 431-0876. Orthotics and prosthetics shall be reimbursed up to a maximum of 115% of the Tennessee Medicare allowable amount 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 and the maximum reimbursement shall be the usual and customary amount. Charges should be submitted on a HCFA or CMS 1500 form.

(1) ~~(1)~~ Orthotics and prosthetics, not supplied under 0800-02-18-.077(i), should be coded according to the HCFA Common Procedures Coding System (HCPCS). ~~Copies may be obtained from the American Orthotic and Prosthetic Association, 330 John Carlyle Street, Suite 200, Alexandria, VA 22314, (571) 431-0876.~~ Payment shall be 115% of Tennessee Medicare allowable amount. If the invoice costs exceed the Medicare payments amounts at the time of delivery, the payment for Orthotics and prosthetics shall be the higher of invoice costs or reimbursed up to a maximum of 115% of the Tennessee Medicare allowable amount and coded using the HCPCS code. Charges for these items are in addition to, and shall be billed separately from, all other facility and professional service fees. Supplies and equipment should be coded 99070 if appropriate codes are not available in the HCPCS and the maximum reimbursement shall be the usual and customary amount. Charges should be submitted on the HCFA 1500 form or its approved successor form.

~~(1)(2)~~ Fitting and customizing codes may be reimbursed separately according to Medicare guidelines.

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendment filed December 20, 2007; effective March 4, 2008. Amendment filed June 12, 2009; effective August 26, 2009.

0800-02-18-.12 PHARMACEUTICAL SCHEDULE GUIDELINES.

(1) The Pharmacy Fee Guideline maximum allowable amount for prescribed drugs (medicines by pharmacists and dispensing practitioners) under the Tennessee workers' compensation laws is the lesser of:

- (a) The provider's usual charge;
- (b) A negotiated contract or lower amount; or
- (c) The fees established by the formula for brand-name and generic pharmaceuticals as described in the following subsections.
- (d) Prescribed Medication Services

1. "Drug" has the meaning set out in Tenn. Code Ann. § 63-10-204.

2. Medicine or drugs may only be dispensed by a currently licensed pharmacist or a dispensing practitioner.
3. 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.
4. 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."

(e) Reimbursement

1. The pharmaceutical reimbursement formula for prescribed drugs (medicines by pharmacists and dispensing practitioners) is the lesser of:
 - (i) Average Wholesale Price* ("AWP") + \$5.10 filling fee; (only the original manufacturer's NDC number should be used in determining AWP); or
 - (ii) the provider's usual charge;
 - ~~(iii)~~ (ii) a negotiated contractual or other lesser amount, that is less than or equal to the above reimbursements.

~~The Administrator 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 Administrator's discretion.~~

2. If the original manufacturer's NDC number is not provided on the bill, then the reimbursement shall be based on the AWP of the lowest priced therapeutically equivalent drug, calculated on a per unit basis.

- 2.3. Reimbursement to pharmacists or any third-party billing agency or other contracted agent of a pharmacy shall never exceed the maximum amount calculated by the pharmaceutical reimbursement formula for prescribed drugs. The usual and customary charge of the pharmacy for the medication must be included on each bill. A generic drug must be substituted for any brand name drug unless there is no pharmaceutical and bioequivalent drug available, or 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.

- (i) A bill or receipt for a prescription drug shall include all of the following:
 - (l) 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."

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- (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 original manufacturer's National Drug Code Number ("NDC - Number"), if one is available.
- (ii) 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 Medi-Span, available online at the following web site: www.medi-span.com/Products/index.aspx?id+27.
 - (II) Secondary reference: (for drugs NOT found in PriceAlert) the Red Book from Medical Economics.
- (iii) 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.
- (iv) A compounding fee not to exceed ~~Twenty-five~~ 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 or pharmacy or provider of service other than a physician.
- ~~(v) 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 0800-02-17.10 of the Medical Cost Containment Program Rules.~~

(vi)(v) 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.

(f) "Patent" or "Proprietary Preparations"

1. "Patent" or "Proprietary preparations," frequently called "over-the-counter drugs," are sometimes prescribed for a work-related injury or illness instead of a legend drug.
2. Generic substitution as discussed in (e)(2) above applies also to "over-the-counter" preparations.
3. Pharmacists must bill and be reimbursed their usual retail price and ~~customary charge~~ for the "over-the-counter" drug(s).
4. The reimbursement formula does not apply to the "over-the-counter" drugs and no filling fee may be reimbursed.

(g) Dispensing Practitioner

1. Dispensing practitioners shall be reimbursed the same as pharmacists for prescribed drugs (medicines), except such practitioners shall not receive a filling fee.
2. "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:
 - (i) 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.
 - (ii) An invoice indicating the cost to the dispensing physician of the "proprietary preparation" must be submitted to the carrier with the HCFA 1500 Form.
 - (iii) Reimbursement is limited to the lesser of the provider's billed charge or 20 percent above the actual cost to the dispensing physician of the item.

(h) Repackaged or Compounded Products

All pharmaceutical bills submitted for repackaged or compounded products must include the NDC Number of the original manufacturer registered with the U.S. Food & Drug Administration or its authorized distributor's stock package used in the repackaging or compounding process. The reimbursement allowed shall be based on the current published manufacturer's AWP of the product or ingredient, calculated on a per unit basis, as of the date of dispensing. A repackaged or compounded NDC Number shall not be used and shall not be considered the original manufacturer's NDC Number. If the original manufacturer's NDC Number is not provided on the bill, then the reimbursement shall be based on the AWP of the lowest priced therapeutically equivalent drug, calculated on a per unit basis. The filling fees otherwise provided in these Rules shall be payable when applicable.

Authority: T.C.A. §§ 50-6-102, 50-6-204, 50-6-205, 50-6-226, 50-6-233 (Repl. 2005), and Public Chapters 282 & 289 (2013). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30,

2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendment filed June 12, 2009; effective August 26, 2009. Amendments filed March 12, 2012; to have been effective June 10, 2012. The Government Operations Committee filed a stay on May 7, 2012; new effective date August 9, 2012. Amendment filed December 26, 2013; effective March 26, 2014.

0800-02-18-.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 may be retrospectively certified reviewed within 72 hours of the service or within three (3) business days.
- (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 or CMS 1500 claim form by HCPCS code. Hospital based or owned providers must submit charges on a HCFA or CMS 1500 form by HCPCS code.
- (4) Reimbursement shall be based upon the lesser of the submitted charge or 150% of the current Medicare rate. To the extent permitted by federal law, the rates determined in the preceding sentence shall also apply to air ambulance services.

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendment filed March 12, 2012; to have been effective June 10, 2012. The Government Operations Committee filed a stay on May 7, 2012; new effective date August 9, 2012.

0800-02-18-.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 twelve (12)~~fifteen (15)~~ sessions/visits, then such treatment may 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 ~~twelve (12)~~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 and 50-6-233 (Repl. 2005). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006.

0800-02-18-.15 PENALTIES FOR VIOLATIONS OF FEE SCHEDULES.

- (1) ~~Except when a waiver is granted by the Bureau, 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 for Medical Payments, Medical Fee Schedule Rules or the In-patient Hospital Fee Schedule Rules, when that amount exceeds the maximum allowable payment established by these Rules, unless otherwise provided by T.C.A. 50-6-204. Any provider accepting and any employer or carrier paying an amount in excess of the TDWC Medical Cost Containment Program Rules for Medical Payments, Medical Fee Schedule Rules or the In-patient Hospital Fee Schedule Rules, unless otherwise provided by T.C.A. 50-6-204, shall be in violation of these Rules and may, at the Administrator's discretion, be subject to civil penalties whenever a pattern or practice of such activity is found, in accordance with the Uniform Rules of Procedure for Penalty Assessments and Hearing Contested Cases before the Bureau of Workers' Compensation of up to ten thousand dollars (\$10,000.00)(one thousand) 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. Any provider reimbursed or employercarrier paying an amount which is in excess of these Rules shall have a period of ninetyone hundred eighty (180)(90) calendar days from the time of receipt/payment of such excessive payment in which to refund/recover the overpayment amount. Overpayments refunded/recovered within this time period shall not constitute a violation under these Rules. At the discretion of the Administrator, the Administrator's Designee, or an agency member appointed by the Administrator, 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 violations of the Medical Cost Containment Program Rules for Medical Payments, Medical Fee Schedule Rules, or the In-patient Hospital Fee Schedule Rules except as allowed by law shall subject the violator(s) to a civil penalties of not less than one hundred dollars (\$100.00) nor more than ten thousand dollars (\$10,000.00) (one thousand) per violation in accordance with the Uniform Rules of Procedure for Penalty Assessments and Hearing Contested Cases before the Bureau of Workers' Compensation, at the discretion of the Administrator, Administrator's Designee, or an agency member appointed by the Administrator.~~
- (2) A provider, employer or carrier found 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. All rights, duties, obligations, and procedures applicable under the Uniform Administrative Procedures Act, Tenn. Code Ann. § 4-5-101 et seq., are applicable under these Rules, including, but not limited to, the right to judicial review of any final departmental decision.
- (3) The request for a hearing shall be made to the ~~Bureau~~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 ~~Bureau~~Division within fifteen (15) calendar days of the date of issuance of the Notice of Violation and, if applicable, of civil penalty by the Administrator. 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 Administrator, Administrator's Designee, or an agency member appointed by the Administrator being deemed a final order and not subject to further review.
- (5) The ~~Administrator~~ Commissioner, ~~Administrato~~Commissioner's Designee, or an agency member appointed by the ~~Administrator~~Commissioner shall have the authority to hear any matter as a contested case and determine if any civil penalty assessed should have been assessed. All procedural aspects set forth in the ~~Bureau~~Division's Penalty Program Rules, Chapter 0800-2-13, shall apply and be followed in any such contested case hearing.

- (6) Upon receipt of a timely filed request for a hearing, the AdministratorCommissioner shall issue a Notice of Hearing to all interested parties.

Authority: T.C.A. §§ 50-6-102, 50-6-204, 50-6-205, 50-6-226, 50-6-233 (Repl. 2005), Public Chapters 282 & 289 (2013). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendment filed June 12, 2009; effective August 26, 2009. Amendment filed December 26, 2013; effective March 26, 2014.

I certify that the information included in this filing is an accurate and complete representation of the intent and scope of rulemaking proposed by the agency.

Date: _____

Signature: _____

Name of Officer: _____

Title of Officer: _____

Subscribed and sworn to before me on: _____

Notary Public Signature: _____

My commission expires on: _____

Department of State Use Only

Filed with the Department of State on: _____

Tre Hargett
Secretary of State

- (6) Upon receipt of a timely filed request for a hearing, the Administrator shall issue a Notice of Hearing to all interested parties.

Authority: T.C.A. §§ 50-6-102, 50-6-204, 50-6-205, 50-6-226, 50-6-233 (Repl. 2005), Public Chapters 282 & 289 (2013). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendment filed June 12, 2009; effective August 26, 2009. Amendment filed December 26, 2013; effective March 26, 2014.

* If a roll-call vote was necessary, the vote by the Agency on these rules was as follows:

Board Member	Aye	No	Abstain	Absent	Signature (if required)

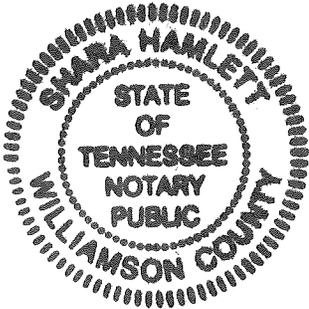
I certify that this is an accurate and complete copy of rulemaking hearing rules, lawfully promulgated and adopted by the Tennessee Bureau of Workers' Compensation on 8/22/17 and is in compliance with the provisions of T.C.A. § 4-5-222.

I further certify the following:

Notice of Rulemaking Hearing filed with the Department of State on April 13, 2017.

Rulemaking Hearing Conducted on June 8, 2017.

Date: August 22, 2017
 Signature: Abbie Hudgens
 Name of Officer: Abbie Hudgens
 Title of Officer: Administrator, Bureau of Workers' Compensation
 Subscribed and sworn to before me on: August 22, 2017
 Notary Public Signature: [Signature]
 My commission expires on: 2/19/20



All proposed rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

Herbert H. Slatery III
 Herbert H. Slatery III
 Attorney General and Reporter
 Date 10/23/2017

Department of State Use Only

Filed with the Department of State on:

11/27/17

Effective on:

2/25/18

Tre Hargett

Tre Hargett
Secretary of State

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G.O.C. STAFF RULE ABSTRACT

DEPARTMENT: Labor and Workforce Development

DIVISION: Bureau of Workers' Compensation

SUBJECT: Rules for Medical Payments

STATUTORY AUTHORITY: Tennessee Code Annotated, Section 50-6-204

EFFECTIVE DATES: February 25, 2018 through June 30, 2018

FISCAL IMPACT: Minimal

STAFF RULE ABSTRACT: These rules together with the Medical Fee Schedule and Inpatient Hospital Fee Schedule Rules establish a comprehensive medical fee schedule, procedures for review of bills and enforcement procedures.

Public Hearing Comments

One copy of a document containing responses to comments made at the public hearing must accompany the filing pursuant to T.C.A § 4-5-222. Agencies shall include only their responses to public hearing comments, which can be summarized. No letters of inquiry from parties questioning the rule will be accepted. When no comments are received at the public hearing, the agency need only draft a memorandum stating such and include it with the Rulemaking Hearing Rule filing. Minutes of the meeting will not be accepted. Transcripts are not acceptable.

PUBLIC COMMENTS AND RESPONSES

Comment (Concentra): In 0800-02-17-.05(5), it is suggested that the Bureau clarify that the Bureau does not intend to apply the Medicare "only rural" guideline for telehealth services, but will use the accepted concept of telehealth services to be used across the state with no geographic limitations as reflected in the Department of Health rules.

Response: The Bureau agrees with this comment, and clarifying language has been added to 0800-02-17-.05 (5): "with the exception of any geographic restriction."

Comment (NCPDP): In 0800-02-17.03(75), 0800-02-17-.10(4), it is recommended that the NCPDP Workers' Compensation/Property & Casualty Universal Claim Form (WC/PC UCF) be adopted as a standard form.

Response: The Bureau agrees and has made the following change in 0800-02-17-.03 (75) and 17-.10 (4): "and the NCPDP WC/PC UCF for pharmacies."

Comment (Bureau of WC): In 0800-02-17-.18, there is concern regarding out-of-state providers not accepting the Tennessee fee schedule, particularly in border states, where the fee schedule may be higher.

Response: The Bureau has added the following language: "Upon waiver granted by the Bureau."

Comment (Bureau of WC): The following clarifying edits were suggested and were made:

In 0800-02-17-.03, the Medical Care Cost Containment Program Rules are now known as the Rules for Medical Payment.

In 0800-02-17-.11, a qualifier was added as to how to determine if the fee schedule does or does not apply: "If the service delivered is determined to be reasonable and necessary, the reimbursed expenses may exceed the maximum fee schedule amount."

In 0800-02-17-.24 (3) the word "may" should be changed to "shall".

Regulatory Flexibility Addendum

Pursuant to T.C.A. §§ 4-5-401 through 4-5-404, prior to initiating the rulemaking process as described in T.C.A. § 4-5-202(a)(3) and T.C.A. § 4-5-202(a), all agencies shall conduct a review of whether a proposed rule or rule affects small businesses.

1. The type or types of small business and an identification and estimate of the number of small businesses subject to the proposed rule that would bear the cost of, or directly benefit from the proposed rule: The amended rules will affect small employers that fall under the Tennessee Workers' Compensation Laws, which would be employers with at least five employees, or for those in the construction industry at least one employee. There should be no additional costs associated with these rule changes.

2. The projected reporting, recordkeeping and other administrative costs required for compliance with the proposed rule, including the type of professional skills necessary for preparation of the report or record. There is no additional record keeping requirement or administrative cost associated with these rule changes.

3. A statement of the probable effect on impacted small businesses and consumers: These rules should not have any impact on consumers or small businesses.

4. A description of any less burdensome, less intrusive or less costly alternative methods of achieving the purpose and objectives of the proposed rule that may exist, and to what extent the alternative means might be less burdensome to small business: There are no less burdensome methods to achieve the purposes and objectives of these rules.

5. Comparison of the proposed rule with any federal or state counterparts: None.

6. Analysis of the effect of the possible exemption of small businesses from all or any part of the requirements contained in the proposed rule: Exempting small businesses could frustrate the small business owners' access to the services provided by the Bureau of Workers' Compensation and timely medical treatment for injured workers, which would be counter-productive.

Impact on Local Governments

Pursuant to T.C.A. §§ 4-5-220 and 4-5-228 "any rule proposed to be promulgated shall state in a simple declarative sentence, without additional comments on the merits of the policy of the rules or regulation, whether the rule or regulation may have a projected impact on local governments." (See Public Chapter Number 1070 (<http://state.tn.us/sos/acts/106/pub/pc1070.pdf>) of the 2010 Session of the General Assembly)

These proposed rules will have little, if any, impact on local governments.

Additional Information Required by Joint Government Operations Committee

All agencies, upon filing a rule, must also submit the following pursuant to T.C.A. § 4-5-226(i)(1).

- (A) A brief summary of the rule and a description of all relevant changes in previous regulations effectuated by such rule;

These rules together with the Medical Fee Schedule and In-patient Hospital Fee Schedule Rules establish a comprehensive medical fee schedule, procedures for review of bills and enforcement procedures.

- (B) A citation to and brief description of any federal law or regulation or any state law or regulation mandating promulgation of such rule or establishing guidelines relevant thereto;

T.C.A. § 50-6-204 provides that the Bureau administrator is authorized to establish by rule a comprehensive medical fee schedule and will review it annually and make revisions as necessary.

- (C) Identification of persons, organizations, corporations or governmental entities most directly affected by this rule, and whether those persons, organizations, corporations or governmental entities urge adoption or rejection of this rule;

All parties to a workers' compensation claim will be affected by the adoption or rejection of these rules.

- (D) Identification of any opinions of the attorney general and reporter or any judicial ruling that directly relates to the rule;

None

- (E) An estimate of the probable increase or decrease in state and local government revenues and expenditures, if any, resulting from the promulgation of this rule, and assumptions and reasoning upon which the estimate is based. An agency shall not state that the fiscal impact is minimal if the fiscal impact is more than two percent (2%) of the agency's annual budget or five hundred thousand dollars (\$500,000), whichever is less;

The overall effect will have little fiscal impact upon state or local government.

- (F) Identification of the appropriate agency representative or representatives, possessing substantial knowledge and understanding of the rule;

Troy Haley, Legislative Liaison and Director of Administrative Legal Services

- (G) Identification of the appropriate agency representative or representatives who will explain the rule at a scheduled meeting of the committees;

Troy Haley, Legislative Liaison and Director of Administrative Legal Services

- (H) Office address, telephone number, and email address of the agency representative or representatives who will explain the rule at a scheduled meeting of the committees; and

Tennessee Bureau of Workers' Compensation
220 French Landing Drive, Floor 1-B
Nashville, TN 37243
(615) 532-0179
troy.haley@tn.gov

- (I) Any additional information relevant to the rule proposed for continuation that the committee

requests.

None

Department of State
Division of Publications
 312 Rosa L. Parks, 8th Floor Snodgrass/TN Tower
 Nashville, TN 37243
 Phone: 615.741.2650
 Email: publications.information@tn.gov

For Department of State Use Only

Sequence Number: 11-18-17
 Rule ID(s): W652
 File Date: 11/27/17
 Effective Date: 2/25/18

Rulemaking Hearing Rule(s) Filing Form

Rulemaking Hearing Rules are rules filed after and as a result of a rulemaking hearing (Tenn. Code Ann. § 4-5-205).

Pursuant to Tenn. Code Ann. § 4-5-229, any new fee or fee increase promulgated by state agency rule shall take effect on July 1, following the expiration of the ninety (90) day period as provided in § 4-5-207. This section shall not apply to rules that implement new fees or fee increases that are promulgated as emergency rules pursuant to § 4-5-208(a) and to subsequent rules that make permanent such emergency rules, as amended during the rulemaking process. In addition, this section shall not apply to state agencies that did not, during the preceding two (2) fiscal years, collect fees in an amount sufficient to pay the cost of operating the board, commission or entity in accordance with § 4-29-121(b).

Agency/Board/Commission:	Tennessee Department of Labor and Workforce Development
Division:	Bureau of Workers' Compensation
Contact Person:	Troy Haley
Address:	220 French Landing Drive 1-B, Nashville, TN 37243
Phone:	615-532-0179
Email:	troy.haley@tn.gov

Revision Type (check all that apply):

- Amendment
- New
- Repeal

Rule(s) (ALL chapters and rules contained in filing must be listed. If needed, copy and paste additional tables to accommodate more than one chapter. Please enter only **ONE** Rule Number/Rule Title per row.)

Chapter Number	Chapter Title
0800-02-17	Rules for Medical Payments
Rule Number	Rule Title
0800-02-17-.01	Purpose and Scope
0800-02-17-.02	Repealed
0800-02-17-.03	Definitions
0800-02-17-.04	Repealed
0800-02-17-.05	Procedure Codes/Adoption of the CMS Medicare Procedures, Guidelines and Amounts
0800-02-17-.06	Procedures for Which Codes Are Not Listed
0800-02-17-.07	Modifier Codes
0800-02-17-.08	Total Procedures Billed Separately
0800-02-17-.09	Independent Medical Examination to Evaluate Medical Aspects of Case
0800-02-17-.10	Payment
0800-02-17-.11	Reimbursement for Employee-Paid Services
0800-02-17-.12	Recovery of Payment

0800-02-17-.13	Penalties for Violations of Fee Schedule Rules
0800-02-17-.14	Missed Appointment
0800-02-17-.15	Medical Report of Initial Visit and Progress Reports for Other than In-patient Hospital Care
0800-02-17-.16	Additional Records
0800-02-17-.17	Deposition/Witness Appearances
0800-02-17-.18	Out-of-State Providers
0800-02-17-.19	Preauthorization
0800-02-17-.20	Repealed
0800-02-17-.21	Process for Resolving Differences Between Employers and Providers Regarding Bills
0800-02-17-.22	Committee Review of Fee Schedule Disputes/Hearings
0800-02-17-.23	Repealed
0800-02-17-.24	Provider and Facility Fees for Copies of Medical Records
0800-02-17-.25	Impairment Ratings-Evaluations and in Medical Records

Chapter 0800-02-17
Rules for Medical Payments
New Rules

0800-02-17-.01 Purpose and Scope.

(1) Purpose:

Pursuant to Tenn. Code Ann. § 50-6-204 (Repl. 2005), this chapter, together with the Medical Fee Schedule Rules, Chapter 0800- 02-18-.01 et seq., and the In-patient Hospital Fee Schedule Rules, Chapter 0800-02-19-.01 et seq., (collectively hereinafter "Rules") are hereby adopted by the Administrator in order to establish a comprehensive medical fee schedule and a related system which includes, but is not limited to, procedures for review of bills, enforcement procedures and appeal hearings. The Administrator promulgates these Rules to establish the maximum allowable fees for health care services falling within the purview of the Tennessee Workers' Compensation Act ("Act"). This chapter must be used in conjunction with the Medical Fee Schedule Rules (Chapter 0800-02-18) and the In-patient Hospital Fee Schedule Rules (Chapter 0800-02-19). The Rules establish maximum allowable fees and procedures for all medical care and services provided to any employee claiming medical benefits under the Tennessee Workers' Compensation Act. Employers and providers may negotiate and contract or pay 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 Administrator, the Administrator's designee, or an agency member appointed by the Administrator. These Rules are applicable only to those injured employees claiming benefits under the Tennessee Workers' Compensation Act.

(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 sustains a personal injury, illness, or occupational disease, 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 treat, so far as reasonably and necessarily possible, and provide relief from the effects of that 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 bill, (2) the maximum fee established under these Rules, or (3) the MCO/PPO or any other negotiated and contracted or lower price, where applicable. Unless authorized by the administrator, in no event shall reimbursement be in excess of these Rules. Reimbursement in

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Notice of Rulemaking Hearing

Hearings will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, T.C.A. § 4-5-204. For questions and copies of the notice, contact the person listed below.

Agency/Board/Commission:	Tennessee Department of Labor and Workforce Development
Division:	Bureau of Workers' Compensation
Contact Person:	Troy Haley
Address:	220 French Landing Drive, 1-B, Nashville, TN 37243
Phone:	615-532-0179
Email:	troy.haley@tn.gov

Any Individuals with disabilities who wish to participate in these proceedings (to review these filings) and may require aid to facilitate such participation should contact the following at least 10 days prior to the hearing:

ADA Contact:	Troy Haley
Address:	220 French Landing Drive, 1-B, Nashville, TN 37243
Phone:	615-532-0179
Email:	troy.haley@tn.gov

Hearing Location(s) (for additional locations, copy and paste table)

Address 1:	220 French Landing Drive, 1-A	
Address 2:	Tennessee Room	
City:	Nashville	
Zip:	37243	
Hearing Date :	XX/XX/2016	
Hearing Time:	XX:XX a.m. CST/CDT	

Additional Hearing Information:

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Revision Type (check all that apply):

- Amendment
 New
 Repeal

Rule(s) (ALL chapters and rules contained in filing must be listed. If needed, copy and paste additional tables to accommodate more than one chapter. Please enter only **ONE** Rule Number/Rule Title per row.)

Chapter Number	Chapter Title
0800-02-17	Rules for Medical Payments Medical Cost Containment Program

Rule Number	Rule Title
0800-02-17-.01	Purpose and Scope
0800-02-17-.02	Severability and Preemption Repealed
0800-02-17-.03	Definitions
0800-02-17-.04	Information Program Involving Rules
0800-02-17-.05	Procedure Codes/Adoption of the CMS Medicare Procedures, Guidelines and Amounts
0800-02-17-.06	Procedures for Which Codes Are Not Listed
0800-02-17-.07	Modifier Codes
0800-02-17-.08	Total Procedures Billed Separately
0800-02-17-.09	Independent Medical Examination to Evaluate Medical Aspects of Case
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0800-02-17-.16	Additional Records
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0800-02-17-.18	Out-of-State Providers
0800-02-17-.19	Preauthorization
0800-02-17-.20	Utilization Review Repealed
0800-02-17-.21	Process for Resolving Differences Between Carrier e Employer s and Providers Regarding Bills
0800-02-17-.22	Committee Review of Fee Schedule Disputes/Hearings
0800-02-17-.23	Rule Review Repealed
0800-02-17-.24	Provider and Facility Fees for Copies of Medical Records
0800-02-17-.25	Impairment Ratings-Evaluations and in Medical Records

(Place substance of rules and other info here. Statutory authority must be given for each rule change. For information on formatting rules go to <http://state.tn.us/sos/rules/1360/1360.htm>)

0800-02-17-.01 PURPOSE AND SCOPE.

- (1) Purpose. Pursuant to Tenn. Code Ann. § 50-6-204 (Repl. 2005), ~~this chapter~~ the following ~~Medical Cost Containment Program Rules~~, together with the Medical Fee Schedule Rules, Chapter 0800- 02-18-.01 et seq., and the In-patient Hospital Fee Schedule Rules, Chapter 0800-02-19-.01 et seq., (collectively hereinafter "Rules") are hereby adopted by the Administrator in order to establish a comprehensive medical fee schedule and a related system which includes, but is not limited to, procedures for review of bills, enforcement procedures and appeal hearings, ~~to implement a medical fee schedule~~. The Administrator promulgates these Rules to establish the maximum allowable fees for health care services falling within the purview of the Tennessee Workers' Compensation Act ("Act"). ~~This chapter~~ ~~ese~~ ~~Medical Cost Containment Program Rules~~ must be used in conjunction with the Medical Fee Schedule Rules (Chapter 0800-02-18) and the In-patient Hospital Fee Schedule Rules (Chapter 0800-02-19). The Rules establish maximum allowable fees and procedures for all medical care and services provided to any employee claiming medical benefits under the Tennessee Workers' Compensation Act. ~~Employer~~~~e~~Employer~~s~~, carriers and providers may negotiate and contract or pay 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 Administrator, the Administrator's designee, or an agency member appointed by the Administrator. These Rules are applicable only to those injured employees claiming

benefits under the Tennessee Workers' Compensation Act, but are applicable to ~~medical services provided in any state in which that employee receives~~ such medical benefits.

(2) Scope. These rules do all of the following:

- (a) Establish procedures by which the employer~~“employer”~~ shall furnish, or cause to be furnished to an employee who ~~sustains~~receives a personal injury, illness, or suffers an occupational disease, ~~primarily arising out of and in the course and scope of employment, 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~~“employer”~~ shall also supply to the injured employee dental services, crutches, artificial limbs, eyes, teeth, eyeglasses, hearing apparatus, and other appliances necessary to ~~treat~~ure, so far as reasonably and necessarily possible, and ~~provide relief~~ve from the effects of ~~that~~e 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 bill, (2) the maximum fee established under these Rules, or (3) the MCO/PPO or any other negotiated and contracted or lower price, where applicable. ~~Unless authorized by the administrator, in no event shall reimbursement be in excess of these Rules. Reimbursement in excess of these Rules may, at the Administrator's discretion, result in civil penalties of not less than fifty dollars (\$50) nor greater than five thousand dollars (\$5,000.00) up to one ten thousand dollars (\$10,000.00) per violation each assessed severally against the provider accepting such fee and the carrier“employer” paying the excessive fee, if a pattern or practice of such activity is found. At the Administrator's discretion, multiple violations by a such provider may also be reported to the appropriate certifying board, and may be subject the provider to exclusion from further participating in providing medical care to injured workers 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~~“employer”~~ and the ~~Bureau~~Division to obtain necessary records, medical bills, and other information concerning any health care or health service under review.
- (e) Establish a system for the evaluation by an ~~carrier“employer”~~ 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.

~~Authorize carriers to withhold payment from, or recover payment from, health facilities or health care providers which have excessive bills or which have required unjustified and/or unnecessary treatment, hospitalization, or visits.~~

- (f) Permit review by the ~~Bureau~~Division of the records and medical bills of any health facility or health care provider to determine whether or not they are in compliance with these Rules, or which may be requiring unjustified and/or unnecessary treatment, hospitalization or office visits ~~or other healthcare services.~~

~~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. 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.
- (g) ~~Provide for deposition and witness fees~~ Establish maximum fees for depositions/witnesses.
 - (h) Establish maximum fees for medical reports.
 - (i) Provide for uniformity of billing for provider services.
 - (j) Establish the effective date for implementation of these Rules. Adopt by reference as part of these Rules, the American Medical Association's CPT[®], Medical Fee Schedule Rules (Chapter 0800-02-18), the In-patient Hospital Fee Schedule (Chapter 0800-02-19) and any amendments to them.
 - (k) Establish procedures for reporting of medical claims.
 - (l) Establish procedures for pre-authorization utilization review of non-emergency hospitalizations, transfers between facilities, and outpatient services.
 - (m) Establish procedures for imposing and collecting civil penalties for violations of these Rules.
 - (n) These rules shall apply where appropriate in conjunction with electronic submission of payments (e-billing).
 - ~~(n) The Rules shall become effective May 1, 2006.~~

Authority: T.C.A. §§ 50-6-102, 50-6-118, 50-6-125, 50-6-128, 50-6-204, 50-6-205 50-6-226, 50-6-233 (Repl. 2005), T.C.A. § 50-6-202 and Public Chapters 282 & 289 (2013). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendments filed June 12, 2009; effective August 26, 2009. Amendment filed December 26, 2013; effective March 26, 2014.

~~0800-02-17-.02 SEVERABILITY AND PREEMPTION~~ **0800-02-17-.02 RESERVED.**

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006.

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 state rule or regulation, these Rules shall prevail.

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006.

0800-02-17-.03 DEFINITIONS. The following definitions are for the purposes of and are applicable to the Medical Cost Containment Program Rules (Chapter 0800-02-17), the Medical Fee Schedule Rules (Chapter 0800-02-18) and the In-patient Hospital Fee Schedule Rules (Chapter 0800-02-19):

- 1) (1) "Act" means Tennessee's Workers' Compensation Act, Tenn. Code Ann. §§ 50-6-101-et seq. as currently enacted by the Tennessee General Assembly, specifically including any future enactments by the Tennessee General Assembly involving amendments, deletions, additions, repeals, or any other modification, in any form of the Workers' Compensation Act.

as amended.

- 2) "Adjust" means that an carrier"employer" or a carrier's agent changes reduces a health care provider's request for paymentr payment, including but not limited to such as:
 - (a) Applies the maximum fee allowable under these Rules;
 - (b) Applies an agreed upon discount to the provider's usual bill, in accordance with the requirement in TCA §50-6-215;
 - (c) Adjusts to a usual and customary reasonable amount when the maximum fee is by report;
 - (d) Recodes a procedure;(d) Reduces or, denies all or part of a properly-submitted bill for payment as a result of bill review;
 - (d)(e) Recodes a procedure. utilization review
- 3) "Administrator" means the chief administrative officer of the Bureau of Workers' Compensation Division of the Tennessee Department of Labor and Workforce Development, or the Administrator's designee.
- 4) "Appropriate care" means health care that is suitable for a particular person, condition, occasion, or place as determined by the Administrator or the Administrator's designee after consultation with the Medical Director.
- 5) "Bill" means a request by a provider submitted to an carrier"employer" for payment for health care services provided in connection with a compensable injury, illness or occupational disease.
- 6) ~~"Bill adjustment" means any changes a reduction of to a fee on a provider's bill. See (69) in this subsection for notification requirements. See (2) above.~~
- 7)6) "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.
 - (b) Consultation reports.
 - (c) Progress notes.
 - (d) Office notes or other applicable documentation.
 - (e) Description of equipment or supply (when that is the bill).
- 7) "Bureau" means the Tennessee Bureau of Workers' Compensation as defined in T. C.A. § 50-6-102, an autonomous unit attached for administrative purposes to the Tennessee Department of Labor and Workforce Development for administrative matters only pursuant to T. C.A. § 4-3-1409.
- 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. Carrier is also deemed to mean any employer, should that employer not be insured for workers' compensation as required by the Act.~~
- (8) "Case" means a compensable injury, illness or occupational disease identified by the worker's

name and date of injury, illness or occupational disease.

~~9) "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.~~

9) "CMS" means the U.S. Centers for Medicare & Medicaid Services (formerly Health Care Financing Administration). The rules promulgated by CMS used in these chapters are referred to as "Medicare".

~~10) "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.~~

~~10) "Complete procedure" means a procedure containing a series of steps which are not to be billed separately, as defined by Medicare.~~

11)

"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.

~~12)~~

~~"Compensable injury, illness or occupational disease" means an injury, illness or occupational disease for which health care treatment is mandated under the Tennessee Workers' Compensation Act.~~

~~13) 12) "CPT®" means the most current edition of the American Medical Association's Current Procedural Terminology.~~

~~14) 13) "Critical care" has the same meaning as defined by Medicare that in the most current version of the CPT.~~

~~15) 14) "Day" means a calendar day, unless otherwise designated in these Rules.~~

~~"Department" means the Tennessee Department of Labor and Workforce Development.~~

15) ~~(20)~~ "Diagnostic procedure" means a service which aids in determining the nature and/or cause of an occupational disease, illness or injury.

16) "Diagnostic Code" means the properly constructed numeric code from the International Classification of Diseases, version ICD-9-CM for dates of service before October 1, 2015. For dates of service on or after October 1, 2015, it means the properly constructed alpha-numeric code, ICD-10-CM.

~~(22) "Division" means the Workers' Compensation Division of the Tennessee Department of Labor and Workforce Development.~~

17) "Dispute" means a disagreement between an carrier/employer or a carrier's agent and a health care provider on interpretation, payment under, or application of these Rules.

18) "MS-DRG" (Diagnosis Related Group) means one of the classifications of diagnoses in

which patients demonstrate similar resource consumption and length of stay patterns as defined for Medicare purposes by CMS (see "HCFA").

- 19) "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.
- 20) "Employer" means an "employer" as defined in T.C.A. § 50-6-102, but also includes an "employer"s insurer, third party administrator, self-insured "employer"s, self-insured pools and trusts, as well as the "employer"s legally authorized representative or legal counsel, and agents to accomplish billing and payment transactions, as applicable.
- 20)21) "Established patient" has the same meaning as in the most current version of the CPT®.
- 21)22) "Expendable medical supply" means a disposable article which is needed in quantity on a daily or monthly basis.
- 22)23) "Focused review" means the evaluation of a specific health care service or provider to establish patterns of use and dollar expenditures.
- 23)24) "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, as defined by Medicare, but does not include care for complications.
- 24)25) "Follow-up days" means the days of care following a surgical procedure which are included in the procedure's maximum allowable payment, as defined by Medicare, but does not include care for complications.
- 25)26) "Follow-up visits" means the number of office visits following a surgical procedure which is included in the procedure's maximum allowable payment, as defined by Medicare, but does not include care for complications.
- 26) "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.
- 27) "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.
- 28) "Health care review" means the review of a health care case or bill, or both, by an carrier "employer", or the carrier's agent.
- 29) "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.
- 30) ~~"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.~~
- 31)30) "Inappropriate health care" means employment related health care that is not suitable for a particular person, condition, occasion, or place as determined by the Administrator or the Administrator's designee after consultation with the Bureau Division's

Medical Director.

32)31) "Incidental surgery" means a surgery performed through the same incision, on the same day, by the same doctor, and not related to the original or covered diagnosis that is in accord with the Medicare rules.

(32) "Independent ~~M~~medical ~~E~~examination" means an examination and evaluation conducted by a practitioner different from the practitioner who has not previously been involved in providing care to the examinee. There is no doctor/therapist-patient relationship, other than This does not include one conducted under the Bureau Division's Medical Impairment Rating Registry ("MIRR") Program.

33) "Independent procedure" means a procedure which may be carried out by itself, separate and apart from the total service that usually accompanies it according to CPT® guidelines.

34) "Injury" has the same meaning defined in T.C.A 50-6-102.

35) "Inpatient services" mean services rendered to a person who is formally admitted to a hospital and whose condition is such that requires Inpatient admission in accordance with industry standard guidelines length of stay exceeds 23 hours.

36) "Institutional services" mean all non-physician services rendered within the institution by an agent of the institution.

37) "Maximum allowable payment" means the maximum fee for a procedure established by these Rules or the usual and customary bill as defined in these Rules, whichever is less, except as otherwise might be specified. In no event shall reimbursement be in excess of the Bureau Division's Medical Fee Schedule, unless otherwise authorized by the administrator. Fee collected Bills in excess of the Bureau Division's Medical Fee Schedule and reported to the Bureau, may shall, at the Administrator's discretion, result in civil penalties of fifty dollars (\$50.00) to five thousand dollars (\$5,000.00) up to ten thousand dollars (\$10,000.00) per violation for each violation, assessed severally against the provider accepting such fee and the carrier "employer" paying the excessive fee, whenever a pattern or practice of such activity is found. At the Administrator's discretion, multiple violations by a such provider may also be reported to the appropriate certifying board, and may be subject the provider to exclusion from participating in providing workers care under the Act.

37)38)

"Maximum fee" means the maximum allowable payment fee for a procedure established by this rule, the Medical Fee Schedule and the In-patient Hospital Fee Schedule.

38)39) "Medical admission" means any hospital admission where the primary services rendered are not surgical or in an acute care hospital where the admission is to special unit such as inpatient psychiatric or rehab beds, or in a separately licensed psychiatric or rehabilitation hospital.
in nature

(47) "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:

Professional performance.

Professional credentials.

The actual or predicted effects of care.

The range of variation from the norm.

- ~~(48) "Medically appropriate care" means health care that is suitable for a particular person, condition, occasion, or place.~~
- ~~39)40) "Medical Director" means the Bureau~~Division's Medical Director appointed by the Administrator pursuant to T.C.A. § 50-6-126 (Repl. 1999).
- ~~40)41) "Medical only case" means a case which does not involve lost work time.~~
- ~~41)42) "Medical supply" means either a piece of durable medical equipment or an expendable medical supply.~~
- ~~42)43) "Modifier code" means a 2-digit number or alphabetical designation used in conjunction with the procedure code to describe unusual circumstances, as defined by CMS which arise in the treatment of an injured or ill employee.~~
- ~~43)44) "New patient" designation for billing purposes 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, according to the definitions in the most recent edition of CPT®.~~
- ~~44)45) "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.~~
- ~~45)46) "Ophthalmologist" shall be defined according to T.C.A. § 71-4-102(3).~~
- ~~46)47) "Optician" shall mean a licensed dispensing optician as set forth in T.C.A. § 63-14-103.~~
- ~~47)48) "Optometrist" means an individual licensed to practice optometry.~~
- ~~48)49) "Optometry" shall be defined according to T.C.A. § 63-8-102(12).~~
- ~~49)50) "Orthotic equipment" means an orthopedic apparatus designed to support, align, prevent, correct deformities, or improve the function of a movable body part.~~
- ~~50)51) "Orthotist" means a person skilled in the construction and application of orthotic equipment.~~
- ~~51)52) "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.~~
- ~~52)53) "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, or global follow-up period and/or visits as defined by CMS-CPT[®]™, uncomplicated follow- This includes a standard
- 53)54) "Pattern of practice" means at least one (1) or more repeated, similar violations over a three-year period in one year of the Medical Fee Schedule Rules, the Medical Cost Containment Rules (Chapter 0800-02-17) and/or the In-patient Hospital Fee Schedule Rules (Chapter 0800-02-19), have occurred after notice of a violation has issued from the Department for the first violation. To support civil penalties, such violations must be found to not have been inadvertent, as determined by the Administrator.
- 54)55) "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 and governed by the Board of Pharmacy.
- 55)56) "Practitioner" means a person licensed, registered, or certified as an audiologist, doctor of chiropractic physician, 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, or their agents used to accomplish medical records, billing and payment transactions.
- 56)57) "Preauthorization" for workers' compensation claims means that the employer, prospectively, retrospectively, or concurrently, authorizes the payment of medical benefits. Preauthorization for workers' compensation claims does not mean that the employer accepts the claim or has made a final determination on the compensability of the claim. Preauthorization for workers' compensation claims does not include utilization review. "Preauthorization" means that the employer or carrier accepts the injured or disabled employee's injury or disease as compensable under the Act and authorizes payment of medical benefits under the Act. Preauthorization does not in any way include Utilization Review (defined below) and does not include any decision on the medical appropriateness or necessity of a medical service or treatment.
- 57)58) "Primary procedure" means the therapeutic procedure most closely related to the principle diagnosis.
- 58)59) "Procedure" means a unit of health service.
- 59)60) "Procedure code" means an alpha/numeric or numeric sequence used to identify a service performed and billed by a qualified provider. 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.
- 61) "Properly submitted and complete bill" means a request by a provider for payment of health care services submitted to a carrier the employer on the appropriate forms which are completed pursuant to this rule or the rules appropriate to electronic billing. To be properly submitted and complete, the bill shall:
- a. Identify:
 - (1) The injured employee who received the service;
 - (2) The employer and the responsible paying agent with information sufficient to contact the responsible party in case of a dispute or questions. This information shall be provided by the payer if the bill is adjusted, contested or rejected and shall include a clear explanation of the reasons.
 - (3) The health care provider with an IRS, NPI or other appropriate identifier;
 - (4) The medical service product;
 - (5) Other information required by the form;

b. include a valid MS-DRG, Revenue Code, CPT® or HCPCS code as applicable.

c. include a ICD-10-CM codes where necessary shall be used by all parties.

d. have attached, in legible text, all supporting documentation required for the particular bill format, including, but not limited to, medical reports and records, evaluation reports, narrative reports, assessment reports, progress reports/notes, clinical notes, hospital records and diagnostic test results that may be expressly required by law or can reasonably be expected by the payer or its agent under the laws of Tennessee;

(1) "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.

(62) "Prosthesis" means an artificial substitute for a missing body part.

(63) "Prosthetist" means a person skilled in the construction and application of prosthesis.

(64) "Provider" means a facility, health care organization, or a practitioner, or their agents to accomplish medical records, correspondences, billing and payment transactions.

"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.

(65) "Reject" means that an carrier/employer or a carrier's agent denies partial or total payment to a provider or denies a provider's request for reconsideration. Notification of any full or partial rejection must be made within fifteen (15) business days of receipt of the bill by the employer.

(66) "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, as defined by Medicare.

(67) "Stop-Loss Payment" or "SLP" means an independent method of payment for an unusually costly or lengthy stay.

(68) "Stop-Loss Reimbursement Factor" or "SLRF" means a factor established by the Administrator to be used as a multiplier to establish a reimbursement amount when total hospital bills have exceeded specific stop-loss dollar thresholds.

(69) "Stop-Loss Threshold" or "SLT" means a dollar threshold of bills established by the Administrator, beyond which reimbursement is calculated by multiplying the applicable SLRF times the total dollars billeds identifying following that particular dollar threshold.

(70) "Surgical admission" means any hospital admission for which the patient has a surgical MS-DRG as defined by Medicare CMS, where there is an operating room bill, the patient has a surgical procedure or ICD-9 code, or the patient has a surgical DRG as defined by the CMS.

(71) "Timely Filing of bills for medical services" means the period of time within which a request for payment from a provider must be billed consistent with within Medicare CMS guideline time limits.

(72) "Timely Payment" means the period of time that the employer has to remit payment to the provider.

(73) "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.

(74) "Usual and customary" means eighty percent (80%) of a specific provider's billed charges.

(75) "UB-92, HCFA-1450, CMS-1500 or CMS-1450, UB04" or their successors means the most recent industry standard health insurance claim forms maintained for use by medical care providers and institutions, including the ADA form for dentists and the NCPDP WC/PC UCF for pharmacies.

(76) "Utilization Review" means evaluation of the necessity, appropriateness, efficiency and quality of medical care services, including the prescribing of one (1) or more Schedule II, III or IV controlled substances for pain management for a period of time exceeding ninety (90) days from the initial prescription of such controlled substances, provided to an injured or disabled employee based upon medically accepted standards and an objective evaluation of the medical care services provided; provided, that "utilization review" does not include the establishment of approved payment levels, of a review of medical bills charges or fees, or an initial evaluation of an injured or disabled employee by a physician specializing in pain management. "Utilization review," also known as "Utilization management," does not include the evaluation or determination of causation or the compensability of a claim. For workers' compensation claims, "utilization review" is not a component of preauthorization. The employer shall be responsible for all costs associated with utilization review and shall in no event obligate the employee, health care provider or Bureau to pay for such services.

(2) "Wage loss case" means a case that involves the payment of wage loss compensation.

(3) "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, 50-6-202, 50-6-204, 50-6-205, 50-6-226, 50-6-233 (Repl. 2005), and Public

Chapters 282 & 289 (2013). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendment filed December 20, 2007; effective March 4, 2008. Amendments filed June 12, 2009; effective August 26, 2009. Amendment filed December 26, 2013; effective March 26, 2014.

0800-02-17-.04 RESERVED INFORMATION PROGRAM INVOLVING RULES.

~~The Bureau/Division may institute an ongoing information program regarding these Rules for providers, carrier employers, 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 and 50-6-204 (Repl. 2005). Administrative History: Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006.~~

0800-02-17-.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 ("AMA").
- (2) The most current effective editions of the American Medical Association's Current Procedural Terminology ("CPT®"), the Medicare MS-DRG table and the Medicare RBRVS in effect on

the date of service or date of discharge. The Physicians' Guide and the National Correct Coding Initiative edits ("NCCI") are incorporated in these Rules and must be used in conjunction with these Rules.

- (3) Unless otherwise explicitly stated in these Rules, the most current effective 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 Medicarethe CMS.
- (4) 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 current, effective-CMS Medicare allowable amount. The current effective Medicare guidelines and procedures on the date of service shall be followed in arriving at the correct amount, subject to the requirements of Rule 0800- 02-18-.02(4). The Medical Fee Schedule conversion factor and TN specific conversion percentages amounts may be, upon review by the Administrator, adjusted periodicallyannually. Whenever there is no applicable Medicare code or methodology, the service, equipment, diagnostic procedure, etc. shall be reimbursed at the usual and customary amount as defined in Rule 0800-02-17-.03(80) of this Chapter.
- (5) Telehealth: the definitions, licensing and processes for the purpose of these rules shall be the same as adopted by the Tennessee Department of Health. Payments shall be based upon the applicable Medicare guidelines and coding for the different service providers with the exception of any geographic restriction.

Authority: T.C.A. §§ 50-6-102, 50-6-204, 50-6-205, 50-6-226, 50-6-233 (Repl. 2005), and Public Chapters 282 & 289 (2013). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendment filed June 12, 2009; effective August 26, 2009. Amendment filed December 26, 2013; effective March 26, 2014.

0800-02-17-.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 or revenue code, as applicable. 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 bill).
- (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 (by report, see 0800-02-17-.03(6)).
- (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 average bills for similar services, as identified by the carrier based on data which is representative of Tennessee bills, if available/applicable.

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendment filed March 12, 2012; to have been effective June 10, 2012. The Government Operations Committee filed a stay on May 7, 2012; new effective date August 9, 2012.

0800-02-17-.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/employer. It is not appropriate to use Modifier 21, 22, or 25 for routine billing.
- (4) The maximum allowable additional amount under these Rules for Modifier 22 is 4050%, not to exceed billed charges of the primary procedure, provided that such maximum shall only apply to those board certified or eligible physicians performing neurosurgery or orthopedic surgery at a rate of up to 275% of applicable Medicare rates.

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (~~Repl. 2005~~). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendment filed June 12, 2009; effective August 26, 2009.

0800-02-17-.08 TOTAL PROCEDURES BILLED SEPARATELY.

- (1) 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.
 - (a) When billing for the professional component only, Modifier 26 must be added to the appropriate 5-digit procedure code.
 - (b) When billing for the technical component only, Modifier TC (Technical Component) is to must be added to the appropriate 5-digit procedure code.

Authority: T.C.A. §§ 50-6-128, 50-6-204 and 50-6-205 (~~Repl. 2005~~). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006.

0800-02-17-.09 INDEPENDENT MEDICAL EXAMINATION TO EVALUATE MEDICAL ASPECTS OF CASE.

- (1) An Independent Medical Examination, other than one conducted under the BureauDivision's 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 BureauDivision's MIRR Program), shall be billed using the appropriate independent medical examination procedure, 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 bill is included with the CPT@ code, 99456, and shall not be billed separately. The total amount for an IME under this Rule shall not exceed \$500.00 per hour, and shall be pro-rated per halfquarter hour, i.e. two and one-half hours may not exceed \$1,250.00. Physicians may only require pre-payment of \$500.00 for an IME; provided, that following the completion of the IME and report, the physician may bill for other amounts appropriately due, and tThe payer may recover any amounts that were overpaid.

- (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.
- (4) Physicians who perform consultant services and/or records review in order to determine whether to accept a new patient shall not bill for an IME. Rather, such physicians shall bill using CPT codes 99358 and 99359. The reimbursement shall be \$200.00 for the first hour of review and \$100.00 for each additional hour; provided, that each halfquarter hour shall be pro-rated. Any prepayment request may not exceed \$500.00.

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (~~Repl. 2005~~). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendments filed March 12, 2012; to have been effective June 10, 2012. The Government Operations Committee filed a stay on May 7, 2012; new effective date August 9, 2012.

0800-02-17-.10 PAYMENT.

- (1) Reimbursement for all health care services and supplies shall be the lesser of (a) the provider's usual billed charge, (b) the maximum fee calculated according to these Rules (and/or any amendments to these Rules) or (c) the agreed contracted or published upon rate between the provider and the MCO/PPO pursuant to T.C.A. § 50-6-215, ~~or any other lower price~~. A licensed provider or institution 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. Any provider reimbursed or ~~carrier~~ "employer" paying an amount which is in excess of these Rules shall have a period of ~~ninety (90)~~ one hundred eighty (180) calendar days from the time of receipt/payment of such excessive payment in which to refund/recover the overpayment amount. Overpayments refunded/recovered within this time period shall not constitute a violation under these Rules.
- (2) The most current edition of the Medicare RBRVS: The Physicians' Guide in effect on the date of service or date of discharge is adopted by reference as part of these Rules. The Medicare RBRVS is distributed by the American Medical Association and by the Office of the Federal Register and is also available on the Internet— at www.cms.hhs.gov/home/medicare.asp. Whenever a different guideline or

procedure is not set forth in these Rules, the most current effective Medicare guidelines and procedures in effect on the date of service shall be followed.

- (3) When extraordinary services resulting from severe head injuries, major burns, 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, Chapter 0800-02-19.
- (4) Billing for provider services shall be submitted on industry standard billing forms; UB-04, CMS-1450, CMS-1500, the ADA form for dental providers and the NCPDP/PC UCF for pharmacies, or their official replacement forms. Electronic billing submissions shall be in accord with the Bureau's rules for electronic billing approved by the Division UB-92 and CMS-1500, or their official replacement forms. If the Division does not designate a specific form, then the proper form shall be according to Medicare guidelines.
- (5) ~~A carrier shall not make a payment for a service unless all required review activities pertaining to that service are completed.~~
- (6)(5) An carrier employer's payment shall reflect any adjustments in the bill.
 - (a) An carrier employer shall must provide an explanation of medical benefits with current and complete contact information for to a health care provider whenever the carrier employer's reimbursement differs from the amount billed by the provider, using industry standard remark codes.
 - (b) ~~A provider shall not attempt to collect from the injured employee, employer, or carrier employer any amounts properly reduced by the carrier employer.~~
 - (c) All such communications shall comply with all applicable Medicare and _____ HIPAA requirements.
 - (d) Remittances for electronically submitted bills shall be in accordance with the Bureau's rules for electronic billing rules.

(76) All providers and carriers shall use electronic billing and EDI, if they have the capability to do so. All such communications shall comply with all applicable Medicare and HIPPA requirements.

- (87) ~~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. An employer shall date stamp medical bills and reports not submitted electronically upon receipt. Payment for all properly submitted and complete bill not disputed within 15 business days (or uncontested portions of the bill) shall be made to the provider within thirty 30 calendar days.~~

~~(8)~~ The employer ~~shall~~ must notify the provider within fifteen (15) business days of receipt of the bill that it was not properly submitted and specify the reason(s).

(9) ~~When an employer-carrier disputes a bill or portion thereof, the employer-carrier shall pay the undisputed portion of the bill within thirty-one (304) 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 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.~~

(10) 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.~~

(11) 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 an ~~carrier~~ "employer" returns such billings, it must do so within ~~15 business~~ 20-calendar days of receipt of the bill. The number of days between the date the ~~carrier~~ employer returns

~~the billing to the provider and the date the carrier"employer" receives the corrected billing, shall not apply toward the thirty-one (3031) calendarcalendar days within which the carrier"employer" is required to make payment. (a) Payments to providers for initial examinations and continuing necessary treatment authorized by the carrier or employer (or not authorized urgent or emergent treatments but determined to be medically necessary by utilization review or an utilization review appeal to the Bureas) shall be paid by that carrier"employer" or employer"employer" and shall not later be subject to reimbursement by the employee. The rules for electronic billing shall apply to the types of forms where applicable.~~

~~, even if the injury or condition for which the employee was sent to the provider is later determined non-compensable under the Act.~~

(12) Payments to providers for initial examinations and treatment authorized by the carrier or employer shall be paid by that ~~carrier or employer~~ and shall not later be subject to reimbursement by the employee, even if the injury or condition for which the employee was sent to the provider is later determined non-compensable under the Act.

(13) Provider requests for pre-payment may not exceed five hundred (\$500.00) dollars for any individual services except the impairment rating.

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (~~Repl. 2005~~). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendments filed June 12, 2009; effective August 26, 2009. Amendments filed March 12, 2012; to have been effective June 10, 2012. The Government Operations Committee filed a stay on May 7, 2012; new effective date August 9, 2012.

0800-02-17-.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 an ~~carrier~~ employer is determined to be responsible for the payment for that specific service, then the employee shall be fully reimbursed by the ~~carrier~~ employer. Medical fee schedule maximum payments may not apply under this provision.

Authority: T.C.A. §§ 50-6-128, 50-6-204 and 50-6-205 (~~Repl. 2005~~). **Administrative History:** Public

necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006.

0800-02-17-.12 RECOVERY OF PAYMENT.

- (1) Nothing in these Rules 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. Likewise, nothing in these Rules shall preclude any provider from receiving additional payment for services or supplies if it is properly due that provider and does not exceed the amount allowed by these Rules.

Authority: T.C.A. §§ 50-6-204, 50-6-205, 50-6-226 and 50-6-233 (~~Repl. 2005~~). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendment filed March 12, 2012; to have been effective June 10, 2012. The Government Operations Committee stayed the amendment on May 7, 2012; new effective date August 9, 2012. Amendment filed December 26, 2013; effective March 26, 2014.

0800-02-17-.13 PENALTIES FOR VIOLATIONS OF FEE SCHEDULE RULES.

- (1) ~~Except when a waiver has been granted by the Bureau, providers shall not accept and employer 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 these 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 employer paying an amount in excess of the Division's these 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 Administrator's discretion, be subject to civil penalties of not less than fifty dollars (\$50.00) nor more than up to five ten thousand dollars (\$540,000.00) per violation, for each violation which may be assessed severally against the provider accepting such fee and the carrier employer or employer employer paying the excessive fee, except as authorized pursuant to T.C.A. §50-6-204, whenever a pattern or practice of such activity is found. Any provider reimbursed or carrier employer paying an amount which is in excess of these Rules shall have a period of ninety (90) one hundred eighty (180) calendar days from the time of receipt/payment of such excessive payment in which to refund/recover the overpayment amount. Overpayments refunded/recovered within this time period shall not constitute a violation under these Rules. At the discretion of the Administrator, the Administrator's Designee, or an agency member appointed by the Administrator, 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 these 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 fifty dollars (\$10050.00) nor more than ten thousand dollars (\$10,000.00) one five thousand dollars (\$15,000.00) per violation, at the discretion of the Administrator, Administrator's Designee, or an agency member appointed by the Administrator.~~
- (2) A provider or carrier employer 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 business 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 Bureau within the fifteen (15) calendar business days of issuance of the Notice of Violation, the determination of such violation shall be deemed a final order of the Bureau Department and not subject to further review. All rights, duties, obligations, and procedures applicable under the Bureau's Rules for Penalty Assessments and Hearing Contested Cases (Chapter 0800-02-13) and that are applicable under these Rules, including,

but not limited to, the right to judicial review of any final Bureau decision.

- (3) —A request for hearing shall be made to the Bureau~~Division~~ in writing by an employer~~employer, carrier or provider~~ notified of violation of these Rules.
- (4) Any request for a hearing shall be filed with the Bureau~~Division~~ within fifteen (15) business ~~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 ~~business~~ days of the date of issuance of the Notice of Violation shall result in the decision of the Administrator, Administrator's Designee, or an agency member appointed by the Administrator becoming a final order and not subject to further review.
- (5) The Commissioner~~Administrator~~, Administrato~~Commissioner's~~ Designee, or an agency member appointed by the Commissioner ~~Administrator~~ shall have the authority to hear the matter as a contested case and determine if any civil penalty assessed should have been assessed. All procedural aspects set forth in the Bureau~~Division's~~ Penalty Program~~Rules for Penalty Assessment and Hearing Contested Cases~~, Chapter 0800-02-13, shall apply and be followed in any such contested case hearing.
- (6) Upon receipt of a timely filed request for a hearing, the Commissioner ~~Administrator~~ shall issue a Notice of Hearing to all interested parties.

Authority: T.C.A. §§ 50-6-102, 50-6-118, 50-6-125, 50-6-128, 50-6-204, 50-6-205, 50-6-226, 50-6-233 (Repl. 2005), ~~and Public Chapters 282 & 289 (2013)~~. **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendment filed June 12, 2009; effective August 26, 2009. Amendment filed December 26, 2013; effective March 26, 2014.

0800-02-17-.14 MISSED APPOINTMENT.

A provider shall not receive payment for a missed appointment unless the appointment was arranged by the Division~~Bureau~~, the case manager, ~~the carrier, the carrier's case manager or the employer~~employer. If the case manager or ~~carrier, carrier's case manager or employer~~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 or employer~~employer for the missed appointment using procedure code 99199, with a maximum fee being the amount which would have been allowed under these Rules had the patient not missed the appointment. The ~~carrier~~employer~~employer~~ shall make payment to the provider for the missed appointment pursuant to these Rules. This amount shall not include any bill for diagnostic testing that would have been billed.

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 ~~(Repl. 2005)~~. **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendment filed June 12, 2009; effective August 26, 2009.

0800-02-17-.15 MEDICAL REPORT OF INITIAL VISIT AND PROGRESS REPORTS FOR OTHER THAN IN-PATIENT HOSPITAL CARE.

- (1) —(1) Except for inpatient hospital care, a provider shall furnish the ~~carrier~~employer~~employer~~ 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) calendar days after examination or treatment of the injured employee, ~~and a progress report for every 60 calendar 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 who is receiving temporary

disability payments (total or partial) for the same compensable injury, illness or occupational disease, at intervals which exceed 60 calendar days, then the provider shall provide an updated medical progress report following each treatment that is to the employer, including an assessment of functional progress toward employment (restricted or unrestricted as appropriate), at intervals exceeding not to exceed sixty (60) calendar days.

(3) The narrative medical report or the medical office visit note, including an assessment of functional progress toward employment, of the initial visit and the progress or follow-up visit report shall include (in addition to applicable identifying information) 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 and the diagnosis.
- (c) 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.
- (d) Physical limitations and expected work restrictions and length of time of those limitations and/or restrictions if applicable.

(4) When copies of Cost of these narrative medical reports required by 0800-02-17-.15(1) and (2) are requested, the provider of the requested reports 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 that are in addition to the standard medical office note shall be billed using procedure code WC101, subsequent reports shall be billed using procedure code WC102, and all final reports shall be billed using procedure code WC103. No charge is allowed for routine office notes as these are not considered narrative reports under this Rule. No charge fee shall be paid if a request for copies of medical records does not produce any records.

(5) A medical provider shall complete charge any medical report required by the Bureau without charge for completing a medical report form required by the Division, except completion of the C-30A (Final Medical Report) or the C-32 (Standard Form Medical Report) or their replacement forms.

(6) After an initial opinion on causation has been issued by the physician, a request for a subsequent review based upon new information not available to the physician initially, may be billed by the physician and paid by the requesting party under CPT® code 99358-9 (\$200/one hour or less and \$100 for an extra hour). No additional reimbursement is due for the initial opinion on causation or a response to a request for clarification (that does not include any new information) of a previously issued opinion on causation.

(7) -Extra time spent in explanation or discussion with an injured worker or the case manager (that is separate from the discussion with the injured worker) may be charged using CPT™ code 99354-52 up to a maximum payment of forty dollars (\$40), added to the standard E/M CPT® code, if the extra service exceeds 15 minutes. Use code 99354 up to a maximum of eighty dollars (\$80) if that extra service exceeds 30 minutes. The Medicare allowable fee does not apply to the service.) There is no extra reimbursement charge if the service is less than 15 minutes.

(8)

If a provider assesses, counsels, or provides behavioral intervention for drug and/or alcohol use for to a Workers' Compensation patient for substance drug and/or alcohol use, or for substance and/or alcohol use disorder, -the provider may charge for the extra time involved using CPT[®]™ code 99408 (or codes 96150-96155, if appropriate) up to a maximum of eighty dollars (\$80) in addition to a standard E&M code. An assessment by structured screening must be documented. The code may only be charged if the patient is on a long term (over 90 days) Schedule II medication or a combination of one or more Schedule II, III, or IV medications.-The Medicare allowable fee does not apply to this service..

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (~~Repl. 2005~~). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006.

0800-02-17-.16 ADDITIONAL REPORTS.

Nothing in this rule shall preclude an carrier"employer" or an employee from requesting reports from a provider in addition to those specified in Rule 0800-02-17-.15.

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (~~Repl. 2005~~). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006.

0800-02-17-.17 DEPOSITION/WITNESS FEE LIMITATION APPEARANCES.

- (1) Any provider who gives a deposition or appears in person as a witness shall be allowed a witness fee. The fee for appearance in person as a witness- should be negotiated and agreed to in advance.
- (2) Procedure Code 99075 must be used to bill for a deposition.
- (3) Licensed physicians shall be reimbursed for depositions at the rate established in Bureau's Division Rule Chapter 0800-02-16-.04, and shall be subject to penalties under these Rules for charging any amount which exceeds that amount.
- (4) Other Providers giving depositions shall be reimbursed at a fee at or below the fee for a licensed physician agreed to in advance.

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (~~Repl. 2005~~). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006.

0800-02-17-.18 OUT-OF-STATE PROVIDERS.

Upon waiver granted by the Bureau, providers rendering medically appropriate care outside of the state of Tennessee to an injured employee pursuant to the Tennessee Workers' Compensation Act may be paid in accordance with the medical fee schedule, law, and rules governing in the jurisdiction where such medically appropriate care is provided.

All medical services provided by out-of-state providers are subject to must be made by 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 and 50-6-205 (~~Repl. 2005~~). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006.

0800-02-17-.19 PREAUTHORIZATION.

- (1) ~~Preauthorization shall be required for all non-emergency hospitalizations, non-emergency transfers between facilities, and non-emergency surgery, and non-emergency outpatient services. Decisions regarding authorization shall must be communicated to the requesting provider within seven (7) business days of the request being received. Failure to provide a timely decision within seven (7) business days shall result in the authorization being deemed approved. Preauthorization is the determination of whether the injury is recognized as compensable and whether a service or treatment is related to the compensable injury or occupational disease such that the carrier authorizes the treatment. Preauthorization does not involve utilization review.~~
- (2) ~~If a provider makes a written request by fax or e-mail (and receives acknowledgement of receipt of the request) for authorization for a treatment at least 21 business days in advance of the anticipated date that treatment is to be delivered and has not been notified of a denial or modification in writing or confirmed telephone call or confirmed fax at least 7 business days in advance of the date of the proposed treatment, it is presumed to be medically necessary, a covered service, and to be paid for by the employer.~~
- (1)(3) ~~If a provider makes a verbal request for authorization, the burden of proof for showing that authorization was granted by the employer rests with the provider.~~
- (2) ~~Any decision of denial for payment for any type of health care service and/or treatment resulting from utilization review, as opposed to preauthorization, shall only be made by an agent of a utilization review company properly approved by the Division and the Tennessee Department of Commerce and Insurance, as prescribed in Rule 0800-02-06-.02.~~

Authority: T.C.A. §§ 50-6-118, 50-6-125, 50-6-128, 50-6-204 and 50-6-205 (Repl. 2005).

Administrative History: Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendment filed June 12, 2009; effective August 26, 2009.

0800-02-17-.20 UTILIZATION REVIEW RESERVED.

- (1) ~~Scope of this part:
 - (a) ~~Requirements contained in this Rule pertain to Utilization Review activity as defined by Tenn. Code Ann. § 50-6-102(17) (Repl. 2005) 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. The Division's Utilization Rules, Chapter 0800-02-06, provide detailed specifics regarding Utilization Review and must be consulted as they are incorporated in this Rule as if set forth fully herein. Notwithstanding any other provision in this Chapter which may be to the contrary, this Rule is intended to merely supplement Chapter 800-2-6 on Utilization Review and does not in any way displace the Utilization Review Rules, Chapter 0800-02-06.~~~~
- (2) ~~Carrier's Utilization Review Program:
 - (a) ~~All carriers shall have a utilization review program.~~
 - (b) ~~Utilization review shall be performed when mandated by and in accordance with Chapter 0800-02-06.~~~~

Authority: T.C.A. §§ 50-6-102, 50-6-122, 50-6-124, 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005).

Administrative History: Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendments filed December 20, 2007; effective March 4, 2008. Amendment filed June 12, 2009; effective August 26, 2009. Amendment filed March 12, 2012; to

have been effective June 10, 2012. The Government Operations Committee filed a stay on May 7, 2012; new effective date August 9, 2012.

0800-02-17-.21 PROCESS FOR RESOLVING DIFFERENCES BETWEEN CARRIERS EMPLOYEREMPLOYERS AND PROVIDERS REGARDING BILLS.

(1) Disputes

- (a) Unresolved disputes between an an carrier-employer and provider concerning bills 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 submitted presented to the Medical Payment Committee (~~or "Committee"~~) on or after July 1, 2014 in accordance with the provisions in T.C.A. § 50-6-125. A request for Committee Review may be submitted on the form posted by the Bureau within one (1) year of the date of service to: Medical Director of the Bureau of Workers' Compensation Division, Tennessee Department of Labor and Workforce Development, Suite 1-B, 220 French Landing Drive, Nashville, Tennessee 37243, or any subsequent address as prescribed by the Division Bureau.
- (b) Valid requests for Committee Review must be accompanied by thea form prescribed by the Division Bureau, must be legible and complete, and must contain copies of the following:
 - 1. Copies of the original and resubmitted bills in dispute which include dates of service, procedure codes, bills for services rendered and any payment received, and an explanation of unusual services or circumstances;
 - 2. Copies of all explanations of benefit (EOB's);
 - 3. Supporting documentation and correspondence, if any;
 - 4. Specific information regarding the contacts made with the employer or carrierspayor employer; and

5. A verified or declared written medical report signed by the provider physician and all pertinent medical records; and:

5.6. A redacted copy of the above information removing all patient specific identifying information.

(c) The party requesting Committee Review must send a copy of the request and all documentation accompanying the request to the opposing party at the same time it is submitted to the Medical Director.

(d) If the request for review does not contain proper documentation, then the Committee will decline to review the dispute. Likewise, if the timeframe in this Rule is not met, then the Committee will decline to review the dispute, but such failure shall not provide an independent basis for denying payment or recovery of payment.

(e) Resubmission of a request will be entertained by the Bureau and the Medical Payment Committee for 3 months from the date the Committee declined to hear the original dispute but only if pertinent or new information is forwarded with the resubmission.

Authority: T.C.A. §§ 50-6-126, 50-6-204, 50-6-205, 50-6-226, 50-6-233 (~~Repl. 2005~~), and ~~Public Chapters 282 & 289 (2013)~~. **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendments filed June 12, 2009; effective August 26, 2009. Amendments filed March 12, 2012; to have been effective June 10, 2012. The Government Operations Committee filed a stay on May 7, 2012; new effective date August 9, 2012. Amendment filed December 26, 2013; effective March 26, 2014.

0800-02-17-.22 COMMITTEE REVIEW OF FEE SCHEDULE DISPUTES/HEARINGS.

(1) Medical Payment Committee (the Committee) Review Procedure

(a) When a valid request for Committee Review is received by the Bureau ~~Division's~~ Medical Director, the parties will be notified at least seven (7) business days in advance of when the Committee will consider the dispute. The Committee may consider the dispute at any meeting during which it has a quorum of the voting members. Members may participate by telephone or by video conferencing or by properly executed proxy. ~~M~~ ~~and~~ ~~members~~ ~~that~~ ~~who~~ participate by telephone or video conferencing or properly executed proxy shall be counted as if physically present for purposes of establishing a quorum.

(b) The parties will have the opportunity to submit documentary evidence and present arguments to the Committee prior to and during the Committee meeting in which the dispute will be heard.

(c) The Committee shall consider the dispute and issue its decision on the merits as to the proper resolution of the dispute, based upon a simple majority vote of the members present for the purpose of a quorum. ~~If the dispute cannot be decided in one meeting is not ripe for a decision, then the Committee may continue it to the next meeting.~~

(d) If the parties to the dispute do not follow the decision of the Committee, 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 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 Tennessee State holiday, by the President or Congress of the United States or so designated by the laws of this State.]

(a) —

Authority: T.C.A. §§ 50-6-204, 50-6-205, 50-6-233 (~~Repl. 2005~~), and ~~Public Chapters 282 & 289 (2013)~~.

Administrative History: Public necessity rule filed June 5, 2005; effective through November 27, 2005.

Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed

February 3, 2006; effective April 19, 2006. Amendment filed December 26, 2013; effective March 26, 2014.

0800-02-17-.23 RESERVED DULE 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 Administrator. After analysis, the Division may incorporate such recommended changes into Rules after appropriate consideration, public comment and compliance with the Uniform Administrative Procedures Act regarding promulgation of rules. The Medical Fee Schedule Rules, Medical Cost Containment Program Rules and In-Patient Hospital Fee Schedule Rules shall be reviewed by the Administrator, in consultation with the Medical Payment Committee and the Advisory Council on Workers' Compensation, on an annual basis. When appropriate, the Administrator may revise these Rules as necessary, and appropriate.

Authority: T.C.A. § 50-6-102, 50-6-204 (*Repl. 2005*), 50-6-205, 50-6-226, 50-6-233, and Public Chapters 282 & 289 (*2013*). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendment filed December 26, 2013; effective March 26, 2014.

0800-02-17-.24 PROVIDER AND FACILITY FEES FOR COPIES OF MEDICAL RECORDS.

- (1) Health care providers and facilities are entitled to recover an amount in accordance with Tenn. Code Ann. § 50-6-204 to cover the cost of copying documents requested by the ~~carrier~~employer, self-insured employer, employee, attorneys, etc. Documentation which is submitted by the provider and/or facility, but was not specifically requested by the ~~carrier~~employer, shall not be allowed a copy charge. The cost set forth in this subsection shall also apply to paper records transmitted on a disc or by other electronic means based upon the number of pages reproduced on the disc or other media.
- (2) Health care providers and facilities ~~shall~~must furnish an injured employee or the employee's attorney and ~~carrier~~employer /self-insureds or their legal representatives copies of records and reports as set forth in Tenn. Code Ann. § 50-6-204, as amended.
- (3) Health care providers and facilities may be reimbursed up to the usual and customary amount, as defined in these Rules at 0800-02-.03, for 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. Payment of all charges shall be made within thirty (30) calendar days.
- ~~(5)~~(6) There shall be no charge fee paid should a requested search not produce identified records.

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (*Repl. 2005*). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendments filed March 12, 2012; to have been effective June 10, 2012. The Government Operations Committee filed a stay on May 7, 2012; new effective date August 9, 2012.

0800-02-17-.25 IMPAIRMENT RATINGS-EVALUATIONS AND IN MEDICAL RECORDS.

- (1) This rule applies to authorized treating physicians. This rule is not applicable to independent Mmedical Eexaminations ("IME") or impairment ratings rendered as a part of an IME pursuant to Rule 0800-02-17-.09. As used in this Rule 0800-02-17-.25 only, an authorized treating physician is that physician, chiropractor or medical practitioner who

determines the employee has reached maximum medical improvement regarding the condition or injury for which the physician has provided treatment. The authorized A-treating physician may include any of the following:

- (a) a physician chosen from the panel required by T.C.A. Section 50-6-204;
 - (b) a physician referred to by the physician chosen from the panel required by T.C.A. Section 50-6-204;
 - (c) a physician recognized and authorized by the employer to treat an injured employee for a work-related injury; or
 - (d) a physician designated by the Bureau~~Division~~ to treat an injured employee for a work-related injury.
- (2) The authorized A-treating physician is required and responsible for determining the employee's maximum medical improvement date (MMI) and providing the employee's impairment rating for the injury the physician is treating. In some circumstances, a work-related accident may lead to multiple injuries that require multiple authorized treating physicians. In such cases, the physician that is treating a distinct injury shall determine that the employee has reached maximum medical improvement as to that injury only and is required and responsible for providing an impairment rating for that injury only. An authorized treating physician shall not be required or responsible for providing an impairment rating for an injury that the physician is not treating. The authorized treating physician shall only be required to provide an impairment rating when the physician believes in good faith that the employee retains a permanent impairment upon reaching maximum medical improvement. If, after completion of the rating, it is determined that the employee has an impairment rating of zero, then the provisions of Rule 0800-02-17-.25(6) shall still apply. If the treating physician does not have a good faith belief that the employee retains a permanent impairment upon reaching maximum medical improvement, then the authorized treating physician shall still not be required to provide complete an impairment rating on the Bureau's form and but shall not charge a fee for an the impairment rating.
- (3) All impairment ratings shall be made pursuant to T.C.A. ~~§Section 50-6-204.(d)(3)(A).(k)(3).~~
- (4) Within twenty-one (21) calendar days of the date the authorized treating physician determines the employee has reached maximum medical improvement, the authorized treating physician shall submit to the ~~employer~~employer or carrier, as applicable, a fully completed report on a form prescribed by the Administrator. The ~~employer~~employer or carrier, as applicable, shall submit a fully completed form to the ~~Division~~ Bureau (if requested) and the parties within thirty (30) calendar days of the date the authorized treating physician determines the employee has reached maximum medical improvement.
- (5) Upon determination of the employee's impairment rating, the authorized treating physician shall enter the employee's impairment rating into the employee's medical records. In a response to a request for medical records pursuant to T.C.A. Section ~~§~~50-6-204, a provider, authorized treating physician or hospital shall include the portion of the medical records that includes the impairment rating.
- (6) The authorized treating physician is required and responsible for providing the impairment rating, fully completing the report on a form prescribed by the Administrator, and submitting the report to the ~~employer~~employer or carrier, as applicable, as required by these Rules, using CPT® code 99455. Notwithstanding Rule 0800-02-17-.15, the authorized treating physician shall receive payment of no more than \$250.00 for these services to be paid by the ~~employer~~employer or carrier. The payment shall only be made to the authorized treating physician, if the authorized treating physician documents the consultations with the applicable AMA Guides™. The authorized treating physician shall not require prepayment of such fee.
- (7) Failure to fully complete the form and submit it within the appropriate timeframes shall subject the ~~employer~~employer, carrier or authorized treating physician, as

applicable, to a civil penalty of \$100 for every fifteen (15) calendar days past the required date until the fully completed form is received by the Division parties and the Bureau (if requested).

Authority: T.C.A. §§ 50-6-102, 50-6-204, 50-6-205, 50-6-226, 50-6-233, 50-6-246, and Public Chapters 282 & 289 (2013). **Administrative History:** Original rule filed December 20, 2007; effective March 4, 2008. Public necessity rule filed January 8, 2009; effective through June 22, 2009. Public necessity rule filed May 19, 2009; effective through October 31, 2009. Amendment filed June 12, 2009; effective August 26, 2009. Amendment filed December 26, 2013; effective March 26, 2014.

I certify that the information included in this filing is an accurate and complete representation of the intent and scope of rulemaking proposed by the agency.

Date: _____

Signature: _____

Name of Officer: _____

Title of Officer: _____

Subscribed and sworn to before me on: _____

Notary Public Signature: _____

My commission expires on: _____

Department of State Use Only

Filed with the Department of State on: _____

Tre Hargett
Secretary of State

* If a roll-call vote was necessary, the vote by the Agency on these rules was as follows:

Board Member	Aye	No	Abstain	Absent	Signature (if required)

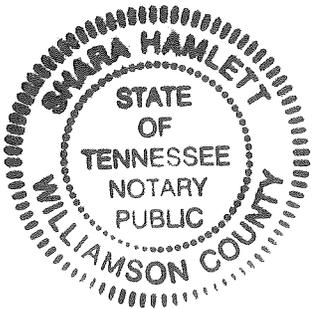
I certify that this is an accurate and complete copy of rulemaking hearing rules, lawfully promulgated and adopted by the Tennessee Bureau of Workers' Compensation on 8/22/17 and is in compliance with the provisions of T.C.A. § 4-5-222.

I further certify the following:

Notice of Rulemaking Hearing filed with the Department of State on April 13, 2017.

Rulemaking Hearing Conducted on June 8, 2017.

Date: August 22, 2017
 Signature: Abbie Hudgens
 Name of Officer: Abbie Hudgens
 Title of Officer: Administrator, Bureau of Workers' Compensation
 Subscribed and sworn to before me on: August 22, 2017
 Notary Public Signature: [Signature]
 My commission expires on: 2/19/20



All proposed rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

Herbert H. Slatery III
 Herbert H. Slatery III
 Attorney General and Reporter
 Date 10/33/2017

RECEIVED
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 PUBLIC AFFAIRS

Department of State Use Only

Filed with the Department of State on: 11/27/17
 Effective on: 2/25/18
[Signature]

Tre Hargett
 Secretary of State

G.O.C. STAFF RULE ABSTRACT

DEPARTMENT: Finance and Administration

DIVISION: TennCare

SUBJECT: CoverKids

STATUTORY AUTHORITY: Tennessee Code Annotated, Sections 4-5-202, 71-3-1106, and 71-3-1110

EFFECTIVE DATES: February 26, 2018 through June 30, 2018

FISCAL IMPACT: The promulgation of these Rule Chapters is not anticipated to have an impact on state and local government revenues and expenditures.

STAFF RULE ABSTRACT: The new rulemaking hearing Rule Chapter 1200-13-21 rewrites the rules for the CoverKids program, which included changes to some CoverKids copays, and places them in the same Control number and Division as the rules of the other health care-related programs in the Division of TennCare, under the control of the Commissioner of the Department of Finance and Administration. Rule Chapter 0620-05-01 found in the Department of Finance and Administration, Division of Insurance Administration, is repealed in its entirety.

NOTE: Please see p. 302-318 for portions of repealed rule and p. 320-330 for the new rule.

Public Hearing Comments

One copy of a document containing responses to comments made at the public hearing must accompany the filing pursuant to T.C.A. § 4-5-222. Agencies shall include only their responses to public hearing comments, which can be summarized. No letters of inquiry from parties questioning the rule will be accepted. When no comments are received at the public hearing, the agency need only draft a memorandum stating such and include it with the Rulemaking Hearing Rule filing. Minutes of the meeting will not be accepted. Transcripts are not acceptable.

There were no comments on these rule chapters.

Regulatory Flexibility Addendum

Pursuant to T.C.A. §§ 4-5-401 through 4-5-404, prior to initiating the rule making process, all agencies shall conduct a review of whether a proposed rule or rule affects small business.

The rule chapters are not anticipated to have an effect on small businesses.

Impact on Local Governments

Pursuant to T.C.A. §§ 4-5-220 and 4-5-228 “any rule proposed to be promulgated shall state in a simple declarative sentence, without additional comments on the merits of the policy of the rules or regulation, whether the rule or regulation may have a projected impact on local governments.” (See Public Chapter Number 1070 (<http://state.tn.us/sos/acts/106/pub/pc1070.pdf>) of the 2010 Session of the General Assembly)

The rule chapters are not anticipated to have an impact on local governments.

Additional Information Required by Joint Government Operations Committee

All agencies, upon filing a rule, must also submit the following pursuant to T.C.A. § 4-5-226(i)(1).

- (A)** A brief summary of the rule and a description of all relevant changes in previous regulations effectuated by such rule;

The new rulemaking hearing Rule Chapter 1200-13-21 rewrites the rules for the CoverKids program, which included changes to some CoverKids copays, and places them in the same Control number and Division as the rules of the other health care-related programs in the Division of TennCare, under the control of the Commissioner of the Department of Finance and Administration. Rule Chapter 0620-05-01 found in the Department of Finance and Administration, Division of Insurance Administration, is repealed in its entirety.

- (B)** A citation to and brief description of any federal law or regulation or any state law or regulation mandating promulgation of such rule or establishing guidelines relevant thereto;

The Rule Chapter is lawfully adopted by the Division of TennCare in accordance with T.C.A. §§ 4-5-202, 71-3-1106 and 71-3-1110, and the Tennessee Title XXI Children's Health Insurance Program State Plan.

- (C)** Identification of persons, organizations, corporations or governmental entities most directly affected by this rule, and whether those persons, organizations, corporations or governmental entities urge adoption or rejection of this rule;

The persons and entities most directly affected by these Rule Chapters are the CoverKids enrollees and providers. The governmental entity most directly affected by this Rule Chapter is the Division of TennCare, Tennessee Department of Finance & Administration.

- (D)** Identification of any opinions of the attorney general and reporter or any judicial ruling that directly relates to the rule or the necessity to promulgate the rule;

These Rule Chapters were approved by the Tennessee Attorney General. No additional opinion was given or requested.

- (E)** An estimate of the probable increase or decrease in state and local government revenues and expenditures, if any, resulting from the promulgation of this rule, and assumptions and reasoning upon which the estimate is based. An agency shall not state that the fiscal impact is minimal if the fiscal impact is more than two percent (2%) of the agency's annual budget or five hundred thousand dollars (\$500,000), whichever is less;

The promulgation of these Rule Chapters is not anticipated to have an impact on state and local government revenues and expenditures.

- (F)** Identification of the appropriate agency representative or representatives, possessing substantial knowledge and understanding of the rule;

Donna K. Tidwell
Deputy General Counsel

- (G)** Identification of the appropriate agency representative or representatives who will explain the rule at a scheduled meeting of the committees;

Donna K. Tidwell
Deputy General Counsel

- (H)** Office address, telephone number, and email address of the agency representative or representatives who will explain the rule at a scheduled meeting of the committees; and

310 Great Circle Road
Nashville, TN 37243
(615) 507-6852
donna.tidwell@tn.gov

(l) Any additional information relevant to the rule proposed for continuation that the committee requests.

GW10117240

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For Department of State Use Only

Sequence Number: 11-19-17
Rule ID(s): 6653-6654
File Date: 11/28/17
Effective Date: 2/26/18

Rulemaking Hearing Rule(s) Filing Form

Rulemaking Hearing Rules are rules filed after and as a result of a rulemaking hearing (Tenn. Code Ann. § 4-5-205).

Pursuant to Tenn. Code Ann. § 4-5-229, any new fee or fee increase promulgated by state agency rule shall take effect on July 1, following the expiration of the ninety (90) day period as provided in § 4-5-207. This section shall not apply to rules that implement new fees or fee increases that are promulgated as emergency rules pursuant to § 4-5-208(a) and to subsequent rules that make permanent such emergency rules, as amended during the rulemaking process. In addition, this section shall not apply to state agencies that did not, during the preceding two (2) fiscal years, collect fees in an amount sufficient to pay the cost of operating the board, commission or entity in accordance with § 4-29-121(b).

Agency/Board/Commission:	Tennessee Department of Finance & Administration
Division:	Division of TennCare
Contact Person:	George Woods
Address:	310 Great Circle Road
Zip:	37243
Phone:	(615) 507-6446
Email:	george.woods@tn.gov

Revision Type (check all that apply):

- Amendments
 New
 Repeal

Rule(s) (ALL chapters and rules contained in filing must be listed here. If needed, copy and paste additional tables to accommodate multiple chapters. Please make sure that ALL new rule and repealed rule numbers are listed in the chart below. Please enter only ONE Rule Number/Rule Title per row)

Chapter Number	Chapter Title
1200-13-21	CoverKids
Rule Number	Rule Title
1200-13-21-.01	Scope and Authority
1200-13-21-.02	Definitions
1200-13-21-.03	Eligibility
1200-13-21-.04	Benefits
1200-13-21-.05	Cost Sharing
1200-13-21-.06	Disenrollment
1200-13-21-.07	Review of CoverKids Decisions
1200-13-21-.08	Providers

Chapter Number	Chapter Title
0620-05-01	Cover Kids Rules
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**RULES
OF
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF INSURANCE ADMINISTRATION**

**CHAPTER 0620-05-01
COVER KIDS RULES**

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0620-05-01-.01 DEFINITIONS.

- (1) ~~Unless otherwise specifically defined in these rules, these terms will have the following meaning:~~
- (a) ~~“Administrative Contractor” or “AC” is the entity responsible for determining eligibility of applicants to CoverKids. This may be a private contractor, government agency, or Departmental entity.~~
 - (b) ~~“Budget Group” means for each applicant, the following family members living with the applicant: the applicant’s spouse, the applicant’s minor unmarried children, the siblings of children in the home when the applicant child and siblings do not have income of their own, and each of the applicant’s financially responsible adults as indicated by the family including natural, adoptive, and step-parents. Children with SSI or Families First are not included in a budget group.~~
 - (c) ~~“Commissioner” is the executive officer in charge of the Tennessee Department of Finance and Administration.~~
 - (d) ~~“Commissioner’s Designee” means a person or group of persons appointed by the Commissioner to perform a particular function under these rules.~~
 - (e) ~~“CoverKids” is the program created by Tennessee Code Annotated Section 71-3-1101 et seq. and includes its authorized employees and agents as the context of the rules requires.~~
 - (f) ~~“Days” means calendar days rather than business days.~~
 - (g) ~~“Health insurance” shall include but not be limited to basic medical coverage (hospitalization plans), major medical insurance, comprehensive medical insurance, short-term medical policies, limited-benefit plans, mini-medical plans and high deductible health plans with health savings accounts. Health insurance shall not include the following:~~
 - 1. ~~CoverTN;~~
 - 2. ~~AccessTN;~~

(Rule 0620-05-01-.01, continued)

- ~~3. catastrophic health insurance plans that only provide medical services after satisfying a deductible in excess of \$3,000 (or the maximum allowed deductible for a health savings account plan);~~
- ~~4. dental-only plans;~~
- ~~5. vision-only plans;~~
- ~~6. coverage through the State of Tennessee's Children's Special Services (CSS) program; or~~
- ~~7. medical insurance that is available to an enrollee pursuant either to the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986 (Pub. L. No. 99-272, codified at 29 U.S.C. § 1161 *et seq.*) and which the individual declined, or to § 56-7-2312 *et seq.* and which the individual declined.~~

~~Consistent with 42 U.S.C. § 1397jj(b)(2)(B) and 42 C.F.R. 457.301 and 310(c)(1)(ii), health insurance shall also not include state-administered or other medical coverage offered by means of a family member's employment with a local education agency (LEA) if the LEA does not make more than a nominal contribution (as defined at 42 CFR 457.310(c)(1)(ii)) to the premium for the dependent who is applying (or re-applying) for coverage through CoverKids.~~

~~(h) "Involuntary loss of coverage" means the loss of health benefits coverage arising from (but not limited to) the following circumstances:~~

- ~~1. a separation from employment (voluntary or involuntary);~~
- ~~2. a health insurance carrier's cancellation of group or individual health benefits coverage for reasons other than premium non-payment, fraud, or misrepresentation;~~
- ~~3. a health insurance carrier's decision to no longer sell small group health benefits coverage; or~~
- ~~4. the loss of eligibility for TennCare Medicaid or TennCare Standard.~~

~~Involuntary loss of coverage shall not include situations in which the primary insured dropped dependent spouse and/or dependent child(ren) from the health benefits coverage policy.~~

~~(i) "Meaningful Access" is insurance coverage that includes a network of providers within a reasonable distance from the area in which the covered individual lives.~~

~~(j) "Parent" means a natural or appointed guardian of minor children as defined by Title 34, Part 1 of Tennessee Code Annotated subject to court orders entered or recognized by the courts of the state of Tennessee.~~

~~(k) "Plan Administrator" or "PA" is the entity responsible for providing health care services to CoverKids enrollees. This may be a private contractor, government agency, or Departmental entity.~~

~~(l) "SSI" means Supplemental Security Income benefits provided by the Social Security Administration.~~

(Rule 0620-05-01-.01, continued)

Authority: T.C.A. §§ 4-5-202, 71-3-1104, 71-3-1106, 71-3-1110. **Administrative History:** Public necessity rule filed March 13, 2007; expired August 25, 2007. Original rule filed May 30, 2007; effective August 13, 2007. Amendment filed May 22, 2008; effective August 5, 2008. Amendments filed February 25, 2009; effective June 26, 2009. Amendments filed July 20, 2016; effective October 18, 2016.

0620-05-01-.02 ELIGIBILITY.

~~(1) — Citizenship.~~

~~(a) — Children must be citizens of the United States or persons designated as qualified aliens under 8 U.S.C. 1642 as applied to programs under Title XXI of the Social Security Act by federal law including 42 C.F.R. 457.320(b)(6). Notwithstanding any language to the contrary, CoverKids will grant eligibility to an unborn child whose mother is either an undocumented alien or a permanent resident alien who has not resided in the United States in that status for at least five years, to the extent that such coverage is mandated by the United States Department of Health and Human Services.~~

~~(b) — CoverKids will comply with applicable amendments to Federal laws and regulations concerning eligibility of non-citizens.~~

~~(2) — Residency.~~

~~(a) — The applicant must be a resident of the state of Tennessee.~~

~~(3) — Social Security Number.~~

~~(a) — All applicants must have a Social Security Number (SSN) or proof of application for a SSN. For newborns less than 4 months of age an application for an SSN must be filed. SSN are not required for parents and children not applying for CoverKids coverage.~~

~~(b) — Families with children under 4 months of age who were approved for CoverKids coverage without an SSN should submit the SSN to the AC as soon as received. A SSN must be received by redetermination.~~

~~(4) — Age.~~

~~(a) — Applicants must be either a child under 19 years of age or a pregnant woman. CoverKids coverage for children ends the last day of the month in which the child turns 19.~~

~~(b) — A female that that become pregnant at 18 years of age with a delivery date that occurs after her 19th birthday, will be allowed to retain coverage so as not to create discontinuity of care for prenatal, delivery, and post-partum care. This coverage will continue until the end of the month in which the 60th postpartum day occurs. All services rendered would be related to post-pregnancy care.~~

~~(c) — Information of the child's age on the CoverKids application is sufficient verification of age. Any applicant for whom a date of birth is not provided will be denied CoverKids coverage.~~

~~(5) — Health Insurance.~~

(Rule 0620-05-01-.02, continued)

~~(a) Factors in Determining Current Health Insurance.~~

- ~~1. The applicant must not be currently covered by health insurance, as defined in rule 0620-05-01-.01(1)(g); and~~
- ~~2. The applicant must not have had health insurance in the past three months unless the applicant experienced an involuntary loss of insurance, as defined in rule 0620-05-01-.01(1)(h).~~

~~(b) If the applicant is a pregnant woman with health insurance, as defined in rule 0620-05-01-.01(1)(g), she may be enrolled in CoverKids if her health insurance does not cover prenatal/maternity care. The AC will use the information on the application, the copy of the insurance card and information obtained by contacting the insurance company to determine if prenatal/maternity care is covered by her health insurance.~~

~~(c) Information on the CoverKids application is sufficient verification of an applicant being uninsured. The State reserves the right to investigate the insurance status of applicants. If the State determines that the applicant has other insurance or has not been without comprehensive health insurance for at least three (3) months, the State has the right to cancel coverage. The CoverKids application must be submitted with a copy of the front and back side of the insurance card for any applicants who indicate there is other insurance coverage.~~

~~(6) Assets.~~

~~(a) No asset test is used.~~

~~(7) Income~~

~~(a) To be eligible for CoverKids, children and pregnant women must have adjusted gross income above TennCare Medicaid levels but at or below 250% of the Federal Poverty Level. CoverKids may enroll persons above 250% of the Federal Poverty Level under the terms and conditions set forth in these Rules. This program will use the limited self-declared information on the application to screen each applicant for potential TennCare Medicaid eligibility by aligning with the guidelines currently used in the Department of Human Services for determination of both budget groups and income calculation to the extent possible. Final determination of TennCare eligibility will be determined by the Department of Human Services or TennCare. These guidelines are subject to change with changes to the Department of Human Services guidelines. Further, these guidelines are for TennCare screening purposes only and are subject to change in accordance with any mandatory regulations issued from the federal level.~~

~~(b) The CoverKids application will request income information for adults who are parents (biological, adopted or step) and for caretaker relatives who are caring for children when neither parent lives in the home or in the event a parent lives in the house but the parent's current circumstances or conditions necessitate that a caretaker relative is the responsible adult assuming care of that child.~~

~~(c) All family income of the budget group must be reported on the application. Self-declaration of income by the responsible adult(s) of the applicant or the applicant is sufficient verification and must include the payee's name and the gross amount of monthly income.~~

(Rule 0620-05-01-.02, continued)

~~(d) The financial eligibility for CoverKids will be calculated as follows:~~

- ~~1. Depending on family relationships, a family may be comprised of one or multiple budget groups.~~
- ~~2. If a child receives income and is applying for coverage, then that child and his income must be counted in the budget group.~~
- ~~3. If a pregnant female is under the age of 19 and lives in the household with her parents, the pregnant female's budget group would consist of the pregnant minor and her parents.~~

~~(e) Countable Income:~~

- ~~1. Self-declaration of income is allowed for applicants using the CoverKids application.~~
- ~~2. Income must be reported as a monthly amount.~~

~~(f) Financial Factors The AC will calculate each budget group's adjusted gross income for the month that eligibility will begin based on recent income information provided by the family on the CoverKids application. Adjusted gross income is the sum of all countable income for persons in the budget group.~~

~~(8) Non-factors:~~

~~(a) The following must not be a factor in determining CoverKids eligibility:~~

- ~~1. Disability status.~~
- ~~2. Pre-existing condition.~~
- ~~3. Diagnosis.~~

~~(9) Excluded Children:~~

~~(a) Individuals who are not eligible for CoverKids include children who:~~

- ~~1. Are eligible for TennCare Medicaid;~~
- ~~2. Are enrolled in TennCare Medicaid or TennCare Standard;~~
- ~~3. Have been criminally adjudicated and are in a correctional facility, including a detention home or training school;~~
- ~~4. Are admitted to an institution for mental disease;~~
- ~~5. Are eligible for health insurance, as defined in rule 0620-05-01-.01(1)(g), on the basis of a responsible adult's (self, parent, spouse, etc.) employment by a state agency or local education agency (unless such person has been denied enrollment due to medical underwriting); or~~

(Rule 0620-05-01-.02, continued)

- ~~6. Have had health insurance, as defined in rule 0620-05-01-.01(1)(g), in the past three months and voluntarily discontinued the comprehensive insurance, regardless of the cost.~~
- ~~(10) Updated Federal Poverty Levels:~~
- ~~(a) Upon release by the federal government of a new calendar year's Federal Poverty Levels (usually in late winter), the AC will update the eligibility database to reflect the update.~~
- ~~(11) Changes in Family Status. If the family has applied for CoverKids and coverage was denied, applicants may reapply for CoverKids any time a change occurs that may make them eligible. This could include a change in family size, pregnancy, loss of a job, or change in family income. (A change in the child's health status does not make a child eligible for CoverKids.) If a family has a change in status that makes the children newly eligible for CoverKids, the family should reapply as soon as possible.~~
- ~~(12) Annual Redetermination of Eligibility:~~
- ~~(a) Eligibility determinations will be done annually. The AC will mail a CoverKids redetermination form to families within 60 calendar days of the beneficiary's last day of continuous eligibility. The family must review the renewal letter, note changes, attach documentation as appropriate, sign it and return it to AC. The AC will make an eligibility determination for each applicant on the redetermination form. The AC may present an option of renewal online.~~
- ~~(b) For beneficiaries at or above 250% of the FPL who continue to be otherwise eligible in this category, CoverKids eligibility will continue as long as the family continues to pay premiums timely each month.~~
- ~~(13) Pregnant women with income above 250% of the Federal poverty level will only be eligible for CoverKids enrollment if they are presently enrolled in the CoverTN program or presently enrolled in the CoverKids program.~~
- ~~(14) Enrollment Caps. CoverKids may impose enrollment caps for the program as a whole or for any category of enrollees when, in its discretion, it determines that either~~
- ~~(a) sufficient Federal funds will not be available;~~
- ~~(b) sufficient appropriations from the Tennessee General Assembly will not be available; or~~
- ~~(c) CoverKids expenditures will exceed the existing funds available for the program.~~

Authority: T.C.A. §§ 4-5-202, 4-5-208, 71-3-1104, 71-3-1106 and 71-3-1110. **Administrative History:** Public necessity rule filed March 13, 2007; expired August 25, 2007. Original rule filed May 30, 2007; effective August 13, 2007. Public necessity rule filed February 22, 2008; effective through August 5, 2008. Amendments filed May 22, 2008; effective August 5, 2008. Amendments filed February 25, 2009; effective June 26, 2009. Emergency rule filed October 12, 2009; effective through April 10, 2010. Amendment filed January 11, 2010; effective April 11, 2010. Amendments filed July 20, 2016; effective October 18, 2016.

0620-05-01-.03 BENEFITS AND COST SHARING.

(Rule 0620-05-01-.03, continued)

(1) The following benefits are covered by the CoverKids program as medically necessary, subject to the limitations stated.

(a) Medical benefits.

1. Ambulance services (air and ground).
2. Chiropractic care.
3. Durable medical equipment. Limited to the most basic equipment that will provide the needed care.
4. Emergency room care.
5. Home health.
6. Hospice.
7. Hospital care.
8. Inpatient mental health treatment. Pre-authorization required.
9. Inpatient substance abuse treatment. Pre-authorization required.
10. Lab and X-ray.
11. Maternity care.
12. Medical supplies. Quantities for a single prescription will be limited to a 31-day supply.
13. Outpatient mental health and substance abuse treatment.
14. Physical, speech, and occupational therapy. Limited to 52 visits per calendar year, per type of therapy.
15. Physician office visits.
16. Prescription drugs.
17. Rehabilitation hospital services.
18. Routine health assessments and immunizations.
19. Skilled nursing facility services. Limited to 100 days per calendar year following an approved hospitalization.
20. Vision benefits.
 - (i) Annual vision exam including refractive exam and glaucoma screening.
 - (ii) Prescription eyeglass lenses. Limited to one pair per calendar year. \$85 maximum benefit per pair.

(Rule 0620-05-01-.03, continued)

- (iii) Eyeglass frames. Coverage for replacement frames limited to once every two calendar years. \$100 maximum benefit per pair.
 - (iv) Prescription contact lenses in lieu of eyeglasses. Limited to one pair per calendar year. \$150 maximum benefit per pair.
- (b) Dental benefits.
- 1. Dental services. Limited to a \$1,000 annual benefit maximum per child.
 - 2. Orthodontic services. Limited to a \$1,250 lifetime benefit maximum per child. Covered only after a 12-month waiting period.
- (2) The following benefits are excluded from coverage by the CoverKids program.
- (a) Comfort or convenience items not related to an enrollee's illness.
 - (b) Dietary guidance services.
 - (c) Homemaker or housekeeping services.
 - (d) Maintenance visits when no additional progress is apparent or expected to occur.
 - (e) Meals.
 - (f) Medical social services.
 - (g) Non-treatment services.
 - (h) Private duty nursing services.
 - (i) Routine transportation.
- (3) There are no premiums or deductibles required for participation in CoverKids.
- (4) Copays. The following copays are required, depending upon family income.

Service	Copays When Family Income is Less than 150% of Poverty	Copays When Family Income is 150%-250% of Poverty
MEDICAL BENEFITS		
Chiropractic care	\$5 per visit	\$15 per visit
Emergency room (emergency—waived if admitted)	\$5 per use	\$50 per use
Emergency room (non-emergency)	\$10 per use	\$50 per use
Home health	\$5 per visit	\$15 per visit
Hospital care	\$5 per admission; waived if readmitted within 48 hours for the same episode	\$100 per admission; waived if readmitted within 48 hours for the same episode
Inpatient mental health treatment	\$5 per admission; waived if readmitted within 48 hours for the same episode	\$100 per admission; waived if readmitted within 48 hours for the same episode

(Rule 0620-05-01-.03, continued)

Service	Copays When Family Income is Less than 150% of Poverty	Copays When Family Income is 150%-250% of Poverty
Inpatient substance abuse treatment	\$5 per admission; waived if readmitted within 48 hours for the same episode	\$100 per admission; waived if readmitted within 48 hours for the same episode
Maternity	\$5 OB or specialist, first visit only \$5 hospital admission	\$15 OB or specialist, first visit only \$20 per visit, specialist \$100 hospital admission
Medical supplies	\$5 per 31-day supply	\$5 per 31-day supply
Outpatient mental health and substance abuse treatment	\$5 per session	\$20 per session
Physical, speech, and occupational therapy	\$5 per visit	\$15 per visit
Physician office visits	\$5 per visit, primary care physician or specialist No copay for routine health assessments and immunizations rendered under the American Academy of Pediatrics guidelines	\$15 per visit, primary care physician \$20 per visit, specialist No copay for routine health assessments and immunizations rendered under the American Academy of Pediatrics guidelines
Prescription drugs	\$1, generics \$3, preferred brands \$5, non-preferred brands	\$5, generics \$20, preferred brands \$40, non-preferred brands
Rehabilitation hospital services	\$5 per admission	\$100 per admission
Vision services	\$5 for lenses; \$5 for frames (when lenses and frames are ordered at the same time, only one copay is charged)	\$15 for lenses; \$15 for frames (when lenses and frames are ordered at the same time, only one copay is charged)
DENTAL BENEFITS		
Dental	\$5 per visit No copay for routine preventive oral exam, X-rays, and fluoride application	\$15 per visit No copay for routine preventive oral exam, X-rays, and fluoride application
Orthodontic services	\$5 per visit	\$15 per visit
ANNUAL OUT-OF-POCKET MAXIMUM PER ENROLLEE		
Annual out-of-pocket maximum per enrollee	5% of the family's annual income	

- (5) Eligible children in a family that does not pay a required copay remain enrolled in the program. An individual provider may at his discretion refuse service for non-payment of a copay unless a medical emergency exists. The state does not participate in collection action or impose any benefit limitations if enrollees do not pay their copays.

Authority: T.C.A. §§ 4-5-202, 71-3-1104, 71-3-1106, and 71-3-1110. **Administrative History:** Public necessity rule filed March 13, 2007; expired August 25, 2007. Original rule filed May 30, 2007; effective August 13, 2007. Amendments filed May 22, 2008; effective August 5, 2008.

(Rule 0620-05-01-.03, continued)

Amendment filed June 17, 2014; effective September 15, 2014. Amendment filed July 27, 2015; effective October 25, 2015;

0620-05-01-.04 DISENROLLMENT.

- (1) Grounds for Disenrollment from CoverKids.
 - (a) Children enrolled in CoverKids at or below 250% of the FPL are financially eligible for 12 months, except in the following situations, which will result in disenrollment from CoverKids coverage prior to the end of the 12 month period.
 1. An enrollee, through an authorized family member, requests disenrollment.
 2. Admission of a CoverKids enrollee into a correctional facility or an institution for mental disease.
 3. A CoverKids enrollee moves from the state.
 4. Death of a CoverKids enrollee.
 5. A CoverKids enrollee is enrolled in TennCare.
 6. A CoverKids enrollee meets a TennCare Medicaid spend-down.
 7. A CoverKids enrollee turns age 19.
 8. A woman 19 or older who was enrolled because of pregnancy is no longer eligible after the last day of the month in which the sixtieth post-partum day occurs.
 9. ~~A CoverKids enrollee gains access to health insurance, as defined in rule 0620-05-01-.01(1)(g), through a family member's employment with a state agency or local education agency.~~
 10. ~~A CoverKids enrollee is enrolled into individual, group or employer-based coverage.~~
 11. A CoverKids enrollee is discovered not to have been eligible for CoverKids at the time of enrollment. This includes, but is not limited to, enrollees whose enrollment was obtained by fraud or misrepresentations by an enrollee, parent, guardian, or representative.
 - (b) A child above 250% of the Federal poverty level, as defined in these rules and under Federal law, may be disenrolled for nonpayment of premiums, as described more fully in regulation 0620-05-01-.03, as well as the reasons set forth in subparagraph (1)(a).
- (2) Procedures.
 - (a) ~~Disenrollments shall be conducted under the procedures set forth in section 0620-05-01-.05 of these rules.~~

Authority: T.C.A. §§ 4-5-202, 71-3-1106, 71-3-1110. **Administrative History:** Public necessity rule filed March 13, 2007; expired August 25, 2007. Original rule filed May 30, 2007; effective

(Rule 0620-05-01-.04, continued)

August 13, 2007. Repeal and new rule filed May 22, 2008; effective August 5, 2008. Amendment filed February 25, 2009; effective June 26, 2009.

0620-05-01-.05 ADMINISTRATIVE REVIEW OF COVERKIDS DECISIONS.

- (1) **Eligibility and Enrollment Matters.** ~~The parent of an enrollee or applicant may obtain review of a denial of eligibility, suspension or termination of enrollment (including termination for failure to pay premiums or cost sharing), or a situation in which eligibility decisions have not been made in a timely manner, through the following procedures:~~

~~(a) Informal Review.~~

- ~~1. A parent will be notified of a denial of eligibility or suspension or termination of enrollment in writing, and such notice will contain the reason for the denial, the procedures for seeking review of this decision, and the anticipated time by which review will be completed. Parents may also request a review for situations in which eligibility determination have not been made in a timely manner. Parents will be notified that termination or suspension of enrollment will not be effective until the completion of the review process provided in these rules.~~
- ~~2. Parents may request review by sending a written request to the Administrative Contractor (AC) or calling the eligibility and enrollment AC's toll-free number. This request for review must be received by the AC within 30 days of issuance of written notice of the action for which review is requested or, if notice is not provided, 30 days from the time the applicant becomes aware of the action. They may report additional information or clarify information on the applicant's account. The AC will document the call and any additional information/clarification provided. AC eligibility staff will review the matter.~~
- ~~3. If the AC's review does not result in the child being eligible, the parent will be notified of the reason the denial was upheld. The notification letter will inform the parent that they may submit a formal request in writing to the Division of Insurance Administration, to be reviewed by the state-level CoverKids Eligibility Appeals Committee.~~

~~(b) Formal Review.~~

- ~~1. The parent may request a formal review of the informal review decision with a written request to the Division of Insurance Administration. This request must be received by the Division within 30 days of issuance of the informal review decision. Receipts of requests for review will be acknowledged in writing within 10 days, including notification that a decision should be issued within one calendar month of receipt of the acknowledgment letter.~~
- ~~2. The Eligibility Appeals Committee, composed of five Division of Insurance Administration staff members, will review eligibility and enrollment matters. The members of this committee shall not have been directly involved in the matter under review. If the Committee disagrees with the decision of the AC, the child will be enrolled in CoverKids. If at any level of dispute, the appropriate party determines the child is eligible for enrollment in CoverKids, the enrollment will become effective~~

(Rule 0620-05-01-.05, continued)

~~retroactive to the first day of the month following the initial eligibility determination.~~

- ~~3. Parents may represent themselves or have a representative of their choosing in connection with formal reviews. Parents may review information relevant to the review of the decision in a timely manner and may submit supplemental information during the review process. Enrollees will remain enrolled pending completion of the review in the case of suspension or termination of enrollment.~~
- ~~4. The Committee is not required to conduct in-person hearings or to conduct a contested case under the requirements of the Uniform Administrative Procedures Act.~~
- ~~5. If the Committee agrees with the decision to deny eligibility, a letter will be sent to the parent detailing the reason for denial. The decision of the Eligibility Appeals Committee will be the final administrative recourse available.~~

~~(c) Deadlines for Review.~~

- ~~1. Expedited review will be provided if an applicant provides a statement from a medical professional that she or he has a medical situation that is life threatening or would seriously jeopardize the enrollee's health or ability to attain, maintain or regain maximum functioning. Expedited review should be completed within 10 days of receipt of the request.~~
- ~~2. All enrollment or eligibility matters not subject to expedited review shall be determined within a reasonable time.~~

(2) Health Services Matters. A parent of a CoverKids enrollee may request review of a Cover Kids action to delay, deny, reduce, suspend, or terminate health services, or a failure to approve, furnish, or provide payment for health services in a timely manner, according to the following provisions.

- (a) Notice. Any decision denying, or delaying a requested health service, reducing, suspending, or terminating an existing health service, or failure to approve, furnish, or provide payment for health services in a timely manner shall be in writing and must contain the reason for the determination, an explanation of review rights and procedures, the standard and expedited time frames for review, the manner of requesting a review, and the circumstances under which existing health services may continue pending review unless there is question that the existing health services are harmful.
- (b) Contractor Review. Parents commence the review process by submitting a written request to the Plan Administrator (PA) within 30 days of issuance of written notice of the action or, if no notice is provided, from the time the enrollee becomes aware of the action not to exceed six (6) months from when the action occurred. The PA will review this request and issue a written decision within 30 days of receipt of this request. Expedited reviews (within 72 hours) will be available for situations in which a benefit determination or a preauthorization denial has been made prior to services being received and the attending medical professional determines in writing (including legible handwriting) the medical situation to be life threatening or would seriously jeopardize the enrollee's health or ability to attain, maintain or regain maximum

(Rule 0620-05-01-.05, continued)

functioning. This determination should be made in legible writing with an original signature.

- (c) **State Informal Review.** After the PA's internal review is completed, the parent of an enrollee who disagrees with the decision may request further review by submitting a letter or form to the State Division of Insurance Administration which must be received within 8 days of the Administrator's decision. The Appeals Coordinator within the Division will review the matter and gather supplemental information from the family, physician, and/or insurer as needed. The Appeals Coordinator may also request review by the state's independent medical consultant. A written decision of the Appeals Coordinator should be issued within 20 days of receipt of the request for further review.
 - (d) **State Review Committee.** If the informal review does not grant the relief requested by the parent, the request will be scheduled for review by the CoverKids Review Committee. The Committee will be composed of five members, including Division of Insurance Administration staff and at least one licensed medical professional, selected by the Commissioner or his designee. The members of the Committee will not have been directly involved in the matter under review. The parent will be given the opportunity to review the file, be represented by a representative of the parent's choice, and provide supplemental information. The Committee may allow the parent to appear in person if it finds that scheduling the appearance will not cause delay in the review process. The Review Committee is not required to provide an in-person hearing or a contested case under the Uniform Administrative Procedures Act. The parent will receive written notification of the final decision stating the reasons for the decision. The decision of the CoverKids Review Committee is the final administrative recourse available to the member.
 - (e) **Time for Reviews.** Review of all non-expedited health services appeals will be completed within 90 days of receipt of the initial request for review by the PA. Reviews by both the Appeals Coordinator and the Committee may be expedited (completed within 72 hours at each the PA and State levels) for situations in which a benefit determination or a preauthorization denial has been made prior to services being received and the attending medical professional determines in writing (including legible handwriting) that the medical situation to be life threatening or would seriously jeopardize the enrollee's health or ability to attain, maintain or regain maximum functioning.
- (3) **Scope of Review.** CoverKids will not provide a review process for a change in enrollment, eligibility, or coverage under the health benefits package required by a change in the State plan or Federal and State law requiring an automatic change that affects all or a group of applicants or enrollees without regard to their individual circumstances.

Authority: T.C.A. §§ 4-5-202, 71-3-1106, 71-3-1110. **Administrative History:** Public necessity rule filed March 13, 2007; expired August 25, 2007. Original rule filed May 30, 2007; effective August 13, 2007.

0620-05-01-.06 PROVIDERS.

- (1) This rule shall be in effect from October 1, 2013.
- (2) For purposes of this rule, the following definitions shall apply:

(Rule 0620-05-01-.06, continued)

- (a) Covered services. Benefits listed in ~~Rule 0620-05-01-.03~~ and authorized by the Plan Administrator ("PA").
 - (b) CoverKids network. A group of health care providers that have entered into contracts with the PA to furnish covered services to CoverKids enrollees. These contracts may take the form of general contracts or single case agreements.
 - (c) CoverKids provider. An appropriately licensed institution, facility, agency, person, corporation, partnership, or association that delivers health care services and that participates in the PA's network.
 - (d) Emergency services, including emergency mental health and substance abuse emergency treatment services. Services to treat the sudden and unexpected onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to potentially result in:
 - 1. Placing the person's (or with respect to a pregnant woman, her unborn child's) health in serious jeopardy; or
 - 2. Serious impairment to bodily functions; or
 - 3. Serious dysfunction of any bodily organ or part.
 - ~~(e) HealthyTNBabies. The program that provides coverage of maternity care for pregnant CoverKids enrollees, including the unborn children of pregnant women with no source of coverage who meet the CoverKids eligibility requirements.~~
 - (f) Non-CoverKids provider. A health care provider of non-emergency services that does not participate in the PA's network.
- (3) Payment in full.
- (a) All CoverKids providers, as defined in this rule, must accept as payment in full for provision of covered services to a CoverKids enrollee, the amount paid by the PA, plus any copayment required by the CoverKids program to be paid by the individual.
 - (b) Any non-CoverKids providers who furnish CoverKids covered services by authorization from the PA must accept as payment in full for provision of covered services to CoverKids enrollees the amounts paid by the PA plus any copayment required by the CoverKids program to be paid by the individual.
 - (c) CoverKids will not pay for non-emergency services furnished by non-CoverKids providers unless these services are authorized by the PA. Any non-CoverKids provider who furnishes CoverKids Program covered non-emergency services to a CoverKids enrollee without authorization from the PA does so at his own risk. He may not bill the patient for such services except as provided for in Paragraph (5).
- (4) Non-CoverKids Providers.

(Rule 0620-05-01-.06, continued)

- (a) In situations where the PA authorizes a service to be rendered by a non-CoverKids provider, payment to the provider shall be no less than 80% of the lowest rate paid by the PA to equivalent participating CoverKids network providers for the same service, consistent with the methodology contained in Rule 1200-13-13-.08(2)(a).
 - (b) Covered medically necessary outpatient emergency services, when provided to CoverKids enrollees by non-CoverKids network hospitals, shall be reimbursed at 74% of the 2006 Medicare rates for the services, consistent with the methodology contained in Rule 1200-13-13-.08(2)(b). Emergency care to enrollees shall not require preauthorization.
 - (c) Covered medically necessary inpatient hospital admissions required as the result of emergency outpatient services, when provided to CoverKids enrollees by non-CoverKids network hospitals, shall be reimbursed at 57% of the 2008 Medicare DRG rates (excluding Medical Education and Disproportionate Share components) determined according to 42 CFR § 412 for the services, consistent with the methodology contained in Rule 1200-13-13-.08(2)(c). Such an inpatient stay will continue until no longer medically necessary or until the patient can be safely transported to a network hospital, whichever comes first.
- (5) Providers may seek payment from a CoverKids enrollee only under the following circumstances. These circumstances include situations where the enrollee may choose to seek a specific covered service from a non-CoverKids provider.
- (a) If the services are not covered by the CoverKids program and, prior to providing the services, the provider informed the enrollee that the services were not covered.
 - (b) If the services are not covered because they are in excess of an enrollee's benefit limit and one of the following circumstances applies:
 - 1. The provider has information in her own records to support the fact that the enrollee has reached his benefit limit for the particular service being requested and, prior to providing the service, informs the enrollee that the service is not covered and will not be paid for by CoverKids. This information may include:
 - (i) A previous written denial of a claim on the basis that the service was in excess of the enrollee's benefit limit for a service within the same benefit category as the service being requested, if the time period applicable to the benefit limit is still in effect; or
 - (ii) That the provider had personally provided services to the enrollee in excess of his benefit limit within the same benefit category as the service being requested, if the time period applicable to that benefit period is still in effect; or
 - (iii) The enrollee's PA has provided confirmation to the provider that the enrollee has reached his benefit limit for the applicable service.
 - 2. The provider submits a claim for service to the PA and receives a written denial of that claim on the basis that the service exceeds the enrollee's benefit limit. After informing the enrollee and within the remainder of the period applicable to that benefit limit, the provider may bill the enrollee

(Rule 0620-05-01-.06, continued)

- for services within that same exhausted benefit category without having to submit claims for those subsequent services for repeated PA denial. If the provider informed the enrollee prior to providing the service for which the claim was denied that the service would exceed the enrollee's benefit limit and would not be paid for by CoverKids, the provider may bill the enrollee for that service.
3. The provider had previously taken the steps in parts 1. or 2. above and determined that the enrollee had reached his benefit limit for the particular service being requested, if the time period applicable to the benefit limit is still in effect, and informs the enrollee, prior to providing the service, that the service is not covered and will not be paid for by CoverKids.
- (c) If the services are covered only with prior authorization and prior authorization has been requested but denied, or is requested and a specified lesser level of care is approved, and the provider has given prior notice to the enrollee that the services are not covered, the enrollee may elect to receive those services for which prior authorization has been denied or which exceed the authorized level of care and be billed by the provider for such services.
- (6) Providers may not seek payment from a CoverKids enrollee under the following conditions:
- (a) The provider knew or should have known about the patient's CoverKids enrollment prior to providing services.
- (b) The claim submitted to the PA for payment was denied due to provider billing error or a CoverKids claim processing error.
- (c) The provider accepted CoverKids assignment on a claim and it is determined that another payer paid an amount equal to or greater than the CoverKids allowable amount.
- (d) The provider failed to comply with CoverKids policies and procedures or provided a service which lacks medical necessity or justification.
- (e) The provider failed to submit or resubmit claims for payment within the time periods required by the PA or CoverKids.
- (f) The provider failed to inform the enrollee prior to providing a service not covered by CoverKids that the service was not covered and the enrollee may be responsible for the cost of the service. Services which are non-covered by virtue of exceeding limitations are exempt from this requirement if the provider has complied with paragraph (5) above.
- (g) The enrollee failed to keep a scheduled appointment(s).
- (7) Pharmacy providers may not waive pharmacy copayments for CoverKids enrollees as a means of attracting business to their establishments. This does not prohibit a pharmacy from exercising professional judgment in cases where an enrollee may have a temporary or acute need for a prescribed drug, but is unable, at that moment, to pay the required copayment.

Authority: T.C.A. §§ 4-5-202, 71-3-1104, 71-3-1106 and 71-3-1110. **Administrative History:** Emergency rule filed September 26, 2013; effective through March 25, 2014. Repeal of

(Rule 0620-05-01-.06, continued)

emergency rule filed September 26, 2013 was filed on December 20, 2013. In its place, emergency rule 0620-05-01-.06 was filed December 20, 2013; effective through June 18, 2014. New rule filed March 17, 2014; effective June 15, 2014.

GW10117332redline

I certify that this is an accurate and complete copy of rulemaking hearing rules, lawfully promulgated and adopted by the Tennessee Department of Finance & Administration (board/commission/ other authority) on 10/09/2017 (mm/dd/yyyy), and is in compliance with the provisions of T.C.A. § 4-5-222.

I further certify the following:

Notice of Rulemaking Hearing filed with the Department of State on: 07/21/17

Rulemaking Hearing(s) Conducted on: (add more dates). 09/13/17

Date: 10/9/17

Signature: Wendy Long MD

Name of Officer: Wendy Long, M.D., M.P.H.
Director, Division of TennCare

Title of Officer: Tennessee Department of Finance & Administration



Subscribed and sworn to before me on: 10/9/17

Notary Public Signature: Robin A. Page

My commission expires on: 11/3/2020

All rulemaking hearing rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

Herbert H. Slatery III
Herbert H. Slatery III
Attorney General and Reporter

11/21/2017
Date

Department of State Use Only

Filed with the Department of State on: 11/20/17

Effective on: 2/26/18

Tre Hargett
Tre Hargett
Secretary of State

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PUBLICATIONS

(Place substance of rules and other info here. Please be sure to include a detailed explanation of the changes being made to the listed rule(s). Statutory authority must be given for each rule change. For information on formatting rules go to http://sos.tn.gov/sites/default/files/forms/Rulemaking_Guidelines_August2014.pdf)

New Rules

Rules of the Tennessee Department of Finance and Administration, Division of TennCare, are amended by adding the following new Chapter 21 CoverKids:

Rules
of
Tennessee Department of Finance and Administration

Division of TennCare

Chapter 1200-13-21
CoverKids

Table of Contents

1200-13-21-.01 Scope and Authority
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 1200-13-21-.06 Disenrollment
 1200-13-21-.07 Review of CoverKids Decisions
 1200-13-21-.08 Providers

1200-13-21-.01 Scope and Authority.

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

Authority: T.C.A. §§ 4-5-202, 71-3-1103 through 1108 and 71-3-1110, and the Tennessee Title XXI Children's Health Insurance Program State Plan.

1200-13-21-.02 Definitions.

- (1) Covered services. Benefits listed in this Chapter and authorized by the Plan Administrator or Dental Benefits Manager.

- (2) CoverKids. The program created by T.C.A. §§ 71-3-1101, et seq., its authorized employees and agents, as the context of this Chapter requires.
- (3) CoverKids network. A group of health care providers that have entered into contracts with the Plan Administrator or Dental Benefits Manager to furnish covered services to CoverKids enrollees. These contracts may take the form of general contracts or single case agreements.
- (4) CoverKids provider. An appropriately licensed institution, facility, agency, person, corporation, partnership or association, that delivers health care services and that participates in the Plan Administrator's or Dental Benefits Manager's network.
- (5) Days. Calendar days, not business days.
- (6) Dental Benefits Manager (DBM). The entity responsible for the administrative services associated with providing covered dental services, preventive, routine and orthodontic, to CoverKids enrollees.
- (7) Emergency services. Includes emergency medical, emergency mental health and substance abuse emergency treatment services, furnished by a provider qualified to furnish the services, needed to evaluate, treat, or stabilize an emergency medical condition manifested by the sudden and unexpected onset of acute symptoms of sufficient severity, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:
 - (a) Placing the person's (or with respect to a pregnant woman, her unborn child's) health in serious jeopardy;
 - (b) Serious impairment to bodily functions; or
 - (c) Serious dysfunction of any bodily organ or part.
- (8) Medically necessary. A medical item or service which meets all the following criteria:
 - (a) Recommended by a licensed physician who is treating the enrollee or other licensed healthcare provider practicing within his scope of licensure who is treating the enrollee;
 - (b) Required in order to diagnose or treat an enrollee's medical condition;
 - (c) Safe and effective;
 - (d) The least costly alternative course of diagnosis or treatment that is adequate for the medical condition of the enrollee; and
 - (e) Not experimental or investigational.
- (9) Non-CoverKids provider. A health care provider of non-emergency services that does not participate in the Plan Administrator's or Dental Benefits Manager's network.
- (10) Parent. A natural or adoptive father or mother of a minor child; or, a guardian as defined by T.C.A. § 34-1-101, subject to court orders entered or recognized by the courts of the state of Tennessee.
- (11) Plan Administrator or PA. The entity or entities responsible for the administrative services associated with providing health care, pharmaceutical or other related services to CoverKids enrollees. This may be a private contractor, government agency, or Departmental entity.

Authority: T.C.A. §§ 4-5-202, 71-3-1106 and 71-3-1110, and the Tennessee Title XXI Children's Health Insurance Program State Plan.

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

Authority: T.C.A. §§ 4-5-202, 71-3-1106 and 71-3-1110, and the Tennessee Title XXI Children's Health Insurance Program State Plan.

- (1) The following benefits are covered by the CoverKids program for children under age 19 as medically necessary, subject to the limitations stated:
 - (a) Ambulance services, air and ground.
 - (b) Care coordination services.
 - (c) Case management services.
 - (d) Chiropractic care. Maintenance visits not covered when no additional progress is apparent or expected to occur.
 - (e) Clinic services and other ambulatory health care services.
 - (f) Dental benefits:
 1. Dental services. Limited to a \$1,000 annual benefit maximum per enrollee.
 2. Orthodontic services. Limited to a \$1,250 lifetime benefit maximum per enrollee. Covered only after a 12-month waiting period.
 - (g) Disposable medical supplies.
 - (h) Durable medical equipment and other medically-related or remedial devices:
 1. Limited to the most basic equipment that will provide the needed care.
 2. Hearing aids are limited to one per ear per calendar year up to age 5, and limited to one per ear every two years thereafter.
 - (i) Emergency care.
 - (j) Home health services. Prior approval required. Limited to 125 visits per enrollee per calendar year.
 - (k) Hospice care.
 - (l) Inpatient hospital services, including rehabilitation hospital services.
 - (m) Inpatient mental health and substance abuse services.
 - (n) Laboratory and radiological services.
 - (o) Outpatient mental health and substance abuse services.
 - (p) Outpatient services.
 - (q) Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders. Limited to 52 visits per calendar year per type of therapy.
 - (r) Physician services.
 - (s) Prenatal care and prepregnancy family services and supplies.
 - (t) Prescription drugs.
 - (u) Routine health assessments and immunizations.
 - (v) Skilled Nursing Facility services. Limited to 100 days per calendar year following an approved hospitalization.

- (w) Surgical services.
- (x) Vision benefits:
 - 1. Annual vision exam including refractive exam and glaucoma screening.
 - 2. Prescription eyeglass lenses. Limited to one pair per calendar year. \$85 maximum benefit per pair.
 - 3. Eyeglass frames. Coverage for replacement frames limited to once every two calendar years. \$100 maximum benefit per pair.
 - 4. Prescription contact lenses in lieu of eyeglasses. Limited to one pair per calendar year. \$150 maximum benefit per pair.
- (2) Mothers of eligible unborn children who are over age 19 receive all benefits listed in Paragraph (1), subject to the same limitations and as medically necessary, except chiropractic services, routine dental services, and vision services are not covered for these enrollees.
- (3) All services covered by CoverKids must be medically necessary.
- (4) The following services and items are excluded from coverage by the CoverKids program:
 - (a) Comfort or convenience items not related to an enrollee's illness.
 - (b) Dietary guidance services.
 - (c) Homemaker or housekeeping services.
 - (d) Maintenance visits when no additional progress is apparent or expected to occur.
 - (e) Meals.
 - (f) Medical social services.
 - (g) Non-treatment services.
 - (h) Private duty nursing services.
 - (i) Routine transportation.

Authority: T.C.A. §§ 4-5-202, 71-3-1106 and 71-3-1110, and the Tennessee Title XXI Children's Health Insurance Program State Plan.

1200-13-21-.05 Cost Sharing.

- (1) There are no premiums or deductibles required for participation in CoverKids.
- (2) Copays.
 - (a) The following services are exempt from copays:
 - 1. Ambulance services.
 - 2. Emergency services.
 - 3. Lab and X-ray services.
 - 4. Maternity services. There are no copays for prenatal visits or for hospital admissions for the birth of a child.

5. Routine health assessments and immunizations given under American Academy of Pediatrics guidelines.

(b) The following copays are required, based on the enrollee's household income:

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

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

Authority: T.C.A. §§ 4-5-202, 71-3-1106 and 71-3-1110, and the Tennessee Title XXI Children's Health Insurance Program State Plan.

1200-13-21-.06 Disenrollment.

- (1) Grounds for Disenrollment from CoverKids. Children enrolled in CoverKids at or below 250% of the FPL are financially eligible for 12 months, except in the following situations which will result in disenrollment from CoverKids coverage prior to the end of the 12 month period:
- (a) An enrollee, through an authorized family member, requests disenrollment.
 - (b) Admission of a CoverKids enrollee into a correctional facility or an institution for mental disease.
 - (c) A CoverKids enrollee moves from the state.

- (d) Death of a CoverKids enrollee.
 - (e) A CoverKids enrollee is enrolled in TennCare.
 - (f) A CoverKids enrollee meets a TennCare Medicaid spend-down.
 - (g) A CoverKids enrollee turns age 19.
 - (h) A woman 19 or older who was enrolled because of pregnancy is no longer eligible after the last day of the month in which the sixtieth postpartum day occurs.
 - (i) A CoverKids enrollee is discovered not to have been eligible for CoverKids at the time of enrollment. This includes, but is not limited to, enrollees whose enrollment was obtained by fraud or misrepresentation by an enrollee, parent, guardian, or representative.
- (2) Procedures. Disenrollment shall be conducted as set out in Chapter 1200-13-19.

Authority: T.C.A. §§ 4-5-202, 71-3-1106 and 71-3-1110, and the Tennessee Title XXI Children's Health Insurance Program State Plan.

1200-13-21-.07 Review of CoverKids Decisions.

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

and at least one independent licensed medical professional. The members of the Committee will not have been directly involved in the matter under review. The parent or authorized representative will be given the opportunity to review the file, be represented by a representative of the parent's or authorized representative's choice, and provide supplemental information. The Committee may allow the parent or authorized representative to appear in person if it finds that scheduling the appearance will not cause delay in the review process. The Review Committee is not required to provide an in-person hearing or a contested case under the Uniform Administrative Procedures Act. The parent or authorized representative will receive written notification of the final decision stating the reasons for the decision. The decision of the CoverKids Review Committee is the final administrative recourse available to the member.

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

Authority: T.C.A. §§ 4-5-202, 71-3-1106 and 71-3-1110, and the Tennessee Title XXI Children's Health Insurance Program State Plan.

1200-13-21-.08 Providers.

- (1) Payment in full.
 - (a) All CoverKids providers, as defined in this rule, must accept as payment in full for provision of covered services to a CoverKids enrollee, the amount paid by the PA or DBM, plus any copayment required by the CoverKids program to be paid by the individual.
 - (b) Any non-CoverKids providers who furnish CoverKids covered services by authorization from the PA or DBM must accept as payment in full for provision of covered services to CoverKids enrollees the amounts paid by the PA or DBM plus any copayment required by the CoverKids program to be paid by the individual.
 - (c) CoverKids will not pay for non-emergency services furnished by non-CoverKids providers unless these services are authorized by the PA or DBM. Any non-CoverKids provider who furnishes CoverKids Program covered non-emergency services to a CoverKids enrollee without authorization from the PA or DBM does so at his own risk. He may not bill the patient for such services except as provided in Paragraph (3).
- (2) Non-CoverKids Providers.
 - (a) When the PA or DBM authorizes a service to be rendered by a non-CoverKids provider, payment to the provider shall be no less than 80% of the lowest rate paid by the PA or DBM to equivalent participating CoverKids network providers for the same service, consistent with the methodology contained in Rule 1200-13-13-.08(2)(a).
 - (b) Covered medically necessary outpatient emergency services, when provided to CoverKids enrollees by non-CoverKids network hospitals, shall be reimbursed at 74% of the 2006 Medicare rates for the services, consistent with the methodology contained in Rule 1200-13-13-.08(2)(b). Emergency care to enrollees shall not require preauthorization.
 - (c) Covered medically necessary inpatient hospital admissions required as the result of emergency outpatient services, when provided to CoverKids enrollees by non-CoverKids network hospitals, shall

be reimbursed at 57% of the 2008 Medicare DRG rates (excluding Medical Education and Disproportionate Share components) determined according to 42 CFR § 412 for the services, consistent with the methodology contained in Rule 1200-13-13-.08(2)(c). Such an inpatient stay will continue until no longer medically necessary or until the patient can be safely transported to a network hospital, whichever comes first.

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

an amount equal to or greater than the CoverKids allowable amount.

- (d) The provider failed to comply with CoverKids policies and procedures or provided a service which lacks medical necessity or justification.
 - (e) The provider failed to submit or resubmit claims for payment within the time periods required by the PA or DBM or CoverKids.
 - (f) The provider failed to inform the enrollee prior to providing a service not covered by CoverKids that the service was not covered and the enrollee may be responsible for the cost of the service. Services which are non-covered by virtue of exceeding limitations are exempt from this requirement if the provider has complied with paragraph (3) above.
 - (g) The enrollee failed to keep a scheduled appointment(s).
- (5) Pharmacy providers may not waive pharmacy copayments for CoverKids enrollees as a means of attracting business to their establishments. This does not prohibit a pharmacy from exercising professional judgment in cases where an enrollee may have a temporary or acute need for a prescribed drug, but is unable, at that moment, to pay the required copayment.

Authority: T.C.A. §§ 4-5-202, 71-3-1106 and 71-3-1110, and the Tennessee Title XXI Children's Health Insurance Program State Plan.

Repeal

Rules of the Tennessee Department of Finance and Administration, Division of Insurance Administration, are amended by repealing Chapter 0620-05-01 Cover Kids Rules in its entirety.

Authority: T.C.A. §§ 4-5-202, 71-3-1106 and 71-3-1110, and the Tennessee Title XXI Children's Health Insurance Program State Plan.

I certify that this is an accurate and complete copy of rulemaking hearing rules, lawfully promulgated and adopted by the Tennessee Department of Finance & Administration (board/commission/ other authority) on 10/09/2017 (mm/dd/yyyy), and is in compliance with the provisions of T.C.A. § 4-5-222.

I further certify the following:

Notice of Rulemaking Hearing filed with the Department of State on: 07/21/17

Rulemaking Hearing(s) Conducted on: (add more dates). 09/13/17

Date: 10/9/17

Signature: Wendy Long MD

Name of Officer: Wendy Long, M.D., M.P.H.

Director, Division of TennCare

Title of Officer: Tennessee Department of Finance & Administration



Subscribed and sworn to before me on: 10/9/17

Notary Public Signature: Rob A. Page

My commission expires on: 11/3/2020

All rulemaking hearing rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

Herbert H. Stutz III
Herbert H. Stutz III
Attorney General and Reporter

11/21/2017 Date

Department of State Use Only

Filed with the Department of State on: 11/20/17

Effective on: 7/26/18

Tre Hargett
Tre Hargett
Secretary of State

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