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Sequence Number: 09-05-16
Rule ID(s): 6299
File Date: 9/6/16
Effective Date: 12/5/16

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 Health
Division: Children's Special Services
Contact Person: Mary Kennedy
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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
1200-11-03	Children's Special Services
Rule Number	Rule Title
1200-11-03-.01	Statement of Purpose
1200-11-03-.02	Definitions
1200-11-03-.03	Eligibility Requirements
1200-11-03-.04	Covered Services
1200-11-03-.05	Authorizations and Reimbursements
1200-11-03-.06	Standards of Care
1200-11-03-.07	Out-of-State Treatment
1200-11-03-.08	Appeals and Closure of Cases

(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>)

Chapter 1200-11-03
Children's Special Services

Chapter 1200-11-03 Children's Special Services is being repealed and rewritten including its table of contents.

Authority: T.C.A. §§ 4-5-202, 68-1-103, and 68-12-101 et seq.

Chapter 1200-11-03
Children's Special Services

New Rule

New Table of Contents

1200-11-03-.01 Statement of Purpose
1200-11-03-.02 Definitions
1200-11-03-.03 Eligibility Requirements
1200-11-03-.04 Covered and Non-Covered Services
1200-11-03-.05 Authorization and Reimbursements
1200-11-03-.06 Providers
1200-11-03-.07 Out-of-State Treatment
1200-11-03-.08 Appeals and Termination of Enrollment

1200-11-3-.01 Statement of Purpose

In an effort to provide comprehensive services and eliminate health barriers and disparities for children with special health care needs in Tennessee, the Tennessee Legislature created the Children's Special Services (CSS) Program. The program is intended to assure that children in this population are identified early and receive high quality coordinated care and that their families receive support. The program serves those children who meet the T.C.A 68-12-102 definition of "a child with a physical disability." To the extent that funding is available, program resources provide for diagnostically related services for enrolled children when other payors are unable to provide payment.

Authority: T.C.A. §§ 4-5-202, 68-1-103, 68-12-101 et seq., 68-12-104, and 42 U.S.C. § 701(a)

1200-11-3-.02 Definitions. Unless otherwise specifically indicated by the context, for the purpose of these rules and regulations, the terms used herein are defined as follows.

- (1) "Assistive technology/augmentative communication device" means any device or equipment that may promote independence and communication skills for children unable to utilize typical methods for independence.
- (2) "Care Coordination" means case management services promoting the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special healthcare needs and their families. Care coordinators assist families with services such as third party payor billing, filing appeals when third party payors deny payment, and seeking prior approval from third party payors for covered services.
- (3) "Child" or "children" means a person or persons under the age of twenty-one (21) years.

- (4) "Child with a physical disability" means a child under the age of twenty-one (21) who shall be deemed to have a physical disability by any reason, whether congenital or acquired as a result of accident or disease, which requires medical, surgical, dental or rehabilitation treatment, who is or may be totally or partially incapacitated for the receipt of a normal education or for self-support. This definition shall not include those children whose sole diagnosis is blindness or deafness; nor shall this definition include children who are diagnosed as psychotic. This definition does not prohibit CSS from accepting for treatment children with acute conditions such as, but not necessarily limited to, fractures, burns, and osteomyelitis.
- (5) "Commissioner" means the Commissioner of the Tennessee Department of Health or the Commissioner's designee.
- (6) "Covered Services" means medical, surgical, and rehabilitative treatment for eligible diagnoses, including the services necessary in order for a child to follow a prescribed treatment plan for an eligible diagnosis.
- (7) "Department" means the Tennessee Department of Health.
- (8) "Diagnostic evaluation" means physical examinations, medical procedures, laboratory tests, or other procedures deemed necessary for diagnosis.
- (9) "Drugs, devices and supplies" means medications, devices and supplies necessary for treatment related to an eligible diagnosis.
- (10) "Durable medical equipment" means equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury, and is appropriate for use in the home, including orthotics, prosthetics, and communication aid devices.
- (11) "Elective Hospital Admission" means any hospital admission for diagnoses or treatments not immediately necessary to save the patient's life or prevent impending harm.
- (12) "Eligible Diagnosis" means a health-related impairment, described in T.C.A. § 68-12-102 and diagnosed by a provider, which may hinder achievement of normal growth and development.
- (13) "Hospitalization" means any overnight stay in a hospital which is:
 - (a) capable of providing the type of service(s) needed by the child; and
 - (b) licensed pursuant to applicable regulations and/or statutes.
- (14) "Inpatient hospitalization services" means medical and surgical services (including screening, diagnostic evaluation, therapeutic, corrective, preventive, and palliative services) and facility usage charges (including room and board) provided during hospitalization in a licensed hospital.
- (15) "Orthodontic/dental treatment" means medical, surgical, and rehabilitative treatment for eligible cranio-facial (including cleft lip and cleft palate) and cranial diagnoses.
- (16) "Outpatient hospitalization services" means medical and surgical services (including screening, diagnostic evaluation, therapeutic, corrective, preventive, and palliative services) and facility usage charges (including temporary room and board) provided as an outpatient service by a licensed hospital or hospital-based Ambulatory Surgical Treatment Center.
- (17) "Outpatient clinic services" means diagnoses or treatment services delivered by a licensed health care provider in a facility other than a hospital setting.

- (18) "Provider" means a healthcare provider which is a person, persons, or facility licensed pursuant to T.C.A. Titles 63 or 68 to provide healthcare services in Tennessee, or, if the services are being provided in another state, licensed pursuant to the licensing laws of that state.
- (19) "Rehabilitation" means services required to assist the individual to achieve or maintain independence. Rehabilitative services may include physical, speech/language, nutritional/feeding, and occupational therapies.
- (20) "Resident of Tennessee" means a person who has established a bona fide residence in Tennessee. The test for such residence is (1) an intention to stay indefinitely in a place, joined with (2) some objective indication consistent with that intent, e. g., enrollment of a child in school.
- (21) "Support services" means activities that may be necessary to assist the individual or family to access medically necessary and/or recommended care to participate in the activities of daily living.
- (22) "Third party payor" means a party, other than the recipient of healthcare, who pays for healthcare. Third party payors include private insurance and the following resources:
 - (a) The Patient Protection and Affordable Care Act, which is the health-related portion of the Health Care and Education Reconciliation Act of 2010.
 - (b) Children's Health Insurance Program (CHIP), which is a health insurance program mandated by Title XXI of the Social Security Act that is jointly financed by Federal and State governments and administered by the States. CHIP was previously known as the State Children's Health Insurance Program (SCHIP). Tennessee's CHIP includes the CoverKids program.
 - (c) CoverRX, which is a program that offers affordable prescription drugs to persons ages nineteen (19) years and older who lack pharmacy coverage.
 - (d) TennCare, which is the State of Tennessee Medicaid Waiver program that replaced the State's Medicaid program. The TennCare Bureau contracts with managed care organizations (MCOs) to provide a network of providers to serve TennCare enrolled individuals.
- (23) "Title V Children with Special Health Care Needs (CSHCN)" means the section of the Title V Maternal and Child Health CSHCN Block Grant that supports the program.
- (24) "Vendor or supplier" means authorized person, persons, or facilities approved by the State of Tennessee to provide services in conjunction with established Department of Health and Department of Finance and Administration guidelines.

Authority: T.C.A. §§ 4-5-202, 68-1-103, 68-12-101 et seq., and 42 U.S.C. § 701(b).

1200-11-3-.03 Eligibility Requirements.

- (1) General Eligibility. To be eligible for the Program's services, a child shall:
 - (a) be a resident of Tennessee;
 - (b) not have reached his or her twenty-first birthday;
 - (c) meet the diagnostic and financial eligibility requirements below;
 - (d) complete and sign the application form approved by the Program; and
 - (e) provide proof of application to Medicaid or CHIP within ninety (90) days of completing and signing the Program's application form (if Medicaid or CHIP eligible).
- (2) Diagnostic Eligibility. To be eligible for the Program's services, a child shall provide a physician's certification that the child has an eligible diagnosis which causes the child to meet the definition of

"child with a physical disability" defined by T.C.A. § 68-12-102. The physicians shall base the certification upon a physical examination conducted within the 12 months preceding the date of certification.

- (3) Financial Eligibility. A child shall be financially eligible for services if his or her family's gross annual income as adjusted is at or below 200% of the Federal Poverty Guidelines. When a family has more than one (1) child with an eligible diagnosis(es), the program may add one person to the total number of family members when determining eligibility.
 - (a) For purposes of financial eligibility, a "family" is defined as two or more persons (including the child) related by birth, marriage or adoption who reside together, unless one of the following alternative scenarios applies.
 1. If the parent or parents of a child under the age of eighteen (18) have voluntarily placed the child in another party's home to reside, the child and the parents are a "family."
 2. If the parent or parents of a child under the age of eighteen (18) have been court-ordered to provide financial support to the child when the child lives in another party's home, the child and the parent or parents are a "family."
 3. If a child eighteen (18) years of age or older does not live with a relative, the child alone is considered a "family."
 4. A foster child alone is considered a "family" and the Department of Children's Services (DCS) foster care board payments to the foster parents are considered the family's income.
 - (b) The program shall determine the family's gross annual income and financial eligibility by calculating the following:
 1. Wages, salaries, tips/gratuities, and/or commissions;
 2. Income from rental property or equipment;
 3. Profits from self-employment enterprises, including farms;
 4. Alimony, maintenance and/or child support;
 5. Inheritances, lottery winnings and/or other windfalls
 6. Pensions and benefits;
 7. DCS foster care board payments; and
 8. Public assistance grants.
 - (c) After the program determines the family's gross annual income, the program may adjust income by taking into consideration the probable total cost of treatment and the family's other financial responsibilities, including but not limited to the following:
 1. Verification of medical payments including medical or health insurance premiums made by the family for any family member during the previous twelve (12) months. The program shall deduct this amount from the gross annual income.
 2. Verification of alimony, maintenance and/or child support paid to another household, which the program shall deduct from the gross annual income.
 3. Number of dependents.

- (d) The program shall review its available funding and historical spending annually. In any year in which, in the best judgment of the program, it appears that funds are available to serve families with gross annual income as adjusted greater than 200% of the Federal Poverty Guideline, the program may, in its sole discretion, post on its website an increased income eligibility limit and serve families with gross annual incomes as adjusted up to the posted limits.
- (4) Subsequent determinations of eligibility. The program shall recertify enrolled children annually. A child shall meet all eligibility criteria in order to remain enrolled in the program.

Authority: T.C.A. §§ 4-5-202, 68-1-103, 68-12-101 et seq., 68-12-103, 68-12-112, 42 U.S.C. § 701; and 42 U.S.C. § 705(a)(1)(C) and (a)(3)(B).

1200-11-3-.04 Covered and Non-Covered Services.

- (1) When a child enrolled in the program requires services for which one or more third party payors are financially responsible, the program may provide the child with services limited to care coordination, subject to availability of funding.
- (2) Covered services are those described in Rule 1200-11-3-.02 that are not covered by third party payors and are limited to those that directly relate to the child's eligible diagnosis. Covered services may include, but are not limited to, the following:
 - (a) inpatient hospitalization; outpatient hospitalization or clinic services; care coordination services; orthodontic/dental treatment; drugs, devices and supplies such as medication, and nutritional supplements, standard rehabilitative therapies, assistive technology/augmentative communication devices, co-pays, co-insurance and deductibles; or other support services as determined by the Commissioner and the program;
 - (b) subsequent hospitalizations, clinic visits, routine care, transplants and implants deemed medically necessary, medications (including immunosuppressive therapy), and supplies after transplant and implant surgeries; and
 - (c) rental or purchase of durable medical equipment; maintenance, repair, or replacement of durable medical equipment; and, where appropriate, training of the enrolled child or the child's family in the use of the equipment.
- (3) Services not eligible for reimbursement from the program include, but are not limited to, the following:
 - (a) Drugs, food and nutritional/dietary supplements not approved by the Food and Drug Administration (FDA);
 - (b) Orthodontic/Dental services except treatment for eligible cranio-facial (including cleft lip and cleft palate) and designated cardiac diagnoses;
 - (c) Psychiatric treatment and psychological services; treatment and services for mental, emotional and behavioral disorders, developmental disabilities and learning disabilities;
 - (d) Treatment for alcohol and drug abuse and/or dependence;
 - (e) Ambulance fees and transportation costs, except for emergency transportation from one hospital to another, as related to the child's eligible diagnosis;
 - (f) Services rendered while a child is admitted to a nursing home for continuous or episodic care.
- (4) The program shall determine the type and amount of covered services by the availability of funds. When budgetary constraints are indicated the program may:

- (a) Create a waiting list of children requesting elective hospital admissions. (The program will evaluate the waiting list on a monthly basis and approve elective admissions according to availability of funds);
- (b) Eliminate inpatient hospitalization services as defined in 1200-11-3-.02, except for life-threatening conditions and conditions that would cause a permanent disability, if not treated immediately;
- (c) Eliminate services for less severe diagnostic categories as designated by the program; and/or
- (d) Reduce the type and amount of support services, durable medical equipment, care coordination, or other covered services.

Authority: T.C.A. §§ 4-5-202, 68-1-103, 68-12-101 et seq., and 42 U.S.C. § 704(b)(1).

1200-11-3-.05 Authorization and Reimbursements.

- (1) The program shall authorize only those services for reimbursement that relate to the child's eligible diagnosis(es). The Program shall be a payor of last resort, paying for covered services only after exhaustion of the family's other payor sources, except for applicable deductibles, co-insurance, and/or co-payment. The program shall not pay the difference between the billed amount for a service and the amount paid by a third party payor based upon a contractual agreement. Except as provided in 1200-11-3-.05(5), the program shall only authorize reimbursement for services for children currently enrolled in the program.
- (2) Reimbursement.
 - (a) The program shall authorize reimbursement for services as follows:
 - 1. Inpatient hospitalization and rehabilitation services shall be based on a per diem rate as negotiated between the Program and the facility.
 - 2. Drug reimbursements shall be based upon the Department's average wholesale price. The shipping and handling fee may be reimbursed according to the program's most current Delegated Authority (DA).
 - 3. Services for which there is a Medicare fee shall be at least the equivalent of the prior year's Medicare fee schedule for Tennessee multiplied by 75%. The program shall update the required minimum reimbursement rate on a biennial basis, but at its discretion, the program may at other times update the reimbursement rate to account for significant changes in fees. The updated National Conversion Factor is referenced in the Federal Register on or about October 31 each year.
 - 4. Therapies, medical supplies, durable medical equipment, prosthetics, orthotics, and orthodontic/dental treatment services shall be based on the American Medical Association Physicians' Current Procedural Terminology (CPT) codes relative value units and determined by the State of Tennessee purchasing procedures and the Delegated Purchase Authority for the program.
 - 5. Nutritional supplements, hearing aids, and hearing aid supplies shall be determined by the State of Tennessee purchasing procedures and the Delegated Purchasing Authority for the Program.
 - 6. Non-hospital services for which there is no Medicare fee shall be paid at least 75% of the average of three (3) bids, one from each grand division of the state.
 - (b) The program shall not authorize reimbursement for any covered service provided over twelve (12) months prior to the receipt of the request for reimbursement.

- (3) The program shall determine authorization of providers and vendors for reimbursement in accordance with the standards as designated in these rules and determined by the Department of Health and the Department of Finance and Administration.
- (4) The Department shall determine billing procedures for hospitals, institutions, facilities, agencies, providers, vendors, or distinct parts thereof rendering services.
- (5) Upon receipt of a determination from the assigned provider that a requested service is urgent and medically necessary, the State CSS Program Director may grant authorization prior to exhaustion of resources from third party payors, provided however, that the grant or denial of such authorization shall be final.

Authority: T.C.A. §§ 4-5-202, 68-1-103, 68-12-101 et seq., 42 U.S.C. § 701(a); 42 U.S.C. § 704(b)(1); and 42 U.S.C. § 706(a)(2)

1200-11-3-.06 Providers.

- (1) All providers shall be appropriately certified and/or licensed in their respective specialties.
- (2) Providers participating in a TennCare Managed Care Organization (MCO) network shall be recognized by the program as providers and must complete an application to the program for reimbursement purposes. Providers not participating in a TennCare MCO network must complete an application and be approved to serve as a provider before submitting any costs for reimbursement.
- (3) All providers must sign the Department's vendor agreement and abide by these rules.
- (4) Providers shall not submit additional and concurrent charges to the family for the care of a child over and above the amount covered by third party payors, as provided in these rules. This does not preclude a family or other party from making a contribution toward the care of the child when they are willing and able but providers shall not solicit or accept such contributions from the family of a child on TennCare for services covered in whole or in part by TennCare.
- (5) No provider shall charge program enrolled children more than the amount charged for private clients for equivalent accommodations and services.

Authority: T.C.A. §§ 4-5-202, 68-1-103, and 68-12-101 et seq., and § 42 U.S.C. 701(a).

1200-11-3-.07 Out-of-State Treatment.

- (1) The program may approve a provider's services in an out-of-state facility under the following conditions.
 - (a) The referring physician shall provide evidence that requested services are not available within Tennessee, or shall provide explicit medical justification to prove such out-of-state treatment is in the best interest of the child;
 - (b) The program shall base reimbursement for services on a negotiated rate paid by the Title V CSHCN Program in that state, or on that state's Medicaid rate, whichever is less;
 - (c) The out-of-state length of stay and estimated hospital charge shall be within the limits established by the program;
 - (d) The out-of-state estimated cost of out-patient follow-up and/or discharge services shall be equal or comparable to the Title V CSHCN rate in that state or that state's Medicaid rate, whichever is less;
 - (e) The program shall provide written approval to the provider prior to the provider's performance of services.

- (2) In order to maintain continuity of care, the program shall refer children receiving services under these rules and regulations who move out of state to the appropriate Title V CSHCN program within the state of new residence upon written permission of the parents or legal guardian, or in the case of an emancipated minor, the minor's permission.

Authority: T.C.A. §§ 4-5-202, 68-1-103, and 68-12-101 et seq., 42 U.S.C. § 701(a).

1200-11-3-.08 Appeals and Termination of Enrollment.

(1) Appeals

- (a) An enrolled child who receives a determination of ineligibility for program services (or his or her representative) may appeal the decision in writing to the program director within (30) calendar days of receipt of the program's written notice of the child's ineligibility. If the program director upholds the program's determination of ineligibility, the individual may appeal the decision in writing to the Commissioner within ten (10) calendar days of receipt of the written notice upholding the program's determination. The decision of the Commissioner shall be final.

(2) Termination of Enrollment

- (a) The program may terminate a child's enrollment in the Program for the following reasons, none of which are subject to appeal:
1. Child has received maximum treatment for the eligible diagnosis;
 2. Child has attained the age of twenty-one (21) years;
 3. Child has moved out of state;
 4. Child is deceased;
 5. Child is not diagnostically eligible;
 6. Child is not financially eligible;
 7. Child's family is not interested; and/or
 8. Child cannot be located by the program.

Authority: T.C.A. §§ 4-5-202, 68-1-103, and 68-12-101 et seq., and 42 U.S.C. § 701(a).

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

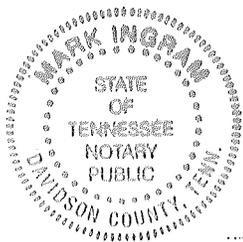
Board Member	Aye	No	Abstain	Absent	Signature (if required)
N/A					

I certify that this is an accurate and complete copy of rulemaking hearing rules, lawfully promulgated and adopted by the Division of Children's Special Services (board/commission/ other authority) on 05/01/2015 (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: 02/26/15 (mm/dd/yy)

Rulemaking Hearing(s) Conducted on: (add more dates). 05/01/15 (mm/dd/yy)



Date: 6.16.15

Signature: Mary Kennedy

Name of Officer: Mary Kennedy

Deputy General Counsel

Title of Officer: Department of Health

Subscribed and sworn to before me on: 6/16/15

Notary Public Signature: Mark Ingram

My commission expires on: July 6, 2015

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

8/4/2016

Date

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Filed with the Department of State on: 9/6/16

Effective on: 12/5/16

Tre Hargett

Tre Hargett
Secretary of State

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.

Children's Special Services Rulemaking Hearing
May 1, 2015

Public Comments

The agency received no oral comments at the public hearing, but did receive some written comments suggesting ways to improve the rule and further control costs, all of which have been incorporated into the final document:

- a) By defining more specifically those hospitalizations which were eligible for CSS reimbursement, those resources which qualify as third party payors and those resources for which a CSS applicant must apply prior to applying for CSS;
- b) By giving the program the flexibility to increase the income eligibility limit to include more Tennessee children where funds are available, and to include a greater range of medically necessary procedures which have been shown to be efficient and effective childhood interventions;
- c) By clarifying the program's status as payor of last resort, and by providing more specificity about the reimbursement structure for drugs, therapies, medical supplies and equipment;
- d) By limiting submission of claims to a twelve-month window, and limiting the rate for out of state treatment to the lower of the other state's CSHCN or Medicaid rate; and
- e) By granting the program flexibility to respond quickly in medically emergent situations.

The agency also received one comment from an individual objecting to the discontinuation of CSS funding for adults over age 21 with Cystic Fibrosis. While the agency did not incorporate that comment into the final version, it did provide the commenter with assistance in locating other state and private resources for those individuals.

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 extent to which the rule or rules may overlap, duplicate, or conflict with other federal, state, and local governmental rules.**

These rules do not overlap, duplicate, or conflict with other federal, state, or local governmental rules.

- (2) **Clarity, conciseness, and lack of ambiguity in the rule or rules.**

These rules exhibit clarity, conciseness, and lack of ambiguity.

- (3) **The establishment of flexible compliance and/or reporting requirements for small businesses.**

These rules do not create flexible compliance and/or reporting requirements for small businesses.

- (4) **The establishment of friendly schedules or deadlines for compliance and/or reporting requirements for small businesses.**

These rules do not involve schedules or deadlines for compliance or reporting requirements for small businesses.

- (5) **The consolidation or simplification of compliance or reporting requirements for small businesses.**

These rules do not consolidate or simplify compliance reporting requirements for small businesses.

- (6) **The establishment of performance standards for small businesses as opposed to design or operational standards required in the proposed rule.**

These rules do not establish performance, design, or operational standards.

- (7) **The unnecessary creation of entry barriers or other effects that stifle entrepreneurial activity, curb innovation, or increase costs.**

These rules do not create unnecessary barriers or stifle entrepreneurial activity or innovation.

STATEMENT OF ECONOMIC IMPACT TO SMALL BUSINESSES

Name of Board, Committee or Council: Children's Special Services

Rulemaking hearing date: 05/01/2015

1. **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, and/or directly benefit from the proposed rule:**

This rule affects service recipients. It does not affect small business.

2. **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:**

This rule should not involve administrative costs to the service recipients.

3. **Statement of the probable impact small businesses and consumers:**

This rule does not impact small businesses or consumers.

4. **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:**

Not applicable.

5. **Comparison of the proposed rule with any federal or state counterparts:**

Federal: This program is administered at the state level; it has no federal counterpart.

State: Indiana's program is similar, however the income ceiling is 250% of the poverty rate rather than 200% of the poverty rate, and it provides for cystic fibrosis patients above the age of twenty-one;

Michigan's program is similar, however it charges an application fee to families seeking services, and it provides for cystic fibrosis and hemophilia patients above the age of twenty-one.

North Dakota's program is similar, however the income ceiling is 185% of the poverty rate rather than 200% of the poverty rate. Like Tennessee, it provides no services above the age of twenty-one.

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.**

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)

The proposed rule amendments should 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;

Describes the conditions for the Department's provision of Special Services for disabled children. Eliminates provision whereby certain patients could obtain services under this program after the age of twenty-one; Expands the type of services available; Limits program to available funding but permits program flexibility to make best use of available funding.

- (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 program is operated pursuant to the Department's Maternal and Child Health block grant from the U.S. Department of Health and Human Services, created under 42 U.S.C. § 701et.seq.

- (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 program is intended to assure that children in this population are identified early and receive high quality coordinated care and that their families receive support. The program serves those children who meet the T.C.A 68-12-102 definition of "a child with a physical disability." Program resources provide for diagnostically related necessary health care services for enrolled children when other payors are unable to provide payment.

- (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;

These rules should not result in any increase or decrease in state and local government revenues and expenditures.

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

Mary Kennedy, Deputy General Counsel, Department of Health

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

Mary Kennedy, Deputy General Counsel, Department of Health

- (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

710 James Robertson Parkway, 5th Floor – Andrew Johnson Building, Nashville, Tennessee 37243, (615) 532-7161, Mary.Kennedy@tn.gov.

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

None.

**RULES
OF
TENNESSEE DEPARTMENT OF HEALTH
BUREAU OF HEALTH SERVICES**

**CHAPTER 1200-11-3
CHILDREN'S SPECIAL SERVICES**

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~~1200-11-3-.01 STATEMENT OF PURPOSE.~~

~~(1) In an effort to provide more comprehensive services to children with special health care needs in Tennessee, the Department of Health merged the Crippled Children's Services and the Speech and Hearing Services into one unit and implemented care coordination services to children enrolled in the program in 1992. The program was then identified as the Children's Special Services (CSS) program. The implementation of the TennCare managed care system with the resulting enrollment of previously non-Medicaid eligible CSS population requires the Department to redefine the CSS program's medical and financial eligibility, provider network, covered services, and reimbursement methods. Children with special health care needs, especially those who are uninsured now have access to insurance through TennCare. The program recognizes the need to serve a broader group of children with special health care needs who meet the T.C.A. 68-12-102 definition of "physically handicapped". Program resources will provide for diagnostically related necessary services for enrolled children when other payors will not provide coverage.~~

~~Authority: T.C.A. §§ 4-5-202, 68-1-103, and 68-12-101 et seq. Administrative History: Original rule filed April 12, 1979; effective May 28, 1979. Repeal and new rule filed December 30, 1983; effective January 29, 1984. Amendment filed May 29, 1990; effective July 13, 1990. Repeal and new rule filed March 21, 2000; effective July 28, 2000. Repeal and new rule filed October 9, 2002; effective December 23, 2002.~~

~~1200-11-3-.02 DEFINITIONS. Unless otherwise specifically indicated by the context, for the purpose of these rules and regulations, the terms used herein are defined as follows:~~

- ~~(1) Assistive Technology/Augmentative Communication Devices - Any device or equipment that may promote independence and communication skills for children unable to utilize typical methods for independence.~~
- ~~(2) Care Coordination/Case Management - Services to promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families.~~

(Rule 1200-11-3-.02, continued)

- (3) ~~Commissioner~~ — The Commissioner of the Tennessee Department of Health or the Commissioner's designee.
- (4) ~~Department~~ — The Tennessee Department of Health.
- (5) ~~Diagnostic Condition~~ — Diagnoses specifically designated by the program as conditions qualifying a child for program eligibility.
- (6) ~~Diagnostic Evaluation~~ — Physical examinations, medical procedures, laboratory tests, or other procedures deemed necessary for diagnosis.
- (7) ~~Durable Medical Equipment~~ — Durable Medical Equipment means equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury, and is appropriate for use in the home. Orthotics, Prosthetics, and Communication Aid Devices are also included in the definition of "Durable Medical Equipment".
- (8) ~~Elective Hospital Admission~~ — Any hospital admission for conditions or treatments not immediately necessary to save the patient's life or prevent impending harm.
- (9) ~~Family~~ — For the purpose of the CSS program, a family is defined as follows:
- (a) ~~Two or more persons related by birth, marriage, or adoption, which reside together. (If a household includes more than one family, the guidelines are applied separately to each family.)~~
 - (b) ~~A person eighteen (18) years of age or older who is not living with any relative;~~
 - (c) ~~A child under eighteen (18) years of age and his/her non-parent custodians when financial responsibility has been assigned to them by the court; or~~
 - (d) ~~Parents of a child under eighteen (18) years of age when the child has been voluntarily placed outside the parent's home.~~
 - (e) ~~If a child under the age of eighteen (18) is living with someone other than the parent or legal guardian, the parent or legal guardian's income will be considered when determining eligibility.~~
- (10) ~~Hospitalization~~ — Any overnight stay in a hospital capable of providing the type of service(s) needed by the child and licensed pursuant to applicable regulations and/or statutes.
- (11) ~~Inpatient Hospital Services~~ — Medical and surgical services (including screening, diagnostic, therapeutic, corrective, preventive, and palliative services) and facility usage charges (including room and board) provided during hospitalization in a licensed hospital.
- (12) ~~Medical Services~~ — Medical, surgical, and rehabilitative treatment for conditions related to an approved diagnostic condition.
- (13) ~~Medically Related Services~~ — Services deemed necessary to follow the treatment plan for an approved medical condition.
- (14) ~~Orthodontic/Dental Intervention~~ — Medical, surgical, and rehabilitative treatment for conditions related to an approved cranial-facial diagnostic condition.
- (15) ~~Outpatient Hospital Services~~ — Medical and surgical services (including screening, diagnostic, therapeutic, corrective, preventive, and palliative services) and facility usage charges (including temporary room and board) provided as an outpatient service by a licensed hospital or hospital-based Ambulatory Surgical Treatment Center.

(Rule 1200-11-3-.02, continued)

- (16) ~~Outpatient/Clinic Services—Diagnostic evaluation or treatment services delivered in a public or private setting outside of the hospital.~~
- (17) ~~Pharmaceuticals and Supplies—Medications and supplies necessary for treatment related to a diagnostic condition covered by the program.~~
- (18) ~~Physically handicapped or crippled child—A child under the age of twenty-one (21) who shall be deemed “chronically handicapped” by any reason of physical infirmity, whether congenital or acquired, as a result of accident or disease, which requires medical, surgical, dental, or rehabilitation treatment, and who is or may be, totally or partially incapacitated for the receipt of a normal education or for self support. This definition shall not include those children whose sole diagnosis is blindness or deafness; nor shall this definition include children who are diagnosed as psychotic. This definition does not prohibit CSS from accepting for treatment children with acute conditions such as, but not necessarily limited to, fractures, burns and osteomyelitis.~~
- (19) ~~Provider—A person, persons, or facility giving direct service to the child as outlined in the child's plan of treatment.~~
- (20) ~~Rehabilitation—Services required to assist the individual to achieve or maintain independence. Rehabilitative services may include physical, speech/language, nutritional/feeding, and occupational therapies.~~
- (21) ~~Resident of Tennessee—A person who has established a bona fide residence in Tennessee. The test for such residence is (1) an intention to stay indefinitely in a place, joined with (2) some objective indication consistent with that intent, e. g., enrollment of a child in school.~~
- (22) ~~Support Services—Activities that may be necessary to assist the individual or family to access medically necessary and/or recommended care to participate in the activities of daily living.~~
- (23) ~~TennCare—The State of Tennessee Medicaid Waiver program that replaced the State's Medicaid program. The TennCare Bureau contracts with managed care organizations (MCOs) to provide a network of providers to serve TennCare enrolled children.~~
- (24) ~~Third Party Payor—The payment for health care by a party other than the beneficiary.~~
- (25) ~~Title V Children with Special Health Care Needs (CSHCN)—The Federal Title V CSHCN section of the Title V Maternal and Child Health CSHCN Block Grant that supports the program.~~

Authority: T.C.A. §§4-5-202, 68-1-103, and 68-12-101 et seq. *Administrative History:* Original rule filed April 12, 1979; effective May 28, 1979. Repeal and new rule filed December 30, 1983; effective January 29, 1984. Amendment filed May 29, 1990; effective July 13, 1990. Amendment filed December 7, 1998; effective April 30, 1999. Repeal and new rule filed March 21, 2000; effective July 28, 2000. Repeal and new rule filed October 9, 2002; effective December 23, 2002. Amendment filed May 27, 2005; effective September 28, 2005.

1200-11-3-.03 ELIGIBILITY REQUIREMENTS.

- (1) ~~Any child from birth to twenty one years of age who is a resident of Tennessee will be deemed eligible for medical services, medically related services, and care coordination through the CSS program provided the child meets the diagnostic and financial guidelines as established by the program.~~
- (2) ~~Any child from birth to twenty one years of age who is a resident of Tennessee and enrolled in TennCare will be deemed eligible for care coordination (case management) services, provided the~~

(Rule 1200-11-3-.03, continued)

child meets the diagnostic guidelines as established by the program and staff are available to provide these services:

- (3) ~~Any child with a diagnosis of cystic fibrosis can remain on the program past the age of 21 years until their demise.~~
- (4) ~~Financial eligibility will be determined based on an amount equal to, or a percentage rate above, the Federal Poverty Guidelines as published annually in the Federal Register. Children will be eligible if the family income is at or below 200% of poverty, for the number in the family. When a family has more than one (1) child with an eligible condition, one person may be added to the total number of family members when determining eligibility. Family is defined in Rule 1200-11-3-.02.~~
- (a) ~~Income shall include:~~
- ~~1. wages, salaries, and/or commissions;~~
 - ~~2. income from rental property or equipment;~~
 - ~~3. profits from self-employment enterprises, including farms;~~
 - ~~4. alimony and/or child support;~~
 - ~~5. inheritances;~~
 - ~~6. pensions and benefits; and~~
 - ~~7. public assistance grants.~~
- (b) ~~After the gross monthly income of the family is determined, it may be adjusted for the following:~~
- ~~1. verification of medical payments including medical or health insurance premiums made by the family for any family member during the previous twelve (12) months. The amount of such payments shall be prorated over twelve (12) months and deducted from the gross monthly income.~~
 - ~~2. verification of child support or alimony paid to another household which shall be deducted from the gross monthly income.~~
- (5) ~~The family's adjusted gross monthly income must be at or below 200% Federal Poverty Level (FPL) in effect at the time of application for program enrollment. Enrolled children will be re-certified annually.~~
- (a) ~~Children without insurance coverage who meet financial and diagnostic guidelines will be enrolled in the program and assisted with applying to TennCare. Proof of applying to TennCare must be provided within ninety (90) days in order for clients to remain in the program.~~
- (b) ~~Children who have access to other health insurance must apply for coverage under TennCare. Proof of applying for TennCare must be provided within ninety (90) days in order for clients to remain in the program. When a child enrolled in the program becomes covered by TennCare, resources from all other insurance payors will be exhausted before CSS considers payment for services. The program will coordinate services paid by other payors.~~
- (6) ~~The child's medical diagnosis may determine the level of financial or supportive services provided by the program.~~

(Rule 1200-11-3-.03, continued)

- (7) ~~As a condition of eligibility, children who have access to other health insurance whose family has income below 200% FPL must apply for coverage under TennCare. In the event that a child is then covered and also enrolled in the program, the CSS program will be the payor of last resort and coordinate benefits.~~

Authority: ~~T.C.A. §§4-5-202, 68-1-103, 68-12-101 et seq., 68-12-103, and 68-12-112. Administrative History: Original rule filed April 12, 1979; effective May 28, 1979. Repeal and new rule filed December 30, 1983; effective January 29, 1984. Amendment filed May 29, 1990; effective July 13, 1990. Repeal and new rule filed March 21, 2000; effective July 28, 2000. Repeal and new rule filed October 9, 2002; effective December 23, 2002. Amendments filed May 27, 2003; effective September 28, 2003.~~

1200-11-3-.04 COVERED SERVICES.

- (1) ~~Covered services are those described in Rule 1200-11-3-.02 that are not covered by other payors and are limited to those that directly relate to the diagnostic condition which made the child eligible for the program. Covered services may include:~~
- (a) ~~inpatient hospitalization; outpatient hospitalization or clinic services; care coordination services; orthodontic/dental intervention; pharmaceuticals and supplies such as medication; nutritional supplements; other supplies; durable medical equipment; standard rehabilitative therapies; assistive technology/augmentative communication devices; co-pay and deductibles; or other support services as determined by the Commissioner and the program;~~
 - (b) ~~subsequent hospitalizations, clinic visits, routine care, medications (excluding immunosuppressive therapy), and supplies after transplant surgery, but not services for the surgery itself;~~
 - (c) ~~subsequent hospitalizations, clinic visits, routine care, medications, and supplies after cochlear implant surgery, but not services for the surgery itself;~~
 - (d) ~~rental or purchase of durable medical equipment; maintenance, repair, or replacement of durable medical equipment; and, where appropriate, training of the enrollee or the enrollee's family in the use of the equipment.~~
- (2) ~~For children with other insurance payors, those resources will be exhausted before the program considers payment.~~
- (3) ~~If requested service is determined urgent, and is medically necessary, authorization may be granted by CSS, and reimbursements by insurers coordinated.~~
- (4) ~~Any payment for services will conform to policies and procedures of the CSS program.~~
- (5) ~~Services not covered:~~
- (a) ~~Transplant surgeries and cochlear implants surgeries will not be covered. Medications and supplies used in transplant surgeries and cochlear implant surgeries also will not be covered.~~
 - (b) ~~Drug treatments will not be reimbursed unless the drug is FDA approved for the purpose intended.~~
 - (c) ~~Dental and Orthodontic treatment will not be covered except in craniofacial malformations, cleft palate conditions, and designated cardiac conditions as outlined in program policy.~~

(Rule 1200-11-3-.04, continued)

- ~~(d) Psychiatric treatment and psychological services will not be covered.~~
- ~~(e) Alcohol and drug treatment will not be covered.~~
- ~~(f) Ambulance fees and transportation will not be covered except for emergency transportation from one hospital to another, as related to the child's eligible CSS diagnosis.~~
- ~~(g) Children admitted to a nursing home for continuous or episodic care will not be covered for CSS medical services until discharged.~~
- (6) ~~The type and amount of covered services will be determined by the availability of funds. When budgetary constraints are indicated, the department may:~~
 - ~~(a) create a waiting list of patients requesting elective hospital admissions. (The waiting list will be evaluated on a monthly basis and elective admissions will be approved according to availability of funds.);~~
 - ~~(b) eliminate in-patient hospitalization services as defined in 1200.11.3-.02, except for life-threatening conditions and conditions that would cause a permanent disability, if not treated immediately;~~
 - ~~(c) eliminate services for less severe diagnostic categories as designated by the program; or~~
 - ~~(d) reduce the type and amount of support services, durable medical equipment, care coordination, or other covered services.~~

Authority: T.C.A. §§4-5-202, 68-1-103, and 68-12-101 et seq. *Administrative History:* Original rule filed April 12, 1979; effective May 28, 1979. Repeal and new rule filed December 30, 1983; effective January 29, 1984. Amendment filed May 29, 1990; effective July 13, 1990. Repeal and new rule filed March 21, 2000; effective July 28, 2000. Repeal and new rule filed October 9, 2002; effective December 23, 2002. Amendments filed May 27, 2005; effective September 28, 2005.

1200-11-3-.05 AUTHORIZATION AND REIMBURSEMENTS.

- (1) Except for applicable deductibles, co-insurance, and/or co-payment, no reimbursement shall be made for covered services rendered under these rules, unless available third party payors, such as TennCare or private insurance, have been exhausted.
- (2) After all third party payors have been exhausted, or in the event no third party payors are available, reimbursement for covered services shall be in accordance with these rules.
- (3) Services must be authorized by the CSS program for reimbursement and must relate to the diagnosis for which the child is eligible for the program.
- (4) Additional and concurrent charges over and above the amount covered by third party payors, as provided in these rules, shall not be submitted to the family. This does not preclude a family or other party from making a contribution toward the care of the child when they are willing and able but such contributions shall not be solicited or accepted from the family of a child on TennCare for services covered in whole or in part by TennCare.
- (5) Reimbursement:
 - (a) Reimbursement for inpatient hospitalization and rehabilitation services shall be based on a per diem rate as negotiated between the Department and the facility.

(Rule 1200-11-3-.05, continued)

(b) ~~Reimbursement for covered medical services shall be based on:~~

- ~~1. Average wholesale price for pharmacy plus a \$4.00 shipping and handling fee.~~
- ~~2. For medical services, on an annual basis the required minimum reimbursement rate shall be updated to the equivalent of the prior year Medicare fee schedule for Tennessee multiplied by 75% and inflated with expected trend values as reported by Medicare. The updated National Conversion Factor is referenced in the Federal Register on or about October 31 each year.~~
- ~~3. Reimbursement for therapies, medical supplies, durable medical equipment, prosthetics, orthotics, and orthodontic/dental intervention services shall be based on the American Medical Association Physicians' Current Procedural Terminology (CPT) codes relative value units and the Direct Purchase Authority for the CSS program.~~
- ~~4. Reimbursement for nutritional supplements, hearing aids, and hearing aid supplies shall be based on the competitive bid system as designated in the State of Tennessee purchasing procedures and the Direct Purchasing Authority for the CSS Program.~~
- ~~5. Non-hospital services for which there is no Medicare price shall be paid at 75% of the billed charges.~~

(c) ~~No reimbursement will be paid for any covered service over 24 months old.~~

- ~~(6) Authorization of providers and vendors for reimbursement shall be determined in accordance with the standards as designated in these rules and determined by the program.~~
- ~~(7) Billing procedures for hospitals, institutions, facilities, agencies, providers, vendors, or distinct parts thereof rendering care or medical services shall be determined by the Department.~~
- ~~(8) No CSS provider shall charge CSS clients more than is charged for private clients for equivalent accommodations and services.~~
- ~~(9) The CSS program is not responsible for paying for services that could have or would have been paid by private insurance or TennCare except for failure to follow their requirements.~~

Authority: T.C.A. §§ 4-5-202, 68-1-103, and 68-12-101 et seq. *Administrative History:* Original rule filed April 12, 1979; effective May 28, 1979. Repeal and new rule filed December 30, 1983; effective January 29, 1984. Amendment filed May 29, 1990; effective July 13, 1990. Repeal and new rule filed March 21, 2000; effective July 28, 2000. Repeal and new rule filed October 9, 2002; effective December 23, 2002.

1200-11-3-.06 STANDARDS OF CARE.

- ~~(1) Participating physicians shall be licensed to practice medicine in Tennessee (or in the state where the service is delivered) and be certified and/or board eligible in their respective specialties. The Board of Dentistry must certify all dentists in their respective specialty. All other providers must be appropriately certified and/or licensed in their respective specialty.~~
- ~~(2) Physicians and dentists participating in a TennCare Managed Care Organization (MCO) network shall be recognized by the program as providers and must complete an application to the CSS program for reimbursement purposes. Physicians and dentists not participating in a TennCare MCO network must complete an application and be approved to serve as a CSS provider.~~

- (3) ~~All physicians and dentists must sign an agreement whereby they agree to abide by these rules and regulations and CSS program policy.~~
- (4) ~~Hospitals, facilities, physicians, dentists, and therapists, as well as other providers and vendors receiving payment from the CSS program for a patient, may not submit to the family of that patient, concurrent charges over and above the amount covered by TennCare, private insurance, or as provided in these rules and regulations.~~

~~*Authority:* T.C.A. §§ 4-5-202, 68-1-103, and 68-12-101 et seq. *Administrative History:* Original rule filed December 30, 1983; effective January 29, 1984. Amendment filed May 29, 1990; effective July 13, 1990. Repeal and new rule filed March 21, 2000; effective July 28, 2000. Repeal and new rule filed October 9, 2002; effective December 23, 2002.~~

~~1200-11-3-.07 OUT OF STATE TREATMENT.~~

- (1) ~~Services may be provided in out-of state facilities, with prior written approval from the CSS program director, when the following conditions are met:~~
 - (a) ~~Evidence is provided by the referring physician that services requested are not available within Tennessee or explicit medical justification is given to prove such out of state treatment to be in the best interest of the child.~~
 - (b) ~~Reimbursement for services shall be based on a negotiated rate paid by the CSS program in that state or that state's Medicaid rate, whichever is less.~~
 - (c) ~~The out of state length of stay and estimated hospital charge shall be within the limits established by the program.~~
 - (d) ~~The out-of state estimated cost of out-patient follow-up and/or discharge services shall be equal or comparable to the Title V CSHCN rate in that state or that state's Medicaid rate, whichever is less.~~
 - (e) ~~Tennessee's Children's Special Services Rules and Regulations 1200-11-3-.05 Authorization and Reimbursement for Services shall apply.~~
- (2) ~~In order to maintain continuity of care, children receiving services under these rules and regulations who move out of state shall be referred to the appropriate Title V CSHCN program within the state of new residence upon written permission of the legal guardian.~~

~~*Authority:* T.C.A. §§ 4-5-202, 68-1-103, and 68-12-101 et seq. *Administrative History:* Original rule filed March 21, 2000; effective July 28, 2000. Repeal and new rule filed October 9, 2002; effective December 23, 2002.~~

~~1200-11-3-.08 APPEALS AND CLOSURE OF CASES.~~

- (1) ~~Appeals~~
 - (a) ~~Applicants who are denied participation in the Children's Special Services program, or participants who are discontinued from the program in accordance with these rules and regulations, may appeal the decision in writing to the program director within thirty (30) calendar days of receipt of the program's written notice of denial or closure. If the denial is upheld, the individual may appeal the decision in writing to the Commissioner within ten (10) calendar days of receipt of the written notice that the initial appeal has been denied. The decision of the Commissioner shall be final.~~

(Rule 1200-11-3-.08, continued)

(2) Closure of Cases

(a) Cases may be closed or participants may be denied services for the following reasons:

1. participant has received maximum treatment for the eligible diagnosis;
2. participant has attained the age of twenty-one (21). Those with a diagnosis of Cystic fibrosis may remain on the program past the age of 21 years, pursuant to rule 1200-11-3-.03 (3).
3. participant moved out of state;
4. participant expired;
5. participant not diagnostically eligible;
6. participant not financially eligible;
7. participant's family not interested; or
8. participant can not be located by the Department.

Authority: T.C.A. §§ 4-5-202, 68-1-103, and 68-12-101 et seq. *Administrative History:* Original rule filed March 21, 2000; effective July 28, 2000. Repeal and new rule filed October 9, 2002; effective December 23, 2002.

1200-11-3-.01 Statement of Purpose

In an effort to provide comprehensive services and eliminate health barriers and disparities for children with special health care needs in Tennessee, the Tennessee Legislature created the Children's Special Services (CSS) Program. The program is intended to assure that children in this population are identified early and receive high quality coordinated care and that their families receive support. The program serves those children who meet the T.C.A. 68-12-102 definition of "a child with a physical disability." To the extent that funding is available, program resources provide for diagnostically related services for enrolled children when other payors are unable to provide payment.

Authority: T.C.A. §§ 4-5-202, 68-1-103, 68-12-101 et seq., 68-12-104, and 42 U.S.C. § 701(a)

1200-11-3-.02 Definitions Unless otherwise specifically indicated by the context, for the purpose of these rules and regulations, the terms used herein are defined as follows.

- (1) "Assistive technology/augmentative communication device" means any device or equipment that may promote independence and communication skills for children unable to utilize typical methods for independence.
- (2) "Care Coordination" means case management services promoting the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special healthcare needs and their families. Care coordinators assist families with services such as third party payor billing, filing appeals when third party payors deny payment, and seeking prior approval from third party payors for covered services.
- (3) "Child" or "children" means a person or persons under the age of twenty-one (21) years.

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(Rule 1200-11-3-.08, continued)

- (4) "Child with a physical disability" means a child under the age of twenty-one (21) who shall be deemed to have a physical disability by any reason, whether congenital or acquired as a result of accident or disease, which requires medical, surgical, dental or rehabilitation treatment, who is or may be totally or partially incapacitated for the receipt of a normal education or for self-support. This definition shall not include those children whose sole diagnosis is blindness or deafness, nor shall this definition include children who are diagnosed as psychotic. This definition does not prohibit CSS from accepting for treatment children with acute conditions such as, but not necessarily limited to, fractures, burns, and osteomyelitis.
- (5) "Commissioner" means the Commissioner of the Tennessee Department of Health or the Commissioner's designee.
- (6) "Covered Services" means medical, surgical, and rehabilitative treatment for eligible diagnoses, including the services necessary in order for a child to follow a prescribed treatment plan for an eligible diagnosis.
- (7) "Department" means the Tennessee Department of Health.
- (8) "Diagnostic evaluation" means physical examinations, medical procedures, laboratory tests, or other procedures deemed necessary for diagnosis.
- (9) "Drugs, devices and supplies" means medications, devices and supplies necessary for treatment related to an eligible diagnosis.
- (10) "Durable medical equipment" means equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury, and is appropriate for use in the home, including orthotics, prosthetics, and communication aid devices.
- (11) "Elective Hospital Admission" means any hospital admission for diagnoses or treatments not immediately necessary to save the patient's life or prevent impending harm.
- (12) "Eligible Diagnosis" means a health-related impairment, described in T.C.A. § 68-12-102 and diagnosed by a provider, which may hinder achievement of normal growth and development.
- (13) "Hospitalization" means any overnight stay in a hospital which is:
- (a) capable of providing the type of service(s) needed by the child, and
 - (b) licensed pursuant to applicable regulations and/or statutes.
- (14) "Inpatient hospitalization services" means medical and surgical services (including screening, diagnostic evaluation, therapeutic, corrective, preventive, and palliative services) and facility usage charges (including room and board) provided during hospitalization in a licensed hospital.
- (15) "Orthodontic/dental treatment" means medical, surgical, and rehabilitative treatment for eligible cranio-facial (including cleft lip and cleft palate) and cranial diagnoses.
- (16) "Outpatient hospitalization services" means medical and surgical services (including screening, diagnostic evaluation, therapeutic, corrective, preventive, and palliative services) and facility usage charges (including temporary room and board) provided as an outpatient service by a licensed hospital or hospital-based Ambulatory Surgical Treatment Center.

(Rule 1200-11-3-.08, continued)

- (17) "Outpatient clinic services" means diagnoses or treatment services delivered by a licensed health care provider in a facility other than a hospital setting.
- (18) "Provider" means a healthcare provider which is a person, persons, or facility licensed pursuant to T.C.A. Titles 63 or 68 to provide healthcare services in Tennessee or, if the services are being provided in another state, licensed pursuant to the licensing laws of that state.
- (19) "Rehabilitation" means services required to assist the individual to achieve or maintain independence. Rehabilitative services may include physical, speech/language, nutritional/feeding, and occupational therapies.
- (20) "Resident of Tennessee" means a person who has established a bona fide residence in Tennessee. The test for such residence is (1) an intention to stay indefinitely in a place, joined with (2) some objective indication consistent with that intent, e. g., enrollment of a child in school.
- (21) "Support services" means activities that may be necessary to assist the individual or family to access medically necessary and/or recommended care to participate in the activities of daily living.
- (22) "Third party payor" means a party other than the recipient of healthcare who pays for healthcare. Third party payors include private insurance and the following resources:
- (a) The Patient Protection and Affordable Care Act, which is the health-related portion of the Health Care and Education Reconciliation Act of 2010.
 - (b) Children's Health Insurance Program (CHIP), which is a health insurance program mandated by Title XXI of the Social Security Act that is jointly financed by Federal and State governments and administered by the States. CHIP was previously known as the State Children's Health Insurance Program (SCHIP). Tennessee's CHIP includes the CoverKids program.
 - (c) CoverRX, which is a program that offers affordable prescription drugs to persons ages nineteen (19) years and older who lack pharmacy coverage.
 - (d) TennCare, which is the State of Tennessee Medicaid Waiver program that replaced the State's Medicaid program. The TennCare Bureau contracts with managed care organizations (MCOs) to provide a network of providers to serve TennCare enrolled individuals.
- (23) "Title V Children with Special Health Care Needs (CSHCN)" means the section of the Title V Maternal and Child Health CSHCN Block Grant that supports the program.
- (24) "Vendor or supplier" means authorized person, persons, or facilities approved by the State of Tennessee to provide services in conjunction with established Department of Health and Department of Finance and Administration guidelines.

Authority: T.C.A. §§ 4-5-202, 68-1-103, 68-12-101 et seq. and 42 U.S.C. § 701(b).

1200-11-3-.03 Eligibility Requirements.

- (1) General Eligibility. To be eligible for the Program's services, a child shall:
- (a) be a resident of Tennessee.

(Rule 1200-11-3-.08, continued)

- (b) not have reached his or her twenty-first birthday;
 - (c) meet the diagnostic and financial eligibility requirements below;
 - (d) complete and sign the application form approved by the Program; and
 - (e) provide proof of application to Medicaid or CHIP within ninety (90) days of completing and signing the Program's application form (if Medicaid or CHIP eligible).
- (2) Diagnostic Eligibility. To be eligible for the Program's services, a child shall provide a physician's certification that the child has an eligible diagnosis which causes the child to meet the definition of "child with a physical disability" defined by T.C.A. § 68-12-102. The physicians shall base the certification upon a physical examination conducted within the 12 months preceding the date of certification.
- (3) Financial Eligibility. A child shall be financially eligible for services if his or her family's gross annual income as adjusted is at or below 200% of the Federal Poverty Guidelines. When a family has more than one (1) child with an eligible diagnosis(es), the program may add one person to the total number of family members when determining eligibility.
- (a) For purposes of financial eligibility, a "family" is defined as two or more persons (including the child) related by birth, marriage or adoption who reside together, unless one of the following alternative scenarios applies:
 - 1. If the parent or parents of a child under the age of eighteen (18) have voluntarily placed the child in another party's home to reside, the child and the parents are a "family."
 - 2. If the parent or parents of a child under the age of eighteen (18) have been court-ordered to provide financial support to the child when the child lives in another party's home, the child and the parent or parents are a "family."
 - 3. If a child eighteen (18) years of age or older does not live with a relative, the child alone is considered a "family."
 - 4. A foster child alone is considered a "family" and the Department of Children's Services (DCS) foster care board payments to the foster parents are considered the family's income.
 - (b) The program shall determine the family's gross annual income and financial eligibility by calculating the following:
 - 1. Wages, salaries, tips/gratuities, and/or commissions;
 - 2. Income from rental property or equipment;
 - 3. Profits from self-employment enterprises, including farms;
 - 4. Alimony, maintenance and/or child support;
 - 5. Inheritances, lottery winnings and/or other windfalls;
 - 6. Pensions and benefits.

(Rule 1200-11-3-.08, continued)

7. DCS foster care board payments, and

8. Public assistance grants.

(c) After the program determines the family's gross annual income, the program may adjust income by taking into consideration the probable total cost of treatment and the family's other financial responsibilities, including but not limited to the following:

1. Verification of medical payments including medical or health insurance premiums made by the family for any family member during the previous twelve (12) months. The program shall deduct this amount from the gross annual income.

2. Verification of alimony, maintenance and/or child support paid to another household, which the program shall deduct from the gross annual income.

3. Number of dependents.

(d) The program shall review its available funding and historical spending annually. In any year in which, in the best judgment of the program, it appears that funds are available to serve families with gross annual income as adjusted greater than 200% of the Federal Poverty Guideline, the program may, in its sole discretion, post on its website an increased income eligibility limit and serve families with gross annual incomes as adjusted up to the posted limits.

(4) Subsequent determinations of eligibility. The program shall recertify enrolled children annually. A child shall meet all eligibility criteria in order to remain enrolled in the program.

Authority: T.C.A. §§ 4-5-202, 68-1-103, 68-12-101 et seq., 68-12-103, 68-12-112, 42 U.S.C. § 701, and 42 U.S.C. § 705(a)(1)(C) and (a)(3)(B).

1200-11-3-.04 Covered and Non-Covered Services.

(1) When a child enrolled in the program requires services for which one or more third party payors are financially responsible, the program may provide the child with services limited to care coordination, subject to availability of funding.

(2) Covered services are those described in Rule 1200-11-3-.02 that are not covered by third party payors and are limited to those that directly relate to the child's eligible diagnosis. Covered services may include, but are not limited to, the following:

(a) inpatient hospitalization, outpatient hospitalization or clinic services, care coordination services, orthodontic/dental treatment, drugs, devices and supplies such as medication and nutritional supplements, standard rehabilitative therapies, assistive technology/augmentative communication devices, co-pays, co-insurance and deductibles; or other support services as determined by the Commissioner and the program;

(b) subsequent hospitalizations, clinic visits, routine care, transplants and implants deemed medically necessary, medications (including immunosuppressive therapy), and supplies after transplant and implant surgeries, and

(c) rental or purchase of durable medical equipment, maintenance, repair, or replacement of durable medical equipment, and, where appropriate, training of the enrolled child or the child's family in the use of the equipment.

(Rule 1200-11-3-.08, continued)

- (3) Services not eligible for reimbursement from the program include, but are not limited to, the following:
- (a) Drugs, food and nutritional/dietary supplements not approved by the Food and Drug Administration (FDA);
 - (b) Orthodontic/Dental services except treatment for eligible cranio-facial (including cleft lip and cleft palate) and designated cardiac diagnoses;
 - (c) Psychiatric treatment and psychological services, treatment and services for mental, emotional and behavioral disorders, developmental disabilities and learning disabilities;
 - (d) Treatment for alcohol and drug abuse and/or dependence;
 - (e) Ambulance fees and transportation costs, except for emergency transportation from one hospital to another, as related to the child's eligible diagnosis;
 - (f) Services rendered while a child is admitted to a nursing home for continuous or episodic care;
- (4) The program shall determine the type and amount of covered services by the availability of funds. When budgetary constraints are indicated the program may:
- (a) Create a waiting list of children requesting elective hospital admissions. (The program will evaluate the waiting list on a monthly basis and approve elective admissions according to availability of funds);
 - (b) Eliminate inpatient hospitalization services as defined in 1200-11-3-.02, except for life-threatening conditions and conditions that would cause a permanent disability, if not treated immediately;
 - (c) Eliminate services for less severe diagnostic categories as designated by the program, and/or
 - (d) Reduce the type and amount of support services, durable medical equipment, care coordination, or other covered services;

Authority: T.C.A. §§ 4-5-202, 68-1-103, 68-12-101 et seq., and 42 U.S.C. § 704(b)(1).

1200-11-3-.05 Authorization and Reimbursements.

- (1) The program shall authorize only those services for reimbursement that relate to the child's eligible diagnosis(es). The Program shall be a payor of last resort, paying for covered services only after exhaustion of the family's other payor sources, except for applicable deductibles, co-insurance, and/or co-payment. The program shall not pay the difference between the billed amount for a service and the amount paid by a third party payor based upon a contractual agreement. Except as provided in 1200-11-3-.05(5), the program shall only authorize reimbursement for services for children currently enrolled in the program.

(2) Reimbursement.

- (a) The program shall authorize reimbursement for services as follows:

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(Rule 1200-11-3-.08, continued)

1. Inpatient hospitalization and rehabilitation services shall be based on a per diem rate as negotiated between the Program and the facility.
 2. Drug reimbursements shall be based upon the Department's average wholesale price. The shipping and handling fee may be reimbursed according to the program's most current Delegated Authority (DA).
 3. Services for which there is a Medicare fee shall be at least the equivalent of the prior year's Medicare fee schedule for Tennessee multiplied by 75%. The program shall update the required minimum reimbursement rate on a biennial basis but at its discretion the program may at other times update the reimbursement rate to account for significant changes in fees. The updated National Conversion Factor is referenced in the Federal Register on or about October 31 each year.
 4. Therapies, medical supplies, durable medical equipment, prosthetics, orthotics, and orthodontic/dental treatment services shall be based on the American Medical Association Physicians' Current Procedural Terminology (CPT) codes relative value units and determined by the State of Tennessee purchasing procedures and the Delegated Purchase Authority for the program.
 5. Nutritional supplements, hearing aids, and hearing aid supplies shall be determined by the State of Tennessee purchasing procedures and the Delegated Purchasing Authority for the Program.
 6. Non-hospital services for which there is no Medicare fee shall be paid at least 75% of the average of three (3) bids, one from each grand division of the state.
- (b) The program shall not authorize reimbursement for any covered service provided over twelve (12) months prior to the receipt of the request for reimbursement.
- (3) The program shall determine authorization of providers and vendors for reimbursement in accordance with the standards as designated in these rules and determined by the Department of Health and the Department of Finance and Administration.
 - (4) The Department shall determine billing procedures for hospitals, institutions, facilities, agencies, providers, vendors, or distinct parts thereof rendering services.
 - (5) Upon receipt of a determination from the assigned provider that a requested service is urgent and medically necessary, the State CSS Program Director may grant authorization prior to exhaustion of resources from third party payors, provided however, that the grant or denial of such authorization shall be final.

Authority: T.C.A. §§ 4-5-202, 68-1-103, 68-12-101 et seq., 42 U.S.C. § 701(a), 42 U.S.C. § 704(b)(1), and 42 U.S.C. § 706(a)(2)

1200-11-3-.06 Providers

- (1) All providers shall be appropriately certified and/or licensed in their respective specialties.
- (2) Providers participating in a TennCare Managed Care Organization (MCO) network shall be recognized by the program as providers and must complete an application to the program for reimbursement purposes. Providers not participating in a TennCare MCO network must complete an application and be approved to serve as a provider before submitting any costs for reimbursement.

(Rule 1200-11-3-.08, continued)

- (3) All providers must sign the Department's vendor agreement and abide by these rules.
- (4) Providers shall not submit additional and concurrent charges to the family for the care of a child over and above the amount covered by third party payors, as provided in these rules. This does not preclude a family or other party from making a contribution toward the care of the child when they are willing and able but providers shall not solicit or accept such contributions from the family of a child on TennCare for services covered in whole or in part by TennCare.
- (5) No provider shall charge program enrolled children more than the amount charged for private clients for equivalent accommodations and services.

Authority: T.C.A. §§ 4-5-202, 68-1-103, and 68-12-101 et seq. and § 42 U.S.C. 701(a).

1200-11-3-.07 Out-of-State Treatment.

- (1) The program may approve a provider's services in an out-of-state facility under the following conditions:
 - (a) The referring physician shall provide evidence that requested services are not available within Tennessee, or shall provide explicit medical justification to prove such out-of-state treatment is in the best interest of the child.
 - (b) The program shall base reimbursement for services on a negotiated rate paid by the Title V CSHCN Program in that state, or on that state's Medicaid rate, whichever is less.
 - (c) The out-of-state length of stay and estimated hospital charge shall be within the limits established by the program.
 - (d) The out-of-state estimated cost of out-patient follow-up and/or discharge services shall be equal or comparable to the Title V CSHCN rate in that state or that state's Medicaid rate, whichever is less.
 - (e) The program shall provide written approval to the provider prior to the provider's performance of services.
- (2) In order to maintain continuity of care, the program shall refer children receiving services under these rules and regulations who move out of state to the appropriate Title V CSHCN program within the state of new residence upon written permission of the parents or legal guardian, or in the case of an emancipated minor, the minor's permission.

Authority: T.C.A. §§ 4-5-202, 68-1-103, and 68-12-101 et seq., 42 U.S.C. § 701(a).

1200-11-3-.08 Appeals and Termination of Enrollment.

- (1) Appeals
 - (a) An enrolled child who receives a determination of ineligibility for program services (or his or her representative) may appeal the decision in writing to the program director within (30) calendar days of receipt of the program's written notice of the child's ineligibility. If the program director upholds the program's determination of ineligibility, the individual may appeal the decision in writing to the Commissioner within ten (10)

(Rule 1200-11-3-.08, continued)

calendar days of receipt of the written notice upholding the program's determination.
The decision of the Commissioner shall be final.

(2) Termination of Enrollment

(a) The program may terminate a child's enrollment in the Program for the following reasons, none of which are subject to appeal:

1. Child has received maximum treatment for the eligible diagnosis;
2. Child has attained the age of twenty-one (21) years;
3. Child has moved out of state;
4. Child is deceased;
5. Child is not diagnostically eligible;
6. Child is not financially eligible;
7. Child's family is not interested, and/or
8. Child cannot be located by the program.

Authority: T.C.A. §§ 4-5-202, 68-1-103, and 68-12-101 et seq., and 42 U.S.C. § 701(a).

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