

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

**CHAPTER 1200-11-03
CHILDREN'S SPECIAL SERVICES**

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1200-11-03-.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).
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. Repeal and new rules filed September 6, 2016; effective December 5, 2016.

1200-11-03-.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

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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

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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). **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. Repeal and new rules filed September 6, 2016; effective December 5, 2016.

1200-11-03-.03 ELIGIBILITY REQUIREMENTS.

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

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- (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;

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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). **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. Repeal and new rules filed September 6, 2016; effective December 5, 2016.

1200-11-03-.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 1200-11-03-.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;

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- (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 1200-11-03-.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). **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. Repeal and new rules filed September 6, 2016; effective December 5, 2016.

1200-11-03-.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 1200-11-03-.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

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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). **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. Repeal and new rules filed September 6, 2016; effective December 5, 2016.

1200-11-03-.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, 68-12-101 et seq., and § 42 U.S.C. 701(a). **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. Repeal and new rules filed September 6, 2016; effective December 5, 2016.

1200-11-03-.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;

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- (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, 68-12-101 et seq., and 42 U.S.C. § 701(a). **Administrative History:** Original rule filed March 21, 2000; effective July 28, 2000. Repeal and new rule filed October 9, 2002; effective December 23, 2002. Repeal and new rules filed September 6, 2016; effective December 5, 2016.

1200-11-03-.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, 68-12-101 et seq., and 42 U.S.C. § 701(a). **Administrative History:** Original rule filed March 21, 2000; effective July 28, 2000. Repeal and new rule filed October 9, 2002; effective December 23, 2002. Repeal and new rules filed September 6, 2016; effective December 5, 2016.