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Notice of Rulemaking Hearing

Hearings will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, T.C.A. § 4-5-204. For questions and copies of the notice, contact the person listed below.

Agency/Board/Commission:	Department of Health
Division:	Children's Special Services
Contact Person:	Mary Kennedy
Address:	710 James Robertson Parkway, 5th Floor, Nashville, TN 37243
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Any Individuals with disabilities who wish to participate in these proceedings (to review these filings) and may require aid to facilitate such participation should contact the following at least 10 days prior to the hearing:

ADA Contact:	ADA Coordinator
Address:	710 James Robertson Parkway, Andrew Johnson Building, 5th Floor, Nashville, Tennessee 37243
Phone:	(615) 741-6350
Email:	Tina.M.Harris2@tn.gov

Hearing Location(s) (for additional locations, copy and paste table)

Address 1:	Andrew Johnson Building		
Address 2:	710 James Robertson Parkway, 8th Floor – Conference Room A		
City:	Nashville, Tennessee		
Zip:	37219		
Hearing Date :	05/01/15		
Hearing Time:	12:00 p.m.	X CST/CDT ___EST/EDT	

Additional Hearing Information:

Revision Type (check all that apply):

X Amendment
X New
___ Repeal

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

Chapter Number	**Chapter Title**
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 and Non-Covered Services
1200-11-03-.05	Authorizations and Reimbursements
1200-11-03-.06	Providers
1200-11-03-.07	Out-of-State
1200-11-03-.08	Appeals and Termination 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

New Rule

New Table of Contents

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" Program resources provide payment for diagnostically related necessary healthcare services for enrolled children when other payors are unable to provide payment.

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

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 healthcare 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, 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, osteomyelitis.

(5) "Commissioner" means the Commissioner of the Tennessee Department of Health or the Commissioner's designee.

(6) "Department" means the Tennessee Department of Health.

(7) "Diagnostic evaluation" means physical examinations, medical procedures, laboratory tests, or other procedures a provider deems necessary for diagnosis.

(8) "Drugs, devices and supplies" means medications, devices and supplies necessary for treatment related to an eligible diagnosis.

(9) "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.

(10) "Elective hospital admission" means any hospital admission for a condition or treatment not immediately necessary to save the patient's life or prevent impending harm.

(11) "Eligible diagnosis" means a chronic health-related impairment, diagnosed by a provider, which causes the child to meet the definition of "physically disabled" as defined by T.C.A. § 68-12-102.

(12 "Healthcare services" means medical, surgical and rehabilitative treatment for eligible diagnosis, including the services necessary in order for a child to follow a prescribed treatment plan for an eligible diagnosis.

(13) "Hospitalization" means any overnight stay in a hospital which is capable of providing the type of service(s) needed by the child and which is 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 designated cardiac diagnosis.

(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 diagnosis or treatment delivered by a licensed health care professional 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 provider is providing services in another state, licensed pursuant to the licensing laws of that state.

(19) "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.

(20) "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.

(21) "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.

(22) "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.

(23) "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) AccessTN, which is a program that offers comprehensive health insurance for persons ages nineteen (19) and older who are uninsurable due to preexisting conditions.

(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 the 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) CoverKids, which is a program that offers comprehensive health coverage to qualifying uninsured children in Tennessee, ages eighteen (18) years and younger.

(d) CoverRx, which is a program that offers affordable prescription drugs to persons ages nineteen (19) years and older who lack pharmacy coverage.

(e) CoverTN, which is a program that is a partnership between the state, employers, and individuals that makes health care coverage affordable for working, uninsured individuals ages nineteen (19) years and older.

(f) 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.

(24) "Title V Children with Special Health Care Needs (CSHCN)" means 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.

1200-11-3-.03 Eligibility Requirements.

1200-11-03-.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 all available third party payors within ninety (90) days of completing and signing the program's application form.

(2) Diagnostic Eligibility. To be eligible for the program's services, a family or child shall provide a physician's certification that the child has an eligible diagnosis which causes the child to meet the definition of "physically disabled " as defined by T.C.A. § 68-12-102. The physician shall base the certification upon a physical examination conducted within the 12 months immediately preceding the date of certification.

(3) Financial Eligibility. A child shall be financially eligible for services if his or her family's adjusted gross annual income is at or below 200% of the Federal Poverty Guidelines. When a family has more than one (1) child with an eligible condition, 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. If a foster child is under the age of twenty-one (21), the 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 adjusted gross annual income by calculating the following:

1. Wages, salaries, 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;

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 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 program shall add the amount of such payments over twelve (12) months and deduct it from the gross annual income; and

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

(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, and 68-12-112.

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 care coordination services only to that child, 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 (excluding FM systems); 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, medications (excluding immunosuppressive therapy) and supplies after transplant and implant surgeries, but not services for the surgery itself; 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) Transplant and implant surgeries, and medications and supplies used in transplant and implant surgeries;

(b) Drugs, food and nutritional/dietary supplements not approved by the Food and Drug Administration (FDA);

(c) Orthodontic/Dental services except treatment for eligible cranio-facial (including cleft lip and cleft palate) and designated cardiac diagnosis;

(d) Psychiatric treatment and psychological services; treatment and services for mental, emotional and behavioral disorders, developmental disabilities and learning disabilities;

(e) Treatment for alcohol and drug abuse and or dependence;

(f) Ambulance fees and transportation costs, except for emergency transportation from one hospital to another, as related to the child's eligible diagnosis;

(g) 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 Rule 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, and 68-12-101 et seq.

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

(1) The program shall authorize only those services for reimbursement that relate to the child's eligible condition. Except for applicable deductibles, co-insurance, and/or co-payment, the program shall not reimburse providers for covered services found in Rule 1200-11-03-.02 and rendered under these rules unless the family first exhausts all resources from available third party payors. The program shall not authorize reimbursement for services that could have or would have been paid by third party payors, nor shall the program authorize reimbursement for the remaining balance on any service that is only partially reimbursed by third party payors. The program shall only authorize reimbursement for services for children currently enrolled in the program. (If the assigned provider determines that a requested service is urgent and medically necessary, the State CSS Program Director may grant authorization prior to exhausting resources from third party payors.)

(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. Drugs shall be the average wholesale price plus a $6.00 shipping and handling fee.

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 Direct 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 Direct Purchase 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 over twenty-four (24) months old.

(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.

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

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 a program application and receive approval to serve as a provider before submitting any costs for reimbursement.

(3) All providers must sign an agreement to abide by these rules and regulations and program policy.

(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 is 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.

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 provider 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 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 outpatient 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 parent or legal guardian.

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

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 thirty (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;

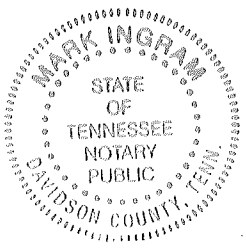
6. Child is not financially eligible;

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.

I certify that the information included in this filing is an accurate and complete representation of the intent and scope of rulemaking proposed by the agency.



Date: February 25, 2015

Signature: Mary Kennedy

Name of Officer: Mary Kennedy

Title of Officer: Deputy General Counsel, Department of Health

Subscribed and sworn to before me on: 2-25-2015

Notary Public Signature: Mark Ingram

My commission expires on: My Commission Expires: July 6, 2015

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Tre Hargett

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