Children and Youth with Special Health Care Needs

Children's Special Services (CSS) Program

EMBRACING SPECIAL CHILDREN TODAY

FOR INDEPENDENT CITIZENS TOMORROW

Provider Enrollment Manual

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CHILDREN'S SPECIAL SERVICES (CSS) PROGRAM DESCRIPTION

The Children Special Services (CSS) Program provides assistance statewide for individuals from birth to age 21 who have a physical disability by any reason whether congenital or acquired, as a result of accident, or disease, that requires medical, surgical, or dental treatment and rehabilitation, and who is or may be totally or partially incapacitated for the receipt of a normal education or for self-support. This does not include those children whose sole diagnosis is blindness or deafness; nor does this definition include children who are diagnosed as psychotic. Neither does this prevent the program from accepting or providing treatment for children with acute conditions such as, but not necessarily limited to fractures, burns and osteomyelitis.

The program focuses on early identification and care coordination for individuals who meet eligibility guidelines. As payor of last resort, the Program also provides limited funding for medically necessary diagnostic treatment and services.

Vision

Embracing special children today, for independent citizens tomorrow.

Mission

The Tennessee Children's Special Services Program assures appropriate, timely, comprehensive, quality services to children birth to 21 who have or are at risk for special needs. The program promotes the well-being of children in a manner that is family-centered, culturally sensitive and community based through service coordinators acting as liaisons for children, families and providers – facilitating, collaborating and forming partnerships that are flexible and creative in meeting the unique needs of each child.

Core Values

The Program respects the dignity of each individual and their family, and partners with the participants/families to achieve coordinated ongoing comprehensive care within a medical home which will provide for successful transitions to adulthood. The Program is guided by core values and standards that include:

- Family/Professional Partnerships
- Medical Home
- Transition to Adulthood
- Community-Based Services and Support
- Access to Care
- Insurance and Financing
- Screening, Assessment and Referral

PARTICIPANT ELIGIBILITY

To be eligible for Program Services, the participant must:

- Be a resident of the State of Tennessee
- Be Under the Age twenty-one (21)

- Have an eligible special health care need, and
- Meet financial eligibility guidelines (income less than 225% of the federal poverty level (FPL) based on family size) or as currently established by the Department of Health.

PROGRAM SERVICES

The Program provides two primary services:

1) Care Coordination

- Care coordination facilitates, implements, coordinates, monitors, and evaluates services and outcomes, and encourages participants/families to develop skills needed to function at their maximum level of independence.

- Care coordination is a central, ongoing component of an effective system of care for children and youth with special health care needs and their families.

- Care coordination engages families in development of a care plan and links them to health and other services that address the full range of their needs and concerns.

- Principles of care coordination reflect the central role of families and the prioritization of child and family concerns, strengths and needs in effective care of children with special health care needs.

- Activities of care coordination may vary from family to family, but start with identification of individual child and family needs, strengths and concerns, and aim simultaneously at meeting family needs, building family capacity and improving systems of care.

2) Medically Necessary Services and Treatment

The CSS Program is a payor of last resort. Limited funding for medically necessary diagnostic, treatment and rehabilitative services is provided through a delegated purchase authority. CSS may assist with payments for services related to an approved eligible diagnosis.

- Covered services may include but are not limited to:
  - Diagnostic screening, testing, evaluations and treatment
  - OT, ST, PT
  - Surgeries – inpatient and outpatient
  - Hospitalization
  - Office Visits – Primary Care/Specialty Visits
  - Prescription Drugs
  - Durable Medical Equipment
  - Assistive technology - augmentative communication devices
  - Supplies (ex. Diabetic, tube feedings, diapers, etc.)
  - Hearing aids, batteries, molds etc.,
  - Rehabilitative services
  - Special Food and Formula
  - Orthotic Equipment and Wheelchairs

  - Respiratory Devices
  - Seating Devices
  - Vision Aids
  - Co-pays, co-insurance and deductibles

- All third-party payors must be exhausted prior to CSS funds being utilized.
- Prior authorization is required.

HEALTH CARE PROVIDER ELIGIBILITY

Children's Special Services will authorize health care providers, durable medical equipment and special food and formula vendors/suppliers to obtain medical care and ancillary services for participants enrolled in the CSS Program. Participants enrolled in the CSS Program must receive services from a CSS authorized provider.

General Policies

CSS health care providers, i.e., physicians, dentists, nurse practitioners, physician assistants, etc., must be licensed to practice in Tennessee (or in the state where services are provided) and be certified and/or board eligible in their respective specialty.

All other providers must be appropriately certified and/or licensed in their respective specialty, i.e., occupational, physical, speech therapists, audiologist, registered dietitians, etc.

When a specialist is needed, Pediatric specialty providers should be utilized whenever possible.

Provider participation in the TennCare Managed Care Organization is recommended.

No health care provider may be authorized to provide services for the CSS program if he/she is being investigated by Tennessee Department of Health, Health Related Boards, TennCare, Tennessee Bureau of Investigation Centers for Medicaid/Medicare Services or any other agency until the investigation is complete and CSS policy staff, as well as the CSS Advisory Committee if necessary, has reviewed the findings.

Authorization to provide services for the CSS Program will be determined by the CSS Central Office staff.

Health care providers in the CSS provider network who follow CSS participants in their offices may not submit to the family concurrent charges over and above the amount reimbursed by third party payers and/or the CSS program.

The only amount a provider may charge a TennCare enrollee, even if he or she has private insurance, is the deductible or co-pay that is required under TennCare per federal regulations.

The CSS program may provide reimbursement for medical specialty care. Specialty care may be provided in a physician’s office, public or private outpatient clinics or inpatient hospitalizations.

CSS enrolled clients are required to utilize primary care providers (PCP) and specialty care providers in the network designated by their insurance plan. Some insurance plans may provide approval for children to be seen by "out of network" specialty providers. The CSS program shall not reimburse for service or treatment performed by an "out of network" provider unless prior approval from the designated insurance plan was obtained.

Provider Enrollment

1. Requests to become a CSS authorized provider are received by the CSS Regional/Metro Coordinators or central office CSS staff.

2. The Regional/Metro Coordinator or CSS central office program staff forwards to the requesting provider or facility representative a complete vendor agreement packet including:
   a. **Letter of Agreement**
   b. Vendor Authorization
   c. W-9 Form
   d. State of Tennessee Supplier Direct Deposit Authorization Form *
   (See Appendices 1-4)

3. The original Letter of Agreement, Vendor Authorization, and W-9 Tax Form, along with verification of licensure in good standing are submitted to CSS Central Office administrative staff for processing.

   *** The State of Tennessee Supplier Direct Deposit Authorization Form must be mailed by the provider to the address listed on the top right side of the form (See Appendix 4)**

4. Upon receipt of the completed vendor agreement packet, verification of the provider/facility licensure status with the appropriate licensing board to assure providers/facilities license are current and there are no pending violations is conducted.
   Health Related Boards – http://www.tn.gov/health/health-program-areas/health-professional-boards.html
   Health Care Facilities - http://www.tn.gov/health/health-professionals/hcf-main.html

5. CSS Central Office administrative staff notifies the CSS Regional/Metro Coordinators when provider/facility has been entered into State payment system for CSS reimbursement and sends the letter of acceptance to health care provider or facility, and copies the CSS Regional/Metro Coordinator.

6. The Vendor Authorization and CSS Letter of Agreement shall be renewed every three years.

NOTE: If change of personal/company information occurs, a provider/facility representative must notify CSS Regional/Metro Coordinator and request the Change of Personal/Company Information Form. A new Vendor Authorization Form, CSS Letter of Agreement or State of Tennessee Supplier Direct Deposit Form may be required depending on the change reported. The complete change form must be submitted to CSS central office administrative staff for processing. (See Appendix 5).

Prior Authorization

The CSS Program has limited financial resources. Prior authorization of services allows the Program to ensure efficient utilization of these resources through appropriate planning and budgeting.

Medically necessary services/treatment or equipment that are directly related to the participant's eligible diagnosis(es) will be considered for CSS coverage. To ensure there is adequate documentation of medical necessity and that participants receive the most appropriate services/equipment prior authorization is required. It is the responsibility of the provider to obtain prior authorization. The CSS program will not be responsible for payment of services/treatment or equipment when the provider fails to complete the CSS prior authorization process.

Prior authorization must be obtained through the CSS Regional/Metro Medical Services Lead and must be requested in writing on the CSS Treatment Plan (See Appendix 6 – CSS Program Treatment Plan Request) and include a detailed description of the service/treatment or equipment being requested, including justification of medical necessity, any consultations required, potential problems if the service/treatment or equipment is delayed, and an itemized statement of the charges including the Current Procedural Terminology (CPT) codes or the Healthcare Common Procedure Coding System (HCPCS) codes.

Requests for prior authorization must be submitted **at least two (2) weeks prior** to the anticipated date of service. Verification of prior authorization must be obtained by the provider prior to the date of service in order for CSS to consider reimbursement.

NOTE: In case of an emergency admission or services/treatment, the Regional/Metro Medical Services Lead must receive notification of ER visit **within 48 hours of admission**.

Additional Provider Responsibilities

- CSS Program participants are issued an eligibility identification card and are instructed to present this card to providers before the provision of service/treatment. It is the provider's responsibility to obtain a copy of this identification card from the participant. (See Appendix 7– CSS Program Identification Card)
- The provider should consult with the participant's Regional/Metro Medical Services Lead at the number listed on the back of the identification card to verify participant eligibility and to obtain prior authorization for services/treatment and equipment when required.
- It is the responsibility of the provider to obtain prior authorization of services from the CSS Program. The CSS Program will not be responsible for services/treatment or equipment reimbursement when the provider fails to complete the CSS prior authorization process.

BILLING AND CLAIMS PROCEDURES

The CSS Program billing and claims guidelines must be followed in order for services to be considered for payment. Billing guidelines include but are not limited to:

- Participant must be actively enrolled in the CSS Program on the date of service.
- Provider must be an approved CSS Program Vendor/Supplier on the date of service.
- The CSS Program **must** receive provider claims within ninety (90) calendar days of the date of service or within ninety (90) calendar days of the Explanation of Benefits (EOB)/Remittance Advice (RA) process date within **twelve (12) months** from the date of service.
- No claims will be considered for payment if received **twelve (12) months** following the date of service.
- Claims must include required documentation for reimbursement, i.e., medical records, EOB, RA, and/or denial from private insurance, or TennCare, Health Insurance Claim Forms, CMS 1500 or UB-04, National Drug Code (NDC) name of medication, dosing, etc.
- CSS will only reimburse up to the allowable amount according to the current Delegated Authority (DA) contract.
- Treatment, service and equipment require prior authorization which must be obtained prior to the delivery. (See Appendix 6 – CSS Program Treatment Plan Request)
- Treatment and services must be medically necessary and directly related to the participant's CSS eligible diagnosis(es).
- Participants with private insurance or TennCare must utilize in-network providers who must also be authorized CSS Program vendor/supplier for reimbursement purposes.
- For participants with other insurance payors, those resources will be exhausted before the CSS program considers payment.
- Except for applicable deductibles, co-insurance, and/or co-payment, no reimbursement shall be made for covered services rendered under these guidelines, unless available third party payors, such as TennCare or private insurance, have been exhausted.
- 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 the current Delegated Authority contract.
- The CSS Program is always payor of last resort and may only be billed after all third party sources have been exhausted.
- Claims are processed in order of date received by CSS regional/metro program staff.

REIMBURSEMENT

Reimbursement is determined by the annual CSS Delegated Authority (DA) contract. Monthly or annual reimbursement limits will be set by the CSS program and may change as necessary based on funding availability – For questions regarding current DA categorical limits, please contact the regional/metro Medical Services Lead.

- Additional and concurrent charges over and above the amount covered by third party payors, as provided in these guidelines, 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 or those with private insurance when the Usual and Customary Rate (UCR) has been met.
- Reimbursement for inpatient hospitalization and rehabilitation services shall be based on a per diem rate as negotiated between the Department and the facility.
- Reimbursement for pharmacy cost shall be based on The Department of Health's current average wholesale price for the National Drug Code (NDC) plus a $6.00 shipping and handling fee when mailed to the participant.
- For medical services, the required minimum reimbursement rate shall be updated annually to the equivalent of the prior year Medicare fee schedule for Tennessee multiplied by 75%.
- 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 Delegated Authority for the CSS program.
- Reimbursement for nutritional supplements, hearing aids, and hearing aid supplies shall be based on the annual Delegated Authority for the CSS Program.
- Non-hospital services for which there is no Medicare price shall be paid at 75% of the billed charges.
- CSS will not reimburse any claims received after **twelve (12) months** from date of covered service.
- Authorization of providers and vendors/suppliers for reimbursement shall be determined in accordance with the standards as designated in these guidelines and determined by the State of TN purchasing procedures.
- Billing procedures for hospitals, institutions, facilities, agencies, providers, vendors, or distinct parts thereof rendering care or medical services, treatment or equipment shall be determined by the Department in accordance with the Department of General Services Central Procurement Office purchasing and reimbursement guidelines.
- No CSS provider shall charge CSS clients more than is charged for private clients for equivalent accommodations and services.
- 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 of the provider and family to follow their requirements.
- CSS retains the right to deny payment when a participant becomes ineligible for coverage.
- CSS will not reimburse for services provided by a non-authorized vendor.

TennCare Payments and Reimbursements

- The TennCare/MCO contract, private insurance and marketplace insurance contracts with providers state that the provider will accept the rate paid by that particular entity for authorized services.
- At no time will CSS pay more to a provider than what TennCare/MCO, private or marketplace insurance carriers have already paid to the provider for a particular service excluding co-pays, deductibles, and co-insurance.

Co-pays, Deductibles, and Co-Insurance

- CSS may pay the participating provider for any co-pays, deductibles, and co-insurance charges related to the CSS eligible diagnosis(es).
- Co-pays, deductibles, and co-insurance will be paid according to the current Delegated Authority (DA) for current reimbursement rate in effect at the time of service delivery.
- Other than co-pays, deductibles, or co-insurance, at no time will CSS pay more to a provider than what the private insurance or TennCare has already paid based on the contractual agreement between the provider and the insurance carrier.

Overpayments/Refunds

If a provider submits a claim that results in an overpayment or receives payment from another third-party source, after a claim has been reimbursed by CSS, it is the responsibility of the provider to notify CSS. The provider shall submit a refund to CSS immediately and include:

- Participant Name/ID Number
- Date of Service
- Invoice Date and Invoice Number
- EOB/RA when applicable; and
- Explanation for the refund

Refunds shall be made to Tennessee Department of Health, Children's Special Services Program and mailed to 710 James Robertson Parkway, 8th Floor Andrew Johnson Towers, Nashville, TN 37243

ELIGIBLE DIAGNOSIS(ES)

Diagnostic Criteria for CSS

- Diagnosis will be in accordance with the definition of a child with a physical disability as defined in CSS Rule 1200-11-3-.02 (04). A list of acceptable diagnoses is included.

- The following diagnoses will not be covered:
  - Autism
  - Mental, emotional and behavioral disorders, intellectual or developmental disabilities and learning disabilities

- 90 Day Temporary Diagnostic Eligibility and Certification:

    - If a child is suspected to have a CSS approved diagnosis, a CSS application must be completed, AND if a diagnostic evaluation is needed to determine a CSS eligible diagnosis a ninety (90) day temporary certification period, called Temporary Diagnostic Eligibility may be approved.

    - This temporary certification will be used for diagnostic evaluations and assessments only and will not include treatment for the qualifying condition, unless deemed medically emergent. <u>All conditions for eligibility must be met prior to the provision of treatment.</u>

Qualifying Medical Diagnoses may include, but are not limited to:

1. **Cardiology**
   Aneurysm
   Aortic Stenosis or Insufficiency
   Asplenia
   Arrhythmia
   Arrhythmia requiring drug therapy or pacemaker
   Atrial Septal Defect
   AV Fistula
   Cardiomyopathies
   Coarctation of the Aorta
   Congestive Heart Failure
   Congenital Heart Disease
   Congenitally Corrected Transposition
   Complicated Congenital Defects
   Double Outlet Right Ventricle
   Ebstein's Anomaly
   Eisenmenger's Syndrome
   Endocardial Cushion Defect
   Hypoplastic left ventricle
   Hypertension
   Interrupted Aortic Arch
   Mitral Stenosis, Atresia or Insufficiency
   Myocarditis
   Patent Ductus Arteriosus
   Pulmonary Atresia
   Pulmonary Insufficiency
   Pulmonary Stenosis
   Renal Artery Stenosis
   Rheumatic Fever
   Rheumatic Heart Disease
   Single Ventricle and Common AV Valve
   Tetralogy of Fallot
   Transposition of Great Arteries
   Tricuspid Atresia
   Truncus Arteriosus
   Total Anomalous Pulmonary Venous Connection
   Vascular Ring/Slings
   Ventricular Septal Defect

2. **Collagen-Vascular**
   Ankylosing Spondylitis
   Dermatomyositis
   Eczema (chronic)
   Systemic Lupus Erythematosus
   Polyarteritis Arthritis
   Polyarteritis Nodosa
   Psoriatic Arthritis
   Rheumatoid Arthritis
   Scleroderma
   Takayasu Arteritis

3. **Dermatology**
   Eczema
   Giant Melanocytic Nevus
   Melanoma
   Psoriasis

4. **Digestive Disorders/Gastroenterology**
   Anorectal Atresia
   Celiac Disease [1]

[1] Celiac diagnosis must be confirmed by a gastroenterologist or metabolic genetic physician.

Congenital Lactase Deficiency[2]
Crohn's Disease
Chronic Multiple Stage Obstructive Condition
Chronic Pancreatitis
Cystic Fibrosis
Diaphragmatic Hernias
Eosinophillic Esophagitis
Esophageal Atresias
Gastroesophageal Reflux
Glycogen Storage Disease
Hepatic conditions
Hirschsprung's Disease
Inguinal Hernia
Intestinal Obstruction
Juvenile Polyposis
Lactose Malabsorption[3]
Necrotizing Enterocolitis
Obesity
Omphalocele and Gastroschisis
Irritable Bowel Syndrome
Short Bowel Syndrome
Tracheoesophageal Fistula
Ulcerative Colitis
Wilson Disease

5. Endocrinology/Genetic

Addison's Disease
Chromosomal disorders
Congenital Adrenal Hyperplasia (CAH)
Cystic Fibrosis
Diabetes Mellitus
Dubowitz Syndrome
Failure to Thrive [4]
Galactosemia
Genetic and metabolic Inborn Errors of Metabolism
Graves Disease
Growth Hormone Deficiency [5]
Hashimoto's Thyroiditis
Hyperthyroidism
Hypopituitary Dysfunction
Hypothyroidism
Hypocorticalism
Hypogonadism
Metabolic disorders of amino acids
Phenylketonuria (PKU)
Pheochromocytoma
Obesity

6. Genito-Urinary

Acute Renal Failure
Ambiguous Genitalia
Cystic/Dysplastic Kidney
Ectopic Ureter
Epispadias
Epispadias-extrophy
Hypospadias
Neurogenic bladder
Obstructive Myopathy (variable severity)
Reflux-more severe conditions (i.e. posterior ureteral valves etc.)
Posterior Urethral Valves – mild
Recurrent Urinary Tract Infections
Undescended Testicle
Ureteropelvic Junction Obstruction
Ureteroceles
Urethral Stricture
Vesicoureteral Reflux

7. Hematology-Oncology

Benign Tumors, Hemangiomas, Lymphangiomas, and Neurofibromas
Brain Tumors
Ewing's Sarcoma
Hemoglobinopathies (SC - SS etc.)
Hemophilia
Histiocytosis-X
Hodgkin's Disease
Idiopathic Thrombocytopenic Purpura

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[2] Congenital Lactase Deficiency must be confirmed by a gastroenterologist using a test of absorption or malabsorption

[3] Lactose Malabsorption must be confirmed by a gastroenterologist using a test of absorption or malabsorption

[4] Weight below the 2nd percentile for gestation-corrected age and sex on more than one occasion, weight less than 80 percent of ideal weight for age, a rate of weight change that causes a decrease of two or more major percentile lines (90th, 75th, 50th, 25th, 10th, and 5th) over time (e.g., from 75th to 25th). The CSS nutritional policy should be followed in providing nutritional supplements

[5] Growth hormone deficiency must be confirmed by an endocrinologist. Growth hormone replacement therapy (medication) is only approved for a maximum of six (6) months. A redetermination will be made at the end of the initial 6 month period following receipt of medical records.

Lymphocytic Leukemia
Myelocytic Leukemia
Neuroblastoma
Non-Hodgkin's Lymphoma
Osteogenic Sarcoma
Retinoblastoma
Rhabdomyosarcoma
Thalassemia Major
Von Willebrand Disease
Wilms' Tumor

8. Infectious Disease

HIV/AIDS[6]
Tuberculosis
Lyme Disease

9. Immunology

Immunologic Deficiency Disorder
Raynaud Phenomenon
Rheumatic Fever

10. Neurology and Neurosurgery

Acquired or late onset Hydrocephalus (Aqueductal stenosis, etc.)
Aneurysms
Arachnoidal Cysts
Arnold-Chiari Malformation
Arteriovenous Malformations
Brain Abscess
Cervical Fracture with quadriplegia without respiratory disability
Cervical fracture with complete quadriplegia with respiratory disability
Congenital Diplegia
Congenital Hydrocephalus
Congenital Quadriplegia
Craniofacial Reconstruction
Craniosynostosis
Depressed Skull Fracture
Dermal Sinus - spinal or cranial
Diastematomyelia
Distal peripheral nerve injuries
Encephalocele
Extensive head injuries
Extensive deep arteriovenous malformations
Guillain-Barre Syndrome
High level or extensive Peripheral Nerve Injuries
Hydranencephaly
Intracranial Neoplasm
Intraspinal Neoplasm
Intracranial Tumor (benign or malignant)
Intraspinal Tumor (benign or malignant)
Malignant Intracranial Neoplasm-repeat resection
Malignant Intraspinal Neoplasm-repeat resection
Meningocele with full skin cover and no neuro deficit
Meningomyelocele (High and Low level)
Myasthenia Gravis
Plagiocephaly (excluding cranial shaping for positional head deformities)
Reye's Syndrome
Ruptured Disc
Seizure Disorders
Skull Lesions
Spina Bifida
Subdural Hematoma
Syringomyelia
Tethered Cord Syndrome (tight filum)
Thoracolumbar spinal fracture with paraplegia

11. Neuromuscular Diseases

Familial dysautonomia
Glycogenesis II, V, VII, IX, X, or XI
Mitochondrial myopathy
Motor-sensory neuropathy
Muscle carnitine deficiency
Muscle carnitine palmityltransferase deficiency
Muscular dystrophies

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[6] The Following criteria must be met for CSS Medical Services for Children diagnosed with HIV or AIDS.

1. Children who become HIV Positive or who have AIDS as a result of a contaminated blood transfusion associated with treatment for hemophilia must apply for the Department of Health, Bureau of Health Services, Hemophilia Program before being placed on CSS.
2. Children must apply for the Department of Health, HIV Drug Assistance Program (HDAP).
3. Children must apply for the Department of Health Ryan White Program.

Myotonia congenita
Myotubular myopathy
Nemaline rod myopathy
Paramytonia congenita
Periodic paralysis
Spinal muscular atrophy

12. Opthalmologic

Amblyopia
Anismetropia (> 1.5 D)
Astigmatism (> 1.5 D)
Hypermetropia (> +3.5 D)
Myopia (> 2.0 D)
Aniridia
Congenital cataract
Esotropia
Eye injuries
Herpes Simplex Eye Disease
Nystagmus
Pediatric Cataract
Pediatric Glaucoma
Ptosis
Retinopathy of Prematurity
Strabismus
Esotropia
Exotropia
Hypertropia

13. Oral Surgery/Orthodontic Conditions

Benign tumors and cysts of jaws
Crainiofacial anomalies
Cleft lip and/or palate
Pierre Robin anomaly: hypoplasia of the mandible, glossoptosis cleft palate
Treacher Collins Syndrome: mandibular facial dystosis
Apert's Craniofacial Synostosis
Goldenhar Syndrome
Growth deformity of jaws
Pain and dysfunction of the temporomandibular joint secondary to internal derangement
(refer also to Section 16 Plastic**)**

14. Orthopedic

Amputees, congenital or acquired
Angular or torsional deformity of extremities
Arthrogryposis
Benign Bone Tumors – bone cysts; histiocytosis-X, osteochondroma, etc
Blount's Disease
Cerebral Palsy
Impending or painful hip dislocation
Club foot
Complications of fractures; infections, non-union, avascular necrosis
Congenital dislocation of hip or knee
Diagnostic workup (e.g., limping child; painful joints, etc.)
Epiphyseal Injury
Foot deformities (matatarsus varus, calcaneo-valgus)
Leg length problems
Legg-Perthes Disease (Surgical Treatment)
Myelodysplasia
Neurofibromatosis
Osteochondroses, including Legg-Perthes
Osgood Schlatters, etc.
Osteomyelitis
Pyoarthrosis
Rheumatoid and other arthritis
Scoliosis
Slipped Capital Femoral Epiphysis
Spinal fracture
Syndactylism, Polydactylism
Synovitis, non-specific
Tumors of bone or soft parts, malignant or benign

15. Otolaryngology

Acoustic Tumors
Aphasia
Conductive Hearing Loss of 25 dB or greater (not due to effusion)
Conductive Hearing Loss of 25 dB or greater (due to persistent middle ear effusion)
Congenital Malformation of external ear canal, middle ear or inner ear
Choanal Atresia, unilateral or bilateral
Chronic Sinusitis
Cholesteatoma
Chronic Mastoiditis
Dyspraxia limited to diagnosis and speech

therapy
Laryngeal Papillomatosis
Mastioditis
Meniere's Disease
Meningitis (residual effects)
Moderate to severe language or articulation disorder related to an eligible CSS diagnosis
limited to diagnosis and speech therapy
Motor speech disorder secondary to neuromuscular diseases related to an eligible CSS diagnosis limited to diagnosis
and speech therapy
Otitis Media
Otosclerosis
Perforated tympanic membranes
Sensorineural Hearing Loss
Severe sleep apnea or cor pulmonale due to
hypertrophy of tonsils or adenoids

16. Plastic

Burn reconstruction
Cleft Lip and/or Palate (including orthodontia, appropriate dental care, speech
and hearing therapy)
Congenital facial abnormalities
Congenital hand deformities
Congenital Nevi, extensive
Congenital Ptosis
Hemangiomas (non-cosmetic)
Malignant tumors with good prognosis
Microtia
Pressure ulcers
Trauma, lacerations, avulsions, etc.

17. Respiratory

Asthma
Bronchochiectasis
Bronchopulmonary Dysplasia (BPD)
Chronic Obstructive Pulmonary Disease
Congential Cystic Adenomatoid Malformation (CCAM)
Congenital Lobar Emphysema
Cystic Fibrosis
Malacia (Tracheomalacia,Tracheobronchomalacia, Bronchomalacia, etc.)

18. Syndrome(s)[7]

Achondroplasia syndrome
Andermann syndrome
Alport syndrome
Angelman syndrome
Apert syndrome
Bardet-Biedl syndrome
Beckwith-Wiedermann syndrome
Char syndrome
CHARGE syndrome
Cohen syndrome
Cri-du-chat syndrome
Crouzon syndrome
Cushing's syndrome
Dandy Walker syndrome
Denys-Drash syndrome
DiGeorge syndrome
Down syndrome
Duane syndrome
Dubowitz syndrome
Edwards syndrome
Ehlers Danlos syndrome
Fragile X syndrome
Goldenhar syndrome
Gorlin syndrome
Guillain-Barre' syndrome
Holt-Oram syndrome
Hunter syndrome
Hurler syndrome
Irritable bowel syndrome
Kallman syndrome
Kearns-Sayre syndrome
KID syndrome
Kippel-Trenaunay-Weber syndrome
Klinefelter syndrome
Marfan's syndrome
Meckel-Gruber syndrome
Noonan syndrome
Patau syndrome
Pendred syndrome
Perlman syndrome

[7] CSS will cover "syndromes" to the extent that there are associated physical diagnoses. In accordance with state rules and regulations, we cannot cover for developmental, behavioral, mental, or psychological conditions that may be associated with syndromes.

Pickwickian syndrome
Pierre-Robin syndrome
Prader- willi syndrome
Raynaud's syndrome
Rett syndrome
Reye's Syndrome
Serotonin syndrome
Short bowel syndrome
Sotos syndrome
Stickler syndrome
Tethered Cord syndrome
Tourette syndrome
Townes-Brocks syndrome
Treacher Collins syndrome
Turner syndrome
Usher syndrome
Van der Woude syndrome
WAGR syndrome
Weaver syndrome
Werner Syndrome
West syndrome
Williams Syndrome
Withdrawal Syndromes:

- Benzodiazepine Syndrome
- Fetal Alcohol Syndrome (FAS)
- Neonatal Nicotine Syndrome
- Wolf-Hirschhorn Syndrome
- Neonatal Abstinence Syndrome (NAS)[8]

[8] Two major types of neonatal abstinence syndrome are recognized: neonatal abstinence syndrome due to prenatal or maternal use of substances that result in withdrawal symptoms in the newborn and postnatal neonatal abstinence syndrome secondary to discontinuation of medications such as fentanyl or morphine used for pain therapy in the newborn.

CSS PROGRAM COVERED SERVICES

The following is a list of possible medical services that may be covered by the CSS program for children who meet the diagnostic and financial eligibility criteria for medical services. The list may not be all-inclusive, and the CSS Regional/Metro Medical Services Lead should request approval from the CSS Central Office Director for services not listed. All medical services, equipment and supplies must be ordered by the health care provider, i.e., primary care provider, specialty provider, or nurse practitioner, etc.

Purchase of all medical services listed below should be obtained through the child's insurance plan when possible. CSS may cover services for individuals with no insurance or a service that was denied by the insurance plan. Prior authorization should be obtained from CSS Regional/Metro Medical Services Lead. A copy of the written denial from the TennCare MCO, private insurance carrier, or the marketplace insurance carrier must be provided.

All services must be approved by the CSS Regional/Metro Medical Services Lead or State CSS Director/ Designee, as outlined in CSS Rules 1200-11-3-.04.

Services will be provided that are medically necessary and related to the child's CSS eligible diagnosis(es). See also Non-Covered Services.

Clients who have insurance, private or public should utilize primary and specialty providers in the network designated by their insurance plan. All providers requesting reimbursement for services rendered to CSS participants must be authorized with the CSS program and have a current signed Vendor Authorization and CSS Letter of Agreement**.**

1) **Durable Medical Equipment/Appliances**
    - Augmentative Communication Devices
    - Diabetic Monitoring Devices
    - Hearing Aids/Devices/Supplies
        - Children receiving hearing aids must have an ENT evaluation and clearance for hearing aid usage prior to the initial fitting. The evaluation should be within the prior six (6) months.
    - Orthotic equipment including Prosthesis
    - Respiratory Devices
    - Safety Equipment
    - Seating Devices
    - Vision Device

2) **Supplies**
    - Catheter Supplies
    - Dental
    - Disposable Diapers/Pads
        - pull-on diapers (children over three years old) number to be specified by physician
    - Syringes

- Tube Feeding
- Wound supplies/dressings

3) Special Foods, Formula and Nutritional Supplements

- **Special food** - Food(s) recommended by a health care provider, for consumption by a person suffering from a specific physical or physiological condition of disease or disorder.
  - Low protein food products have not been considered medically necessary by insurance companies and therefore have not been covered. The CSS program recognizes the need for participants to transition from strictly formula to low protein foods. Food cost may be prohibitive to some families. CSS will provide a limited amount of reimbursement per child for low protein foods. (Please see current DPA for limits.)
- **Formula** - Formula which has been specially processed or formulated to satisfy particular dietary requirements as a result of physical or physiological conditions of disease or disorder.
- **Nutritional supplement** - A product that is added to the diet. A nutritional supplement is taken by mouth, and usually contains one or more dietary ingredients (such as vitamin, mineral, herb, amino acid, or enzyme). Also called dietary supplement.
  - Nutritional supplement(s) approved by FDA for the purpose intended and prescribed by a health care provider **may** be authorized by the CSS Central Office Director/Designee on a case-by-case basis.

Note: Formulas, nutritional supplements and special foods must be FDA approved and prescribed for CSS eligible diagnosis.

4) Hospitalization

Hospitalization shall be provided only in Medicare certified hospitals and only those accredited by the Joint Commission on Accreditation of Hospitals, or as designated by the participant's managed care organization or insurance company, except in life threatening conditions.

- Overnight hospitalization shall occur when necessary as determined by the physician in charge of the child's treatment plan. The number of hospital days that the CSS program will reimburse for shall not exceed twenty (20) days per year.
- CSS enrolled children must be cared for by an approved CSS provider if reimbursement is requested (this includes the assigned TennCare MCO or private provider).
- All scheduled admissions for which CSS is to be the payor source must receive prior authorization by the CSS Regional/Metro Medical Services Lead and CSS Central Office Director.
- An Admitting Treatment Plan (See Appendix 6 – CSS Program Treatment Plan Request) and pertinent medical records if necessary, must be submitted to the CSS Regional/Metro Medical Services Lead and CSS Central Office Director at least fourteen (14) days prior to the date of admission for both outpatient and inpatient services, excluding life threatening emergencies.

- In the event of an emergency admission, CSS must receive the Admitting Treatment Plan and pertinent medical records within ten (10) calendar days of the admission.
- Outpatient services related to the CSS approved diagnosis will be covered at the current CSS approved reimbursement rate.
- Emergency Room visits will be covered only if they are related to the CSS approved diagnosis and notification is received by the regional/metro medical services lead within forty-eight (48) hours of admission.
- Anesthesia will be covered for CSS approved surgical procedures.

5) Outpatient Clinics and Physician Office Visits

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. In addition, CSS may reimburse for diagnostic evaluation or treatment services delivered in a public or private setting outside the hospital.

6) Dental/Orthodontic Intervention

(Limited to medical, surgical, and rehabilitative treatment for conditions related to an approved craniofacial diagnostic condition and to designated cardiac conditions.) In addition, CSS will pay for treatment for gum/dental conditions caused by medications (ex: Dilantin).

7) Rehabilitation

- Therapy (including evaluation and treatment)
  - nutritional counseling related to the medical diagnosis and medically necessary
  - occupational
  - physical
  - speech/language limited to diagnostic and speech therapy related to CSS eligible diagnoses
  - vision

- The location of therapy and funding source should be coordinated with insurance, school, client needs and other appropriate programs or agencies (Tennessee Early Intervention Services (TEIS), Traumatic Brain Injury (TBI) etc.). The location could be at the participant's school, in the home, at an outpatient clinic, at a day care facility, another special program or facility, or a rehabilitation facility.

8) Pharmacy

- Medications as prescribed by a health care provider, FDA approved and prescribed for the CSS eligible diagnosis(es).
- Formulations covered include:
  - liquid
  - tablet

- injectable
- oral
- topical
- intravenous
- inhalant
- other as indicated

- Over the counter medications approved by FDA for the purpose intended **may** be authorized by the Central Office CSS Director/Designee on a case by case basis.

9) Well Child Screening

A well child screening visit may be covered annually when no other payor source exists.

10) Out of State Coverage

- Only in cases of emergency or when the service is not available in the State of Tennessee
- The provider will notify CSS within 2 business days of the emergency in order for CSS to consider payment. CSS will not be responsible for out of state emergency care service when the two (2) business days' notification is not received.
- When service is not available in the State of Tennessee, the Regional/Metro CSS Medical Services Lead will coordinate the treatment including the prior authorization and reimbursement procedures.

NON-COVERED SERVICES

- Ambulance fees and transportation will not be covered except for emergency transportation from one hospital to another if related to the child's CSS eligible diagnosis.
- Dental treatment including orthodontia except in craniofacial malformations, cleft lip/palate conditions; gum/dental conditions caused by medication or designated cardiac conditions.
- Psychiatric treatment and psychological services for mental, emotional and behavioral disorders, developmental disabilities and learning disabilities.
- Alcohol and drug treatment, abuse and/or dependency services.
- Prescription drugs unless the drug is FDA approved and prescribed for the eligible diagnosis.
- Over the counter drugs or supplements shall not be covered unless FDA approved, prescribed by a health care provider for a CSS eligible diagnosis and approved by the CSS Central Office Director/Designee on a case by case basis.
- Participants who enter a correctional facility, a mental health facility or a nursing home will no longer be considered eligible for CSS. If a child is placed in a group home where the parent continues to manage the client's medical care of the CSS covered diagnosis, the child is not excluded from CSS.
- Health care services defined as routine medical treatment, medical care of acute childhood illnesses (defined as diseases which are normally not physically disabling and which are not unusual in the course of a child's maturation) or trauma or short-term complications related thereto, are not covered.

APPEAL PROCESS

CSS Program enrolled providers may appeal decisions regarding denial of services or payment for services.

To appeal a decision made by the CSS Program, the provider must submit the following documentation to the State CSS Director within thirty (30) calendar days of the CSS denial date.

- A letter describing the reason for the appeal;
- Documentation to support overturning the denial; and
- A copy of the claim being appealed.

The CSS Director will review the documentation and render a written decision to the provider within (thirty) 30 business days of the receipt of the appeal.

If the decision is unsatisfactory, the provider may submit a second appeal letter addressed to the CYSHCN Section Chief. The appeal and supporting documentation must be received by the Section Chief within thirty (30) calendar days of the CSS Director's written decision date. The CYSHCN Section Chief will review the documentation and render a written decision to the provider within thirty (30) business days of the receipt of the appeal.

A final decision based on the evidence and documentation submitted with the appeal will be rendered. A letter outlining that decision will be mailed to the provider within thirty (30) business days of the receipt of the appeal.

All appeals should be addressed to the Children's Special Services Program Director, 710 James Robertson Parkway, 8th Floor Andrew Johnson Tower, Nashville, Tennessee 37243.

ADDITIONAL INFORMATION

For additional information, please contact the CSS Program Director at 615 532-3755 or the Regional/Metro CSS Medical Services Lead located in Appendix 8.

Tennessee Code Annotated – Chapter 12, Treatment of Disabled Children §68-12-101-112 http://www.lexisnexis.com

Rules of Tennessee Department of Health Bureau of Health Services – Chapter 1200-11-3 Children's Special Services http://tennessee.gov/sos/rules/1200/1200-11/1200-11-03.pdf

Appendices

Appendix 1 Tennessee Children's Special Services Program Letter of Agreement

TENNESSEE CHILDREN'S SPECIAL SERVICES (CSS) PROGRAM

LETTER OF AGREEMENT

(July 2021)

I, _____, representing
(Print Full Name)

_____
(Print Name of Business)

I would like to serve as a Provider for the Children's Special Services Program. Pursuant to program guidelines, I agree to provide the agreed services for eligible participants and abide by the following conditions as applicable:

- Requests for services shall be submitted to the CSS Regional/Metro Coordinator for prior approval or authorization.

- All medical/diagnostic reports shall be sent to the designated CSS Regional/Metro Coordinator.

- Providers shall provide proof of licensure, certification, and/or accreditation if applicable.

- Providers shall agree to accept the reimbursement rates for CPT codes used by the CSS program.

- Providers shall agree to acceptance of payments as listed in the CSS fee schedule and may seek outstanding payment(s) from CSS enrollee if the service(s) are not covered by CSS or other third-party payor sources.

- The requested service or procedure must be related to the CSS eligible diagnosis and must be medically necessary.

- Providers shall submit a treatment plan to the CSS Regional/Metro Coordinator.

  - The admitting treatment plan shall include the following:
  - Diagnosis for which the service or procedure is requested.
  - Diagnostic or surgical procedure with the appropriate CPT codes.
  - Any appliances or equipment for which there will be an additional charge.
  - Anticipated length of stay.
  - Estimated Cost.

- Providers shall provide written notification to the CSS Regional/Metro Coordinator of a change in physical or billing address within thirty (30) days. In addition, any changes in Tax ID will be submitted to the CSS Central Office within thirty (30) days.

- Providers in the CSS provider network who provide service to CSS eligible participants may not submit to the family concurrent charges over and above the amount reimbursed by third party payers and/or the CSS program. This does not preclude a family or other party from making a contribution towards the care of the child when they are willing and able, but such contribution shall not be solicited or accepted from the family of a child on TennCare for services covered in whole or in part by TennCare or other state insurance plans.

Page 2 Letter of Agreement

I fully understand and agree with all conditions evidenced by the information provided below:

Provider (Taxpayer Name): _____

Tax ID#: _____

Physical Address: _____
(Actual physical address of business)

Phone: (_____) _____

Fax: (_____) _____

Email: _____

License Information
Have you ever been convicted of a felony? _____ Yes _____ No (If yes, please explain below):

_____

Have you ever been investigated by any regulatory authority or subjected to disciplinary action by any agency or hospital? _____ Yes _____ No (If yes, please explain below):

_____

_____ (Check to confirm document is attached) Copy of the State License for Facility and/or Health Care Provider is attached.

Release Statement:
I certify that the information I am providing in this Letter of Agreement is correct and complete to the best of my knowledge. I hereby give permission to the Tennessee Department of Health to request and obtain references or reports of any information from present or previously affiliated individuals or institutions, if needed, in considering my application as a service provider to the Children's Special Services Program. I hereby release any previously affiliated individual or institution from liability in providing information needed by the Tennessee Department of Health for the purpose of considering this application.

Signature: _____

Name: (printed) _____

Title: _____

Date: _____

Remittance Address (Address for payment if different from business address):

_____

_____

_____

Appendix 2 Tennessee Children's Special Services Program Vendor Authorization

TENNESSEE DEPARTMENT OF HEALTH
VENDOR AUTHORIZATION FORM

AUTHORIZATION PERIOD	
Begin:	**End:**

STATE INFORMATION			
Program:	**Children's Special Services (CSS)**		
Program Contact:	**Kathy Robinson - Program Director, Children's Special Services**		
Edison Record #	**53207**	**Edison PO #**	
Delegation #	**DA1853207**	**Account Code: 70804000**	**Speed Code: HL00011979**
CFDA #	**93.994**		

VENDOR INFORMATION	
Vendor:	
Address:	
Phone:	
Edison Vendor ID:	**FEIN/SSN** (optional)**:**

AUTHORIZATION/REIMBURSEMENT DETAIL

Service Authorized	Units Authorized	Unit Cost	Amount Authorized
Medical and Ancillary Services to participants in the Children's Special Services Program			
		TOTAL AMOUNT AUTHORIZED :	

NOTICE: VENDOR AUTHORIZATION TERMS AND CONDITIONS ARE ATTACHED

AUTHORIZATION & ACCEPTANCE	
State Authorization: (signature required)	**Vendor Acceptance:** (signature required)
Printed name and title: Kathy Robinson, Program Director Children's Special Services	**Printed name and title:**

Terms and Conditions

A. Standard Terms and Conditions

1. Total Authorized Amount. In no event shall the liability of the State under this Authorization exceed the "Total Amount Authorized" as indicated on this Vendor Authorization Form.

2. Inspection and Acceptance. The State shall have the right to inspect all goods or services provided by Vendor under this Authorization. If upon inspection, the State determines that the goods or services are defective, the State shall notify Vendor, and Vendor shall re-deliver the goods or provide the services at no additional cost to the State. If after a period of thirty (30) days following delivery of goods or performance of services the State does not provide a notice of any defects, the goods or services shall be deemed to have been accepted by the State.

3. Modification, Amendment or Change Order. This Authorization may be modified only by a written amendment or change order signed by the State and the Vendor.

4. Limitation of Liability. The State shall have no liability except as specifically provided in this Authorization. In no event shall the State be liable to the Vendor or any other party for any lost revenues, lost profits, loss of business, decrease in the value of any securities or cash position, time, money, goodwill, or any indirect, special, incidental, punitive, exemplary or consequential damages of any nature, whether based on warranty, contract, statute, regulation, tort (including but not limited to negligence), or any other legal theory that may arise. The State's total liability under this Authorization or otherwise shall under no circumstances exceed the Total Authorization Amount.

5. Limitation of Vendor's Liability. The Vendor's liability for all claims arising under this Authorization shall be limited to an amount equal to two (2) times the Total Authorization Amount. In no event shall this Section limit the Vendor's liability for intentional torts, criminal acts, fraudulent conduct, or omissions that result in personal injuries or death.

6. Termination for Convenience. The State shall have the right to immediately terminate this Authorization, without cause and for any reason, upon written notice to the Vendor, delivered by mail or electronic means. The State's notice of termination is effective upon the State's issuance.

7. Subject to Funds Availability. The State's payment of the Purchase Order generated from this Authorization is subject to the appropriation and availability of State or federal funds. In the event that funds are not appropriated or are otherwise unavailable, the State reserves the right to terminate this Authorization, effective immediately, upon written notice to the Vendor. If the State terminates this Authorization due to lack of funds availability, the Vendor shall be entitled to compensation for all conforming goods requested and accepted by the State and for all satisfactory and authorized services completed as of the termination date.

8. Payment of Purchase Order. A payment by the State shall not prejudice the State's right to object to or question any payment, invoice, or other matter. A payment by the State shall not be construed as acceptance of goods delivered, any part of the services provided, or as approval of any amount invoiced.

9. Deductions. The State reserves the right to deduct from amounts, which are or shall become due and payable to the Vendor, under any contract between the Vendor and the State.

10. Hold Harmless. The Vendor agrees to indemnify and hold harmless the State of Tennessee as well as its officers, agents, and employees from and against any and all claims, liabilities, losses, and causes of action which may arise, accrue, or result to any person, firm, corporation, or other entity which may be injured or damaged as a result of acts, omission, or negligence on the part of the Vendor, its employees, or any other person acting for or on its or their behalf relating to this Authorization. The Vendor further agrees it shall be liable for the reasonable costs of attorneys for the State to enforce the terms of this Authorization.

    In the event of any suit or claim, the State and Vendor shall give each other immediate notice and provide all necessary assistance to respond. The State's failure to give notice shall only relieve the Vendor of its obligations under this Section to the extent that the Vendor can demonstrate actual prejudice arising from the failure to give notice. This Section shall not grant the Vendor, through its attorneys, the right to represent the State in any legal matter, as the right to represent the State is governed by Tenn. Code Ann. § 8-6-106.

    Note- "Hold Harmless" clause is not subject to other governmental entities.

11. State and Federal Compliance. The Vendor shall comply with all applicable state and federal laws and regulations in the provision of goods or services under this Authorization.

12. Governing Law. This Authorization shall be governed by and construed in accordance with the laws of the State of Tennessee. The Tennessee Claims Commission or the state or federal courts in Tennessee shall be the venue for all claims, disputes, or disagreements arising under this Authorization. The Vendor acknowledges and agrees that any rights, claims, or remedies against the State of Tennessee or its employees arising under this Authorization shall be subject to and limited to those rights and remedies available under Tenn. Code Ann. §§ 9-8-101 through 9-8-407.

13. Entire Agreement. This Authorization contains the entire understanding between the State and the Vendor relating to its subject matter, including all terms and conditions of the parties' agreement. This Authorization supersedes any and all prior understandings, representations, negotiations, and agreements between the State and the Vendor, whether written or oral.

B. Special Terms and Conditions

1. Conflicting Terms and Conditions. Should any of these Special Terms and Conditions in Section B conflict with the Standard Terms and Conditions in Section A, the Standard Terms and Conditions shall control.

Appendix 3 W-9

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▸ **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▸ _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▸

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any)

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–			–			

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here **Signature of U.S. person** ▸ **Date** ▸

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

Appendix 4 State of Tennessee Supplier Direct Deposit Authorization Form

STATE OF TENNESSEE
DEPARTMENT OF FINANCE & ADMINISTRATION
SUPPLIER DIRECT DEPOSIT AUTHORIZATION
(NOT WIRE TRANSFERS)

Mail the **ORIGINAL** form to the address below **DIRECTLY** from your financial institution. Please have them mark the outside of the envelope "**CONFIDENTIAL**".

State of Tennessee
Attn: Supplier Maintenance
21st Floor WRS Tennessee Tower
312 Rosa L Parks Ave
Nashville, TN 37243

SECTION 1: TYPE OF REQUEST

☐ New
☐ Change Existing Account: Enter Existing Routing No: _____ Existing Account No: _____

SECTION 2: ACCOUNT HOLDER INFORMATION

Name (as shown on your income tax return): _____

Business Name, if different from above: _____

Federal Employer Identification Number (FEIN): _____ or Social Security Number (SSN): _____

Enter the address that should be associated with the account number::

Address Line 1: _____

Address Line 2: _____

City: _____ State: _____ Zip Code: _____

Contact Name: _____ Telephone: _____

Enter the email address to which the remittance advices should be routed:

Email: _____

SECTION 3: AUTHORIZATION

Are payments deposited into this account subject to being transferred, in its entirety, to a financial institution outside of the United States? Yes ◯ No ◯

Account Type: Checking ◯ Savings ◯

Financial Institution Name: _____

Routing Number: _____ Account Number: _____

I authorize my financial institution to verify any information provided on this form with the State of Tennessee. I also authorize the state to initiate credit entries and to initiate if necessary, debit entries and adjustments for any credit entries in error, to my account indicated above. This authorization will remain in effect until the state has received written notification of its termination and has adequate time to act upon the request.

Authorized Signatory Printed Name: _____

Authorized Signature: _____ Date: _____

SECTION 4: FINANCIAL INSTITUTION VERIFICATION

I certify the account and routing numbers in Section 3 are for the above specified account holder and is signed by an authorized signatory on the account.

Representative Name: _____ Representative Signature: _____

Title of Representative: _____ Date: _____

Business Fax Number: _____ Business Phone Number: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

FA-0825 (Rev. 2/18) RDA SW20

Appendix 5 Change of Personal/Company Information Form

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
ANDREW JOHNSON TOWER
710 JAMES ROBERTSON PARKWAY
NASHVILLE, TENNESSEE 37247

CHANGE OF PERSONAL/COMPANY INFORMATION FORM

SSAN#:_____Or FEIN#: _____

Important- Please check one to specify whether you are:

☐ a new vendor ☐ changing information ☐ adding another location, same tax identification number

Name: _____
(list only the name associated with the tax id number)
Mailing Address: _____
Mailing Address: _____
City, State and Zip Code: ____
Phone Number: _____

Effective Date for this change: ____

Name: _____
(printed name of authorized representative)
Title: _____
(if applicable)

Prior information that is or may be on our current files. *
Name: _____
(list only the name associated with the tax id number)
Mailing Address: _____
Mailing Address: _____
City, State and Zip Code: ____
Phone Number: _____

Are you a TN state employee? Yes ☐ No ☐ If no, are you a former TN state employee?
Yes ☐ No ☐ If yes, please indicate separation date _____

I,_____, verify the above information is complete and true.
(Signature of Vendor)

This information has been verified by Department Staff of _____

_____ , _____
(Signature of Staff) (Position)

Date: _____

*Old information is not needed if this is to add an additional location. Only lines that are to be changed need to be filled out. Example: To change PO Box at same office, completely fill out new address and list old PO Box number on Mailing address line. Please contact Ruma Purkayastha at (615) 253-3987, if you have any questions.

APPENDIX 6 TREATMENT PLAN REQUEST

CSS Sample Treatment Plan Request

STATE OF TENNESSE
DEPARTMENT OF HEALTH
CHILDREN'S SPECIAL SERVICES

Treatment Plan

Name: _____ Date of Birth: _____

Address: _____ Social Security # _____

City:_____ Insurance Policy ID # _____

County: _____ Hospital:_____

Admission Date: _____ Estimated Length of Stay: _____

Primary Diagnosis: _____

Chief Complaint:_____

Pertinent History: _____

_____

Diagnostic Procedures Anticipated_____

Surgical Procedures Anticipated: _____

Consultations Expected: _____

Please explain why, in your opinion, postponement of this admission would result in permanent disability or a threat to this child's life._____

_____

Provider's Name:_____

Please print or type

Provider's Signature:_____ Date:_____

Provider's Phone Number: _____Provider's Fax Number: _____

Return to: _____

Regional/Metro Coordinator's Name

Address: _____City, State, Zip:_____

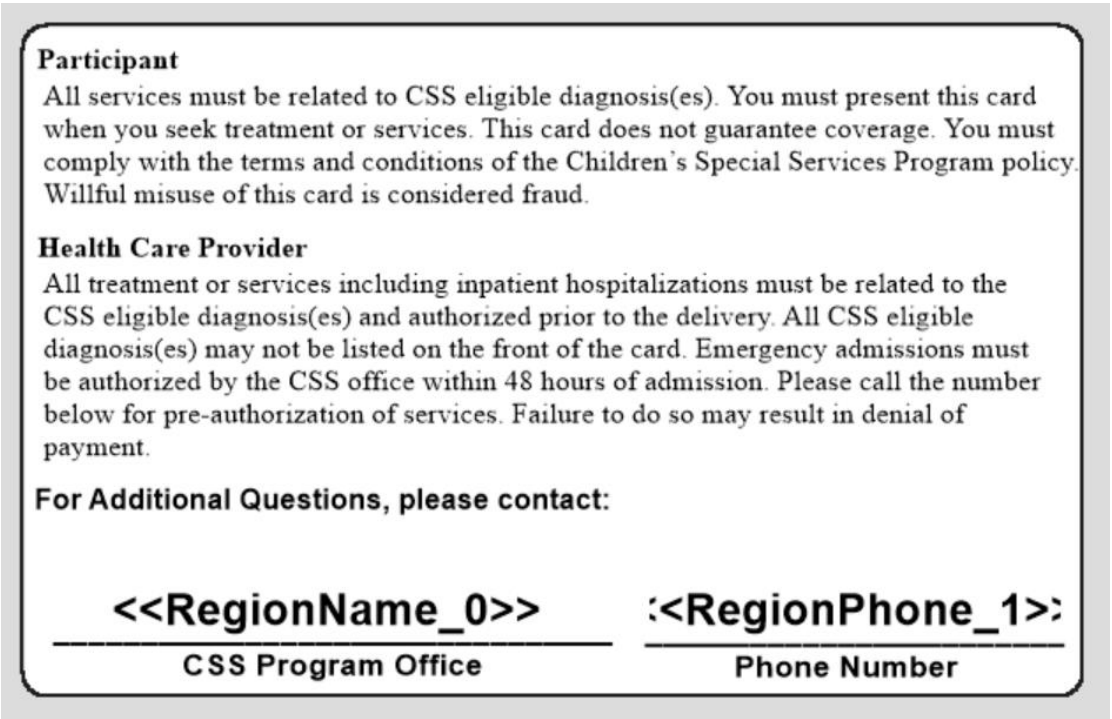
Phone: _____Fax: _____

APPENDIX 7 CSS IDENTIFICATION CARD

CSS Identification Card

Front of Card

Back of Card



APPENDIX 8 REGIONAL/METRO CHANT MEDICAL LEADS

METRO MEDICAL LEADS

County	Name	Phone	Fax	Email
DAVIDSON	NAKISHUA GAULDIN	615-340-8533	615-340-7789	Nakishua.Gauldin@nashville.gov
HAMILTON	GRETCHEN MILLER	423-209-8162	423-209-8156	gretchenm@hamiltontn.gov
MADISON	TANIKA PROWELL	731-423-3020	731-927-8601	tprowell@madisoncountytn.gov
SHELBY	ANA JANECEK	901-222-9709	901-222-7976	Ana.Janecek@shelbycountytn.gov
SULLIVAN	TRACY DAYTON	423-279-2662	423-279-7594	tdayton@sullivanhealth.org
KNOX	ANGELA STAFFORD	865-215-5192	865-215-5199	angela.stafford@knoxcounty.org

REGIONAL MEDICAL LEADS

EAST TN	JULIANNE ALLEN	865-549-5262	865-594-4898	Julianne.Allen@tn.gov
MID-CUMBERLAND	KIM SHAW	615-650-7015	615-253-3178	kim.shaw@tn.gov
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CYSHCN- https://www.tn.gov/health/health-program-areas/mch-cyshcn.html
CHANT- https://www.tn.gov/health/health-program-areas/fhw/early-childhood-program/chant.html

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