

**EPSDT – TARGETED POPULATION
SUPPORT COORDINATION
TRAINING HANDBOOK
2014**

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How to Locate Medicaid Services & Medical Equipment for the Home

HOW CAN MEDICAID HELP YOU?

PERSONAL CARE SERVICES

Personal care services (PCS) are provided by a trained worker. They may be needed if your child has a disability, illness, or injury and needs help with things like eating, bathing, dressing or grooming. PCS **does not include** medical or nursing tasks, like giving medicine, tube feeding, or suctioning. PCS **is not a substitute** for child care. If the child is 14 years of age or younger, an adult caregiver must be in the home while the PCS worker is there.

A physician must order this service. Personal Care Services must be prior authorized.

EXTENDED HOME HEALTH

Extended Home Health is home nursing care for people who need more skilled care than PCS. Home Health agencies can also provide physical, occupational and speech therapy in the home if this is medically necessary. There is no fixed limit on how many nurse visits or how long the nurse can be in the home for people under age 21.

A physician must order this service. Extended Home Health Services must be prior authorized.

MEDICAL EQUIPMENT AND SUPPLIES

Children are entitled to medical supplies and equipment needed to help with physical or mental conditions. This includes lifts, wheelchairs, and other devices to help the family deal with a child's circumstances. It also includes necessary dietary or nutritional assistance, and diapers or pull-ups if they are needed because of a medical problem.

Medical Equipment and Supplies must be prescribed by a physician and prior authorized.

Behavior analysis is based on a scientific study of how people learn. By doing research, techniques have been developed that increase useful behavior and reduce harmful behavior. Applied behavior analysis (ABA) therapy uses these techniques. ABA has been found helpful in treating autism spectrum disorders. For more information about ABA therapy call **1-844-423-4762**.

ABA-based therapies must be prior authorized and administered by a licensed behavior analyst.

CUSTOMER SERVICE INFORMATION FOR MEDICAID INQUIRIES:

If you are unable to locate an Extended Home Health provider or a Personal Care Services (PCS) provider, or if you have an authorization for services but are not receiving them, please call toll-free **1-888-758-2220**.

Specialty Care Help Desk • 1-877-455-9955.

Medicaid Eligibility Hotline • 1-888-342-6207.

Medicaid Services Chart

http://new.dhh.louisiana.gov/assets/docs/BayouHealth/Medicaid_Services_Chart2012.pdf

E-mail • medicaidweb@la.gov

Medicaid Website • www.medicaid.la.gov

What if a provider is not available, or if the provider can't find staff?

If you cannot find a provider of any services you need in your area willing to submit a request, contact your support coordinator. If you do not have a support coordinator, contact DHH directly at **1-888-758-2220** and tell them you cannot find a provider. DHH will take all reasonable steps to find a willing and able provider within ten days.

FOR YOUR INFORMATION! SPECIAL MEDICAID BENEFITS FOR CHILDREN AND YOUTH

**THE FOLLOWING SERVICES ARE AVAILABLE TO CHILDREN AND YOUTH WITH DEVELOPMENTAL DISABILITIES.
TO REQUEST THEM CALL THE OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES (OCDD)/DISTRICT/AUTHORITY IN YOUR AREA.
(See listing of numbers on attachment)**

DD MEDICAID WAIVER SERVICES

To sign up for "waiver programs" that offer Medicaid and additional services to eligible persons (including those whose income may be too high for other Medicaid), ask to be added to the Developmentally Disabled (DD) Request for Services Registry (RFSR). The **New Opportunities Waiver (NOW)** and the **Children's Choice Waiver** both provide services in the home, instead of in an institution, to persons who have intellectual disabilities and/or other developmental disabilities. Both waivers cover Family Support, Center-Based Respite, Environmental Accessibility Modifications, and specialized medical equipment and supplies. In addition, **NOW** covers services to help individuals live alone in the community or to assist with employment, and professional and nursing services beyond those that Medicaid usually covers. The **Children's Choice Waiver** also includes Family Training. Children remain eligible for the Children's Choice Waiver until their nineteenth birthday, at which time they will be transferred to an appropriate Developmentally Disabled (DD) Waiver.

The **Supports Waiver** provides specific, activity focused services rather than continuous custodial care. This waiver offers Supported Employment, Day Habilitation, Pre-Vocational Services, Respite, Habilitation and the Personal Emergency Response System. The **Residential Options Waiver (ROW)** is only appropriate for those individuals whose health and welfare can be assured via the support plan with a cost limit based on their level of support need. This waiver offers Community Living Supports, Companion Care, Host Home, Shared Living, Environmental Modifications, Assistive Technology, Center Based Respite, Nursing, Dental, Professional, Transportation-Community Access, Supported Employment, Pre-Vocational Services and Day Habilitation.

(If you are accessing services for someone 0-3 please contact EarlySteps at 1-866-327-5978.)

SUPPORT COORDINATION

A support coordinator works with you to develop a comprehensive list of all needed services (such as medical care, therapies, personal care services, equipment, social services, and educational services) then assists you in obtaining them. **If you are a Medicaid recipient and under the age of 21 and it is medically necessary, you may be eligible to receive support coordination services immediately.** Contact Statistical Resources, Inc. (SRI) at 1-800-364-7828.

**THE FOLLOWING BENEFITS ARE AVAILABLE TO ALL MEDICAID ELIGIBLE CHILDREN AND YOUTH UNDER THE AGE OF 21 WHO HAVE A MEDICAL NEED
TO ACCESS THESE SERVICES CALL MAGELLAN HEALTH SERVICES (TOLL FREE) 1-800-424-4399
(or TTY 1-800-424-4416)**

PSYCHOLOGICAL AND BEHAVIORAL HEALTH SERVICES

Children and youth may receive behavioral health services if it is medically necessary. These services include necessary assessments and evaluation; individual and/or group therapy; medication management; individual and parent/family intervention; supportive and group counseling; individual and group psychosocial skills training; behavior intervention plan development and service integration. All behavioral health services must be approved by Magellan Health Services.

Coordinated System of Care (C-SoC) helps at-risk children and youth who have serious behavioral health challenges and their families. It offers services and supports that help these children and youth return to or remain at home. Services include: Youth Support and Training, Parent Support and Training, Independent Living Skill Building Services, Short-Term Respite and Crisis Stabilization.

Parents/guardians will be assisted in selecting a provider in their area to best meet the needs of the child/youth and family.

THE FOLLOWING BENEFITS ARE AVAILABLE TO ALL MEDICAID ELIGIBLE CHILDREN AND YOUTH UNDER THE AGE OF 21 WHO HAVE A MEDICAL NEED

Children enrolled in Bayou Health can access the listed services below through their individual health plan. Chisholm Class Members (Medicaid eligible children who are on the DD Request for Services Registry) are exempt and do not participate in Bayou Health. They access these services through their Medicaid providers.

EPSDT EXAMS AND CHECKUPS

Medicaid recipients under the age of 21 are eligible for checkups ("EPSDT screens"). These checkups include a health history; physical exam; immunizations; laboratory tests, including lead blood level assessment; vision and hearing checks; and dental services. They are available both on a regular basis, and whenever additional health treatment or services are needed. EPSDT screens may help to find problems, which need other health treatment or additional services. **Children under 21 are entitled to receive all medically necessary health care, diagnostic services, and treatment and other measures covered by Medicaid to correct or improve physical or mental conditions. This includes a wide range of services not covered by Medicaid for recipients over the age of 21.**

PERSONAL CARE SERVICES

Personal Care Services (PCS) are provided by attendants when physical limitations due to illness or injury require assistance with eating, bathing, dressing, toileting and personal hygiene. PCS do not include medical tasks such as medication administration, tracheostomy care, feeding tubes or catheters. The Medicaid *Home Health* program or *Extended Home Health* program covers those medical services. PCS must be ordered by a physician. The PCS provider must request approval for the service from Medicaid.

EXTENDED SKILLED NURSING SERVICES

Children and youth may be eligible to receive Skilled Nursing Services in the home. These services are provided by a Home Health Agency. A physician must order this service. Once ordered by a physician, the home health agency must request approval for the service from Medicaid.

PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH THERAPY, and AUDIOLOGY SERVICES

If a child or youth wants rehabilitation services such as Physical, Occupational, or Speech Therapy, or Audiology Services; these services can be provided at school, in an early intervention center, in an outpatient facility, in a rehabilitation center, at home, or in a combination of settings, depending on the child's needs. For Medicaid to cover these services at school (ages 3 to 21), or early intervention centers and *EarlySteps* (ages 0 to 3), they must be part of the Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP). For Medicaid to cover the services through an outpatient facility, rehabilitation center, or home health, they must be ordered by a physician and be prior-authorized by Medicaid.

FOR INFORMATION ON RECEIVING THESE THERAPIES CONTACT YOUR SCHOOL OR EARLY INTERVENTION CENTER OR OTHER PROVIDERS. EARLYSTEPS CAN BE CONTACTED (toll free) AT 1-866-327-5978. CALL SPECIALTY RESOURCE LINE REFERRAL ASSISTANCE AT 1-877-455-9955 TO LOCATE OTHER THERAPY PROVIDERS.

APPLIED BEHAVIORAL ANALYSIS-BASED THERAPY SERVICES (ABA)

ABA therapy is the design, implementation, and evaluation of environmental modification using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the direct observation, measurement, and functional analysis of the relations between environment and behavior. ABA-based therapies teach skills through the use of behavioral observation and reinforcement or prompting to teach each step of targeted behavior. ABA-based therapies are based on reliable evidence of their success in alleviating autism and are not experimental. This service is available through Medicaid for persons 0-21. For Medicaid to cover ABA services through a licensed provider they must be ordered by a physician and be prior authorized by Medicaid. For information on ABA please contact DHH directly at 1-844-423-4762

MEDICAL EQUIPMENT AND SUPPLIES

Children and youth can obtain any medically necessary medical supplies, equipment and appliances needed to correct, or improve physical or mental conditions. Medical equipment and supplies must be ordered by a physician. Once ordered by a physician, the supplier of the equipment or supplies must request approval for them from Medicaid.

TRANSPORTATION

Transportation to and from medical appointments, if needed, is provided by Medicaid. These medical appointments do not have to be with Medicaid providers for the transportation to be covered. Arrangements for non-emergency transportation must be made at least 48 hours in advance.

The “Friends and Family” Program allows family members/friends to become Medicaid funded transportation providers for specific family members. To assist someone that may benefit from this arrangement, call First Transit at 1-800-259-1944.

If you need a service that is not listed above you can call the referral assistance coordinator at SPECIALTY RESOURCE LINE (toll free) 1-877-455-9955. If they cannot refer you to a provider of the service you need call 225-342-5774.

STATE OF LOUISIANA

PARISH OF _____

Non-legal Custodian's Affidavit

Use of this affidavit is authorized by R.S. 9:975.

Instructions: Completion of items 1 through 4 and the signing of the affidavit are sufficient to authorize educational services and school-related medical services for the named child. Completion of items 5 through 8 is additionally required to authorize any other medical services. Please print clearly or type.

The child named below lives in my home and I am at least 18 years of age.

1. Name of child: _____

2. Child's date of birth: _____

3. Name of adult giving authorization: _____

4. Adult's home address: _____

5. I am a non-legal custodian.

6. Check one or both (for example, if one parent was advised and the other cannot be located):

I have advised the parent(s) or legal custodian(s) of the child of my intent to authorize the rendering of educational or medical services, and have received no objections.

I am unable to contact the parent(s) or legal custodian(s) of the child at this time to notify them of my intended authorization.

7. Adult's date of birth: _____

8. Adult's Louisiana driver's license or identification card number: _____

WARNING: Do not sign this form if any of the above statements are incorrect, or you will be committing a crime punishable by fine, imprisonment, or both.

I declare under penalty of perjury under the laws of Louisiana that the above statements are true and correct.

Signed: _____

Date: _____

NOTICES:

1. This declaration does not affect the rights of the child’s parent or legal guardian regarding the care, custody, and control of the child, and does not mean that the non-legal custodian has legal custody of the child.
2. A person who relies on this affidavit has no obligation to make any further inquiry or investigation.
3. This affidavit is not valid for more than one year from the date on which it was executed.

ADDITIONAL INFORMATION:

TO NON-LEGAL CUSTODIANS:

1. If the child stops living with you, you are required to notify anyone to whom you have given this affidavit as well as anyone of whom you have actual knowledge who received the affidavit from a third party.
2. If you do not have the information in item 8 (Louisiana driver’s license or identification card), you must provide another form of identification, such as a social security card.

TO SCHOOL OFFICIALS:

The school district may require additional reasonable evidence that the non-legal custodian lives at the address provided in item 4, such as a recent bill.

TO HEALTH CARE PROVIDERS AND HEALTH CARE SERVICE PLANS:

1. No person who acts in good faith reliance upon a non-legal custodian’s affidavit to render educational or medical services, without actual knowledge of facts contrary to those stated in the affidavit, is subject to criminal prosecution or civil liability to any person, or subject to any professional disciplinary action, for such reliance if the applicable portions of the form are completed.
2. This affidavit does not confer dependency for health care coverage purposes.

Sworn to and subscribed before me, NOTARY PUBLIC, on this _____ day of _____, 200__ at _____, Louisiana.

Name of Notary Public:

LOUISIANA DEPARTMENT OF HEALTH & HOSPITALS

MEDICAID SERVICES CHART

March 2014

Note: E-mail corrections for this document to cheryl.allain@la.gov.

NOTE: The information listed in this document is applicable to Medicaid recipients in the fee-for-service Medicaid program. Bayou Health Plan members should contact their plan’s member services with questions about how to access care (https://bayouhealth.com/LASelfService/en_US/plans.html).

MEDICAID SERVICES					
SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
Adult Denture Services	<i>Dentist</i>	<p>Medicaid recipients 21 years of age and older.</p> <p>(Adults, 21 and over, certified as Qualified Medicare Beneficiary (QMB) only, Medically Needy Program, or other programs with limited benefits are not eligible for dental services.)</p>	<p>Dentures, denture relines, and denture repairs.</p> <p>Examination and X-rays are covered if in conjunction with the construction of a Medicaid-authorized denture.</p>	<p>All services other than repairs require Prior Authorization. The provider will submit requests for the Prior Authorization.</p> <p>Only one complete or partial denture per arch is allowed in an eight-year period. The partial denture must oppose a full denture. Two partials are not covered in the same oral cavity (mouth). Additional guidelines apply.</p>	Cordelia Clay 225/342-7878
Applied Behavioral Analysis (ABA)	<i>Medicaid enrolled ABA provider</i>	<ol style="list-style-type: none"> 1. be from birth up to 21 years of age; 2. be determined by a qualified health care professional to meet the medical necessity and other requirements in DHH regulations; 3. be diagnosed by a qualified health care professional with a condition for which ABA-based therapy services are recognized as therapeutically appropriate, including autism spectrum disorder; 4. have a comprehensive diagnostic evaluation by a qualified health care professional; and 5. have a prescription for ABA-based therapy services ordered by a qualified health care professional. 	<p>ABA-based therapy services shall be rendered in accordance with the individual’s treatment plan.</p>	<p>All medically necessary services must be prescribed by a physician and Prior Authorization is required. The provider of services will submit requests for Prior Authorization.</p>	Anita Milling 1-844-423-4762
Appointment Scheduling Assistance – <i>See EPSDT Screening Services</i>					

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MEDICAID SERVICES					
SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
Audiological Services –See EarlySteps; EPSDT Screening Services; Hospital- Outpatient services; Physician/ Professional Services; Rehabilitation Clinic Services; Therapy Services					
Behavioral Health Services – Adults		<p><i>Medicaid eligible adult</i></p> <p>1915(i) SPA Adults eligible for the 1915(i) State Plan Amendment (SPA) Adults eligible to receive 1915(i) State Plan services include those who meet one of the following criteria and is 21 years and older:</p> <p>Persons with acute stabilization needs; with a MMD; meet the federal definition of SMI, or who has previously met the above criteria and needs subsequent medically necessary services for stabilization and maintenance</p>	<p>Any Medicaid eligible adult may receive the following behavioral health service if medical necessity is established by a licensed mental health professional:</p> <ol style="list-style-type: none"> 1. Addiction Services (outpatient and residential) 2. Psychiatrist Inpatient Hospital For 1915(i) State Plan Amendment (SPA) eligible recipients the following additional services are available: 1. Case Conference 2. Treatment Plan Development 3. Psychosocial Rehabilitation 4. Crisis Intervention 5. Community Psychiatric Support & Treatment 6. Assertive Community Treatment 7. Outpatient Therapy 	<p>Adult Behavioral Health services are part of The Louisiana Behavioral Health Partnership (LBHP) managed by DHH-OBH (Office of Behavioral Health)</p>	<p>Magellan Health Services of Louisiana 1-800-424-4399</p> <p>Visit online at www.MagellanofLouisiana.com</p>

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MEDICAID SERVICES					
SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
Chemotherapy Services -See Hospital-Outpatient Services; Physician/ Professional Services	<i>Hospital Physician’s office or clinic</i>	All Medicaid Recipients.	Chemotherapy administration and treatment drugs, as prescribed by physician.		
Chiropractic Services	<i>EPSDT Medical Screening Provider/PCP</i>	Medicaid recipients 0 through 20 years of age.	Spinal manipulations.	Medically necessary manual manipulations of the spine when the service is provided as a result of a referral from a EPSDT medical screening provider or Primary Care Provider (PCP).	Angela Hebert 225/342-7878
Coordinated System of Care (CSoC)- Home and Community Based Services Waiver		Any child/youth experiencing a serious emotional disturbance who is at risk of out-of home placement. A recipient must be under the age of 22 and meet the level of care or level of need through a Child and Adolescent Needs and Strengths (CANS) comprehensive assessment	<ol style="list-style-type: none"> 1. WRAP Around Planning 2. Parent Support & Training 3. Youth Support & Training 4. Independent Living/Skills Building 5. Short Term Respite Care 6. Crisis Stabilization 7. Case Conference 8. Treatment Planning 	CSoC services are part of The Louisiana Behavioral Health Partnership (LBHP) managed by DHH-OBH (Office of Behavioral Health)	Magellan Health Services of Louisiana 1-800-424-4399 Visit online at www.MagellanofLouisiana.com
Dental Care Services - See Adult Denture Services; EPSDT Dental Services; and Expanded Dental Services for Pregnant Women					

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MEDICAID SERVICES					
SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
Durable Medical Equipment (DME)	<i>Physician</i>	All Medicaid recipients.	<p>Medical equipment and appliances such as wheelchairs, leg braces, etc.</p> <p>Medical supplies such as ostomy supplies, etc.</p> <p>Diapers and blue pads are not reimbursable as durable medical equipment items. EPSDT RECIPIENTS ARE EXCLUDED FROM THIS LIMITATION.</p>	<p>All services must be prescribed by a physician and must be Prior Authorized.</p> <p>DME providers will arrange for the Prior Authorization request.</p>	<p>Sylvia Green 225/342-7878</p> <p>Stephanie Young 225/342-7878</p>
EarlySteps <i>(Infant & Toddler Early Intervention Services)</i>		<p>Children ages birth to three who have a developmental delay of at least 1.5 SD (standard deviations) below the mean in two areas of development listed below:</p> <ol style="list-style-type: none"> a. cognitive development b. physical development (vision & hearing) c. -- communication development social or emotional development d. adaptive skills development (also known as self-help or daily living skills) <p>1. Children with a diagnosed medical condition with a high probability of resulting in developmental delay.</p>	<p>Covered Services (Medicaid Covered)</p> <ul style="list-style-type: none"> -Family Support Coordination (Service Coordination) -Occupational Therapy -Physical Therapy -Speech/Language Therapy -Psychology -Audiology <p>EarlySteps also provides the following services, not covered by Medicaid:</p> <ul style="list-style-type: none"> -Nursing Services/Health Services (Only to enable an eligible child/family to benefit from the other EarlySteps services). -Medical Services for diagnostic and evaluation purposes only. -Special Instruction -Vision Services -Assistive Technology devices and services -Social Work -Counseling Services/Family Training -Transportation -Nutrition -Sign language and cued language services. 	<p>All services are provided through a plan of care called the Individualized Family Service Plan. Early Intervention is provided through EarlySteps in conformance with Part C of the Individuals with Disabilities Education Act. (IDEA).</p>	<p>Office for Citizens with Developmental Disabilities</p> <p>1-866-783-5553 or 1-866-earlystep For families</p>

NOTE: The information listed in this document is applicable to Medicaid recipients in the fee-for-service Medicaid program. Bayou Health Plan members should contact their plan’s member services with questions about how to access care (https://bayouhealth.com/LASelfService/en_US/plans.html).

MEDICAID SERVICES					
SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
EPSDT Behavioral Health Services		<p>Medicaid eligible youth who meets the medical necessity criteria for behavioral health services as determined by a licensed mental health professional.</p> <p>Meets medical necessity criteria for rehabilitation services for children under the age of 21 restrictive level of care</p> <p>Addiction Services: Any Medicaid-eligible person needing medically necessary substance abuse services</p> <p>Outpatient & Inpatient Hospital and PRTF: Medicaid eligible</p> <p>Outpatient Therapy By Licensed Practitioners: Medicaid-eligible children who meet medical necessity criteria.</p>	<ol style="list-style-type: none"> 1. Psychosocial Rehabilitation 2. Crisis Intervention 3. Community Psychiatric Support & Treatment 4. Therapeutic Group Home 5. Addiction Services (outpatient and residential) 6. Outpatient & Inpatient Hospital 7. Psychiatric Residential Treatment Facility (PRTF) 8. Outpatient Therapy 9. Multi-systemic Therapy 10. Functional Family Therapy 11. Homebuilders <p>Addiction Services</p> <p>Outpatient & Inpatient Hospital Psychiatric Residential Treatment Facility</p> <p>Outpatient Therapy By Licensed Practitioners Other Licensed Practitioner Outpatient Therapy Medical, Physician/Psychiatrist Behavioral Health in FQHC</p>	<p>EPSDT Behavioral Health services are part of The Louisiana Behavioral Health Partnership (LBHP) managed by DHH-OBH (Office of Behavioral Health)</p>	<p>Magellan Health Services of Louisiana 1-800-424-4399</p> <p>Visit online at www.MagellanofLouisiana.com</p>

NOTE: The information listed in this document is applicable to Medicaid recipients in the fee-for-service Medicaid program. Bayou Health Plan members should contact their plan’s member services with questions about how to access care (https://bayouhealth.com/LASelfService/en_US/plans.html).

MEDICAID SERVICES					
SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
EPSDT Dental Services	<i>Dentist</i>	<p>Medicaid recipients 0 to 21 years of age.</p> <p>Presumptive Eligible (Type case 12) recipients are not eligible for dental care services.</p>	<p>Bi-annual dental screening consisting of an examination, radiographs (x-rays) as appropriate, prophylaxis (cleaning), topical fluoride application and oral hygiene instruction.</p> <p>The EPSDT Dental Program provides coverage of certain diagnostic; preventive; restorative; endodontic; periodontic; removable prosthodontic; maxillofacial prosthetic; oral and maxillofacial surgery; orthodontic; and adjunctive general services. Specific policy guidelines apply.</p> <p><u>Comprehensive Orthodontic Treatment (braces) require Prior Authorization and are paid only when there is a cranio-facial deformity, such as cleft palate, cleft lip, or other medical conditions which possibly results in a handicapping malocclusion. If such a condition exists, the recipient should see a Medicaid-enrolled orthodontist. Patients having only crowded or crooked teeth, spacing problems or under/overbite are not covered for braces, unless identified as medically necessary.</u></p>	<p>Some EPSDT Dental Program services must be Prior Authorized by Medicaid. The dental provider will submit the request for Prior Authorization of these services to Medicaid on behalf of the patient. A prior authorization approval does not guarantee patient eligibility</p>	<p>Cordelia Clay 225/342-7878</p>

NOTE: The information listed in this document is applicable to Medicaid recipients in the fee-for-service Medicaid program. Bayou Health Plan members should contact their plan’s member services with questions about how to access care (https://bayouhealth.com/LASelfService/en_US/plans.html).

MEDICAID SERVICES					
SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
<p>EPSDT Personal Care Services</p> <p><i>(See Long Term – Personal Care Services (LT-PCS) for Medicaid recipients ages 65 or older, or age 21 or older with disabilities)</i></p>	<p><i>Physician and Personal Care Attendant Agencies</i></p>	<p>All Medicaid recipients 0 to 21 not receiving Individual Family Support waiver services. However, once a recipient receiving Individual Family Support waiver services has exhausted those services they are then eligible for EPSDT Personal Care Services.</p> <p>Recipients of Children’s Choice Waiver can receive both PCS and Family Support Services on the same day; however, the services may not be rendered at the same time.</p>	<p>Basic personal care-toileting & grooming activities.</p> <p>Assistance with bladder and/or bowel requirements or problems.</p> <p>Assistance with eating and food preparation.</p> <p>Performance of incidental household chores, only for the recipient.</p> <p>Accompanying, not transporting, recipient to medical appointments.</p> <p>Does NOT cover any medical tasks such as medication administration, tube feedings.</p>	<p>The Personal Care Agency must submit the Prior Authorization request.</p> <p>Recipients receiving Support Coordination (Case Management Services) must also have their PCS Prior Authorized by Molina.</p> <p>PCS is <i>not subject to service limits</i>. Units approved will be based on medical necessity and the need for covered services.</p> <p>Recipients receiving Personal Care Services must have a physician’s prescription and meet medical criteria.</p> <p>Does not include medical tasks.</p> <p>Provided by licensed providers enrolled in Medicaid to provide Personal Care Attendant services.</p>	<p>Kellea Tuminello 225/342-7882</p>
<p>Eyeglass Services - See Optical Services</p>					
<p>Family Planning Clinic Services</p>	<p><i>Planned Parenthood Locations</i></p> <p><i>Office of Public Health-Family Planning Clinics</i></p>	<p>Female Medicaid recipients between the ages of 10 and 60.</p>	<p>Doctor visits to assess the patient’s physical status and contraceptive practices; nurse visits; physician counseling regarding sterilization; nutrition counseling; social services counseling regarding the medical/family planning needs of the patient; contraceptives; and certain lab services.</p>	<p>Medicaid will reimburse the family planning clinic for routine family planning services for family planning purposes only and not treatment of other medical conditions. Referrals should be made for other medical problems as indicated.</p> <p>Family Planning Clinics do not provide services to pregnant women.</p>	<p>Cordelia Clay 225/342-7878</p>

NOTE: The information listed in this document is applicable to Medicaid recipients in the fee-for-service Medicaid program. Bayou Health Plan members should contact their plan's member services with questions about how to access care (https://bayouhealth.com/LASelfService/en_US/plans.html).

MEDICAID SERVICES					
SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
Family Planning Waiver Services – <i>See Waiver Services</i>					
Family Planning Services in Physician's Office – <i>See Physician/ Professional Services</i>					
Federally Qualified Health Centers (FQHC)	<i>Nearest FQHC</i>	All Medicaid recipients.	Professional medical services furnished by physicians, nurse practitioners, physician assistants, nurse midwives, clinical social workers, clinical psychologists, and dentists. Immunizations are covered for recipients under age 21.	There are 3 components that may be provided: 1) Encounter visits; 2) EPSDT Screening Services; and 3) EPDST Dental, Adult Denture Services, and Expanded Dental services for Pregnant Women.	Kimberly Cezar 225/342-7878
Hearing Aids - See Durable Medical Equipment	<i>Durable Medical Equipment Provider</i>	Medicaid recipients 0 through 20 years of age.	Hearing Aids and any related ancillary equipment such as earpieces, batteries, etc. Repairs are covered if the Hearing Aid was paid for by Medicaid.	All services must be Prior Authorized and the DME provider will arrange for the request of Prior Authorization .	Sylvia Green 225/342-7878 Stephanie Young 225/342-7878
Hemodialysis Services - See Hospital-Outpatient Services	<i>Dialysis Centers Hospitals</i>	All Medicaid recipients.	Dialysis treatment (including routine laboratory services); medically necessary non-routine lab services; and medically necessary injections.		Christine Sullivan 225/342-7878

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MEDICAID SERVICES					
SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
Home Health	<i>Physician</i>	All Medicaid recipients. Medically Needy (Type Case 20 & 21) recipients are not eligible for Aide Visits, Physical Therapy, Occupational Therapy, Speech/Language Therapy.	<ul style="list-style-type: none"> • Intermittent/part-time nursing services including skilled nurse visits. • Aide Visits • Physical Therapy Services • Occupational Therapy • Speech/Language Therapy 	Recipients receiving Home Health must have physician’s prescription and signed plan of care. PT, OT, and Speech/Language Therapy require Prior Authorization .	Cheryl Allain 225/342-7878 Angela Hebert 225/342-7878
Home Health - Extended	<i>Physician</i>	Medicaid recipients 0 through 20 years of age.	Multiple hours of skilled nurse services. All medically necessary medical tasks that are part of the plan of care can be administered in the home.	Recipients receiving extended nursing services must have a letter of medical necessity and physician’s prescription. Extended Skilled nursing services require Prior Authorization .	Cheryl Allain 225/342-7878 Angela Hebert 225/342-7878
Hospice Services	<i>Hospice Provider/ Physician</i>	All Medicaid recipients. Hospice eligibility information: 1-800-877-0666 Option 2	Medicare allowable services.		Deloris Young 225/342-1417
Hospital Claim Questions - Inpatient and Outpatient Services, including Emergency Room Services	<i>Physician/ Hospital</i>	All Medicaid recipients. Medically Needy (Type Case 20 & 21) under age 22 are not eligible for Inpatient <i>Psychiatric</i> Services.	Inpatient and Outpatient Hospital Services, including Emergency Room Services	All Questions Regarding Denied Claims and/or Bills for Inpatient and Outpatient Hospital Services, including Emergency Room Services	Recipients should first contact the provider, then may contact an MMIS Staff Member at 225/342-3855 if the issue cannot be resolved Providers should contact Provider Relations at 1-800-473-2783

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MEDICAID SERVICES					
SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
Hospital - Inpatient Services	<i>Physician/ Hospital</i>	All Medicaid recipients. Medically Needy (Type Case 20 & 21) under age 22 are not eligible for Inpatient <i>Psychiatric</i> Services.	Inpatient hospital care needed for the treatment of an illness or injury which can only be provided safely & adequately in a hospital setting. Includes those basic services that a hospital is expected to provide.	Inpatient hospitalization requires Pre-certification and Length of Stay assignment. Hospitals are aware of this and will submit the request to the Prior Certification Unit.	Annette Passman 225/342-7878
Hospital - Outpatient Services	<i>Physician/ Hospital</i>	All Medicaid recipients.	Diagnostic & therapeutic outpatient services, including outpatient surgery and rehabilitation services. Therapeutic and diagnostic radiology services. Chemotherapy Hemodialysis	Outpatient rehabilitation services require Prior Authorization . Provider will submit request for Prior Authorization .	Gaynell Denova 225/342-7878
Hospital - Emergency Room Services	<i>Physician/ Hospital</i>	All Medicaid recipients.	Emergency Room services.	Recipients 0 to 21 years - No service limits. Recipients 21 and older - Limited to 3 emergency room visits per calendar year (January 1 - December 31).	Gaynell Denova 225/342-7878
Immunizations <i>See FQHC; EPSDT Screening Services; Physician/Professional Services; Rural Health Clinics</i>					

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MEDICAID SERVICES					
SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
<i>Child Health Screenings/Checkups</i> (EPSDT Screening Services)	Physician	All Medicaid recipients 0 through 20 years of age.	Medical Screenings (including immunizations and certain lab services). Vision Screenings Hearing Screenings Dental Screenings Periodic and Interperiodic Screenings	Recipients receive their screening services from the primary care provider (PCP) or someone designated by the PCP.	Kimberly Cezar 225/342-7878 <i>Specialty Care Resource Line</i> (877) 455-9955
Laboratory Tests and Radiology Services	<i>Physician</i>	All Medicaid recipients.	Most diagnostic testing and radiological services ordered by the attending or consulting physician. Portable (mobile) x-rays are covered only for recipients who are unable to leave their place of residence without special transportation or assistance to obtain physician ordered x-rays.	Some Radiology Services require prior approval. This process is accomplished thru a contractual agreement with MedSolutions. All requests for any radiology services requiring prior approval are initiated by the ordering physician. Recipients may follow up with the ordering physician for the status of any ordered radiology service.	Annette Passman 225/342-7878

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MEDICAID SERVICES					
SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
<p>Long Term -Personal Care Services</p> <p>(LT-PCS)</p> <p><i>(See EPSDT Personal Care Services for Medicaid recipients ages 0 to 21)</i></p>		<p>All Medicaid recipients age 65 or older, or age 21 or older with disabilities (meets Social Security Administration disability criteria), meet the medical standards for admission to a nursing facility and additional targeting criteria, and be able to participate in his/her care and direct the services provided by the worker independently or through a responsible representative. Applicant must require at least limited assistance with at least one Activity of Daily Living.</p>	<ul style="list-style-type: none"> -Basic personal care-toileting & grooming activities. -Assistance with bladder and/or bowel requirements or problems. -Assistance with eating and food preparation. -Performance of incidental household chores, only for the recipient. -Accompanying, not transporting, recipient to medical appointments. -Grocery shopping, including personal hygiene items. 	<p>Recipients or the responsible representative must request the service. This program is NOT a substitute for existing family and/or community supports, but is designed to supplement available supports to maintain the recipient in the community. Once approved for services, the selected PCS Agency must obtain Prior Authorization. Amount of services approved will be based on assessment of assistance needed to perform daily living. Provided by PCS agencies enrolled in Medicaid.</p>	<p>Office of Aging and Adult Services (OAAS)</p> <p>Contact: Louisiana Options in Long Term Care (XEROX) 1-877-456-1146</p>
<p>Medical Transportation (Emergency)</p>	<p><i>Emergency ambulance providers</i></p>	<p>All Medicaid recipients.</p>	<p>Emergency ambulance service may be reimbursed if circumstances exist that make the use of any conveyance other than an ambulance medically inadvisable for transport of the patient.</p>		<p>Ronald W. Johnson 225/342-2604</p> <p>Steffan Rutledge 225/342-6227</p>

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MEDICAID SERVICES					
SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
Medical Transportation (Non-Emergency)	<i>Regional Dispatch Offices</i> Dispatch Office Phone Numbers: <i>Alexandria</i> 800-446-3490 <i>Baton Rouge</i> 800-259-1944 <i>Lafayette/ Lake Charles</i> 800-864-6034 <i>Monroe</i> 800-259-1835 <i>New Orleans</i> 800-836-9587 <i>Shreveport</i> 800-259-7235	All Medicaid recipients except some who have Medicaid and Medicare.	Transportation to and from medical appointments. The medical provider the recipient is being transported to, does not have to be a Medicaid enrolled provider but the services must be Medicaid covered services. The dispatch office will make this determination. Recipients under 17 years old must be accompanied by an attendant.	Recipients should call dispatch offices 48 hours before the appointment. Transportation to out-of-state appointments can be arranged but requires Prior Authorization . Same day transportation can be scheduled when absolutely necessary.	Ronald W. Johnson 225/342-2604 Steffan Rutledge 225/342-6227
Midwife Services (Certified Nurse Midwife) - See FQHC; Physician/ Professional Services; Rural Health Clinics					

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MEDICAID SERVICES					
SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
Nurse Practitioners/ Clinical Nurse Specialists - See FQHC; Physician/ Professional Services; Rural Health Clinics					
Nursing Facility		Medicaid recipients and persons who would meet Medicaid Long Term Care financial eligibility requirements and who meet nursing facility level of care as determined by OAAS.	Skilled Nursing or medical care and related services; rehabilitation needed due to injury, disability, or illness; health-related care and services (above the level of room and board) not available in the community, needed regularly due to a mental or physical; condition.		Office of Aging and Adult Services (OAAS) Contact: Louisiana Options in Long Term Care (XEROX) 1-877-456-1146
Occupational Therapy Services See EarlySteps; Home Health; Hospital- Outpatient Services; Rehabilitation Clinic Services; Therapy Services					

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MEDICAID SERVICES					
SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
Optical Services	<i>Optometrist, Ophthalmologist or Optical Supplier</i>	All Medicaid recipients.	<p><u>Recipients 0 to 21</u></p> <p>Examinations and treatment of eye conditions, including examinations for vision correction, refraction error.</p> <p>Regular eyeglasses when they meet a certain minimum strength requirement. Medically necessary specialty eyewear and contact lenses with prior authorization. Contact lenses are covered if they are the only means for restoring vision.</p> <p>Other related services, if medically necessary.</p> <hr/> <p><u>Recipients 21 and over</u></p> <p>Examinations and treatment of eye conditions, such as infections, cataracts, etc.</p> <p>If the recipient has both Medicare and Medicaid, some vision related services may be covered. The recipient should contact Medicare for more information since Medicare would be the primary payer.</p>	<p><u>Recipients 0 to 21</u></p> <p>Specialty eyewear and contact lenses, if medically necessary for EPSDT eligibles requires Prior Authorization. The provider will submit requests for the Prior Authorization. A prior authorization approval does not guarantee patient eligibility.</p> <p>Prescriptions are required for all glasses/contacts. After a prescription is obtained, the recipient may see an optical supplier to receive the glasses/contacts.</p> <hr/> <p><u>Recipients 21 and over</u></p> <p>NON-COVERED SERVICES:</p> <ul style="list-style-type: none"> - routine eye examinations for vision correction - routine eye examinations for refraction error - eyeglasses 	<p>Sylvia Green 225/342-7878</p> <p>Stephanie Young 225/342-7878 (Optical services other than eyeglasses/eyewear)</p>
Orthodontic Services <i>- See Dental Care Services</i>					

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MEDICAID SERVICES					
SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
Pediatric Day Health Care (PDHC)	Physician or PDHC Agencies	Medicaid recipient 0 to 21 who have a medically fragile condition and who require nursing supervision and possibly therapeutic interventions all or part of the day due to a medically complex condition.	Nursing care, Respiratory care, Physical Therapy, Speech-language therapy, occupational, personal care services and transportation to and from PDHC facility	<p>The PDHC facility must submit the Prior Authorization request.</p> <p>In order to receive PDHC, the recipient must have a prescription from their prescribing physician and meet the medical criteria.</p> <p>PDHC may be provided up to seven days per week and up to 12 hours per day for Medicaid recipients as documented by the recipient’s Plan of Care.</p> <p>Services are provided by licensed providers enrolled in Medicaid to provide PDHC services.</p> <p>The following services are not covered– before and after school care; medical equipment, supplies and appliances; parenteral or enteral nutrition; infant food or formula.</p> <p>Prescribed medications are to be provided each day by recipient’s parent/guardian.</p>	<p>Cheryl Allain 225/342-7878</p> <p>Angela Hebert 225/342-7878</p>

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MEDICAID SERVICES					
SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
<p>Program of All-Inclusive Care for the Elderly (PACE)*</p> <p><i>*Program available in New Orleans and in Baton Rouge area.</i></p>		<p>Participants are persons age 55 years or older, live in the PACE provider service area, are certified to meet nursing facility level of care and financially eligible for Medicaid long term care. Participation is voluntary and enrollees may disenroll at any time.</p>	<p>ALL Medicaid and Medicare services, both acute and long-term care</p>	<ul style="list-style-type: none"> - Emphasis is on enabling participants to remain in community and enhance quality of life. - Interdisciplinary team performs assessment and develops individualized plan of care. - Each PACE program serves a specific geographic region. - PACE programs bear financial risk for all medical support services required for enrollees. - PACE programs receive a monthly capitated payment for Medicaid and Medicare eligible enrollees. 	<p>Office of Aging and Adult Services (OAAS)</p> <p>Contact: PACE GNO at (504)945-1531</p> <p>Franciscan PACE Baton Rouge: (225)490-0640</p>

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MEDICAID SERVICES					
SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
Pharmacy Services	Pharmacies	All Medicaid recipients except some who are Medicare/Medicaid eligible. Recipients who are full benefit dual eligible (Medicare/Medicaid) received their pharmacy benefits through Medicare Part D.	Covers prescription drugs except: Cosmetic drugs (Except Accutane); Cough & cold preparations; Anorexics (Except for Xenical); Fertility drugs when used for fertility treatment; Experimental drugs; Compounded prescriptions; Vaccines covered in other programs; Drug Efficacy Study Implementation (DESI) drugs; Over the counter (OTC) drugs with some exceptions; Narcotics prescribed only for narcotic addiction	Co-payments (\$0.50-\$3.00) are required except for some recipient categories. NO co-payments for recipients under age 21, pregnant women, or those in Long Term Care. Prescription limits: 4 per month (The physician can override this limit when medically necessary.) <i>Limits do not apply to recipients under age 21, pregnant women, or those in Long Term Care.</i> Prior Authorization is required for <i>some</i> drug categories if the medication is not on the Preferred Drug List (PDL). Children are not exempt from this process. The PDL can be accessed at www.lamedicaid.com .	Melwyn Wendt 225/342-7878 For general pharmacy questions: 1-800-437-9101
Physical Therapy - <i>See EarlySteps; Home Health; Hospital-Outpatient Services; Rehabilitation Clinic Services; Therapy Services</i>					
Physician Assistants - <i>See FQHC; Physician/Professional Services; Rural Health Clinics</i>					

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MEDICAID SERVICES					
SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
Physician/ Professional Services	<i>Physician or Healthcare Professional</i>	All Medicaid recipients.	Professional medical services including those of a physician, nurse midwife, nurse practitioner, clinical nurse specialists, physician assistant, audiologist. Immunizations are covered for recipients under age 21. Certain family planning services when provided in a physician’s office.	Some services require Prior Authorization . Providers will submit requests for Prior Authorization . Services are subject to limitations and exclusions. Your physician or healthcare professional can help you with this. <u>Recipients 21 and over</u> are limited to 12 outpatient visits per calendar year unless an extension is granted. Your physician or healthcare professional must request an extension if deemed necessary. <u>Recipients under 21</u> are not limited to the number of outpatient visits.	Angela Hebert 225/342-7878 Cheryl Allain 225/342-7878
Podiatry Services	<i>Podiatrist</i>	All Medicaid recipients.	Office visits. Certain radiology & lab procedures and other diagnostic procedures.	Some Prior Authorization , exclusions, and restrictions apply. Providers will submit request for Prior Authorization .	Angela Hebert 225/342-7878
Pre-Natal Care Services	<i>Physicians or Healthcare Professional</i>	Female Medicaid recipients of child bearing age.	Office visits. Other pre- & post-natal care and delivery. Lab and radiology services.	Some limitations apply.	Cordelia Clay 225/342-7878
Psychiatric Hospital Care Services - See Hospital-Inpatient Services					
Rehabilitation Clinic Services	<i>Physician</i>	All Medicaid recipients	Occupational Therapy Physical Therapy Speech, Language and Hearing Therapy	All services must be Prior Authorized . The provider of services will submit the request for Prior Authorization .	Cheryl Allain 225/342-7878 Angela Hebert 225/342-7878

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MEDICAID SERVICES					
SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
Rural Health Clinics	<i>Rural Health Clinic</i>	All Medicaid recipients	Professional medical services furnished by physicians, nurse practitioners, physician assistants, nurse midwives, clinical social workers, clinical psychologists, and dentists. Immunizations are covered for recipients under age 21.	There are 3 components that may be provided: 1) Encounter visits; 2) KIDMED Screening Services; and 3) EPDST Dental, Adult Denture Services, and Expanded Dental services for Pregnant Women.	Kimberly Cezar 225/342-7878
Sexually Transmitted Disease Clinics (STD)	<i>Local Health Unit</i>	All Medicaid recipients.	Testing, counseling, and treatment of all sexually transmitted diseases (STD). Confidential HIV testing.		Stephanie Young 225/342-7878
Speech and Language Evaluation and Therapy – See EarlySteps; Home Health; Hospital-Outpatient Services; Rehabilitation Clinic Services; Therapy Services					

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MEDICAID SERVICES					
SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
Support Coordination Services (Case Management) - Children’s Choice Waiver		<p>Medicaid recipients must be in the Children’s Choice Waiver.</p> <p>There is a Request for Services Registry (RFSR) for those requesting waiver services. To get on the Request for Services Registry, call the Office for Citizens with Developmental Disabilities District/Authority/Local Regional Office contact information is located at: http://new.dhh.louisiana.gov/index.cfm/page/134/n/137</p>	<p>Coordination of Medicaid and other services. The Support Coordinator (Case Manager) helps to identify needs, access services and coordinate care. Services available through the Waiver are identified in the waiver section of this document.</p>	<p>Services must be prior authorized by DHH, Office for Citizens with Developmental Disabilities, Waiver Supports and Services. The support coordinator will submit requests for the Prior Authorization.</p>	<p>Office for Citizens with Developmental Disabilities, Waiver Supports and Services 1-866-783-5553</p>
Support Coordination Services (Case Management) - Community Choices Waiver		<p>Medicaid recipients must be in the Community Choices Waiver (CCW).</p> <p>There is a Request for Services Registry (RFSR) for those requesting CCW Waiver services. Contact Louisiana Options in Long Term Care at 1-877-456-1146.</p>	<p>Coordination of Medicaid and other services. The Support Coordinator (Case Manager) helps to identify needs, access services and coordinate care.</p>	<p>Services must be prior authorized by DHH, <i>Office of Aging and Adult Services (OAAS)</i>. The provider will submit requests for the Prior Authorization.</p>	<p>Office of Aging and Adult Services (OAAS) 1-866-758-5035</p> <p>Applicants/ Participants call 1-866-758-5035 or 225-219-0643</p>

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MEDICAID SERVICES					
SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
Support Coordination Services (Case Management) - EPSDT Targeted Populations		<p>Must be Medicaid eligible and on the DD Request for Services Registry prior to receipt of case management services; or any Medicaid recipient 3 through 20 years of age for whom support coordination is medically necessary (Call SRI at 1-800-364-7828).</p> <p>To get on the Request for Services Registry, call the Office for Citizens with Developmental Disabilities District/Authority/Local Regional Office</p>	Coordination of Medicaid and other services. The Support Coordinator (Case Manager) helps to identify needs, access services and coordinate care.	Support Coordination Services must be prior authorized by DHH, BHSF, and Waiver Compliance Section. The Support Coordination Agency will submit requests for the Prior Authorization to SRI. For other EPSDT services, see that portion of the chart.	<p>SRI 1-800-364-7828</p> <p>Must be on the DD Request for Services Registry</p>
Support Coordination Services (Case Management) - Infants and Toddlers		<p>Medicaid recipients must be 0 to 3 years of age and have a developmental delay or an established medical condition and eligible for the EarlySteps system contact information is located at: http://new.dhh.louisiana.gov/index.cfm/page/134/n/137</p>	Coordination of Medicaid and other services. The Support Coordinator (Case Manager) helps to identify needs, access services and coordinate care in EarlySteps.	Services must be authorized by EarlySteps. Authorizations are approved through the Individualized Family Service Plan (IFSP) process.	<p>Office for Citizens with Developmental Disabilities (OCDD)</p> <p>1-866-783-5553</p>

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MEDICAID SERVICES					
SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
Support Coordination Services (Case Management) - New Opportunities Waiver (NOW)		<p>Medicaid recipients must be receiving the NOW.</p> <p>There is a Request for Services Registry (RFSR) for those requesting waiver services. To get on the Request for Services Registry, call the Office for Citizens with Developmental Disabilities District/Authority/Local Regional Office contact information is located at: http://new.dhh.louisiana.gov/index.cfm/page/134/n/137</p>	<p>Coordination of Medicaid and other services. The Support Coordinator (Case Manager) helps to identify needs, access services and coordinate care. Services available through the Waiver are identified in the waiver section of this document.</p>	<p>Services must be prior authorized by DHH, Office for Citizens with Developmental Disabilities, Waiver Supports and Services. The support coordinator will submit requests for the Prior Authorization.</p>	<p>Office for Citizens with Developmental Disabilities, Waiver Supports and Services 1-866-783-5553</p> <p>Complaints Line: 1-800-660-0488</p>
Support Coordination Services (Case Management) – Residential Options Waiver		<p>Medicaid recipients must be in the Residential Options Waiver.</p> <p>To access the Residential Options Waiver contact the Office for Citizens with Developmental Disabilities District/Authority Local Regional Office or the Office for Citizens with Developmental Disabilities Central Office Residential Options Program Manager.</p> <p>Contact information is located at: http://new.dhh.louisiana.gov/index.cfm/page/134/n/137</p>	<p>Coordination of Medicaid and other services. The Support Coordinator (Case Manager) helps to identify needs, access services and coordinate care. Services available through the Waiver are identified in the waiver section of this document.</p>	<p>Services must be prior authorized by DHH, Office for Citizens with Developmental Disabilities, Waiver Supports and Services. The support coordinator will submit requests for the Prior Authorization.</p>	<p>Office for Citizens with Developmental Disabilities, Waiver Supports and Services 1-866-783-5553</p>

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MEDICAID SERVICES					
SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
Support Coordination Services (Case Management) – Supports Waiver		<p>Medicaid recipients must be in the Supports Waiver.</p> <p>There is a Request for Services Registry (RFSR) for those requesting this waiver. To get on the Request for Services Registry, call the Office for Citizens with Developmental Disabilities District/Authority/Local Regional Office contact information is located at: http://new.dhh.louisiana.gov/index.cfm/page/134/n/137</p>	Coordination of Medicaid and other services. The Support Coordination (Case Manager) helps to identify needs, access services and coordinate care. Some services available through this waiver are identified in the waiver section	Services must be prior authorized by DHH, Office for Citizens with Developmental Disabilities, Waiver Supports and Services. The support coordinator will submit requests for the Prior Authorization .	<p>Office for Citizens with Developmental Disabilities, Waiver Supports and Services 1-866-783-5553</p> <p>Complaints Line: 1-800-660-0488</p>
Therapy Services	<i>Recipients have the choice of services from the following provider types: Home Health; Hospital-Outpatient Services; Rehabilitation Clinic Services</i>	Medicaid recipients birth through 20 years of age.	<ul style="list-style-type: none"> • Audiological Services (Available in Rehabilitation Clinic and Hospital-Outpatient settings only.) • Occupational Therapy • Physical Therapy • Speech & Language Therapy 	<p>Covered services can be provided in the home through Home Health and Rehabilitation Clinics. Services provided by Rehabilitation Clinics can also be provided at the clinic. Services provided through Hospital-Outpatient Services must be provided at the facility/clinic. Covered services may be provided in addition to services provided by EarlySteps/EICs or School Boards if prescribed by a physician and Prior Authorized.</p> <p>All medically necessary services must be prescribed by a physician and Prior Authorization is required. The provider of services will submit requests for Prior Authorization.</p>	<p>Cheryl Allain 225/342-7878 Angela Hebert 225/342-6908</p> <p>NOTE: <i>For details on services provided in Home Health, Rehabilitation Clinic, or Hospital-Outpatient settings, please refer to those sections of this Medicaid Services Chart.</i></p>

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MEDICAID SERVICES					
SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
Therapy Services continued	<i>EPSDT Health Services-Early Intervention Centers (EIC) or EarlySteps Program</i>	Medicaid recipients under 3 years of age.	<ul style="list-style-type: none"> • Audiological Services • Occupational Therapy • Physical Therapy • Speech & Language Therapy • Psychological Therapy 	All EPSDT Health Services through EICs and EarlySteps must be included in the infant/toddler’s Individualized Family Services Plan (IFSP). If services are provided by an EIC or EarlySteps, Prior Authorization requirements are met through inclusion of services on the IFSP.	Cheryl Allain 225/342-7878 Angela Hebert 225/342-7878
Therapy Services continued	<i>EPSDT Health Services- Local Education Agencies (LEA) e.g. School Boards</i>	Medicaid recipients 3 through 20 years of age.	<ul style="list-style-type: none"> • Audiological Evaluation and Therapy • Occupational Therapy Evaluation and Treatment services • Physical Therapy Evaluation and Treatment services • Speech & Language Evaluation and Therapy • Psychological Evaluation including a battery of tests, interviews, and behavioral evaluations that appraise cognitive, emotional, social, and behavioral functioning and self-concept. • Psychological Therapy includes diagnosis and psychological counseling for children and their parents. 	Services are performed by the Local Education Agencies (LEA) All EPSDT Health Services must be included in the child’s Individualized Education Program (IEP). If services are provided by a, LEA Prior Authorization requirements are met through inclusion of services on the IEP.	Anissa Young 225/342-2173
Transportation <i>See Medical Transportation</i>					
Tuberculosis Clinics	<i>Local Health Unit</i>	All Medicaid recipients	Treatment and disease management services including physician visits, medications and x-rays.		Stephanie Young 225/342-7878

NOTE: The information listed in this document is applicable to Medicaid recipients in the fee-for-service Medicaid program. Bayou Health Plan members should contact their plan’s member services with questions about how to access care (https://bayouhealth.com/LASelfService/en_US/plans.html).

MEDICAID SERVICES					
SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
<i>X-Ray Services - See Laboratory Tests and X-Ray Services</i>					
<u>WAIVER SERVICES:</u>		There is a Request for Services Registry (RFSR) for those requesting any of the waiver services below.			See Specific Waiver
Adult Day Health Care (ADHC)		Individuals 65 years of age or older, who meet Medicaid financial eligibility, imminent risk criteria and meet the criteria for admission to a nursing facility; or age 22-64 who are disabled according to Medicaid standards or SSI disability criteria, meet Medicaid financial eligibility and meet the criteria for admission to a nursing facility	<ul style="list-style-type: none"> - Adult Day Health Care services - Transition Services - Support Coordination - Transition Intensive Support Coordination 	This is a home and community - based alternative to nursing facility placement.	Office of Aging and Adult Services (OAAS) Louisiana Options in Long Term Care 1-877-456-1146 Applicants/ Participants call 1-866-758-5035 or 225-219-0643

NOTE: The information listed in this document is applicable to Medicaid recipients in the fee-for-service Medicaid program. Bayou Health Plan members should contact their plan’s member services with questions about how to access care (https://bayouhealth.com/LASelfService/en_US/plans.html).

MEDICAID SERVICES					
SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
Children’s Choice		Child must be on the DD Request for Services Registry, less than 19 years old, disabled according to SSI criteria, require ICF/DD level of care, have income less than 3 times SSI amount, resources less than \$2,000 and meet all Medicaid non-financial requirements.	<ul style="list-style-type: none"> - Center Based Respite -Environmental Accessibility Adaptation -Family Training -Family Support -Crisis Support -Non-Crisis Support -Support Coordination 	<p>There is a \$16,410 limit per individual plan year. (\$1500 for Case Management balance for other services).</p> <p>* Call the Office for Citizens with Developmental Disabilities Districts/Authorities/Local Regional Offices for status on the Request for Services Registry. (See Appendix for telephone numbers)</p> <p><i>Complaints Line: 1-800-660-0488</i></p>	<p>Office for Citizens with Developmental Disabilities Districts/ Authorities/Local Regional Offices (SYSTEM ENTRY) contact information is located at: http://new.dhh.louisiana.gov/index.cfm/page/134/n/137</p> <p>T. Denise Boyd 225/342-9261 or 225/342-0095</p>
Community Choices Waiver (CCW)		Individuals 65 years of age or older, who meet Medicaid financial eligibility and meet the criteria for admission to a nursing facility; or age 21-64 who are disabled according to Medicaid standards or SSI disability criteria, meet Medicaid financial eligibility, and meet the criteria for admission to a nursing facility	<ul style="list-style-type: none"> - Support Coordination - Environmental Accessibility Adaptation -Transition Intensive Support Coordination -Transition Service - Personal Assistance Services - Adult Day health Care Services - Assistive Devices and Medical - Supplies - Skilled Maintenance Therapy Services - Nursing Services - Home Delivered Meal Services - Caregiver Temporary Support Services 	<p>This is a home and community-based alternative to nursing facility placement.</p>	<p>Office of Aging and Adult Services (OAAS)</p> <p>Contact: Louisiana Options in Long Term Care 1-877-456-1146</p> <p>Applicants/ Participants call 1-866-758-5035 or 225-219-0643</p>

NOTE: The information listed in this document is applicable to Medicaid recipients in the fee-for-service Medicaid program. Bayou Health Plan members should contact their plan’s member services with questions about how to access care (https://bayouhealth.com/LASelfService/en_US/plans.html).

MEDICAID SERVICES					
SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
Family Planning Waiver-TAKE CHARGE	<i>Any Medicaid provider who offers family planning services.</i> <i>For assistance with locating a provider call 1-877-455-9955</i>	Women ages 19-44 who are Louisiana residents, with an income below 200% of the Federal Poverty level, without health insurance that offers family planning services.	Covered services include a yearly physical exam, pap smear, laboratory tests, contraceptive counseling, medications, and supplies (such as birth control pills, patches, injections, IUDs and diaphragms), and voluntary sterilization.	This is a wavier program with benefits being limited to family planning services. There are no enrollment fees, no premiums, co-payments or deductibles. Mammograms and Hysterectomies are not a covered service. American Indian “638” Clinics, RHCs and FQHCs are reimbursed at fee-for-service rates.	Tara DiSandro 225/342-9201
New Opportunities Waiver (NOW)		Individuals three(3) years of age or older, who have a developmental disability which manifested prior to the age of 22, and who meet both SSI Disability criteria and the level of care determination for an ICF/DD.	An array of services to provide support to maintain persons in the community: Individual Family Support, Day and Night; Shared Supports; Center Based Respite Care; Community Integration Development; Environmental Accessibility Adaptations, Specialized Medical Equipment and Supplies; Substitute Family Care Services; Supported Living; Day Habilitation; Supported Employment; Employment-Related Training; Professional Services; One Time Transitional Expense; Skilled Nursing; and Personal Emergency Response System.	*Call the Office for Citizens with Developmental Disabilities Districts/Authorities/Local Regional Offices for status on the Request for Services Registry. (See Appendix for telephone numbers) <i>Complaints Line: 1-800-660-0488</i>	Office for Citizens with Developmental Disabilities Districts/Authorities/Local Regional Offices SYSTEM ENTRY contact information is located at: http://new.dhh.louisiana.gov/index.cfm/page/134/n/137 Anita Lewis 225/342-4464 or 225/342-0095

NOTE: The information listed in this document is applicable to Medicaid recipients in the fee-for-service Medicaid program. Bayou Health Plan members should contact their plan’s member services with questions about how to access care (https://bayouhealth.com/LASelfService/en_US/plans.html).

MEDICAID SERVICES					
SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
Residential Options Waiver (ROW)		Individuals, birth to end of life, who have a developmental disability which manifested prior to the age of 22. (Must meet the Louisiana definition of DD).	Covered services include: Support Coordination, Community Living Supports, Host Home Services, Companion Care Services, Shared Living, Respite Care-Out of Home, Personal Emergency Response System, One Time Transition Services, Environmental Accessibility Adaptations, Assistive Technology/Specialized Medical Equipment and Supplies, Transportation-Community Access, Professional Services, Nursing Services, Dental Services, Supported Employment, Prevocational Services, and Day Habilitation.	Complaints Line: 1-800-660-0488	Office for Citizens with Developmental Disabilities Districts/Authorities/Local Regional offices. System Entry contact information is located at: http://new.dhh.louisiana.gov/index.cfm/page/134/n/137 Jeannathan H. Anderson 225/342-0095 Jeannathan.Anderson2@la.gov
Supports Waiver		Individuals age 18 and older who have been diagnosed with a Developmental Disability which manifested prior to age 22. (Must meet the Louisiana definition of DD).	Covered services include: Support Coordination, Supported Employment, Day Habilitation, Pre-Vocational, Habilitation, Respite, and Personal Emergency Response System	Complaints Line: 1-800-660-0488	Office for Citizens with Developmental Disabilities Districts/Authorities/Local Regional Offices System Entry contact information is located at: http://new.dhh.louisiana.gov/index.cfm/page/134/n/137 Rosemary Morales 225/342-8901

NOTE: The information listed in this document is applicable to Medicaid recipients in the fee-for-service Medicaid program. Bayou Health Plan members should contact their plan's member services with questions about how to access care (https://bayouhealth.com/LASelfService/en_US/plans.html).

*** Exclusion from this list does not necessarily mean that a service is not covered. Please call one of the appropriate contacts for questions regarding coverage of services not listed on this chart.**

General Information about Documentation Requirements

- It is the responsibility of the support coordination agency to provide adequate documentation of services offered to EPSDT participants for the purposes of continuity of care/support for the individual and the need for adequate monitoring of progress toward outcomes and services received. This documentation is an on-going chronology of activities undertaken on behalf of the participant.
- Progress notes must be of sufficient content to reflect descriptions of activities and cannot be so general that a complete picture of the services and progress cannot be drawn from the content of the note, i.e., general terms such as “called the participant” or “supported participant” or “assisted participant” is not sufficient and does not reflect adequate content. Check lists alone are not adequate documentation.
- Service logs must support the activity that is billed and provide enough narrative documentation/information to clearly identify the activity and the participants. BHSF allows the support coordinators of EPSDT services to utilize the service log to document required “progress notes” and “progress summaries.”
- The Department of Health and Hospitals (DHH) offices, BHSF, do not prescribe a format for EPSDT documentation, but must find all components outlined below.
- All notes, summaries and service log entries in a participant’s record should include:
 1. Name of author/person making entry
 2. Signature of author/person making entry
 3. Functional title of person making entry
 4. Full date of documentation
 5. Signature or Initials indicating review by supervisor if required
 6. Must be legible and if hand written, in ink
 7. Narrative that follows definition for the type of documentation used.

Issued 6/9/09

Revised 8/31/07 Memo

Minimum Requirements for Case Record Documentation

**REQUIRED DOCUMENTATION
FOR
SUPPORT COORDINATORS**

Support coordination providers will document progress as follows:

- **Service Logs:** - Chronology of events and contacts which support justification of critical support coordination elements for Prior Authorization (PA) of services in the LSCIS system. Each service contact is to be briefly defined (i.e., telephone call, face to face visit) with a narrative in the form of a progress note. See below. **NOTE:** *EPSDT support coordinators are to utilize the service log to document "Progress Notes" and "Progress Summary."*
 - All contacts with participant, provider, PAL, DHH Program Staff Line etc.
 - Offer of assist with appeals
- **Progress Notes** - Narrative that reflects each entry into the service log and elaborates on the substance of the contact. (**Note:** *The service log is to be used for this documentation.*)
- **Monthly contact**
 - Assure implementation of requested services.
 - Determine service start date after the PA is received.
 - Assistance provided with identified needs and problems with providers.
 - Follow up on obtaining information to obtain the PA request.
 - Assistance with appeals.
 - Any behavior issues
 - Offer of services for identified needs.
 - Offer to switch providers if service not received or in the amount PA'd and at the times desired.
 - PAL contacts
 - Contacts with DHH
- **Quarterly Review/Progress Summary** - Summary that includes the synthesis of all activities for a specified period which addresses significant activities, summary of progress/lack of progress toward desired outcomes and changes to the social history. This summary should be of sufficient detail and analysis to allow for evaluation of the appropriateness of the current CPOC, allow for sufficient information for use by other support coordinators or their supervisors, and allows for evaluation of activities by program monitors. (**Note:** *The service log and LSCIS Quarterly Review Form must be used for this documentation.*)

Completion of the LSCIS Quarterly Review Form and narrative is required.
Receiving the amount of services as Prior Authorized, Service needs and status, Additional Service requests, Scheduling issues, etc.
- **PA Tracking Log-** Documents the coordination process of services that require Prior Authorization. Entries must be up to date to verify services and PA information.
- **Discharge Summary for Transfers and Closures** - All transfers/closures will require a summary of progress prior to final closure. (**Note:** *The service log must be used for this documentation; the LSCIS Closure Summary MUST be completed.*)

Issued 6/9/09

Revised 8/31/07 Memo

Minimum Requirements for Case Record Documentation

Documentation for EPSDT (June 2009 mandatory training)

1. Must find documentation of meeting/discussions/info with the client and/or family about continuing to receive additional services during the school year, over and above what the IEP required.
2. Must find documentation of meeting/discussions/info with the client and/or family about continuing to receive the IEP services during the summer months.
 - Service logs will identify if the contacts was with those providing the IEP Services, the doctors, with the family or client.
 - a) Service Needs section of the CPOC, Quarter Reviews, and Service logs should document if the services are received.
 - b) Quarter Review and Service Logs should document if the family is satisfied with current services.
 - c) CPOC, Quarter Review, and Service Logs should document if the client is progressing with the current and/or IEP services.
 - d) Quarter Review and Service Logs should document discussion with the family/client regarding the continuation of IEP services and/or additional services during the summer.
 - e) CPOC, Quarter Review, and/or Service Log should document the FOC and information regarding the requirements to obtain a PA for the services requested was given to the family/client.
3. If summer therapies are requested, they are to be entered in the CPOC Service Needs section. PA tracking is to begin 60-45 days prior to the last day of school. (If the service is requested prior to this, the parent should be obtaining the Rx so it can be submitted with the referral.) SC is to document if the Rx is not obtained due to physician refusal, parent did not schedule a required doctor visit, etc. SC is to document any barriers to obtaining the Rx and SC attempt to remove them.
4. Psychological and/or Behavioral Services

If formal information documents, interviews with caretakers, information in the case record, or SC observations identify the need for Psychological and or Behavioral Services it must be addressed on the CPOC. Any participant with issues such as child abuse, withdrawn, loss of parent or close family member, school suspension or expulsion, recent catastrophic injury, etc., should be offered services.

If there is an identified need for a psychological behavioral health service and the family/client declines the offer of the service it should be placed in the Service Needs Section of the CPOC.
5. Assisting with Appeals
 - a) SC must document the required contacts and offer of assistance with the appeals when a PA is totally or partially denied.

If assistance is requested, document coordination of documents and filing of the appeal, if documents were sent to the appeal office, or if no documentation was available.
(Appeals section in the handbook. Appendix L, Appendix T-1, LSCIS PA tracking log)

b) If a Notice of Insufficient Prior Authorization Documentation is received the SC should document the contact with the family and offer to assist with obtaining the additional information and their response, contact with the provider to obtain or have them submit additional information, if no additional information was available, and all SC activities to follow through with the PA request until the PA is either approved or denied based on medical necessity.

See Appendix R-5 for PA Tracking

Additional Documentation

Behavior Concerns

- Document month and year of incidents. The CPOC covers a year and documenting “recently” or couple of months ago is not helpful in determining a time frame. SC will need to know if there has been improvement in behavior or frequency of the events.
- Ask monthly about any behavior concerns or issues. Clarify if the reported incident is new and the frequency of occurrences. Is there something that caused the behavior such as the effect of a medication, beginning of illness, personality clash, antagonized by someone, toy taken away, unknown, etc.?
- List the specific behaviors and what is observed by the SC. (Recipient pulled a knife on a neighbor at the apartment and suspended from school. It was not documented that the neighbor was a schoolmate and that was the reason for the suspension.)
- What is the behavior? Give specific information. Include month/year.
- Were significant behavior concerns or incidents discussed with or reported to their physician?
- Ask the participant, not just the guardian, about behaviors and need for services.
- How often do the behaviors occur? Have they improved or gotten worse?
- How are they managed?
- What is reported on the IEP? Home and school may have different concerns.
- Do they have a school behavior plan?
- Receiving any services? If service was discontinued, clarify why.
- Document offer of service and family response.
- Be clear on what service is received or offered. See Appendix I-1 and the additional services in the EPSDT SC Training handbook.
- If there is an identified need for a psychological behavioral health service and the family/client declines the offer of the service it should be placed in the Service Needs Section of the CPOC.

Medical Diagnosis

- Have documentation to support the diagnosis.
- Each agency is required to have a nurse consultant. Use them as a resource for medical information that is not understood. Use the internet for information.
- It can be documented that “Mom states” a diagnosis, but also document that you do not have the documentation to support this.
 - Don’t have documentation to support what Mom states? Has it been requested or does it not exist? The nurse consultant may be able to assist in obtaining the diagnosis.
 - Don’t automatically list MR. Obtain the formal information documents to support it.
 - Diagnosis can change over time. Update with current information.

Competent Majors (8/8/11 Monthly Support Coordination Agency Meeting)
Support Coordinators are contacting and following up with Competent Majors' parents or caregivers regardless of the client's ability to self direct their own care. There is no documentation to support the clients request to have the parent or caregiver contacted or the clients inability to self direct their care.

Additional documentation is required for Competent Majors.

-Client Demo section: Must answer "yes" or "no" Is able to direct his/her own care (If they are unable to self direct their own care, an adult must be present with the PCS worker.)

-Medical Diagnosis section:

-If answered no, explain the basis for answering "no." (Personal observation during the face to face meeting, a specific psychological evaluation, IEP, etc.) ____ is unable to direct their own care based on _____. (Name or parent or other caregiver) has agreed or is responsible for assisting the client in obtaining needed services.

-If answered yes, and the Competent Major does not want to be the SC's phone contact, document if the client:

-Asks that the SC contact _____ to assist and communicate on their behalf.

-Requests that SC speak with _____ if they are not available at the time of the SC contact.

*SC must attempt to ask all the participants, regardless of their ability to self direct, about their preferences.

*During each Quarter Review ask and document if they still want representation.

*CPOC and Quarterly Reviews are to be signed by competent majors that are able to self direct their own care.

Service Log Example: Phone contact made with Mary Clark on behalf of Josh. Josh is at school.

CPOC Completion Tips

The information that was contained in the previous CPOC format is required in the LSCIS CPOC. Space may be limited so there is no need to repeat information in each section. Save often.

Contact/Demographic Information

Review all of the information and update as necessary.

If the participant's name is spelled or listed incorrectly, there may be a problem in resolving the PAs from Medicaid. PAs are issued to the name that is on file at Medicaid. If there is a discrepancy in the name documented by the family and Medicaid, the family may need assistance in obtaining a correction.

Legal guardian- The relationship of the legal guardian must be placed beside their name on the contact page. If someone other than a parent is the guardian, you must obtain the legal guardianship papers from Medicaid, OCDD, or the guardian. The legal guardianship document must be in the OCDD or the SC agency case record.

The ICD-9 code for the diagnosis may have changed since the last submitted CPOC. Make sure the code continues to match the participant's diagnosis. List the secondary diagnosis.

MR Status- Not MR is an option on the dropdown bar. Do not select this option unless it is valid. Review the IEP and other formal information documents for changes in the status.

Legal status. A legal document must be on file if the participant is at least 18 years of age and is not a competent major.

Ability to self direct if a competent major.

Current Education/Employment-

Homebound vs. Home-schooled

Homebound Service is provided by the School Board. Services are delivered per the IEP.

Home-schooled- Parent's choice to provide educational services. Parent is required to apply to the Board of Elementary and Secondary Education for approval of a home study program. A renewal application must be made annually.

Number and name of **other** MR/DD/Special Needs individuals in the home must be complete.

Residential Placement- If they are living with relatives but in the custody of DCFS (OCS), DCFS Foster Care is the correct code to use.

Section II - Medical/Social/Family History

Information included on this section is relevant to the individual's life today and provides a means of sharing social/family history not addressed in the content of the CPOC. Include information that is important to share and relevant to supporting and achieving the goals determined by the person.

Past

List the cause of the disability, the date and/or their age when this occurred. If not known, put unknown. Document briefly the placement history, reoccurring situations that impact their care, response to past interventions, events that lead to the request for services at this time.

Present/Natural Supports

What is the current family situation? Does the family have an understanding of the of the participant's situation/condition and knowledge of the disability? Document the source of household income, economic status and if disability funds are received; relevant social environmental and health factors that impact individual (i.e., health of care givers; home in rural/urban area; accessibility to resources; own home/rental/living with relatives/extended family or single family dwelling.)

Does home environment adequately meet the needs of individual or will environmental modifications be required? If the home does not meet their needs due to falling down stairs, not wheelchair accessible, no ramp, needs structural repair (not cosmetic), etc., there is an identified need. How do they manage without the DME or modifications? Problem solve and locate resources. Do they rent the home? Can they relocate to adequate housing? Family does not want?

If a participant needs to be carried because they do not have a lift or wheelchair accessible home, how much do they weight and is it safe for the participant and caregiver to carry them?

What is the diagnosis of other household members that have special needs? Do the needs of other special needs household members affect the recipients' needs being met? Do they receive any service in the home?

Address the competent major's desires and requests, not just parental input. What do they want for their future? School, employment, leisure, living situation, etc.

If they receive homeschooling, are they registered with the Department of Education?

Natural Supports are to be addressed in this section. List family members, names and ages, how they are involved/not involved; who is the primary care giver? Include information on both parents, document if they in the picture or if the family declined to disclose when asked. Description of complete social support network - list friends and other community resources involved in supporting the individual on a daily basis;

Individuals significant life events which may include family issues, issues with social/law enforcement agencies. Does the individual have social services case worker or Probation Officer assigned? Will you have to interact with that agency/individual?) If they have a guardian, it must be documented that the legal guardianship document is in the SC agency's case record. If child/ young adult is not attending school, document if they have interaction with friends, participate in leisure and social activities, and get out of the home.

HEALTH STATUS

Summarize important aspects of the person's health, behavioral and/or psychiatric concerns. This portion of the Plan of Care must be addressed initially, and updated as significant change occurs in the individual's life. Any pertinent information about the individual that can be provided by the family should be documented.

Physical

List the name of the participant's physician and the date of the participant's last appointment. Are they obtaining physicals at the recommended EPSDT Screening Exam interval? If not, are you encouraging that they do so? Is the participant enrolled in Bayou Health?

Immunizations

All information on immunizations should be current. This is extremely important. If immunizations are not up to date, this will need to be addressed.

Medical Diagnosis and Concerns/ Significant Medical History

A brief narrative description of the person's health history, current medical condition, including medical diagnoses, hospitalizations and continuing health concerns and medical needs should be included.

What were the findings of the last physical? List the participant's diagnosis and medications. What are the medications prescribed for? Allergies, blood pressure, behavior, etc List the medical specialists that the participant is required to see for follow up/routine appointments. Are they receiving the recommended annual dental checkups? Are linkages needed? What are the person's current physical abilities (if not addressed in the previous section) in the areas of vision, hearing, mobility, communication, use of arms, hands and legs and any need for assistive devices or DME? How does the participant communicate? (Assistive technology, PECS, sign language, point or grunts, etc.)

Are they toilet trained? Why are diapers a need- due to incontinence of bowel or bladder, bedwetting, occasional soiling, etc.? Do they have a gastrostomy tube, tracheostomy tube, or urinary catheter? How often is a special procedure administered? Do they receive formula, require a special diet, or receive funds for a special diet? Are they receiving any therapies? Are there any medical needs? Document any significant family health risk.

PCS is not PCA. List the correct service need. Be clear on what the identified service need is and what is requested. What two Activities of Daily Living do they need PCS to assist with? Do they need mentoring, supervision, respite, assist with homework, etc., which are not provided by PCS? What is the service needed to provide this?

If an individual meets the criteria for PCS and declines the service, document the recipient/parent declining the service. If the individual is capable of doing Activities of Daily Living or Instrumental Activities of Daily Living, document this.

Clarify if it is EHH (multiple hours of skilled nursing per day) or basic home health skilled nurse visit that is requested/received. Document what skilled service is needed that can't be provided by PCS.

Competent majors – Are they able to self direct. Are they able to communicate in any form, engage in their life and make choices of what is important to them and what they want in their life? Can they self direct and have other family members or concerned individuals assist? If they are able to self direct, did they request that the SC contact someone else to assist and communicate on their behalf? Did they request that SC speak with someone if they are not available at the time of the SC contact?

If unable to self direct, explain the basis for this. (Personal observation during the face to face meeting, a specific psychological evaluation, IEP, etc. Should not be based only on the parent states they are unable to self direct.) Physical disability does not prevent the ability to self direct. Who has agreed or is responsible for assisting the client in obtaining needed services? (See Appendix BB part 2 of 3 for required documentation)

*The SC must attempt to ask all the participants, regardless of their ability to self direct, about their preferences.

*The CPOC and Quarterly Reviews are to be signed by competent majors that are able to self direct their own care.

Medical Diagnosis

-Have documentation to support the diagnosis.

Each agency is required to have a nurse consultant. Use them as a resource for medical information that is not understood. Use the internet for information.

- It can be documented that Mom states a diagnosis, but also document that you do not have documentation to support this.

-Don't have documentation to support what Mom states? Has it been requested or does it not exist? The nurse consultant may be able to assist in obtaining the diagnosis.

-PDD is not autism.

-Don't automatically list MR. Obtain the information documents to support it.

-Diagnosis can change over time. Update with current information.

Psychiatric/Behavioral Concerns

A narrative description of the person's psychiatric status, diagnoses and significant behavior concerns should be provided in the Health Profile. Any relevant history that poses a potential risk for the individual or others should be provided. Also, information on effective behavior interventions, support plan and skills training should be detailed in accompanying information. This information can be obtained from the psychological.

Do they have a behavior plan at school? Are they taking medications for behavioral or psychiatric issues? If these services are received, they should be listed in the service needs and supports section.

Document how the behavior concern is managed, offers of services and the parent/participant's response. CPOCs will be returned if they do not appropriately address this here and in the service needs section if appropriate.

Don't state N/A in this section. These items must be assessed. Documenting "none" instead, would indicate that it was assessed.

Behavior Concerns

- Clarify placements. Is the facility a detention center, psychiatric hospital, etc?
- List the specific behaviors and what is observed by the SC. (Recipient pulled a knife on a neighbor at the apartment and was suspended from school. It was not documented that the neighbor was a schoolmate and that was the reason for the school suspension.)
- Document month and year of incidents. CPOC covers a year and documenting "recently" or couple of months ago is not helpful in determining time frame. The SC will need to know if there has been improvement in behavior or frequency of the events.
- What is the behavior? Give specific information. Include month/year.
- Were significant behavior concerns or incidents discussed with or reported to their physician?
- Clarify if the reported behavior is new and the frequency of occurrences. Is there something that caused the behavior? Effect of a medication, beginning of illness, personality clash, antagonized by someone, toy taken away, unknown, etc.
- How often do the behaviors occur? Have they improved or gotten worse?
- How are they managed?
- What is reported on the IEP? Home and school may have different concerns.
- Do they have a school behavior plan?
- Receiving any services? If a service was discontinued, clarify why.
- Be clear on what service is received or offered. See Appendices I and I-1 and the additional services in the EPSDT SC Training handbook.
- Ask the participant, not just the guardian, about behaviors and need for services.
- Document offers of service and the recipient/family response.
- If there is an identified need for a psychological behavioral health service and the family/client declines the offer of the service it should be placed in the Service Needs Section of the CPOC.

Evaluations/Documentation

You should have the SOA and all assessments/evaluations and supporting documents (listed on the IER) that OCDD used to determine DD eligibility, the current IEP and any other assessments by professionals (Form 90, Home Health Plan of Care, Evaluations) that would be current. The current EHH Plan of Care must be obtained and listed if this service is received. If the participant is not receiving Special Ed. services, a current formal information document must be obtained and listed. Contact BHSF/SRI if OCDD does not provide their documents. OCDD should release the documents within 5 working days of the request (faxed FOC and request for records).

SOA

The SC should be aware of the participants Request for Services Registry (RFSR) date and approx date of offers. How will SC know if there is a problem with the family not responding to the offers?

The SC should refer a participant to OCDD two months prior to the SOA expiration. DHH/SRI should not be receiving annual CPOCs that have expired SOAs. SC agencies were instructed to obtain valid SOAs and ITS Applications for Services June 2008.

- A valid SOA is required unless they are identified in LSCIS as ‘Special Needs’.
- The SOA expiration date should not be blank unless an expiration is not listed on the SOA notice, the IER, or the “Redet Due” box on the ITS Application for Services is blank.
- If the SOA has expired, contact OCDD and obtain the ITS Application for Services or “Approval for Continued Services and Requested Waiver Date” notice. If the SOA has expired and a redetermination is required, list the expiration date. The identified need for the OCDD redetermination should be listed in the Service Needs section.
- A SC is to refer a participant to OCDD for a redetermination if it appears that they no longer meet the eligibility criteria, even if they have a SOA.
- A short term PA will be issued while the redetermination process is being completed. If it is determined that they are not eligible for OCDD services, the PA will be extended to allow for an appeal and a review by BHSF for possible identification as “Special Needs”.

IEP

IEPs should be requested from the parent on intake. If the parent does not have a copy, SC should request a copy from the school or school board office.

Obtain the current annual IEP, not just the progress report or Extended School Year Program (ESYP) that does not have all of the assessment information. IEPs are valid for one year. If the IEP is more than a year old, the SC may need to confirm the date of the last IEP with the school board. Sometimes parents do not attend the IEP meetings, forget it was renewed, or misplace the IEPs.

Obtain the annual IEP as it is renewed and update services with an interim CPOC as needed. School services should be current. (An annual CPOC was randomly selected for monitoring. The current IEP dated 9/18/08 had ST and PT services removed yet the monthly service logs, Quarter Reviews, and 5/5/09 CPOC that was submitted, wrongly documented the services were still received.)

If the IEP is obtained as it is renewed, the CPOC submit and approval will not be delayed while the SC tries to obtain the document.

Discuss the IEP with the parent/guardian. Are they aware of what services their child is or is not receiving? Does the parent need to request another IEP meeting to have the IEP services corrected. The School Board is legally obligated to provide the services on the IEP.

Always offer and document the offer of medically necessary community therapies in addition to the therapies received per the IEP.

Contact the parent after Easter to see if the participant qualified for Extended School Year Program (ESYP) and if they will be attending.

Contact Child Search if the participant has not had a Special Ed Evaluation. A Special Ed. Eval. is needed before an IEP can be done to receive school services. School or education should be an identified need unless they have a Doctor's statement that it is not appropriate or if they have completed an educational program.

If the recipient does not have an IEP, do they have a 504 education plan and/or a school health care plan? If so, obtain that document to identify their needs and services.

Review the IEP for information. When documenting placement grade, also document academic functioning level. Some CPOCs give the impression that participant does not meet the eligibility criteria. (Documented the recipient was in the 11th grade but did not document it was inclusion and they were functioning academically on 3rd grade level.)

When will the participant graduate? Will they receive a diploma, Certificate of Achievement, or GED? If they are leaving school prior to age 21, do they need to be transitioned to LRS, Supports Waiver, higher education, etc.?

Current formal information must be reviewed to identify needs while developing the CPOC. Information from the documents must be incorporated into the CPOC. Were additional assessments or services recommended? What services are they to receive at school? Are there any behavioral issues that were not identified or mentioned by the family?

Formal information documents used in the development of the CPOC are to be listed. On initial and “Special Needs” CPOCs, this documentation is to be sent to SRI and must be received prior to CPOC approval. Annual CPOCs are to have the documents placed in the case record and submitted to BHSF/SRI immediately upon request.

If the CPOC is randomly selected for monitoring when it is submitted to DHH/SRI for approval, Appendix X-2 and the required documents must be submitted to SRI.

Information gathered from the family is informal information and should not be listed as an evaluation/document.

A participant may be identified as “Special Needs” by BHSF if the participant is not eligible for the waivers or other OCDD services. Special Needs participants must have current formal information documentation submitted to BHSF/SRI with the annual CPOC to document that they continue to qualify for EPSDT Support Coordination.

Section III - CPOC Service Needs and Supports

This section will assist the case management agency and the direct service provider to develop the individual's plan of care.

Service Strategy/Description

"What" is needed for the individual to achieve his/her personal goals? This section identifies the support needed. This may reflect training, needed supports, and/or skill acquisitions, or may regard the person's maintenance in the home and community with provided supports. Make sure that you address all issues on the IEP and learning disabilities.

Check boxes are to be used to identify "Who and How" the person can be supported to achieve his/her personal outcome. This section identifies whether paid staff will be utilized or natural supports (friends/family) are in place to provide the service need.

“What, Who, and How” can also be clarified in the Section IV, Additional Information section.

The drop down bar will identify a list of Medicaid services that require a PA and other services for identified needs. Additional needed services can be added to this list.

Do not list the name of the provider or brand in the service description box. The CPOC will be locked after approval and won't allow for this identifier to be edited when a new provider or brand is selected. List the brand or provider's name in Section IV, Additional Information.

Do not list other terms, such as amounts of service, “applying” or “requested” in the description box. These descriptions may change over time without having a change in the need for the service. There is a separate box for amount approved.

The description box should clarify the service need that is requested. If there is not enough space, clarify the service in Section IV, Additional Information. Example: Dental Services/ routine care, Dental Services/ tooth decay, Dental Services/locate provider.

All identified service needs must be listed. Don't forget to include all identified needs such as, respite, smoke alarm, behavior medications, cash subsidy, DME maintenance, specialized treatments such as chemotherapy or dialysis, MH services, van lift, etc. If it is not a Medicaid service, the SC is to assist in locating resources to provide the service need.

If they are homeschooled, are they registered and approved by BESE or is this a need?

DME products for a specific task can be grouped. Gauze, tape, gloves, and saline for wound care can be identified as DME/wound care if all of the products are ordered from the same provider with the same PA service dates.

Therapies

Therapies received at school and in the community should be listed separately. Their amounts approved and PA tracking requirement differ.

Identify what services are on the IEP.

OT consult is not a direct service. They consult with the teacher and parent and may observe the child in the classroom. It may be received only once a semester. It should be identified as "OT consult".

Adaptive Physical Education, A.P.E., is not a therapy. It is provided to a student who is unable to participant in regular physical education (P.E.).

Unless the SC checked with the contact person listed on the Medicaid Services Chart, never state that Medicaid does not cover a service. Medicaid must cover items that are medically necessary.

Examples: Aquatic therapy may be covered under an OT provider.

A liquid thickener may be medically necessary to prevent choking. Will the physician write a prescription?

Behavioral Health Rehab. is a specific Medicaid program. Review the service information in the EPSDT SC Training Handbook. This service requires a PA. Do not use this term unless it is the service requested/received. Other/Mental Health Service, Other/Psychiatric care, Other/counseling, etc. can be used if this is the service need that is requested/received. See Appendix I-1.

Psychological and Behavioral Health Services (PBS) is provided by psychologists. If the service they are receiving is not provided by a psychologist or identified as the specific BH Rehab service, Other/counseling, Other/ MH service, Other/behavior medication, Other/_____, should be listed. See Appendix I-1.

PCS is a specific Medicaid service that can not be provided by the family. OCDD does not provide this service. Other/ assist with ADL, Other/PCA contract, Other/respite, etc., should be used for non PCS services.

EHH vs. Basic Home Health Services

EHH provides multiple hours per recipient per day of skilled nursing care. Recipients under 21 only. Prior Authorization is required.

Basic Home Health Services are provided in the home under the order of a physician that are necessary for the diagnosis and treatment of the patient's illness or injury, including: skilled nursing, physical therapy, speech-language therapy, occupational therapy, home health aide services or medical supplies, equipment and appliances suitable for use in the home (with approved Prior Authorization). Recipients must have a physician's prescription and signed Plan of Care. PT, OT, and ST require a PA.

EHH is a Specific Medicaid program. Use the EHH drop down for Extended Nursing Home Health only.

If they are requesting or receiving basic home health services, Other/ skilled nurse visits or Other/Home Health PT, etc. should be listed.

EPSDT Transition must be listed as a service need if the participant is 20 ½ or older during the CPOC service dates. The strategy is to be documented in the Additional Information section.

The service strategy for Support Coordination is included in section IV and denotes that the CPOC will be reviewed quarterly and revised at least annually. Do not list SC as a service need in this section.

“Requires PA tracked by Support Coordinator” and “Medicaid” must be checked in order to enter the required PA Tracking log.

“Requires PA tracked by SC” must be checked for all requested services that require a PA, unless a valid reason is documented. If the PA is issued monthly, a PA tracking log can't be done due to the quick turn around. The required provider contact timelines can't be met since a PA renewal request is submitted by the provider prior to the required 45 day renewal notice being sent by the Support Coordinator. The EHH nurse may be the person ordering and tracking the supplies. The valid reason for not tracking the PA (PA is “issued” monthly, the Extended Home Health nurse orders and tracks the supplies or on a wait list for therapy.) and how the SC will ensure that the service is received must be documented in the “Additional Information” box. The PA notices must be kept in the case record and the “amount approved” placed in the CPOC service needs and supports section.

Note: Diapers and formula may be delivered or released in monthly increments due to storage when the PA is issued for 6 months. PA tracking would be required in this case.

-Don't uncheck PA tracking unless there is a valid reason. SC must document the reason in the Additional Information section. Example: The recipient is placed on a wait list after they are referred to the provider. The SC would document in Additional Information how they will ensure the recipient moves up on the wait list and receives the service. (The SC must confirm with the provider that the participant is on the wait list and complete a PAL Referral to notify them of placement on a wait list before PA tracking is unchecked)

SOA

If the SOA will expire during the CPOC year, Other/ month & year redetermination, (Other/ 4/10 Redetermination) should be listed as an identified need. The SC should refer a participant to OCDD two months prior to the SOA expiration. DHH/SRI should not be receiving annual CPOCs that have expired SOAs. SC agencies were instructed to obtain valid SOAs and ITS Applications for Services June 2008.

Service Needs section

Carried over-resolved

- 1) The service is no longer requested or an identified need. (DME that is to be maintained or renewed is to remain as a Service Need.)
- 2) The service was listed in error or incorrectly identified and is locked on the CPOC.

Document why service need was resolved in the Additional Information section.

Family does not want- The need for the service has been identified but the participant/family declines the service.

Other/explain –The service is an identified need but is placed on hold. Must explain in the Additional Information section. Example: Has a PA for PT but had a recent surgery and the PT was placed on hold with the intention of returning. *This is not appropriate if on a wait list for therapy. They are requesting the service now.

Section IV - Additional Information/CPOC Participants

Additional Information

This section is provided to document additional information regarding service needs and supports. The names of all service providers and any additional strategy information are to be placed in this section.

Strategy information may be required to clarify who, what, and how the service need will be met. Example: If the service need is "Other/recreational activity" and family and community are checked as providing the service, document the family is taking him to the library and sporting events and he is involved in YMCA activities.

If a current service need was requested on the previous CPOC and is not checked as “receiving”, document the barriers and the strategy to obtain the service need now.

Specific EPSDT transition strategies must be listed in this section.

SUPPORT STRATEGY NEEDED

- “What” is needed to achieve the Goal?
- “How” will the support be delivered?
- “Who” will deliver the support?
- “Where” will the support be provided?

CPOC Participants

As the Support Coordinator, it is your responsibility to have everyone sign (especially the participant/parent/guardian) the printed LSCIS CPOC signature page indicating their participation.

The participant/guardian must also sign and date the printed LSCIS CPOC signature page after they have reviewed and agree with the services in the CPOC. Participants age 18 or older must sign all documents if they are able to direct their own care. If they are not able to sign, document why. This signature date is to be entered in this section of LSCIS.

Section V - CPOC Approval

You, the Support Coordinator, must sign and date the CPOC and have your supervisor review and sign the plan prior to submitting an approvable CPOC to BHSF/Statistical Resources, Inc. (SRI). The supervisor’s signature denotes that they approve and agree with the contents of the CPOC being submitted. The Formal Information documents, prior CPOC, Service Logs, and Quarterly Reviews must be reviewed by the Supervisor for identified needs and status of requested services. The entire CPOC must be reviewed to ensure that all identified service needs are addressed, all required information is included, the information from the prior approved CPOC has been updated with current information, outdated information has been edited, and no discrepancies exist. (Is this requirement met when CPOCs are submitted to SRI for approval after office hours, on weekends, and holidays?)

Some discrepancies and errors should be caught if the supervisor carefully reads the CPOC prior to DHH/SRI submittal. Read the evaluations and assessments to determine if all needs and recommendations have been addressed.

If the caregiver is not the parent, it must be documented on the CPOC that the legal guardianship document is in the SC agency’s case record. The demographic sheet from OCDD documenting the caregiver or a letter documenting the SSI payee is not a legal guardianship document. A non-legal custodian affidavit (Appendix AA) can be obtained by the caregiver. This affidavit does not require a parent signature. It must be notarized

and renewed each year. If this is the only CPOC deficiency, the CPOC will be denied but the approvable CPOC submit date will be honored when the CPOC is resubmitted with the required documentation.

An initial or “Special Needs” CPOC submitted to SRI must include formal information documents. This is to be sent to SRI and must be received prior to CPOC approval. All other information as required on the Checklist for EPSDT Support Coordination Approval Process (Appendix X) must be maintained in the participant’s file. It must be available and submitted to BHSF/SRI immediately upon request or monitoring (*Appendix X-2*).

BHSF/SRI will review the CPOC to assure that all components of the plan have been identified. If any part of the CPOC is not completed by the Support Coordinator, the plan will be returned to the Support Coordinator without an approval.

Review the Approval /Denial Note box on all returned CPOCs. An approved CPOC may have a note to address something on an interim CPOC or information regarding the PA.

Service logs should not be voided unless they are to be considered nonexistent.

Delete records placed in another clients LSCIS record. Print the log prior to deleting it so that the information can be entered in the correct client’s record. You must have “administrator” security status in LSCIS to delete a log.

Use current forms in the latest Training Handbook. Send Appendix X-2 with monitoring documents.

HIPAA. List the participant’s initials, not their name, on the fax cover or e-mail subject line. Don’t forget to put the participant’s name in the body of the e-mail or faxed documents.

Send faxes with a cover. The SRI fax is used by all departments and documents sent to me may end up with the PA or registry personnel.

Section VI – CPOC Quarterly Review

This is to be used for the required face to face quarterly review visit. Print out the Quarterly Review form after an interim CPOC is entered. Service Needs will then be on the form for you to take to the face to face meeting. Individuals participating in the meeting are to sign and date the paper copy.

If additional service needs were identified during the face to face visit, the interim CPOC will need to be edited to update the service needs section. This is required before completing the electronic Quarterly Review so that the updated Service Need will appear on the Quarterly Review and be available for comments.

Refer to the current EPSDT Support Coordination Training Handbook for additional information.

List the SC as an attendee. The SC date is the date of the meeting, not the date the log was entered.

* A Quarter Review will not be counted on the required action report if the participant does not have a PA for SC. (Late CPOC or case transfer of record not signed at the time of the face to face visit)

Section VII - Typical Weekly Schedule (Paper form only)

The weekly schedule is a tool that the Support Coordinator uses to assure that services are delivered at appropriate days and times and do not overlap, unless this is medically necessary.

The weekly schedule should indicate what services are already in place and the services that are being requested through Medicaid prior authorization or other sources. The schedule should show when the participant is in school, at home or participating in other activities. The schedule can be forwarded to in-home providers and prospective providers to support and clarify prior authorization requests. If prior authorization is denied and not appealed, or if for any other reason the planned services are not delivered, the schedule should be amended to reflect services actually put in place.

Case Closure

Close cases in LSCIS timely. Agencies will be responsible for deficiencies in services if the case is not closed. Participant will continue to be included in reports (Aging, Quarterly Report, Timely CPOC, EHH and PCS request, etc) until they are closed. If a participant has not had an initial PA issued, the Program Manager must be contacted prior to closure. Documentation to support the closure must be found in LSCIS to have the linkage closed. If this is not done they will remain linked to the agency. Appendix U.

Initial linkage closures. EPSDT SC is not just for individuals with a need for PCS. Why did they request SC and decline it prior to an assessment for identified needs and discussion of services and available resources? The recipient/family made the effort to receive the service by completing and submitting a FOC for the linkage. The program manager may have additional information regarding referrals from OCDD, DCFS, social worker, etc.

Give participants SRI's 800-364-7828 contact number in letters sent to the families re: no contact/closure. DHH requires a toll free number for the participants.

CHILDREN'S CHOICE WAIVER FACT SHEET

Description	<p>The Children's Choice Waiver began on February 21, 2001 to offer supplemental support to children with developmental disabilities who currently live at home with their families or who will leave an institution to return home.</p> <ul style="list-style-type: none"> • Children's Choice is an option offered to children on the Developmental Disabilities Request for Services Registry (RFSR) for the New Opportunity Waiver (NOW), as funding permits. • Families choose to either apply for Children's Choice, or remain on the Developmental Disabilities Request for Services Registry for the NOW. • Waiver participants are eligible for all medically necessary Medicaid services, including EPSDT screenings and extended services, and will also receive up to \$16,410 per year in Children's Choice services (including required Support Coordination (case management). Services received through the Medicaid State plan will not count against the Children's Choice Waiver cap. • Service package is designed for maximum flexibility. • Children who "age out" (reach their 19th birthday) will transfer into an appropriate waiver for adults as long as they remain eligible for waiver services. <p>The follow services are available through the Children's Choice Waiver:</p> <p>Support Coordination, Family Support, Center-Based Respite, Family Training, Environmental Accessibility Adaptations, Specialized Medical Equipment and Supplies.</p> <p>Therapy Services include Aquatic Therapy, Art Therapy, Music Therapy, Hippotherapy/ Therapeutic Horseback Riding, Sensory Integration and Applied Behavioral Analysis (ABA)-based Therapy.</p> <p>Additional services include Housing Stabilization Services and Housing Stabilization Transition Services.</p> <ul style="list-style-type: none"> • A family choosing Children's Choice may later experience a crisis increasing the need for paid supports to a level, which would be more than the \$16,410 cap on Children's Choice expenditures. During an initial one-year trial period, special provisions have been made to provide additional supports during the crisis period until other arrangements can be made. • A family may also experience a temporary "non-crisis" that could increase the need for additional supports beyond the \$16,410 cap and allow the participant's name to be restored to the Developmental Disabilities Request for Services Registry for the NOW. Current Children's Choice Waiver services will not be terminated as a result of restoring the name to the registry. Special provisions have been made to allow someone to be restored to the registry until a NOW opportunity becomes available. <p>Note: Planning of services is crucial for Children's Choice Waiver participants. Over utilization of services does not constitute necessity for crisis support.</p>
Level of Care	Recipients must meet the ICF/DD level of care for medical and/or psychological criteria. Procedures and requirements for admission to the waiver are the same as for ICF/DD determination.
Population	Age - Birth through age 18 years. Disability – Meets the Louisiana definition for a developmental disability.
Eligibility	<p>Income – Up to three times the SSI amount. Income of other family members is not considered.</p> <p>Needs Allowance – Three times the SSI amount.</p> <p>Resources – Less than \$2,000.</p> <p>Non-Financial – Meets all Medicaid non-financial requirements (citizenship, residence, Social Security number, etc.</p> <p>Other – Same resource, disability, parental deeming, etc. as ICF/DD.</p>

**For Information about Accessing Children's Choice Waiver Services,
Please Contact Your OCDD Regional Office/District/Authority.**

Frequently Asked Children's Choice Questions

1. What is Children's Choice?

Children's Choice is a program designed to help families who provide in-home care and support for their children with developmental disabilities. Children's Choice assists by providing funding for medical care, home modifications, care-giving assistance and support, and other specialty services. Children's Choice is a support program designed to be flexible enough to let families choose when they need the covered services.

Children's Choice is intended to supplement the care and support that eligible children already receive at home, through their extended families or that is already available within local communities. Funds available through Children's Choice are capped at \$16,410 per care plan year. Recipients are also eligible for services through the Medicaid State Plan which includes all medically necessary services.

2. What are the eligibility requirements for Children's Choice?

- Child is on the Request for Services Registry.
- Child is under nineteen (19) years of age.
- Child is disabled according to SSI criteria.
- Child requires the level of care provided in an ICF/DD facility (institution).
- Child has income less than three (3) times the SSI amount.
- Child has resources less than \$2,000.
- Child meets all Medicaid non-financial requirements (citizenship, residence, Social Security number, etc.).
- Child's plan of care meets the health and welfare needs of the child.
- Appropriate level of care can be provided outside an institution.

3. What services are available through Children's Choice?

- Support Coordination
- Family Support
- Center-based Respite
- Environmental Accessibility Adaptations
- Specialized Medical Equipment and Supplies
- Therapy Services include Aquatic Therapy, Art Therapy, Music Therapy, Hippotherapy/Therapeutic Horseback Riding, Sensory Integration and Applied Behavioral Analysis(ABA)-based Therapy
- Housing Stabilization Services and Housing Stabilization Transition Services
- Family Training
- Medical coverage via the Medicaid program

4. What are some of the things that would be covered by the Medicaid card?

When a child is certified for Children's Choice, they will be entitled to receive medical services and get a Medicaid card. Some services include physician services, hospital services, home health, additional personal care services, durable medical equipment, pharmacy services and many others.

5. What is the New Opportunities Waiver (NOW)?

The NOW is a comprehensive community-based waiver program that serves both children and adults with developmental disabilities. Traditionally, Medicaid pays for and provides services for these individuals in institutional settings. Through the waiver program, citizens with developmental disabilities have greater flexibility to choose where they want to live, and the services and supports that best suit their needs, while still receiving Medicaid benefits.

The NOW pays for services such as personal care attendants, environmental modifications, assistive devices, respite care, Housing Stabilization Services, Housing Stabilization Transition Services. and many

other services. In addition, day/vocational services and residential alternatives (such as supervised independent living and extended family living) are provided.

6. How can a parent find out what their child's request date is on the Request for Services Registry?

A parent can call Toll Free 1-866-783-5553 or contact their Local Governing Entity (LGE) (EPSDT Appendix G) to obtain their child's request date. Registry Dates that are currently being served can be accessed at the OCDD Request for Services Registry web page at <http://new.dhh.louisiana.gov/index.cfm/page/155>

7. How often are the opportunity letters offering Children's Choice to families sent out and will families who initially declined Children's Choice be contacted again in the future to see if they have changed their mind, especially if there are changes in the program?

When Children's Choice opportunities are available, letters go out to families. Families who have initially said "no" will not be offered a Children's Choice Waiver again. Recipient's name will remain on the DD Request for Services Registry (RFSR) for a New Opportunities Waiver Slot.

8. What if I think my child needs more services in excess of the yearly limit?

Children's Choice is designed for children under age nineteen (19) with low to moderate needs and whose families provide most of the care and support. But if a crisis situation develops and additional supports are warranted, there are crisis provisions designed to meet the needs of families on a case-by-case basis.

9. I've waited several years for community services. If I accept Children's Choice instead of the NOW, do I lose the opportunity to get the NOW if my child's needs change?

If a child's needs significantly change and the crisis or non-crisis designation is met, the child's name would be returned to the Request for Services Registry with the child's original request date. There is also an administrative appeal process for families who request and are denied either crisis or non-crisis designation. Additionally, once your child turns age nineteen (19), and continues to meet the eligibility criteria, your child would transfer to an appropriate adult Waiver.

10. If I take Children's Choice and my child's name comes up for DD Waiver services on the DD RFSR before he/she reaches age nineteen (19) can I transfer to the NOW?

It depends on whether or not crisis or non-crisis designations are met.

11. What are the non-crisis provisions?

The non-crisis provisions allow Children's Choice Waiver participants to have their names restored to the Request for Services Registry for the NOW. Names are restored to the registry in original date order, when all of the following four (4) criteria are met:

- The recipient would benefit from services through the NOW which are not available through his/her current waiver or through Medicaid State Plan Services; AND
- The recipient would qualify for those services under the standards utilized for approving and denying services to the NOW participants; AND
- There has been a change in circumstances since his or her enrollment in the Children's Choice Waiver causing these other services to be more appropriate.

A change in the recipient's medical condition is not required. A change in circumstances can include the loss of in-home assistance through a caretaker's decision to take on or increase employment, or to obtain education or training for employment. The temporary absence of a caretaker due to a vacation is not considered "good cause"; AND

- The recipient's request date for the NOW has passed on the Request for Services Registry.

Re-adding the recipient to the DD RFSR will allow him or her to be placed in the next available waiver slot that will provide appropriate services provided the individual is still eligible when the slot becomes available.

12. If a crisis occurs and additional services are needed beyond the cap, how long will it take to access those services?

When the crisis occurs, the family should contact the support coordination agency to convene the team to evaluate the need and to request approval of the needed services.

13. What happens when my child reaches age nineteen (19) and Children's Choice benefits expire?

Once your child turns age nineteen (19), and continues to meet the eligibility criteria, your child would transfer to an appropriate adult waiver. Approximately ninety (90) days before your child turns nineteen (19), this eligibility and transfer process would begin.

14. I've been told that some of the \$16,410 is used for mandatory support coordination. Can I forgo these services and instead use these funds to purchase additional community-based services?

No, support coordination is a Children's Choice Waiver service. The support coordination agency is responsible for development of the comprehensive plan of care and assuring the services your child needs are delivered. However, DHH/OCDD will continue to seek ways to make the support coordination requirement more flexible.

15. Are there any other services under Children's Choice that families/children are required to take or use in a specific amount of funding?

No. There are no other "required" services under Children's Choice.

16. How do I choose a support coordination agency?

Support Coordination agencies are selected from a "Freedom of Choice" list. This list is sent at the same time a Children's Choice Waiver offer is sent to the family.

17. Can families who accept Children's Choice for their child receive the funding directly, or through a fiscal intermediary, so they can recruit, hire or fire the in-home supporters?

Yes, this services was approved by Centers for Medicare and Medicaid Services (CMS) and added to the Children's Choice Waiver. Self –Direction Option for family supports services was implemented on February 1, 2014.

18. How long does it take to get services once my child has been determined to be eligible?

The process works as follows:

- 1) The family accepts Children's Choice Services
- 2) A support coordinator is chosen and development of a Plan of Care (POC) begins
- 3) The child is determined eligible for the Children's Choice Waiver; and
- 4) The POC is approved.

The support coordinator then begins to implement the POC and arrange other necessary services.

19. How often is our family required to get an eligibility determination?

Re-certification is required annually, and the POC is renewed annually as well.

20. I've been told that the service limit cap of \$16,410 per year represents a decrease. Is this true?

Yes. The Department of Health and Hospitals (DHH) raised the yearly cap from \$7,500 to \$15,000 to \$17,000 per plan-of-care-year and as a result of a budgetary shortfall for fiscal year 2010-2011; the service cap was decreased to \$16,660 effective September 1, 2010. It was again decreased to \$16,410 effective August1, 2012.

21. If I have concerns about my service provider(s) or support coordinator, who should I call?

Call the OCDD toll-free help line at 1-866-783-5553.

22. If I accept Children's Choice, how will that affect the services I am receiving from other programs?

Regarding state funded programs, it is a case-by-case decision as to whether there would be an effect.

23. Can a family "stockpile" time for family supports such as respite or family support for use during holidays or summer vacation?

The Plan of Care (POC) determines the number of service hours a recipient can receive based on the individual's need. The POC should be flexible to meet the individual's needs, and if one's needs change, the POC can change, thus allowing the individual flexibility.

24. Will accepting Children's Choice affect my child's Supplemental Security Income (SSI) or the Medicaid services he receives now?

This acceptance should have no effect on other Medicaid state plan services, other than if the participant was receiving EPSDT SC they would then receive Support Coordination as a service under the Children's Choice Waiver. There will be no effect to your SSI benefits if you choose the Children's Choice Waiver, but you may contact the Social Security office with any questions regarding your SSI.

25. What is considered "direct care"?

Direct care can be services and supports provided in a direct manner to the individual.

Early Periodic Screening, Diagnosis and Treatment Personal Care Services

1. Tasks that are medically necessary as they pertain to an EPSDT eligible recipient's physical requirements when cognitive or physical limitations necessitate assistance with eating, bathing, dressing, personal hygiene, bladder or bowel requirements.
2. Services which prevent institutionalization and enable the recipient to be treated on an outpatient basis rather than an inpatient basis to the extent that services on an outpatient basis are projected to be more cost effective than services provided on an inpatient basis.

Recipient Qualifications

Conditions for Provision of EPSDT Personal Care Services

1. The person must be a categorically –eligible Medicaid recipient birth through 20 years of age (EPSDT eligible) **and have been prescribed EPSDT PCS as medically necessary by a physician.** To establish medical necessity the parent or guardian must be physically unable to provide personal care services to the child.
2. The recipient's condition includes a need for nursing care to manage a plan of care and/or more assistance with extensive personal care, ambulation, and mobilization. This may include professional nursing care and assessment on a daily basis due to a serious condition which is unstable or rehabilitative therapeutic regime requiring professional staff.
3. When determining whether a recipient qualifies for EPSDT PCS, **consideration must be given not only to the type of services needed, but also the availability of family members and/or friends who can aid in providing such care. EPSDT PCS are not to function as a substitute for childcare arrangements.**
4. EPSDT personal care services **must be prescribed by the recipients attending physician initially and every 180 days thereafter (or rolling six months), and when changes in the Plan of Care occur.** The physician should only sign a fully completed plan of care which shall be acceptable for submission to BHSF only after the physician signs and dates the form. The physician's signature must be an original signature and not a rubber stamp.

Place of Service

EPSDT personal care services must be provided in the **recipient's home** or in another location if medically necessary to be outside of the recipient's home.

Services

EPSDT personal care services include:

1. basic personal care, toileting and grooming activities, including bathing, care of the hair, and assistance with clothing;
2. assistance with bladder and/or bowel requirements or problems, including helping the client to and from the bathroom or assisting the client with bedpan routines, but excluding catheterization;
3. assistance with eating and food, nutrition, and diet activities, including preparation of meals for the recipient **only**;

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Mandatory Training

Revised 10/28/10, 2/9/12, 6/16/14

4. performance of incidental household services essential to the clients health and comfort in her/his home. Examples of such activities are changing and washing bed linens and rearranging furniture to enable the recipient to move about more easily in his/her own home;
5. accompanying not transporting the recipient to and from his/her physician and/or medical facility for necessary medical services;
6. EPSDT personal care services are not to be provided to meet childcare needs nor as a substitute for the parent in the absence of the parent;
7. personal care services (PCS) are not allowable for the purpose of providing respite care to the primary caregiver;
8. EPSDT personal care services provided in an educational setting shall not be reimbursed if these services duplicate services that are provided by or must be provided by the Department of Education;

Nonreimbursable Services

- custodial care or provision of only instrumental activities of daily living tasks or provision of only one activity of daily living task;
- EPSDT personal care services provided to meet childcare needs or as a substitute for the parent in the absence of the parent shall not be reimbursed.
- EPSDT personal care services provided for the purpose of providing respite to the primary caregiver shall not be reimbursed.

. Provider Qualifications

A. Personal care services must be provided by a licensed personal care services agency which is duly enrolled as a Medicaid provider. **Staff assigned to provide personal care services shall not be a member of the recipient's immediate family.** (Immediate family includes father, mother, sister, brother, spouse, child, grandparent, in-law, or any individual acting as parent or guardian of the recipient). Personal care services may be provided by a person of a degree of relationship to the recipient other than immediate family, if the relative is not living in the recipient's home, or, if she/he is living in the recipient's home solely because her/his presence in the home is necessitated by the amount of care required by the recipient.

EPSDT Personal Care Services vs. Home Health Services

(including Extended Skilled Nursing Services also known as Extended Home Health)

EPSDT Personal Care Services (PCS)	Home Health (Basic and Extended)
<ul style="list-style-type: none"> ▪ Services include: basic personal care – bathing, dressing and grooming activities. Assistance with bladder and/or bowel requirements or problems. Assistance with eating and food preparation. Performance of incidental household chores for the recipient only. ▪ The recipient's condition includes a need for nursing care to manage a plan of care and/or more assistance with extensive personal care, ambulation, and mobilization. This may include 1) professional nursing care and assessment on a daily basis due to a serious condition which is unstable or 2) rehabilitative therapeutic regime requiring professional staff. ▪ Does not cover any medical tasks, medication administration, or NG tube feeding. ▪ Accompanying, NOT TRANSPORTING recipients to medical appointments. ▪ EPSDT PCS is not to function as a substitute for childcare arrangements or to provide respite care to the primary caregiver. ▪ Must be prior authorized by BHSF/Molina. Documentation that must accompany PCS request: PA-14, Daily Time Schedule, EPSDT-PCS Form 90, Plan of care approved by the physician, Social Assessment and any supporting documentation. ▪ Ages: birth through 20 ▪ Services provided by a Medicaid enrolled Personal Care Services provider. 	<ul style="list-style-type: none"> ▪ Basic Home Health Services include skilled nurse visits (RN or LPN), Aid visits, Physical Therapy, Occupational Therapy and Speech Therapy. ▪ Recipients may also receive Extended Skilled Nursing Services (Extended HH) which is multiple hours per day, several days per week for an extended period of time. Can provide medical tasks such as tube feeding, catheter maintenance and medication administration. ▪ Extended Skilled Nursing Services (Extended HH) and all therapies must be prior authorized. Home Health visits above one per day must be prior authorized by BHSF/Molina. Documentation that must accompany HH request: Physician referral on letterhead, home health plan of care, and a completed PA-07. ▪ Children may still be eligible for Extended Skilled Nursing Services even if they attend school outside the home. ▪ For Extended Services, a prescription is needed from the doctor stating the number of hours requested and a letter of medical necessity justifying the reason for extended services and the number of hours requested. ▪ Therapies can be provided by Home Health agencies, an outpatient facility, in an Early Intervention Center, rehabilitation center and at school.

Services Available to Medicaid Eligible Children Under 21

If you are a Medicaid recipient under the age of 21, you may be eligible for the following services:

- *Doctor's Visits
- *Hospital (inpatient and outpatient) Services
- *Lab and X-ray Tests
- *Family Planning
- *Home Health Care
- *Dental Care
- *Rehabilitation Services
- *Prescription Drugs
- *Medical Equipment, Appliances and Supplies (DME)
- *Support Coordination
- *Speech and Language Evaluations and Therapies
- *Occupational Therapy
- *Physical Therapy
- *Psychological Evaluations and Therapy
- *Psychological and Behavior Services
- *Podiatry Services
- *Optometrist Services
- *Hospice Services
- *Certified Nurse Practitioners
- *Residential Institutional Care or Home and Community Based (Waiver) Services
- *Medical, Dental, Vision and Hearing Screenings, both Periodic and Interperiodic
- *Immunizations
- *Applied Behavioral Analysis
- *Eyeglasses
- *Hearing Aids
- *Psychiatric Hospital Care
- *Personal Care Services
- *Audiological Services
- *Necessary Transportation: Ambulance Transportation, Non-ambulance Transportation
- *Appointment Scheduling Assistance
- *Substance Abuse Clinic Services
- *Chiropractic Services
- *Prenatal Care
- *Certified Nurse Midwives
- *Extended Skilled Nurse Services
- *Mental Health Clinic Services
- * Ambulatory Care Services, Rural Health Clinics, and Federally Qualified Health Centers
- * Ambulatory Surgery Services
- * Developmental and Behavioral Clinic Services
- * Early Intervention Services
- * Nursing Facility Services
- * Prenatal Care Services
- * Sexually Transmitted Disease Screening
- *Pediatric Day Health Care

and any other medically necessary health care, diagnostic services, treatment, and other measures which are coverable by Medicaid, which includes a wide range of services not covered for recipients over the age of 21.

If you need a service that is not listed above you can call the referral assistance coordinator at SPECIALTY RESOURCE LINE (toll free) 1-877-455-9955. If they cannot refer you to a provider of the service you need call 225-342-5774.

Some of these services must be approved by Medicaid in advance. Your medical provider should be aware of which services must be pre-approved and can assist you in obtaining those services. Also, SPECIALTY RESOURCE LINE can assist you or your medical provider with information as to which services must be pre-approved.

Whenever health treatment or additional services are needed, you may obtain an appointment for a screening visit by contacting SPECIALTY RESOURCE LINE. Such screening visits also can be recommended by any health, developmental, or educational professional. To schedule a screening visit, contact SPECIALTY RESOURCE LINE at (toll-free) 1-800-259-4444 (or 928-9683, if you live in the Baton Rouge area), or you may contact your physician if you already have a SPECIALTY RESOURCE LINE provider. If you have a communication disability or are non-English speaking, you may have someone else call SPECIALTY RESOURCE LINE and the appropriate assistance can be provided.

Louisiana Medicaid encourages you to contact the SPECIALTY RESOURCE LINE office and obtain a SPECIALTY RESOURCE LINE provider so that you may be better served.

**OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES
HUMAN SERVICES DISTRICTS and AUTHORITIES**

Metropolitan Human Services District

Donna Francis, DD Calvin Johnson, Ex. Dir.
1010 Common St., 5th Floor, N.O., LA 70112
Phone: (504) 599-0245 Fax: (504) 568-4660
Toll Free: 1-800-889-2975

Orleans – Plaquemines – St. Bernard**Capital Area Human Services District**

Scott Meche, DD Jan Kasofsky, Ex. Dir.
4615 Government St. – Building 2, B.R., La. 70806
Phone: (225) 925-1910 Fax: (225) 925-1966
Toll Free: 1-866-628-2133

**Ascension – EBR – East Fel. – Iberville
Pointe Coupee – WBR – West Fel.****South Central La. Human Services Authority**

Wesley Cagle, DD Lisa Schilling, Ex. Dir.
1000 Plantation Rd, Suite E, Thibodaux, LA 70301
Phone: (985) 449-5167 Fax: (985) 449-5180
Toll Free: 1-800-861-0241

**Assumption – LaFourche – St. Charles – St. James
St. John – St. Mary – Terrebonne****Acadian Area Human Services District**

Richard Landry, DD Brad Farmer Ex Dir
302 Dulles Dr, Lafayette, LA 70506
Phone: (337) 262-5610 Fax: (337) 262-5233
Toll Free: 1-800-648-1484

**Acadia – Evangeline – Iberia – Lafayette
St. Landry – St. Martin – Vermillion****Imperial Calcasieu Human Services Authority**

James Lewis, DD
3501 Fifth Ave., Ste C2, Lake Charles, LA 70607
Phone: (337) 475-8045 Fax: (337) 475-8055
Toll Free: 1-800-631-8810

**Allen - Beauregard – Calcasieu – Cameron
Jefferson Davis****Central Louisiana Community Services District**

Leola Joshua DD
429 Murray St.-Ste B, Alexandria, LA 71301
Phone: (318) 484-2347 Fax (318) 484-2458
Toll Free: 1-800-640-7494

**Avoyelles – Catahoula – Concordia – Grant
LaSalle – Rapides – Vernon – Winn****Northwest Louisiana Human Services District**

Sharon Doyle, DD
3018 Old Minden Rd, Ste. 1211, Bossier City, LA 71112
Phone: (318) 741-7455 Fax: (318) 741-7445
Toll Free: 1-800-862-1409

**Bienville – Bossier – Caddo - Claiborne – DeSoto
Natchitoches – Red River – Sabine - Webster****Northeast Delta Human Services Authority**

Jennifer Purvis, DD
2513 Ferrand St., Monroe, LA 71201
Phone: (318) 362-3396 Fax: (318) 362-5306
Toll Free: 1-800-637-3113

**Caldwell – East Carroll – Franklin – Jackson – Lincoln
Madison- Morehouse – Ouachita – Richland-
Tensas – Union – West Carroll****Florida Parishes Human Services Authority**

Janise Monetta, DD Melanie Watkins, Ex. Dir.
835 Pride Drive, Suite B, Hammond, LA 70401
Phone: (985) 543-4730 Fax: (985) 543-4752
Toll Free: 1-800-866-0806

**FPHSA: Livingston – St. Helena – St. Tammany
Washington - Tangipahoa****Jefferson Parish Human Services Authority**

Nicole Green, DD Lisa English Rhoden, Ex. Dir.
3616 s. I-10 Service Road West, Metairie, LA 70001
Phone: (504) 838-5357 Fax: (504) 838-5400

JPHSA: Jefferson

OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES
Regional EPSDT Specialists

METROPOLITAN HUMAN SERVICES DISTRICT

Vanetta Tasker
1010 Common Street, 6th Floor
New Orleans, LA 70112
Phone: (504) 599-0245
FAX: (504) 568-4660
Toll Free: 1-800-889-2975

CENTRAL LOUISIANA COMMUNITY SERVICES DISTRICT

Nancy Thigpen and Marjorie Kress
429 Murray Street – Suite B
Alexandria, LA 71301
Phone: (318) 484-2347
FAX: (318) 484-2458
Toll Free: 1-800-640-7494

CAPITAL AREA HUMAN SERVICES DISTRICT

Polly Rheams
4615 Government St. – Bin#16 – 2nd Floor
Baton Rouge, LA 70806
Phone: (225) 925-1910
FAX: (225) 925-1966
Toll Fee: 1-866-628-2133

NORTHWEST LOUISIANA HUMAN SERVICES DISTRICT

Tanya Murphy and Nancy Howard
3018 Old Minden Road – Suite 1211
Bossier City, LA 71112
Phone: (318) 741-7455
FAX: (318) 741-7445
Toll Free: 1-800-862-1409

SOUTH CENTRAL LOUISIANA HUMAN SERVICES AUTHORITY

Shannon Foret and Freda Green
1000 Plantation Rd., Suite E
Thibodaux, LA 70301
Phone: (985) 449-5167
FAX: (985) 449-5180
Toll Free: 1-800-861-0241

NORTHEAST DELTA HUMAN SERVICES AUTHORITY

Emily Lyle
2513 Ferrand St.
Monroe, LA 71201
Phone: (318) 362-3396
FAX: (318) 362-5306
Toll Free: 1-800-637-3113

ACADIANA AREA HUMAN SERVICES DISTRICT

Tina Lyon
302 Dulles Dr
Lafayette, LA 70506
Phone (337) 262-5610
FAX: (337) 262-5233
Toll Free: 1-800-648-1484

FLORIDA PARISHES HUMAN SERVICES AUTHORITY

Steve Leggio & Christine Armand-Perret
835 Pride Drive, Suite B
Hammond, LA 70401
Phone: (985) 543-4730
FAX: (985) 543-4752
Toll Free: 1-800-866-0806

IMPERIAL CALCASIEU HUMAN SERVICES AUTHORITY

Doanie Perry
3501 Fifth Avenue, Suite C2
Lake Charles, LA 70607
Phone: (337) 475-8045
FAX: (337) 475-8055
Toll Free: 1-800-631-8810

JEFFERSON PARISH HUMAN SERVICES AUTHORITY

Tanisha Peterson
3316 S. I-10 Service Road West
Metairie, LA 70001
Phone (504) 838-5357
FAX: (504) 838-5400

LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS
OFFICE OF BEHAVIORAL HEALTH SERVICES
Local Governing Entities - Community Behavioral Health Clinics

Allen Mental Health Clinic
402 Industrial Drive, Oberlin, LA 70655 | PH: (337) 639-3001

Avoyelles Mental Health Clinic
694 Government Street, Marksville, LA 71351 | PH: (318) 253-9638

Bastrop Behavioral Health Clinic
320 S. Franklin Street, Bastrop, LA 71220 | PH: 318-283-0868

Beauregard Mental Health Clinic
Standard Building, Office #1, 106 West Port Street, DeRidder, LA 70634
PH: (337) 462-1641

Bogalusa Mental Health Clinic
619 Willis Avenue, Bogalusa, LA 70427 | PH: (985) 732-6610

Center for Adult Behavioral Health (CAHSD)
4615 Government Street, Baton Rouge, LA 70806 | PH: 225.925.1906

Central City Mental Health Clinic
2221 Philip Street, New Orleans, LA 70113 | PH: (504) 568-6650

Chartres-Pontchartrain Mental Health Clinic
719 Elysian Fields, New Orleans, LA 70117 | PH: (504) 942-8101

Columbia Behavioral Health Clinic
5159 Highway 4 East, Columbia, LA 71418 | PH: (318) 649-2333

Crowley Behavioral Health Clinic
1822 W. 2nd Street, Crowley, LA 70527 | PH: (337) 788-7511

Desire/Florida Counseling Clinic
3400 Florida Avenue, New Orleans, LA 70117 | PH: (504) 942-8345

Donaldsonville Mental Health Center
901 Catalpa Street, Donaldsonville, LA 70346 | PH: (225) 621-5770

East Jefferson Behavioral Health Center

3616 S, I-10 Service Road, Metairie, LA 70001 | PH: (504) 838-5257

Gonzales Mental Health Clinic

1112 S. East Ascension Complex Avenue, Gonzales, LA 70737 | PH: (225) 621-5770

Jonesboro Behavioral Health Clinic

4134 Hwy. 4, Jonesboro, LA 71251 | PH: (318) 259-6624

Jonesville Mental Health Center

2801 4th St. Suite 2, Jonesville, LA 71343 | PH: 318.339.8553

Lake Charles Mental Health Clinic

4105 Kirkman Street, Lake Charles, LA 70607 | PH: (337) 475-8022

Leesville Mental Health Clinic

105 Belview Road, Leesville, LA 71446 |PH: (337) 238-6431

Lurline Smith Mental Health Clinic

900 Wilkinson Street, Mandeville, LA 70448 | PH: (985) 624-4450

Mansfield Behavioral Health Clinic

501 Louisiana Avenue, Mansfield, LA 71052 | PH: 318-872-5576

Many Behavioral Health Clinic

265 Highland Drive, Many, LA 71449 | PH: (318) 256-4119

Margaret Dumas Mental Health Clinic

3843 Harding Boulevard, Baton Rouge, LA 70807 | PH: (225) 359-9315

Mental Health Clinic of Central Louisiana (MHCCL)

242 West Shamrock St; Pineville, LA, Alexandria, LA 71306 |
PH: Main: (318) 484-6850

Minden Behavioral Health Clinic

435 Homer Road, Minden, LA 71055 | PH: (318) 371-3001

Monroe Behavioral Health Clinic - Adult Services

4800 South Grand Street, Monroe, LA 71202 | PH: (318) 362-3339

Monroe Behavioral Health Clinic - Women and Children Services
3200 Concordia Street, Monroe, LA 71201 | PH: 318.362.5188

Natchitoches Behavioral Health Clinic
210 Medical Drive, Natchitoches, LA 71457 | PH: (318) 357-3122

New Iberia Behavioral Health Clinic
611 West Admiral Doyle Drive, New Iberia, LA 70560 | PH: (337) 373-0002

New Orleans Mental Health Clinic
3100 General DeGaulle Drive, New Orleans, LA 70114-6699 | PH: (504) 361-6211

Opelousas Behavioral Health Clinic
220 South Market Street, Opelousas, LA 70570 | PH: 337-948-0226

Red River Behavioral Health Clinic
1313 Ringgold Avenue , Coushatta, LA 71019 | PH: (318) 932-4029

River Parishes Assessment Center
421 West Airline Highway, Suite L, LaPlace, LA 70068 | PH: (985) 651-7064

River Parishes Treatment Center
1809 West Airline Highway, LaPlace, LA 70068 | PH: (985) 652-8444

Rosenblum Mental Health Center - Adult Services
130 Robin Hood Drive, Hammond, LA 70403 | PH: 985.543.4800

Rosenblum Mental Health Clinic - Child Services
15785 Medical Arts Plaza, Hammond, LA 70403 | PH: (985) 543-4080

Ruston Behavioral Health Clinic
602 East Georgia Street, Building A, Ruston, LA 71270 | PH: (318) 251-4125

Shreveport Behavioral Health Clinic - Adult Treatment Services
1310 North Hearne Avenue, Shreveport, LA 71107 | PH: (318) 676-5111

Shreveport Behavioral Health Clinic - Children/Youth Division
2924 Knight Street, Building 3, Suite 350, Shreveport, LA 71105 | PH: 318.862.3053

St. Bernard Mental Health Clinic
2712 Palmisano Blvd., Bldg. B, Chalmette, LA 70043 | PH: (504) 278-7401

Tallulah Behavioral Health Clinic

1012 Johnson Street, Tallulah, LA 71284 | PH: (318) 574-1713

Tyler Behavioral Health Clinic

302 Dulles Dr, Lafayette, LA 70506 | PH: (337) 262-4100

Ville Platte Behavioral Health Clinic

312 Court Street, Ville Platte, LA 70586 | PH: (337) 363-5525

West Jefferson Behavioral Health Clinic

5001 Westbank Expressway, Marrero, LA 70072 | PH: 504.349.8833

Winnsboro Behavioral Health Clinic

1301 B Landis Street, Suite 202-B, Winnsboro, LA 71295 | PH: (318) 435-2146

Behavioral Health Local Governing Entities

Find regional mental health treatment services. Link to additional information at:
<http://new.dhh.louisiana.gov/index.cfm/directory/category/100>

Acadiana Area Human Services District
302 Dulles Drive, Lafayette, LA 70506-3008 | PH: 337.262-4190

Capital Area Human Services District
4615 Government Street, Building 2, Baton Rouge, LA 70806 | PH: 225.922.2700

Central Louisiana Human Services District
401 Rainbow Drive, #35, Pineville, LA 71360 | PH: 318.487.5191

Florida Parishes Human Services Authority (FPHSA)
835 Pride Drive, Suite B, Hammond, LA 70401 | PH: 985.543.4333

Imperial Calcasieu Human Services Authority
3505 Fifth Avenue, Suite B, Lake Charles, LA 70607 | PH: 337.475.3100

Jefferson Parish Human Services Authority
3616 S. I-10 Service Road West, Metairie, LA 70001 | PH: 504.838.5215

Metropolitan Human Services District
1010 Common Street, Suite 600, New Orleans, LA 70112 | PH: 504.568.3130

Northeast Delta Human Services Authority
2513 Ferrand Street, Monroe, LA 71201 | PH: 318.362.3020

Northwest Louisiana Human Services District
2924 Knight Street, Suite 350, Shreveport, LA 71105 | PH: 318.862.3085

South Central Louisiana Human Services Authority
521 Legion Avenue, Houma, LA 70364 | PH: 985. 858.2931

<http://new.dhh.louisiana.gov/index.cfm/directory/category/100> 1/31/14

Louisiana Behavioral Health Partnership

The Louisiana Behavioral Health Partnership (LBHP) includes the Department of Health and Hospitals (DHH), the Department of Children and Family Services (DCFS), the Office of Juvenile Justice (OJJ), the Department of Education (DOE), and Magellan Health Services, Inc. Magellan is contracted as the Statewide Management Organization (SMO) to manage the majority of behavioral health services in the state. There is still a limited number of behavioral health programs managed directly by several agencies in the LBHP.

Levels of Care & Service Definitions

Magellan Behavioral Health of Louisiana believes that optimal, high-quality care is best delivered when members receive care that meets their needs in the least-intensive, least-restrictive setting possible. Magellan's philosophy is to endorse care that is safe and effective, and that maximizes the member's independence in daily activity and functioning.

Magellan has defined six levels of care and eleven outpatient and other services as detailed below. These levels of care and services may be further qualified by the distinct needs of certain populations who frequently require behavioral health services. Children, adolescents, and adults often have special concerns not present with mental health disorders alone. In particular, special issues related to family/support system involvement, physical symptoms, medical conditions and social supports may apply. More specific criteria sets in certain of the level of care definitions address these population issues.

1. Addiction services

Services include an array of individual-centered outpatient, intensive outpatient and residential/inpatient services consistent with the individual's assessed treatment needs, with a rehabilitation and recovery focus designed to promote skills for coping with and managing substance abuse symptoms and behaviors. Services for adolescents must be separate from adult services, be developmentally appropriate, involve the family or caregiver and coordinate with other systems (such as child welfare, juvenile justice and the schools). These services are designed to help individuals achieve changes in their substance abuse behaviors. Services should address an individual's major lifestyle, attitudinal and behavioral problems that have the potential to be barriers to the goals of treatment. Outpatient services may be indicated as an initial modality of service for an individual whose severity of illness warrants this level of treatment or when an individual's progress warrants a less intensive modality of service than they are currently receiving. Intensive outpatient treatment is provided any time during the day or week and provides essential skill restoration and counseling services for individuals needing more intensive treatment. Outpatient, intensive outpatient and residential/inpatient services are delivered on an individual or group basis in a wide variety of settings, including treatment in residential

settings of 16 beds or less, designed to help individuals achieve changes in their substance abuse behaviors.

Addiction services are reviewed utilizing the American Society of Addiction Medicine (ASAM) PPC-2R criteria. These levels of care criteria are found in the ASAM PPC-2R manual, which will be used for authorizing and reviewing addiction services.

2. Assertive Community Treatment (ACT)

ACT services are therapeutic interventions that address the functional problems of individuals 18 years and older who have the most complex and/or pervasive conditions associated with a major mental illness or co-occurring addictions disorder. These interventions are strength-based and focused on promoting symptom stability, increasing the individual's ability to cope and relate to others and enhancing the highest level of functioning in the community. Interventions may address adaptive and recovery skill areas, such as supportive or other types of housing, school and training opportunities, daily activities, health and safety, medication support, harm reduction, money management and entitlements and service planning and coordination. The Level of Care Utilization System (LOCUS), psychiatric evaluation and treatment plan will be updated at least every six months, with an additional LOCUS score being completed prior to discharge.

3. Community Psychiatric Support and Treatment (CPST) (Rehabilitation Service)

CPST are goal-directed supports and solution-focused interventions intended to achieve identified goals or objectives as set forth in the individual's individualized treatment plan. CPST is a face-to-face intervention with the individual present; however, family or other collaterals also may be involved. A minimum of 51 percent of CPST contacts must occur in community locations where the person lives, works, attends school and/or socializes. Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child-serving systems should occur, as needed, to achieve the treatment goals.

4. Crisis intervention (CI) (Rehabilitation Service)

CI services are provided to a person who is experiencing a psychiatric crisis and are designed to interrupt and/or ameliorate a crisis experience, via a preliminary assessment, immediate crisis resolution and de-escalation and referral and linkage to appropriate community services to avoid more restrictive levels of treatment. The goals of CIs are symptom reduction, stabilization and restoration to a previous level of functioning. All activities must occur within the context of a potential or actual psychiatric crisis. CI is a face-to-face intervention and can occur in a variety of locations, including an emergency room or clinic setting, in addition to other community locations where the person lives, works, attends school and/or socializes. An episode is defined as the initial face-to-face contact with the individual until the current crisis is resolved, not to exceed 14 days.

5. Family functional therapy (FFT)

FFT services are targeted for youth (**aged 10-18**) primarily demonstrating externalizing behaviors which affect family functioning. Youth behaviors include antisocial behavior or acts, violent behaviors and other behavioral issues that impair functioning. Youth also may meet criteria for a disruptive behavior disorder attention-deficit hyperactivity disorder (ADHD), oppositional defiant disorder and/or conduct disorder). Youth with other mental health conditions, such as anxiety and depression, also may be accepted as long as the existing mental and behavioral health (BH) issues manifest in outward behaviors that impact the family and multiple systems. Youth with substance abuse issues may be included if they meet the criteria below, and FFT is deemed clinically more appropriate than focused drug and alcohol treatment. A youth receives FFT for approximately three to four months. During the course of this three-month period, the therapist works with the family in nine to 14, one- to two-hour sessions for less severe cases and up to 26-32, one- to two-hour sessions for youth with more substantial acting-out behaviors.

6. Homebuilders

Homebuilders is an intensive, in-home program providing cognitive behavioral therapy (CBT) through family therapy and parent training for families with children (**birth to 18 years of age**) demonstrating the following characteristics:

- Antisocial behavior and alienation/delinquent beliefs/general delinquency involvement/drug dealing
- Favorable attitudes toward drug use/early onset of alcohol and other drug use, alcohol and/or drug use
- Early onset of aggression and/or violence
- Victimization and exposure to violence.

The target population is children who are returning from, or at risk of, placement into foster care, group or residential treatment, psychiatric hospitals or juvenile justice facilities. Louisiana also utilizes Homebuilders for children with serious behavior problems at home and/or school. The Homebuilders model is designed to eliminate barriers to service while using research-based interventions to improve parental skills, parental capabilities, family interactions, children's behavior and family safety. The primary intervention components are engaging and motivating family members, conducting holistic, behavioral assessments of strengths and problems, developing outcome-based goals, using evidence-based cognitive/behavioral interventions, teaching skills to facilitate behavior change and developing and enhancing ongoing supports and resources. Families receive four to six weeks of intensive intervention with up to two "booster sessions." Therapists typically serve two families at a time and provide 80 to 100 hours of service, with an average of 45 hours of face-to-face contact with the family.

7. Multi-Systemic therapy (MST)

MST services are targeted for **youth 12 to 17 years old**. MST provides an intensive home/family and community-based treatment for youth who are at risk of out-of-home placement or who are returning from out-of-home placement. The MST model is based on empirical data and evidence-based interventions that target specific behaviors with individualized behavioral interventions. Services are primarily provided in the home, but workers also intervene at school and in other community settings. All MST services must be provided to, or directed exclusively toward, the treatment of the Medicaid-eligible youth. The duration for MST services is three to six months but, typically no longer than six months. The therapist meets with the youth and family at least weekly but often during a four month period, as well as about 35 hours of non-direct contact provided to the ecology of the youth (e.g., consultation and collaboration with other systems).

8. Outpatient Therapy

Outpatient treatment is typically individual, family and/or group outpatient psychotherapy, consultative services (including nursing home consultation), mental health assessment, evaluation and testing. Times for provision of these service episodes range from fifteen minutes (e.g., medication checks) to fifty minutes (e.g., individual, conjoint, family psychotherapy), and may last up to two hours (e.g., group psychotherapy).

9. Psychosocial rehabilitation (PSR) (Rehabilitation Service)

PSR services are designed to assist the individual with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their mental illness. Activities included must be intended to achieve the identified goals or objectives as set forth in the individual's individualized treatment plan. The intent of PSR is to restore the fullest possible integration of the individual as an active and productive member of his or her family, community and/or culture with the least amount of ongoing professional intervention. PSR is a face-to-face intervention with the individual present. Services may be provided individually or in a group setting. A minimum of 51 percent of a PSR's contacts must occur in community locations where the person lives, works, attends school and/or socializes.

10. Coordinated System of Care (CSoC)

Youth in out-of-home placement or at risk of out-of-home placement and children and youth who are enrolled in the Coordinated System of Care (CSoC) may receive these additional services: Youth Support and Training, Parent Support and Training, Independent Living Skill-Building Services, Short-Term Respite, and Crisis Stabilization. Refer to the link below, LBHP Service Definitions Manual, for more detail.

11. Psychological Testing

Consistent with LAC, Title 46, Part LXIII, Chapter 17, Title 46, § 1702, psychological tests are defined as intellectual, personality and emotional, and neurological instruments, which

require the administration of a psychologist/medical psychologist or of a qualified technician supervised by a psychologist/medical psychologist (without limiting or restricting the practice of physicians duly licensed to practice medicine by the Board of Medical Examiners). Tests of language, educational and achievement tests, adaptive behavior tests or behavior rating scales, symptom screening checklists or instruments, semi-structured interview tools, and tests of abilities, interests, and aptitude that may be administered by other appropriately licensed or certified professionals are not deemed as psychological tests. Testing may be completed at the onset of treatment to assist in the differential diagnosis and/or help resolve specific treatment planning questions. It also may occur later in treatment if the individual's condition has not progressed and there is no clear explanation for the lack of improvement.

12. Hospital (Inpatient), Psychiatric (IP)

IP service is the highest level of skilled psychiatric services provided in a facility. This could be a free-standing psychiatric hospital, or a psychiatric unit of general hospital. Settings that are eligible for this level of care are licensed at the hospital level and provide 24-hour medical and nursing care.

13. Psychiatric Residential Treatment Facility (PRTF)

Residential Treatment is defined as a 24-hour level of care that provides residential care and services for children and adolescents younger than 21 years of age with long-term or severe mental disorders. This care is medically monitored, with 24-hour medical and nursing services availability. Residential care includes treatment with a range of diagnostic and therapeutic behavioral health services that cannot be provided through existing community programs.

PRTF are required to ensure that all medical, psychological, social, behavioral and developmental aspects of the member's situation are assessed and that treatment for those needs is reflected in the Plan of Care (POC) per 42 CFR 441.155. In addition, the PRTF must ensure that the resident receives all treatment needed for those identified needs. In addition to services provided by and in the facility, when they can be reasonably anticipated on the active treatment plan, the PRTF must ensure that the resident receives all treatment identified on the active treatment plan and any other medically necessary care required for all medical, psychological, social, behavioral and developmental aspects of the member's situation. The facility must provide treatment meeting State regulations per LAC 48: I. Chapter 90.

Services must meet active treatment requirements, which mean implementation of a professionally developed and supervised individual POC that is developed and implemented no later than 72 hours after admission and designed to achieve the member's discharge from residential status at the earliest possible time. "Individual POC" means a written plan developed for each member to improve his or her condition to the extent that residential care is no longer necessary.

The plan must be reviewed as needed or at a minimum of every thirty days by the facility treatment team to:

- Determine that services being provided are or were required on a residential basis
- Recommend changes in the plan, as indicated by the member's overall adjustment as a resident.

14. Therapeutic Group Homes (TGH)

TGH provides a community-based residential service in a home-like setting of no greater than eight beds, under the supervision and program oversight of a psychiatrist or psychologist. The treatment should be targeted to support the development of adaptive and functional behaviors that will enable the child or adolescent to remain successfully in his/her home and community and to regularly attend and participate in work, school or training. TGHs deliver an array of clinical and related services within the home, including psychiatric supports, integration with community resources and skill-building taught within the context of the home-like setting. TGH treatment must target reducing the severity of the BH issue that was identified as the reason for admission. Most often, targeted behaviors will relate directly to the child's or adolescent's ability to function successfully in the home and school environment (e.g., compliance with reasonable behavioral expectations, safe behavior and appropriate responses to social cues and conflicts). Treatment must:

- Focus on reducing the behavior and symptoms of the psychiatric disorder that necessitated the removal of the child or adolescent from his/her usual living situation
- Decrease problem behavior and increase developmentally appropriate, normative and pro-social behavior in children and adolescents who are in need of out-of-home placement
- Transition child or adolescent from TGH to home- or community-based living, with outpatient treatment (e.g., individual and family therapy).

The psychiatrist or psychologist must provide 24-hour, on-call coverage seven days a week. The psychologist or psychiatrist must see the member at least once, prescribe the type of care provided, and if the services are not time-limited by the prescription, review the need for continued care every 14 days. Average length of stay ranges from 14 days to six months. TGH programs focusing on transition or short-term crisis are typically in the 14 to 30 day range.

15. Therapeutic Foster Care (TFC)

Therapeutic foster care (TFC) services are defined as community-based surrogate family services provided to children living in foster care, who require an intensive period of treatment. TFC services work in partnership with the child, the child's family and other persons identified by the family, Child and Family Team, and placing agency towards the

goals outlined in the family's and/or child's plan of care. TFC services allow the child to benefit from a home environment and community-based setting while receiving additional intensive treatment and clinical services, as needed. Children are assessed to need this level of placement through a CANS screening that demonstrates TFC is a sufficient level and regular basic foster care is not a sufficient level. Children in this program are placed in foster families (one or two children per family), whose members are trained and can provide a structured environment in which participants can learn social, and display age appropriate, emotional skills.

16. Non-Medical Group Home (NMGH)

NMGH is a residential setting for up to 16 beds. Children are considered for placement in a NMGH when screened to need this level of care through the Child and Adolescent Needs and Strengths (CANS) criteria. This basic type of placement should be limited to children whose needs cannot be met in their own home, foster home or children who have reached their treatment goals in a more restrictive setting and are ready to be "stepped down" into a lesser restrictive setting. Services provided in a group home setting must be provided by a community practitioner certified and credentialed by Magellan to provide those services. Children are assessed to need this level of placement through a Coordinated System of Care (CSoC) screening tool that demonstrates NMGH is a sufficient level and regular basic foster care is not a sufficient level. Both the NMGH intervention and other services are decided upon through the Child and Family Team process (or Magellan Care Management where wrap-around services are not available) and Magellan authorization. The NMGH staff is required to participate in the Child and Family Team process. For the child entering placement, group home provides a chance to work on issues in a structured, safe and orderly environment. Group home care presents an opportunity to improve the safety, permanency and well-being of a child through a specialized offering of services that are flexible to meet the particular needs of a child and his or her family or other permanency resource.

17. Case Conference

A case conference is a scheduled face-to-face meeting between two or more individuals to discuss the member's treatment. The conference may include treatment staff, collateral contact or the member's other agency representatives, not including court appearances and/or testimony. Case conference includes communication between a LMHP, advanced practice registered nurse (APRN) or psychiatrist for a member consultation that is medically necessary for the medical management of psychiatric conditions.

LBHP Member Handbook with details about what is included in the benefits and how they can help can be viewed at:

http://www.magellanoflouisiana.com/media/115656/2012_la_handbook_final.pdf

Additional Service Authorization Criteria can be viewed at:

http://magellanoflouisiana.com/media/84978/2012_louisiana_service_authorization_criteria_mnc_june_18_2012_v5.pdf

LBHP Service Definitions Manual can be viewed at:

<http://new.dhh.louisiana.gov/assets/docs/BehavioralHealth/LBHP/ServicesManual-Current.pdf>

Information on the different **types of behavioral health providers** and the various levels of training, education and licenses can be viewed at:

<http://www.magellanoflouisiana.com/find-a-provider-la-en/about-providers.aspx>

To find a provider go to: www.magellanoflouisiana.com or call 1-800-424-4399

TTY: 1-800-424-4416

Revised 2/18/14

Bureau of Health Services Financing

Rights and Responsibilities for Applicants / Participants of EPSDT Targeted Support Coordination

These are your **rights** as an applicant for or a participant in EPSDT Targeted Support Coordination Services:

- To be treated with dignity and respect.
- To participate in and receive person-centered, individualized planning of supports and services.
- To receive accurate, complete, and timely information that includes a written explanation of the process of evaluation and participation in EPSDT Targeted Support Coordination Services including how you qualify for it and what to do if you are not satisfied.
- To work with competent, capable people in the system.
- To file a complaint, grievance, or appeal with a support coordination agency, direct service provider, or the Department of Health and Hospitals regarding services provided to you if you are dissatisfied. Please call Health Standards at 1-800-660-0488.
- To have a choice of service/support providers when there is a choice available.
- To receive services in a person-centered way from trained, competent care givers.
- To have timely access to all approved services identified in your Comprehensive Plan of Care (CPOC).
- To receive in writing any rules, regulations, or other changes that affect your participation in EPSDT Targeted Support Coordination Services.
- To receive information explaining support coordinator and direct service provider responsibilities and their requirements in providing services to you.
- To have all available Medicaid services explained to you and how to access them **if you are a Medicaid recipient.**
- To discontinue Support Coordination services at any time without discontinuance of the prior authorized Medicaid services which you are receiving or have requested; you may request to resume EPSDT Support Coordination Services at any time by calling Statistical Resources at 1-800-364-7828

Appendix K

These are your **responsibilities** as an applicant for or participant of EPSDT Targeted Support Coordination Services:

- To actively participate in planning and making decisions on supports and services you need.
- To cooperate in planning for all the services and supports you will be receiving.
- To refuse to sign any paper that you do not understand or that is not complete.
- To provide all necessary information about yourself. This will help the support coordinator to develop a Comprehensive Plan of Care (CPOC) that will determine what services and supports you need.
- To not ask providers to do things in a way that are against the laws and procedures they are required to follow.
- To cooperate with Medicaid and your support coordinator by allowing them to contact you by phone and visit with you at least quarterly. Necessary visits include an initial in-home visit in order to gather information and complete an assessment of needs, regular quarterly visits at the location of your choice to assure your plan of care is sufficient to meet your needs, and visits resulting from complaints to BHSF.
- To immediately notify the support coordinator and direct service provider who works with you if your health, medications, service needs, address, phone number, alternate contact number, or your financial situation changes.
- To help the support coordinator to identify any natural and community supports that would be of assistance to you in meeting your needs.
- To follow the requirements of the program, and if information is not clear, ask the support coordinator or direct service provider to explain it to you.
- To verify you have received the medical services the provider says you have received, including the number of hours your direct care provider works, and report any differences to your support coordinator.
- To obtain assessment information /documentation requested by your support coordinator or service provider that is required for accessing the services that you are requesting, i.e. BHSF Form 90-L "Request for Level of Care Determination", 1508 Evaluation/Update, IEP, etc.
- To understand that EPSDT Targeted Support Coordination Services have an age requirement and that support coordination services and some Medicaid services will be discontinued at the 21st birthday.

Appendix K

Responsibilities as an applicant for or participant of EPSDT Targeted Support Coordination Services (continued):

- To understand that you may request to discontinue Support Coordination services at any time without discontinuance of the prior authorized Medicaid services which you are receiving or have requested; to understand that you may request to resume EPSDT Support Coordination Services at any time by calling SRI at 1-800-364-7828.

I have read and understand my rights and responsibilities for applying for / participating in EPSDT Support Coordination Services. I also understand the reasons that Support Coordination Services may be discontinued for me or the person whom I am authorized to represent in this matter.

<i>Applicant/Participant Name</i>	
<i>Signature of Applicant/Participant or Authorized Representative</i>	<i>Date</i>
<i>Support Coordinator</i>	<i>Date</i>

<p style="text-align: center;">Can I Appeal a Medicaid Decision?</p> <p>Yes, you have the right to appeal:</p> <ul style="list-style-type: none"> ▪ If all the services you requested were denied ▪ If part of the services you requested were denied ▪ If you were offered different services than you requested ▪ If the service provider did not submit for full amount of services you requested. (In this case, a doctor’s note showing the need for the requested services must be included with the appeal.) <p style="text-align: center;">Is There Anything Besides Appealing That I Can Do to Get Services?</p> <p>The provider that sent in your request for services can request a reconsideration, with additional information. This must be done within 30 days of the denial. You will get a new decision, and if services are denied again, you can appeal then.</p>	<p style="text-align: center;">How do I appeal?</p> <p>Send a written request for appeal to: Ann Wise Division of Administrative Law Health and Hospitals Section P.O. Box 4189 Baton Rouge, LA 70821-4189 (fax) 225-219-9823</p> <p>Or call: 225-342-5800 or 225-342-0443 <i>(Telephone appeals are allowed, but are not encouraged)</i></p> <p style="text-align: center;">Do I Have to Get Another Doctor’s Statement?</p> <p>To win the appeal, you may need to get your doctor to give a statement with more details about why the services are needed. The doctor’s statement should include the number of hours of services needed.</p> <p style="text-align: center;">Can my Case Manager help with my appeal?</p> <p><u>YES!</u> Your case manager should have received training to assist you with an appeal. He/she can help you gather the necessary information within the allotted time.</p>	<p style="text-align: center;">What Deadlines Apply?</p> <ul style="list-style-type: none"> ▪ The notice of denial will tell you when the appeal must be filed. You <u>must</u> appeal before or by that date. ▪ Appealing within 10 days of denial may keep services you are already receiving from being cut while the appeal is going on. ▪ You must get a final decision on your appeal within 90 days of the date you file it, unless you request or agree to additional time. <p style="text-align: center;">Can Someone Help me with the Appeal?</p> <p>You can have someone else represent your situation if you choose. That person can be a friend, relative, attorney or other spokesperson. The Advocacy Center (1-800-960-7705) helps with appeals.</p>
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APPEAL FORM

I want to appeal.

Name of Medicaid Recipient appealing _____.

Social Security Number of Medicaid Recipient _____.

Describe Items or Services requested (or enclose copy of denial notice):

Signature of Recipient

Date

Submit form to:

**Ann Wise, Director
Division of Administrative Law
Health and Hospitals Section
P. O. Box 4189
Baton Rouge, LA 70821-4189
(fax) (225) 219-9823**

**Louisiana Department of Health and Hospitals
Bureau of Health Services Financing
EPSDT Comprehensive Plan of Care Instructions**

GENERAL PURPOSE:

The Comprehensive Plan of Care (CPOC) is designed to briefly summarize important information so that it can be reviewed and considered in evaluating the need for proposed services and supports. Information critical to the person's health and safety or that of others should be extensively documented in the Plan.

The CPOC is intended to be user friendly, person-centered and flexible to varying approaches, orientations and programs. The CPOC is to be completed in Louisiana Support Coordinator Information System (LSCIS).

The goal is to provide support and services in a person focused, cost effective and accountable manner. The CPOC should always emphasize the person's personal goals and that of his/her family in order to maintain the EPSDT program as a viable and appealing alternative to institutional care. Information relevant and applicable to justifying services requested by the applicant must be provided.

COMPREHENSIVE PLAN OF CARE SECTIONS:

I. DEMOGRAPHICS/CONTACT INFORMATION

This initial portion of the CPOC is self explanatory and requires the Support Coordinator to provide current information on the person, including name, address, Medicaid number, ICD-9, other contact and guardian addresses. The relationship of the guardian must be placed beside their name on the contact page.

II. MEDICAL/SOCIAL/FAMILY HISTORY

Social/Family History

This section provides specific information on the past and current situations in the person's life. Explore the past and current situation in the individual's life through a personal interview with the person or the people who know the person best (his/her family and the people who provide support to the person).

Natural Supports should be explored to determine who is involved/not involved in the individual's social support network (i.e., what friends/family and community resources are involved in supporting the individual on a daily basis). Address both parents and whether they are in the picture, or state the family did not disclose that. Include issues with social/law enforcement agencies and whether a social services case worker or Probation Officer is assigned. Information regarding the natural supports is to be included in the "Present" information box.

Information included should reflect the individual's life today and provide a means of sharing social/family history not addressed in the content of the CPOC. Include information that is important to share and relevant to supporting and achieving the goals determined by the person.

Evaluations/Documentation

A formal information document must be reviewed to identify needs while developing the CPOC. You should have and list all assessments and evaluations that OCDD used to determine the DD eligibility, the current IEP and any other assessments by professionals that would be current. At least one current document is required in the development of an annual CPOC. On initial CPOCs, these documents are to be mailed or faxed to SRI and must be received prior to CPOC approval. Annual CPOCs are to have the documents placed in the file. If the CPOC is randomly selected for monitoring when it is submitted to DHH for approval, send Appendix X-2 and the required documents to SRI within the required timeline. (Appendix V- Formal Information)

HEALTH STATUS

Summarize important aspects of the person's health, behavioral and/or psychiatric concerns. This portion of the Plan of Care must be addressed initially, and updated as significant change occurs in the individual's life. Any pertinent information about the individual that can be provided by the family or gathered from the formal information documents should be documented.

Physical

List the name of the participant's physician and the date of the participant's last physical. Are they obtaining physicals at the recommended EPSDT Screening interval? If not, are you encouraging that they do so?

Immunizations

All information on immunizations should be current. This is extremely important. If immunizations are not up to date, this will need to be addressed.

Medical Diagnosis and Concerns/ Significant Medical History

A narrative description of the person's health history, current medical condition, including medical diagnoses, hospitalizations and continuing health concerns and medical needs should be included. (Findings in the last physical, documentation of any significant family health risk and other medical needs should also be included).

What were the findings of the last physical? List the participant's diagnosis and medications. List the name and specialty of all their medical providers. What are the person's current physical abilities (if not addressed in the previous section) in the areas of vision, hearing, mobility, communication, use of arms, hands, and legs and any need for assistive devices or DME? Are they toilet trained? Do they have a gastrostomy tube, tracheostomy tube, or urinary catheter? How often is a special procedure administered? Do they receive formula or receive funds for a special diet? Are they receiving any therapies? Document any significant family health risk.

If an individual meets the criteria for PCS and declines the service, document the parent declining the service. If the individual is capable of doing Activities of Daily Living or Instrumental Activities of Daily Living, document this.

Psychiatric/Behavioral Concerns

A narrative description of the person's psychiatric status, diagnoses and significant behavior concerns should be provided in the Health Profile. Any relevant history that poses a potential risk for the individual or others should be provided. Also, information on effective behavior interventions, support plan and skills training should be detailed in accompanying information. This information can be obtained from the psychological.

Document how the behavior concern is managed, offers of services and the parent/participant's response. CPOCs will be returned if they do not appropriately address this here and in the service needs section if appropriate.

III. CPOC SERVICE NEEDS AND SUPPORTS

This section will assist the case management agency and the direct service provider to develop the individual's plan of care.

Goals: What the individual wants in the future for him/herself. These are unique **personal outcomes** envisioned, defined and prioritized by the participant/family.

Service Needs (What/Who/How): "What" is needed for the individual to achieve his/her personal goals. This section identifies the support needed. This may reflect training, needed supports, and/or skill acquisitions, or may regard the person's maintenance in the home and community with provided supports. Make sure that you address all issues on IEP and learning disabilities. Check boxes are to be used to identify "Who and How" the person can be supported to achieve his/her personal outcome. This section identifies whether paid staff will be utilized or natural supports (friends/family) are in place to support the strategy.

All applicable services that require Prior Authorization must be identified. The drop down bar will identify a list of Medicaid services that require a PA and other services for identified needs. Additional needed services can be added to this list.

"Requires a PA" and "Medicaid" must be checked in order to generate the required PA Tracking log.

Do not list the name of the provider in the service description box. The CPOC will be locked after approval and won't allow for this identifier to be edited when a new provider is selected. The provider can be identified in Section IV (Additional Information). The CPOC can be revised at any time.

All services the recipient is receiving shall be placed on the typical weekly schedule in the times the individual receives them. If there needs to be a scheduling change, identify and then fax it to the provider to facilitate the change.

How was the need determined: This column is provided to document how the service need was determined.

Requested by participant/family: This column will document the participant/family's choice to access services relating to the identified needs at the time of the CPOC meeting.

Amount Approved: In this column, describe the frequency of service delivery the provider will use to meet the person's need.

Review/Resolution: The minimum requirement for a review of the plan is quarterly. The goal for Support Coordination is included in section IV and denotes that the CPOC will be reviewed at least quarterly and revised at least annually. The review will determine whether the person's needs have been adequately met and whether the services continue to be necessary.

Identify if the goal was met or if the participant/family no longer wants the service, on the Quarterly Review/Interim CPOC. The CPOC is to be revised at least annually or sooner if the individual's situation significantly changes.

No Services to Coordinate

If there are no services to coordinate, the Support Coordinator is to inform the family/participant of this and that they can access support coordination at any time until the child's 21st birthday. Declining EPSDT Support Coordination will not affect their eligibility to receive Medicaid services or their placement on the Waiver Request for Services Registry. The family can choose to continue EPSDT Support Coordinator service, but they must be informed.

NOTE: The delivery of requested services should not be held until the CPOC is approved by BHSF. BHSF does not approve State Plan Services. The Medicaid services identified in this plan are state plan services.

IV. ADDITIONAL INFORMATION/ CPOC PARTICIPANTS

Medicaid Services

This section of the CPOC to ensures that the individual/family has been made aware of the services available to them through Medicaid. The Support Coordinator must review the Medicaid Services Chart with the individual/family. The Support Coordinator must also provide information on Medicaid EPSDT and EPSDT Screening services.

Signatures

All individuals/providers shall sign the printed LSCIS CPOC signature page to indicate their participation in the planning of the CPOC. The Medicaid EPSDT participant/parent/guardian must also sign and date the LSCIS CPOC signature page after they have reviewed and agree with the services in the CPOC. This signature date is to be entered in this section of LSCIS. The Support Coordinator present shall sign the CPOC.

NOTE: If the participant is 18 or older and able to direct their own care, they should sign the CPOC and other required documents. If they are unable to do this, the reason should be documented.

Additional Information

This section is provided to document additional information regarding service needs and supports. The name of the service providers and any additional strategy information is to be placed in this section.

Section V - CPOC Approval

The Support Coordinator's supervisor is to review and sign the plan prior to submitting the CPOC to Statistical Resources, Inc. (SRI). The supervisor's signature denotes that they approve and agree with the contents of the CPOC being submitted.

An initial CPOC submitted to SRI must include a formal information documents. These are to be mailed to SRI and must be received prior to CPOC approval. All other information, as required on the Checklist for EPSDT Support Coordination Approval Process, must be maintained in the participant's case record. It must be available and submitted to BHSF/SRI immediately upon request. (Appendix X).

BHSF/SRI will review the CPOC to assure that all components of the plan have been identified. If identified needs are not addressed or any part of the CPOC is not completed with the required information, the plan will be returned to the Support Coordinator without an approval. Approval or denial of the CPOC does not approve or deny any of the services and only addresses the Support Coordinator's required services implementation and documentation.

An approvable initial CPOC must be completed and sent to SRI within 35 days of the date of referral to the Support Coordination agency.

An annual CPOC meeting should not be held more than 90 days prior to the expiration of the current CPOC. The approvable annual CPOC must be completed and submitted to SRI within 35 days of the CPOC expiration date.

NOTE: The delivery of requested services should not be held until the CPOC is approved by BHSF. BHSF does not approve State Plan Services. The services identified in this plan are state plan services.

Section VI – TYPICAL WEEKLY SCHEDULE (Paper form only)

The weekly schedule is a tool that the Support Coordinator uses to assure that services are delivered at appropriate days and times and do not overlap, unless this is medically necessary.

The weekly schedule should indicate what services are already in place and the services that are being requested through Medicaid prior authorization or other sources. The schedule should show when the participant is in school, at home or participating in other activities. The schedule can be forwarded to in-home providers and prospective providers to support and clarify prior authorization requests. If prior authorization of a requested service is denied and not appealed, or if for any other reason the planned services are not delivered, the schedule should be revised to reflect only services actually put in place. If the participant wishes to change any of the times for established services, the Support Coordinator shall give the revised schedule to all appropriate providers informing them of the time changes.

LSCIS CPOC Section 1 Demographics/ Contact Information

Case #: 12345 Name: Last Doe First John MI Target Pop: ETP Vent. Dep.: DCFS/OCS: S. C. SC

Contact Information Demographic Information Closure Information PA History CPOC History Trading History

Client SSN: 123-45-6789 Medicaid ID: 1234567890132
 Parish: 17 E. BATON ROUGE Region: 02
 Date of Birth: 01/01/2000 Age: 13 / Adolescence
 Case Open: 05/17/2012
 Sex: 1 Male Race: 1 White
 Legal Status: 2 Minor
 Is able to direct his/her own care:
 MR: Moderate Adaptive Functioning: Moderate
 Residential Placement: 12 Lives with Family/Friends
 Number of MR/DD/Special Needs in Home (excluding recipient): 0
 Names:
 Current Education/Employment: 05 Regular and Special Education
 Primary Diagnosis: 758.0 DOWN'S SYNDROME
 Secondary Diagnosis: 429.9 HEART DISEASE UNSP

LSCIS CPOC Section 2 – Medical/Social/Family History

LSCIS Client Data Form Tuesday, March 19, 2013 [Log Out](#) [Sally](#)

V 2.73 Site: 0299030 [My Home](#)

[Add Client](#) [Find Services](#) [Add Services](#) [Reviewable CPOCs](#) [Reports](#) [Electronic PA](#)
[Denied CPOCs](#) [Map](#)

Case #: Name: Last First MI Target Pop: Vent. Dep.:

[Contact Information](#) | [Demographic Information](#) | [Closures Information](#) | [Pa History](#) | [CPOC History](#) | [Tracking History](#)
CPOC History Cannot add CPOC until the most recent CPOC is approved.

CPOC Type	Support Coordinator	Submit or review by DHH	Approval Status	Reviewer	Begin Date	End Date	Q.R. Date	Void	Void	Void
Annual	SC	Sally Coordinator					02/27/2013	<input type="button" value="V"/>	<input type="button" value="V"/>	<input type="button" value="V"/>

[2. Medical/Social/Family History](#) | [3. CPOC Service Needs and Supports](#) | [4. CPOC Participants](#) | [5. CPOC Approval Information](#) | [6. CPOC Quarterly Review](#) | [Approval/ Denial/ Notes History](#)

[PAST: Pertinent Historical Information](#)

HEALTH STATUS
 Comm. Care: Physician: Last Appointment Date:
 Immunization Current:
 Medical Diagnoses and Concerns/Significant Medical History (Include findings of last physical):
 Psychiatric/Behavioral Concerns:
 PRESENT: Describe Current Living Situation and Natura Supports:

Dates of Evaluations/Documentation used to develop this CPOC
 Social Evaluation
 Psychological Evaluation
 Psychiatric Evaluation
 Special Education Eval.
 Current IEP
 Behavior Management Plan
 Home Health Plan of Care
 Form 90 or Medical Records
 SOA
 Expiration:
 Other
 Describe:

LSCIS CPOC Section 3 – CPOC Service Needs and Supports

Denied CPOCs Map Add Client Find Services Add Services Reviewable CPOCs Reports Electronic PA
 Case #: 12345 Name: Last [Doe] First [John] MI [] Target Pop: [ETP] Vent. Dep.: [] DCFS/OCS: [] S. C. [SC] Edit Print

Contact Information | Demographic Information | Closure Information | Es History | CPOC History | Tracking History
CPOC History Cannot add CPOC until the most recent CPOC is approved.
 CPOC Type: [Support Coordinator] Submit for Review by: [D+H] Approval Status: [] Reviewer: [] Begin Date: [] End Date: [] Q.F. Date: [] 03/27/2013 [] [Void] [Print]
 Annual ISC: [Sally Coordinator] [] [Void] [Print]

2. Medical/Social/Family History | 3. CPOC Service Needs and Supports | 4. CPOC Participants | 5. CPOC Approval Information | CPOC Quarterly Review | Approval/ Denial Notes History

Service Needs

Service Strategy/Description	How was Need determined	Requested by participant/family	If not why not?	Primary Goal	Receiving	Medicaid	School	Community	Family	OCDD	Required PA	Amount	Approved	Edit
DME (1) AFO	Physician	<input type="checkbox"/>	Carried over - Resolved		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/	<input type="checkbox"/>	<input type="checkbox"/>
Personal Care Serv (1) assist with ADL	Family	<input checked="" type="checkbox"/>	Best possible health		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	2/ day	<input type="checkbox"/>	<input type="checkbox"/>				
Other (2) eyeglasses	Physician	<input checked="" type="checkbox"/>	Best possible health		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/	<input type="checkbox"/>	<input type="checkbox"/>
Speech Therapy (1) Community	Physician	<input checked="" type="checkbox"/>	Best possible health		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	/	<input type="checkbox"/>	<input type="checkbox"/>				
Other (1) example strategy	Physician	<input checked="" type="checkbox"/>	Best possible health		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/	<input type="checkbox"/>	<input type="checkbox"/>

LSCIS CPPOC Section 4 – Additional Information / CPPOC Participants

Tuesday, March 19, 2013 Log Out: Sally

LSCIS Client Data Form V 2/73 Site: 0299030 My Home

Add Client
 Find Services
 Add Services
 Reviewable CPPOCs
 Reports
 Electronic PA

Client ID: 12315
 Name: Last [Doc]
 First [John]
 MI []
 Target Pop: [ET]
 Vent. Dep: []
 DCFS/OCS: []
 S. C. [SC]

Contact Information
 Demographic Information
 Closure Information
 PA History
 CPPOC History
 Tracking History

Case History: Cancel add CPPOC until the most recent CPPOC is approved.

Type	Support Coordinator	Submit for Review	Approval Status	Assign Date	End Date	Q.R. Date	Void	Void
Annual SC	Early Coordinator					02/27/2013		

2. Medical/Service/Agency History
 3. CPPOC Service Needs and Supports
 4. CPPOC Participants
 5. CPPOC Approval Information
 CPPOC Quarterly Review
 Approval Detail/Notes History

Additional Information about Services, Needs and Supports:

S. C. has explained that Medicaid will provide medically necessary therapies. In addition to the therapies received at school through the IEP.

If no why not:

Support Coordinator: has reviewed Medicaid Services Chart with the participant and family: If no why not:

Support Coordinator: has provided the participant and family with information on Medicaid EPSDT Services: If no why not:

Support Coordinator: has provided the participant and family with information on EPSDT Screening Services:

If not why not:

EPSDT Screening Services requested: If yes referral Date:

Participant Signature Date:

The Support Coordinator will coordinate all services, Medicaid and non-Medicaid, and ensure that the participant receives the services he or she needs to attain or maintain their personal outcomes. The Support Coordinator will have phone contact with the family/participant at least monthly and meet face to face at least quarterly to assure that the CPPOC continues to address the participant's need and that the services are being provided. The CPPOC will be reviewed by the Support Coordinator at least quarterly and revised annually and as needed.

If there are no services to be added, the family/participant has been informed of this and that they can access support receive Medicaid services or their placement on the Waiver Request for Services Registry.

Signature of Support Coordinator: S. C. Signature Date: Ready for Supervisor Review:

LSCIS CPOC Section 5 – CPOC Approval Information

My Home

Denied CPOCs | Add Client | Find Services | Add Services | Reviewable CPOCs | Reports | Electronic PA

Case #: 12345 Name: Last Doe First John MI Target Pop: ETP Vent. Dep.: DCFS/OCs: S. C. SC Edit Print

Contact Information | Demographic Information | Closure Information | Pa History | CPOC History | Tracking History

CPOC History Cannot add CPOC until the most recent CPOC is approved.

Table with columns: CPOC Type, Support Coordinator, Annual SC, Submit for review by DHH, Approval Status, Reviewer, Begin Date, End Date, Q.R. Date, Void, Void

2. Medical/Social/Family History | 3. CPOC Service Needs and Supports | 4. CPOC Participants | 5. CPOC Approval Information | CPOC Quarterly Review | Approval/Denial Notes History

1. the Support Coordinator Supervisor, have reviewed all of the listed evaluations/documentation used to develop this CPOC, service logs, and quarterly reviews for identified needs and the status of requested services. The entire CPOC was reviewed to ensure that all identified needs are addressed, all required information is included, information is edited and updated, and no discrepancies exist.

Signature Support Coordinator Supervisor [] Date: / /

Submit for review by DHH: [] See Service Tickets

Edit

Approval/Denial Information

By: [] Approval/Denial Date: / /

Approval/Denial Notes: []

LSCIS CPOC Quarterly Review

Denied CPOCs: 1/6/8
 Case #: 12345 | Member: Last, Due | M | Submit | MC | Target Pwr: ETP | Net IL Dept: S.C. | S.C. |

Support Information: Demographic Information Absence Information Ex History CPOC History Medical History
CPOC History Cannot add CPOC until the most recent CPOC is approved.

CPOC Type: Annual SC | Support Coordinator: Sally Coordinator |

Approved | Review from Date: 02/27/2013 | Approved | Review from Date: 02/27/2013 |

1. Medical/Specialty History 2. CPOC Service Needs and Supports 3. CPOC Participation 4. CPOC Approval Information

Service Needs	Requested/Received	Explanation for Need/Approval	Due to EA	Response
DMF (1)	<input type="checkbox"/>	NA	NA	Dr. told mom if eye not needed
AFO	<input type="checkbox"/>	NA	NA	wears daily
Other (2)	<input checked="" type="checkbox"/>	NA	NA	Has res. mother receiving therapy
eyeglasses	<input checked="" type="checkbox"/>	NA	NA	mom on Rx. will obtain at checkup next wk.
Personal Care Serv. (1)	<input checked="" type="checkbox"/>			
assist with ADL	<input type="checkbox"/>			
Speech Therapy (1)	<input type="checkbox"/>			
Community	<input type="checkbox"/>			
Health Changes (Include Nutritional Changes)	<input type="checkbox"/>			
Safety Issues	<input type="checkbox"/>			
Changes in Living Situations	<input type="checkbox"/>			
Medicaid Services Chart	<input type="checkbox"/>			
Rights and Responsibilities	<input type="checkbox"/>			
Grievance Policy	<input type="checkbox"/>			
Abuse Policy	<input type="checkbox"/>			
Health Standards Provider compliant (1-800-690-0488)	<input type="checkbox"/>			

Are you requesting any medical/necessary the copies now or want to receive the tables on the IEP during the school's summer break?

Participant Questions: Completed:

Are you receiving the services that you requested? Yes No
 Are the Services at the day/time needed? Yes No
 Are you pleased with the services that you are receiving? Yes No
 Are there Additional services that you need? Yes No

Comments:

Support Coordinator: SC | Date: 02/27/2013
 Names of Attendees: Relation (Title) Agency Date
 Jane Doe Mother 02/27/2013
 Sally, Coordinator Participant 02/27/2013
 Patricia Workman CCS worker 02/27/2013

SECTION VI: TYPICAL WEEKLY SCHEDULE

CONFIDENTIAL

For Planning Purposes Only. If needs change, I will contact my Support Coordinator as soon as possible.

Time	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
12:00 AM							
1:00 AM							
2:00 AM							
3:00 AM							
4:00 AM							
5:00 AM							
6:00 AM							
7:00 AM							
8:00 AM							
9:00 AM							
10:00 AM							
11:00 AM							
12:00 PM							
1:00 PM							
2:00 PM							
3:00 PM							
4:00 PM							
5:00 PM							
6:00 PM							
7:00 PM							
8:00 PM							
9:00 PM							
10:00 PM							
11:00 PM							

CODE	COMMENTS:
F = FAMILY/FRIENDS	
S = SELF	
SC = SCHOOL	
OT = OCCUPATIONAL THERAPY	
PCS = EPSDT/PERSONAL CARE	
EHH = EXTENDED HOME HEALTH	
PT = PHYSICAL THERAPY	

Above is the schedule of services requested by the individual and should be provided at these times. PCS can be provided at the same time as skilled nursing or therapy services as long as the PCS worker is performing duties that do not require one-on-one contact with the participant such as meal preparation and cleaning but should never be idle during the time they are billing for services. On rare occasions PT and OT can be performed concurrently when the provision of services in this manner is determined to be more effective treatment. Otherwise, there should not be concurrent services provided to the participant.

Participant Name: _____ CPOC: Begin Date: _____ End Date: _____

LSCIS Service Log

LSCIS Service Log Form V2.08 Site: 02990050 Thursday, October 09, 2008 LOG Out: Your Name

My Home Authorization Management Delete Voided Ticket

Find Client Add Client Find Services Agency Info. Provider Numbers Delete Voided Ticket
 Modify/Delete Case Number Reviewable CPOCs Reports Download Site Data Electronic PA Request Deleted Elec. PAs Reassign Case Load
 Denied CPOCs

Ticket No: Case No: S. C. P/P Contact

1. Date: 10/09/2008
 2. Begin Time: :
 End Time: :
 3. Place:
 4. Type of Contact:
 5. Activity:
 7. Service Participants:

Entered: Modified: Reviewed:
 8. Begin Mileage: End Mileage:
 9. Minutes spent documenting log:

Notes:

Service Need:

Save Cancel Void

CMIS SERVICE LOG CODES
MILITARY TIME CONVERSION TABLE

<u>STANDARD</u>	<u>MILITARY</u>	<u>STANDARD</u>	<u>MILITARY</u>
1:00 A.M.	1:00	1:00 P.M.	13:00
2:00 A.M.	2:00	2:00 P.M.	14:00
3:00 A.M.	3:00	3:00 P.M.	15:00
4:00 A.M.	4:00	4:00 P.M.	16:00
5:00 A.M.	5:00	5:00 P.M.	17:00
6:00 A.M.	6:00	6:00 P.M.	18:00
7:00 A.M.	7:00	7:00 P.M.	19:00
8:00 A.M.	8:00	8:00 P.M.	20:00
9:00 A.M.	9:00	9:00 P.M.	21:00
10:00 A.M.	10:00	10:00 P.M.	22:00
11:00 A.M.	11:00	11:00 P.M.	23:00
12:00 Noon	12:00	12:00 Midnight	24:00

CASE MANAGEMENT SERVICE LOG CODES

3. PLACE OF SERVICES

- 02. Home
- 09. Day Program/ADHC
- 10. Mental Health Clinic
- 12. School
- 13. Support Coordination Agency
- 14. Jail or Correctional Facility
- 15. Day care or nursery school
- 16. OT, PT, Speech Therapist's Office
- 18. Early Intervention Provider
- 19. Service Provider's Place of Business
- 21. Hospital
- 22. Medical / Public Health Clinic
- 23. ICF/DD
- 24. Nursing Facility
- 99. Other Community Location

4. TYPE OF CONTACT

- 1. In person
- 2. Telephone
- 3. Written
- 4. In person contact plus documentation
- 5. Telephone contact plus documentation
- 6. Documentation Only

5. SERVICE ACTIVITY

(Service activity codes 20-26 are for VACP only)

- 20. Medical Consultation
- 21. Health Management
- 22. Medical Crisis Management
- 23. Medical Crisis Training & Tech. Assistance - School
- 24. Medical Crisis Training & Tech. Assistance - Community
- 25. Intense Informing for Complex Health Needs
- 26. Annual Staffing
- 51. Intake (1)
- 52. Initial Assessment (2.1)
- 53. Reassessment (not-annual) (2.2)
- 54. Annual Assessment (2.3)

5. SERVICE ACTIVITY *(continued)*

- 55. Service Planning (3)
- 56. Advocacy (3.6)
- 57. Follow-up Monitoring (4)
- 58. Observation of Services (4.3.2)
- 59. Monitoring of Records (4.3.3)
- 60. Transition / Closure (5)
- 61. Record Keeping / Documentation (6)
- 62. Revisions (not related to critical incident/crisis activities) (7.1)
- 63. Critical Incident (7.2)
- 64. Revisions Resulting from Critical Incident Activities (7.2a)
- 65. Crisis Response (7.3)
- 66. Revisions Resulting from Crisis Response Activities (7.3a)
- 67. EPSDT PA Tracking
- 68. EPSDT Provider Follow-Up
- 69. EPSDT PAL Referral
- 70. EPSDT Appeal Follow-Up
- 71. Travel *(does not count for billing requirement)*
- 72. Nurse Consultant *(does not count for billing requirement)*
- 73. Supervisor Contact *(does not count for billing requirement)*
- 74. Service Note *(does not count for billing requirement)*
- 75. Training *(does not count for billing requirement)*
- 76. SIS / LA Plus related activities
- 77. SIS / LA Plus completed

7. SERVICE PARTICIPANTS

- 01. Recipient
- 02. Parent or Legal Guardian
- 03. Other Family Member or Essential Other
- 07. Education
- 08. Health Care Providers
- 09. Community Services / Resources
- 10. Program Office (OCDD, OAAS, BHSF)
- 11. Medicaid Eligibility Office
- 12. Waiver Service Provider
- 13. Medicaid Provider (non-waiver/State Plan)
- 14. Non-Medicaid Other Provider (paid/non-paid)
- 15. PAL
- 16. Advocacy Representative
- 17. Nurse Consultant *(not in the capacity of an S.C.)*
- 18. SRI
- 98. None *(documentation / record keeping)*
- 99. Other

OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES
CMIS SERVICE LOG

Service Log #: _____

Case Number: _____ Client Name: _____

Case Manager ID: _____

1. Date: ____/____/____	5. Activity: ____	Proc Code (NOW) or P/P Contact (ETP) : _____	8. If this is a travel log: Begin Mileage: _____
2. Begin Time: ____:____ (hh:mm)	Activity: ____	Proc Code (NOW) or P/P Contact (ETP) : _____	End Mileage: _____
End Time: ____:____ (hh:mm)	Activity: ____	Proc Code (NOW) or P/P Contact (ETP) : _____	9. Minutes spent documenting log: ____
3. Place of Service: ____	Activity: ____	Proc Code (NOW) or P/P Contact (ETP) : _____	
4. Type of Contact: ____	7. Service Participants: _____		

Note: _____

Support Coordinator's Signature (required): _____ Date: ____/____/____

SECTION II: Medical/Social/Family History

Appendix O

PAST: Pertinent Historical Information: (date age and Cause of disability. If not known, put unknown. Placement situations that impact care; response to interventions in the past summary of events leading to request for services at this time.)

HEALTH STATUS:

Community Care:

Physician Name:

Date of Last Appointment:

Immunizations Current:

Medical Diagnoses and Concerns/Significant Medical History:
(Include findings of last physical)

Psychiatric/Behavioral Concerns:

**Dates of Evaluations/Documentatio
used to develop this CPOC**

Social

Pyschological

Psychiatric

Special Education

Individual Education Plan

Behavior Management Plan

Home Health Plan of Care

Form90 or Medical Records

SOA

Expiration

Other

PRESENT: Describe Current Living Situation: (describe current family situation; identify all available natural supports; identify family's understanding of individual's situation/condition - knowledge of disability; economic status; relevant social environmental and health factors that impact individual (i.e., health of care givers; home in rural/urban area; accessibility to resources; own home/rental/living with relatives/extended family or single family dwelling. Does home environment adequately meet the needs of individual or will environmental modifications be required?)

Information included on this page is relevant to the individual's life today and provides a means of sharing medical/social/family history not addressed in the content of the CPOC. Include information that is important to share and relevant to supporting and achieving the goals determined by the person.

SECTION III: CPOC SERVICE NEEDS AND SUPPORTS

Appendix O

Service Strategy/ Descript	How was need determined?	Requested by participant/family	Why Not	Goal (s)	Receiving Service						Amount Approved
					Medicaid	School	Community	Family	OCDD	Requires PA tracked by S. C.	
DME AFO	Physic ian	<input type="checkbox"/>	Carried over - Resolved		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Personal Care Serv assist with ADL	Family	<input checked="" type="checkbox"/>		Best possible health	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2
Other eyeglasses	Physic ian	<input checked="" type="checkbox"/>		Best possible health	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Speech Therapy Community	Physic ian	<input checked="" type="checkbox"/>		Best possible health	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
		<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Service Strategy List:

Personal Care Serv, Extended Hme Serv, DME, OT, Physical Therapy, Speech Therapy, M. H. ReHab, Dental Services, Psch/Behav. Serv, Specialty Eyewear, NEMT, Air Ambulance, Out-of-State Care, Organ Transplants, Diapers, School, Vocational, Employment, Transition, Pediatric Day H.C., Other

If the above has not been completed, the CPOC will be returned. All services requested shall be included and shall be re-addressed at each quarterly meeting.

Participant/Guardian's Signature: _____

Date:

Additional Information about Service Needs and Supports:

SECTION IV: CPOC PARTICIPANTS

Appendix O

PLANNING PARTICIPANTS	TITLE & AGENCY NAME

S. C. has explained that Medicaid will provide medically necessary therapies, in addition to the therapies received at school through the IEP.

If not why not:

Support Coordinator has reviewed the Medicaid Services Chart with me:

If not why not:

Support Coordinator has provided me with information on Medicaid EPSDT Services:

If not why not:

Support Coordinator has provided me with information on EPSDT Screening Services:

If not why not:

EPSDT Screening Services requested: Referral Date:

I have reviewed and agree with the services contained in this plan. I understand it is my responsibility to notify the Support Coordinator of any change in my status which might affect the effectiveness of the services provided. I further agree to notify the Support Coordinator of any change in my income which might affect my child's financial eligibility. I understand the services in this plan of care are not authorized by the Support Coordinator and the services may begin as soon as I am notified of their approval whether or not this plan of care has been approved.

Jane Doe (Mother)

Participants/Guardian's Signature

Date

The Support Coordinator will coordinate all services, Medicaid and non-Medicaid, and ensure that the participant receives the services he or she needs to attain or maintain their personal outcomes. The Support Coordinator will have phone contact with the family/participant at least monthly and meet face to face at least quarterly to assure that the CPOC continues to address the participant's need and that that services are being provided. The CPOC will reviewed by the Support Coordinator at least quarterly and revised annually and as needed.

If there are no services to coordinate, the family/recipient has been informed of this and that they can access support coordination at any time until the child's 21st birthday. Declining EPSDT Support Coordination will not affect their eligibility to receive Medicaid services or their placement on the Waiver Request for Services Registry.

Support Coordinator's Signature

Date

I, the Support Coordinator Supervisor, have reviewed all of the listed evaluations/documentation used to develop this CPOC, service logs, and quarterly reviews for identified needs and the status of requested services. The entire CPOC was reviewed to ensure that all identified needs are addressed, all required information is included, information is edited and updated, and no discrepancies exist.

Support Coordinator Supervisor's Signature

Date

SECTION V: CARE PLAN ACTION

Participant Name: John Doe

Date Approvable CPOC Rec'd by DHH:

CPOC Status:

Approval or denial of this CPOC does not approve or deny any of the services the participant may be eligible for, and only addresses the Support Coordinator's required services implementation and documentation.

Approved CPOC: Begin Date:

End Date:

Signature/Title of DHH Representative:

Date:

Notes:

	Yes/No	Comments	Appendix O
Health Changes (include Nutritional Changes)	No		
Safety Issues	No		
Changes in Living Situation	No		
Medicaid Services Chart	Yes		
Rights and Responsibilities	Yes		
Grievance Policy	Yes		
Abuse Policy	Yes		
Health Standards Provider Complaint (1-800-660-0488)	Yes		
Are you requesting any medically necessary therapies now or want to receive therapies on the IEP during the school's summer break?	No		
Participant Questions (complete Compliant if NO answered to the following questions)	Yes/No	Participant Complaint Form Completed	Comments
Are you receiving the services you requested?	Yes	X	
Are the services delivered at the times/days needed?	Yes	X	
Are you pleased with the services you are receiving?	Yes	X	
Are there additional Services that you Need?	No		

Participant Name: John Doe

Medicaid ID: 1234567890132

CPOC: Begin Date:

End Date:

Notes: (include narrative of above LSCIS codes, additional explanations as needed, and a summary of status and progress for the quarter. Use additional page for narrative if needed)

Appendix O

example note

SC Sally Coordinator

02/27/13

Support Coordinator Signature

Date

Signature of Quarterly Meeting Attendees

Names of Attendees	Relationship/Title/Agency	Date
Jane Doe	mother	02/27/13
John Doe	participant	02/27/13
Sally Coordinator	SC	02/27/13
Patrica Workman	OCS worker	02/27/13

BUREAU OF HEALTH SERVICES FINANCING

Early Periodic Screening Diagnosis and Training (EPSDT) – Targeted Population Support Coordination
FACT SHEET

<u>Description</u>	<p>EPSDT targeted support coordination is a Medicaid State Plan Service. Support Coordination is a service that can assist families to access the services available to them through Medicaid EPSDT. This includes all services that individuals under age 21 may be entitled to receive with a Medicaid Card. These services may help address the individual's medical, social and educational needs. The Support Coordinator will review all available services and assist with making referrals for the services they may be eligible to receive. These <u>MAY</u> include services such as medical equipment, occupational, physical or speech therapy, Personal Care Service (PCS), Home Health and EPSDT screening. Support Coordinators will assure families will also be informed of any new services in the future that may help their children.</p> <p>EPSDT services are not waiver services.</p>
<u>Level of Care</u>	Individuals who have multiple medical needs or who meet the definition of a person with special needs. (See eligibility requirements below.)
<u>Population</u>	Age → 3 to 21 years old
<u>Eligibility</u>	<ul style="list-style-type: none"> • Individuals are on the DD Request for Services Registry <ul style="list-style-type: none"> ➤ Placement on the DD Request for Services Registry on or after October 20, 1997 and have passed the OCDD Diagnosis and Evaluation (D&E) process by the later of October 20, 1997 or the date they were placed on the RFSR; OR ➤ Placement on the DD Request for Services Registry (RFSR) on or after October 20, 1997 but who did not have a D & E by the later of October 20, 1997 or the date they were placed on the DD RFSR. Those in this group who subsequently pass or passed the D & E process are eligible for these targeted support coordination services. For those who do not pass the D & E process or who are not undergoing a D & E, they may still receive support coordination services if they meet the definition of a person with special needs. ➤ Must have documentation from Medicaid to substantiate that the EPSDT recipient meets the definition of special needs for support coordination services (e.g., receipt of special education services through state or local education agency, receipt of regular services from one or more physicians, receipt of or application for financial assistance such as SSI because of medical condition or the unemployment of the parent due to the need to provide specialized care for the child, a report by the participants physician of multiple health or family issues that impact the participants ongoing care or a determination of developmental delay based upon the Parent's Evaluation of Pediatric Status, the Brigrance Screens, the Child Development Inventories, Denver Developmental Assessment, or any other nationally recognized diagnostic tool. AND • Under the age of 21, AND • Are Medicaid Eligible
<u>Follow-up & Monitoring</u>	The Support Coordinator will follow-up with the participant at least monthly regarding all approved services, to ensure they are receiving services in the amount approved and at the times requested. (If the participant is not satisfied, the support coordinator will follow-up with the provider.) The support coordinator will meet face-to-face with the participant & family at least one time per quarter. The Health Standards Office will conduct Complaint investigations for all Support Coordination Agencies. They will also conduct monitoring for RFP Contracted Support Coordination Agencies utilizing a 5% sample annually.

****Requests for EPSDT Targeted Population Support Coordination should be directed to the
BHSE/SRI toll-free Help Line at 1-800-364-7828**

For information regarding all Medicaid State Plan Services, visit

<http://new.dhh.louisiana.gov/index.cfm/page/319>.

Referral to Provider

EPSDT - Targeted Population

Date:

TO: Provider Name		
FROM: Support Coordination Agency	Support Coordinator's Name:	Support Coordinator's Phone #:
Provider #:		Fax#:
Address:	City:	State/Zip:
RE: Service Type (if DME be specific):	Service Name: <input type="checkbox"/> Initial <input type="checkbox"/> Renewal	Amount/# of Hours of Service:
Participant Name:	MID#:	Phone#:
Address:	City:	State/Zip:
This is to inform you that this individual is receiving EPSDT - Targeted Population Support Coordination Services and we are sending this notice to: (Check the following that apply)		
	1. Make a referral for the above noted service. Please make sure that you include our Provider #, Agency Name and Address on the request for Prior Authorization (PA) to Medicaid. We are also requesting that you send us a copy of the PA request packet at the same time that it is sent to Medicaid/Molina.	
	2. The participant has asked that their schedule for your services be changed as per the attached Typical Weekly Schedule form. If this presents a scheduling problem, please contact the Support Coordinator so that we can all discuss this with the participant/family.	
	3. This is a reminder that the above named participant's PA for your service expires on ___/___/___ and the renewal needs to be sent to Molina/Medicaid for continued services.	
	4. The Medicaid PAL (Prior Authorization Liaison) has informed us they need the following additional information in order to process the request for the PA packet you submitted:	
	5. Other:	

 Support Coordinator's Signature

 Issued May 30, 2003
 Reissued August 4, 2006
 Revised October 29, 2010

 Date

BHSF-PF-03-016

Prior Authorization for Medicaid State Plan Services

Prior Authorization Request Forms *Physician Forms	R-1
Sample of Prior Authorization Notices	R-2
Sample of PAL Notices	R-4
Other:	
Inability to locate a provider	refer to handbook pages 15 and 34
Changing PCS Providers within an authorization period	refer to handbook page 15
Review of Possible Eligibility when providers refuse to submit a request	refer to handbook page 34 and Appendix Y
Reconsideration Requests	Refer to handbook page 42
Chronic Needs Designation	refer to handbook page 46
Emergency PA requests	refer to handbook page 41

*Physician Forms can be obtained at www.LaMedicaid.com

PRESCRIPTION REQUEST FORM FOR DISPOSABLE INCONTINENCE PRODUCTS

Recipient Information													
Name: _____	Date of birth: _____ Age: _____												
Medicaid ID: _____	Height: _____ Weight: _____												
Recipient's Address _____													
Prescribing Provider:													
Prescriber's Name: _____	Phone #: _____												
Address: _____	Fax #: _____												
<p>➤ Medical Diagnoses causing the urine and/or fecal incontinence (Specify ICD-9 CM code):</p> <p>Primary: _____ Secondary: _____</p>													
<p>➤ Specify Urine/Fecal incontinence diagnoses (Specify ICD-9 CM code):</p> <p>Primary: _____ Secondary: _____</p>													
<p>➤ Mobility</p> <p><input type="checkbox"/> Ambulatory <input type="checkbox"/> Minimal assistance ambulating</p> <p><input type="checkbox"/> Transfer Assistance <input type="checkbox"/> Confined to bed or chair</p>													
<p>➤ Extraordinary Needs - if you are requesting more than 8 per day ONLY</p> <p>Complete and provide additional supporting documentation for acute medical condition and/or extenuating circumstances for the increased need for incontinence products</p>													
<p>➤ Mental Status/Level of Orientation</p> <p><input type="checkbox"/> Has the ability to communicate needs</p> <p><input type="checkbox"/> Sometimes communicates needs</p> <p><input type="checkbox"/> Unable to communicate needs</p>	<p>Frequency of anticipated change</p> <p>During Day time (6 AM-10PM) _____</p> <p>During Night time (10PM - 6 AM) _____</p>												
<p>➤ Additional supporting Diagnoses (Specific ICD-9-CM Code)</p> <p>_____</p> <p>_____</p>	<p>Indicate current supportive services</p> <p><input type="checkbox"/> Home Health</p> <p><input type="checkbox"/> Skilled Nursing Services</p> <p><input type="checkbox"/> Personal Care Services</p> <p><input type="checkbox"/> Other _____</p>												
<p>➤ List any medications and/or nutritional therapy that would increase urine or fecal output:</p> <p>_____</p>													
<p>➤ Specify incontinence supply, size, quantity/24 hours and duration of need:</p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:60%;"></th> <th style="width:15%; text-align: center;">Qty per day</th> <th style="width:25%; text-align: center;">Size (S, M, L, XL)</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> Diapers (Check one): <input type="checkbox"/> child size <input type="checkbox"/> youth-sized <input type="checkbox"/> adult-sized</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td><input type="checkbox"/> Pull-ups (Check one): <input type="checkbox"/> child size <input type="checkbox"/> youth-sized <input type="checkbox"/> adult-sized</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td><input type="checkbox"/> Liner/shield (Check one): <input type="checkbox"/> child size <input type="checkbox"/> youth-sized <input type="checkbox"/> adult-sized</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> </tbody> </table>			Qty per day	Size (S, M, L, XL)	<input type="checkbox"/> Diapers (Check one): <input type="checkbox"/> child size <input type="checkbox"/> youth-sized <input type="checkbox"/> adult-sized	_____	_____	<input type="checkbox"/> Pull-ups (Check one): <input type="checkbox"/> child size <input type="checkbox"/> youth-sized <input type="checkbox"/> adult-sized	_____	_____	<input type="checkbox"/> Liner/shield (Check one): <input type="checkbox"/> child size <input type="checkbox"/> youth-sized <input type="checkbox"/> adult-sized	_____	_____
	Qty per day	Size (S, M, L, XL)											
<input type="checkbox"/> Diapers (Check one): <input type="checkbox"/> child size <input type="checkbox"/> youth-sized <input type="checkbox"/> adult-sized	_____	_____											
<input type="checkbox"/> Pull-ups (Check one): <input type="checkbox"/> child size <input type="checkbox"/> youth-sized <input type="checkbox"/> adult-sized	_____	_____											
<input type="checkbox"/> Liner/shield (Check one): <input type="checkbox"/> child size <input type="checkbox"/> youth-sized <input type="checkbox"/> adult-sized	_____	_____											
<p>By my signature I attest that I have seen the patient and the item prescribed is medically necessary. I have personally completed this request and a copy will be maintained in the patient's medical record.</p> <p>Prescriber's Signature:</p> <p>_____</p> <p>Date:</p> <p>_____</p>	<p>➤ Comments</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> Additional documentation attached</p>												

Disposable Incontinence Products (T4521 - T4535)

Standards of Coverage:

Diapers are covered for individuals age four years through age twenty years when:

- Specifically prescribed by the recipient's physician, and
- The individual has a medical condition resulting in permanent bowel/bladder incontinence, and
- The individual would not benefit from or has failed a bowel/bladder training program when appropriate for the medical condition.

Pull-on briefs are covered for individuals age four years through age twenty years when:

- Specifically prescribed by the recipient's physician, and
- There is presence of a medical condition resulting in permanent bowel/bladder incontinence, and
- The recipient has the cognitive and physical ability to assist in his/her toileting needs.

Liners/guards are covered for individuals age four years through age twenty years when:

- Specifically prescribed by the recipient's physician, and
- They cost-effectively reduce the amount of other incontinence supplies needed.

Note: Permanent loss of bladder and/or bowel control is defined as a condition that is not expected to be medically or surgically corrected and that is of long and indefinite duration.

Documentation: The prescription request form for disposable incontinence products may be completed by the physician, or a physician's prescription along with the required documentation as listed below.

Documentation must reflect the individual's current condition and include the following:

- Diagnosis (specific ICD-9-CM code) of condition causing incontinence (primary and secondary diagnosis).
- Item to be dispensed.
- Duration of need (*physician must provide*).
- Size
- Quantity of item and anticipated frequency the item requires replacement.
- Description of mobility/limitations

To avoid unnecessary delays and need for reconsideration, care should be taken to use the correct HCPC code from among T4521-T4535.

Documentation for extraordinary needs must include all of the above and:

- Description of mental status/level of orientation
- Indicate current supportive services
- Additional supporting diagnosis to justify increased need for supplies
- Additional documentation to justify increased need may include but are not limited to any prescriptions that would increase urinary or fecal output.

If completed, DHH's "Prescription Request Form for Disposable Incontinence Supplies" collects this information.

Approved providers of incontinence products:

- Pharmacy
- Home health agency
- Durable medical equipment provider

Prior Authorization Requirements: Prior authorization is required for all disposable incontinence supplies. The PA requests shall meet all previously defined criteria for:

- Eligible recipient.
- Eligible provider.
- Covered product.
- Documentation requirements - the prescription request form for disposable incontinence products may be completed, or a physician's prescription along with the required documentation as indicated above.

Quantity Limitations:

- Disposable incontinence supplies are limited to eight per day.
- ICF-MR and nursing facility residents are excluded as these products are included in the facility per diem.
- Additional supporting documentation is required for requests that exceed the established limit.

Dispensing and Billing:

- Only a one-month supply may be dispensed at any time as initiated by the recipient.
- Bill one unit per item. Shipping costs are included in the DHH maximum allowable payment and may not be billed separately.
- Although specific brands are not required, DHH maximum allowable amounts may preclude the purchase of some products. The rate has been established so that the majority of products on the market are obtainable.

Providers should always request authorization for the appropriate product for the recipient's current needs.

- Providers must provide at the minimum, a moderate absorbency product that will accommodate a majority of the Medicaid recipient's incontinence needs. Supplying larger quantities of inferior products is not an acceptable practice.
- For recipients requesting a combination of incontinence supplies, the total quantity shall not exceed the established limit absent approval of extraordinary needs.
- Because payment cannot exceed the number of units prior authorized, providers who choose to have incontinent supplies shipped directly from the manufacture to the recipient's home, shall be responsible for any excess over the number of supplies approved by the prior authorization.

MAIL TO:
Molina / LA. MEDICAID
P.O. BOX 14919
Baton Rouge, La. 70898-4919

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
Bureau of Health Services Financing
REHABILITATION SERVICES REQUEST

Patient Name: _____ Age: _____ Provider Name: _____

BACKGROUND INFORMATION

DATE OF ACCIDENT OR SURGERY: _____

LIMITATIONS : ___ AMBULATORY ___ NON - AMBULATORY ___ YES ___ NO TRANSPORTATION AVAILABLE
AIDS NEEDED: ___ WALKER ___ CANE ___ WHEELCHAIR ___ LIMBS OR BRACES _____ OTHER

REHABILITATION PLAN

PLAN OF SERVICES: _____ INITIAL _____ EXTENSION

IF INITIAL, INITIAL EVALUATION DATA AND MD REFERRAL / PRESCRIPTION MUST BE ATTACHED

IF EXTENSION, PRIOR ATTENDANCE: _____ REGULAR _____ NON-REGULAR. MUST ALSO ATTACH PROGRESS REPORTS

REQUESTED SERVICES: PROCEDURE CODE DESCRIPTION FREQUENCY TIME / VISIT TOTAL UNITS

PHYSICAL THERAPY: _____

SPEECH THERAPY: _____

OCCUPATIONAL THERAPY _____

LENGTH OF PLAN SERVICE: FROM: _____ TO: _____
MONTH DAY YEAR MONTH DAY YEAR

DATE OF RE-EVALUATION: _____
MONTH DAY YEAR

PROPOSED GOALS / COMMENTS: _____

REQUESTED BY: _____ DATE: _____

REQUEST FOR MEDICAID EPSDT - PERSONAL CARE SERVICES
 (Personal Care Services are to be provided in the home and not in an institution)

I. IDENTIFYING INFORMATION

1. Applicant Name:	MID#
Address:	Ph # ()
	<input type="checkbox"/> Male <input type="checkbox"/> Female DOB:
2. Responsible Party/Curator:	Relationship:
Address:	Home Phone # ()
	Work or Cell Phone # ()
By signing this form I give my consent for my medical information to be released to the Department of Health and Hospitals to be used in determining eligibility for Personal Care Services.	
Signature: _____	Date: _____

II. MEDICAL INFORMATION

NOTE: The following information is to be completed by the applicant's attending physician.			
1. Patient Name:			
2. Primary Diagnosis:		Diagnosis Code:	
Secondary Diagnosis:		Diagnosis Code:	
3. Physical Examination:		4. Special Care/Procedures: check appropriate box and give type, frequency, size, stage and site when appropriate	
General _____	Head and CNS _____	<input type="checkbox"/> Trach Care: <input type="checkbox"/> Daily <input type="checkbox"/> PRN	
Mouth and EENT _____	Chest _____	<input type="checkbox"/> Respiratory: <input type="checkbox"/> Ventilator <input type="checkbox"/> Daily <input type="checkbox"/> Other _____	
Heart and Circulation _____	Abdomen _____	<input type="checkbox"/> Suctioning/Oral Care: <input type="checkbox"/> Daily <input type="checkbox"/> PRN	
Genitalia _____	Extremities _____	<input type="checkbox"/> Glucose Monitoring: <input type="checkbox"/> Insulin Injections <input type="checkbox"/> Daily <input type="checkbox"/> Other	
Skin _____	Height _____	<input type="checkbox"/> Restraints (positioning)	
Wt. _____	Pulse _____	<input type="checkbox"/> Dialysis	
Resp _____	Temp _____	<input type="checkbox"/> Urinary Catheter	
B/P _____	Bowel/Bladder Control _____	<input type="checkbox"/> Seizure Precautions	
Impaired Vision _____	Impaired Hearing _____	<input type="checkbox"/> Ostomy	
<input type="checkbox"/> Glasses	<input type="checkbox"/> Hearing Aid	<input type="checkbox"/> IV	
Lab Results:	HCB _____	<input type="checkbox"/> Decubitus/Stage _____	
HCT _____	Radology _____	<input type="checkbox"/> Diet/Tube Feeding	
U/A _____		<input type="checkbox"/> Rehab (OT,PT,ST)	
		Assistive Device:	
		<input type="checkbox"/> Walker <input type="checkbox"/> Cane	
		<input type="checkbox"/> Bed/Chair <input type="checkbox"/> Lift	
		<input type="checkbox"/> Other _____	
5. Medications	Dosage	Frequency	Route

II. MEDICAL INFORMATION (Continued)

6. Recent Hospitalizations: (Include psychiatric):								
7. Mental Status/Behavior: Check Yes or No. If Yes, indicate frequency: 1 = seldom; 2 = frequent; 3 = always								
Oriented	<input type="checkbox"/> Yes (1 2 3)	<input type="checkbox"/> No	Depressed	<input type="checkbox"/> Yes (1 2 3)	<input type="checkbox"/> No	Cooperative	<input type="checkbox"/> Yes (1 2 3)	<input type="checkbox"/> No
Passive	<input type="checkbox"/> Yes (1 2 3)	<input type="checkbox"/> No	Physically Abusive	<input type="checkbox"/> Yes (1 2 3)	<input type="checkbox"/> No	Verbally Abusive	<input type="checkbox"/> Yes (1 2 3)	<input type="checkbox"/> No
Verbal	<input type="checkbox"/> Yes (1 2 3)	<input type="checkbox"/> No	Comatose	<input type="checkbox"/> Yes (1 2 3)	<input type="checkbox"/> No	Hostile	<input type="checkbox"/> Yes (1 2 3)	<input type="checkbox"/> No
Forgetful	<input type="checkbox"/> Yes (1 2 3)	<input type="checkbox"/> No	Confused	<input type="checkbox"/> Yes (1 2 3)	<input type="checkbox"/> No	Combative	<input type="checkbox"/> Yes (1 2 3)	<input type="checkbox"/> No
Non-responsive	<input type="checkbox"/> Yes (1 2 3)	<input type="checkbox"/> No	Injures Self/Others	<input type="checkbox"/> Yes (1 2 3)	<input type="checkbox"/> No			
8. Impairments: Please rate the following. 1- Mild, 2-Moderate, 3-Severe								
Walking	(1 2 3)	Chronic heart failure	(1 2 3)	Vision impairment	(1 2 3)			
Spasticity	(1 2 3)	Speech impairment	(1 2 3)	Oral feeding	(1 2 3)			
Limb weakness	(1 2 3)	Seizure Disorder	(1 2 3)	Bladder and bowel incontinence	(1 2 3)			
Hypotonia	(1 2 3)	Developmental delay	(1 2 3)	Intellectual impairment	(1 2 3)			
Chronic Resp distress	(1 2 3)	Hearing impairment	(1 2 3)					

III. LEVEL OF CARE DETERMINATION

Activities of Daily Living:

Based on the recipient's impairment, the attending physician should check the appropriate box as it applies to the recipient's ability to perform this age appropriate tasks using the following definitions and PCS Level of Assistance Guide:

Not Independent at this Age – not age appropriate to perform this task independently

Independent – recipient able to perform task **without assistance**

Limited Assistance – recipient aids in task, but receives help from other persons **some of the time**

Extensive Assistance – recipient aids in task, but receives help from other persons **all of the time**

Maximal Assistance – recipient is **entirely dependent** on other persons

Note: An additional 15 minutes can be added to bathing, dressing and toileting if mobility/transfer assistance is required

(EPSDT – PCS Level of Assistance Guide)

This is a **general guide** to assist physicians with determining the level of assistance recipients require to complete their activities of daily living (ADL). Additional time to complete the tasks will be considered if there is sufficient medical documentation provided. Please use the comments section below and attach documentation to support the need for additional time to complete the ADL's. In addition to the PCS tasks listed, assistance with incidental household chores may be approved. This does not include routine household chores such as regular laundry, ironing, mopping, dusting, etc., but instead arises as the result of providing assistance with personal care to the recipient.

PCS Task	Levels of Assistance				Mobility/Transfer Requirement
	Independent	Limited Assistance	Extensive Assistance	Maximal Assistance	
Bathing	0	15 min	30 min	45 min	Additional 15 min
Dressing	0	15 min	30 min	45 min	Additional 15 min
Grooming	0	15 min	15 min	15 min	
Toileting	0	15 min	30 min	45 min	Additional 15 min
Eating	0	15 min	30 min	45 min	
Meal Prep	0	30 min	30 min	30 min	

III. LEVEL OF CARE DETERMINATION (Continued)

NOTE: The following information is to be completed by the applicant's attending physician. Check the appropriate box using the definitions and EPSDT PCS Level of Assistance Guide to assist with determining the level of care.						
Activity	Not Independent at this Age	Independent	Limited Assistance	Extensive Assistance	Maximal Assistance	Comments
Bathing						
Dressing						
Grooming						
Toileting						
Eating						

Level of care is provided under classifications dependent upon the type and/or complexity of care and services rendered, as well as, the amount of time required to render the necessary care and services. **Please select one of the following:**

This individual's condition includes a need for nursing care to manage a plan of care and/or more assistance with extensive personal care, ambulation, and mobilization. May include professional nursing care and assessment on a daily basis due to a serious condition which is unstable or a rehabilitative therapeutic regime requiring professional staff.

Yes, this individual requires this level of care.
 No, this individual does not require this level of care.

Mobility/Transfer Requirements: Please indicate below the activities of daily living for which the recipient will require assistance with mobility/transfer.

Bathing Yes No Dressing Yes No Toileting Yes No

Medical Appointments:

Will the recipient need the PCS worker to accompany him/her to medical appointments? Yes No

How often will the recipient have scheduled medical appointments? weekly monthly quarterly other _____

Reason for PCS worker to accompany child to medical appointments: _____

IV. PHYSICIAN'S ORDER

<p>The above named patient is in need of EPSDT PCS due to his/her current medical condition. I am prescribing Personal Care Services for _____ hours, _____ days a week as determined by the level of care determination.</p>

Physician's Name (type or print):	Phone: ()
Address:	
<p>I certify/recertify that I am the attending physician for this patient and that the information provided is accurate and correct to the best of my knowledge. I authorize these EPSDT personal care services and will periodically review the plan. In my professional opinion, the services listed on this form are medically necessary and appropriate due to the child's medical condition. I understand that if I knowingly authorize services that are not medically necessary, I may be in violation of Medicaid rules and subject to sanctions described therein. I understand a face to face evaluation must be held between recipient and physician.</p>	
Physician's Signature _____	Date _____

HOME HEALTH CERTIFICATION AND PLAN OF CARE

1. Patient's HI Claim No.	2. Start Of Care Date	3. Certification Period From: _____ To: _____	4. Medical Record No.	5. Provider No.	
6. Patient's Name and Address			7. Provider's Name, Address and Telephone Number		
8. Date of Birth			9. Sex <input type="checkbox"/> M <input type="checkbox"/> F		
11. ICD-9-CM	Principal Diagnosis	Date			
12. ICD-9-CM	Surgical Procedure	Date			
13. ICD-9-CM	Other Pertinent Diagnoses	Date			
14. DME and Supplies			15. Safety Measures:		
16. Nutritional Req.			17. Allergies:		
18.A. Functional Limitations			18.B. Activities Permitted		
1 <input type="checkbox"/> Amputation	5 <input type="checkbox"/> Paralysis	9 <input type="checkbox"/> Legally Blind	1 <input type="checkbox"/> Complete Bedrest	6 <input type="checkbox"/> Partial Weight Bearing	A <input type="checkbox"/> Wheelchair
2 <input type="checkbox"/> Bowel/Bladder (Incontinence)	6 <input type="checkbox"/> Endurance	A <input type="checkbox"/> Dyspnea With Minimal Exertion	2 <input type="checkbox"/> Bedrest BRP	7 <input type="checkbox"/> Independent At Home	B <input type="checkbox"/> Walker
3 <input type="checkbox"/> Contracture	7 <input type="checkbox"/> Ambulation	B <input type="checkbox"/> Other (Specify)	3 <input type="checkbox"/> Up As Tolerated	8 <input type="checkbox"/> Crutches	C <input type="checkbox"/> No Restrictions
4 <input type="checkbox"/> Hearing	8 <input type="checkbox"/> Speech		4 <input type="checkbox"/> Transfer Bed/Chair	9 <input type="checkbox"/> Cane	D <input type="checkbox"/> Other (Specify)
19. Mental Status:			5 <input type="checkbox"/> Disoriented		7 <input type="checkbox"/> Agitated
1 <input type="checkbox"/> Oriented	3 <input type="checkbox"/> Forgetful		6 <input type="checkbox"/> Lethargic	8 <input type="checkbox"/> Other	
2 <input type="checkbox"/> Confused	4 <input type="checkbox"/> Depressed		3 <input type="checkbox"/> Fair	4 <input type="checkbox"/> Good	5 <input type="checkbox"/> Excellent
20. Prognosis:			1 <input type="checkbox"/> Poor		2 <input type="checkbox"/> Guarded
21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)					

22. Goals/Rehabilitation Potential/Discharge Plans

23. Nurse's Signature and Date of Verbal SOC Where Applicable: _____ 25. Date HHA Received Signed POT _____

24. Physician's Name and Address _____ 26. I certify/re-certify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized the services on this plan of care and will periodically review the plan.

27. Attending Physician's Signature and Date Signed _____ 28. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICES FINANCING
P O BOX 91030, BATON ROUGE, LOUISIANA 70821-9030

DATE 08/01/2006
PRIOR AUTH. NBR

RECIPIENT NAME
RECIPIENT NUMBER

PROVIDER NUMBER

DEAR PROVIDER,

THE RECIPIENTS REQUEST FOR PRIOR AUTHORIZATION OF SERVICE(S) HAS BEEN

A P P R O V E D .

THE FOLLOWING SERVICE(S) WAS REQUESTED THROUGH OUR PRIOR AUTHORIZATION SERVICE

PROCEDURE: T4526 ADULT SIZE PULL-ON MED
REQUESTED: 917 APPROVED: 917
DATES OF SERVICE: 08/01/2006 - 12/31/2006 STATUS: APPROVED

PROCEDURE: T4526 ADULT SIZE PULL-ON MED
REQUESTED: 1 APPROVED: 1
DATES OF SERVICE: 08/01/2006 - 12/31/2006 STATUS: APPROVED

THIS RECIPIENT HAS BEEN DEEMED AS A "CHRONIC NEEDS CASE". WRITE "CHRONIC NEEDS CASE" ON TOP OF THE NEXT PRIOR AUTHORIZATION REQUEST.

SUBMIT ONLY THE PRIOR AUTHORIZATION FORM AND THE DOCTORS STATEMENT STATING THE CONDITION OF THE PATIENT HAS NOT CHANGED.

IF YOU DISAGREE WITH OUR DECISION, YOU HAVE THE RIGHT TO APPEAL, AND MAY BRING ADDITIONAL EVIDENCE TO THE HEARING TO SUPPORT YOUR REQUEST FOR SERVICES.

IN ORDER TO APPEAL, PLEASE WRITE TO:

OFFICE OF THE SECRETARY
BUREAU OF APPEALS
P.O. BOX 4183
BATON ROUGE, LA 70821-4183

YOUR REQUEST FOR APPEAL MUST BE RECEIVED OR POSTMARKED WITHIN 30 DAYS OF THE NOTICE DATE.

THIS AUTHORIZATION IS NOT A GUARANTEE OF RECIPIENT MEDICAID ELIGIBILITY.

CLAIMS FOR COMMUNITY CARE RECIPIENTS MUST HAVE PCP REFERRAL NUMBER ON THE CLAIM IN ORDER TO BE REIMBURSED BY MEDICAID.

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICES FINANCING
P O BOX 91030, BATON ROUGE, LOUISIANA 70821-9030

DATE 06/25/2009 RECIPIENT NAME
PRIOR AUTH. NBR RECIPIENT NUMBER 9382978185190

AAA CARE LLC
P O BOX 640402
KENNER LA 70064

PROVIDER NUMBER 1461610

DEAR PROVIDER,

THE RECIPIENTS REQUEST FOR PRIOR AUTHORIZATION OF SERVICE(S) HAS BEEN

P A R T I A L L Y A P P R O V E D .

THE FOLLOWING SERVICE(S) WAS REQUESTED THROUGH OUR PRIOR AUTHORIZATION SERVICE

PROCEDURE: T1019 EP PERSONAL CARE SERVICE, EACH 15 MIN
REQUESTED: 2912 APPROVED: 1456
DIFFERENCE: 1466
DATES OF SERVICE: 05/12/2009 - 11/12/2009 STATUS: PARTIALLY APPROVED

YOU ASKED FOR 4 HOURS PER DAY, 7 DAYS A WEEK OF PERSONAL CARE SERVICES. BASED ON THE MEDICAL AND SOCIAL INFORMATION PROVIDED, WE HAVE APPROVED FOR YOU TO BEGIN RECEIVING 2 HOURS A DAY, 7 DAYS A WEEK OF PERSONAL CARE SERVICES.

PLEASE NOTE THAT ALL TIME ALLOTMENTS FOR ACTIVITIES OF DAILY LIVING ARE APPROVED AS REQUESTED EXCEPT FOR MEAL PREPARATION AND MEDICAL APPDINTMENTS.

35 MINUTES FOR BATHING

15 MINUTES FOR DRESSING

15 MINUTES FOR GROOMING

15 MINUTES FOR TOILETING

15 MINUTES FOR EATING

20 MINUTES FOR INCIDENTAL HOUSEHOLD SERVICES

WE DID NOT APPROVE TIME FOR MEAL PREPARATION AS THE INFORMATION INDICATES THAT YOUR MOTHER PREPARES REGULAR MEALS. PLEASE EXPLAIN THE NEED FOR PERSONAL CARE SERVICE WORKER TO PREPARE MEALS OR HELP THE MOTHER.

PLEASE PROVIDE INFORMATION AS TO THE NEED FOR THE PERSONAL CARE SERVICE WORKER TO ACCOMPANY RECIPIENT TO THE DOCTOR'S OFFICE.

THE HOURS NOT APPROVED WERE REFERRED TO THE PRIOR AUTHORIZATION LIAISON IN ORDER TO OBTAIN THE INFORMATION NEEDED TO MAKE A DETERMINATION AS TO WHETHER THE ADDITIONAL HOURS CAN BE APPROVED. WE ARE GOING TO REQUEST ADDITIONAL INFORMATION TO JUSTIFY THE HOURS OF SERVICE NOT APPROVED. YOU WILL RECEIVE A SEPARATE NOTICE APPROVING OR DENYING THESE HOURS.

THIS INFORMATION SHOULD BE PROVIDED BY YOUR PRIMARY CARE PHYSICIAN.

IF YOU DISAGREE WITH OUR DECISION, YOU HAVE THE RIGHT TO APPEAL, AND MAY BRING ADDITIONAL EVIDENCE TO THE HEARING TO SUPPORT YOUR REQUEST FOR SERVICES.

IN ORDER TO APPEAL, PLEASE WRITE TO:

OFFICE OF THE SECRETARY
BUREAU OF APPEALS
P.O. BOX 4183
BATON ROUGE, LA 70821-4183

YOUR REQUEST FOR APPEAL MUST BE RECEIVED OR POSTMARKED WITHIN 30 DAYS OF THE NOTICE DATE.

THIS AUTHORIZATION IS NOT A GUARANTEE OF RECIPIENT MEDICAID ELIGIBILITY.

CLAIMS FOR COMMUNITY CARE RECIPIENTS MUST HAVE PCP REFERRAL NUMBER ON THE CLAIM IN ORDER TO BE REIMBURSED BY MEDICAID.

IF CLARIFICATION ON THIS DECISION IS NEEDED, CONTACT THE PRIOR AUTHORIZATION UNIT AT UNISYS 1-800-488-6334.

SINCERELY,

BUREAU OF HEALTH SERVICES FINANCING

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICES FINANCING
P O BOX 91030, BATON ROUGE, LOUISIANA 70821-9030

DATE 06/25/2009 PROVIDER NAME AAA CARE LLC
PRIOR AUTH. NBR 818550860 PROVIDER NUMBER 1461610

* THIS IS NOT A BILL *

RECIPIENT NUMBER
CCN NUMBER

DEAR

YOUR REQUEST FOR PRIOR AUTHORIZATION OF SERVICE(S) HAS BEEN

P A R T I A L L Y A P P R O V E D .

THE FOLLOWING SERVICE(S) WAS REQUESTED THROUGH OUR PRIOR AUTHORIZATION SERVICE

PROCEDURE: T1019 EP PERSONAL CARE SERVICE, EACH 15 MIN
REQUESTED: 2912 APPROVED: 1456
DIFFERENCE: 1456
DATES OF SERVICE: 05/12/2009 - 11/12/2009 STATUS: PARTIALLY APPROVED

YOU ASKED FOR 4 HOURS PER DAY, 7 DAYS A WEEK OF PERSONAL CARE SERVICES. BASED ON THE MEDICAL AND SOCIAL INFORMATION PROVIDED, WE HAVE APPROVED FOR YOU TO BEGIN RECEIVING 2 HOURS A DAY, 7 DAYS A WEEK OF PERSONAL CARE SERVICES.

PLEASE NOTE THAT ALL TIME ALLOTMENTS FOR ACTIVITIES OF DAILY LIVING ARE APPROVED AS REQUESTED EXCEPT FOR MEAL PREPARATION AND MEDICAL APPOINTMENTS.

35 MINUTES FOR BATHING

15 MINUTES FOR DRESSING

15 MINUTES FOR GROOMING

15 MINUTES FOR TOILETING

15 MINUTES FOR EATING

20 MINUTES FOR INCIDENTAL HOUSEHOLD SERVICES

WE DID NOT APPROVE TIME FOR MEAL PREPARATION AS THE INFORMATION INDICATES THAT YOUR MOTHER PREPARES REGULAR MEALS. PLEASE EXPLAIN THE NEED FOR PERSONAL CARE SERVICE WORKER TO PREPARE MEALS OR HELP THE MOTHER.

PLEASE PROVIDE INFORMATION AS TO THE NEED FOR THE PERSONAL CARE SERVICE WORKER TO ACCOMPANY RECIPIENT TO THE DOCTOR'S OFFICE.

THE HOURS NOT APPROVED WERE REFERRED TO THE PRIOR AUTHORIZATION LIAISON IN ORDER TO OBTAIN THE INFORMATION NEEDED TO MAKE A DETERMINATION AS TO WHETHER THE ADDITIONAL HOURS CAN BE APPROVED. WE ARE GOING TO REQUEST ADDITIONAL

INFORMATION TO JUSTIFY THE HOURS OF SERVICE NOT APPROVED. YOU WILL RECEIVE A SEPARATE NOTICE APPROVING OR DENYING THESE HOURS.

THIS INFORMATION SHOULD BE PROVIDED BY YOUR PRIMARY CARE PHYSICIAN.

YOU MAY HAVE YOUR CASE MANAGER ASSIST YOU WITH OBTAINING MEDICAID SERVICES. IF YOU DO NOT HAVE A CASE MANAGER AND WOULD LIKE TO OBTAIN ONE, YOU SHOULD CALL STATISTICAL RESOURCES, INC (SRI) AT 1-800-364-7828.

IF YOU DISAGREE WITH OUR DECISION, YOU HAVE THE RIGHT TO APPEAL, AND MAY BRING ADDITIONAL EVIDENCE TO THE HEARING TO SUPPORT YOUR REQUEST FOR SERVICES.

IN ORDER TO APPEAL, PLEASE WRITE TO:

OFFICE OF THE SECRETARY
BUREAU OF APPEALS
P.O. BOX 4183
BATON ROUGE, LA 70821-4183

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IF CLARIFICATION ON THIS DECISION IS NEEDED, CONTACT THE PRIOR AUTHORIZATION UNIT AT UNISYS 1-800-488-6334.

SINCERELY,

BUREAU OF HEALTH SERVICES FINANCING

IF YOU DISAGREE WITH OUR DECISION, YOU HAVE THE RIGHT TO APPEAL, AND MAY BRING ADDITIONAL EVIDENCE TO THE HEARING TO SUPPORT YOUR REQUEST FOR SERVICES.

IN ORDER TO APPEAL, PLEASE WRITE TO:

OFFICE OF THE SECRETARY
BUREAU OF APPEALS
P.O. BOX 4183
BATON ROUGE, LA 70821-4183

YOUR REQUEST FOR APPEAL MUST BE RECEIVED OR POSTMARKED WITHIN 30 DAYS OF THE NOTICE DATE.

THIS AUTHORIZATION IS NOT A GUARANTEE OF RECIPIENT MEDICAID ELIGIBILITY.

CLAIMS FOR COMMUNITY CARE RECIPIENTS MUST HAVE PCP REFERRAL NUMBER ON THE CLAIM IN ORDER TO BE REIMBURSED BY MEDICAID.

IF CLARIFICATION ON THIS DECISION IS NEEDED, CONTACT THE PRIOR AUTHORIZATION UNIT AT UNISYS 1-800-488-6334.

SINCERELY,

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SINCERELY,

BUREAU OF HEALTH SERVICES FINANCING

STATE OF LOUISIANA
 DEPARTMENT OF HEALTH AND HOSPITALS
 BUREAU OF HEALTH SERVICES FINANCING
 P O BOX 91030, BATON ROUGE, LOUISIANA 70821-8030

DATE 06/26/2008 RECIPIENT NAME
 PRIOR AUTH. NBR RECIPIENT NUMBER

DELAUNES FAMILY DRUG STORE
 308 N LEWIS
 NEW IBERIA LA 70563

PROVIDER NUMBER 1218210

DEAR PROVIDER,

THE RECIPIENTS REQUEST FOR PRIOR AUTHORIZATION OF SERVICE(S) HAS BEEN

D E N I E D .

THE FOLLOWING SERVICE(S) WAS REQUESTED THROUGH OUR PRIOR AUTHORIZATION SERVICE

 PROCEURE: A6261 ABSORPT DRG <=16 SQ IN W/O B
 REQUESTED: 132.00 APPROVED: .00
 DATES OF SERVICE: 06/01/2008 - 11/30/2008 STATUS: DENIED

THE FOLLOWING REQUEST IS DENIED BECAUSE THE PROVIDER, RECIPIENT AND OR THE CASE
 MANAGER FAILED TO RESPOND TO THE NOTICE OF INSUFFICIENT PRIOR AUTHORIZATION
 DOCUMENTATION. THE DATE ON THE NOTICE THAT WAS SENT OUT WAS DATED 06/22/2008
 PLEASE NOTE THAT THE FDLLOWING INFORMATION IS NEEDED FOR A DETERMINATION TO BE
 MADE ON THE REQUESTED SERVICES FOR STERILE GAUZE:

1. SUBMIT WHAT THE STERILE IV GAUZE IS BEING USED FOR.
2. IF THE GAUZE IS BEING USED FOR THE GASTRO-TUBE THEN NEEDS TO SUBMIT CORRECT
 PROCEDURE CODE FOR THAT GAUZE.
3. SUBMIT A LETTER OF MEDICAL NECESSITY FROM THE PHYSICIAN AS TO WHY IV STERILE
 GAUZE ARE NEEDED FOR GASTRO-TUBE SITE.

IF YOU DISAGREE WITH OUR DECISION, YOU HAVE THE RIGHT TO APPEAL, AND MAY BRING
 ADDITIONAL EVIDENCE TO THE HEARING TO SUPPORT YOUR REQUEST FOR SERVICES.

IN ORDER TO APPEAL, PLEASE WRITE TO:

OFFICE OF THE SECRETARY
 BUREAU OF APPEALS
 P.O. BOX 4183
 BATON ROUGE, LA 70821-4183

YOUR REQUEST FOR APPEAL MUST BE RECEIVED OR POSTMARKED WITHIN 30 DAYS OF THE
 NOTICE DATE.

CLAIMS FOR COMMUNITY CARE RECIPIENTS MUST HAVE PCP REFERRAL NUMBER ON THE CLAIM IN
 ORDER TO BE REIMBURSED BY MEDICAID.

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICES FINANCING
P O BOX 91030, BATON ROUGE, LOUISIANA 70821-9030

DATE 06/26/2009 PROVIDER NAME DELAUNES FAMILY DRUG
PRIOR AUTH. NBR PROVIDER NUMBER 1215210

* THIS IS NOT A BILL *

RECIPIENT NUMBER
CCN NUMBER

DEAR :

YOUR REQUEST FOR PRIOR AUTHORIZATION OF SERVICE(S) HAS BEEN

D E N I E D .

THE FOLLOWING SERVICE(S) WAS REQUESTED THROUGH OUR PRIOR AUTHORIZATION SERVICE

PROCEDURE: A6251 ABSORPT DRG <=16 SQ IN W/O B
REQUESTED: 132.00 APPROVED: .00
DATES OF SERVICE: 06/01/2009 - 11/30/2009 STATUS: DENIED

THE FOLLOWING REQUEST IS DENIED BECAUSE THE PROVIDER, RECIPIENT AND OR THE CASE MANAGER FAILED TO RESPOND TO THE NOTICE OF INSUFFICIENT PRIOR AUTHORIZATION DOCUMENTATION. THE DATE ON THE NOTICE THAT WAS SENT OUT WAS DATED 05/22/2009 PLEASE NOTE THAT THE FOLLOWING INFORMATION IS NEEDED FOR A DETERMINATION TO BE MADE ON THE REQUESTED SERVICES FOR STERILE GAUZE:

- 1. SUBMIT WHAT THE STERILE IV GAUZE IS BEING USED FOR.
- 2. IF THE GAUZE IS BEING USED FOR THE GASTRO-TUBE THEN NEEDS TO SUBMIT CORRECT PROCEDURE CODE FOR THAT GAUZE.
- 3. SUBMIT A LETTER OF MEDICAL NECESSITY FROM THE PHYSICIAN AS TO WHY IV STERILE GAUZE ARE NEEDED FOR GASTRO-TUBE SITE.

YOU MAY HAVE YOUR CASE MANAGER ASSIST YOU WITH OBTAINING MEDICAID SERVICES. IF YOU DO NOT HAVE A CASE MANAGER AND WOULD LIKE TO OBTAIN ONE, YOU SHOULD CALL STATISTICAL RESOURCES, INC (SRI) AT 1-800-364-7828.

IF YOU DISAGREE WITH OUR DECISION, YOU HAVE THE RIGHT TO APPEAL, AND MAY BRING ADDITIONAL EVIDENCE TO THE HEARING TO SUPPORT YOUR REQUEST FOR SERVICES.

IN ORDER TO APPEAL, PLEASE WRITE TO:

OFFICE OF THE SECRETARY
BUREAU OF APPEALS
P.O. BOX 4183
BATON ROUGE, LA 70821-4183

YOUR REQUEST FOR APPEAL MUST BE RECEIVED OR POSTMARKED WITHIN 30 DAYS OF THE NOTICE DATE.

SINCERELY,

BUREAU OF HEALTH SERVICES FINANCING

IF CLARIFICATION ON THIS DECISION IS NEEDED, CONTACT THE PRIOR AUTHORIZATION UNIT
AT UNISYS 1-800-488-6334.

SINCERELY,

BUREAU OF HEALTH SERVICES FINANCING



**Unisys Corporation
Prior Authorization Liaison**

Phone: 800-807-1320
Fax: 225-929-6803
225-216-6342

NOTICE OF INSUFFICIENT PRIOR AUTHORIZATION DOCUMENTATION

RECIPIENT: DATE OF NOTICE: 4/14/2009
CASE MANAGER: PROVIDER: Bethesda Community Programs
DATE OF REQUEST: 03/16/2009 SERVICE REQUESTED: Personal Care Services
DATE OF SERVICE REQUESTED: PA NUMBER:
Began: 02/08/2009 Ended: 08/08/2009

The following documentation and/or information are still needed in order to complete your prior authorization request.

The following information is needed so a determination can be made on the request for personal care service for . Please submit the following item(s):

1. Give us more details about any special needs or behavior that occur during bathing, dressing, grooming, toileting and eating that would extend the period of time it takes to complete the activity.
2. List and describe other incidental household services being done in addition to the routine household duties.
3. The provider is requested 2 hours 30 minutes a day 7 days a week and the request is approved for 1 hour 30 minutes a day 7 days a week.
4. Additional information should be provided by the primary care physician.

Dr. Cecily Turner and Bethesda Community Programs can assist the recipient in obtaining the requested information.

The following provider can provide this information: Dr Cecily Turner

(If you need help finding such a provider, contact KIDMPD) toll free at 1-800-259-4444 for the name, address and phone number of such a provider in your area.)

[This form tells the provider what information is needed. You can give this form directly to him or her.]

If you are enrolled in Community Care, you may need to get a referral from your Community Care provider.

If you, your case manager, or any health professional have questions, please call (800) 807-1320 and press option 2 to reach the Prior Authorization Liaison (PAL).

UNISYS CORPORATION
ATTN: PRIOR AUTHORIZATION LIAISON
P. O. BOX 14919 • BATON ROUGE, LOUISIANA 70819-0919
PHONE: 800-807-1320 • FAX: 225-929-6803

YOU NOTIFY THE PAL IN WRITING, WITHIN 30 DAYS OF THE DATE ON THIS NOTICE, ABOUT AN APPOINTMENT YOU MADE WITH A HEALTH CARE PROVIDER OF THE TYPE WE SPECIFIED, AND YOU ATTEND THE APPOINTMENT, OR

WE HAVE RECEIVED ALL NEEDED DOCUMENTATION WITHIN 30 DAYS.

If you need help scheduling an appointment with a health care professional or transportation to the appointment, you can contact your case manager or contact KIDMED at 1-800-259-4444.

YOU MUST complete and return the form below to notify the PAL if you make an appointment to provide the necessary information described in this notice.

I HAVE AN APPOINTMENT WITH _____
PROVIDER'S NAME

THE DATE OF MY APPOINTMENT IS _____, 200__.

Your Name

1

Medicaid ID Number

SEND THIS FORM TO THE PRIOR AUTHORIZATION LIAISON:

Name: Jimmie Hayes

Address: P. O. Box 14919 Baton Rouge, LA 70898-4919

Phone: (800) 807-1320/option 2

Fax: (225) 929-6803 or (225) 216-6342

PA Tracking

PA Tracking begins with the request for the service, not the Choice of Provider, prescription, or when the CPOC is approved.

Medicaid and PA tracking must be checked for all requested PA services in the LSCIS Service Needs section. If this is not done, a valid reason and how the Support Coordinator will ensure the service is received must be documented in the Additional Information section. Valid reasons could be the PA is “issued” monthly, the Extended Home Health nurse orders and tracks the supplies or on a wait list for therapy.

Don't uncheck “Requires PA tracked by SC” on the CPOC unless there is a valid reason. If it was not a onetime PA for DME that was received, the Support Coordinator must document the reason in the Additional Information section.

The Support Coordinator is to work with the family and provider to obtain the PA and requested service or to resolve the request for the service.

Use the comment box on the PA Tracking Log to leave a trail of what has occurred.

Complete the “explanation of why the PA was not issued within 60 days”, “reason for denial” and all other required boxes.

Don't void a PA Tracking Log if it was not entered in error.

- 1) Uncheck PA tracking in the Service Needs section and the tracking will not be required.
- 2) Enter a new PA tracking log and it will replace the prior tracking log.

PA Notices

-List the date the PA request was submitted to Molina on the PA tracking log. Request the PA, as prompted, 10 days after PA request was submitted to Molina (25 days for DME). This will prevent the Support Coordinator from missing required activities. If the provider does not respond, contact the PAL for the status.

-Follow up with the family and provider to be informed timely of PA denials or notices. The Support Coordinator should be informed of the PA status. Don't wait for them to notify you.

Notice of Insufficient Documentation

-If a Notice of Insufficient PA Documentation (NOISD) was received by the provider or a partial or full denial the Support Coordinator needs to act timely to obtain information or offer to assist with an appeal. Make sure the information is sent to the PAL. (If you obtain the PA request packet from the provider when they submit it to Molina, you may identify errors, such a missing signature, Rx, Plan of Care or if the Form 90 does not document the need for assistance with ADLs, before a denial or NOISD is received. The Support Coordinator can intervene to have the information corrected.)

-Call the family and explain what is needed.

-Contact the PAL if what is needed is not clear.

-Work with the provider to obtain the information.

Revised 3/11/11

Revised 3/31/14

-Make sure the information is sent to the PAL.

If a Notice of Insufficient Prior Authorization Documentation is received the Support Coordinator should document the contact with the family and offer to assist with obtaining the additional information and their response, contact with the provider to obtain or have them submit additional information, if no additional information was available, and all Support Coordination activities to follow through with the PA request until the PA is either approved or denied based on medical necessity.

Partial Approval

Partial Approval- There is enough documentation to approve some of the request. It is sent to the PAL to notify that more documentation is required.

A final Partial Denial will be issued if the information is not received or if the service is not medically necessary or it will be an Approval if additional information is received to support the medical necessity. If a partial denial is received as a final decision it can be appealed.

Partial Approvals don't need to be appealed if the family can get the additional information to get an Approval.

Partial Approvals are done so that the family can start receiving some of the service.

If the participant asks for 8 hours and Molina has enough documentation to partial approve 4 hours, the participant can get the 4 hours without accepting the decision. They can appeal for the other 4 hours later, if a Partial Denial occurs. They do not need to do anything to receive the hours that are partial approved.

-Enter in the PA tracking Log.

-Document in the Tracking Log note box that a partial approval was received.

-Document if the Support Coordinator and family are working with the PAL.

-If the participant/family does not want to work with the PAL or submit additional information, they can do an appeal now.

-Why was the full approval denied? What was denied? Was it due to a dollar amount but the correct product amount was received?

-If the PA is for PCS, exactly what help does the family need or want? Is it PCS for ADLS or IADLS, respite, homework assist, someone to take in the community, do they want family to be paid for services provided, etc.

-Discuss what was approved and what needed tasks are not included in the PA. Are additional hours still requested?

-Offer to assist the family in obtaining the information from the provider.

Partial Denial/Full Denial

-Contact the family within 10 days of the Notice of Denial and explain the appeal rights, give appeal brochure, offer to assist with an appeal, help family develop the information for the appeal if requested to do so.

-Contact the PAL to ask what information is necessary to get an approval or additional hours.

Revised 3/11/11

Revised 3/31/14

Assisting with Appeals

The Support Coordinator must document the required contacts and offer of assistance with the appeals when a PA is totally or partially denied. If assistance is requested, document coordination of documents and filing of the appeal, if documents were sent to the appeal office, or if no documentation was available.

(Appeals section in the handbook, Appendix L, Appendix T-1, LSCIS PA tracking log)

STATISTICAL RESOURCES, INC.

Revised 3/11/11

Revised 3/31/14

11505 Perkins Road, Suite H
Baton Rouge, LA 70810
(225) 767-0501
FAX (225) 767-0502

MEMORANDUM

TO: ESPDT Support Coordination Agencies

FROM: Ellen Bachman

SUBJECT: Modification of Rehab Services PA Tracking/PAL Referral

DATE: March 11, 2011

We are aware that a number of community therapy providers (OT, PT, and ST rehab services) are not submitting their PA requests to Molina, but are delivering services to the EPSDT clients. The providers can wait a year to bill Medicaid for services and some are waiting until then to submit the PA requests. The PA tracking procedure has been modified for these cases.

When Support Coordinators are tracking rehab services (OT, PT, ST) they do not always need a PA. Prior to completing a 35 or 60 day PAL Referral the Support Coordinator is to contact the provider to confirm if the participant is receiving the service. If the provider confirms that service is being delivered, the family is to be contacted to also confirm the delivery of services. If **BOTH** the family and provider confirm that the client is receiving the prescribed therapy, a PAL referral would not be needed. The Support Coordinator must document this confirmation in the service log and in the note box of the PA tracking log. PAL referrals and continued PA tracking would not be needed. The Support Coordinator will need to ensure the client continues to receive the requested services through monthly contact with the family/participant.

If the Support Coordinator cannot confirm that services are being provided and there is no PA in place, the coordinator must initiate a PAL referral within the prescribed timelines. If the PAL can confirm with the family and provider that the services are being delivered, the PAL will contact the Support Coordinator to inform the Support Coordinator that services are being delivered and provide them with the date services began. The Support Coordinator is to document the PAL's notification in the service log and PA tracking log note box. Continued PA Tracking is not needed. The Support Coordinator will need to ensure the client continues to receive the requested services through monthly contact with the family/participant.

If the Support Coordinator receives a PA notice, it is to be entered on a tracking log and PA Tracking will restart.

Revised 3/11/11
Revised 3/31/14

Referral to Medicaid PAL

EPSDT - Targeted Population

Date:

TO: Medicaid Prior Authorization Liaison (PAL) · P.O. Box 91030 · Baton Rouge, LA · 70821-9030

Attn: Linda Smith

Fax 225-342-9474

FROM: Support Coordination Agency	Support Coordinator's Name:	Support Coordinator's Phone #:
Provider #:		Fax#:
RE: State Plan Provider:	Provider #:	Phone #:
Address:	City:	State/Zip:
Service Type (if DME be specific):	Service Name: <input type="checkbox"/> Initial <input type="checkbox"/> Renewal	Amount/# of Hours of Service:
Participant Name:	MID#:	Phone#:
Address:	City:	State/Zip:

This is to inform you that this individual is receiving EPSDT - Support Coordination Services and we are having/had the following problem with the Medicaid State Plan Provider identified above (only those requiring PA): (Check the following that apply.)

	1. The provider has not submitted the PA packet within 35 calendar days from the date of the provider's receipt of referral.
	2. We have not received an approval within 60 days from the Choice of Provider date.
	3. The participant has been advised of their right to choose another provider and we are beginning the process again.
	4. The participant has been advised of their right to choose another provider but has decided to stay with the same provider and wait until the PA packet is submitted.
	5. We have not received a notice of approval from Molina for the renewal approval and the previous PA expired on ___/___/___ .
	6. The provider is not providing services at the times the participant requested and we have been unable to resolve the issue.
	7. The provider is not providing the amount of services as per the CPOC and as prior authorized and we have been unable to resolve the issue.
	8. Other:

Attached are the EPSDT Prior Authorization Tracking Log and the supporting EPSDT Service Logs that document the contacts made regarding the issues identified above. (This documentation must be sent with this form letter.)

Support Coordinator's Signature

Date

Issued May 30, 2003
Reissued August 4, 2006
Revised July 19, 2007, April 17, 2008, 10/29/10
Revised 5/1/12
Revised 4/18/13 Revised 10/15/13

BHSF-PF-03-015

Referral to Medicaid Behavioral Health Rehab PAL

EPSDT - Targeted Population

Date:

TO: BH Rehab. Prior Authorization Liaison (PAL) 628 N. 4 th Street, 4 th Floor, Baton Rouge, LA 70802 Fax 1-225-342-0001 (BH Rehab only) Attn: Margaret Hubbard Secure e-mails margaret.hubbard@la.gov		
FROM: Support Coordination Agency Provider #:	Support Coordinator's Name: Provider #:	Support Coordinator's Phone #: Fax#:
RE: State Plan Provider:	Provider #:	Phone #:
Address:	City:	State/Zip:
Service Type: BH Rehab (Use Appendix S for other services)	Service Name: <input type="checkbox"/> Initial <input type="checkbox"/> Renewal	Amount/# of Hours of Service:
Participant Name:	DOB MID#:	Phone#:
Address:	City:	State/Zip:

This is to inform you that this individual is receiving EPSDT - Support Coordination Services and we are having/had the following problem with the Medicaid State Plan Provider identified above (only those requiring PA): (Check the following that apply.)

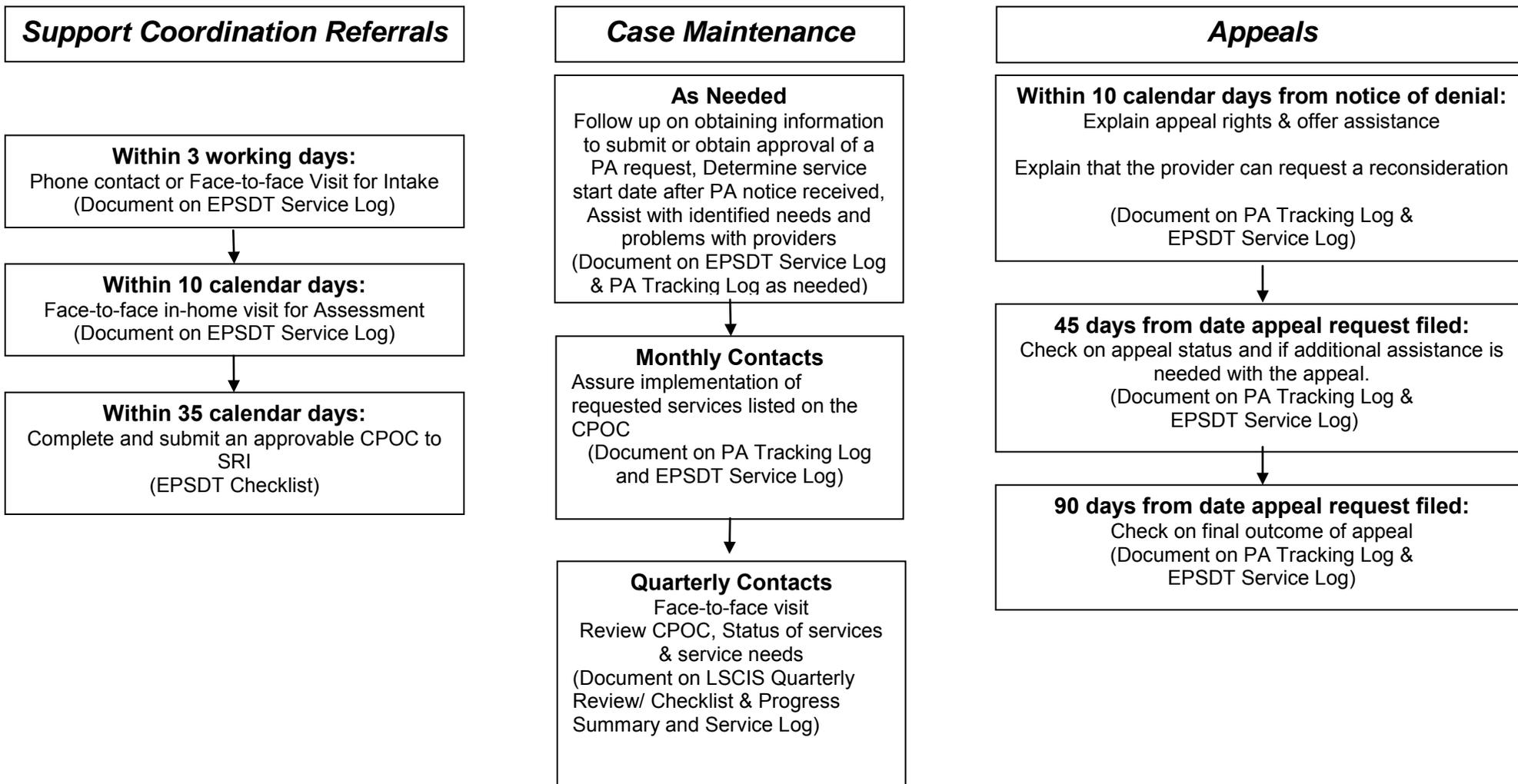
	1. The provider has not submitted the PA packet within 35 calendar days from the date of the provider's receipt of referral.
	2. We have not received an approval within 60 days from the Choice of Provider date.
	3. The participant has been advised of their right to choose another provider and we are beginning the process again.
	4. The participant has been advised of their right to choose another provider but has decided to stay with the same provider and wait until the PA packet is submitted.
	5. We have not received a notice of approval from Magellan for the renewal approval and the previous PA expired on ___ / ___ / ___ .
	6. The provider is not providing services at the times the participant requested and we have been unable to resolve the issue.
	7. The provider is not providing the amount of services as per the CPOC and as prior authorized and we have been unable to resolve the issue.
	8. Other:

Attached are the EPSDT Prior Authorization Tracking Log and the supporting EPSDT Service Logs that document the contacts made regarding the issues identified above. (This documentation must be sent with this form letter.)

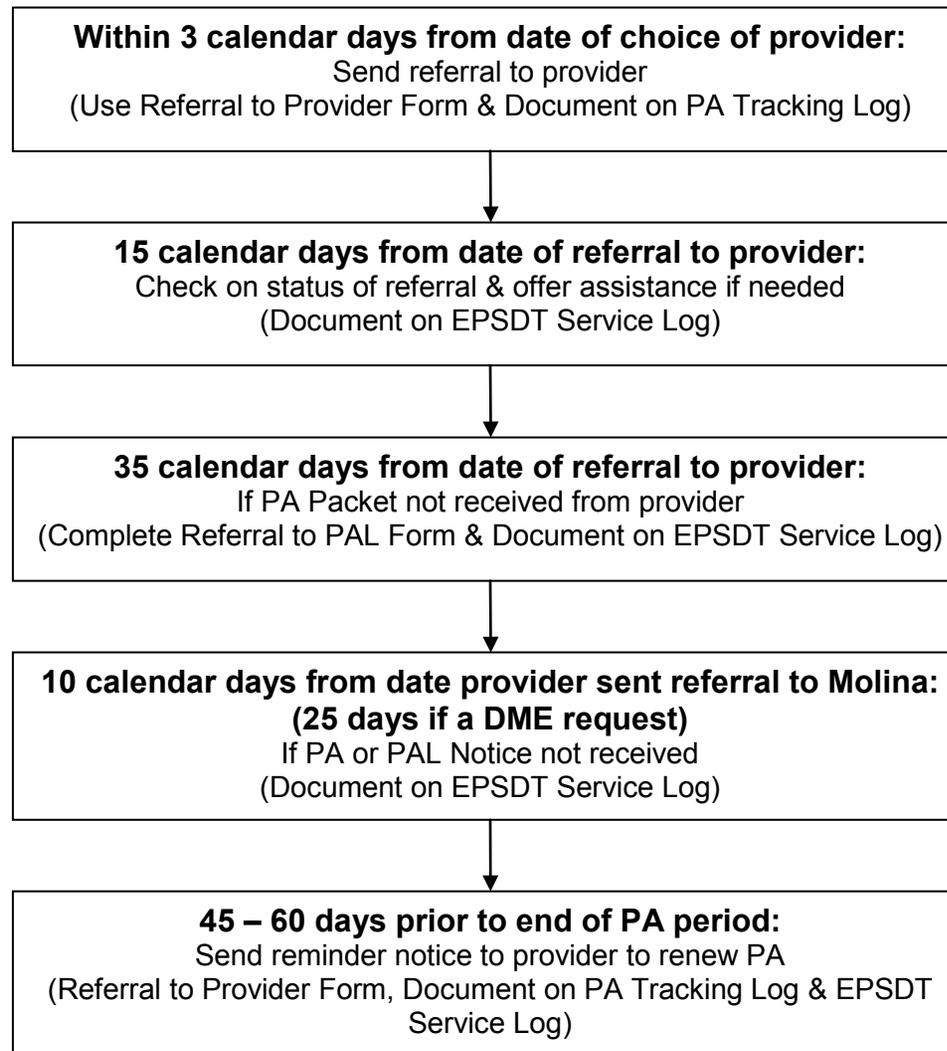
 Support Coordinator's Signature
Issued October 23, 2008
 Revised October 29, 2010 March 23, 2012, December 4, 2013
 Revised February 18, 2014

 Date

EPSDT Timeline & Documentation Participant Contacts



EPSDT Timeline & Documentation Provider Contacts



EPSDT Timeline & Documentation PAL Referrals

PA Requests

35 calendar days from date of provider referral:

If provider has not sent PA Packet to Molina,
Send referral to PAL using Referral to PAL Form
(Document on PA Tracking Log & EPSDT Service Log)



60 calendar days from participant's date of choice of provider:

If PA approval not received,
Send referral to PAL using Referral to PAL Form
(Document on PA Tracking Log & EPSDT Service Log)

Other PAL Referrals

If PA Renewal Approval Not Received:

Complete Referral to PAL Form,
Document on PA Tracking Log &
Document on EPSDT Service Log)

If Participant Chooses a New Provider:

Complete Referral to PAL Form,
Document on PA Tracking Log &
Document on EPSDT Service Log

**If Service not provided in the amount in PA or
Service not at times according to PA**

Complete Referral to PAL Form &
EPSDT Service Log

**Unable to find a provider that is willing to submit a
request for a PA**

Complete Referral to PAL Form &
EPSDT Service Log

***Contact the DHH Staff Line for PCS and EHH**

***Service logs are to be faxed with the PAL Referrals**

EPSDT SUPPORT COORDINATION TRANSITION/ CLOSURE

The transition or closure of support coordination services for recipients in EPSDT target population must occur in response to the request of the recipient/family or if the recipient is no longer eligible for services. The closure process must ease the transition to other services or care systems.

Closure Criteria

Support Coordination services closure criteria include but are not limited to the following:

- The participant/family requests termination of services;
- The participant/family chooses to transfer to another support coordination agency;
- The participant/family refuses services and/or refuses to comply with support coordination;
- Death of the participant;
- The participant is no longer Medicaid eligible;
- Permanent relocation of the participant out of the service area;
- If the participant is institutionalized. The support coordinator must provide information as to whether this is a permanent or temporary placement such as the need for rehabilitation services;
- Participant refuses to comply with support coordination and BHSF requirements;
- The support coordination agency closes (transfer procedures must be followed);
- Participant no longer meets the criteria for EPSDT support coordination services.
- The participant has a change in target population.

Note: If the participant/family refuses to comply with support coordination requirements, the support coordinator must document all instances appropriately.

Required Transition/Closure Procedures by the Support Coordinator

- Transition/closure decisions should be reached with the full participation of the participant/family when possible. If the participant becomes ineligible for services, the support coordinator must notify the participant/family immediately.
- If the support coordinator is unable to locate the participant/family or have them respond to phone calls, a notification is to be mailed to the last known address. They are to be notified that the file will be closed and how they can reopen services.
- The EPSDT program manager is to be contacted by e-mail or letter before a participant that has not had an initial face to face assessment or issued a PA is closed.
- At closure and/or 90 days prior to the participants reaching their 21st birthday, the support coordinator must complete a final written reassessment identifying any unresolved problems or needs. The support coordinator is to discuss with the participant/family methods of negotiating their own services needs.

- The support coordinator must begin making arrangements for transition six months prior to the participant's 21st birthday.
- Instruct all participants/families to update their contact information on the Request for Services Registry.
- Inform the participant/family of a possible emergency waiver slot if the participant is being institutionalized.
- If the participant relocates within the state but out of their current region, the support coordinator must assist them with linkage to an agency in the new region prior to closure. The support coordinator must obtain the participant's new address and contact information. The LSCIS closure report, participant contact information, and documentation of actions taken to link/ transfer the participant are to be sent to SRI.
- The support coordination agency must close the case immediately and enter the closure in LSCIS no later than seven days after closure.
- The agency must follow their own policies and procedures regarding intake and closure.

Transition of the Participant into a Waiver

If the participant becomes eligible for a waiver, a FOC will be provided to the participant/family by SRI to request services under the waiver.

The FOC form will be sent to SRI for linkage.

If SRI sees that the participant is currently receiving EPSDT services it will be noted on the linkage form.

The participant will be linked as per the established contract guidelines on agency capacity. The support coordination agency is responsible for ensuring that an approved EPSDT plan of care is in place until the waiver certification is issued. The EPSDT case will remain open until receipt of the waiver certification. The EPSDT case will then be closed effective the day prior to the date of waiver certification.

The participant/family may choose a different agency for waiver services. The receiving agency is required to obtain any existing documentation from the previous EPSDT-Targeted Populations provider. The FOC Transfer of Records form shall be used. If the participant changes agencies, the participant will be linked to the receiving agency for both EPSDT and waiver support coordination services. See procedures For Changing Providers below.

The EPSDT Support Coordination cases are to remain open until the waiver certification is issued. The PA for the EPSDT Support Coordination will temporarily end on waiver linkage. When the waiver certification is received, the PA for the EPSDT services will be adjusted as follows, provided that an approved EPDST plan of care is in place up through the day prior to waiver certification,:

- Children’s Choice Waiver (CCW) - The last day of the month prior to the CC certification date but no later than the last day of the month after linkage to the CCW.
- New Opportunities Waiver (NOW) - The day prior to the beginning of the NOW PA but no later than 120 days after linkage to the NOW.
- Supports Waiver (SW) - The last day of the month prior to SW certification date, but no later than the last day of the month after linkage to the SW.

If an approved EPSDT plan of care is not in place for the entire waiver linkage period up through the day prior to waiver certification, the EPSDT PA will end on the day of waiver linkage.

EPSDT Support Coordination is to be closed in LSCIS with the code “change in target population” when the waiver certification is issued. The closure date is the last day of the revised PA once issued.

PROCEDURE FOR REOPENING A CASE

Support coordination cases can be reopened after the case is closed in LSCIS if the participant requests to receive services again and they continue to meet eligibility criteria.

- If it has been less than 6 months since the closure, the support coordination agency can call SRI to reopen the linkage.
- If the case has been closed more than 6 months, the participant should be instructed to call SRI to request services.
- The CPOC must be revised if there are significant changes in the services needed but the CPOC date will not change.
- If the CPOC expired, and a new CPOC was not approved before closure, then a new CPOC with a new begin and end date must be completed and approved.

PROCEDURES FOR CHANGING PROVIDERS

General Procedures for Support Coordinators

A participant may change support coordination agencies once after a six month period or for “Good Cause” at any time, provided that the new agency has not met maximum number of participants. “Good Cause” is defined as:

- The participant moves to a different DHH Administrative Region.
- The participant is offered a waiver slot.
- The participant and support coordination agency have unresolved difficulties and mutually agree to transfer. This transfer must be approved by the EPSDT SC Program Manager, Ellen Bachman.

- The participant has another family member living in the same home receiving support coordination from another agency.

Once the participant/family has selected a new support coordination agency: SRI links them to a contract provider and notifies the participant/family and the receiving and transferring agencies of the change in linkage. The receiving provider must complete the FOC file transfer form. Also, the provider must obtain the case record and authorized signature from the transferring support coordination agency.

Upon receipt of the complete form, the transferring agency must have provided copies of the following information to the receiving agency:

- Client demographics
- Current and approved CPOC (If the CPOC is expiring, indicate the date it was submitted to SRI for approval)
- Current assessment, EPSDT Screening exams, IEP, and other documents on which the CPOC is based
- The last two quarterly review/summary (Include any service needs that have not been implemented)
- The most recent 6 months of progress notes
- The current PA tracking logs and PA notices
- The LSCIS Annual CPOC will be transferred when the receiving agency sends the completed Transfer of Records form to SRI and requests the transfer of LSCIS records.

The transferring provider shall provide services through the last day of the prior authorization month for which they are eligible to bill. The transfer of records shall be completed by the last week of the month prior to the transfer effective date. The receiving EPSDT agency shall begin services within three days after the effective date of the prior authorization. The receiving agency must submit the required documentation to SRI to begin prior authorization immediately. The CPOC dates will not change.

Formal Information for CPOC

To adequately perform an assessment, the Support Coordinator will need to gather both current formal and informal information. Formal information will include documented medical, psychological, pharmaceutical, social, educational information and information from OCDD. Informal information will include information gathered in discussions with the family and the participant, and it may also include information gathered from talking to friends and extended family. All of this information is vital to performing a good assessment of the participant's needs. The information gathered in the assessment is to be incorporated into the CPOC.

The process of gathering formal information should occur prior to the CPOC meeting. On intake, ask the participant/guardian about documents they may have or can request from their school. Contact OCDD to obtain records. Follow up on requests for records.

The Support Coordinator may need to assist the participant with arranging professional evaluations and appointments including EPSDT screenings and follow-up evaluations. The information provided as a result of these appointments could prove critical in the assessment that will be used to develop the participant's person-centered Comprehensive Plan of Care.

Obtain all assessments/evaluations and documents that OCDD used to determine eligibility, the current IEP and any other assessments by professionals (EPSDT-PCS Form 90, Home Health Plan of Care, LRS and Special Education Evaluations, behavior plans, psychological and other evaluations, etc.)

Where to obtain some of the formal information:

On linkage, send the FOC which has a release of information section to the regional OCDD office. Request the SOA, and all assessments/evaluations and documents used to determine eligibility. The Individual Entry Review and supporting documents, Eligibility Recap Sheet, I-CAP, DD-SNAP, psychological evaluation, and the OCDD Plan of Support can be obtained. Notify BHSF/SRI if you have any problem in obtaining the documents. Allow OCDD a five work day turnaround.

Individualized Educational Plans (IEP) and Special Education Evaluations can be obtained from the parent, school, or the School Board's Special Education Department. Even if the participant is not attending school or receiving Special Ed Services, they should have an Evaluation. It is required that the IEP be done annually and Special Education Re-evaluations are required every three years. Vision and hearing screenings are done at school if the student is able to cooperate with the testing. This is required with the Special Education Evaluation and Re-Evaluation.

An Individualized Healthcare Plan (IHP) should be attached to the IEP, but it could be separate. The school nurse gathers medical information for the IHP. They usually have forms completed by a physician to obtain documented diagnosis and needs. The school nurse can be contacted to see if the participant has an IHP or other medical documentation in the school records. It may be easier to obtain medical records from the school by having the parent request that the information be sent home with the participant.

If the participant is receiving PCS, an EPSDT-PCS Form 90 can be obtained from the provider or physician. If the participant is receiving EHH a Plan of Care (CMS form 485) is signed by the physician every 60 days.

The PCP or the PCP's contracted provider is required to do yearly EPSDT Screenings (physicals and assessments) for children 3-6 years of age, and every other year after age 6. These records can be obtained by the participant/guardian, or support coordinator with a signed release of information.

Progress notes or a copy of a physical can be obtained from the physician's office. Mental Health records require a special release of information form. Contact the provider to obtain the release form that is required or obtain one from the DHH website.

Record Review for EPSDT Quarterly Reports

PA not issued within 60 days or Gap in PAs

Agency/Region _____
Participant _____
Service _____

Quarter/Year _____
SC _____
SC Supervisor _____

____ PA not issued within 60 days
____ Gap in PA Authorization Periods

Gap in Authorization Period

Are the “Date of Service Request” and renewal COP dates correct on the PA Tracking Logs?

PA end date on the prior PA Tracking _____

PA start date on the current PA notice _____

Gap consisted of how many days _____

Was the service provided during the Gap?

Was the gap due to the family choice? If so, explain. (If yes, don't include it on the report.)

Was the referral to the provider for the PA renewal sent 45-60 days prior to the PA expiration?

PA Not Issued Within 60 Days

Was the PA received?

Date Received _____

Approval Status: Full Approval _____ Partial Approval _____ Partial Denial _____ Denied _____

Required review for “PAs not issued within 60 days” and “Gaps in Authorization Periods”	Yes	No	Supporting Document and Service Date	Comments
Is the PA “type of request” correctly identified on the PA Tracking Log?				
Did PA tracking begin with the initial request date documented in the Service Logs or Quarter Review? (Review Service Logs and Qrt Reviews prior to the request date listed on the tracking log to ensure this is the initial request date.)				
Was the family informed that a prescription was required and given the forms to be completed by the physician? Was assistance offered in scheduling appointment if it is required for the prescription?				
Is there documentation of timely assistance with the FOC and participant/guardian follow up to obtain a COP?				
If a provider could not be found, is there documentation of attempts to locate a provider and DHH Staff Line contact?				
Was the Referral to the provider made within 3 days of the COP?				
Is there documentation of a provider contact within 15 days of the referral to check on the status of the referral and offer assistance if needed? (Service Log and PA Tracking Log)				
Is there documentation that the SC followed up with the family to see if the provider contacted them and if they contacted the physician or obtained the prescription?				
Is there documentation of a provider contact within 35 days of the referral to the provider to check on the PA status?				
Was the PA packet submitted to Molina within 35 days of the referral?				
If not, why?				
Was there a barrier?				
Did the SC assist in identifying and removing the barrier?				
Was the 35 day PAL referral completed timely?				
Was an offer to switch providers made and documented?				
If the PA request was submitted, was the PA packet requested and/or received?				
Was the “date packet submitted to Molina” entered on the PA Tracking Log?				
Is there documentation of a follow up with the provider 10 days after the PA request was submitted (25 days for DME)?				

Required review for “PAs not issued within 60 days” and “Gaps in Authorization Periods”	Yes	No	Supporting Document and Service Date	Comments
If the PA was not received, was the 60th day PAL referral timely?				
Is there documentation of ongoing contact with the participant/guardian and provider until the PA notice is received or the service request is resolved?				
Did the SC follow up and do planned activities and contacts as documented in the Service Logs, Quarter Reviews or CPOC. Is there documentation of the planned actions, contacts and follow up?				
Was there adequate SC supervision to ensure the required contacts, PA tracking and follow ups were completed timely and assist the SC with problem solving?				
Date of PA decision *If a PA has not been received, submit notification to ebachman@statres.com when the PA is received or the requested service is resolved				
If the PA has not been received, what action will the SC take to obtain the PA? (What is the barrier and how will it be removed? Frequent follow up is required.)				
Were deficiencies found in the required contacts, timelines, follow up, documentation, etc.? If so, the agency will submit a Corrective Action Plan within 7 days.				
Documentation that the Corrective Action Plan was carried out will be submitted within 14 days.				

EPSDT Specialist Signature_____

Date_____

EPSDT Specialist’s Supervisor
Signature_____

Date_____

On-Site Project Manager
Signature_____

Date _____

CHECKLIST FOR EPSDT SUPPORT COORDINATION APPROVAL PROCESS

RECIPIENT NAME:	DATE:
SUPPORT COORDINATOR AND AGENCY NAME:	

This checklist identifies the forms that are to be maintained in the participant's file. They are to be available for immediate review and approval upon the request of BHSF/SRI.

	FORM
	<p>CURRENT FORMAL INFORMATION DOCUMENT</p> <p>*An initial CPOC requires all assessments/evaluations and supporting documents from the regional OCDD office in addition to current formal documents. These must be sent to SRI to receive approval of an initial CPOC.</p> <p>*Send the information documents to SRI if the record is flagged as "Special Needs".</p>
	SOE and/or ITS Application for Services if needed to verify a valid SOE
	LSCIS CPOC SIGNATURE PAGE WITH PARTICIPANT'S SIGNATURES, PARTICIPANT/GUARDIAN'S CPOC APPROVAL SIGNATURE AND DATE, AND THE SC AND SC SUPERVISOR SIGNATURE AND DATE
	WEEKLY SCHEDULE
	EPSDT PARTICIPANT'S RIGHTS & RESPONSIBILITES
	LEGAL GUARDIANSHIP DOCUMENT or AUTHORIZED REPRESENTATIVE*
	EXTENDED HOME HEALTH PLAN OF CARE (If using home health now)

* **Required if the recipient is interdicted or has given power of attorney to another person.**

The following is a list of common EPSDT Support Coordination CPOC deficiencies:

- ✓ Recipient is not receiving PCS and there is no indication that the parent refused the service at this time.
- ✓ Participant's identified needs are not addressed.
- ✓ Discrepancy in the information documented within the CPOC sections.
- ✓ Formal information document is not current.
- ✓ Signatures are not dated.
- ✓ No services identified to coordinate. No documentation that the participant/family was informed that SC is optional and can be accessed at any time until the child's 21st birthday.
- ✓ Transition prior to the participant's 21st birthday is not addressed.

YOUR SIGNATURE BELOW INDICATES THAT THE PACKET HAS BEEN REVIEWED BY YOUR AGENCY FOR COMPLETENESS AND THAT ALL REQUIRED INFORMATION IS BEING SUBMITTED FOR REVIEW BY DHH-BHSF.

SIGNATURE: _____
SUPPORT COORDINATION AGENCY REPRESENTATIVE

DATE: _____

EPSDT CPOC MONITORING CHECKLIST

RECIPIENT NAME:	DATE:
SUPPORT COORDINATOR AND AGENCY NAME:	

This checklist identifies the items that are being faxed to SRI as required for monitoring the CPOC. The documents must be maintained in the agency's case record.

	FORM
	FORMAL INFORMATION EVALUATIONS /DOCUMENTATION (An initial CPOC requires the SC to obtain all assessments and evaluations from the regional OCDD office in addition to current formal documents.)
	SOE and/or ITS Application for Services if needed to verify a valid SOE
	LSCIS CPOC SIGNATURE PAGE WITH PARTICIPANT'S SIGNATURES, PARTICIPANT/GUARDIAN'S CPOC APPROVAL SIGNATURE AND DATE, AND THE SC AND SC SUPERVISOR SIGNATURE AND DATE
	WEEKLY SCHEDULE
	EPSDT PARTICIPANT'S RIGHTS & RESPONSIBILITIES SIGNATURE PAGE
	AUTHORIZED REPRESENTATIVE*
	EXTENDED HOME HEALTH PLAN OF CARE (If using home health now)

Required if the recipient is interdicted or has given power of attorney to another person.

The following is a list of common EPSDT Support Coordination CPOC deficiencies:

- ✓ Recipient is not receiving PCS and there is no indication that the parent refused the service at this time or that the participant does not require the service.
- ✓ Participant's identified needs are not addressed.
- ✓ Discrepancy in the information documented within the CPOC sections.
- ✓ Formal information document is not current.
- ✓ Signatures are not dated.
- ✓ No services identified to coordinate. No documentation that the participant/family was informed that SC is optional and can be accessed at any time until the child's 21st birthday.
- ✓ Transition prior to the participant's 21st birthday is not addressed.
- ✓ Legal guardianship document is not in the agency case record or at the regional OCDD office.

YOUR SIGNATURE BELOW INDICATES THAT THE PACKET HAS BEEN REVIEWED BY YOUR AGENCY FOR COMPLETENESS AND THAT ALL REQUIRED INFORMATION IS BEING SUBMITTED FOR REVIEW BY DHH-BHSF.

SIGNATURE: _____
SUPPORT COORDINATION AGENCY REPRESENTATIVE

DATE: _____

Appendix Y

Dear Recipient:

Enclosed is a card to keep that has phone numbers to call for assistance.

This is to let you know that if you feel you need a Medicaid covered service that requires prior approval, but providers of the service have refused to submit your request, you may request a "Review of Possible Eligibility" for the services. This review is available only if two (2) providers have refused to submit your full request, or if there is no other provider from whom to request the service.

To submit your request for a review, simply fill out the bottom of this form and send it to the address listed below. A physician's written statement as to why the services are necessary must be attached to the request. Medicaid will rule on whether you might be eligible for the service you are seeking. If you might be eligible Medicaid will find a provider to submit the request for you.

This option is only available to Medicaid recipients under age 21 who have been on the MR/DD Request for Services Registry on or after October, 1997 (the "Chisholm" class).

The enclosed card has a phone number to call if you need additional forms. You can also obtain them from a Medicaid case manager or from Medicaid's Prior Authorization Liaison (PAL), who can be reached at 1-800-807-1320.

Sincerely,

Department of Health and Hospitals

Name: _____ Medicaid Identification #: _____

Social Security #: _____ Phone Number(s): _____

How can we contact you? _____

Service(s) being requested: _____

A Doctor's statement as to why the services are necessary must be attached. Below, you must also list the providers that have refused to submit a request for these services:

Provider 1: _____
Name Phone Number

Provider 2: _____
Name Phone Number

Mail to: DHH-PAL
Post Office Box 91030 Bin #24
Baton Rouge, Louisiana 70821-9030

CHOICE of PROVIDER FORM For EPSDT MEDICAID PROVIDERS

This form should be used for all Medicaid services requiring prior authorization

Type of Service (Check the following service(s) that applies.)

Physical Therapy

Occupational Therapy

Speech Therapy

Audiology Services

Medical Equipment (DME)

Medical Supplies

Personal Care Services

Mental Health Services

Dental Services

Vision Services

Extended Home Health

Nutritional Services

Other _____

The participant/family must check the appropriate statement below.

- My support coordinator has explained to me that I have a choice of service providers when there is a choice available. I have reviewed a list of available providers and I understand that this list may not include every available provider. I understand that I may choose a new provider at any time. I have selected the following provider(s).** (Participant/family may choose to list 1st, 2nd, 3rd choice.)

1. _____

2. _____

3. _____

- My support coordinator has explained to me that I have a choice of service providers when there is a choice available. I have been informed that there is only one (1) provider available for this service. I understand that I may choose a new provider at any time if another provider is available. I have requested that a referral be made to this provider.** (List provider.)

4. _____

- I have already chosen the provider that I want. I do not wish to review a list of available providers. I understand that I may choose a new provider at any time. I have requested that a referral be made to this provider.** (List provider.)

5. _____

Participant/authorized representative must sign and date below.

Participant/Authorized Representative

Date

Relationship to Participant