

EPSDT - Targeted Population Support Coordination Training/Handbook

Trainer Information

There are four major sections to this training taken directly from the Support Coordinator's handbook that should flow sequentially.

- Part I - Services**
- Part II - Intake, Assessment and CPOC**
- Part III - Prior Authorization**
- Part IV - Other**

Each of these sections includes valuable information for the Support Coordinator. If you use this information properly, participants will be aware of all services available.

There will be different forms/flyers/brochures discussed in each section. These are mandatory forms that should help the Support Coordinator to serve the participant better. If at any time a Support Coordinator has a suggestion on how to change a form to make it more useful, that information will gladly be accepted. Suggestions can be sent to Ellen Bachman at SRI.

As each form is discussed, an overhead or PowerPoint slide of the form should be used to enhance understanding and discussion. The Support Coordinator should have a full understanding of the use and importance of each form. It is especially crucial to explain to the Support Coordinators how the use of each form will benefit the participant in the end. The forms were not developed simply to create work for Support Coordinators, but in response to needs identified within service provision.

If the training consists of a small group, there is no need to use an overhead projector, but be sure that each trainee has a copy of the form being discussed.

In addition to the Part I - IV above, it is very important that the Trainer allow time for a Questions and Answer session. The information provided in this document is quite extensive, and extremely important. Support Coordinators must be given every opportunity to ask questions prior to the end of the training, about the Medicaid Service Chart (*Appendix B*) which should be reviewed as part of the training, as well as about this Handbook.

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EPSDT Support Coordinator Handbook

Support Coordination is a service provided by Louisiana Medicaid through contracts with agencies to serve different groups of Medicaid participants. This handbook provides information on services available to individuals under 21 years of age who have developmental disabilities or chronic health needs. Early Periodic Screening, Diagnosis and Treatment (EPSDT) Support Coordination is available to all Medicaid eligibles under the age of 21 who are on the New Opportunities Waiver Request for Services Registry (RFSR) or for whom the service is determined medically necessary or have documentation from Medicaid to substantiate that the EPSDT participant meets the definition of special needs. (Appendix P)

PART I – Services Available to EPSDT Participants

(Refer to Appendix A - Service Description brochure)

Parents of children and young adults with developmental disabilities are sometimes unaware of the services that may be available to assist them. Therefore, it is important for the Support Coordinator to be knowledgeable of these services and how to access them. As the Support Coordinator, it is part of your responsibility to make suggestions for these services. Do not wait for the family to request a service. If you see a need for one of these services, inform the family. If the child may need additional services, but it is not clear, suggest and document appropriate evaluations to determine whether there is a need. If the family states they aren't interested in the service, accept that. However, feel free to remind the parent of the service again when the opportunity presents.

Children and young adults receiving targeted EPSDT Support Coordination are eligible to receive **all medically necessary Medicaid services** that are available to people under the age of 21. In addition, because of their disabilities and being on the RFSR, they are eligible for services through the **Louisiana Developmental Disabilities services system**, administered by OCDD through the Human Services Districts and Authorities. Further, they may be able to receive services at **school** or in **early intervention centers**.

MEDICAID SERVICES

Through Medicaid, children under 21 are entitled to receive all necessary health care, diagnostic services and treatment and other measures coverable by Medicaid to correct or improve physical or mental conditions, *even if these are not normally covered as part of the state's Medicaid program*. This includes a wide range of services not covered by Medicaid for participants over the age of 21. For a complete listing of Medicaid services, consult the **Medicaid Services Chart** (*Appendix B*).

Some services, which children can access, but that are not available to those ages 21 or older, or are only available under limited circumstances are:

- Support Coordination (only adults who receive Waiver services can get these services)
- Psychological evaluations and therapy
- Psychiatric residential care
- Medical, dental, vision and hearing screenings
- Audiology services
- Speech and language evaluations and therapies
- Occupational therapy
- Physical therapy
- Personal Care Services
- Extended Home Health visits
- Pediatric Day Health Care
- Dental care
- Hearing aids and supplies needed for them
- Eyeglasses and/or contact lenses
- Disposable Incontinence Products
- Nutritional supplements needed for their growth or sustenance
- Applied Behavioral Analysis
- Any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice

There are **no fixed limits** on the amounts of services participants under age 21 can receive. They are entitled to as many doctor visits, hours, and amounts of any services as are **medically necessary** for their individual conditions.

Medicaid's offered services may be more comprehensive than services offered through schools as part of a child's Individualized Educational Plan (IEP). IEPs only cover services that help with a child's *education*. Medicaid, outside of the IEP process, should cover services needed to help any other aspect of a child's life, as well.

Some Medicaid services must be “prior authorized” (PA) before the service can be received. (Prior Authorization is discussed in Part III of this handbook.) Typically, a Medicaid-enrolled provider of the service develops and submits an application for authorization to provide the service. Once the request has been reviewed, a notice of decision is sent to the participant, the provider, and to the Support Coordination agency. These are not waiver services and **the prior authorization process for these services is a separate process from the approval of the CPOC.**

If prior authorization for any service is denied in whole or in part, the participant can appeal to the Division of Administrative Law. The Support Coordinator must offer to assist with the appeal.

The following services are often used by and are very important to children and young adults with disabilities and/or chronic health conditions:

Support Coordination

Individuals under the age of 21 with disabilities and/or chronic health conditions typically need more Medicaid services than do their peers without disabilities or health concerns. A Support Coordinator should help in identifying and coordinating these necessary services. Parents often do not understand aspects of the Medicaid system. Therefore, the Support Coordinator should provide assistance in this area. The Support Coordinator can and should make referrals for these services and then follow-up to assure they are being delivered.

One of the primary responsibilities of the Support Coordinator is to follow through with requests for services until the PA is either approved or denied based on medical necessity.

EPSDT Screening Exams and Checkups

Medicaid participants 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, hearing, and dental screenings. They are available both on a regular basis, and whenever additional health treatment or services are needed.

The EPSDT Screenings are the responsibility of the Primary Care Physician (PCP) to perform. The PCP can contract with EPSDT Screening providers and bill Medicaid. The PCP will reimburse the EPSDT Screening provider.

EPSDT Screenings are recommended at the following ages:

•Newborn	•12 Months	•4 Years
•2 Months	•15 Months	•5 Years
•4 Months	•18 Months	•6 Years
•6 Months	•2 Years	•After Age 6: Every Two Years
•9 Months	•3 Years	

Dental checkups are recommended yearly.

In addition, an **interperiodic screen** can be obtained whenever one is requested by the parent or is recommended by a health, developmental, or educational professional (including a Support Coordinator), in order to determine a child's need for health treatment or additional services.

Medical conditions such as lead poisoning, sickle cell anemia, developmental delays, nutritional deficiencies, and behavioral disorders consistently result in successful outcomes and cost effective treatment plans when detected early.

As a Support Coordinator, you can contact the **Specialty Care Resource Line** to find medical providers of various types and specialties for referral of your participants. The Specialty Care Resource Line can even help you find a needed source for referrals that, otherwise, may be difficult to find.

The Specialty Care Resource Line is supported by an **automated resource directory** of all Medicaid-enrolled providers of medical services, including physicians, dentists, mental health clinics, and many other health care professionals. The database is updated regularly.

For assistance, call the toll-free Referral Assistance Hotline at 1-877-455-9955. When you call this number, you will reach a Referral Administrator who will be glad to assist you.

If the Specialty Care Resource Line has no provider listed, call the contact person listed on the Medicaid Services Chart (Appendix B) for that service. For Personal Care Services and Extended Home Health, call DHH at 1-888-758-2220.

NOTE: Chisholm class members are not allowed to participate in **Bayou Health** plans. For recipients under Amerigroup, LaCare, and Louisiana Healthcare Connections, consult the plan to find out how to obtain services **other than PCS, dental, and hospice.** (https://bayouhealth.com/LASelfService/en_US/plans.html)

Home and Community Based Waivers

Louisiana has four Medicaid waivers for persons with developmental disabilities: the New Opportunities Waiver (NOW), which provides comprehensive home and community based services for individuals of all ages, the Children's Choice waiver, which provides a limited package of similar services, to children under the age of 19, the Supports Waiver which provides specific, activity focused services for those age 18 years and older, and the Residential Options Waiver (ROW) which offers expanded home and community based services for individuals of all ages.

Most children currently receiving EPSDT Support Coordination services are on the Request for Services Registry for these waivers programs. For children with similar needs, it is important to have their name added to the list as soon as possible since slots are offered in order of the date of request. Emergency slots may occasionally be available through a request to the Office for Citizens with Developmental Disabilities. Slots may also be available for children in DCFS/OCS custody or living in facilities. To find the participant's date of request on the Registry refer to the Statement of Approval or call 1-866-783-5553 or the Human Services Authorities/Districts (Appendix G). 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/136/n/138>

New Opportunities Waiver

The New Opportunities Waiver (NOW) provides services for individuals who can benefit from home and community based services, but who qualify for care in an intermediate care facility for persons with mental retardation or developmental disabilities. Services include: day and night individualized and family supports; center-based respite services; community integration development; environmental accessibility modifications; specialized medical equipment and supplies; supervised independent living; day habilitation; supported employment; transportation for day habilitation and supported employment; skilled nursing services; permanent supportive housing stabilization, permanent supportive housing stabilization transition, and other services. NOW services are not subject to an individual monetary limit.

Children's Choice Waiver

Children who are on the Registry are offered an opportunity to participate in the Children's Choice waiver as slots become available. Children's Choice slots are sometimes available earlier than a NOW slot. Children's Choice provides funding for medical care, home modifications, care-giving assistance and support, and other specialty services. Funds available through Children's Choice for special additional services are capped at \$16,410 per care plan year. Regular Medicaid services, including EPSDT services, do not count against the cap.

When the family chooses to accept Children's Choice, the child's name is taken off the Request for Services Registry for the NOW program. 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. **However, the child can later receive an appropriate adult waiver slot under the following circumstances:**

1. **When a Children's Choice participant reaches the age of 19**, he/she will transfer into an appropriate waiver for adults as long as they remain eligible for waiver services.
2. **If a crisis situation develops** and additional supports are warranted, the Children's Choice waiver has crisis provisions designed to meet the needs of families on a case-by-case basis. These additional supports must be approved by the Office for Citizens with Developmental Disabilities.
3. Even in the absence of a crisis, if there is a **change in the participant's or the family's circumstances** that makes the services under the NOW program more helpful to them than services provided under the Children's Choice waiver, NOW services can be accessed. However, this can only occur if **the participant's original Registry date has been reached or passed for the NOW program**. (In other words, after the participant would have been offered NOW services if he/she had not chosen Children's Choice waiver.) An example of a "change in circumstances" could be a loss of in-home assistance through a caretaker's decision to take on or increase employment, or to obtain education or training for a job.

A fact sheet on the Children's Choice waiver program and "Frequently Asked Questions about Children's Choice" are included as *Appendix D*.

Supports Waiver

The Supports Waiver is available for those individuals age 18 and older whose health and welfare can be assured via the Individual Service Plan and for whom home and community-based waiver services represent a least restrictive treatment alternative. This waiver is intended to provide specific, activity focused services rather than continuous custodial care. Services include: support coordination, supported employment, day habilitation, prevocational services, respite, habilitation, permanent supportive housing stabilization, permanent supportive housing stabilization transition, and personal emergency response systems. Each service is limited based on annual service limits. (Refer to Appendix D-2)

Residential Options Waiver

The Residential Options Waiver (ROW) offers a choice of expanded services for individuals who can benefit from home and community based services, but who qualify for care in an intermediate care facility for persons with mental retardation or developmental disabilities. The Residential Options Waiver will only be

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 and for whom home and community-based waiver services represent a least restrictive treatment alternative. Services include: support coordination, community living supports, companion care, host home, shared living, one-time transitional services, environmental modifications, assistive technology/specialized medical equipment, personal emergency response systems, respite (center-based), nursing, dental, professional (dietary, speech therapy, occupational therapy, physical therapy, social work, psychology), transportation-community access, supported employment, prevocational services, and day habilitation.

Louisiana Behavioral Health Partnership

The Louisiana Behavioral health Partnership (LBHP) is the system of care for Medicaid and non-Medicaid adults and children who require specialized behavioral health services. The LBHP is managed by the Office of Behavioral Health, which oversees the Behavioral Health Statewide Management Organization (SMO), Magellan Health Services of Louisiana. Magellan manages behavioral health services for Medicaid and Non-Medicaid eligible populations including those Medicaid eligible children who will need coordination of services provided by the multiple partner agencies of the LBHP: OBH, Medicaid, Office of Juvenile Justice, Department of Children and Family Services, and Department of Education. The LBHP is designed to serve the needs of individuals who comprise one of the following target populations:

1. Children with extensive behavioral health needs either in or at-risk of out-of-home placement;
2. Medicaid-eligible children with medically necessary behavioral health needs who need coordinated care;
3. Adults with severe mental illness and/or addictive disorders who are Medicaid eligible; and,
4. Non-Medicaid children and adults who have severe mental illness and/or addictive disorders.

Individuals can go directly to a provider in Magellan's network and request services or they can call 1-800-424-4399 /TTY 800-424-4416 and Magellan can make a referral if they do not know which provider they want to see. Providers can also be located at www.MagellanofLouisiana.com. **No authorization is required for the first 24 routine outpatient visits and 12 medication management visits delivered by a qualified licensed mental health professional.** If it is any other service including rehabilitation, evidenced based services, substance abuse services, the provider will

complete an assessment and call Magellan to request an authorization for those services.

Children receiving or eligible for Medicaid can receive these services when medically necessary: 1) Coordinated System of Care (CSoC); 2) Case Conference; 3) Wraparound Facilitation; 4) Behavioral Health Rehabilitation; 5) Outpatient and Inpatient Hospital Services; 6) Psychiatric Residential Treatment Facility; 7) Outpatient Therapy by Licensed Practitioners; 8) Therapeutic Foster Care; 9) Non-Medical Group Home; 10) Assertive Community Treatment (ACT); and 11) Multi-Systemic Therapy; 12) Homebuilders, 13) Functional Family Therapy 14) Outpatient and Residential Substance Abuse Services.

Some of the more innovative changes you will see in the delivery of behavioral health services include Coordinated System of Care (CSoC), Wraparound Facilitation, and Behavioral Health Rehabilitation.

Coordinated System of Care (C-SoC) and Wraparound Facilitation

The Coordinated System of Care (CSoC) helps Louisiana's at-risk children up to the age of 22 years old 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 while they are being helped.

Anyone can make a referral for CSoC by calling Magellan's 24 hour line at 1-800-424-4399. This service is available in 5 regions of the state and plans are underway to expand services statewide. Call Magellan to determine if it is available in your area.

The Magellan "care manager" will administer a brief assessment. If the child appears to qualify, Magellan will make a referral to have an independent full assessment (Comprehensive Child and Adolescent Needs and Strengths-CANS) by an independent assessor who cannot be the treatment provider. Parents/caregivers and family members have a voice and play a key role in CSoC. Every youth and family in the CSoC will be enrolled with a Wraparound Agency (WWA) and will work with a wraparound facilitator who coordinates their care. The WAAs develop a plan of care and provide lots of help for children in the CSoC.

CSoC also has Family Support Organizations (FSO) to help families. FSO provides Parent and Youth Support and Training and makes sure families are involved and have a voice in their care.

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

Behavioral Health Rehabilitation Services

(Community Psychiatric Support and Treatment (CPST), Crisis intervention (CI), and Psychosocial Rehabilitation (PSR)) Medicaid participants under age 21 with mental illness or emotional/behavioral disorders who meet the program's medical necessity criteria may receive Behavioral Health Rehabilitation Services. These services include: individual and group skills training, individual counseling, crisis intervention, goal setting, and service coordination. Services are accessed by contacting a Rehabilitation Service provider agency or contacting Magellan. No Primary Care Physician (PCP) referral is required. The Magellan prior authorization unit must pre-approve CPST and PSR rehabilitation services.

Behavioral Health Rehabilitation providers arrange the assessments necessary to obtain prior authorization for mental health rehabilitation services required for adults. To find a Behavioral Health Rehabilitation Provider in your area, call a Magellan care manager at 1-800-424-4399

Remember these services offer family intervention, which could help a family struggling with the symptoms of their child's mental health diagnosis. Services may be provided in the home, school, community or at the provider's office. A support coordinator can work with the family and the Behavioral Health Rehabilitation Provider to assure the participant and family are receiving all necessary services from the provider.

As with any service, support coordinators should work with providers and in this case with Magellan on coordination of services.

For more information, see Appendix I-1 for Levels of Care & Service Definitions or visit www.MagellanofLouisiana.com for additional information about Magellan's Services and a copy of the Member Handbook.

Other mental health services not listed here may be covered by Medicaid if medically necessary to meet mental health needs. To obtain a service not listed here, see the section on "Other Medicaid Services Not Listed."

School-Based Behavioral Health Services

Medicaid also funds behavioral health services provided through schools or early childhood educational settings such as regular kindergarten classes; public or private preschools; Head Start Centers; child care facilities; or home instruction. To be funded by Medicaid, these services must be included in the child's IEP.

Behavioral Health services, treatment, and other measures to correct or ameliorate an identified mental health or substance abuse diagnosis may be provided by licensed mental health practitioners or Louisiana Certified School Psychologists and Counselors.

Refer to Appendix I-1 LBHP Services and Links

Personal Care Services

Personal care services (PCS) are defined as tasks that are medically necessary as they pertain to an EPSDT recipient's physical requirements when cognitive or physical limitations necessitate assistance with eating, bathing, dressing, personal hygiene, bladder or bowel requirements.

Assistance is provided with meal preparation if the recipient is on a restricted diet that differs from the rest of the household members and no family member is preparing the meals.

PCS does not include medical tasks such as medication administration, tracheostomy care, feeding tubes or indwelling catheters. Assistance with these tasks can be covered through Medicaid's Home Health program.

Personal Care Services are not intended as a substitute for child care needs or to provide respite care to the primary caregiver.

Staff assigned to provide PCS shall not be a member of the participant's immediate family.

Refer to *Appendix E* for a comparison of PCS and Home Health Services and PCS Rule information.

How to obtain Personal Care Services:

- Personal Care Services must be prior authorized by Molina. Service must be provided by a licensed enrolled PCS provider. A list of providers in your area who offer such services is available through either the Medicaid website or by calling the Specialty Care Resource Line. To obtain the information

- from the website, go to www.dhh.louisiana.gov and Click Medicaid, click on Locate a Provider, click on provider group Personal Care Services, and then the region or parish where the participant resides.
- If you cannot find a PCS provider in your area that is willing to submit a request for authorization, DHH must be notified. Call the DHH program staff line at 1-888-758-2220 and tell them that you cannot find a provider. The support coordinator must notify the PAL if the provider is unable to find direct care staff after having received an authorization to provide the service.
- **If a provider cannot be located, DHH must take all reasonable steps to find a willing and able provider within ten days.**

How to obtain prior authorization:

- To obtain prior authorization, the provider must send in a completed prior authorization request to the Molina prior Authorization unit. The request must include an EPSDT-PCS Form 90 (prescription is included on the form) completed by the participant's attending physician, a completed plan of care that has been signed by the attending physician, a Social Assessment form, an EPSDT PCS Daily Time Schedule, and any other supporting documentation or independent assessment information.
- There are no set limits to the number of service hours a participant under age 21 can receive. The number of hours approved is based on the participant's need for assistance with his/her personal care tasks that are covered through this program.
- The Support Coordinator should provide the family with an EPSDT-PCS Form 90 and inform them of the need to have it completed. This should be done when PCS is requested by the participant/family. The Support Coordinator should assist with scheduling the doctor appointment, transportation, etc., as needed. The Support Coordinator should assist the family to provide all critical information to the physician before he writes the orders requesting the service. All requests should include the necessary documentation to ensure that needed services can be approved.

Changing PCS Providers within an authorization period:

If a recipient is changing PCS providers within an authorization period, the current agency must send a letter to the Molina Prior Authorization Unit notifying them of the recipient's discharge so a new PA can be issued to the new PCS provider that has been selected.

If the earlier provider fails or refuses to promptly send in a letter, the Support Coordinator can work with the new provider to obtain a letter from the recipient/family asking Molina to terminate the prior services. The letter should include the name of the provider being discharged and, if known, the prior authorization number from the last approval notice for the service at issue. The new provider is to send this letter to Molina with their PA request.

The new provider must submit an initial request for prior authorization to the PA Unit using current documentation. The new provider must submit all required documentation necessary for an initial PA request.

Units approved for one provider CANNOT be transferred to another provider.

Home Health Services

Children and youth may be eligible to receive multiple hours of skilled nurse service per day through Extended Home Health (EHH) services if it is determined to be medically necessary for the recipient to receive a minimum of three hours per day of nursing services. These services are provided by a Home Health Agency, and **cover medically necessary home care that can require more skills than Personal Care Services.**

Unlike services for adults, Home Health Services for children and youth are **not limited in terms of frequency or duration.** EHH services must be prior authorized in accordance with the certifying physician's orders and home health plan of care. Recipients who require fewer than three hours per day of nursing services do not need to obtain prior authorization. However, these services are subject to post-payment review.

Some individuals need both PCS and Home Health Services. **(Refer to *Appendix E for a comparison of PCS and Home Health Services.*) Services should not overlap.** The best practice is to develop a detailed schedule of all in-home providers, which can be used to show that multiple services do not overlap.

If you **have contacted all of the providers on the current EHH provider list, and cannot find a Home Health Services provider in your area** that is willing to submit an application for the services the participant needs (including in-home speech, occupational, or physical therapy), DHH must be notified. Call the DHH program staff line at 1-888-758-2220 and tell them that you cannot find a provider. The support coordinator must notify the PAL and DHH program staff line if the

provider is unable to find staff after having received an authorization to provide the service.

If a provider cannot be located, DHH must take all reasonable steps to find a willing and able provider within ten days.

Pediatric Day Health Care Facility

A pediatric day health care (PDHC) facility serves medically fragile individuals under the age of 21, including technology dependent children who require close supervision. These facilities offer an alternative health care choice to receiving in-home nursing care. A PDHC facility may operate 7 days a week and may provide up to 12 hours of services per day per individual served. Care and services to be provided by the pediatric day health care facility shall include but shall not be limited to: (a) Nursing care, including but not limited to tracheotomy and suctioning care, medication management, and IV therapy. (b) Respiratory care. (c) Physical, speech, and occupational therapies. (d) Assistance with aids of daily living. (e) Transportation services. (f) Education and training. It does not cover before and after school care. (Refer to LAC 50:XV. Chapters 275-281)

Physical Therapy, Occupational Therapy, Speech Therapy, Audiology Services and Psychological Evaluation and Treatment

If a child or youth wants rehabilitation services such as Physical, Occupational, or Speech Therapy, Audiology Services, or Psychological Evaluation and Treatment, 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 Early Steps (ages 0 to 3), they must be part of the IEP or IFSP. For Medicaid to cover PT, OT, ST and audiology services through an outpatient facility, rehabilitation center, or home health, they must be ordered by a physician and be prior-authorized by Medicaid. Refer to "Services Available through School Systems" (page 22) for further information.

Community Therapies: The PT, OT, ST and audiology services cited above can be provided in the community in addition to being provided in the school. For Medicaid to cover such services through a provider outside of an educational setting, they do not need to be part of the IEP or IFSP, but must be prior-authorized by Medicaid.

The Support Coordinator is to explain to the family/participant that Medicaid will provide medically necessary therapies in addition to the therapies received at school through the IEP. The Support Coordinator is to ask the family/participant if they

want to request any medically necessary therapies now or if they want to receive therapies on the IEP during the school's summer break. The Support Coordinator helps the family to determine the setting in which the child will receive the greatest benefit, and also helps the family by making the appropriate referral and coordinating the days and times of this service with other services the participant is receiving.

For information on receiving these therapies in schools, contact the child's school. To locate other therapy providers call the Specialty Care Resource Line at 1-877-455-9955.

If you cannot find a PT or OT provider in your area that is willing to submit a request for authorization, DHH must be notified. Call the DHH program staff line at 1-888-758-2220 and tell them that you cannot find a provider. The support coordinator must notify the PAL if the provider is unable to find staff after having received an authorization to provide the service.

If a provider cannot be located, DHH must take all reasonable steps to find a willing and able provider within ten days.

Disposable Incontinence Products

Diapers, pull-on briefs, and liner/guards are covered for individuals age four years through age twenty years if they have a medical condition resulting in bowel/bladder incontinence and meet other DHH criteria. A Prescription Request Form for Disposable Incontinence Products (BHSF Form DIP1) may be completed, or a physician's prescription along with required documentation can be submitted. Both must also include a completed PA-01. Additional supporting documentation is required for requests that exceed eight units per day. If completed, the BHSF DIP 1 collects this additional information. Refer to Appendix R-1.

Providers must provide at a 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.

Medical Equipment and Supplies

Participants under age 21 can obtain any medically necessary medical supplies, equipment and appliances needed to correct, improve, or assist in dealing with physical or mental conditions. This includes lifts and other devices to help the family deal with a child's circumstances, and also some medically necessary dietary or nutritional assistance. **Medical Equipment and Supplies must be prescribed by a physician.** Once prescribed, the supplier of the equipment or supplies must request approval for them from Medicaid since this is a prior authorized service.

New technology is being developed every day; therefore, many families and participants are unaware of equipment and medical supplies available, or do not realize that Medicaid can pay for items deemed medically necessary. As the Support Coordinator, it is your responsibility to investigate if equipment can help families with difficulties they are facing. You can also help to arrange any appointment needed to get the prescription from the doctor.

Alternate approved items: Sometimes, the Medicaid prior authorization unit will not grant prior authorization for the specific equipment or supplies indicated, but will approve **less expensive items** that it believes will meet a participant's needs. If so, the notice of denial should identify the items. You can then consult with the participant and the provider to see if the identified item might work. **The participant can accept the less costly item and still appeal the denial of the item originally requested;** however, they must not dispose of, destroy, or damage (beyond normal wear and tear) the less expensive item while the appeal is pending.

Transportation

Non-emergency medical transportation (NEMT) is provided for Medicaid recipients to and/or from a provider for a Medicaid covered service. Children under 17 must be accompanied by an attendant. Arrangements for non-emergency transportation should be made at least 24-48 hours in advance.

The Support Coordinator can assist the parent(s) in arranging transportation services for the participant. Support Coordinators should be aware of the phone numbers to the dispatcher for Medicaid funded non-emergency medical transit in their area.

Special arrangements: If there is no Medicaid funded transportation service in the participant's parish, or if none of the providers have lift-equipped vehicles needed by the participant, or if special arrangements need to be made because of the long distance of a trip, Medicaid will try to assist the participant to access transportation. In situations where the usual Medicaid funded transportation will not suffice, the support coordinator can call the Medicaid program transportation department at 225-342-2604.

"Friends and Family" program: Support Coordinators should also be aware that Louisiana Medicaid will allow family members/friends to become Medicaid funded transportation providers for specific family members, through the "Friends and Family" transportation program. To assist someone you are serving that may benefit from this arrangement, call Medical Dispatch at 1-800-259-1944.

Other Medicaid Services Not Listed

Refer to *Appendix F* for an expanded list of available services. To ask about other available services, contact the **Specialty Care Resource Line (toll free) at 1-877-455-9955 or TTY 1-877-544-9544.**

Although a service may not be listed, if it is a service permitted by federal Medicaid law, and is necessary to correct or ameliorate a physical or mental condition of a recipient who is under age 21, it must be covered. Persons under age 21 are entitled to receive all equipment that is medically necessary or items that Medicaid can cover. This includes many items that are not covered for adults. These services may be subject to the restrictions allowable under Federal Medicaid law.

Arrangements to tailor additional coverage for children's needs are taken by Louisiana Medicaid staff at **1-888-758-2220**. This number should be contacted only once it is clear that existing offerings will not meet the child's needs, that there is a specific service to meet the need, and potential providers of the service. Medical justification for the service will be required.

OCDD SERVICES

The **Office for Citizens with Developmental Disabilities (OCDD)**, through human services districts and authorities in each region, provides a variety of state-funded services to individuals with developmental disabilities, including children and youth. EPSDT support coordination participants may already have contacted OCDD in order to be assessed and placed on the Request for Services Registry; however, their families may not be aware of all the services and supports OCDD has to offer.

Refer to *Appendix G* for a list of **Human Services Districts and Authorities**.

The following is a list of some supports and services available through OCDD. Visit the DHH/OCDD website for more information on Supports and Services.

Flexible Family Funds (Cash Subsidy)

A monthly stipend to families of eligible children with severe or profound developmental disabilities from birth to age 18 to help families meet the extraordinary costs associated with maintaining their child in the home. There is a waiting list, and stipends are awarded to eligible children on a first come, first served basis.

Community Support Teams (CST)

Community Support Teams are comprised of psychologists, social workers, nurses, and psychiatrists who can provide supports and services on a 24-hour, 7 day a week

basis. These teams provide supports and services to people with developmental disabilities who need intensive treatment intervention in order to allow them to remain in their community living setting. These supports and services include: initial and ongoing assessment, psychiatric services, family support and education, support coordination and any other services critical to an individual's ability to live successfully in the community.

There are nine (9) Community Support Teams located in various regions throughout the state. They are managed through the Resource Centers and are accessed through the Human Services Districts and Authorities.

Individual and Family Support

This service provides supports which are administered by OCDD Regional Offices with state general fund dollars that are not available from any other source. Individual and Family Supports include, but are not limited to: respite care, personal assistance services, specialized clothing, such as diapers and adult briefs, dental and medical services not covered by other sources, equipment and supplies, communication services, crisis intervention, specialized utility costs, specialized nutrition, and family education. Requests for Family Support funding are reviewed each year or when a person's needs change.

Human Services District / Authorities Support Coordinators

Provide information about supports and services available through OCDD and other sources; make referrals; assess the need for support and services; develop an individualized Plan of Support which identifies formal and natural supports; and provide ongoing coordination of the person's support plan.

In addition, each Human Services District and Authority has an **EPSDT Specialist** on staff, who can answer questions about EPSDT services. Refer to *Appendix H* for a list of the EPSDT Specialists.

OFFICE OF BEHAVIORAL HEALTH SERVICES

Local Governing Entities (LGE) -Behavioral Health Clinics

The Department of Health and Hospitals, Office of Behavioral Health, ensures children and youth with serious emotional disturbances are provided with **outpatient mental health services** through the operation of licensed Local Governing Entities (LGE) and their satellite outreach clinics. The LGE facilities may provide an array of services: screening and assessment; emergency crisis care; individual evaluation and treatment; medication administration and management;

clinical casework services; specialized services for children and adolescents; specialized services for criminal justice; specialized services for the elderly; and pharmacy services. LGEs provide services to Medicaid and non-Medicaid individuals, so inability to pay does not preclude services.

Refer to *Appendix I* for a listing of LGE and Behavioral Health Clinics.

Child-Adolescent Response Team (CART)

CART services are available through the mental health clinics 24 hours a day, 7 days a week, in **crisis situations** (situations in which a child’s behavior is unmanageable and threatens harm to the child or others). They provide crisis counseling and intervention to children and youth under age 18 and their immediate family. CART assists the family in the stabilization of the crisis and provides the family with advocacy, referral, and support.

SERVICES AVAILABLE THROUGH SCHOOL SYSTEMS

From **birth to age three**, children with disabilities and developmental delays are served by a program called **Early Steps**.

At age three, children are transitioned to other services, including the school system’s **Early Childhood Education** programs. Each school system in Louisiana has a Child Search Coordinator who can arrange for evaluations of children to determine whether or not the child has a disability and requires special educational services. For more information about Child Search and Early Childhood Education programs, contact your school district or:

Cindy Ramagos
LA Dept. of Education/Office of District Support
Early Childhood Education
cynthia.ramagos@la.gov
(225) 342-3647
1-877-453-2721
(225) 342-4180 fax

“The Early Childhood Transition Process” booklet is a guide for helping families prepare for the transition and can be requested from the above contacts. It is available in English, Spanish, and Vietnamese versions. It can also be found at <http://www.louisianabelieves.com/resources/library/early-childhood> “Guide for Families Early Childhood Transition”

Regardless of age, **each child who is suspected of needing special education and related services has the right to be evaluated** by the special education department of his local school system. The child will be professionally evaluated through test results, interviews, observations, and other relevant information. Reevaluation should be completed every 3 years. **The evaluation results in a final written report** on the child's level of functioning, strengths and weaknesses, needs, and conditions that qualify the child for special educational services. This report can be useful to the Support Coordinator in developing a CPOC and in supporting any need for Personal Care Services.

The services that will be provided to the child by the school system are determined at a meeting called an **Individualized Education Program (IEP) meeting**. The IEP team includes the parent, the child's special education teacher, regular education teacher (if the child is or may be participating in regular education), a representative of the school system, and other individuals who have knowledge or experience about the child (as determined by the parent or the school). The meeting results in a **written plan ("IEP")** that should address all of the child's educational goals, needs, and services.

In addition to addressing educational methods and goals, the IEP may include **"related services"**--such services as transportation, speech pathology and audiology, psychological services, physical and occupational therapy, orientation and mobility services, recreation, counseling services, and school health services. The IEP can also include **assistive technology devices and services**. Examples of such devices are adapted toys and computer games, remote control switches, electronic communication devices, and standers and walkers. Such devices may be taken home if use in other settings is included in the IEP.

An Individualized Healthcare Plan (IHP) is completed by the school nurse for children with special health care needs. It is usually attached to the IEP, but may be in the child's school record file. The school nurse gathers medical information and develops the IHP with input from the parent, student, physician and/or others. The IHP documents health concerns, goals and interventions required to ensure the health needs of the student are met in the school setting.

Children with disabilities are not limited to the services they may be able to receive at school. **Even though a child with a disability may receive therapy or use assistive devices at school, they can also receive those services in other settings through Medicaid, if this is medically necessary.**

At age 14, the child's IEP should start to address the transition the child will make from school to post-secondary education, employment, or other post-high school

activities. If employment will be sought at some point, the Louisiana Rehabilitation Service should be contacted to see if they can provide services after high school.

The Louisiana Department of Education maintains a **toll-free hotline** that parents can call for information and referrals regarding school services: 1-877-453-2721.

Part II - Intake, Assessment and Comprehensive Plan of Care

INTAKE

Once the referral has been made to the support coordination agency, the participant's family or caretaker should be contacted within three days. At that time, an appointment should be set up to discuss what support coordination is and how it can benefit the participant.

The Support Coordination Choice and Release of Information Form (FOC) can be used to obtain all plans, evaluations, and assessments that OCDD has developed or used in connection with its determination that the participant is eligible for services through the developmental disability services system. Formal information will be needed for the assessment and CPOC completion. Refer to *Appendix N* for a copy of the Consent form. The family can also be asked about formal information documents they may have or can obtain prior to the CPOC assessment.

At the face to face visit, the Support Coordinator should explain his/her responsibilities to the family and give specific examples about how these services can benefit the participant. This must include a review of the Medicaid Services Chart (*Appendix B*). By reviewing the Medicaid Services Chart, the Support Coordinator can begin to obtain additional information as to the participant's need for services and help the participant and his/her family become aware of the support systems available and how to access them. In addition, the Support Coordinator should explain all contact requirements, including the required face-to-face meetings. Once the participant and his/her family have been given all of the information, they should be asked again if they want support coordination services.

During this meeting, the Support Coordinator should inform the participant of:

- Support Coordination Responsibilities
- Rights & Responsibilities (*Appendix K*)
- HIPAA & Confidentiality
- Appeal Process (*Appendix L*)
- Availability of formal and non-formal services

- Complaint process for filing a report against support coordinators and/or providers (*Complaint Form – Appendix M*)
- 1-800-660-0488 Health Standards Provider Complaint Line
- Review of Medicaid Services Chart (*Appendix B*)

It is important to note that a family is often overwhelmed with everything they are being told in this first meeting. Do not expect the family to remember everything, even if you are providing information in writing. **REVIEW THIS INFORMATION AS OFTEN AS IS NECESSARY!**

ASSESSMENT

The Support Coordinator should begin performing the participant’s assessment within seven calendar days of the referral. A face-to-face in-home interview must be conducted within 10 days of the referral.

To adequately perform an assessment, the Support Coordinator will need to gather both **formal and informal information**. Formal information will include medical, psychological, pharmaceutical, social, and educational information, and information from OCDD, described above. 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 Support Coordinator may need to assist the participant with arranging professional evaluations and appointments including EPSDT Screening Exams 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.

COMPREHENSIVE PLAN OF CARE (CPOC)

(Refer to Appendix O-CPOC Instructions)

The Comprehensive Plan of Care is the Support Coordinator’s blueprint for assisting the participant. The CPOC is developed using all information gathered during the assessment process and **MUST** be completed in a face-to-face meeting with the participant and others they wish to have present. Because the people at the CPOC meeting are those who know the participant best, more information to be incorporated into the CPOC can be gathered at this meeting. If for some reason the CPOC cannot be completed at the meeting, the participant/guardian must sign the CPOC after it is completed and prior to submittal to SRI.

If the participant is 18 years of age or older, has not been declared incompetent (interdicted), and is able to express his preferences, the service coordinator should

talk directly to the participant. If they are unable to express their preferences due to a disability, the coordinator should document this in the file.

CPOC Planning is the process whereby an **analysis of information from the formal and informal evaluations is utilized**. The CPOC is developed based on the identified needs and the unique personal outcomes envisioned, defined and prioritized by the participant and his/her family. It is important that everyone desired by the participant who can offer valuable information in the development of the CPOC be at the meeting. The CPOC is developed through a collaborative process involving the participant, family, friends or other support systems, the Support Coordinator, direct service providers and others that know the participant best.

The CPOC must be specifically designed to meet the participant's goals and objectives, and should include timelines in which the goals can be met or at least reviewed. The plan must include strategies (agreed upon by all) to achieve or maintain the desired outcomes that rely on informal, natural, community supports and appropriate formal paid services.

The Support Coordinator should provide the participant complete and clear information regarding service options to assure the participant makes informed choices. During the CPOC meeting, the Support Coordinator should have the Medicaid Services Chart (*Appendix B*) available to discuss the available Medicaid services. The most current Medicaid Services Chart can be found on the Internet, at http://new.dhh.louisiana.gov/assets/docs/BayouHealth/Medicaid_Services_Chart2012.pdf . The services discussed in Part I of this handbook should be highlighted in the discussions with the participant and his/her family.

The Support Coordinator must be very familiar with all parts of the CPOC and assure that information from each section is used to determine the Goals and Objectives of the Plan that will lead to the requested services. In addition to understanding the importance of each section, it is very important that the Support Coordinator use the most current CPOC provided to the support coordination agencies by DHH/Bureau of Health Services Financing. **(Review a blank copy of the CPOC in LSCIS and the instructions before conducting each CPOC.)** Refer to *Appendix O*.

The CPOC is comprised of the following six sections:

Section I - Demographics/Contact Information

Be sure that all information is provided. Nothing should be left blank. Include the relationship of the guardian beside their name.

Section II - Medical/Social/Family History

Social/Family

Provide as much information as possible about the participant and his/her family. Consider an interview with all family members who are involved in the participant's life, not just those living in the same household. When designing the goals and objectives of the CPOC, it is important to take into account the strengths and weaknesses of the informal supports. For example, if the primary caregiver has no other supports or has a disability, he/she may not be able to offer much assistance with physical care, and it may prove beneficial for the participant to use more paid care than may be otherwise provided. It is the Support Coordinator's job to look at and respond to the needs of the participant; however, often the family's needs have a direct impact on the participant's needs. It is important that the Support Coordinator give the caregiver assistance that is dependable and that allows the caretaker to continue to meet the child's needs over the long-term.

Health Status

Make sure to note all aspects of the participant's health including behavioral and psychiatric issues. If there is only sketchy information available in any health status area, remember the participant is eligible for screenings, which can help to determine his/her health needs. It is the Support Coordinator's responsibility to help the participant access those screening services.

In some cases, a short term CPOC may need to be developed, setting out the areas that need to be explored towards developing sound and longer term objectives.

In addition, it is important to remember that psychological and behavioral services are available for the participant. If it seems a behavioral support plan would benefit the participant, but there is not one in place, **refer the participant for this service**. Information gathered from the psychologist's assessment could prove invaluable in the development of the CPOC.

When significant new information is obtained from a medical appointment or assessment, including a psychological and behavioral services assessment, the CPOC should be updated by adding and/or revising the goals and objectives according to the most recent information available.

Section III - CPOC Service Needs and Supports

This Section requires that the Support Coordinator review the Medicaid Services Chart (*Appendix B*) with the participant/family/guardian regardless of whether or not the participant is receiving these specific services. The Medicaid Services Chart is first reviewed during the face to face visit and should be kept handy and revisited as many times as necessary during the development of the CPOC.

This section identifies goals and the support strategy needed to meet the goals. This is the section that will identify the services (Medicaid and non-Medicaid) that the participant needs. **It is important that the family know what Medicaid services are available to them before beginning this part of the CPOC. Refer to the drop down bar in this section for a list of some services that require prior authorization.** In addition, this section of the CPOC identifies how the need was determined, if the participant/family requests to receive the identified need and reason why not, personal outcome, who is providing the support, and amount of service approved.

The CPOC must be reviewed at least quarterly to assure that the service being provided is adequate to meet the participant's needs and it remains necessary to his/her health and well-being. It is extremely important for all goals and strategies to be adjusted as the needs of the participant change and as new challenges develop in his/her life, including problems that develop regarding receipt of any services.

The Support Coordinator must assure that the recipient/family understands that services and goals may be added at a later date if they do not choose to access them when the need is first identified. The Support Coordinator must document the participant/family chose not to access a service at the time of the CPOC meeting, and they will be given an opportunity to add that service during the quarterly CPOC reviews or whenever a request is made.

When a service is requested, the Support Coordinator should provide the family with the medical information forms (EPSDT-PCS Form 90, CMS 485, etc.) that are required for the specific service. The Support Coordinator should assist with scheduling the doctor appointment, transportation, etc. as needed.

The Support Coordinator will coordinate all services, Medicaid and non-Medicaid, and ensure that the participant receives the services he/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 needs and that services are being provided. Again, if the participant is 18 or older and has not been declared incompetent, the coordinator should contact the participant unless the coordinator has documented that the participant is unable to express his preferences or the participant has authorized the coordinator to contact a family member. The CPOC will be reviewed at least quarterly and revised annually and as needed.

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.

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. You may also wish to obtain contact information for each person attending, so they can be invited to future meetings, if the participant/family requests assistance with this.

The participant/guardian must also sign and date the LSCIS CPOC signature page after they have reviewed and agree with the services in the CPOC. If someone other than a parent is the guardian, the legal guardianship document must be in the case record.

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.

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 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. The Formal Information documents, Service Logs, and Quarterly Reviews must be reviewed 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.

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

The 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.

An initial CPOC or a CPOC for participants that are not on the RFSR but are identified as Special Needs must submit all formal information evaluations and documents listed on Appendix X. This is to be sent to SRI and must be received prior to CPOC approval. All information as required on the Checklist for EPSDT Support Coordination Approval Process must be maintained in the participant's file. It must be available and submitted to BHSE/SRI immediately upon request. (*Appendix X*).

The supervisor submitting the CPOC to DHH/SRI for review will be notified by LSCIS when the CPOC is randomly selected for monitoring. The required documents and the Monitoring Checklist (Appendix X-2) must be sent to SRI. If the documents are not received within the required timeline, the CPOC will not be approved and it will be returned to the agency.

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

The service provider and participant are to be given a copy of the most current CPOC and any updates.

The Support Coordinator is responsible for requesting and coordinating all services identified in the CPOC immediately upon completion of the CPOC and prior to approval from BHSF/SRI. Since approval of Medicaid state plan services is through the prior authorization unit, there is no reason for the Support Coordinator to await BHSF/SRI approval of the CPOC before making referrals for necessary services.

Section VI -Typical Weekly Schedule (Paper form only)

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.

Approval of the CPOC does not mean that services requiring prior authorization will be approved. Services that require prior authorization include personal care services, extended home health, skilled nursing, disposable incontinence products, durable medical equipment and supplies, rehabilitation services, pediatric day healthcare, and mental health rehabilitation services. Providers of these services are responsible for requesting prior authorization from the prior authorization unit.

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.

COORDINATION OF SERVICES IDENTIFIED IN THE CPOC

Once the needed Medicaid services (personal care, medical equipment and supplies, home health, etc.) have been identified in the CPOC, it is the Support Coordinator's responsibility to make referrals to the appropriate providers. **Do not wait for BHSF/SRI to approve the CPOC!**

The Support Coordinator should provide as much assistance as possible to the family to identify and obtain other non-Medicaid services (home modifications, respite, financial assistance, etc.) that are identified in the plan. The CPOC is considered a holistic plan. Therefore, the Support Coordinator is responsible for coordinating all identified service needs, including paid and un-paid supports as well as non- Medicaid Services.

The following section addresses prior authorized services and the Support Coordinator's role in assisting the participant to obtain such services.

Part III - Prior Authorized Services

The following forms/brochures/flyers will be covered in this section:

- √ Referral to Provider (*Appendix Q*)
- √ Referral to Provider Authorization Liaison "PAL" (*Appendix S*)
- √ EPSDT Prior Authorization Tracking Log (*Appendix O and Appendices T and R-5 for information*)
- √ EPSDT LSCIS Service Log (*Appendix O*)
- √ EPSDT Quarterly Review/ Checklist and Progress Summary (*Appendix O*)
- √ Appeals Brochure (*Appendix L*)
- √ Prior Authorization Requests(*Appendix R*)
- √ Review of Possible Eligibility request (*Appendix Y*)

OVERVIEW OF THE PRIOR AUTHORIZATION PROCESS

Some Medicaid services such as Personal Care Services, Rehabilitation Services, Home Health, and Durable Medical Equipment (DME) require prior authorization before they can be provided. Typically, a Medicaid-enrolled provider of the service develops and submits an application for the service to the prior authorization unit. A notice of authorization or denial of the service will be sent to the participant, the provider, and to you, the Support Coordinator, if your name has been included in the prior authorization request.

Most prior authorization requests are acted on by the Prior Authorization Unit of Molina, a company that contracts with the Department of Health and Hospitals to perform this function. Requests may be denied if the item or service requested is not medically necessary, or if it is outside the scope of services covered by Medicaid. A notice of denial will be sent to the participant, the provider, and you, the Support Coordinator, if you are properly identified in the request. The participant then has the right to appeal the denial.

If services are approved, the provider and the participant are notified and services can begin. If services are authorized for a period of time, it will be necessary to file another request near the end of the period for which they are authorized. **If the request for reauthorization is received by Molina at least 25 days before the end of the period, services may not be discontinued until the request has been ruled upon.** If the requested services are denied, the services may continue while awaiting a ruling on the appeal, *if* the request was submitted 25 days ahead of the end of the authorization period *and* the appeal was filed within 10 days of the denial notice. Participants have 30 days to file an appeal request after the notice of denial of services, but in order to continue receiving the services during the appeal process, the appeal must be filed within 10 days of the denial notice.

For participants under age 21 who are on the NOW Request for Services Registry, **if there is insufficient information for Molina to make a decision as to whether an item or service should be approved or denied, the request will be referred to the Prior Authorization Liaison (PAL)**, whose function is to communicate with providers, Support Coordinators, and participants in order to develop and obtain the necessary documentation. If there is no response within 30 days after a Notice of Insufficient Documentation goes out, the recipient's request will be denied, for not having enough information. No decision will be reached as to the medical necessity for the service. This can be avoided by notifying the PAL of an upcoming doctor's appointment unless the recipient failed to keep the appointment. The PAL shall then follow up with the doctor to get all necessary information.

Support Coordinator Role (general)

The Support Coordinator plays a role in the prior authorization process by:

- assisting participants in identifying services they will request (discussed previously);
- providing the specific medical information forms, that the physician must complete, for the requested services (Refer to Appendix R-1, LaMedicaid.com or the DHH website);
- assisting with the scheduling of physician appointments, transportation, etc., to have the forms required for a PA request completed;
- locating providers willing to submit the request;
- assisting, if necessary, in assembling documentation needed to support the PA request;
- making sure providers submit requests timely and tracking the status of the request;
- communicating with the PAL, notifying them of any upcoming doctor's appointment, and helping to supply any missing documentation of medical need;
- follow through with requests for services until the PA is either approved or denied based on medical necessity; and
- assisting the participant with making a decision about whether to appeal any denials of services, and assisting with the appeal if the participant decides to appeal and wants assistance.

Support Coordinator Role--Locating Medicaid Providers

- When a participant requires a service that must be prior authorized, you must refer the participant to the appropriate provider of his/her choice. Unless the participant already has a provider he or she is satisfied with, you must give the participant a list of agencies where the service they need is offered. From that list, the participant will choose the provider they prefer. The EPSDT Provider list for Personal Care Services (PCS) can be accessed at www.dhh.louisiana.gov click Medicaid, click Locate a Providers, click on provider group Personal Care Services, and the region or parish where the participant resides. The Support Coordinator cannot tell the participant which provider to choose. However, the Support Coordinator may recommend to the participant/family that a list of interview questions may help them in selecting the appropriate provider for their identified needs. The Support Coordinator must have the participant/family list the provider they choose and sign the **Choice of Provider Form for EPSDT Medicaid Providers (Appendix Z)**. The support coordinator may also need to assist the

participant in contacting prospective providers and finding out if they are willing to submit prior authorization requests.

- The family can give a verbal Choice of Provider (COP) to the Support Coordinator per phone if it is needed for a timely referral to the provider. In order to do this, the family must have a list of providers or know who they want. The Support Coordinator may not give a partial list of providers to the family to choose from. The Support Coordinator must complete the Choice of Provider Form documenting the client's choice of provider and have another office employee speak with the family to confirm and witness the Choice of Provider. Make a referral to the provider and mail a copy of the verbal COP to the participant/family.
- As noted previously, if you cannot find a provider in your area that is willing to submit an application for the services the participant needs, DHH must help you find a provider who is willing and able to provide the services. Call the DHH program staff line at 1-888-758-2220 and tell them that you cannot find a provider. The Support Coordinator must notify the PAL if the provider is unable to find staff for the service after the service has been approved.
- **If a EHH, PCS, PT, or OT provider cannot be located, DHH must take all reasonable steps to find a willing and able provider within ten days.**
- **If two providers have refused to submit a request for the needed item or service (other than PCS or EHH), or if there is no willing provider of the service in the area, participants can request a review of possible eligibility for the service directly from Medicaid.** They must first obtain a written statement from a physician as to why the services or items are necessary. If Medicaid finds that the participant may be eligible for the services, Medicaid will find a provider to submit the request or otherwise take steps to obtain a prior authorization decision. Refer to *Appendix Y* for a copy of the form that needs to be completed. Contact the DHH program staff line for PCS and EHH services.

TRACKING PRIOR AUTHORIZATION REQUESTS

PA Tracking begins with the request for the service, not when the COP or prescription is received or when the CPOC is approved.

Complete the Referral to Provider form

Once the participant has chosen a provider, the Support Coordinator, must complete the **Referral to Provider** (*Appendix Q*) form and submit it to the provider. It is

extremely important that the Support Coordinator fill in the name of the support coordination agency and request that their name and contact information be placed on the **Request for Prior Authorization** form.

Referral to providers should be made within 3 days of CPOC completion, or within 3 days of the date the family selects the direct service provider - Choice of Provider date (if the date of provider selection is later than the CPOC meeting).

Obtain a copy of the Request for Prior Authorization Form

In addition to requesting that your name be placed on the form, it is equally important that you request a copy of the Request for Prior Authorization Form for the appropriate service that is submitted by the provider to Molina. Receiving a copy will give you a better opportunity to track the service from your referral to the provider to the prior authorization decision and will also document in your file your active participation in the prior approval process.

Tracking Activities and Contacts

Document in LSCIS all contacts with the provider regarding the request on the EPSDT Prior Authorization Tracking Log and the EPSDT Service Log. Also document all contacts with the participant/family regarding the requested service. Contacts must be, at a minimum, on a monthly basis.

It is the Support Coordinator's responsibility to track all prior authorization requests on behalf of their client. To track each prior authorization request, the Support Coordinator must use the **EPSDT Prior Authorization Tracking Log**. On this form the Support Coordinator will document the nature and the specific amount of each service being sought, provider and PAL referrals, and information about approval, denial and appeals. (Refer to Appendix R-5)

- A separate **EPSDT Prior Authorization Tracking Log** is completed for each service that requires prior authorization. A new log is used for renewals and changes in existing services (i.e., additional hours of service requested). (Note: DME supplies relating to a specific activity may be grouped as one Service Need entered on one tracking log if the provider and PA service dates are the same.)
- The log provides space for ongoing tracking information relating to the status of the prior authorization/service.
 - Type of Service and Amount: Specify the item or services sought, and the amount. For services that are expressed in hours, the total hours per week should be indicated.
 - Date of Service Request and Date of COP (Choice of Provider)
 - Provider Name

- Date of Referral to Provider (within 3 days of date of COP)
 - Provider Contacts
 - Referral to PAL (if required)
 - Reminder Notice to Provider for Renewal: **45 - 60 days prior to the date the services are scheduled to expire**, you should remind the provider to renew the prior authorization request.
 - Date of the PA Decision and the Date PA Notice Received by the agency (If a partial approval is received, enter this information and also enter in the Note Box that a Partial Approval was received. The Partial Approval will be followed by a Full Approval or Partial Denial notice.)
 - PA Approval and Dates: The outcome of the request for prior authorization should be recorded. Because the Support Coordinator is listed on the **Request for Prior Authorization** form, you should receive the notices that the Prior Authorization Unit or the PAL sends to the provider and the participant. If services are approved, record the specific number of hours and/or services approved and follow up with the participant to make sure that services begin and enter the service start date. If services are denied or partially denied, record the reason for denial. If the PA was not issued within 60 days of the request, complete the explanation box.
 - Appeal Information: Review the appeals brochure with the participant, record the date the appeal rights were explained, whether or not the participant requests assistance with the appeal, and the date the appeal request was sent to DHH.
- When the reminder notice for renewal is sent to the provider, a new EPSDT Prior Authorization Tracking Log should be started for the next PA cycle. The date the reminder notice is sent is the date of referral for a new tracking log. The date the participant chose to renew the PA with the provider is the COP date on the renewal. A new Tracking Log should also be started when there are requests for changes to existing services or a change in the choice of provider.

The **EPSDT Prior Authorization Tracking Log** serves as an important tool for Support Coordinators for several reasons.

- It will help you assure the participant is receiving the services requested;
- It will serve as a reminder to contact the provider if you have not received a copy of the Request for Prior Authorization form;
- It will serve as a reminder to make required PAL referrals;
- It will allow you to know at a glance when, and if, services were/were not approved;

- It will serve as a reminder of when the notice should be sent to the provider to renew services;
- It will allow you to document information about the PA decision notice;
- It will allow you to document that you offered/provided appeal assistance to the participant and provided the **Appeals Brochure**.

Review the form and instructions completely before using them. If you have questions about this form, ask your trainer or your supervisor.

The **EPSDT LSCIS Service Log** should be used to provide a narrative of activities related to the request for EPSDT services including each activity and contact with the provider, the participant, and the PAL. A separate service log should be used when possible to document activity related to a specific requested prior authorized service as identified on the EPSDT Prior Authorization Tracking Log.

The EPSDT LSCIS Service Log should be used for documenting all contacts with the participant, provider and PAL. This log should also be used to document the receipt or the approval, denial or reduction of services, the monthly contact with the participant/family regarding the status of implementation of services, and all support coordination activities.

- **Participant contacts:** The support coordinator must make contact with the participant at **least monthly and as needed** until each service included on the CPOC is fully implemented, including receipt of all prior authorized services. **Monthly contacts** are to assure implementation of the services requested on the CPOC. Additional, **as needed contacts** may be required to determine a service start date after the PA is received, assist with identified needs and problems with providers, to follow up on obtaining information to complete a PA request, or to offer assistance with an appeal. (Refer to Appendix T-1 for the contact flow sheet.)
- **Provider contacts:** The support coordinator must contact the provider as needed, but at a minimum:
 - **Within 15 calendar days from referral** to make sure they are working on the request and to see if assistance is needed in obtaining documentation to support the request;
 - If the support coordinator does not receive a copy of the Request for Prior Authorization form **within 35 calendar days of referral**; contact should be made with the provider again at that time to ensure the request has been sent to the Prior Authorization Unit;

- If a notice of decision has not been received **10 days after the date the provider said they submitted the request** or a call from the PAL has been received;
 - **45 - 60 days prior to the date the services are scheduled to expire**, you should remind the provider to renew the prior authorization request. The provider must submit the renewal request at least 25 days prior to expiration to assure uninterrupted services. (Refer to Appendix T-2 for the contact flow sheet.)
- **PAL contacts:** All contacts with the PAL must be documented. (Refer to Appendix T-3 for the contact flow sheet)

The Support Coordinator must document on the *EPSDT Prior Authorization Tracking Log* that a referral was made to the provider. If after 35 calendar days the provider has not submitted the PA packet, the Support Coordinator should complete the **Referral to Medicaid PAL** form. Refer to *Appendix S* for a copy of this form. (The role of the Prior Authorization Liaison or PAL will be discussed in more detail later in this document.) Other reasons this form can be used are:

- When you have not received a decision within 60 days of the CPOC completion date;
- To alert the PAL of situations where the participant has chosen a new provider;
- To alert the PAL of situations where the participant was placed on a wait list for rehabilitative therapies;
- To alert the PAL that a renewal approval has not been received and the previous PA has expired; or
- To alert the PAL that a provider is not providing services at the time the participant requested and/or the amount of services prior authorized and the problem cannot be resolved

If a decision has not been received for any prior authorized Medicaid service 60 days following the selection of the service provider or renewal request, the participant's name and the type of service will be included on the **EPSDT Quarterly Report**.

Quarterly Face to Face Visit

The support coordinator must complete a face-to-face visit with the participant and parent/legal guardian each quarter in order to identify:

- Service needs and status through review of the CPOC
- Additional services requested

- Scheduling issues (update the Typical Weekly Schedule)
- Completion of the EPSDT CPOC Quarterly Review/ Checklist and Progress Summary located in LSCIS.

Each quarter the Support Coordinator must complete the **EPSDT CPOC Quarterly Review/ Checklist and Progress Summary in LSCIS**. The CPOC Quarterly Review form is participant specific and can be printed from LSCIS prior to the visit. A new Quarterly Review form can be obtained by entering an interim CPOC. This form is a reminder to the Support Coordinator about each service the person requested and provides assurance the services are being delivered for the correct amount of time and on the agreed upon days. More importantly, the **EPSDT CPOC Quarterly Review/Checklist and Progress Summary** provides a forum for discussion with the participant regarding their satisfaction with the services they are receiving. If any complaints are detected as a result of the **EPSDT CPOC Quarterly Review/Checklist and Progress Summary**, the participant should be given the **Participant Complaint** form (*Appendix M*) to complete and return to Health Standards. If the Support Coordinator detects the participant has any dissatisfaction with a service provider, it is the Support Coordinator's responsibility to assist the participant in resolving any problem and let the participant know of his/her right to change providers.

EPSDT Quarterly Report

The **EPSDT Quarterly Report** will be completed for each support coordination agency from information entered into LSCIS. Each agency must have all of the required information entered into LSCIS at the end of each quarter so that the report can be generated. It is the responsibility of the Agency to identify participants with a PA not issued within 60 days of the participant's request. As part of that identification, the Agency must review all documentation (CPOC, PA Tracking Log, Service Logs, etc) prior to end of each Quarter. Each Agency must sign and date the Quarterly Report and Record Review (Appendix W-1) and fax it to Ellen Bachman at SRI by the 5th day of the month following the end of each quarter.

- The report will include the names of the participants and the services for the following:
 - Participants with PAs not issued within 60 days
 - Participants with service gaps in the authorization period
 - Participants who submitted requests for appeals within the quarter
- The **Record Review for the Quarterly Report** is to be completed for each participant/service listed on the LSCIS Quarterly Report as not having a PA issued within 60 days or a Gap in Authorization Period. The EPSDT

Specialist, if they are not the Support Coordinator involved, is to complete the form. If the Support Coordinator involved in these cases is the EPSDT Specialist, the onsite manager and supervisor are to complete the form.

- BHSF/SRI and the DHH attorney will review the information to assure that the participants are receiving the services they need and the assistance they need to access the services. BHSF/SRI will request supporting documentation and information from the support coordination agencies as needed.

PRIOR AUTHORIZATION LIAISON

The Prior Authorization Liaison (PAL) was established to assure that requests for prior authorization are not denied simply because of a lack of documentation. The prior authorization unit, which is at Molina, should not deny a request that has a technical error such as overlapping dates of services, missing or incorrect diagnosis codes, incorrect procedure codes, or having a prescription that is not signed by the doctor. These requests for prior authorization are given to the PAL.

The PAL contacts the provider, Support Coordinator and participant when attempting to gather the correct information for resubmission to Molina so a final decision regarding approval or denial of service can be made.

The first of these contacts may be by phone or fax. If the problem is not resolved in a few days, the PAL will send a Notice of Insufficient Documentation to the provider, participant, and Support Coordinator. This notice advises of the specific documentation needed and the type of provider that can supply it. The participant has 30 days to either supply the needed documentation, or notify the PAL with the appointment date that has been made with the health professional to obtain it. The Support Coordinator should assist the participant in this process.

The provider submitting the request is instrumental in gathering the required information when contacted by the PAL. However, the Support Coordinator should work very closely with the provider and offer any assistance possible to assure that Molina receives all necessary information to make the decision that is in the participant's best interest.

The PAL can be reached at 1-800-807-1320 or 225-342-6253.

EMERGENCY PRIOR AUTHORIZATION REQUESTS

Louisiana Medicaid has provisions and procedures in place for emergency authorization requests. *A request is considered an emergency if a delay of 25 days in obtaining the medical equipment or supplies would jeopardize the health of the recipient.*

The items listed below are examples of medical equipment and supplies considered for emergency approval. However, other equipment will be considered on a case by case basis through the Prior Authorization Unit (PAU).

- Apnea monitors
- Breathing equipment
- Enteral therapy
- Parenteral therapy (must be provided by a pharmacy)
- Suction pumps
- Wheelchair rentals for post-operative needs and items needed for hospital discharge

To submit an emergency request for PA, the provider may call the Prior Authorization Unit (PAU) at 1-800-488-6334. NOTE: Emergency requests cannot be submitted via e-PA.

In the event of an **emergency medical need where a delay of twenty-five (25) days would jeopardize the health of the recipient**, a request for prior approval shall be permitted orally or by telephone and the item shall be supplied upon oral approval. All emergency requests shall be approved or denied generally within twenty-four (24) hours of the request, but in no case later than the working day following the request.

The decision will be made by the PAU within two working days of the date the completed request is received, and the PAU will contact the provider by telephone. The PAU will follow-up with written confirmation of the decision.

APPEALS

If services are totally or partially denied, the participant/family may appeal the decision by sending a written request for a fair hearing to the Division of Administrative Law (“DAL”), Health and Hospitals Section. The participant may

appeal the denial of part of the requested services, and still receive the amount that was approved. The participant should be assured that the fact that he or she files an appeal will not result in losing the services that were approved. The support coordinator must inform the participant of his/her Appeal rights, provide the participant with an Appeals Brochure, and offer to assist the participant with the appeal process/fair hearing if the participant decides to request an appeal. A copy of the Appeals Brochure can be found as *Appendix L* and is also located on the internet at <http://new.dhh.louisiana.gov/index.cfm/page/323>. The Appeals Brochure contains the procedures for filing an appeal request. The following is a more detailed description of the appeal process.

Deadlines

Appeals must be filed within 30 days of the participant's receipt of the denial notice or the agency will not consider them. Because of this deadline, you should discuss denial notices and partial denial notices with the participant as soon as they are received. Appeals are filed by sending a letter to the agency at the address indicated on any notice being appealed.

Continued services while awaiting a decision

For services to be continued pending the outcome of the appeal, a participant must file an appeal on or before the effective date of the action. However, if the 30-day deadline for filing an appeal lapses before the effective date of the action, services are continued when the appeal is filed within the 30 day period. For services to be continued, all of the following must be true:

- The service is one the participant had been receiving.
- A request for renewal of the service is denied (or fewer services are approved than were in place before).

Reconsideration

An alternative to requesting a fair hearing is for the provider that submitted the request for services to submit for “reconsideration” of a denial or partial denial.

The request for reconsideration has to be based on some *new documentation* that the provider submits to Medicaid with the request.

Requests for reconsideration are especially appropriate when a denial or partial denial is based on Medicaid not having enough documentation showing the necessity for a service. (This includes instances where Medicaid sent a letter requesting more documentation and no one responded to the letter within 30 days.

Any time such a notice is sent, if further information is not provided, the request for prior approval *will* be denied.)

To request a Reconsideration (Recon), providers should submit the following:

- A copy of the denial notice with the word “RECON” written across the top of the notice and the reason for requesting the reconsideration written at the bottom of the letter.
- All of the original documentation attached as well as any additional information or documentation which supports medical necessity.

Molina physician consultant(s) will review the reconsideration request for medical necessity. When a decision is made on the reconsideration request, a new appealable notice is issued.

Representation

It can be helpful to have an attorney experienced in these types of hearings to represent the participant regarding his/her appeal. Because the attorney may need to collect medical documents or may want to negotiate ahead of time with the agency, it is important to seek an attorney as early as possible in the process. Free representation by an attorney may be available through the Advocacy Center (1-800-960-7705); the Advocacy Center also should have the phone number for a local Legal Services office that might be able to help.

What happens after a fair hearing is requested?

A letter is sent by the DAL notifying the recipient of the hearing date and providing information regarding the appeal process.

Preparing for the fair hearing

The provider that submitted the prior approval request to Medicaid should have all documentation that was reviewed by Medicaid regarding the request. Obtaining all documentation from that provider with a release will often be the fastest way to see what Medicaid has reviewed regarding the request. If you know any facts that help the case, but that were not documented to Medicaid, you have a start in determining what should be documented or demonstrated at the hearing.

The participant (or his or her representative) will receive a written notice of the date and time of the hearing. With or before this notice, Medicaid must also send a “Summary of Evidence” explaining its decision, and attach documents and policies the agency staff will use to back up the decision.

The participant and anyone helping the participant should start seeking any medical records or other documents that could help show their situation and need, as soon as possible, even before receiving the Summary of Evidence.

They should also be talking to people, especially health professionals, who can speak at the hearing or send documents on behalf of the participant.

The participant should contact DAL (1-225-342-0443) if they need to make arrangements to fax in exhibits or for witnesses to call in to the hearing.

The participant or their representative can review all documents Medicaid and Molina have in their possession. Arrangements should be made through staff at the DAL (1-225-342-0443), if documents need to be reviewed.

What happens at the fair hearing?

If it is a telephone hearing, the Administrative Law Judge will be listening by speaker phone. (Some other witnesses may also participate by phone, for instance, prior approval staff from Baton Rouge.) If the hearing is held in person, it is held in a hearing room at the DAL.

At the hearing the Administrative Law Judge tape records the hearing, and begins by swearing in all who have facts to offer to help him/her reach a decision, and will summarize what seems to be at issue. Then the agency presents its side, typically by reading into the record the Summary of Evidence that it mailed out. The agency occasionally will offer testimony from Molina staff or a doctor there explaining their rationale of the decision.

The Administrative Law Judge and participant (or their representative, if any) can ask questions of anyone who speaks for the agency at the hearing.

The participant and those with him will then be given a chance to explain what is wrong.

The participant may ask his/her doctor or a nurse to participate, if the medical necessity of a service is at issue. Doctors are often allowed to testify by phone if this is arranged in advance with the Administrative Law Judge.

The Administrative Law Judge and DHH staff can ask questions of anyone who speaks for the participant.

If arrangements were not made in advance, and a document you have not seen seems pertinent at the hearing, a request to see it can be made then, and the Administrative Law Judge should arrange access to it. Similarly, if at the hearing you realize something else should be submitted for the Administrative Law Judge to see, you can ask that he or she allow you additional time to mail it in.

Remember that just because someone says something, does not make it true. If you or the participant say something, it is best to back it up with other records, such as medical records, if possible.

The Administrative Law Judge does not usually announce his or her decision at the hearing. Occasionally, he or she may encourage the people at the hearing to work out a solution to a problem in advance of any decision. The Administrative Law Judge will mail his or her written decision, which will also summarize what was said at the hearing. These decisions can be appealed to court.

Regardless of whether or not the support coordinator is assisting with the appeal, the support coordinator must follow-up with the participant within 45 calendar days of the appeal request to see if he/she has received a response, and/or needs additional assistance. The support coordinator should follow-up again with the participant at least 90 days after the appeal was sent to check on the final decision regarding the appeal.

The Support Coordinator's File

If a participant's service is denied or partially denied, the Support Coordinator's files (EPSDT Prior Authorization Tracking Log and EPSDT LSCIS Service Log) should document:

- that the client was informed of appeal rights;
- that the client was given the appeals brochure;
- that the Support Coordinator offered to assist with an appeal;
- if assistance was given on the appeal:
 - the coordination of documents;
 - the submission of documents to the appeals office or if no documentation was available;
 - the date the appeal was filed;
- if the Support Coordinator did not assist with the appeal, the reason assistance was not provided; and
- if an appeal was filed, the response to the appeal and the final decision.

IDENTIFICATION OF CHRONIC NEEDS

As Molina reviews a request for prior authorization, the participant requesting the service may be deemed as eligible for Chronic Needs status. If this occurs, providers, participants and Support Coordinators will receive an approval letter with the following codes:

- 822 - Participant has been deemed as a “Chronic Needs case.” Write “Chronic Needs” on top of the next P.A. Request.
- 823 - Submit only P.A. form & doctor’s statement stating condition of patient has not changed.

Once a situation has been deemed a chronic needs case, the provider must submit future packets according to the instructions provided by the above codes. This determination only applies to the services approved where requested services remain at the approved level. Requests for an increase in these services will be treated as a traditional PA request and will be subject to full review.

If “Chronic Needs Case” is not written on the P.A. form, the packet will be reviewed as routine and must have new and complete supporting documentation. Unless these codes were included, do not assume Molina will know *anything* about the documentation submitted during earlier times that prior approval was requested for the same service.

Only DHH/Molina can determine whether or not a situation is a Chronic Needs Case.

ADJUSTMENTS TO THE CPOC

The CPOC should be updated to reflect the changes if prior approval of a requested service is denied (and not successfully challenged through a fair hearing request or other advocacy).

Changes to the CPOC should also be made when:

- Strategies are needed to deal with problems with services or providers. Resolving problems and overcoming barriers to participants’ receiving services is a key goal of the CPOC process.
- Significant new information is obtained from a medical appointment or assessment, including a psychological and behavioral services assessment.

The CPOC should be updated and goals and objectives should be added and/or revised according to the most recent information available. The Typical Weekly Schedule should also be revised to reflect the changes

A list with the names of participants that have a revised/updated CPOC must be submitted to SRI by the last day of the quarter for each quarter that significant changes are made to the CPOC. (Refer to Appendix W)

PART IV - Other

WHAT HAPPENS AT AGE 21?

When participants turn 21, they become ineligible for some of the services they had qualified for under Medicaid, including support coordination, EPSDT Personal Care Services, Extended Home Health Services, Disposable Incontinence Products, and other items or services that are not part of Medicaid offerings for adults.

It is very important, therefore, for the Support Coordinator to learn about the services that will be available at age 21, and to make arrangements to transition participants to receive all services they may need in order to continue to live in the most integrated setting that is appropriate for them.

The Support Coordinator should begin making arrangements for transition at least 6 months prior to the participant's 21st birthday.

Available services may include:

- OCDD services, including (in addition to those listed above) extended family living, supported independent living, and vocational and habilitative services.
- Behavioral Health Rehabilitation Services The provider agency may need to be changed if the current provider only services children.
- Long Term - Personal Care Services (LT-PCS) through Medicaid (1-877-456-1146 (TDD 1-855-296-0226)). A representative from Xerox will be contacting the participant a couple of months before the participant turns age 21 to assist him/her with the LT-PCS application process. All efforts will be made to utilize the existing medical information on file when determining the participant's eligibility for this service; however, the participant may be asked to have his/her doctor complete a medical assessment form. The support coordinator should inform the family to expect notification via phone or mail.

- OAAS Community Choices Waiver and Adult Day Health Care Waiver services Call 1-877-456-1146 (TDD 1-) 855-296-0226 to be placed on a waiting list.
- Louisiana Rehabilitation Services may provide assistance with services needed to pursue short or long-term employment goals.

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.

Refer to Appendix U for Transition/Closure procedures.

EPSDT SUPPORT COORDINATOR REQUIREMENTS

Training

All Support Coordinators must receive EPSDT training.

- New support coordinators and trainees must receive EPSDT training
 - during orientation (must be included as part of the required 16 hours of orientation training), and
 - prior to being assigned an EPSDT caseload
- All support coordinators and trainees must complete the EPSDT training each year (the agency's Designated Trainer and Supervisors will be responsible for training the staff)

All designated EPSDT Trainers and Support Coordinator Supervisors must receive EPSDT training.

- New designated Trainers and Supervisors must receive the EPSDT training
 - during orientation, and
 - prior to beginning supervision of EPSDT support coordinators. (The training may be provided to supervisors and designated trainers by BHSF/SRI or by a trained supervisor or designated trainer within the agency.)
 - All designated Trainers and Supervisors must complete EPSDT training each year. The training may be provided by BHSF/SRI or by a trained supervisor or designated trainer within the agency

The agency must submit documentation of the training to the EPSDT Program Manager. Documentation of annual training must be submitted one time each year, and documentation of training for new staff must be submitted by the last day of each quarter, if applicable for that quarter.

Caseloads

Support Coordinators should have caseloads of no more than 35 participants, and supervisors should supervise no more than 8 support coordinators. Additional job duties require a reduction in caseload size and supervisory ratio.

Participant Calls

Support Coordination agencies must maintain a toll-free, 24-hour telephone number and the ability to reach someone in an emergency, and must make sure that

participants know this information. Non-emergency calls must be returned within one (1) working day.

Participant Visits

Support coordinators must have a minimum monthly contact with participants and parent/legal guardian which could be a telephone contact. However, for each quarter there must be a face-to-face visit with participants and parents/legal guardians along with a review of the CPOC. Refer to Appendix T-1.

Participant Satisfaction Survey

Participants must be given a satisfaction survey asking if they are satisfied or dissatisfied with the type, quantity, and/or quality of services identified in the CPOC. The survey must include the SRI toll free number and mailing address.

LSCIS Reports

The On-Site Manager is responsible for assuring compliance with all program requirements and the EPSDT Specialist is to monitor that all EPSDT requirements are met. They shall check the LSCIS reports at least semiweekly. All deficiencies are to be addressed and resolved.