Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) – Targeted Population Support Coordination Training Handbook

Trainer Information

There are six major sections to this training that should flow sequentially.

Part 1 – Overview
Part 2 – Services Available to EPSDT Beneficiaries
Part 3 – Components of Support Coordination
Part 4 – Coordination of Services
Part 5 – EPSDT Support Coordination Requirements

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

There will be different Appendices discussed in each section. These are mandatory forms that should help the Support Coordinator to meet the needs of the EPSDT beneficiaries. 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 Kim Willems at Statistical Resources, Inc. via e-mail at ksalling@statres.com.

As each form is discussed, a projection of the form should be used to enhance understanding and discussion. If the training consists of a small group, copies of the forms being discussed should be readily available to review. 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 beneficiary. The forms were not developed simply to create work for Support Coordinators, but in response to needs identified within service provision.

In addition to Part 1 - 5 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 *Appendix E - Medicaid Services Chart* which should be reviewed as part of the training, as well as about this Handbook.

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Part 1 – Overview

Louisiana Medicaid

Medicaid provides medical benefits to low-income individuals and families. Although the federal government establishes the general rules for Medicaid, specific requirements are established by each state. The Louisiana Medicaid Program operates within the Louisiana Department of Health (LDH). The Louisiana Medicaid Program is designed to provide certain health benefits for those categorically needy and medically needy beneficiaries who are in need of medical services.

Fee-For-Service Medicaid (FFS)

This is traditional Medicaid for people who are not enrolled in a Managed Care Organization (MCO) for most of their health services. Most Chisholm class members have the option of staying in Fee-for-Service Medicaid (FFS) for their physical health services (medical care). FFS Medicaid beneficiaries will still receive their specialized behavioral health services (SBHS), non-emergency medical transportation (NEMT) and non-emergency ambulance transportation (NEAT) through their Managed Care Organization. Chisholm class members are allowed to participate in the Medicaid Managed Care Program for all of their Medicaid covered services; this is called “opt in”.

Medicaid Managed Care (MCO)

Healthy Louisiana is the way most of Louisiana’s Medicaid beneficiaries receive their health care services. The Medicaid managed care program in Louisiana is responsible for providing high-quality, innovative, and cost-effective healthcare to Medicaid members. The Louisiana Department of Health (LDH) contracts with six managed care organizations (MCOs), two prepaid ambulatory health plans (PAHPs),and one prepaid inpatient health plan (PIHP), collectively called managed care entities (MCEs).

Table 1 – Louisiana Medicaid MCEs

Louisiana’s Medicaid MCEs	Plan Type	Services Provided	Service Region	Acronym or Abbreviated Reference
Aetna Better Health of Louisiana	MCO	Behavioral and physical health	Statewide	ABH
AmeriHealth Caritas Louisiana	MCO	Behavioral and physical health	Statewide	ACLA
Healthy Blue	MCO	Behavioral and physical health	Statewide	HBL
Humana Healthy Horizons	MCO	Behavioral and physical health	Statewide	HUM
Louisiana Healthcare Connections	MCO	Behavioral and physical health	Statewide	LHCC
UnitedHealthcare Community Plan	MCO	Behavioral and physical health	Statewide	UHC
DentaQuest	PAHP	Dental	Statewide	DQ
Managed Care North America	PAHP	Dental	Statewide	MCNA

Magellan of Louisiana	PIHP	Behavioral health services for children and youth with significant behavioral health challenges	Statewide	Magellan

Managed Care Organizations (MCOs)
Managed Care Organizations (MCOs) pay for Medicaid benefits and services included in the Louisiana Medicaid State plan, State statues and administrative rules, and Medicaid policy and procedure manual. All MCOs offer the same core medical, behavioral health and substance use treatment services. The plans also offer extra value-added Medicaid benefits and services that could differ.

Again, Louisiana Department of Health (LDH) contracts with six MCOs. They are:

- Aetna Better Health of Louisiana
- AmeriHealth Caritas Louisiana
- Healthy Blue
- Humana Healthy Horizons
- Louisiana Healthcare Connections
- UnitedHealthcare Community Plan

MCOs have networks or a collective group of providers who have entered into Provider Agreements with the MCO including but, not limited to physical, behavioral, pharmacy and Ancillary Service providers. Some of the MCOs have a different network of doctors, hospitals, and other providers than traditional Fee-For-Service (FFS) Medicaid.

The MCO shall maintain a case management program through a process which provides appropriate and medically-related services, social services, and basic and specialized behavioral health services that are identified, planned and obtained and monitored for identified members who are in the special healthcare needs population and identified members who have high risk or have unique, chronic, or complex needs. The case management process shall integrate the member's and case manager's review of the member's strengths and needs resulting in a mutually agreed upon appropriate plan that meets the medical, functional, social and behavioral health needs of the member.

Choosing a Managed Care Organization
The Enrollment Broker can provide Choice Counseling which includes answering beneficiary's questions and providing information in an unbiased manner on available MCOs and advising Potential Enrollees and Enrollees on what factors to consider when choosing among them. Beneficiaries may contact the Enrollment Broker at 1-855-229-6848.

Things beneficiaries should consider before selecting a Managed Care Organization:

1. **Access to your current doctors and other healthcare providers.** Not all doctors and healthcare providers are enrolled in all the managed care plans. If you want to keep your current providers, it's important to confirm that they are all enrolled in the plan you choose.

2. **Access to prescription medications.** It's important to check that you can access needed medications on the new plan.

A common preferred drug list can be found at: https://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

It is important to check any medications not listed on the common preferred drug list with each of the plans to see if it is covered. Each plan covers different drugs and has different prior authorization and step therapy procedures.

Aetna Better Health of Louisiana • http://www.aetnabetterhealth.com/louisiana/providers/pharmacy
AmeriHealth Caritas Louisiana • http://www.amerihealthcaritasla.com/pharmacy/index.aspx
Healthy Blue • https://www.myhealthybluela.com/la/benefits/pharmacy-benefits.html
Humana Healthy Horizons • https://www.humana.com/medicaid/louisiana/coverage/pharmacy
Louisiana Healthcare Connections •
https://www.louisianahealthconnect.com/providers/pharmacy/preferred-drug-list-info.html
UnitedHealthcare Community Plan •
https://www.uhccommunityplan.com/la/medicaid/healthylouisiana/lookup-tools.html#view-drug
Medicaid Fee-For-Service • https://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

3. **Access to services.** Comparison charts for both the health and dental plans, detailing the extra services each plan provides, can be found at myplan.healthy.la.gov and *Appendix F – MCO Comparison Chart*. The Managed Care Organization has to provide the same amount, duration, and scope as traditional Medicaid. All health and dental plans offer the same basic benefits and health and dental management programs.

Services excluded from Managed Care:

- Coordinated System of Care (CSoC) – contact Magellan at 1-800-424-4489
- Medical Dental with the exception of the EPSDT varnishes provided in a primary care setting – contact MCNA or DentaQuest
- Long Term Nursing facility services – Contact Louisiana Options in Long Term Care at 1-877-456-1146
- Home & Community-Based Waiver Services (except 1915(b) mandatory enrollment waiver, 1915(c) SED waivers, and 1915(i)SPA services) – contact OCDD at 1-866-783-5553
- Targeted Case Management Services
- IEP services provided by a school district

Medicaid Eligibility and Enrollment

Determining eligibility for Medicaid is the responsibility of the Bureau of Health Services Financing (BHSF).

The Louisiana Medicaid managed care program is comprised of mandatory and voluntary opt-in populations. LDH is responsible for determining eligibility for enrollment in the MCO. We broadly refer to enrollees with P-linkages and B-linkages.

P-linkage: Refers to enrollment in an MCO for physical health, behavioral health, and transportation services.

B-linkage: Refers to enrollment in an MCO for specialized behavioral health services (SBHS) and non-emergency medical transportation (NEMT), including non-emergency ambulance transportation (NEAT).

Some of the mandatory and voluntary opt-in populations are described below. For more information on Medicaid eligibility and enrollment contact Medicaid hotline toll free at 1.888.342.6207. Agents are accepting calls Monday through Friday from 8 a.m. to 4:30 p.m.

1. Mandatory MCO Populations for All MCO Covered Services (P-Linkage)

Beneficiaries in the Mandatory MCO Populations will receive all of their Medicaid Covered Services through the MCO including physical health services, specialized behavioral health services (SBHS), non-emergency medical transportation (NEMT), and non-emergency ambulance transportation (NEAT) through their MCO.

The following Louisiana Medicaid Populations are part of the Mandatory MCO Populations for All MCO Covered Services :

Act 421 Children's Medicaid Option – Louisiana implemented Act 421 enacted by the Louisiana Legislature effective January, 1, 2022. The program is titled the Act 421 Children's Medicaid Option ("Act 421-CMO"). The Act 421-CMO extends Medicaid eligibility to children covered by § 1902(e)(3) of the Social Security Act, i.e., children age 18 and younger who meet institutional level of care (Nursing Facility, Hospital, Intermediate Care Facility for Individuals with Intellectual/Developmental Disabilities) and are in families with income that is too high to qualify for Medicaid, who could otherwise become Medicaid eligible if receiving extended care in an institutional setting. With the exception of children with dual coverage in Medicare and Medicaid, enrollment in managed care is required of all participants in order to control costs and enhance budget predictability.

2. Voluntary MCO Populations (B-Linkage, or P-Linkage if they opt-in)

Beneficiaries in the Voluntary MCO Populations will receive their specialized behavioral health services (SBHS), non-emergency medical transportation (NEMT) and non-emergency ambulance transportation (NEAT) through their MCO (B-Linkage).

If the Beneficiary voluntarily enrolls in the Managed Care Program for all other Medicaid Covered Services, the MCO will cover all of their Medicaid Covered Services (P-Linkage).

The following Louisiana Medicaid Populations are part of the Voluntary MCO Population:

Chisholm Class Members – Beneficiaries under the age of 21, eligible for the Louisiana Medicaid Program, and who are listed on the Developmental Disabilities Request for Services Registry are Chisholm Class Members.

Voluntary MCO Populations may elect to receive all Medicaid Covered Services through the Managed Care Program at any time, effective the earliest possible month that the administrative action can be taken.

Voluntary MCO Populations may return to FFS for all Medicaid Covered Services other than SBHS and NEMT/NEAT services at any time, effective the earliest possible month that the administrative action can be taken.

Voluntary MCO Populations who have previously returned to FFS for all Medicaid Covered Services other than SBHS and NEMT/NEAT services may elect to return to the Managed Care Program for all Medicaid Covered Services at any time, effective the earliest possible month that the administrative action can be taken.

When enrolling and disenrolling from the Managed Care Program, beneficiaries should keep in mind that they may be required to resubmit requests or prescriptions. To enroll or disenroll from the Health Plan, members can call 1-855-229-6848. For more information on opting-in and disenrolling from the Health Plan refer to *Appendix S – Voluntary Opt-In to Managed Care for Chisholm Class Members*. It's very important that beneficiaries and their families look closely at the potential advantages and disadvantages of enrolling in a Health Plan for their physical health services before making this decision. Benefits may include access to a different set of medical providers. In addition, some plans offer incentives for successfully meeting certain outcomes. To learn more about the specific benefits that each plan offers, visit: https://www.myplan.healthy.la.gov/choose/compare-plans

3. Mandatory MCO Populations for All MCO Covered Services Except SBHS and CSoC Services (CSoC)

Coordinated System of Care (CSoC) – Children who are deemed clinically and functionally eligible and participate in the CSoC program will receive all Medicaid covered SBHS services - except Psychiatric Residential Treatment Facility (PRTF), Therapeutic Group Home (TGH) and substance use residential services which are covered by their MCO - through the CSoC Contractor, Magellan of Louisiana. All Medicaid covered physical health and transportation services are covered through their MCO.

Medicaid Eligibility Verification

Medicaid Eligibility Verification System (MEVS) / Recipient Eligibility Verification System (REVS) - MEVS is an electronic system used to verify Medicaid beneficiary eligibility and third-party liability. REVS is a telephonic system used to verify Medicaid beneficiary eligibility accessible through toll-free telephone number 1-800-776-6323.

Providers should establish an online account with Gainwell at LaMedicaid.com. The steps to establishing an account are located here. Once you have established an account, you will be able to access MEVS which is the Medicaid Eligibility Verification system. The instructions for accessing MEVS or eMEVS are located here.

Support coordinators must verify the EPSDT beneficiary's Medicaid status each month by the 5th of the month. If the beneficiary becomes ineligible for Medicaid, they are no longer eligible for Support Coordination and closure procedures shall be followed. Refer to the Closure Section of this Handbook. If the EPSDT beneficiary's Medicaid status has changed, the SC must notify each provider of the change by the 5th of the month.

The Support Coordinator must update the Medicaid Identification number and the Physical and Behavioral MCO Agency in LSCIS as needed. SCs must compare the child's Medicaid number from the Medicaid Eligibility Verification System and the number entered in LSCIS. Discrepancies should be reviewed and corrected. Failure to do so results in denied Medicaid claims for EPSDT SC billing due to failure of authorizations to load in the Medicaid Management Information System (MMIS). If Statistical Resources, Inc. needs to correct the Medicaid number on the EPSDT SC Prior Authorization, submit a copy of the MEVS to Kim Willems at Statistical Resources, Inc. via e-mail at ksalling@statres.com. SCs must compare the child's physical and behavioral health coverage. Discrepancies should be reviewed and corrected. **If the EPSDT beneficiary's physical and/or behavioral coverage has changed, the SC must notify each provider of the change by the 5th of the month.** If the provider does not accept the new coverage, the SC must notify the family and offer a freedom of choice list of providers in the new network.

On eMEVS, the Health Plan listed under "Managed Care Coordinator" for "Medical Care" will go in the Physical MCO Agency field. If you do not see this section then they have Medicaid Fee-For-Service for their physical health services and you must leave the Physical MCO Agency blank. The Health Plan listed under "Managed Care Coordinator" for "Specialized Behavioral Health Care" will go in the Behavioral MCO Agency field. **The Physical MCO Agency field controls a lot of the Tracking Required Actions and the fields you see on tracking logs for each beneficiary so it is very important that this is up to date and accurate.**

The user manual for the Electronic Medicaid Eligibility Verification System can be found here: https://www.lamedicaid.com/provweb1/forms/UserGuides/MEVSHelp.pdf. Refer to section 4.2.2 Health Benefit Plan Coverage for different cases and how they are depicted in the eMEVS response.

Prior Authorization

Once the Support Coordinator determines who covers the beneficiary's physical health, behavioral health and transportation services they can determine who will administer/cover specific Medicaid services for the beneficiary.

Some Medicaid services such as Personal Care Services and Extended Home Health require prior authorization before they can be provided. Prior Authorization is a requirement that a provider obtains approval from the beneficiary's health insurance *before* providing a particular service. Prior Authorization is also known as pre-approval. Prior Authorization decisions are reached based on the medical necessity of the request.

For beneficiaries in Fee-For-Service (FFS) Medicaid for their physical health services (B-Linkage), prior authorization requests for physical health services are acted on by the Prior Authorization Unit of

Gainwell Technologies, a company that contracts with the Louisiana Department of Health to perform this function.

For beneficiaries in Managed Care Organizations (MCOs) for their physical health services (P-Linkage or CSoC), prior authorization requests for physical health services are acted on by the individual MCO.

The beneficiary's Managed Care Organization (B-Linkage or P-Linkage) must prior authorize some specialized behavioral health services including, but not limited to, Community Psychiatric Support and Treatment (CPST) - including, but not limited to, Multi-Systemic Therapy (MST), Functional Family Therapy (FFT), Homebuilders, and Assertive Community Treatment (ACT) - Psychosocial Rehabilitation (PSR), Therapeutic Group Homes (TGH), Psychiatric Residential Treatment Facilities (PRTF), and Residential Substance Use Disorder services.

For children and youth enrolled in the Coordinated System of Care (CSoC) their behavioral health services are authorized by Magellan of Louisiana, the contractor for CSoC, except Therapeutic Group Homes (TGH), Psychiatric Residential Treatment Facilities (PRTF) and Residential Substance Use Disorder services. The Support coordinator is not required to do prior authorization tracking for services authorized by Magellan of Louisiana.

The beneficiary's Managed Care Organization must prior authorize Applied Behavioral Analysis (ABA).

The beneficiary's Managed Care Organization will cover medical transportation services including NEMT/NEAT. No prior authorization is required.

Table 2 – Coverage Information by Enrollment

Service Type	Enrollment	What Entity Delivers the Service?	Does it require Prior Authorization Tracking?	Possible valid reasons for not tracking?
ABA	All	MCO	Yes	4
Medical Transportation (NEMT/NEAT)	All	MCO	No	-
CSoC	All	Magellan	No	-
Specialized behavioral health services (SBHS)	P-linkage, B-linkage	MCO	Some SBHS services	1
	CSoC Children	Magellan	No	6
School-Based Health Services	All	Local Education Agencies (LEA) e.g., School Boards	No	-
EPSDT Screening Exams and Checkups	P-linkage, CSoC Children	MCO	No	-
	B-linkage	FFS Medicaid	No	-

EPSDT-PCS	P-linkage, CSoC Children	MCO	Yes	-
	B-linkage	FFS Medicaid	Yes	-
Home Health Services	P-linkage, CSoC Children	MCO	Some HH services	1
	B-linkage	FFS Medicaid	Some HH services	1
Pediatric Day Healthcare	P-linkage, CSoC Children	MCO	Yes	-
	B-linkage	FFS Medicaid	Yes	-
Therapy Services (ST, OT, PT, Audiological Services)	P-linkage, CSoC Children	MCO	Varies per MCO	1, 4, 5
	B-linkage	FFS Medicaid	Yes	4, 5
Disposable Incontinence Products	P-linkage, CSoC Children	MCO	Varies per MCO	1, 3
	B-linkage	FFS Medicaid	Yes	3
Medical Equipment or Supplies	P-linkage, CSoC Children	MCO	Varies per MCO	1, 2, 3
	B-linkage	FFS Medicaid	Some ME&S services	1, 2, 3

Enrollment Types:
P-linkage = Managed care for physical and behavioral health
B-linkage = Managed care for behavioral health only
CSoC Children = Managed care for physical health only

Possible valid reasons for not tracking:
1 A PA is not needed to receive the Medicaid service (e.g., MCO covers via reimbursement and not prior authorization).
2 The PA is issued monthly. SC must enter monthly PA into tracking log before untracking.
3 The EHH nurse is the person ordering and tracking medical supplies.
4 The beneficiary has been placed on a waitlist. SC must complete waitlist placement steps.
5 The beneficiary is receiving the therapy service without a PA (Refer to *Appendix BB-4 – Modification of Rehab Services PA Tracking/PAL Referral*). SC must restart tracking when PA is received.
6 The beneficiary is in CSoC and the service is being authorized by Magellan.

EPSDT – Targeted Population Support Coordination

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides a comprehensive array of preventive, diagnostic, and treatment services for children under age 21 who are enrolled in Medicaid. EPSDT is the same as Medicaid for children under age 21. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health and specialty services.

Early: Accessing and identifying problems early
Periodic: checking children's health at periodic, age-appropriate intervals
Screening: providing physical, mental, developmental, dental, hearing, vision and other screening tests to detect potential problems
Diagnostic: performing diagnostic tests to follow up when a risk is identified, and
Treatment: control, correct or reduce health problems found.

A beneficiary is an individual who has been determined eligible, pursuant to Federal and State law, to receive medical care, goods, or services under the Louisiana Medicaid Program. Beneficiaries under 21 years of age are entitled to receive all medically necessary health care, screening, diagnostic services, treatment, and other measures to correct or improve physical or mental conditions (Section 1905(r) of the Social Security Act). Beneficiaries under age 21 are entitled to EPSDT services, whether they are enrolled in a managed care plan or receive services in a fee-for-service (FFS) delivery system.

Support Coordination is a service provided by Louisiana Medicaid through performance agreements with agencies to serve Medicaid beneficiaries in one of several Medicaid programs, such as EPSDT. EPSDT Support Coordination was established as a result of a lawsuit, Chisholm vs. LDH, to provide support coordination to those individuals who have disabilities and/or chronic health conditions. Support Coordinators help class members access all needed services before they get a waiver. Support Coordinators must identify additional services that might help class members, even before the family requests those services.

Chisholm class members (CCM) are beneficiaries in the State of Louisiana who are under the age of 21 and are on the Developmental Disabilities Request for Services Registry (DD RFSR). Note: children are not placed on the DD RFSR until age 3; they may have a "protected Registry date" prior to age 3 and a Statement of Approval (SOA) for the developmental disabilities services system, but until they are formally found eligible for the DD services system and placed on the RFSR, they are not Chisholm class members.

To be placed on the DD RFSR, beneficiaries must contact their local governing entity (LGE) and complete the System Entry process. Refer to *Appendix J-1 - Local Governing Entity (LGE) Directory* or go to https://ldh.la.gov/page/locate-services.

EPSDT Support Coordination Agencies provide case management for the targeted population group in accordance with applicable Federal and State laws, regulations, rules, policies, procedures, and manuals, and the State Plan. The EPSDT SCA will comply with provider enrollment requirements; Medicaid Support Coordination Service Provider Manual, Support Coordination Standards of Participation; Performance Agreement for Medicaid EPSDT Support Coordination Agencies; EPSDT Support Coordination Training Handbook and Appendices; and the EPSDT Support Coordination Training Module.

Goals of Support Coordination

The primary objective of support coordination is the attainment of the personal outcomes identified in the beneficiary's comprehensive plan of care. All support coordination agencies
shall be required to incorporate personal outcome measures in the development of comprehensive plans of care and to implement procedures for self-evaluation of the agency. Support coordination is defined as services provided to individuals to assist them in gaining
access to the full range of needed services including:

1. medical;
2. social;
3. educational; and
4. other support service.

Beneficiaries under the age of 21 with disabilities and/or chronic health conditions typically need more Medicaid services than their peers without disabilities or health concerns do. Parents of children and youths 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 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 and document their response.** If the child may need additional services, but it is not clear, suggest 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.

A Support Coordinator develops a full list of all the services a beneficiary needs and then helps them get and coordinate these necessary services. Parents often do not understand aspects of the Medicaid system. **Therefore, one of the primary responsibilities of the Support Coordinator is to follow through with requests for services until the Prior Authorization is either approved or denied based on medical necessity and when approved, make sure the services are provided as authorized.**

Part 2 – Services Available to EPSDT Beneficiaries

Children and youths receiving targeted EPSDT Support Coordination are eligible to receive all medically necessary **Medicaid services** that are available to people under the age of 21. Refer to *Appendix A - Special Medicaid Benefits for Children and Youth*. In addition, if they are placed on the DD RFSR, they may be eligible for services through the Louisiana **Developmental Disabilities services system**, administered by the Office for Citizens with Developmental Disabilities (OCDD) through the local governing entity (LGE). Services through the **Office of Behavioral Health** are available for children and youth with emotional disturbances. Further, children and youth may be able to receive services through the **school system** or through Early Childhood Education programs.

Medicaid Services

Through Medicaid, children under the age of 21 are entitled to receive all medically 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 beneficiaries ages 21 or older. Children under age 21 are entitled to receive all medically necessary equipment or items that Medicaid can cover. This includes many items that are not covered for adults. These services may be subject to any restrictions allowable under federal Medicaid law. Refer to *Appendix D - Services Available to Medicaid Eligible Children Under 21* for an expanded list of services available to Medicaid eligible children under the age of 21.

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

- EPSDT Support Coordination
- Psychological evaluations and therapy
- Psychiatric hospital care
- Medical, dental, vision and hearing screenings, both periodic and interperiodic

- Audiological services
- Speech and language evaluations and therapy
- Occupational therapy
- Physical therapy
- Personal Care Services
- Skilled Nursing (intermittent or part-time)
- Extended Skilled Nursing Services
- Pediatric Day Health Care
- Dental care
- Hearing aids and supplies needed for them
- Eyeglasses
- Medical Equipment, Appliances and Supplies (DME)
- Applied Behavioral Analysis
- Any other medically necessary health care, diagnostic services, treatment, and other measures which are covered by Medicaid, which includes a wide range of services not covered for recipients over the age of 21.

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

Medicaid-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 medically necessary services needed to help any other aspect of a child's life, as well.

For a listing of Medicaid services, refer to *Appendix E - Medicaid Services Chart.* Again, even if a service is not on the Medicaid services chart, it must still be covered if it is a service permitted by federal Medicaid law and is necessary to correct or ameliorate a physical or mental condition of a beneficiary who is under age 21.

Support Coordination Services – EPSDT Targeted Population

- EPSDT SC is accessed by calling Statistical Resource, Inc. (SRI) at 1.800.364.7828 or 225.767.0501.
- SRI will issue the EPSDT SC prior authorization to the Support Coordination Agency.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Support Coordination (SC) is available to all Medicaid beneficiaries under the age of 21 who are on the Developmental Disabilities Request for Services Registry (DD RFSR). It is also available for Medicaid beneficiaries under the age of 21 who are <u>not</u> on the DD RFSR if the service is determined medically necessary, with documentation from Medicaid to substantiate that the EPSDT beneficiary meets the definition of special needs. Refer to *Appendix H - EPSDT Support Coordination Fact Sheet.* Beneficiaries may elect to receive or discontinue EPSDT Support Coordination at any time. Discontinuing EPSDT Support Coordination does not affect a beneficiary's eligibility to receive Medicaid services or their placement on the DD RFSR. Beneficiaries

may request to resume EPSDT Support Coordination Services at any time by calling SRI at 1-800-364-7828 and requesting Support Coordination for EPSDT.

SRI will issue the prior authorization to the Support Coordination Agency (SCA) for EPSDT Support Coordination upon approval of the Comprehensive Plan of Care (CPOC). The CPOC does not control the services. This process only controls the payment to Support Coordination Agencies. **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.

Applied Behavioral Analysis-Based Therapy Services (ABA)

- ABA is accessed through a Medicaid enrolled ABA provider.
- ABA must be prior authorized by the beneficiary's MCO.

ABA therapy is a set of behavior treatments that work to increase useful or desired behaviors. ABA-based therapies teach skills through the use of behavioral observation and reinforcement or prompting to teach each step of targeted behavior. ABA therapy is used to increase language and communication skills, to improve attention, focus and social skills, and to reduce problem behaviors. ABA-based therapies are based on reliable evidence of their success in alleviating autism and are not experimental. ABA applies scientific principles about learning and behavior to reduce behaviors that may be harmful or interfere with learning.

ABA-based therapy services shall be rendered in accordance with the beneficiary's treatment plan. ABA services may include:

- Assessment, evaluation, and reevaluation.
- Treatment intervention plan with measurable objective goals.
- Functional communication training.
- Self-monitoring and adaptive living skills.
- Language, verbal, and cognitive skills.
- Peer play and social skills.
- Prevocational and vocational skills.
- Parent training, family education, and counseling.
- Care coordination.

ABA-based services are available to Medicaid beneficiaries under 21 years of age who:

1. Exhibit the presence of excesses and/or deficits of behaviors that significantly interfere with home or community activities (examples include, but are not limited to aggression, self-injury, elopement, etc.);
2. Are diagnosed by a qualified health care professional (QHCP) with a condition for which ABA-based therapy services are recognized as therapeutically appropriate, including autism spectrum disorder;
3. Have a comprehensive diagnostic evaluation (CDE) by a qualified health care professional; and

4. Have a prescription for ABA-based therapy services ordered by a qualified health care professional. (Note: If there is a recommendation in the CDE for ABA therapy, a separate prescription is not needed.)

Prior to requesting ABA services, the beneficiary must have documentation indicating medical necessity for the services through a comprehensive diagnostic evaluation (CDE) that has been performed by a qualified health care professional (QHCP).

The support coordinator should assist the beneficiary in contacting the MCO to ask that they arrange a CDE and should document this request in the service log. **MCOs are responsible for arranging CDEs that are requested.**
Again, all ABA services must be prior authorized by the beneficiary's MCO. If a member has primary coverage available for ABA services through another insurer, the MCO may bypass the prior authorization process and acknowledge the prior authorization granted by the primary insurer. Prior authorization (PA) is a two-fold process. An authorization is first requested for approval to perform a functional assessment and to develop a behavior treatment plan. A second authorization is needed for approval to provide the ABA-based derived therapy services.

All PA requests must be submitted to the beneficiary's MCO. See the MCO's website for details including forms and submission instructions.

If you are unable to locate a provider, refer to page 67 **Unable to Locate a Provider – MCO**. If the beneficiary is placed on a waitlist, refer to page 66 **Waitlist Placement**.

Medical Transportation

- Medical transportation is accessed through the beneficiary's MCO or the Fee-for-Service transportation broker.
- Prior authorization is not required for NEMT services which accommodate the beneficiary who uses an ambulatory or a wheelchair level of service. With the exception of urgent transportation requests and discharges from inpatient facilities, arrangements for NEMT services should be made at least 48 hours in advance. The 48-hour minimum does not include non-business days.
- Non-emergency ambulance transportation services require a prior approval from the medical provider which certifies medical necessity and provides a description of the medical condition which necessitates the ambulance services. Once the transportation service is requested by the beneficiary, the broker must obtain the Certification of Ambulate Transportation (CAT) form prior to assigning an ambulance provider to these services.

Non-Emergency Medical Transportation (NEMT): Non-emergency medical transportation (NEMT) provides an eligible beneficiary transportation to and/or from medical services covered by Medicaid, when no other means of transportation is available. Transportation to additional services may be approved depending on the beneficiary's health plan. Beneficiaries eligible for physical health services through Fee-for-Service Medicaid, both children and adults, are enrolled in a health plan for Medicaid transportation services.

NEMT services include transportation services provided by the Local Transit Authority (local buses) or by NEMT providers contracted with the health plan's transportation broker.

Medicaid beneficiaries eligible for NEMT services through a health plan should contact the following call centers to schedule transportation services. A request for transportation services should be made to the call center at least 48 hours prior to the date the transportation services are needed.

Table 3: Call Centers for NEMT services

Health Plan	Broker	Phone Number	TTY Phone Number
Aetna Better Health of Louisiana	MediTrans	877-917-4150	866-288-3133
AmeriHealth Caritas Louisiana	Verida	888-913-0364	866-428-7588
Healthy Blue	MediTrans	866-430-1101	800-846-5277
Humana Healthy Horizons	MediTrans	844-613-1638	800-618-4781
Louisiana Healthcare Connections	MTM	855-369-3723	855-369-3723 (TTY:711)
United Healthcare Community Plan	ModivCare	866-726-1472	844-488-9724

Children under 17 must be accompanied by an attendant. The only exception to this rule are for all females, regardless of age, seeking prenatal and/or postpartum care. The attendant must be a parent, legal guardian or responsible person designated by the parent/legal guardian; and be able to authorize medical treatment and care for the beneficiary. Attendants may not:

- Be under the age of 17; or
- Be a Medicaid provider or employee of a Medicaid provider that is providing services to the beneficiary being transported, except for employees of a mental health facility in the event a beneficiary has been identified as being a danger to themselves or others or at risk for elopement; or
- Be a transportation provider or an employee of a transportation provider.

If a child is to be transported, either as the beneficiary or an additional passenger, the parent or guardian of the child is responsible for providing an appropriate child passenger restraint system as required in all cars and detailed in La. R.S. 32:295.

Special arrangements: If special arrangements are required such as the need for a lift-capable vehicle, the support coordinator may contact the beneficiary's Managed Care Organization at the numbers shown in the above table. If the MCO is unable to assist, the beneficiary may contact the Louisiana Department of Health (LDH) Medicaid Transportation Division at 225-333-7473 or 225-342-9566 or may be reached via e-mail by sending a correspondence to MedicaidTransportation@la.gov.

Non-emergency Ambulance Transportation (NEAT): Non-emergency ambulance transportation (NEAT) provides an eligible Medicaid beneficiary transportation by ground or air ambulance to and/or from medical services covered by Medicaid when no other means of transportation is available and the beneficiary's condition is such that use of any other method of transportation is contraindicated or would make the beneficiary susceptible to injury. The nature of the trip is not an emergency, but the beneficiary requires the use of an ambulance. Transportation to additional services may be approved depending on the beneficiary's health plan.

Beneficiaries eligible for physical health services through Legacy Medicaid, both children and adults, are enrolled in a health plan for Medicaid transportation services.

All NEAT trips will require a completed, valid Certification of Ambulance Transportation (CAT). The beneficiary's treating physician, a registered nurse, a nurse practitioner, a physician assistant, or a clinical nurse specialist must certify on the Certification of Ambulance Transportation (CAT) that the transport is medically necessary and describe the medical condition, which necessitates ambulance services.

Medicaid beneficiaries eligible for NEAT services through a health plan should contact the following call centers to schedule transportation services. A request for transportation services should be made to the call center at least 48 hours prior to the date the transportation services are needed.

Table 4: Call Centers for NEAT services

Health Plan	Phone Number	Fax Number	E-mail Address
Aetna Better Health of Louisiana	877-917-4150	337-366-6760	Facility@Meditrans.com
AmeriHealth Caritas Louisiana	888-913-0364	225-612-6789	LACompliance@verida.com
Healthy Blue	844-349-4324	337-366-6760	Facility@Meditrans.com
Humana Healthy Horizons	844-613-1638	337-366-6760	Facility@Meditrans.com
Louisiana Healthcare Connections	866-595-8133	480-757-6082	ambulanceclaims@mtm-inc.net
United Healthcare Community Plan	866-886-4081	877-547-3349	TXLAExceptions@modivcare.com

Healthcare facilities arranging NEAT services for an eligible beneficiary may either:

- Schedule the NEAT services through the health plan's broker using the contact information in the above table; or
- Schedule the NEAT services by contacting an ambulance provider directly.

"Gas Reimbursement" program: Louisiana Medicaid allows family members or friends of an eligible beneficiary to act as a gas reimbursement transportation provider. The gas reimbursement provider will transport the beneficiary to and/or from Medicaid covered services and additional services approve by the beneficiary's assigned health plan. The program allows the individual participating as

the gas reimbursement transportation provider to be reimbursed by the health plan based on the total mileage of each trip.

In order to participate as a Gas Reimbursement provider, the individual must be 18 years of age or older and may not reside at the same address as the beneficiary. The beneficiary may not act as a gas reimbursement provider and transport themselves to appointments. If a beneficiary you are serving may benefit from this program, the support coordinator should obtain approval by contacting the transportation broker affiliated with the beneficiary's assigned health plan. The contact information may be found in the above Table 3: Call centers for NEMT services.

The following SPECALIZED BEHAVIORAL HEALTH SERVICES are available to all Medicaid eligible children and youth under the age of 21 who have a medical need:

Coordinated System of Care (CSoC) and Wraparound Facilitation

- CSoC services are accessed through Magellan of Louisiana. The parent/caregiver must participate in the referral.
- No PA tracking is required.

Magellan of Louisiana is the contractor for Louisiana's Coordinated System of Care. To make a referral for CSoC, call Magellan at 1-800-424-4489 or contact the child's/youth's health plan and they will connect you with Magellan.

The State of Louisiana has developed a Coordinated System of Care (CSoC) for Louisiana's children and youth with significant behavioral health challenges or co-occurring disorders that are in or at imminent risk of out of home placement. CSoC offers intensive individualized supports and services in the community in addition to Medicaid State Plan Specialized Behavioral Health services (SBHS) children and youth in need of mental health and/or substance use treatment who are deemed clinically and financially eligible. CSoC is an evidence-informed approach to family and youth-driven care that enables children to successfully live at home, stay in school and reduce involvement in the child welfare and juvenile justice systems.

CSoC might be right if the child:

- Is 5 - 20 years old,
- has a mental health or co-occurring disorder,
- has a history with child welfare, juvenile justice and/or trouble in school, and
- is in an out-of-home placement, or at risk for being placed out of home including:
    - Substance Use Disorder treatment facilities
    - Detention
    - Homeless (as identified by the Department of Education)
    - Intellectual or developmental disabilities facilities
    - Non-medical group home
    - Psychiatric hospitals
    - Psychiatric residential treatment facilities
    - Secure care facilities
    - Therapeutic foster care

- Therapeutic group home

To Make a Referral

Partners play a very important role in the success of CSoC. CSoC intends to ensure that efforts on behalf of children and families are integrated across systems. CSoC is a family driven process. Therefore, referrals should be made with parent's/guardian's knowledge, consent and participation.

You and the parent/guardian will need to be able to provide the following information for the referral:

- Demographic information
- As much clinical information as you have available
- Diagnosis, if known

You may contact Magellan of Louisiana directly to make a referral at 1-800-424-4489. You can also call the child's/youth's Healthy Louisiana Plan to make a referral for CSoC.

To make a referral, the following process must take place:

- Contact Magellan or the Healthy Louisiana plan with the parent/guardian present or on the phone.
- Magellan or the Healthy Louisiana Plan will ask initial risk questions.
  - If you called the Healthy Louisiana plan, they will transfer the call to Magellan if the child meets criteria
- Magellan will conduct a brief CANS assessment to establish preliminary eligibility.
- If, based on the CANS assessment, a child/youth is presumed eligible for CSoC, Magellan will refer the child or youth to a Wraparound Agency to ensure that a comprehensive assessment is completed, offer the child/youth and the family an opportunity to participate in CSoC and begin forming a child and family team.

CSoC Supports and Services

Children and families are eligible for all Medicaid covered services, in addition to the following:
There are four specialized services that are available to children and families enrolled in CSoC if they are needed. These services are in addition to other services the family may be receiving.

Wraparound Facilitation

Children enrolled in CSoC are assigned a worker called a **Wraparound Facilitator**. Wraparound facilitation is provided by wraparound agencies. The child and family will work with the Wraparound Facilitator (WAF) to develop a plan of care with a team of people. The Wraparound plan can include services and supports to meet their behavioral health needs as well as other needed services and supports that affect their wellbeing.

Parent Support and Training

This service connects families with people who are caregivers for children with similar challenges. Parent Support staff provide support to families and help families develop skills. Parent Support staff also provide information and education to families and help families connect with other supports in the community.

Youth Support and Training
Young people who have been involved in behavioral health services or other child-serving systems in the past provide support, mentoring, coaching and skill development to children and youth enrolled in CSoC. This service works with the child or youth at home and in community locations. This service helps the children and youth enrolled in CSoC to develop skills and abilities needed to overcome challenges.

Short Term Respite Care
Respite is designed to help meet the needs of the caregiver and the child. The respite provider cares for the youth or child in the child's home or a community setting to give the caregiver/guardian a break. Children or youth in CSoC can receive up to 300 hours of respite each year. This service helps to reduce stressful situations. Respite may be planned or provided on an emergency basis.

Independent Living and Skills Building
This service helps children or youth who need assistance moving into adulthood. Children or youth learn skills that help them in their home and community. Children or youth learn to be successful with work, housing, school and community life.

Parent Support and Training and Youth Support and Training services are provided by the **Family Support Organization (FSO)**. FSOs make sure families are involved and have a voice in their care. Families can call 1-800-424-4489 or the TTY number at 1-800-424-4416 for information about the Wraparound Agency and Family Support Organization in their region.

Specialized Behavioral Health Services

- SBHS services are administered under the authority of the Louisiana Department of Health (LDH) in collaboration with the Healthy Louisiana plans, as well as through the Coordinated System of Care (CSoC) program contractor, for members enrolled in CSoC.
- The beneficiary's Managed Care Organization must prior authorize some specialized behavioral health services including, but not limited to, Community Psychiatric Support and Treatment (CPST) – including, but not limited to, Multi-Systemic Therapy (MST), Functional Family Therapy (FFT), Homebuilders (HB), Assertive Community Treatment (ACT) –Psychosocial Rehab (PSR), Therapeutic Group Homes (TGH), and Psychiatric Residential Treatment Facilities (PRTF).
- For youth enrolled in the CSoC waiver program, SBHS services are managed by the CSoC Contractor, Magellan of Louisiana - except PRTF, TGH and residential SUD services which are covered by their MCO - and may be subject to prior authorization but, do not require PA tracking by the SC.

Medicaid beneficiaries under age 21 are eligible for a range of specialized behavioral health services based on the medical necessity for those services. Beneficiaries with mental health or substance use issues may receive services from psychiatrists, psychologists, medical psychologists, licensed counselors, licensed clinical social workers, advanced practice nurses (nurses who are especially skilled in mental health treatment) or licensed behavioral health agencies.

Specialized behavioral health services include the following:

- Licensed Practitioner Outpatient Therapy
    - Assessments, evaluations, and testing,
    - Individual, group and family therapy,
    - Parent-Child Interaction Therapy (PCIT)
    - Child Parent Psychotherapy (CPP)
    - Preschool PTSD Treatment (PPT) and Youth PTSD Treatment (YPT)
    - Triple P Positive Parenting Program (Triple P),
    - Trauma-Focused Cognitive Behavioral Therapy (TF-CBT),
    - Eye Movement Desensitization and Processing Therapy (EMDR)
    - Dialectical Behavior Therapy (DBT)
- Mental Health Rehabilitation Services
    - Community psychiatric support and treatment (CPST)*,
        - Multi-Systemic Therapy (MST) (age 0-20)*
        - Functional Family Therapy (FFT) and Functional Family Therapy-Child Welfare*
        - Homebuilders®*
        - Assertive Community Treatment*(ages 18-20),
    - Psychosocial Rehabilitation (PSR)*,
    - Crisis Intervention (CI),
- Mobile Crisis Response (MCR)
- Crisis Stabilization (CS);
- Community Brief Crisis Support (CBCS)*
- Therapeutic Group Homes (TGH)
- Psychiatric Residential Treatment Facilities (PRTF)**
- Inpatient Hospitalization (mental health and substance use treatment)
- Outpatient and Residential Substance Use Disorder Services
- Opioid Treatment Programs (OTP) (ages 18-20)
    - Medication-Assisted Treatment (MAT)

Licensed Practitioner Outpatient Therapy

Outpatient Therapy with Licensed Practitioners (e.g., medication management, individual, family, and group counseling) is outpatient counseling for mental health and substance use treatment.

Parent-child interaction therapy (PCIT) is an evidence-based behavior parent training treatment developed for young children with emotional and behavioral disorders that places emphasis on improving the quality of the parent-child relationship and changing parent child interaction patterns. Children and their caregivers are seen together in PCIT. Parents are taught and practice communication skills and behavior management with their children in a playroom while coached by therapists. The activities and coaching by a therapist enhance the relationship between parent and child and help parents implement non-coercive discipline strategies.

Child Parent Psychotherapy (CPP) is an intervention for children age 0-6 and their parents who have experienced at least one form of trauma including but not limited to maltreatment, sudden traumatic death of someone close, a serious accident, sexual abuse, or exposure to domestic violence. The primary goal of the treatment is to support and strengthen the relationship between a child and his or her parent (or caregiver) in order to repair the child's sense of safety, attachment, and appropriate affect to ultimately improve the child's cognitive, behavioral, and social functioning.

Preschool PTSD Treatment (PPT) and Youth PTSD Treatment (YPT) are cognitive behavioral therapy interventions for posttraumatic stress disorder (PTSD) and trauma-related symptoms. PPT and YPT are adapted for different age groups:

- Preschool PTSD Treatment (PPT) is used for children ages 3-6 with posttraumatic stress symptoms.
- Youth PTSD Treatment (YPT) is used for children and youth ages 7-18 with posttraumatic stress symptoms.

Triple P Positive Parenting Program is a parenting and family support system designed to prevent and treat behavioral and emotional problems in children. It aims to prevent problems in the family, school and community before they arise and to create family environments that encourage children to realize their potential. The "Triple P System" includes a suite of interventions with different intensity levels and delivery methods, to meet the individual needs of youth and parents.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a conjoint child and parent psychotherapy model for children who are experiencing significant emotional and behavioral difficulties related to traumatic life events. It is a components-based hybrid treatment model that incorporates trauma-sensitive interventions with cognitive behavioral, family, and humanistic principles.

Eye Movement Desensitization and Reprocessing (EMDR) Therapy is an evidence-based psychotherapy that treats trauma-related symptoms. EMDR therapy is designed to resolve unprocessed traumatic memories in the brain. The therapist guides the client to process the trauma by attending to emotionally disturbing material in brief, sequential doses, while at the same time focusing on an external stimulus. The most commonly used external stimulus in EMDR therapy is alternating eye movements; however, sounds or taps may be used as well.

Dialectical Behavioral Therapy (DBT) is a comprehensive, multi-diagnostic, modularized behavioral intervention designed to treat both adults and children/adolescents with severe mental disorders and uncontrolled cognitive, emotional and behavior patterns, including suicidal and/or self-harming behaviors.

Mental Health Rehabilitation Services

Beneficiaries eligible to receive Mental Health Rehabilitation (MHR) services under Medicaid State Plan include those who meet one of the following criteria and are 21 years or age or younger:

- Must have a mental health diagnosis

- Must be assessed by a Licensed Mental Health Professional (LMHP)

Licensed Mental Health Professionals can be: licensed psychologists, medical psychologists, professional counselors, clinical social workers, substance use counselors, marriage and family therapists, advanced practice registered nurses (psychiatric specialists).

MHR – assistance and support provided at home, school or work. Additional services may be available for beneficiaries with special mental health care needs.

Mental Health Rehabilitation Services include:

Community Psychiatric Support & Treatment (CPST)* is a type of mental health rehabilitation services designed to reduce the disability resulting from mental illness, restore functional skills of daily living, build natural supports, and achieve identified person-centered goals or objectives through counseling, clinical psycho-education, and ongoing monitoring of needs as set forth in an individualized treatment plan.

Multi-Systemic Therapy (MST)* provides an intensive home/family and community-based treatment for youth who are at risk of out-of-home placement or who are returning from out-of-home placement. MST services are targeted for youth primarily demonstrating externalizing behaviors, such as conduct disorder, antisocial or illegal behavior or acts that lead to costly and, oftentimes, ineffective out-of-home services or excessive use of child-focused therapeutic support services.

Functional Family Therapy (FFT)* services are targeted for youth primarily demonstrating externalizing behaviors or at risk for developing more severe behaviors, which affect family functioning. Youth behaviors include antisocial behavior or acts, violent behaviors and other behavioral issues that impair functioning. FFT is in-home family counseling that aims to reduce disruptive behavior in youths and improve family communication and problem-solving skills.

Functional Family Therapy-Child Welfare (FFT-CW)* services are targeted for youth and families with suspected or indicated child abuse or neglect. Problems include youth truancy, educational neglect, parental neglect or abuse, a history of domestic violence, adult caregiver substance use, and adult caregiver anxiety, depression and other mental health issues.

Homebuilders® (HB)* is an intensive, in-home evidence-based program (EBP) utilizing research-based strategies (e.g., motivational interviewing, cognitive and behavioral interventions, relapse prevention, skills training), for families with children (birth to 18 years of age) at imminent risk of out of home placement (requires a person with placement authority to state that the child is at risk for out of home placement without Homebuilders®), or being reunified from placement.

Assertive Community Treatment (ACT)* is community-based therapeutic interventions that address the functional problems of members who have the most complex and/or pervasive conditions associated with serious mental illness. These interventions are strength-based and focused on supporting recovery through the restoration of functional daily living skills, building strengths, increasing independence, developing social connections and leisure opportunities, and reducing the symptoms of their illness.

Psychosocial Rehabilitation (PSR)* is a type of mental health rehabilitation services, designed to assist the individual with compensating for or eliminating functional deficits and interpersonal or environmental barriers associated with mental illness through skill building and supportive interventions to restore and rehabilitate social and interpersonal skills and daily living skills.

Crisis Intervention (CI) is short-term mental health rehabilitation service for members having a psychiatric crisis and are designed to interrupt and/or ameliorate a crisis experience, through a preliminary assessment, immediate crisis resolution and de-escalation and referral and linkage to appropriate community services to help members avoid more restrictive levels of mental health treatment.

Mental Health Rehabilitation providers arrange the assessments necessary to obtain prior authorization for rehabilitation services.

- Beneficiaries receiving Community Psychiatric Support & Treatment (CPST) and/or Psychosocial Rehabilitation (PSR), ages 6 through 18 years of age, must be assessed using the Child and Adolescent Level of Care/Service Intensity Utilization System (CALOCUS).
- Beneficiaries receiving CPST and/or PSR, ages 19 through 20 years of age, must be assessed using the Level of Care/Service Intensity Utilization System LOCUS.
- Beneficiaries who receive Multi- Systemic Therapy, Homebuilders, Functional Family Therapy and Functional Family Therapy-Child Welfare are not required to be assessed using the CALOCUS.

Remember these services offer family intervention, which could help a family struggling with the symptoms of their child's behavioral 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 specialized behavioral health service 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 with the Managed Care Organization on coordination of services, or Magellan for CSoC enrollees.

Mobile Crisis Response (MCR)

MCR is an initial or emergent crisis response for individuals in a self-identified crisis intended to provide relief, resolution and intervention through crisis supports and services during the first phase of a crisis in the community. MCR is a face-to-face, time-limited service provided to youth who is experiencing a psychiatric crisis due to mental health or substance use until the youth experiences

sufficient relief/resolution and can remain in the community and return to existing services or be linked to alternative behavioral health services.

Crisis Stabilization
Crisis Stabilization for youth is short-term bed-based crisis treatment and support services for members who have received a lower level of crisis services and are at risk of hospitalization or institutionalization. The intent of this service is to provide an out-of-home crisis stabilization option for the youth and their family in order to avoid psychiatric inpatient and institutional treatment of the youth by responding to potential crisis situations that will address current acute and/or chronic mental health needs and coordinate a successful return to the family setting at the earliest possible time.

Community Brief Crisis Support (CBCS)*
CBCS is a face-to-face intervention available to individuals subsequent to receipt of Mobile Crisis Response or Crisis Stabilization. This ongoing crisis intervention response is intended to be rendered for up to fifteen days and are designed to provide relief, resolution and intervention through maintaining the member at home/community, deescalating behavioral health needs, referring for treatment needs, and coordinating with local providers. CBCS is available 24/7.

Residential and hospital-based behavioral health treatment services:

Therapeutic Group Home*
Therapeutic Group Homes (TBH) provide a community-based residential service in a home-like setting with a small group of other youth to get the services needed. TGHs deliver an array of clinical and related services within the home, including psychiatric supports, integration with community resources and skill-building taught within the context of the home-like setting to support the restoration of adaptive and functional behaviors that will enable the youth to return to and remain successfully in their home and community, and to regularly attend and participate in work, school or training, at the youth's best possible functional level.

Psychiatric Residential Treatment Facility (PRTF)***
PRTF allows youth to live in a treatment facility to get the behavioral health care needed. PRTFs are non-hospital facilities offering intensive inpatient and educational services to individuals younger than age 21 who have various behavioral health issues. PRTFs must assess and treat all medical, psychological, social, behavioral and developmental needs identified on the active treatment plan and any other medically necessary care required.

Inpatient Hospitalization (mental health and substance use treatment)

Residential Substance Use Disorder Services
Substance Use Disorder Services include an array of individual-centered residential and inpatient services consistent with the individual's assessed treatment needs with a rehabilitation and recovery focus designed to promote skills for coping with and managing substance user disorder symptoms and behaviors.

Substance Use Disorder Services
Substance Use Disorder Services include an array of individual-centered outpatient and intensive outpatient services consistent with the individual's assessed treatment needs with a rehabilitation and recovery focus designed to promote skills for coping with and managing substance user disorder symptoms and behaviors.

Opioid Treatment Programs (OTP) (ages 18-20)
OTP include **Medication-Assisted Treatment (MAT)** delivered in OTPs, including but not limited to Methadone treatment to adolescents with Opioid Use Disorder (OUD).

***The Managed Care Organization's prior authorization unit must pre-approve CPST, PSR, MST, FFT, HB, ACT (ages 18-20), CBCS, and PRTF.**
*****A certificate of need must be complete prior to admission to a PRTF.***

Recommended Resources:

Center for Evidence to Practice: find evidence-based programs and practices in your area, laevidencetopractice.com including an EBP Referral Guide which can be found at: https://laevidencetopractice.com/wp-content/uploads/2020/11/EBP-Referral-Guide.pdf.

Finding a Specialist:
LDH recognizes the importance of adequate access to healthcare providers and continues to place provider access monitoring and maintenance as one of its highest priorities. MCOs are responsible to ensure the availability of specialists are within the appropriate ratio, distance and appointment time requirements.

To assist providers in finding a specialist for their beneficiaries, each MCO has developed a "Finding a Specialist" dedicated email account. Providers are expected to make a reasonable attempt to locate the appropriate specialist, but the MCOs' email accounts are staffed by knowledgeable provider network staff to assist providers when a specialist may not be easily located. Except for emergency cases, the normal turnaround will be within three business days.

Table 5: Find a Specialist

MCO	E-Mail Account
Aetna Better Health of Louisiana	findaABHspecialist@aetna.com
AmeriHealth Caritas Louisiana	SpecialistsInquiries@amerihealthcaritas.com
Healthy Blue	La1casemgmt@healthybluela.com
Humana Healthy Horizons	LAMCDSDOH@humana.com
Louisiana Healthcare Connections	FindASpecialist@LouisianaHealthConnect.com
United Healthcare Community Plan	La_spc_rep_asst@uhc.com

School-Based Behavioral Health Services

- These services are accessed through the beneficiary's Local Education Agency (LEA) e.g., School Board.
- No prior authorization is required.

Medicaid also funds behavioral health services provided through schools or early childhood educational settings for children ages 3 to 21 years, 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 a written plan of care such as the child's Individualized Education Program (IEP), Individualized Family Service Plan (IFSP), 504 Plan, etc. Behavioral Health services, treatment, and other measures to correct or ameliorate an identified mental health or substance use disorder diagnosis may be provided by licensed mental health practitioners or Louisiana Certified School Psychologists and Counselors.

Other Behavioral Health Services

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

Basic behavioral health services are provided in a primary care clinic and include screening for mental health and substance use issues, prevention, early intervention, medication management, treatment and referral to specialty services.

The following PHYSICAL HEALTH services are available to all Medicaid eligible children and youth under the age of 21 who have a medical need:

EPSDT Screening Exams and Checkups

- EPSDT Screening Exams and Checkups are accessed through the beneficiary's primary care provider (PCP) or appropriate health care provider and are covered by the beneficiary's MCO or FFS.
- No prior authorization is required.

Medicaid beneficiaries under the age of 21 are eligible for well child checkups ("EPSDT Screenings"). These checkups include a health history; physical exam; immunizations; laboratory tests, including lead blood level assessment; vision and hearing checks; developmental screening; autism screenings; perinatal depression screening; and dental screenings. They are available both on a regular basis, and whenever additional health treatment or additional services are needed.

Medicaid follows the "Recommendations for Preventative Pediatric Health Care" periodicity schedule promulgated by the American Academy of Pediatrics (AAP)/Bright Futures. **EPSDT Preventative Screenings are recommended at ages per the Bright Futures/AAP schedule found here.**

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.

When detected early 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. PCPs are responsible for making appropriate referrals when needed based on the results of a screening.

Personal Care Services

- PCS services are accessed through the beneficiary's primary care provider (PCP) and Personal Care Attendant Agency.
- PCS services must be prior authorized by the beneficiary's MCO or FFS.

Personal Care Services (PCS) are defined as tasks that are medically necessary as they pertain to an EPSDT beneficiary's physical requirements when cognitive or physical limitations due to illness or injury necessitate assistance with eating, toileting, bathing, bed mobility, transferring, dressing, locomotion, personal hygiene, and bladder or bowel requirements.

Assistance is provided with meal preparation if the beneficiary 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. A parent or adult caregiver is **not required** to be in the home while services are being provided to children.

Staff assigned to provide PCS shall not be a member of the beneficiary's immediate family. Immediate family includes a father, mother, sister, brother, spouse, child, grandparent, in-law, or any individual acting as a parent or guardian of the recipient. PCS may be provided by a person of a degree of relationship to the beneficiary other than immediate family, if the relative/person is not living in the beneficiary's home, or, if the relative/person is living in the beneficiary's home solely because his/her presence in the home is necessitated by the amount of care required by the beneficiary.

Refer to *Appendix G - EPSDT Personal Care Services vs. Home Health and PCS Rule Information* and *Appendix BB-7 – EPSDT-PCS FAQ and Guide to Provider Locator Tools*.

If you are unable to locate a willing and able provider refer to page 66-67, Unable to Locate a Provider – FFS or Unable to Locate a Provider – MCO.

How to obtain prior authorization:

- To obtain prior authorization, the provider must send in a completed prior authorization request to the Gainwell Technologies Prior Authorization unit for FFS or to the Managed Care Organization's Prior Authorization Unit for MCO. The request must include an EPSDT-PCS Form 90 (prescription is included on the form) completed by the beneficiary's attending

practitioner (physician, advance practice nurse, or physician assistant), a completed plan of care that has been signed by the attending practitioner, 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 beneficiary under age 21 can receive.** The number of hours approved is based on the beneficiary's need for assistance with his/her personal care tasks that are covered through this program. The beneficiary must be of an appropriate age to receive PCS meaning that they are old enough to do the tasks themselves if they did not have a cognitive or physical limitation.
- The Support Coordinator should provide the beneficiary 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 beneficiary/family. The Support Coordinator should assist with scheduling the doctor appointment, transportation, etc., as needed. The Support Coordinator should assist the family with providing all critical information to the physician before the physician 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 for FFS:

- If a beneficiary is changing PCS providers within an authorization period, the current agency must send a letter to Gainwell Technologies Prior Authorization Unit notifying them of the beneficiary's discharge so a new PA can be issued to the new PCS provider.
- 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 beneficiary/family asking Gainwell Technologies 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 Gainwell Technologies 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.**

Changing PCS Providers within an authorization period for Medicaid Managed Care:

- Beneficiaries have the right to change providers at any time; however, **approved authorizations are not transferred between agencies.** If a beneficiary elects to change providers within an authorization period, the current agency must notify the Managed Care Organization of the beneficiary's discharge, and the new agency must obtain their own authorization through the usual authorization process. Beneficiaries may contact their Managed Care Organization directly for assistance in locating another provider.
- Support Coordinators are responsible for assisting CCMs with switching service providers.

Home Health Services

- Home Health services are accessed through the beneficiary's physician and are covered by the beneficiary's MCO or FFS.
- Home Health services are covered by the beneficiary's MCO or FFS.
- Some home health services covered by the MCO require a prior authorization.
- Extended home health and PT, OT, ST covered under FFS require prior authorization.

Children and youth are 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 beneficiary to receive at least 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. Home Health agencies can also provide physical, occupational and speech therapy in the home if this is medically necessary. Home Health Services for children and youth are **not limited in terms of frequency or duration** but are based on medical need**.** Once prescribed/ordered by an authorizing healthcare provider, the service provider must determine if prior authorization is required by Medicaid or the Managed Care Organization.

Beneficiaries that require fewer than three hours per day of nursing services can have those services prescribed by an authorizing healthcare provider and do not need to obtain prior authorization.

Some individuals need both PCS and Home Health Services. Refer to *Appendix G - EPSDT Personal Care Services vs. Home Health* for a comparison of PCS and Home Health Services. **Services must 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.

Refer to *Appendix B – FFS Service and Equipment Flyer* and *Appendix C – MCO Service and Equipment Flyer.*

If you are unable to locate a willing and able provider refer to page 66-67, Unable to Locate a Provider – FFS or Unable to Locate a Provider – MCO.

Pediatric Day Health Care (PDHC)

- PDHC services are accessed through the beneficiary's Physician or PDHC Agency.
- PDHC must be prior authorized by the beneficiary's MCO or FFS.

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, IV therapy, and gastrostomy care. (b) Respiratory care. (c) Physical, speech, and occupational therapies. (d) Assistance with activities of daily living. (e) Transportation to and from the PDHC facility. Transportation shall be paid in a separate per diem.

Therapy Services

Audiological Services (Available in Rehabilitation Clinic and Hospital-Outpatient settings only), Occupational Therapy, Physical Therapy, and Speech and Language Therapy

- Beneficiaries have the choice of services from the following provider types: Home Health, Hospital – Outpatient Services, or Rehabilitation Clinic Services.
- Therapy services are covered by the beneficiary's MCO or FFS.
- Some therapy services covered by the MCO require a prior authorization.
- Therapy services covered under FFS require prior authorization.

Covered services can be provided in the home through Home Health and Rehabilitation Clinics. Services provided by Rehabilitation Clinics can also be provided at the clinic. Services provided through Hospital – Outpatient Services must be provided at the facility/clinic. Covered services may be provided **in addition** to services provided by Early Steps/EICs or School Boards if medically necessary. Covered services can be provided in a combination of settings, depending on the child's needs. For Medicaid to cover these services at school (ages 3 to 21), they must be in a written plan of care such as the child's Individualized Education Program (IEP), Individualized Family Service Plan (IFSP), 504 Plan, etc. For Medicaid to cover such services through a provider outside of an educational setting, they do not need to be part of the school's written plan of care.

The Support Coordinator is to explain to the beneficiary/family that Medicaid will provide medically necessary therapies in addition to the therapies received at school through the school's written plan of care. The Support Coordinator is to ask the beneficiary if they want to receive any medically necessary therapies outside of the school setting, in addition to those they receive in school. The beneficiary should also be asked if they want to request these therapies during the school's summer break. The Support Coordinator helps the family to determine the setting in which the beneficiary 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 beneficiary is receiving and monitoring the delivery of the services.

For information on receiving these therapies in schools, contact the child's school.
If you are unable to locate a willing and able provider refer to page 66-67, **Unable to Locate a Provider – FFS** or **Unable to Locate a Provider – MCO**. If the beneficiary is placed on a waitlist, refer to page 66 **Waitlist Placement**.

Disposable Incontinence Products

- Disposable incontinence products are covered by the beneficiary's MCO or FFS.
- MCOs sometimes require a prior authorization.
- FFS always requires a prior authorization.

Diapers, pull-on briefs, and liner/guards are covered for beneficiary's age four years through age twenty years if they have a medical condition resulting in bowel/bladder incontinence and meet other LDH 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. For FFS and MCOs that require a PA for disposable incontinence products, 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 BB-1 - PA Request Forms and Physician Forms.*

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.

For FFS and MCOs that require a PA for disposable incontinence products, PA tracking can begin 60 days prior to the child's fourth birthday. Instruct the provider to use the child's fourth birthday as the PA service begin date.

Medical Equipment and Supplies

- Medical equipment and supplies are accessed through the beneficiary's physician and Durable Medical Equipment provider.
- Medical equipment and supplies sometimes require a prior authorization from the beneficiary's MCO or FFS.

Beneficiaries 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, wheelchairs, and other devices to help the family deal with a child's medical condition or circumstances such as communication devices. It also includes medically necessary dietary or nutritional assistance, and diapers or pull-ups if they are needed because of a medical problem. **Medical Equipment and Supplies must be prescribed by a physician.** Once prescribed, the supplier of the equipment or supplies may need to request approval for them from the Fiscal Intermediary Gainwell Technologies for FFS or the beneficiary's MCO for Managed Care if the item requires a prior authorization.

New technology is being developed every day; therefore, many families and beneficiaries 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 beneficiary's needs. If so, the notice of denial should identify the items. You can then consult with the beneficiary and the provider to see if the identified item might work. **The beneficiary 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.

Other Medicaid Services Not Listed

Refer to *Appendix D - Services Available to Medicaid Eligible Children Under 21* 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 or the beneficiary's Managed Care Organization Member Services line.** 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** or the beneficiary's Managed Care Organization Case Manager. They 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.

Customer Service Information for Fee-For-Service Medicaid Inquires

Specialty Care Help Desk • 1-877-455-9955
Medicaid Eligibility Hotline • 1-888-342-6207
Medicaid Services Chart • www.ldh.la.gov/medicaidservices
E-mail • MyMedicaid@la.gov
Medicaid Website • www.medicaid.la.gov

Refer to *Appendix B – FFS Service and Equipment Flyer.*

Customer Service Information for Managed Care Organization Inquires

Healthy Louisiana • 1-855-229-6848
E-mail • healthy@la.gov
Medicaid Website • www.myplan.healthy.la.gov

Call your Health Plan Provider:
Aetna Better Health of Louisiana• 1-855-242-0802
AmeriHealth Caritas Louisiana • 1-888-756-0004
Healthy Blue • 1-844-521-6941
Humana Healthy Horizons • 1-800-448-3810
Louisiana Healthcare Connections • 1-866-595-8133
United Healthcare Community Plan • 1-866-675-1607

Refer to *Appendix C – MCO Service and Equipment Flyer.*

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

OCDD Services

The **Office for Citizens with Developmental Disabilities** (OCDD), through Local Governing Entities (LGE) in each region, provides a variety of state-funded services to individuals with developmental disabilities, including children and youth. EPSDT support coordination beneficiaries may already have contacted OCDD in order to be assessed and placed on the Request for Services Registry; however, they may not be aware of all the services and supports that they may be eligible to receive through OCDD.

OCDD serves as the Single Point of Entry into the developmental disabilities services system and oversees public and private residential services and other services for people with developmental disabilities. To apply for services, beneficiaries can call or visit their local governing entity. Refer to *Appendix J-1 – LGE Directory*. LGEs are independent regional health care districts and authorities located throughout the State. Within the jurisdiction of LGEs, services are provided through various arrangements including state operated, state contracted services, private comprehensive providers, rehabilitation agencies, community additional and mental health clinics, licensed mental health professionals, and certified peer support specialists.

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.

Individual and Family Support

This service provides supports which are administered by Local Governing Entities (LGE) 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.

Local Governing Entity (LGE) 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 LGE has an **EPSDT Specialist** on staff, who can answer questions about EPSDT services. Refer to *Appendix J-2 - Local Governing Entity (LGE) Regional EPSDT Specialists* for a list of the EPSDT Specialists.

Most children currently receiving EPSDT Support Coordination services are on the Developmental Disabilities Request for Services Registry (DD RFSR) for these waiver programs:

Developmental Disability (DD) Medicaid Waiver Services

Louisiana has four Medicaid waivers for persons with developmental disabilities: the Children's Choice waiver, which provides a limited package of services to children under the age of 21, the Supports Waiver which provides day and employment services for those age 18 years and older, the Residential Options Waiver (ROW) which offers expanded home and community based services for individuals of all ages, and the New Opportunities Waiver (NOW) which provides comprehensive home and community based services for individuals three years of age or older.

The DD RFSR is arranged by urgency of need and date of application for developmentally disabled waiver services. The tool known as the Screening for Urgency of Need (SUN), was designed to identify any needs a person may have, review current supports a person has and uses now, and determine the urgency of any unmet needs that the person has. To find the beneficiary's date of request on the DD RFSR refer to the Statement of Approval, call 1-866-783-5553 or call the local governing entity. To find the beneficiary's SUN score or to request a rescreening due to a change in status call the local governing entity. To update the beneficiary's contact information on the DD RFSR, call the local governing entity. Refer to *Appendix J-1 - Local Governing Entity (LGE) Directory* for contact information for the LGEs.

Children's Choice Waiver

Children's Choice Waiver opportunities shall be offered to individuals under the age of 21 who are on the registry and have the highest level of need. This waiver provides an individualized support package with a maximum capped cost, and is designed for maximum flexibility. This waiver includes support coordination, family support, crisis support, family training, center-based respite, environmental accessibility modifications, specialized medical equipment and supplies, permanent supportive housing stabilization, permanent supportive housing stabilization transition, some specialized therapies (aquatic, music, art, sensory integration, and hippotherapy/therapeutic horseback riding), and financial management services. 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 Developmental Disabilities Request for Services Registry (DD RFSR). Children's Choice provides services in the home and in the community to individuals 0 through 20 years of age, who currently live at home with their families or will leave an institution to return home.

Note: Children who reach their eighteenth birthday and choose to no longer attend school may transition to the Supports Waiver anytime between their eighteenth and their twenty-first birthday.

However, the child can later receive an appropriate adult waiver slot under the following circumstances:

1. **When a Children's Choice beneficiary reaches the age of 21**, he/she will transition to the most appropriate waiver that meets their needs 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.

A fact sheet on the Children's Choice waiver program is included in *Appendix I*.

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 day and employment services rather than continuous custodial care. This waiver offers support coordination, supported employment (individual or group), day habilitation/community life engagement and transportation, prevocational services/community career planning and transportation, respite (center-based or home), habilitation, permanent supportive housing stabilization and transition, personal emergency response systems, expanded dental services for adult waiver beneficiaries, and specialized medical equipment and supplies.

A fact sheet on the Supports Waiver program is included in *Appendix I*.

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 intellectual or developmental disabilities. The ROW 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. This waiver offers support coordination, community living supports, host home services, companion care services, shared living, adult day health care, respite care (out of home), personal emergency response system, one time transitional services, environmental accessibility adaptations, monitored in home caregiving, specialized medical equipment and supplies, community life engagement development, transportation-community access, professional services, nursing services, supported employment (individual or group)transportation, prevocational/community career planning and transportation, day habilitation/community life engagement and transportation, housing stabilization service, housing stabilization transition, expanded dental services for adult waiver beneficiaries, and financial management services.

A fact sheet on the Residential Options Waiver program is included in *Appendix I*.

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 developmental disabilities, and who cannot be supported in one of the other OCDD waivers. The individual must be 3 years of age or older, and the age of the disability onset must occur prior to age 22. This waiver offers individual and family supports, center-based respite, community life engagement development, environmental accessibility adaptions, specialized medical equipment, supportive independent living, substitute family care, day habilitation/community life engagement and

transportation, supported employment (individual or group) transportation, prevocational/community career planning and transportation, personal emergency response system, skilled nursing, one time transitional services, housing stabilization transition, housing stabilization, monitored in home care giving, adult companion care, professional services, expanded dental services for adult beneficiaries, and financial management services.

A fact sheet on the New Opportunities Waiver program is included in *Appendix I*.

Local Governing Entity (LGE) Community Behavioral Health Services

LDH's Office of Behavioral Health, ensures children and youth with serious emotional disturbances are provided with outpatient behavioral 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 J-3 - Local Governing Entity (LGE) Community Behavioral Health Services.

Child-Adolescent Response Team (CART)

Crisis services for children are accessible in every LGE (local governing entity) of the state. Some LGE's provide this crisis service by utilizing CART services. These can be accessed through the mental health clinics in the LGEs. They 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

Local school systems are responsible for serving students with disabilities beginning at age three. Children who were served in EarlySteps, a program run by the Office for Citizens with Developmental Disabilities for children with disabilities and developmental delays from birth to age three, may transition into services provided by the school system including the school system's Early Childhood Education programs if evaluated and found to be eligible. 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 contact:

Caitlyn Robinson
LA Dept. of Education
Early Childhood Education Strategy
Caitlyn.Robinson@la.gov
(225) 342-7290 or (225) 342-1129

or 1-877-453-2721

"The Early Childhood Transition Process" booklet is a guide for helping families prepare for the transition from EarlySteps to a school system and can be requested from the above contacts. It is available in English and Spanish versions. They can also be found here: https://www.louisianabelieves.com/early-childhood/young-children-with-disabilities

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 for children ages 3 - 21. The child will be professionally evaluated through test results, interviews, observations, and other relevant information. If the student is receiving Special Education Services, it is required that the IEP be done annually and Special Education Reevaluations 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.

Medicaid's EPSDT School-Based Services Program covers medically necessary services pursuant to a written plan of care. Covered services include, special transportation, speech pathology and audiology, psychological services, physical and occupational therapy, person care services and some medical health care services. 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 including their homes through Medicaid, if medically necessary.**

Before age 16, 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, Louisiana Rehabilitation Services should be contacted to see if they can provide services after high school. Louisiana Rehabilitation Services (LRS) office contacts can be found at: http://www.laworks.net/workforcedev/lrs/lrs_regionaloffices.asp

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 3 – Components of Support Coordination

Support coordination agencies are required to perform the following:

1. Intake,
2. Assessment,
3. Plan of care development and implementation,
4. Follow-up/monitoring,
5. Reassessment, and
6. Transition/closure.

Intake

As Medicaid eligible beneficiaries under age 21 are added to the Developmental Disabilities Request for Services Registry, BHSF will offer the beneficiaries EPSDT-Targeted Case Management. If they accept, Statistical Resources, Inc. (SRI) sends a Case Management Freedom of Choice. EPSDT Support Coordination is an optional service and Medicaid eligible beneficiaries under age 21 who are on the Developmental Disabilities Request for Services Registry may request EPSDT Support Coordination at any time by calling SRI. The Support Coordination Choice and Release of Information Form is completed by the beneficiary.

Once the Support Coordination Choice and Release of Information Form is returned to SRI, the beneficiary is linked to his/her chosen support coordination agency.

The Support Coordination Choice and Release of Information Form (linkage form) is sent to the SCA by SRI.

The support coordinator must contact the beneficiary by phone within three (3) working days of receipt of linkage notification to determine the beneficiary's eligibility, need, appropriateness, and desire for Support Coordination services. At that time, an appointment should be set up to discuss what support coordination is and how it can benefit the individual. Within ten (10) calendar days following linkage, the support coordinator meets with the beneficiary face-to-face.

The individual should be asked about formal information documents they may have or can obtain prior to the CPOC assessment, including the current IEP, current PDHC Plan of Care and current EHH Plan of Care as applicable.

The support coordinator shall use MEVS/REVS to determine if the beneficiary is eligible and remains eligible for Medicaid.

The support coordinator shall open the case record in LSCIS.

The purpose of intake is to serve as an entry point for support coordination services and to gather baseline information to determine the beneficiary's need, appropriateness, eligibility and desire for support coordination.

- Determine if the beneficiary accepts support coordination and the contact requirements
- Advise the beneficiary of their right to change support coordination agencies and support coordinators, the availability of services and support coordination.
- Availability of the HSS toll-free 1-800-660-0448 Helpline.
- Determine whether the beneficiary is receiving support coordination from another provider. If so, follow the procedures for transferring agencies.
- If the beneficiary does not meet eligibility for support coordination, notify the beneficiary and SRI/EPSDT Support Coordination immediately, inform the beneficiary and direct them to other service options.

Assessment

The initial assessment must begin within seven (7) calendar days and be completed within 30 calendar days of the linkage to the support coordination agency. The Support Coordinator will need to gather both formal and informal information to be used in the development of the CPOC. Formal information will include medical, psychological, pharmaceutical, social, and educational information, and information from OCDD. Other examples of formal information include the IEP and other assessments by professionals such as EPSDT-PCS Form 90, Home Health Plan of Care, LRS evaluations, Special Education Evaluations, behavior plans, psychological evaluations, etc. Informal information will include information gathered in discussions with the individual and their family, 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 beneficiary's needs. The information gathered in the assessment is to be incorporated into the CPOC.

The SC is to obtain all assessments/evaluations and documents that OCDD used to determine eligibility, the current IEP and any other assessments by professionals (EPSDT-PCS Form 90, Home Health Plan of Care, PDHC Plan of Care, LRS and Special Education Evaluations, behavior plans, psychological and other evaluations, etc.) that are required to obtain CPOC approval.

The SC is to contact OCDD, schools, Pupil Appraisal and health care professionals for necessary records, ask the individual about documents they may have or can obtain from their school, and follow up on requests for records.

The Support Coordination Choice and Release of Information Form can be used to obtain all plans, evaluations, assessments, and documents that OCDD has developed or used in connection with its determination that the beneficiary is eligible for services through the developmental disability services system as well as the Statement of Approval (SOA). The OCDD Statement of Approval (SOA) is a document received by individuals who have completed the System Entry process at one of the ten

Local Governing Entities or LGEs. The SOA document indicates that the individual meets the legal definition of Intellectual/Developmental Disability as defined by La. R.S. 28:451.2. This document further indicates the individual meets the criteria to receive services from the Developmental Disability service system. The Individual Entry Review (IER) and supporting documents, Eligibility Recap Sheet, I-CAP, DD-SNAP, psychological evaluation, Screening for Urgency of Need (SUN) tool, and the OCDD Plan of Support can be obtained from OCDD. Allow OCDD a five-work day turnaround. Refer to *Appendix K - EPSDT Support Coordination FOC (Sample)* – Section 2: Release of Information.

Individualized Educational Plans (IEP) and Special Education Evaluations can be obtained from the beneficiary, guardian, school, or the School Board's Special Education Department with the guardian's written consent. The Louisiana Department of Education consent for access to education records can be found here: https://www.louisianabelieves.com/docs/default-source/links-for-newsletters/personal-consent-form-official.pdf?sfvrsn=343a9e1f_2; a photocopy of a government issued ID as proof of identity, such as a driver's license, is required. It may be easier to obtain the IEP or records from the school by having the guardian request that the information be sent home with the beneficiary. Even if the beneficiary is not attending school or receiving Special Education Services, they should have a Special Education Evaluation to assess their needs. **If the student is receiving Special Education Services, it is required that the IEP be done annually and Special Education Re-evaluations should be completed every three years.** Vision and hearing screenings are done at school if the student is able to cooperate with the testing. This is required with the Special Education Evaluation and Re-Evaluation. If the student has special health needs, an Individualized Healthcare Plan (IHP) should be attached to the IEP. The school nurse gathers medical information for the IHP and the school nurse can be contacted to see if the student has an IHP or other medical documentation in the school records. You can look on the current IEP under Supporting Documentation to see what documents are included with the IEP such as IHP, Behavior Intervention Plan, etc.

The Support Coordinator may need to assist the beneficiary with arranging professional evaluations and appointments including well-child visits, EPSDT screening services 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 beneficiary's person-centered Comprehensive Plan of Care.

Plan of Care Development and Implementation

The Comprehensive Plan of Care (CPOC) is the Support Coordinator's blueprint for assisting the beneficiary. The CPOC is developed through a person-centered planning process and is based on the comprehensive information gathered during the assessment process which identifies the individual's preferences, needs, goals, abilities, health status and available supports. The CPOC must be completed in a face-to-face in-home meeting with the beneficiary's support team.

Establishing the Support Team

The **support team** is made up of the beneficiary, legal guardian, Support Coordinator, and other people chosen by the beneficiary that know them best such as family, friends or other support systems, or direct service providers. The beneficiary will lead the person-centered planning process where possible. **All references to the individual include the role of the individual's representative.** It is important that the Support Coordinator provides necessary information and support to ensure that the individual directs the person-centered planning process to the maximum extent possible.

A **competent major** is a person 18 years of age or older that has not been legally declared incompetent.

An **authorized representative** is someone chosen by the competent major to represent them and can sign documents on the competent major's behalf. An authorized representative can make decisions regarding services. Refer to *Appendix M - Authorized Representative Form.*

Supported decision-making (SDM) allows individuals with disabilities to make choices about their own lives with support from a team of people they choose. A SDM Agreement should contain the name, address, and phone number of at least one supporter; a description of the decision-making assistance that each supporter will provide to the individual; signatures of both the adult with a disability and the supporter(s); and a description of how multiple supporters will work together if there is more than one person. For more information, please visit the National Resource Center for Supported Decision Making and the Arc U.S.

If the beneficiary is a competent major and they are **able** to express their preferences, the Support Coordinator should talk directly to the competent major and have them sign all documents unless the beneficiary *chooses* to have an authorized representative by completing *Appendix M - Authorized Representative Form*.

If the beneficiary is a competent major and they are **unable** to express their preferences due to a disability for which an accommodation cannot bridge the gap, the Support Coordinator should document why they believe the competent major is not able to direct their own care and must obtain *Appendix M - Authorized Representative Form* or a supported decision-making (SDM) agreement.

A **minor** is a person under 18 years of age. For minors, if the caregiver is not the parent you must have legal guardianship documents on file and this must be noted in the CPOC. *Appendix N - Non-legal Custodian Affidavit* can be obtained by the caregiver. This affidavit does not require a parent signature but, it must be notarized and renewed each year. If this is the only CPOC deficiency, the CPOC will be denied but the approvable CPOC submit date will be honored when the CPOC is resubmitted with the required documentation.

If the beneficiary is in **DCFS custody,** the DCFS guardian must be contacted for all monthly contacts, they must sign all documents as the legal guardian**,** and they must be present at assessment and reassessment meetings *unless* you have a letter on file from the DCFS guardian authorizing the foster parent to make medical and educational decisions, sign the documents and be the EPSDT SC contact. This must be documented in the CPOC. Contact SRI if you need a sample letter from DCFS.

Person-Centered Planning Team Meets

Within 10 calendar days of the referral to the Support Coordination Agency, a face-to-face in-home visit must be conducted. **At a minimum, the beneficiary, legal guardian/authorized representative and support coordinator must be present.** At the face-to-face visit, the Support Coordinator should explain

the Support Coordinator responsibilities to the individual and give specific examples about how support coordination services can benefit the individual. This must include a review of Appendix E - Medicaid Services Chart. By reviewing the Medicaid Services Chart, the Support Coordinator can begin to obtain additional information as to the beneficiary's need for specific services and help the individual become aware of the available support systems and how to access them. In addition, the Support Coordinator should explain all contact requirements, including the required face-to-face meetings. Once the individual has been given all of the information, they should be asked again if they want support coordination services.

During the face-to-face meeting, the Support Coordinator must explain the following to the individual:

- *Appendix D - Services Available to Medicaid Eligible Children Under 21*
- *Appendix E - Medicaid Services Chart* - Explanation and review of the Medicaid Services Chart with special emphasis on medical equipment and supplies, EPSDT-PCS and home health.
- *Appendix O – Right and Responsibilities*
- *Appendix L - EPSDT Support Coordination Blank CPOC and Typical Weekly Schedule*
    - CPOC signature page - everyone present at the meeting must sign in the planning participant's box. If anyone cannot sign, document that they were present by writing their name/relationship and state that they cannot sign. If they can make a mark have them make a mark and then document who the mark represents and their relationship. If for some reason the CPOC cannot be completed at the meeting, the individual must sign the CPOC after it is completed and prior to submittal to SRI.
    - Typical Weekly Schedule - 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.
- *Appendix P - Appeal Brochure*
- *Appendix Q – Compliant Form* – complaint process for filing a report against support coordinators and/or FFS providers
- *Appendix R - Managed Care Complaints* - Complaint Process for filing a report against Managed Care Organizations or MCO providers
- *Appendix S – Voluntary Opt-In to Managed Care for Chisholm Class Members* - Discuss with Chisholm Class Members their right to choose between FFS and MCO their physical health services
- HIPAA & Confidentiality Notification
- Referral to EPSDT Screening provider (if requested)
- Availability of formal and non-formal services

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

The CPOC is based on the identified needs and the unique personal outcomes envisioned, defined and prioritized by the individual. The CPOC must include agreed upon strategies to achieve or maintain the personal outcomes using appropriate natural, community supports, non-formal, and formal paid

services. The CPOC must include timelines in which the personal outcomes can be met or at least reviewed (minimum requirement is quarterly). The Support Coordinator is responsible for providing complete and clear information to assure the individual can make informed choices regarding the supports and services they receive and from whom. During the CPOC meeting, the Support Coordinator must use the *Appendix E - Medicaid Services Chart* to discuss the available Medicaid services. The most current Medicaid Services Chart can be found on the Internet, at: https://ldh.la.gov/assets/docs/Making_Medicaid_Better/Medicaid_Services_Chart.pdf. The availability of both formal and non-formal services including the services discussed in Part I of this handbook must be discussed with the individual.

The CPOC is to be completed electronically in Louisiana Support Coordinator Information System (LSCIS). The CPOC is intended to be user friendly, person-centered and flexible to varying approaches, orientations and programs. The CPOC is designed to briefly summarize important information so that it can be reviewed and considered in evaluating the need for proposed services and supports. Information relevant and applicable to justifying services requested by the individual must be provided. Information critical to the individual's health and safety should be documented in the CPOC. The CPOC should always emphasize the individual's personal outcomes in order to maintain the EPSDT program as a viable and appealing alternative to institutional care. The goal is to provide support and services in a person focused, cost effective and accountable manner.

The Support Coordinator must be very familiar with all parts of the CPOC and assure that information from each section is used to determine what services may meet the individual's needs. Do not wait for the individual to request a service. **If you see a need for a service, inform the individual and document their response.** If the individual may need additional services, but it is not clear, suggest appropriate evaluations to determine whether there is a need. If the individual states they aren't interested in the service, accept that. However, feel free to remind the individual of the service again when the opportunity presents. One of the primary responsibilities of the Support Coordinator is to follow through with requests for services.

In addition to understanding the importance of each section of the CPOC, it is very important that the Support Coordinator use the most current CPOC provided to the support coordination agencies by LDH/Bureau of Health Services Financing (BHSF). The SC should review a blank copy of the CPOC in LSCIS and the instructions before conducting each CPOC. Refer to *Appendix L - EPSDT Support Coordination Blank CPOC* and Typical Weekly Schedule.

The CPOC is comprised of the following six sections:

Section I - Contact Information / Demographic Information
Section II - Medical/Social/Family History
Section III - CPOC Service Needs and Supports
Section IV - CPOC Participants
Section V - CPOC Approval
Section VI - Typical Weekly Schedule

Time Frames for Assessment:

- The completed and approvable CPOC packet is sent to BHSF/SRI within thirty-five (35) calendar days of linkage to the Support Coordination Agency.
- The CPOC must be reviewed at least quarterly and revised at least annually (or as necessary) to meet the needs of the beneficiary.
- The Annual CPOC packet is sent to BHSF/SRI no later than 35 calendar days prior to the CPOC expiration date, but as early as 90 calendar days prior to expiration of the CPOC.

Refer to *Appendix Y-2 – CPOC Instructions* for a full guide on the CPOC.

Follow-up and Monitoring

Follow-up/monitoring is the mechanism used by the SC to assure the appropriateness of the CPOC. Through follow-up/monitoring activity, the SC not only determines the effectiveness of the CPOC in meeting the beneficiary's needs, but identifies when changes are needed to the CPOC. The purpose of follow-up/monitoring contacts is to determine if supports are being delivered as planned; if supports are effective and adequate to meet the beneficiary's needs; and whether the beneficiary is satisfied with the supports.

Monthly Contact

Every calendar month after linkage, the support coordination must make contact with the beneficiary to address the following:

- If the services are being received;
- If the beneficiary/family is satisfied with the services and their provider. If not satisfied, document the offer of FOC and response. Offer to switch providers if service not received or if not received in the amount Prior Authorized or at the times desired;
- Any assistance provided with identified needs and problems with providers. Address and problem solve issues over service provision between individual, family and service providers.
- Offer of services for identified needs;
- The Freedom of Choice;
- Information regarding the requirements to obtain a PA for the services requested was given to the family/beneficiary;
- Follow up on obtaining information to obtain the PA request;
- Assistance with appeals;
- Determination of service start date after the PA is received;
- If the beneficiary is progressing with the current services and/or IEP services;
- Meetings/discussions about continuing to receive additional services during the school year, over and above what the IEP required;
- Meetings/discussions about continuing to receive the IEP services during the summer months. If summer therapies are requested, they are to be entered in the CPOC Service Needs section. PA tracking is to begin 60-45 calendar days prior to the last day of school. (If the service is requested prior to this, the parent should be obtaining the Rx so it can be submitted with the referral.) SC is to document if the Rx is not obtained due to physician refusal, parent did not schedule a required doctor visit, etc. SC is to document any barriers to obtaining the Rx and SC attempt to remove them; and

- Any behavior concerns or issues.

As Needed Contact

The support coordinator must make contact with the beneficiary as needed until each service included on the CPOC is fully implemented, including receipt of all prior authorized services. **Do not wait for your next monthly contact.**

- Follow up on obtaining information to submit or obtain approval of a PA request.
- Determine service start date after PA notice is received.
- Assist with identified needs and problems with providers.
- Offer assistance with an appeal.

Reassessment

The assessment process is ongoing and must reflect changes in the beneficiary's life, individual needs and changing personal outcome. These changes include strengths, needs, preferences, abilities and resources. If there are significant changes in the status of the beneficiary or his/her prioritized needs, the support coordinator must revise the CPOC.

Time Frames for Reassessment:

- A reassessment may be conducted at any time, particularly with a significant change, but must be completed within seven calendar days of notice of a change in the beneficiary's status;
- Quarterly reassessments - the Support Coordinator and the beneficiary shall review the CPOC to determine if the beneficiary's needs continue to be addressed; and
- Annually.

Adjustments to the CPOC

The CPOC must be reviewed at least quarterly. 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).
- Strategies are needed to deal with problems with services or providers. Resolving problems and overcoming barriers to beneficiaries' 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 beneficiaries that have a revised/updated CPOC must be submitted to SRI with the Quarterly Report for each quarter that significant changes are made to the CPOC. Refer to *Appendix W-2 - EPSDT Quarterly Report of Revised CPOCs*.

Quarterly Review

The support coordinator must complete an EPSDT CPOC Quarterly Review with the beneficiary 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)
- If the beneficiary is progressing with the current services and/or IEP services.
- FOC and information regarding the requirements to obtain a PA for the services requested was given to the family/beneficiary.
- Completion of the EPSDT CPOC Quarterly Review located in LSCIS.

Location:

- CPOC meetings must be held face-to-face at the beneficiary's home.
- At least one Quarterly Review must occur face-to-face each calendar year and may be completed at the location of the beneficiary's or parent/legal guardian's choosing.
- Two Quarterly Reviews that are <u>not</u> the initial or annual plan of care visit may be conducted virtually when the following conditions are met:
    1. The beneficiary/family is in agreement that a virtual visit is in the best interests of the beneficiary;
    2. The support coordinator is in agreement that a virtual visit is in the best interests of the beneficiary;
    3. The provider agencies are in agreement that a virtual visit is in the best interests of the beneficiary;
    4. The legally responsible individual or family members living in the home are not paid caregivers;
    5. Technology is available to complete the visit with direct observation of the beneficiary and the home;
    6. There is evidence that the requirements for the quarterly visit can be completed virtually.

The CPOC Quarterly Review form is beneficiary specific and must be printed from LSCIS *prior* to the visit. 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 CPOC Quarterly Review provides a forum for discussion with the beneficiary regarding their satisfaction with the services they are receiving.

<u>Before your meeting,</u> to generate a CPOC Quarterly Review form:

- Add a CPOC of the appropriate type (Interim or Annual) prior to the Quarterly Review meeting.
- If you know of any updates to the Service Needs and Supports Section, make them now so that all service needs will show up on the Quarterly Review form.
- Print out the CPOC with the Quarterly Review form by hitting the Printer icon under the Print column and answering "Yes" when asked if you want to print the Quarterly Review section also.
- Conduct the Quarterly Review meeting using the information from the printed copy of the CPOC and Quarterly Review. A service strategy list is printed below the service needs section to assist in identifying additional service needs. **Individuals participating in the meeting are to sign and date the paper copy including the beneficiary, guardian and SC.** List the SC as an attendee. If the meeting is conducted virtually, the SC must be able to

obtain electronic signature using a HIPAA protected platform for electronic signature or the signature page must be signed off on during the virtual visit with a real, wet signature.

After your meeting when entering the CPOC Quarterly Review information into LSCIS:

- Update the CPOC information and enter any newly requested services on the new CPOC before completing the LSCIS Quarterly Review. The modified and newly requested services will then appear on the LSCIS Quarterly Review from so that they can be addressed.
- Complete the LSCIS Quarterly Review. Do not write over a previous CPOC Quarterly Review. Each Quarterly Review document must be maintained in LSCIS. All sections of the Quarterly Review form must be completed.
- The Service Needs section of the Quarterly Review should document if services are requested, received and the Progress/Status should document if the beneficiary is satisfied with the service, their provider, and the current status of the service need.
- Any health changes, safety issues, or changes in living situations.
- Explanation and review of Medicaid Services Chart, Services Available to Medicaid Eligible Children under 21, Rights and Responsibilities, Grievance Policy, Abuse Policy, and Complaint Process.
- Discussion with the beneficiary about replacing or continuing to receive the IEP services during the summer months.
- Address if the beneficiary is receiving the services requested, if services are delivered at the times/days needed, if the beneficiary is pleased with the services received, and if additional services are requested.
- If any complaints are detected against a FFS provider, the beneficiary should be given *Appendix Q - Complaint Form* to complete and return to Health Standards. If the beneficiary has a complaint against their MCO, they should be given *Appendix R - Managed Care Complaints* which includes the Medicaid Managed Care Program Assistance Line at 1-855-229-6848 and the healthy@la.gov e-mail address for complaints against an MCO provider or a MCO.
- If the Support Coordinator detects the beneficiary has any dissatisfaction with a service provider, it is the Support Coordinator's responsibility to assist the beneficiary in resolving any problem and let the beneficiary know of his/her right to change providers.
- **Quarterly Review - Notes:** Summary that includes the synthesis of all activities for a specified period which addresses significant activities, summary of progress/lack of progress toward desired outcomes and changes to the social history. This summary should be of sufficient detail and analysis to allow for evaluation of the appropriateness of the current CPOC, allow for sufficient information for use by other support coordinators or their supervisors, and allow for evaluation of activities by program monitors.
- The Support Coordinator Date is the date of the meeting, not the date the form was entered.
- Complete the Virtual Visit Attestation. Select "No" if your meeting is being held face-to-face. Select "Yes" if your meeting is being held virtually and then answer all the questions to assure the visit meets the virtual visit criteria.
- Complete a service log. The service log can state, "Refer to the Quarterly Review on xx/xx/xxxx."
- File the CPOC Quarterly Review signature page.

The Annual CPOC meeting cannot be conducted more than 90 calendar days prior to the expiration of the CPOC (refer to CPOC Updates Report for First CPOC Meeting Date and Next CPOC Due date). A Quarterly Review will not be counted on the required action report if the beneficiary does not have a PA for SC at the time of the quarterly meeting. (Example: If the CPOC was submitted late, your PA will start on the date the approvable CPOC was submitted. If the case transfer of record was not signed at the time of the face-to-face visit, you will not have a PA.)

Redetermination

As part of the Assessment, Support Coordinators must obtain the current Statement of Approval from the LGE. Refer to pages 38-39. Once obtained, the Support Coordinator will enter the date the Statement of Approval was issued into the Evaluation/Documentation section of the CPOC. The SC will either enter the SOA expiration date or check the Permanent box.

If the SOA has an expiration date that falls in the range of the CPOC year, the SC will add Redetermination as a service need. Please choose Redetermination from the service need picklist and then enter the SOA expiration date in the description box (i.e., Redetermination/ 9/25/24).

60 days prior to the SOA expiration date, refer the family to the LGE using contacts on *Appendix J-1 – LGE Directory.* Let the family know that it's time for their redetermination and that they should return any calls or respond to any letters from the LGE to complete the process. Having a current Statement of Approval is required to remain on the DD RFSR, receive a Waiver offer, or have a SUN assessment. Please send any current formal documents to the LGE to assist with their redetermination.

SRI can continue to approve CPOCs that have expired or expiring Statement of Approvals. Do NOT let this delay submittal of the CPOC. If the SOA is expired or expiring, SRI will approve the CPOC and will issue a short-term PA through the last day of the month prior to the SOA expiration date.

If a short-term PA is issued the CPOC Updates Report will continue to show the First CPOC Meeting Date and the CPOC Due Date based on what the CPOC end date will be if approved for continued services so, continue to follow the dates on the CPOC Updates Report. The Approval/Denial notes of the CPOC will alert the SC that a short-term PA was issued due to the need for an OCDD redetermination; will advise the SC to submit the Approval for Continued Services when the process is completed; will advise the SC that if the PA needs to be extended prior to the completion of the redetermination the SC must submit documentation from OCDD regarding the status and their need for additional time to complete the redetermination process; and will indicate what the CPOC Service Dates will be if approved for continued services. Again, the SC must continue to use the CPOC Updates Report to determine the CPOC Due Date. Do NOT use the short-term PA end date (CPOC end date displayed on the beneficiary's client file in LSCIS). Use the Approval/Denial notes and CPOC Updates Report.

If your EPSDT SC PA **expires** due to the need for a redetermination, the SC must complete the following to receive additional PA:

- Contact the LGE. Request a copy of the new SOA **or** the status of the redetermination and their need for more time.

- Send Kim Willems at SRI a copy of the new SOA **or** documentation from the LGE regarding the status of the redetermination and their need for more time (i.e., an e-mail from the LGE).
- SRI will extend the PA. A full PA will be issued if the new SOA is on file. A PA extension will be issued if the redetermination is still in process.
- If an additional PA extension is needed, contact the LGE for another update. Forward the SOA or the LGE's response regarding the status of the redetermination and their need for more time to Kim Willems at SRI so a full PA or additional PA can be issued.

If the redetermination is **closed** by the LGE, the family has the following options:

1. Complete the Redetermination Process - Contact the LGE to reopen the redetermination and complete the redetermination process so that they remain of the DD RFSR.

2. Decline EPSDT SC - Inform the family how to reopen if they want to request EPSDT SC in the future. Please explain to the beneficiary that if the redetermination remains closed, the beneficiary is no longer eligible for OCDD services and the beneficiary will not receive an OCDD waiver offer or receive any OCDD services; they will be removed from the DD RFSR.

3. Request Special Needs Support Coordination – If the beneficiary/guardian wants to see if they meet the criteria for Special Needs SC, the SC must submit the request to Kim Willems at SRI along with current formal information documents such as the current IEP. BHSF/SRI will temporarily stop their Support Coordination PA and extend it later if needed. LDH will make the Special Needs determination. If the beneficiary is found to meet the criteria, the approval will be sent to SRI and they will be flagged in LSCIS as Special Needs. A copy of the determination will be sent to the SCA for their records. Refer to Appendix H - EPSDT Support Coordination Fact Sheet for Special Needs definition. Please inform the family that if the redetermination remains closed, the beneficiary is no longer eligible for OCDD services and the beneficiary will not receive an OCDD waiver offer or receive any OCDD services; they will be removed from the DD RFSR.

If the beneficiary is issued a **Statement of Denial**, refer to page 53.

Transition/Closure

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

Transition/closure decisions should be reached with the full participation of the beneficiary when possible. If the beneficiary becomes ineligible for services, the support coordinator must notify the beneficiary immediately. **You must inform the beneficiary to contact SRI if they want to access EPSDT SC in the future and give them SRI's 800-364-7828 contact number.** LDH requires a toll-free number for the beneficiaries. This must be documented in the case closure or service logs. Instruct all beneficiaries to update their contact information on the Request for Services Registry.

Closure Criteria

Support Coordination services closure criteria include the following:

01 Recipient moved out of state – Permanent relocation of the beneficiary out of state.

02 Recipient moved to a new region – The beneficiary moved but did *not* transfer to a SCA in their new region and did not refuse EPSDT SC services. If the beneficiary relocates within the state but out of their current region, the support coordinator **must** assist them with linkage to an agency in the new region prior to closure. However, if you're unable to get them linked to a new agency the LSCIS closure report, updated participant contact information, and documentation of actions taken to link/transfer the participant must be sent to Kim Willems at Statistical Resources, Inc. upon case closure. The support coordinator must obtain the beneficiary's new address and contact information and enter it in LSCIS.

03 Recipient Died

04 Recipient aged out of target population - The support coordinator must begin making arrangements for transition six months prior to the beneficiary's 21st birthday. At closure and/or 90 days prior to the beneficiary reaching their 21st birthday, the support coordinator must complete a final written reassessment identifying any unresolved problems or needs. The support coordinator is to discuss with the beneficiary/family methods of negotiating their own service needs.

05 Recipient refused services – The Support Coordinator received actual verbal or written confirmation from the beneficiary that they no longer wanted EPSDT SC. The Support Coordinator must inform them how to access EPSDT SC services in the future (call the SCA within 6 months to reopen or call SRI toll free at 1-800-364-7828 if they want to reopen more than 6 months after case closure).

06 Recipient entered ICF/DD - If the beneficiary is institutionalized for a period not considered temporary. The support coordinator must provide information as to whether this is a permanent or temporary placement such as the need for rehabilitation services.

07 Recipient ineligible for services – If the beneficiary becomes ineligible for Medicaid, they are no longer eligible for Support Coordination. The support coordinator must notify the beneficiary/family immediately. Inform the family to contact you if they become eligible for Medicaid within 6 months to reopen the case and to contact SRI's 800-364-7828 toll-free contact number if they want to access EPSDT SC in the future.

08 Recipient not financially eligible

09 Recipient incarcerated

10 Unresolved difficulties between recipient and support coordinator – If the support coordinator is unable to locate the beneficiary/family or have them respond to phone calls, a notification is to be mailed to the last known address which gives them a deadline to contact you by and informs them that

if they do not meet the deadline their case will be closed. You must inform them to contact SRI if they want to access EPSDT SC in the future and give them SRI's 800-364-7828 contact number. LDH requires a toll-free number for the beneficiaries. This must all be documented in the case closure or service logs. The EPSDT SC Contract Administrator will review all of these closures before SRI closes out the EPSDT SC PA. Please make sure you have enough documentation to support the closure including advising the family to contact SRI toll free at 1-800-364-7828 to request EPSDT SC in the future, if any closure letters were sent to the last known address and what information those letters included, etc. The EPSDT SC Contract Administrator will contact the SCA if more information is needed to complete the closure. **Note: If the beneficiary/family refuses to comply with support coordination requirements, the support coordinator must document all instances appropriately.**

11 Agency Closes – Transfer procedures must be followed. The Agency is responsible for providing services until the transfer of records is completed.

12 Recipient transferred to a new region – The case may be closed by the transferring agency once the transfer of records to the receiving agency is completed. Transferring Agency: If you are notified that a participant has relocated within the state but out of their current region, the support coordinator must assist them with linkage to an agency in the new region prior to closure. The support coordinator must obtain the participant's new address and contact information and enter it in LSCIS. The case will remain open until the Transfer of Records is completed. The transferring support coordination agency shall provide services through the last day of the prior authorization month for which they are eligible to bill. The transfer of records shall be completed by the last week of the month prior to the transfer effective date.

14 Changed Target Population – The beneficiary was certified into another population (NOW, CC, ROW, SW). Note: If the family wants to decline EPSDT SC after linkage to a Waiver and prior to certification, you must use reason **05 Recipient refused services.**

Required Transition/Closure Procedures by the Support Coordinator

Transition/closure decisions should be reached with the full participation of the beneficiary/family when possible. If the beneficiary becomes ineligible for services, the support coordinator must notify the beneficiary/family immediately.

You must inform the beneficiary/guardian to contact SRI if they want to access EPSDT SC in the future and give them SRI's 800-364-7828 toll-free contact number. LDH requires a toll-free number for the beneficiaries. This must be documented in the case closure or service logs.

Instruct all beneficiaries/families to update their contact information on the Developmental Disabilities Request for Services Registry.

The support coordination agency must close the case immediately and enter the closure in LSCIS no later than seven days after closure. All transfers/closures will require a summary of case progress prior to final closure. Agencies will be responsible for deficiencies in services if the case is not closed. Benefi-

ciaries will continue to be included in reports (Aging, Quarterly Report, Timely CPOC, Tracking, etc.) until they are closed in LSCIS. The month that a participant's case is closed becomes the last month of the quarter and all quarterly required services must be completed.

The agency must follow their own policies and procedures regarding intake and closure.

Procedure for Changing Support Coordination Agencies (Transfers)

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

- The beneficiary moves to a different LDH Administrative Region.
- The beneficiary and support coordination agency have unresolved difficulties and mutually agree to transfer. This transfer must be approved by the EPSDT SC Contract Administrator.
- The beneficiary has another family member living in the same home receiving support coordination from another agency.

Once the beneficiary/guardian has selected a new support coordination agency, SRI links them to the support coordination agency and notifies the receiving agencies of the change in linkage. The receiving support coordination agency must complete the Consent and FOC form, Section 3: Transfer of Records. The receiving support coordination agency must obtain the case record and authorized signature from the transferring support coordination agency.

Note: If you are the receiving agency do <u>not</u> enter an "Initial" CPOC for a transfer / moving request Freedom of Choice. An Annual CPOC only needs to be completed if one is due; otherwise, you can pull forward an Interim CPOC. You will know it is a transfer because in Section 3 of the linkage form it will have the name of the agency they are transferring from.

Upon receipt of the complete Transfer or Records form, the transferring support coordination agency must have provided copies of the following information to the receiving agency:

- Participant demographics
- Current and approved CPOC (If the CPOC is expiring, indicate the date it was submitted to SRI for approval)
- Current assessment, EPSDT Screening exams, IEP, and other documents on which the CPOC is based
- The last two Quarterly Reviews (Include any service needs that have not been implemented)
- The most recent 6 months of progress notes
- The current PA tracking logs and PA notices

The receiving support coordination agency must submit the completed Transfer of Records form to the EPSDT SC Contract Administrator to transfer the LSCIS Annual CPOC(s) and the Support Coordination PA. The CPOC dates will not change. The PA for the receiving agency will begin on the first day of the month following the Receiving Agency signature date.

The transferring support coordination agency shall provide services through the last day of the prior authorization month for which they are eligible to bill. The transfer of records shall be completed by the last week of the month prior to the transfer effective date. The receiving support coordination agency shall begin services within three calendar days after the effective date of the prior authorization.

Transition of the Beneficiary into a Waiver

If the beneficiary becomes eligible for a waiver, a FOC will be provided to the beneficiary/family by SRI to request services under the waiver. The FOC form will be sent to SRI for linkage. The beneficiary/family may choose a different agency for waiver services. **If the beneficiary changes agencies, the beneficiary will be linked to the receiving agency for both EPSDT and waiver support coordination services.**

The support coordination agency is responsible for ensuring that an approved EPSDT plan of care is in place until the waiver certification is issued. If an approved EPSDT plan of care is not in place for the entire waiver linkage period up through the day prior to waiver certification, the EPSDT PA will end on the day of waiver linkage.

The EPSDT case will remain open until receipt of the waiver certification or refusal of EPSDT SC services by the beneficiary/legal guardian. The EPSDT case must be closed when the beneficiary is certified into waiver. Use closure reason “change in target population” when the waiver certification is issued or “refused services” if the beneficiary/legal guardian declines EPSDT SC services while waiver certification is pending.

When the waiver certification is received, the PA for EPSDT services will be adjusted as follows, provided that an approved EPDST plan of care is in place up through the day prior to waiver certification:

- the day prior to the 18-W **effective** date.

Procedure for a Statement of Denial

If a Statement of Denial (SOD) is issued by OCDD, the family has 30 days from the date the SOD was received to file an appeal. Refer beneficiaries to Disability Rights Louisiana for assistance (1-800-960-7705). If they do not file an appeal within the timeline, they cannot continue to receive EPSDT SC unless it is determined that they meet the criteria for Special Needs SC. If the SOD stands, the beneficiary is no longer eligible for OCDD services and the beneficiary will not receive an OCDD waiver offer or receive any OCDD services; they will be removed from the DD RFSR. If the beneficiary/guardian wants to see if they meet the criteria for Special Needs SC, the SC must submit the request to Kim Willems at SRI along with current formal information documents such as the current IEP. BHSF/SRI will temporarily stop their Support Coordination PA and extend it later if needed. LDH will make the Special Needs determination. If the beneficiary is found to meet the criteria, the approval will be sent to SRI and they will be flagged in LSCIS as Special Needs. A copy of the determination will be sent to the SCA for their records. Refer to Appendix H - EPSDT Support Coordination Fact Sheet for Special Needs definition.

Procedure for Closure of Initials

Kim Willems at Statistical Resources, Inc. must be contacted by e-mail (ksalling@statres.com) or letter when a beneficiary that has not had an initial face to face assessment or been issued a PA is closed. Documentation to support the closure must be found in LSCIS to have the linkage closed. If this is not done, they will remain linked to the agency and will continue to show up on reports. When closing initial linkages document why they requested and then declined SC. EPSDT SC is not just for beneficiaries with a need for PCS. The beneficiary/family made the effort to receive the service by completing and submitting a FOC for the linkage. Kim Willems may have additional information regarding referrals from OCDD, DCFS, social worker, etc. The closure must document that the beneficiary/guardian was instructed to contact SRI if they want to access EPSDT SC in the future and was given SRI's toll-free 1-800-364-7828 contact number. LDH requires a toll-free number for the beneficiaries. This must be documented in the case closure or service logs.

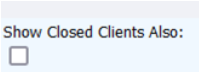
Procedure for Reopening a Case

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

If it has been **less than 6 months** since the closure, the support coordination agency can contact Kim Willems at Statistical Resources, Inc. to reopen the linkage and have the PAs reissued. Please e-mail the request to ksalling@statres.com. The request must include the following information: agency name and region, beneficiary name, and date of re-entry. SRI does not verify Medicaid eligibility nor determine if the beneficiary is in the target population. It is the responsibility of the provider to ensure eligibility.

When you reopen the file in LSCIS, enter a service log to document the date the case was previously closed with the reason for the closure. Also document the contact requesting the case to be reopened. This will document why there may be a gap in services and required actions. To reopen the case in LSCIS:

1. Find Client – Make sure you click the show closed clients also box before you search:

2. Click Select.
3. Click on Closure Information – Make sure the case closure has been printed out for the record/file.
4. Click Edit.
5. Delete the case closure date.
6. Click Save.
7. Case is reopened.
8. Enter a service log documenting when and why the case was closed and when and why the case was reopened.
9. Notify Kim Willems at SRI that the case was reopened and request PAs be reissued. You must provide the beneficiary's name, case closure date, and date the case was reopened.

The CPOC must be revised if there are significant changes in the services needed but the CPOC date will not change. If the CPOC expired, and a new CPOC was not approved before closure, then a new CPOC with a new begin and end date must be completed and approved.

If the case has been closed **more than 6 months**, the beneficiary should be instructed to call SRI at 1-800-634-7828 to request services again. This will result in a new linkage being sent to the Agency. You will open the case under a new case number as an Initial.

What Happens at age 21?

When beneficiaries turn 21, they become ineligible for some of the services they had qualified for under Medicaid, including EPSDT support coordination, EPSDT Personal Care Services, Extended Home Health Services, Disposable Incontinence Products, and other items or services that are not part of Medicaid services 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 beneficiaries 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 beneficiary's 21st birthday. The transition strategy should include informing the beneficiary of LT-PCS, OCDD services, how to obtain the services he/she now receives, link to resources to receive those services, change in Medicaid services on 21st birthday- encourage to obtain exams, glasses, DME, etc. prior to aging out.

Available services may include:

- OCDD services, including (in addition to those listed above) extended family living, supported independent living, and vocational and habilitative services. Contact the local District/Authority to request ID/DD supports. Local District/Authority contacts can be found on *Appendix J-1 – Local Governing Entity (LGE) Directory.*
- Specialized Behavioral Health Services - The provider agency may need to be changed if the current provider only services children.
- Long Term - Personal Care Services (LT-PCS) - Contact Louisiana Options in Long Term Care at 1-877-456-1146 (TTY 1-855-296-0226); for beneficiaries age 21 and older. A representative from Conduent will be contacting the beneficiary a couple of months before the beneficiary turns age 21 to assist him/her with the LT-PCS application process. All efforts will be made to use the existing medical information on file when determining the beneficiary's eligibility for this service; however, the beneficiary may be asked to have his/her doctor complete a medical assessment form. The SC should inform the family to expect notification via phone or mail.
- OAAS Community Choices Waiver and Adult Day Health Care Waiver services – Contact Louisiana Options in Long-Term Care at 1-877-456-1146 (TTY 1-855-296-0226) to be placed on a waiting list. Only beneficiaries without a Statement of Approval for Developmental Disability services through OCDD can be added to the OAAS waiting lists such as those beneficiaries receiving Special Needs Support Coordination.
- Louisiana Rehabilitation Services may provide assistance with services needed to pursue short or long-term employment goals including higher education.

Part 4 – Coordination of Services

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 SC must provide information, education, linkage and referrals to formal and information services, supports and resources. Referrals are self-determined by the individual and align with the individual's goals, cultural beliefs and values. Resources and opportunities are identified in the community in which the individual lives and that match their interests or preferences. Unbiased information about a variety of possible formal and informal resources is shared. Once a referral is made, the SC is responsible for follow-up contacts with referrals to confirm connections are made. The SC agency is responsible for maintaining a current resource file that identifies and describes resources and sharing knowledge of community resources.

The SC is responsible for identifying referrals to the following types of resources including but not limited to:

- Assistive Technology – evaluation and/or provision of AT
- Communication Aids – evaluation and/or provision of aids
- Community Housing Resources
- Community Support
- Counseling
- Home Accessibility Adaptations
- Home Health
- Job Development
- Nursing Care
- Occupational Therapy
- Personal Care Services
- Physical Therapy
- Respite Services
- Specialized Medical Equipment and Supplies (DME)
- Speech Therapy
- Transportation Services

Non-Medicaid Services

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 Support Coordinator must be knowledgeable of potential community resources, including formal resources such as Supplemental Nutrition Assistance Program, SSI, and housing.

The Support Coordination Agency must have knowledge of available community services and methods for accessing them including:

- Have established linkages with the resources available in the community relevant formal and information service providers and community agencies.
- Maintain a current resource file (updated annually) of formal and informal medical, behavioral health, social, financial assistance, vocational, education, housing and other support services available to the unique needs of the target population within the community.
- Demonstrate knowledge of the eligibility requirements and application procedures of federal, state, and local government assistance programs which are applicable to beneficiaries served.

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

Prior Authorized Services

What is a Prior Authorization?

Prior Authorization is a requirement that a provider obtains approval from the beneficiary's health insurance *before* providing a particular service. Prior Authorization is also known as pre-approval. Prior Authorization decisions are reached based on the medical necessity of the request.

Some Medicaid services such as Personal Care 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 beneficiary, the provider, and to you, the Support Coordinator

For beneficiaries in FFS for their physical health services, prior authorization requests are acted on by the Prior Authorization Unit of Gainwell Technologies, a company that contracts with the Louisiana Department of Health to perform this function.

For beneficiaries in MCO for their physical health services, prior authorization is handled by the individual health plan.

The beneficiary's Managed Care Organization must prior authorize some specialized behavioral health services including, but not limited to, CPST – MST, FFT/FFT-CW, Homebuilders, and ACT – and PSR, TGH, PRTF, and residential substance use disorder services. For children and youth enrolled in CSoC their behavioral health services are authorized by Magellan, except PRTF, TGH and residential substance use disorder services which will be accessed through their MCO.

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 beneficiary, the provider, and you, the Support Coordinator. The beneficiary then has the right to appeal the denial.

If services are approved, the provider and the beneficiary 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** the Fiscal Intermediary Gainwell Technologies for FFS or the beneficiary's MCO for Managed Care **at least 25**

calendar 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 calendar days ahead of the end of the authorization period ***and*** the appeal was filed within the 30-day appeal period. Beneficiaries have 30 calendar days to file an appeal request after the notice of denial of services.

Prior Authorization Liaison (PAL)

The Prior Authorization Liaison (PAL) unit was established to facilitate the PA approval process for Medicaid beneficiaries under age 21 who are on the Developmental Disabilities Request for Services Registry and to assure that requests for prior authorization are not denied simply because of a lack of documentation. The PAL will maintain a tracking system to ensure support coordinators remain aware of the status of PA requests, submission dates, decision dates, reconsiderations, and any delays to the PA approval process.

There is a PAL within the Louisiana Department of Health (called the LDH PAL) and a PAL within each MCO (called the MCO PAL). Both PALs assist providers and support coordinators with prior authorization requests – the LDH PAL for physical services for beneficiaries who are under FFS, and the MCO PALs for all behavioral health services and for physical health needs of beneficiaries who are enrolled in a MCO for those services.

Louisiana Department of Health Prior Authorization Liaison (LDH PAL)

The LDH PAL assists providers and support coordinators with prior authorization requests for physical services for beneficiaries who are under FFS.

The prior authorization units at Gainwell Technologies (for FFS beneficiaries) 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 LDH PAL. The LDH PAL contacts the provider, Support Coordinator and beneficiary when attempting to gather the correct information for resubmission to Gainwell Technologies (for FFS beneficiaries), so a final decision regarding approval or denial of service can be made. The first of these contacts may be by phone or fax. Within 10 days of the submission of the prior authorization request, if the problem has not been resolved, the LDH PAL will send a Notice of Insufficient Documentation to the provider, beneficiary, and Support Coordinator. This notice advises of the specific documentation needed and the type of provider that can supply it. The notice also includes a form to return to the LDH PAL with date of appointment and name of provider, and explains how any provider can contact the LDH PAL to find out what information is needed. The beneficiary has 30 calendar days to either supply the needed documentation, or notify the LDH PAL with the appointment date that has been made with the health professional to obtain it. The Support Coordinator should assist the beneficiary in this process. The provider submitting the request is instrumental in gathering the required information when contacted by the LDH PAL. However, the Support Coordinator should work very closely with the provider and offer any assistance possible to assure that Gainwell Technologies receives all necessary information to make the decision that is in the beneficiary's best interest.

The LDH PAL fulfills the function of alerting the Department of the need to take reasonable steps to locate a willing and able provider of prior authorized services. The LDH PAL must be notified for all FFS beneficiaries, when no provider willing and able to provide needed services has been located.

The LDH PAL can be reached at 1-888-758-2220 or 225-342-6711.

Managed Care Organization Prior Authorization Liaison (MCO PAL)
The MCO PAL assists providers and support coordinators with prior authorization requests for all behavioral health services and for physical health needs of beneficiaries who are enrolled in a managed care plan for those services. The MCO shall have a PAL to assist the enrollee with the prior authorization process for all prior authorized services. There are two PAL functions with the MCO, the Coordinator PAL and the Utilization Management (UM) PAL. The Coordinator PAL's function is to assist in locating providers; ensuring that prior authorization requests are submitted and reviewed in a timely manner; and ensuring that services have started once the prior authorization is in place. The UM PAL assists in ensuring that authorization request decisions are made based on medical necessity and not a technical defect.

The UM PAL shall communicate with support coordinators, providers and enrollees on prior authorization requests for prior authorized services.

The prior authorization unit at each Managed Care Organization (for Medicaid Managed Care members), 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 MCO PAL. The MCO PAL contacts the provider, Support Coordinator and beneficiary when attempting to gather the correct information for resubmission to the Managed Care Organization, so a final decision regarding approval or denial of service can be made. The first of these contacts may be by phone or fax. Within 10 days of the submission of the prior authorization request, if the problem has not been resolved, the MCO PAL will send a Notice of Insufficient Documentation to the provider, beneficiary, and Support Coordinator. This notice advises of the specific documentation needed and the type of provider that can supply it. The notice also includes a form to return to the MCO PAL with date of appointment and name of provider, and explains how any provider can contact the MCO PAL to find out what information is needed. The beneficiary has 30 calendar days to either supply the needed documentation, or notify the MCO PAL with the appointment date that has been made with the health professional to obtain it. The Support Coordinator should assist the beneficiary in this process. The provider submitting the request is instrumental in gathering the required information when contacted by the MCO PAL. However, the Support Coordinator should work very closely with the provider and offer any assistance possible to assure that the MCO receives all necessary information to make the decision that is in the beneficiary's best interest.

The MCO must be notified for all Medicaid Managed Care beneficiaries when no provider willing and able to provide the needed services has been located.

Refer to *Appendix X-2 – MCO Contacts for Support Coordinators* for the MCO PAL contact information.

Support Coordinator Role in the Prior Authorization Process

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

- assisting beneficiaries 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 BB-1 – PA Request Forms and Physician Forms*, LaMedicaid.com or the LDH 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 MCO/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 beneficiary with making a decision about whether to appeal any denials of services, and assisting with the appeal if the beneficiary decides to appeal and wants assistance.

Support Coordinator Role in Coordinating Medicaid Services that do not Require a Prior Authorization

Even if a Medicaid service does not require a Prior Authorization, the Support Coordinator is still responsible for ensuring the services are received and may need to assist with obtaining the prescription or letter of medical necessity, scheduling assistance, choice of provider, etc.

The Support Coordinator plays a role in the process by:

- assisting beneficiaries 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 BB-1 – PA Request Forms and Physician Forms*, LaMedicaid.com or the LDH website);
- assisting with the scheduling of physician appointments, transportation, etc., to have the forms required completed;
- locating willing providers;
- assisting, if necessary, in assembling documentation needed to support the service;
- making sure providers provide services timely and tracking the status of services;
- communicating with the MCO;
- following through with requests for services until the service is received .and
- assisting the beneficiary with making a decision about whether to appeal any denials of services, and assisting with the appeal if the beneficiary decides to appeal and wants assistance.

Even if a service does not require a Prior Authorization from Medicaid, the beneficiary may still need medical forms to support the medical necessity of the service. For example, incontinence supplies through MCOs do not require a PA but, the provider still submits a prescription to receive reimbursement from the MCO for the service.

Support Coordinator Role in Locating Medicaid Providers

Freedom of Choice

When a beneficiary requires a Medicaid service, you must refer the beneficiary to the appropriate provider of his/her choice. Unless the beneficiary already has a provider he or she is satisfied with, you

must give the beneficiary a **current** list of agencies where the service they need is offered. From that list, the beneficiary will choose the provider they prefer.

The Support Coordinator cannot tell the beneficiary which provider to choose. However, the Support Coordinator may recommend to the beneficiary/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 beneficiary/family list the provider they choose and sign *Appendix T – Choice of Provider Form.* 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 beneficiary's choice of provider. Make a referral to the provider and mail a copy of the verbal COP to the beneficiary/family.

The support coordinator may also need to assist the beneficiary in contacting prospective providers and finding out if they are willing to submit prior authorization requests and able to provide the services once approved.

Locating Fee-For-Service Medicaid Providers - Physical Health Services
As a Support Coordinator, you can contact the **Specialty Care Resource** to find FFS medical providers of various types and specialties for referral of your beneficiaries. 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 Medicaid Specialty Care Help Desk 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 *Appendix E* - Medicaid Services Chart for that service. For Personal Care Services and Extended Home Health, call LDH at 1-888-758-2220 and refer to *Appendix B – FFS Service and Equipment Flyer.* To obtain the most recent Medicaid Services Chart please visit this website: http://ldh.la.gov/assets/docs/Making_Medicaid_Better/Medicaid_Services_Chart.pdf

A list of available FFS providers is also available through the Medicaid website at ldh.la.gov/medicaid. Click Locate a Provider, select Medicaid under Service Type, chose one of the "Provider Groups" from the drop-down menu, enhance your search by choosing a specialty from the Provider Specialties drop down menu, and then click on the region or parish where the beneficiary lives. The direct website address to find a provider is:
https://www.lamedicaid.com/apps/provider_demographics/provider_map.aspx.
The EPSDT Provider list for Personal Care Services (PCS) for FFS beneficiaries can be accessed at ldh.la.gov/Medicaid. Click Locate a Provider, select Personal Care Services from the Provider Groups picklist, and the region or parish where the beneficiary resides.

Locating Medicaid Managed Care Providers - Physical Health Services
For Medicaid Managed Care members, the list of providers can be accessed via the online provider directory at: http://myplan.healthy.la.gov. Select Choose > Find a Provider. Choose between

Behavioral Health and Medical Health Providers. Indicate if you know the provider's name or phone number. You can look up a specific provider to see what MCO they are affiliated with by selecting "Yes" and then entering the Doctor/Provider's name. If you select "No" you can search by Provider Location and then select the Provider Specialty and narrow the results down further by provider gender (for doctors), provider language or which Plan they are affiliated with. Note: You can search for EPSDT-PCS by selecting Personal Care Attendant from the Provider Specialty picklist.

You can also find providers by calling the Member Services Line at each Managed Care Organization to locate a provider in their network. You can also find providers by accessing the MCO's websites to identify contracted providers. Refer to *Appendix C – MCO Service and Equipment Flyer*. To search for EPSDT-PCS providers please refer to *Appendix BB-7 – EPSDT-PCS FAQ and Guide to Provider Locator Tools*.

Locating Medicaid Managed Care Providers - Behavioral Health Services
Specialized behavioral health services were integrated into the Medicaid Managed Care Program beginning on December 1, 2015. For beneficiaries enrolled in Coordinated System of Care (CSoC), see Locating Behavioral Health Providers – CSoC Enrollees below. For all other beneficiaries, contact their Managed Care Organization to find out how to obtain behavioral health services: https://www.myplan.healthy.la.gov/en/contacting-your-health-or-dental-plan.

Locating Evidence Based Program (EBP) Providers
To locate EBP providers near you, you can: use the interactive map, download the PDF sorted by region, or contact the beneficiary's Managed Care Organization to ask for a list of EBP providers in their provider network.

The interactive map can be found here: https://laevidencetopractice.com/interactivemap/,
Search by Region – Enter a location in the search bar, which can be found in the upper right-hand corner of the map. The map will then zoom in on the area entered. Click on circles to view provider information. Each circle represents a different provider, and each color represents a different EBP (as described in the Legend). Search by EBP - In the upper left-hand corner, click on the arrows to open up the legend. Check the boxes for the EBPs you would like to view. Map will adjust to present selected EBPs. Click on circles to view provider information. Each circle represents a different provider, and each color represents a different EBP (as described in the Legend).

You can download regional PDF lists of verified EBP Providers presented in the interactive map here: https://laevidencetopractice.com/interactivemap/.

You can contact the beneficiary's MCO, and ask for help from a Behavioral Health Care Manager to find an EBP provider that is appropriate for the beneficiary.

The practitioner or agency you contact will make sure that the program you have in mind aligns with the child and caregiver's needs. After an assessment, the provider will either start EBP treatment or refer you to a provider that offers the EBP that they believe would be a better fit.

Locating Behavioral Health Providers - Coordinated System of Care (CSoC) Enrollees
For youth enrolled in the Coordinated System of Care (CSoC) waiver program, specialized behavioral health services are managed by the CSoC Contractor, Magellan Health Services of Louisiana. Specialized behavioral health services can be accessed by contacting Magellan at 1-800-424-4489/TTY 1-800-424-4416. The SC should also consult with the Wraparound Agency to have the provider and service added to the youth's plan of care and be included in the Child and Family Team (CFT). Note: PRTF, TGH and substance use residential services will be prior authorized by their Managed Care Organization.

Locating Transportation Providers – NEMT and NEAT
All beneficiaries can access non-emergency medical transportation (NEMT) through their Managed Care Organization. The transportation phone numbers for each MCO can be found on *Appendix C – MCO Service and Equipment Flyer* and on Table 3 found on page 20. Medicaid beneficiaries eligible for non-emergency ambulance transportation (NEAT) services through a health plan should contact the call centers for NEAT services on Table 4 found on page 21.

Locating Dental Providers
For full dental provider lists, contact their Dental plan to obtain a list of available providers: DentaQuest at 1-800-685-0143 or visit dentaquest.com or MCNA Dental at 1-855-702-6262 or visit mcnala.net.

Waitlist Placement
If at any time a beneficiary is placed on a waitlist for a needed service, the SC must document that the class member was offered alternative providers for whom there might not be a waiting list and document the response received from the beneficiary. The beneficiary may choose to wait for the particular provider to have availability or they may choose to continue to look for alternative providers. This must be documented on the CPOC.

The SC must complete *Appendix V-2 – Referral to PAL* – check box 5 and answer the questions. This must be documented on the CPOC.

The SC must follow up on waitlist placement with the **provider** at least monthly to ensure they move up the waitlist. This must be documented on the CPOC.

Unable to Locate a Provider – FFS
For FFS, if you cannot find a provider which is willing to submit a prior authorization request and able to provide the requested services once they are approved call the LDH program staff line at 1-888-758-2220 and tell them that you cannot find a provider. The SC must complete *Appendix V-2 – Referral to PAL* – check box 4. **If a provider cannot be located, LDH must take all reasonable and necessary steps to find a willing and able provider within ten days.**

Review of Possible Eligibility: If two providers have refused to submit a request for the needed service or if there is no other provider from whom to request the service, beneficiaries 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 are necessary. If Medicaid finds that the beneficiary 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 U - Review of Possible Eligibility Request.*

Unable to Locate a Provider – MCO

For MCO members, if you cannot find a provider from the Medicaid Managed Care Program's website, or the provider directory, which is willing to submit a prior authorization request and able to provide the requested services once they are approved, call the MCO's member services line which operates from 7am-7pm, M-F, for assistance and complete *Appendix V-2 – Referral to PAL* to notify the MCO. The SC must also notify the MCO's member services line and the PAL if the provider is unable to find staff after having received an authorization to provide the service. **The MCO will take all reasonable steps to find a willing and able provider within ten days.** If the MCO is unable to locate a willing and able provider within 10 working days of the Referral to PAL, the MCO must alert the Chisholm Compliance team. This alert should include the actions taken and reasons why the member's services are not in place. **The MCO is contractually responsible for ensuring that services are provided for its beneficiaries including finding an in-home provider within 10 working days of the Referral to PAL.** The MCO may pursue a single case agreement in order to obtain a willing provider.

Review of Possible Eligibility: The MCO must provide a mechanism to ensure that the enrollee can notify the MCO when a provider refuses to submit an enrollee's request for prior authorization of a service (only if prior authorization is required). The MCO shall send a notice to the enrollee and his/her case manager of what was not submitted and shall inform them of a mechanism that can be used to access another provider if so desired. The notice shall state that if two providers have refused to submit the full request, or if there is no provider from whom to request the service, the enrollee can request a review by the MCO of their potential eligibility for the services not submitted. If the enrollee requests the review described above and it includes a physician's statement, the MCO shall review the information provided to determine if the enrollee might meet the criteria to obtain prior authorization of the service sought. If the enrollee could not with further development of the information meet the criteria to receive the service, the MCO shall issue a notice denying prior authorization with the right to request a fair hearing regarding the denial. In all other instances, the determination shall be that with further information prior authorization might be granted. If this is the determination, then the MCO shall find a provider to submit the request or take other steps to obtain a prior authorized decision as to whether the enrollee qualifies for the service.

PA Tracking

When does PA Tracking begin?

With the request for the service. The SC begins PA tracking by adding the service need to the CPOC and checking the Medicaid and Requires PA tracked by SC boxes. After that the SC will begin receiving prompts on the Tracking Required Action report in LSCIS.

What is a PA Tracking log?

The PA Tracking Log is a form in LSCIS that the Support Coordinator uses to document the nature and the specific amount of each service being sought, provider and PAL referrals, and information about approval, denial and appeals.

It is the Support Coordinator's responsibility to track all prior authorization requests on behalf of the beneficiary. To track each prior authorization request, the Support Coordinator must use the EPSDT Prior Authorization Tracking Log. A separate EPSDT Prior Authorization Tracking Log is completed for each service that requires prior authorization. A new tracking log is used for renewals and changes in existing services (i.e., additional hours of service requested, change in providers, etc.).

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

- It will help you assure the beneficiary 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 beneficiary and provided the Appeals Brochure.

Beginning the PA Tracking Process

1. Beneficiary requests a Medicaid service that requires a prior authorization.

2. SC adds service need to the CPOC checking the Medicaid and Requires PA tracked by SC boxes.

3. SC opens a PA tracking log and enters the date the family requested the service into the date service requested box.

4. SC offers freedom of choice. SC may need to assist the beneficiary in contacting prospective providers and finding out if they are willing to submit PA requests.

5. SC provides the specific medical information forms for the requested services. SC is to assist with scheduling the doctor appointment, transportation, etc. as needed. SC is to assist with gathering the appropriate documentation needed to support the request.

ISSUE:
If the SC exhausts the list of available providers at any time and is unable to find a provider that is willing to submit a request for a PA:

For Fee-for-Service:

1. Contact the LDH Program Staff Line.
2. Send *Appendix V-2 - Referral to PAL.*
3. The LDH PAL will take all reasonable and necessary steps to find a willing provider within 10 days of the referral.

For Medicaid Managed Care:

1. Contact the Member Service Line of the MCO. Refer to *Appendix C – MCO Service and Equipment Flyer.*
2. Send *Appendix V-2 – Referral to PAL.*
3. The MCO will take all reasonable and necessary steps to find a willing provider within 10 days of the referral.
4. If the MCO is unable to locate a willing and able provider within 10 working days, the MCO will alert the Chisholm Compliance team. This alert will include the actions the MCO has taken and the reasons why the member's services are not in place.

Choosing a Provider

1. Beneficiary chooses a provider.

2. Have the beneficiary list their chosen provider(s) and sign *Appendix T – Choice of Provider Form.*

3. SC enters COP date and Provider name into tracking log.

4. Within 3 calendar days from date of choice of provider, SC sends *Appendix V-1 - Referral to Provider* – check box 1.

5. Within 15 calendar days from date of referral to provider, SC completes provider contact to confirm they are working on the request and see if they need any assistance gathering information.

6. Within 35 calendar days from date of referral to provider, SC completes provider contact to ask if the request has been submitted to the Fiscal Intermediary Gainwell Technologies for FFS or the beneficiary's MCO for Managed Care or if there are any problems you can assist with.

Waitlist Placement

1. SC completes 15-day provider contact and confirms beneficiary was placed on a waitlist.

2. SC must offer beneficiary alternative providers for whom there may not be a waitlist and document beneficiary's response.

3. If the beneficiary wants to choose another provider begin the process again by entering a Change in Service tracking log (date of service remains the same as previous log) and follow up with family on choice of provider.

4. SC sends *Appendix V-2 - Referral to PAL* to notify PAL of waitlist placement – check box 5 and answer questions. The SC must indicate if they were able to confirm waitlist placement with the provider or if they need assistance from the PAL to do so. The SC must document if the family declined alternative providers or if they want to continue to look for alternative providers. The SC must indicate the date the beneficiary was placed on the waitlist and the estimated wait time.

5. After waitlist placement is confirmed with the provider and the PAL is notified, the SC can then enter an Interim CPOC and uncheck the Requires PA tracked by SC box on the service need. Note: you must have a tracking log with the following information in order to untrack the service need due to waitlist placement:

a. Date of Service Request
b. Date of COP
c. Provider
d. Date of Referral to Provider
e. Day Provider Contact

6. SC must document the following in the Additional Information section of the CPOC:

a. SC confirmed waitlist placement with provider.
b. SC notified PAL of waitlist placement.
c. SC offered the beneficiary alternative providers for whom there may not be a waitlist and document beneficiary's response.
d. How the SC will ensure the beneficiary moves up the waitlist (follow up with the provider at least monthly).

7. Continue to follow up with provider at least monthly to ensure they move up the waitlist and offer family alternative providers.

8. SC will resume PA tracking when SC is notified that the beneficiary is off of the waitlist.

PA Packet

1. Enter the date the provider submitted the PA packet to the Fiscal Intermediary Gainwell Technologies for FFS or the beneficiary's MCO for Managed Care into the date packet submitted to FI/MCO box on the tracking log.

2. If SC receives the PA packet enter the date received into the Date Provider PA Request Packet Received box of the tracking log. If it's not received check the Not Received box on the tracking log.

ISSUE:
If PA packet is not submitted within 35 calendar days of Referral to Provider:

- SC must offer beneficiary alternative providers. If the beneficiary wants to choose another provider, begin the process again by entering a Change in Service tracking log (date of service request remains the same as previous tracking log).
- Send *Appendix V-2 – Referral to PAL* – check box 1.
- Continue to follow-up with the provider until the PA packet is submitted and remind the beneficiary that they can change providers.

Decision Notice

1. When you receive the notice of decision, enter the following information into the tracking log:
   - Date of Decision

- Date PA Notice Received
- Amount of Service Approved
- PA Begin Date
- PA End Date
- If PA was not issued within 60 days of request, enter the explanation.
- Approval/Denial Status

2. If a notice of decision or a PAL notice is not received within 10 calendar days of the date the provider said they submitted the request to the Fiscal Intermediary Gainwell Technologies for FFS or the beneficiary's MCO for Managed Care (or 25 calendar days if it's a DME request), contact the provider. Continue to follow up until the PA is approved or denied based on medical necessity.

ISSUE:
If PA decision is not received within 60 calendar days of date of choice of provider:
Send *Appendix V-2 – Referral to PAL* – check box 2.

Notice of Denial

For Fee for Service Medicaid:

1. Within 4 calendar days from the notice of denial:
   - Explain appeal rights and offer assistance
   - Explain that the provider can request a reconsideration
   - Explain that services can be continued pending appeal if the appeal is filed within 30 days of the notice of denial if the denial was from a request for renewal of services and the renewal request was submitted 25 days before the expiration of services.

2. 20 days from date appeal request filed:
   - Check on appeal status and if additional assistance is needed with the appeal.

3. 90 days from date appeal request filed:
   - Check on final outcome of appeal.

4. Enter the following information into the tracking log:
   - Date Denial of Service Notice Received
   - Approval/Denial Status
   - Reason for Denial
   - Date Appeal Rights Explained
   - Date Appeal Brochure Provided
   - Offered to Help with Appeal Date
   - Is Client Appealing
   - Request Assistance with Appeal
   - Date Appeal Sent to LDH
   - 20 Day Appeal Follow Up
   - 90 Day Appeal Follow Up

- Date of Appeal Decision
- Appeal Outcome

For Medicaid Managed Care:

1. Within 4 calendar days from the notice of denial:
    - Explain appeal rights and offer assistance
    - Explain that the provider can request a peer-to-peer review.
    - Explain circumstances in which continued benefits are provided on appeal under Managed Care. A member is only entitled to a continuation of benefits pending resolution of an appeal or state fair hearing when a previously authorized benefit is terminated, suspended, or reduced prior to the expiration of the current service authorization.

2. 20 days from date appeal request filed:
    - Check on appeal status.

3. Enter the following information into the tracking log:
    - Date Denial of Service Notice Received
    - Approval/Denial Status
    - Reason for Denial
    - Date MCO Appeal Rights Explained
    - Offered to Help with MCO Appeal Date
    - Is Client Appealing
    - Request Assistance with MCO Appeal
    - Date Appeal Sent to MCO
    - 20 Day MCO Appeal Follow Up
    - Date of MCO Appeal Decision
    - MCO Appeal Outcome
    - MCO Appeal Notes

After the Medicaid Managed Care appeal is exhausted, Division of Administrative Law (DAL) State Fair Hearing (SFH):

1. Within 4 calendar days from notice of Appeal Denial from the MCO:
    - Explain DAL State Fair Hearing (SFH) rights and offer assistance.

2. 20 days from date of SFH request filed:
    - Check on SFH status and if additional assistance is needed.

3. 90 days from date SFH request filed:
    - Check on final outcome of SFH.

4. Enter the following information into the tracking log:
    - Date Appeal Rights Explained
    - Date Appeal Brochure Provided
    - Offered to Help with Appeal Date

- Is Client Appealing
- Request Assistance with Appeal
- Date Appeal Sent to LDH
- 20 Day Appeal Follow Up
- 90 Day Appeal Follow Up
- Date of Appeal Decision
- Appeal Outcome

Renewals

1. For Fee-for-Service: 45 - 60 days prior to end of PA period, begin the Renewal process.

   For Medicaid Managed Care: 20 - 60 days prior to end of PA period, begin the Renewal process.

2. Enter the Date Renewal Sent and new tracking started into the current tracking log.

3. Open a Renewal tracking log:
   a. Keep the date of service request the same as the previous tracking log.
   b. Enter a new date of COP = the date you started the Renewal and confirmed the beneficiary wants to stay with their current provider.

4. Send *Appendix V-1 - Referral to the Provider* to remind the provider to renew the PA – check box 3. Enter this date in the Date of Referral to Provider box.

ISSUE:
If you have not received a notice of approval from the Fiscal Intermediary Gainwell Technologies for FFS or the beneficiary's MCO for Managed Care **for the renewal and the previous PA expired**:
Send *Appendix V-2 - Referral to PAL* – check box 3.

Other Issues

If the beneficiary needs a schedule change:
Send *Appendix V-1 - Referral to Provider* – check box 2.

If the provider needs to submit additional information with the PA request and you received a PAL notice:
Send *Appendix V-1 - Referral to Provider* – check box 4.

If service is not provided at the times requested:
Send *Appendix V-2 - Referral to PAL* – check box 6.

If service is not provided in the amount PAed,
Send *Appendix V-2 - Referral to PAL* – check box 7.

If at any time the provider is not working on behalf of the beneficiary:

Send *Appendix V-2 - Referral to PAL* – check box 8.

PA Tracking Frequently Asked Questions

What are valid reasons for not PA Tracking?
For Service Needs that have Medicaid checked you must either check "Requires PA Tracked by SC" or select one of these "Reasons for Not Tracking" from the picklist.

1. **A PA is not needed to receive the Medicaid service.**
   If the service is provided by reimbursement instead of through prior authorization. Refer to *Appendix E – Medicaid Services Chart* for FFS and *Appendix X-1 – Contact Information for EPSDT SCA* for MCO PA Look-Up Tools for help determining if the service need requires a PA. The SC must document that you confirmed with the MCO that a PA is not required for the service on a service log and on the notes section of the PA tracking log (if a tracking log was already created). Once you confirm that a Medicaid service does not require a PA, you can uncheck PA tracking, select the reason for not tracking and document in the Additional Information section of the CPOC how you will ensure the service is received. The SC is still responsible for ensuring the services are received and may need to assist with obtaining the prescription or letter of medical necessity, scheduling assistance, choice of provider, etc.

   Also use this reason for one time PAs *after* the item is received. Example: the beneficiary already has a wheelchair and repairs or a new wheelchair are not needed.

2. **The PA is issued monthly.**
   Must obtain and enter a monthly PA into the PA Tracking Log as documentation. Then the service need may be untracked.

3. **The EHH nurse is the person ordering and tracking medical supplies.**

4. **The beneficiary has been placed on a waitlist.**
   Must complete waitlist placement steps prior to untracking. Refer to page 66. PA tracking must resume when their names comes up on the waitlist or they choose another provider.
5. **The beneficiary is receiving the service without a PA.**
   Refer to *Appendix BB-4 – Modification of Rehab Services PA Tracking/PAL Referral*.
   SC must restart tracking when PA is received. Only applies to Rehab Services (ST, OT, PT) that are being received prior to the provider submitting a PA request. If no PA is required, use reason 1.

6. **The beneficiary is in CSoC and the service is being authorized by Magellan.**

Only applies to beneficiaries currently in CSoC and service needs that are being authorized by Magellan (CSoC or specialized behavioral health). If no PA is required, use reason 1.

What are <u>invalid</u> reasons for not PA Tracking?
Family needs to choose a provider – Choosing a provider is part of the PA tracking process. Do NOT untrack due to the family needing to choose a provider, barriers finding a provider, provider looking for staff, etc.

Ask yourself if the service is requested by the family (they want the service) and if it requires a PA from FFS or MCO. If so, the answer is that it most likely needs to be PA tracked unless one of the above valid reasons for not PA tracking applies.

How do I update a service need?
To make changes to the Service Need, open an Interim CPOC and edit the Service Need. Make sure you also update the rest of the CPOC and remove any discrepancies. All identified needs must be addressed and the status of requested services must be included.

- Change in status of request (requested/not requested by beneficiary/family, declined, on hold, family doesn't want)
- Change in status of service being received (received/not received)
- Change in who is funding/administering (Medicaid, School, Community, Family, OCDD)
- Change in PA tracking required (Requires PA tracked by SC or Reason for not Tracking)
- Amount Approved

What if a beneficiary doesn't want a service right now but, will in the near future?
If the beneficiary requests that the service need be placed **on hold**, the SC should update the CPOC Service Need by unchecking the "Requested" box and selecting "Other-explain next page" from the "If not, why not?" picklist. Explain why the service need is on hold in the Additional Information box. When the beneficiary is ready to request the service need, the CPOC must be updated and PA tracking must restart.

What if a beneficiary no longer wants a service?
If the beneficiary **declines** the service need, the SC should update the CPOC Service Need by unchecking the "Requested" box and selecting "Carried over – resolved" from the "If not, why not?" picklist. Clearly document that the service need is declined in the CPOC. If the beneficiary decides to request the service need in the future, a new service need must be added and PA tracking must restart.

What if an item only requires a one-time PA and doesn't need to be renewed?
If the item/durable medical equipment only requires a one-time Prior Authorization, the SC may update the CPOC Service Need by unchecking the "Requires PA Tracked by SC" box and selecting 1 - PA not needed from the "Reasons for Not Tracking" picklist <u>after</u> the initial PA has been obtained, entered into the tracking log, **and** the item has been delivered. If a repair or a new item is needed, PA tracking must restart. Do not resolve the service need unless the beneficiary no longer has/uses the item.

What if I opened a PA tracking log and then find out that a PA is not required?
If you started PA tracking and find that a PA is not required, the SC should update the CPOC Service Need by unchecking the "Requires PA tracked by SC" box and selecting 01 PA Tracking not Required box from the "If not, why not?" picklist. The SC must assure that the service need is delivered.

What if the family changes providers?
If a change in provider is needed, open a Change in Service tracking log. Do not open a new service need.

What if I cannot get a hardcopy of the PA from the provider, Gainwell or the MCO?
You cannot accept a verbal PA from the provider. The Support Coordinator can accept a verbal PA from the LDH PAL or directly from the MCO (MMCCM, MCO PAL, etc.). Document this in the Notes box of the tracking log.

How do you control if the PA Tracking Log is a FFS tracking log or an MCO tracking log?
If the beneficiary has Medicaid Managed Care for their physical or behavioral health services (check e-MEVS to determine) then you need to make sure the Medicaid Managed Care Plan is entered in LSCIS. Once you manually enter the Medicaid Managed Care Plan you are responsible for making any changes.

All Behavioral Health Rehab PA tracking will be under Medicaid Managed Care. LSCIS will do this automatically as long as you select Specialized Behavioral Health from the picklist on the Service Need. The Managed Care Organization's prior authorization unit must pre- approve community psychiatric support and treatment (CPST), psychosocial rehabilitation (PSR), assertive community treatment [ACT (ages 18-20)], functional family therapy/functional family therapy – child welfare (FFT/CWFFT), Homebuilders, and multi-systemic therapy (MST). CPST and PSR providers arrange the assessments necessary to obtain prior authorization for rehabilitation services.

All Applied Behavioral Analysis PA tracking will be under Medicaid Managed Care. LSCIS will do this automatically as long as you select ABA from the Service Need picklist.

How does PA Tracking work for ABA?

- Clinical Diagnostic Evaluation (CDE): The member's MCO is responsible for arranging and finding a CDE provider. The SC must document the date that the SC and/or beneficiary requested a CDE from the MCO. The SC should follow up with the MCO, beneficiary, and provider and ensure the CDE is completed.
- Follow up on the status of ABA service as needed and at least monthly i.e., status of CDE, CDE scheduled, on waiting list for CDE, CDE completed, waiting list for ABA, request for ABA assessment completed, ABA assessment completed, Behavior Treatment Plan (BTP) submitted for approval, services approved, services started.
- Once a COP has been made and *Appendix V-1 – Referral to Provider* has been sent, contact the provider and find out what their process is.
- If the beneficiary is placed on a waitlist follow waitlist placement procedures on page 62.

What age does PA tracking begin for diapers?
PA tracking can begin 60 days prior to the child's 4th birthday. Instruct the provider to use the child's 4th birthday as the PA service begin date.

The PA Tracking Log only captures a snapshot of information, like two provider contacts (15 day and 35 day). Are those the only contacts I'm required to do? Where does documentation for the rest of the work I do to obtain the PA go?
One of the primary responsibilities of the Support Coordinator is to follow through with requests for services until the Prior Authorization is either approved or denied based on medical necessity and when approved, make sure the services are provided as authorized. You must continue to contact all parties as needed until the PA is obtained. The SC must address all barriers and assist the family as needed. Do not wait for the next monthly contact. Be proactive.

If you don't document it, it didn't happen. The Support Coordinator must document all contacts with the beneficiary, provider(s), MCO, LDH, etc. in a service log.

Use the notes box on the PA tracking log to keep track of what's going on and what attempts have been made to assist with obtaining the PA.

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 calendar 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 for a FFS beneficiary, the provider may call the Prior Authorization Unit (PAU) at 1-800-488-6334. NOTE: Emergency requests cannot be submitted via e-PA.

To submit an emergency request for a PA for a MCO member see *Appendix X-2 – MCO Contacts for Support Coordinators*, Escalation Contacts.

In the event of an **emergency medical need where a delay of twenty-five (25) *calendar* 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 verbal 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 or the MCO within two working days of the date the completed request is received, and the PAU or the MCO will contact the provider by telephone. The PAU or the MCO will follow-up with written confirmation of the decision.

PA Notices

You will need to obtain the PA notice from the provider or MCO. Request the PA notice 10 calendar days after the PA request was submitted to Gainwell Technologies or the Managed Care Organization (25 calendar days if for DME requests) as prompted in LSCIS. This will prevent the SC from missing required activities. If the provider does not respond, contact the PAL (LDH or MCO). Follow-up with the family, provider, and/or MCO to be informed timely of PA notices or denials. The SC should be informed of the PA status.

Types of PA Notices

Notice of Insufficient Documentation

- If a Notice of Insufficient Prior Authorization Documentation (NOISD) was received by the provider the Support Coordinator needs to act timely to obtain information or offer to assist with an appeal. Make sure the information is sent to the PAL. (If you obtain the PA request packet from the provider when they submit it to the Fiscal Intermediary Gainwell Technologies for FFS or the beneficiary's MCO for Managed Care, you may identify errors, such as a missing signature, Rx, Plan of Care or if the Form 90 does not document the need for assistance with ADLs, before a denial or NOISD is received. The Support Coordinator can intervene to have the information corrected.)
- Call the family and explain what is needed.
- Contact the PAL if it is not clear what is needed.
- Work with the provider to obtain the information.
- Make sure the information is sent to the PAL (LDH or MCO).
- If a NOISD is received the Support Coordinator should document the contact with the family and offer to assist with obtaining the additional information and their response, contact with the provider to obtain or have them submit additional information, if no additional information was available, and all Support Coordination activities to follow through with the PA request until the PA is either approved or denied based on medical necessity.

Partial Approval

- Partial Approval means there is enough documentation to approve some of the request. The rest is sent to the PAL (LDH or MCO) to notify that more documentation is required.
- A final Partial Denial will be issued if the information is not received or if the service is not medically necessary or a Full Approval will be issued if additional information is received to support the medical necessity. If a partial denial is received as a final decision, it can be appealed.
- Partial Approvals do not need to be appealed if the family can get the additional information to get an Approval.

- Partial Approvals are done so that the family can start receiving some of the service.
- If the beneficiary asks for 8 hours and the Fiscal Intermediary (Gainwell Technologies for FFS or the beneficiary's MCO for Managed Care has enough documentation to partial approve 4 hours, the beneficiary can get the 4 hours without accepting the decision. They can appeal for the other 4 hours later, if a Partial Denial occurs. They do not need to do anything to receive the hours that are partial approved.
- If the beneficiary/family does not want to work with the PAL or submit additional information, they can do an appeal now.
- Why was the full approval denied? What was denied? Was it due to a dollar amount but the correct product amount was received?
- If the PA is for PCS, exactly what help does the family need or want? Is it PCS for ADLS or IADLs, respite, homework assist, someone to take in the community, do they want family to be paid for services provided, etc.?
- Discuss what was approved and what needed tasks are not included in the PA. Are additional hours still requested?
- Offer to assist the family in obtaining the information from the provider.

Partial Denial/Full Denial

- If a Partial or Full Denial was received by the provider the Support Coordinator needs to act timely to obtain information or offer to assist with an appeal.
- Contact the family within 4 calendar days of the Notice of Denial and explain the appeal rights, give appeal brochure, offer to assist with an appeal, and help family develop the information for the appeal if requested to do so.
- Contact the PAL to ask what information is necessary to get an approval or additional hours.

Appeals

For beneficiaries enrolled in managed care, and for all beneficiaries for behavioral health services, the beneficiary's managed care organization makes the initial decision as to whether to approve or deny the prior authorization request. For beneficiaries enrolled in FFS for their physical health needs, Gainwell Technologies makes the prior authorization decision. Denials of services provided through managed care organizations must be first appealed through the MCO's internal procedures, while denials by FFS can be appealed immediately to the Division of Administrative Law. After the MCO's internal appeal is exhausted, the managed care beneficiary can then file an appeal with the Division of Administrative law.

For both FFS and MCO, the beneficiary may appeal a denial of part of the requested services, and still receive the amount that was approved. The beneficiary should be assured filing an appeal will not result in losing the services that were approved.

The prior authorization unit may deny the request for any prior authorized services if it does not receive additional information or notice that the beneficiary has made an appointment with a provider to obtain the needed documentation within 30 calendar days of the issuance of the notice of insufficient documentation. If services are denied or partially denied, the beneficiary may appeal the decision.

For denials of prior authorization by Managed Care Organizations, the beneficiary must follow the appeals procedures sent to them, the provider, and the Support Coordinator by the Managed Care Organization following the denial or partial denial. If you do not have a copy of the denial notice, refer to the MCO's member handbook to review the MCO's internal appeals procedure; refer to: https://ldh.la.gov/page/member-handbooks. The support coordinator must inform the beneficiary of his/her Appeal rights, go over the Appeals Brochure that both parties received from the Managed Care Organization, and offer to assist the beneficiary with the appeal process/fair hearing if the beneficiary decides to request an appeal. If the internal Managed Care Organization appeal decision is upheld, the beneficiary then has the right to appeal to the Department of Administrative Law. See *Appendix AA-2 – PA Tracking Timelines.*

For beneficiaries with FFS, or for MCO members after the internal appeal process has been exhausted: If services are denied or partially denied, the beneficiary may appeal the decision by mailing or faxing a written request for a fair hearing to the Division of Administrative Law ("DAL"), Health and Hospitals Section. The beneficiary/family can also complete an online form on the Division of Administrative Law's website "Medicaid & Health Cases" section via: http://www.adminlaw.state.la.us/HH.htm. Telephone appeals are also allowed, but are not encouraged.

The support coordinator must inform the beneficiary of his/her Appeal rights to the Department of Administrative Law, provide the beneficiary with an Appeals Brochure, and offer to assist the beneficiary with the appeal process/fair hearing if the beneficiary decides to request an appeal. The Appeals Brochure contains the procedures for filing an appeal request. Refer to *Appendix P – Appeal Brochure*. The following is a more detailed description of the appeal process.

Deadlines

For beneficiaries with FFS appeals with the Department of Administrative Law must be filed within 30 calendar days 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 beneficiary as soon as they are received. Appeals are filed via phone call, fax, online submission or by sending a letter to the DAL. Refer to *Appendix P – Appeal Brochure*. If a recipient chooses to appeal, the SC should follow-up with the beneficiary within 20 calendar days of the appeal being filed to check on the status and see if any assistance is needed.

For beneficiaries with Medicaid Managed Care after the internal appeal process has been exhausted, members may request a state fair hearing with the Division of Administrative Law (DAL). A state fair hearing must be requested within 120 days from the date of the MCO's Notice of Adverse Benefit Determination unless an extension is requested. A state fair hearing may be delayed at the request of the claimant/appellant or authorized representative, but cannot be delayed for more than 30 days without good cause. Members may request a state fair hearing by mail, phone, fax or online. Refer to *Appendix P – Appeal Brochure*.

Continued services while awaiting a decision

For services to be continued pending the outcome of the appeal, a beneficiary must file an appeal on or before the effective date of the action or within the 30-day appeal period, whichever comes later. But

if the effective date of the action is over 30 days after receiving the notice, the appeal must be filed within 30 calendar days of receiving the notice or it will be too late for either appealing or for continuing the services. For services to be continued, all of the following must be true:

- The service is one the beneficiary 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 the Fiscal Intermediary Gainwell Technologies for FFS or the beneficiary's MCO for Managed Care 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 calendar 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.
- Fiscal Intermediary Gainwell Technologies for FFS or the beneficiary's MCO for Managed Care 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 beneficiary 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 Disability Rights Louisiana (1-800-960-7705). Support Coordinators should keep a list of local legal services that may be available to represent members.

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 beneficiary (or his or her representative) will receive a written notice of the date and time of the hearing and a "Summary of Evidence."

The beneficiary and anyone helping the beneficiary 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 beneficiary.

The beneficiary 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 beneficiary or their representative can review all documents Medicaid and Gainwell Technologies 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 Gainwell Technologies staff including one of their physicians, to explain their rationale of the decision.

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

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

The beneficiary 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 LDH staff can ask questions of anyone who speaks for the beneficiary.

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 beneficiary 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 beneficiary within 20 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 beneficiary at least 90 calendar days after the appeal was sent to check on the final decision regarding the appeal.

The Support Coordinator's File

If a beneficiary'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 beneficiary was informed of appeal rights;
- that the beneficiary 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 request for prior authorization is reviewed, the beneficiary requesting the service may be deemed as eligible for Chronic Needs status. If this occurs, providers, beneficiaries and Support Coordinators will receive an approval letter with the following codes for FFS:

- 822 – Beneficiary 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 Gainwell Technologies will know ***anything*** about the documentation submitted during earlier times that prior approval was requested for the same service.

Only LDH, Gainwell Technologies, or the Managed Care Organization can determine whether or not a situation is a Chronic Needs Case.

Part 5 - EPSDT Support Coordination Requirements

The Support Coordination Agency must comply with licensure and certification requirements, provider enrollment, the Case Management Manual, the specific terms of individual Performance Agreements for Medicaid EPSDT Support Coordination Agencies, the EPSDT Support Coordination Training Handbook and Appendices, and the EPSDT Support Coordination Training Module. The requirements outlined in the Rules, Standards, Statutes, Regulations, and other documents as promulgated in accordance with State and Federal law, the Administrative Procedures Act, and other relevant methods as required by law are also considered authority.

Refer to the EPSDT Support Coordination website for more information:
https://ldh.la.gov/page/support-coordination-services-epsdt-targeted-populations

Staffing Requirements

All staffing requirements for education, experience and training as outlined in the Targeted Case Management Rule (LAC 50: XV, Chapters 101-107, §10503) must be adhered to. The agency must employ a sufficient number of support coordinator and supervisory staff to comply with the staff coverage, staffing qualifications and the maximum caseload size requirements described in §10503 and §10701 in the Targeted Case Management Rule.

The On-Site Program Manager may **not** carry a caseload or be a supervisor of support coordinators.

Each Support Coordinator and Supervisor **must** be employed at least forty hours per week.

A supervisor carrying a caseload **must** be supervised by an individual who meets the supervisory qualifications as outlined in the Targeted Case Management Rule (LAC 50: XV, Chapters 101-107, §10505).

A nurse consultant **must** be available to the support coordination agency staff at least four hours per week, whether on-site or remotely. The nurse consultant will provide consultation to support coordination agency staff on health-related issues as well as education and training for support coordinators and supervisors.

The Support Coordination Agency **must** not provide support coordination and Medicaid reimbursed direct services to the same beneficiary(s) unless by an affiliate agency with a separate board of directors.

Orientation

Each Support Coordinator and Supervisor must satisfactorily complete an orientation and training program in the first 90 days of employment. **A minimum of 16 hours of orientation training shall be provided to all staff within one week of employment. A minimum of eight hours of the orientation training shall address the EPSDT targeted population including specific service needs and available resources.** The Support Coordination agency's designated trainer and supervisors will use the EPSDT Training Module in conjunction with the EPSDT – Targeted Population Support Coordination Training Handbook and Appendices to train new support coordinators, supervisors and trainers hired to serve the EPSDT – Targeted Population as part of their 16 hours of orientation training. New support coordinators and trainees must receive EPSDT training prior to being assigned an EPSDT caseload. New designated trainers and supervisors must receive EPSDT training prior to beginning supervision of EPSDT support coordinators. The training may be provided by supervisors or designated trainers by BHSF/SRI or by a trained supervisor or designated trainer. In addition, **staff shall receive a minimum of 16 hours of training during the first 90 calendar days of employment related to the targeted population.**

Training

Training for Support Coordinators and Supervisors shall be provided or arranged for by the Support Coordination Agency.

The agency must submit documentation of EPSDT training to Kim Willems at SRI using *Appendix W-4 – Training Log*.

Each Support Coordinator and Supervisor must satisfactorily complete support coordination related training on an annual basis to meet at least the minimum training requirements:

- **A minimum of 20 hours of annual training shall be provided to all staff.** The Support Coordination agency's designated trainer and supervisors will use the EPSDT Training Module in conjunction with the EPSDT – Targeted Population Support Coordination Training Handbook and Appendices to train existing support coordinators, trainers and supervisors as part of the 20 hours of annual training.
- Satisfactorily complete any support coordination training mandated by LDH.
- Possess adequate support coordination abilities, skills and knowledge to adequately perform each core element of support coordination.

Refer to the **Trainer Information** found on page 1 of this EPSDT - Targeted Population Support Coordination Training Handbook.

The most current **EPSDT Training Materials and Resources for Support Coordination Agencies** can be found at: http://ldh.la.gov/index.cfm/page/371.

Mandatory Annual EPSDT Support Coordinator Training

The EPSDT Support Coordination Training Materials including the Handbook and Training Module are updated annually. All support coordinators and trainees, designated trainers and supervisors must complete the EPSDT training on the new Training Materials each year. The designated trainer and the EPSDT specialist must attend the annual training at LDH in person. Any support coordinators or trainees or supervisors that do not attend the annual training at LDH either in person or via webinar must be trained by a trained supervisor or designated trainer within the agency. All support coordinators or trainees, designated trainers and supervisors must read the updated EPSDT – Targeted Population Support Coordination Training Handbook and Appendices. **Documentation of annual training must be submitted one time each year following the annual training at LDH, and documentation of training for new staff must be submitted by the last day of each quarter.**

Caseloads

The maximum caseload that an EPSDT Support Coordinator can carry is 35 cases at any point in time.

A supervisor may supervise up to eight (8) Support Coordinators. The supervisor may carry one-fifth of a caseload for each SC supervised fewer than eight employees. A supervisor may not use more than 50% of their time in managing a caseload. The intent it to decrease the size of a supervisor's caseload as the number of SCs supervised increase. The chart which follows is intended to provide clarification of the state's requirement for supervisor caseloads. Additional job duties should result in a one-fifth reduction in caseload size and/or supervisory ratio.

A supervisor carrying a caseload **must** be supervised by an individual who meets the supervisory qualifications as outlined in the Targeted Case Management Rule (LAC 50: XV, Chapters 101-107, §10505).

Number of Support Co-ordinators Supervised	Number of Cases that can be on Caseload
8	0
7	3
6	6
5	9
4	12
3	15
2	18
1	21

Supervision Activities

Effective supervision includes direct review, assessment, problem solving, and feedback regarding the delivery of Support Coordination services. Supervisors are responsible for teaching and monitoring of

person-centered principles and practices, assuring quality delivery of services, managing assignments of caseloads, and arranging for and providing training as appropriate.

- Each Supervisor **must** not supervise more than eight full-time Support Coordinators or other professional-level human service staff.
- **Must** be employed 40 hours per week and be continuously available to Support Coordinators.
- Individual, face-to-face sessions to review cases, assess performance, and provide feedback for improving performance. This individual supervision **must** occur at least one time per week per SC for a minimum of one hour.
- Joint sessions in which the supervisor accompanies a Support Coordinator to meet with a family to assess, teach, and give feedback to the Support Coordinator regarding the Support Coordinator's performance related to the particular beneficiary.
- Group face-to-face sessions with all Support Coordination staff to problem-solve, provide feedback, and collegial support to Support Coordinators.
- Supervisors **must** review at least 10% of each Support Coordinator's case records each month for completeness, compliance with these standards, and quality of service delivery.
- The supervisor is accountable for the training, experience, and activities of the Support Coordinator.
- Support Coordinators **must** be evaluated at least annually by their Supervisor according to the Agency's written policy of performance evaluation.

Documentation of Supervision

Each supervisor is required to maintain a file on each Support Coordinator supervised that contains:

- Date, time, and content of the supervisory session; and
- The results of the supervisory case review which addresses completeness and adequacy of records, compliance with standards, and effectiveness of services.
- Documentation of required training.

The requirements for supervisory record keeping are found in the Louisiana Medicaid Program *Case Management Services Provider Manual* and are required for all Agencies.

Support Coordination Activities

Support Coordinators

- Each Support Coordinator **must** not carry more than 35 cases.
- **Must** be employed at least 40 hours per week.
- Maintain the beneficiary record.
- Collect required information necessary to plan and complete CPOC.
- Facilitate annual CPOC team meeting and complete annual CPOC.
- Facilitate and monitor the provision of services, including revisions and Quarterly Review.
- Facilitate the transition events required to support transition.

Calls

Support Coordination agencies must maintain a toll-free telephone number to ensure that beneficiaries have access to support coordination services 24 hours a day, seven days a week. Beneficiaries must be able to reach an actual person in case of an emergency via answering service and not a recording.

Support Coordination Agencies must make sure that beneficiaries know this information. Non-emergency calls must be returned within one (1) working day.

Visits

Each quarter there must be a Quarterly Review with each beneficiary (and their guardian) along with a complete review of the CPOC to assure that the goals and services are appropriate to the beneficiaries needs as identified in the CPOC. Additional visits are required when a major change occurs in the status of the beneficiary and/or his/her family or legal guardian.

At least one Quarterly Review must be completed face-to-face each calendar year. BHSF will allow two Quarterly Reviews per calendar year, that are not the initial visit or annual plan of care visit, to be conducted virtually in lieu of face-to-face visits as long as the case meets the following criteria:

1. The beneficiary/family is in agreement that a virtual visit is in the best interests of the beneficiary;
2. The support coordinator is in agreement that a virtual visit is in the best interests of the beneficiary;
3. The provider agencies are in agreement that a virtual visit is in the best interests of the beneficiary;
4. The legally responsible individual or family members living in the home are not paid caregivers;
5. Technology is available to complete the visit with direct observation of the beneficiary and the home;
6. There is evidence that the requirements for the quarterly visit can be completed virtually.

Medicaid Eligibility Verification

Support coordinators are required to validate Medicaid eligibility through REVS (1-800-776-6323) or e-MEVS at the beginning of every month. The user manual for the Electronic Medicaid Eligibility Verification System can be found at:
https://www.lamedicaid.com/provweb1/forms/UserGuides/MEVSHelp.pdf.

If the beneficiary becomes ineligible for Medicaid, they are no longer eligible for Support Coordination and closure procedures shall be followed. Refer to the Closure Section.

Beneficiary Satisfaction Survey

Beneficiaries 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 SRI's toll-free number and mailing address and must be provided to each beneficiary annually.

LSCIS Reports

The On-Site Program Manager is responsible for assuring compliance with all program requirements and the EPSDT Specialist is to monitor that all EPSDT requirements are met. **The On-Site Program Manager and the EPSDT Specialist shall both check the LSCIS reports at *least* semiweekly. All deficiencies are to be addressed and resolved.** Deficiencies should also be addressed and resolved during the weekly Supervisor Face-to-Face meetings with support coordinators.

Special emphasis should be placed on the following LSCIS reports:

Aging Report

Used to track initial CPOCs. An *approvable* CPOC must be submitted within 35 calendar days of linkage. The beneficiary will remain on this report until the Initial CPOC is approved and the electronic PA is resolved to the file.

CPOC Updates Report

The Current CPOC Ends is the current CPOC end date or the date the CPOC will end if/when the Statement of Approval is issued and the full PA is issued to the Agency.

The First CPOC Meeting Date is the first date an annual assessment meeting can be held (90 days prior to CPOC end date).

The Next CPOC Due date is the date an *approvable* CPOC is due and is 35 days prior to CPOC end date.

The Redetermination Due date is the date the Statement of Approval is expiring. Refer the beneficiary to OCDD 60 days before SOA expires.

Tracking Required Action Report

A negative number of days out indicates that the tracking required action is overdue. A positive number of days out indicates how many days the support coordinator has to complete the tracking required action.

Required Action Report

Used to ensure the flat rate billing requirement has been met. Look for a "Yes" under Req Met (requirement met), a "Yes" under Monthly Criterion Met, and check that a Timely CPOC was completed if one was due that quarter.

The following activities must be completed within a quarter to bill the monthly flat rate:

1) Monthly contact,
2) Quarterly visit, and
3) Timely CPOC.

1) Monthly contact can be completed in-person, by telephone or by telehealth. Monthly contact must be with the legal guardian if the beneficiary is not a competent major. Monthly contact can be with just the beneficiary if the beneficiary is a competent major. Must have a PA on the date of the monthly contact in order to bill. Non-billable activity codes are excluded (74, 75, etc.)

2) Quarterly visits can always be completed in-person. SCs are allowed to complete the quarterly visit via telehealth if they meet the virtual visit criteria and no more than one virtual visit has been completed in the previous three quarters (maximum of two telehealth visits per four quarters). Initial and Annual CPOC meetings must be held in-person. The beneficiary must be

present. The parent or legal guardian must be present if the beneficiary is not a competent major. Must have a PA on the date of the quarterly visit in order to bill. Non-billable activity codes are excluded (74, 75, etc.)

3) An **approvable** initial CPOC must be completed and sent to BHSF/SRI within 35 calendar days of the date of referral to the Support Coordination agency. The annual CPOC meeting cannot be held more than 90 calendar days prior to the expiration of the current CPOC. The **approvable** annual CPOC must be completed and submitted to SRI within 35 calendar days of the CPOC expiration date.

The month that a participant's case is closed becomes the last month of the quarter and all quarterly required activities must be completed. If your PA expires in the middle of a quarter, it will treat the last full month that you have a PA as the last month of the quarter and all quarterly required activities must be completed.

Agencies may bill on service logs entered into LSCIS up to 21 days after the end of the quarter. If entered more than 21 days after the end of the quarter, the services are non-billable and an X will be on the service log.

If a contact is not showing up on your Required Action report make sure you have an EPSDT SCA Prior Authorization resolved to the file for the date you completed the monthly contact or quarterly visit. In LSCIS find the client and click on their PA History to ensure you resolved the electronic PA to the file and that you have a PA for the time period you are attempting to bill on. Remember the PA dates may be affected by an untimely Initial CPOC, a transfer of records, an expiring or expired Statement of Approval, or an EPSDT beneficiary aging out. A quarterly visit will not be counted on the required action report if the beneficiary does not have a PA for Support Coordination at the time of the quarterly visit. If the approvable CPOC was submitted late (outside of the 35 calendar days of linkage) your PA will not start until the approvable CPOC submit date. If the Initial CPOC is submitted timely the PA will start on the participant signature date / Initial Assessment date.

If an Annual CPOC was due during the quarter, the Timely CPOC dates will be shown next to "Timely CPOC." If the approvable CPOC was submitted timely, the date listed under the "Actual" column will fall between the timely CPOC dates. If the approvable CPOC was submitted late, you'll see << next to the "Actual" date. You will not be able to bill the month the CPOC ended and will not be able to bill subsequent months if the approvable CPOC is still not submitted. You will see a "No" under Monthly Criterion Met.

The approvable CPOC submit date is the date the approvable CPOC was submitted. The approvable CPOC submit date is not the date the CPOC was approved nor is it the date the CPOC was previously submitted if the CPOC was denied. If the CPOC is sent back you, the date the approvable CPOC is submitted will be the approvable CPOC submit date. 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.

An **approvable** initial CPOC must be completed and sent to BHSF/SRI within 35 calendar days of the date of referral to the Support Coordination agency. If the approvable CPOC is submitted timely the PA will begin on the CPOC Participant Signature Date. If the approvable CPOC date is late the PA will begin on the approvable CPOC submit date.

The annual CPOC meeting cannot be held more than 90 calendar days prior to the expiration of the current CPOC. The **approvable** annual CPOC must be completed and submitted to SRI within 35 calendar days of the CPOC expiration date. If the CPOC is submitted late you will not meet your flat rate billing requirement of a Timely CPOC.

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. Each Agency must sign and date the Quarterly Report and all *Appendix W-3 - Record Review, Appendix W-2 - EPSDT Quarterly Report of Revised CPOCs* with a print out of the Service Needs Changes report from LSCIS attached and fax it to Kim Willems at SRI by the fifth calendar day of the month following the end of each quarter (January 5th, April 5th, July 5th, October 5th) using *Appendix W-1 - EPSDT Quarterly Report Checklist* as a coversheet to ensure all required information is included.

The report will include the names of the beneficiaries and the services for the following:

- Beneficiaries with PAs not issued within 60 calendar days of date of choice of provider
- Beneficiaries with service gaps in the authorization period
- Beneficiaries who submitted requests for appeals within the quarter.

Appendix W-3 - Record Review is to be completed for each beneficiary/service listed on the LSCIS Quarterly Report as not having a PA issued within 60 calendar days or a Gap in Authorization Period. It is the responsibility of the Agency to identify beneficiaries with a PA not issued within 60 calendar days of the beneficiary's request or those with a Gap in Authorization Period. As part of that identification, the Agency must review all documentation (CPOC, PA Tracking Log, Service Logs, etc.) prior to end of each Quarter. If no gap is found or the gap was due to the family's choice fill out page one of the Record Review to document this and then remove it from the Quarterly Report.

Either the number of trackings without a choice of provider must be zero or documentation and explanation must be attached for each beneficiary and service without a choice of provider.

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 On-Site Program Manager or the EPSDT Specialist's supervisor are to complete the form.

BHSF/SRI and the LDH attorney will review the information to assure that the beneficiaries 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.

Documentation

Signatures

Each face-to-face assessment and each virtual assessment must have the signature of the beneficiary/legal guardian to verify that the service was provided. The SC must obtain a beneficiary/legal guardian signature on the CPOC Signature Page, Quarterly Review, and any other required documents.

LSCIS Service Logs

The **LSCIS Service Log** should be used to document and provide a narrative of activities related to the request for EPSDT services including all support coordination activities and all contacts with the provider, the beneficiary, and the PAL. A separate LSCIS service log should be used to document activity related to a specific prior authorized service.

Service Logs are a chronology of events and contacts which support justification of critical support coordination elements for Prior Authorization (PA) of services in the LSCIS system.
All contacts with beneficiary, provider, PAL, MCO, LDH Program Staff Line, etc. should be documented on a service log.

Identify who the contact was with (i.e., beneficiary, guardian, provider, etc.).

Each service contact is to be briefly defined (i.e., telephone call, face-to-face visit, etc.).

It is the responsibility of the support coordination agency to provide adequate documentation of services offered to EPSDT beneficiaries for the purposes of continuity of care, support for the beneficiary and the need for adequate monitoring of progress toward outcomes and services received. This documentation is an ongoing chronology of activities undertaken on behalf of the beneficiary.

Service logs must support the activity that is billed and provide enough narrative documentation/information to clearly identify the activity and the participants. BHSF allows the support coordinators of EPSDT services to utilize the service log to document required "progress notes" and "progress summaries." **Progress Notes** are a narrative that reflects each entry into the service log and elaborates on the substance of the contact. Progress notes must be of sufficient content to reflect descriptions of activities and cannot be so general that a complete picture of the services and progress cannot be drawn from the content of the note, i.e., general terms such as "called the beneficiary" or "supported beneficiary" or "assisted beneficiary" is not sufficient and does not reflect adequate content. Check lists alone are not adequate documentation.

The Louisiana Department of Health (LDH) offices, BHSF/SRI, do not prescribe a format for EPSDT documentation, but must find all components outlined below.

All service log entries in a beneficiary's record should include:

- Name of author/person making entry
- Signature of author/person making entry
- Functional title of person making entry
- Full date of documentation

- **Strongly prefer you do not use all caps.**
- Notes: A narrative that follows the definition for the type of documentation used.

If an issue is identified, documentation should support that the Support Coordinator took measures to address the issue.

Techniques for documenting the narrative:

PAIP

- **Problem**: Describe what the problem is.
- **Assessment**: What are your general observations about the beneficiary?
- **Intervention**: What did you do?
- **Plan**: What will you do next?

Refer to *Appendix Y-3 - Service Logs*.