

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

TRAINER INFORMATION

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

Part I – Services Available to EPSDT Beneficiaries

Part II - Intake, Assessment and Comprehensive Plan of Care (CPOC)

Part III - Prior Authorization

Part IV - Contacts and Documentation

Part V – EPSDT Support Coordinator 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 Salling Willems at BHSF/SRI 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 the Part I – V above, it is very important that the Trainer allow time for a Questions and Answer session. The information provided in this document is quite extensive, and extremely important. Support Coordinators must be given every opportunity to ask questions prior to the end of the training, about the Medicaid Services Chart (*Appendix C*) which should be reviewed as part of the training, as well as about this Handbook.

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EPSDT – Targeted Population Support Coordination Training Handbook

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 stands for Early and Periodic Screening, Diagnostic, and Treatment. EPSDT means the same thing as Medicaid for people under age 21.

EPSDT Support Coordination is available to all Medicaid beneficiaries under the age of 21 who are on the Developmental Disabilities Request for Services Registry (DD RFSR) or for whom the service is determined medically necessary, with documentation from Medicaid to substantiate that the EPSDT beneficiary meets the definition of special needs (*Appendix P*).

Chisholm Class Members

Chisholm class members (CCM) are children under the age of 21 who currently receive or are eligible for Medicaid, and who are on the Developmental Disabilities Request for Services Registry (DD RFSR). Children do not become Chisholm class members until they are 3 years old because that is when they can be placed on the DD RFSR by their Local Governing Entity (LGE). They may have a “protected Registry date” prior to age 3 and a statement of approval (SOA) for the DD system, but until they are formally found eligible for the DD services system and placed on the RFSR, they are not Chisholm class members.

Legacy Medicaid

This is traditional Medicaid for people who are not enrolled in a Managed Care Organization for most of their health services. Chisholm class members have the option of staying in Legacy Medicaid for their physical health services (medical care). Chisholm class members are allowed to participate in Managed Care.

Medicaid Managed Care Program

Healthy Louisiana is the way most of Louisiana’s Medicaid beneficiaries receive health care services. The state contracts with Managed Care Organizations (MCO) that deliver these services through their provider networks. Some of these Managed Care Organizations (MCO) have a different network of doctors, hospitals, and other providers than traditional Medicaid.

Some Medicaid beneficiaries only receive specialized behavioral health, non-emergency medical transportation or non-emergency ambulance transportation through their Health Plan. Beneficiaries who are part of the Coordinated System of Care (CSoC) receive all covered services except specialized behavioral health and CSoC services through their Health Plan. See below for more detail on who receives what type of services through Healthy Louisiana:

Most Healthy Louisiana Members will receive all their Medicaid covered services through their Health Plan.

Chisholm class members may choose to have all of their health care through the Health Plan or only their specialized behavioral health services. This is called “opt-in.” Chisholm class members may choose to disenroll their medical health care from their Health Plan and go back to regular Medicaid at any time. The disenrollment will be effective the first day of the following month, unless the request is made during the last two days of the month. Then, the disenrollment will be effective the first day of the month after the following month. However, they should keep in mind that they may be required to resubmit requests or prescriptions and they will not be able to return to the Health Plan until the next open enrollment period. 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 *MMC Appendix H*.

Coordinated System of Care (CSoC) beneficiaries will receive coverage for all covered services except their specialized behavioral health and Coordinated System of Care (CSoC) services which will be received from the CSoC Contractor, Magellan Health Services of Louisiana.

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>

Things beneficiaries should consider before selecting a Managed Care Organization:

- 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 doctors, it’s important to confirm that they are all enrolled in the plan you choose.
- 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 Louisiana:**
 - <http://www.aetnabetterhealth.com/louisiana/providers/pharmacy>
 - **AmeriHealth Caritas of Louisiana:**
 - <http://www.amerihealthcaritasla.com/pharmacy/index.aspx>

- **Healthy Blue:**
 - <https://www.myhealthyblue.com/la/benefits/pharmacy-benefits.html>
- **Humana Healthy Horizons in Louisiana:**
 - <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/healthy-louisiana/lookup-tools.html#view-drug>
- **Legacy Medicaid:**
 - <https://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf>
- Access to services. The Managed Care Organization will be determining the services, amounts, and duration of services to be received. The Managed Care Organization has to provide the same amount, duration, and scope as traditional Medicaid.

Refer to all *Medicaid Managed Care Appendices*.

Medicaid Eligibility Verification

Support coordinators are required to validate EPSDT beneficiary's Medicaid eligibility through MEVS/REVS or e-MEVs at the beginning of every 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 on page 119 of this Handbook. **The Support Coordinator must update the Medicaid Identification number and the Physical and Behavioral MCO Agency in LSCIS as needed.** Refer to page 116 for more information.

Part I – 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*. 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 F* 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, consult the Medicaid Services Chart (*Appendix C*). 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

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Support Coordination 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 not 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 (*Appendix P*). 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.

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.

Applied Behavioral Analysis-Based Therapy Services (ABA)

ABA therapy is the design, implementation, and evaluation of environmental modification using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the direct observation, measurement, and functional analysis of the relations between environment and behavior. ABA-based therapies teach skills through the use of behavioral observation and reinforcement or prompting to teach each step of targeted behavior. ABA therapy uses therapeutic techniques to increase useful behavior (including communication) and reduce harmful behavior. ABA-based therapies are based on reliable evidence of their success in alleviating autism and are not experimental. This service is available through Medicaid for persons 0-21. For Medicaid to cover ABA services through a licensed provider the person must meet ALL of the following guidelines, as published in the May 2015 Rule (LAC 50: XV. Chapters 1-7).

The person must:

- Be under 21 years of age;
- 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.);
- Be diagnosed by a qualified health care professional with a condition for which ABA-based therapy services are recognized as therapeutically appropriate, including autism spectrum disorder; and
- Have a comprehensive diagnostic evaluation (CDE) by a qualified health care professional and have a prescription for ABA-based therapy services ordered by a qualified health care professional. (A separate prescription is not needed if the CDE recommends ABA)

To find an ABA Provider in your area, call the Managed Care Organization of the member. Refer to *Medicaid Managed Care Appendix B*.

Transportation

Non-emergency medical transportation (NEMT) to and from medical appointments is covered under the beneficiary's Medicaid Managed Care Program. Medicaid eligible children are enrolled in the Medicaid Managed Care Program for their Medicaid transportation services even if they have Legacy Medicaid for their Physical Health Services. Arrangements for transportation should always be made at least 48 hours in advance by calling the numbers shown below.

Aetna Better Health	1-877-917-4150
AmeriHealth Caritas Louisiana	1-888-913-0364
Healthy Blue	1-866-430-1101
Humana Healthy Horizons in Louisiana	1-844-613-1638
Louisiana Healthcare Connections	1-855-369-3723
United Healthcare Community Plan	1-866-726-1472

If you are not sure who the beneficiary's Managed Care Organization is you can contact the Medicaid Managed Care Program Line at 1-855-229-6848 to find out which Managed Care Organization they are covered under.

Special arrangements: If special arrangements are required, the support coordinator may contact the beneficiary's Managed Care Organization at the numbers shown above. If the MCO is unable to assist, the beneficiary can 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.

“Gas Reimbursement” program: Support Coordinators should also be aware that Louisiana Medicaid will allow family members/friends to become Medicaid funded transportation providers for specific beneficiaries through the “Gas Reimbursement” transportation program. Gas Reimbursement providers may neither reside at the same address as the beneficiary that they transport nor request reimbursement for transporting themselves to appointments. To assist someone you are serving that may benefit from this arrangement, call the beneficiary's Managed Care Organization at the numbers shown above.

Refer to *Medicaid Managed Care Appendix B*.

The following SPECIALIZED 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

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 an array of Medicaid State Plan and Home and Community-Based Waiver services (HCBS) to 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
 - Developmental disabilities facilities
 - Homeless (as identified by the Department of Education)
 - Non-medical group home
 - Psychiatric hospitals
 - Psychiatric residential treatment facilities
 - Secure care facilities
 - Therapeutic foster care
 - Therapeutic group home

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.

A parent or primary caregiver can **call Magellan's direct referral line at 1-800-424-4489** and tell the representative they are calling about a child/youth that they think may meet eligibility criteria for CSoC. Magellan will conduct a CANS brief assessment to establish preliminary eligibility. The caregiver should be prepared to answer several questions from the representative, including: age, insurance/Medicaid coverage, mental health history, substance abuse history, medication, medical history, and history with child welfare, juvenile justice and trouble in school. If the child meets the initial criteria for a CSoC referral, the Magellan representative will then transfer their referral to the local wraparound agency. The wraparound agency will 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. The caregiver should be prepared to answer questions about the child/youth's behaviors and concerns about what is going on in the child's life that makes them think CSoC is needed. They should be prepared to talk about the difficulties the child/youth is having at home, school and/or in the community.

A parent or primary caregiver can also call the beneficiary's Managed Care Organization (MCO). When contacting a MCO to make a referral for CSoC, the MCO will ask initial risk questions and transfer the call to Magellan if the child meets criteria. The caregiver will need to be able to provide the following information for the referral: demographic information, as much clinical information as you have available, and diagnosis, if known. Regardless of CSoC

eligibility, their Managed Care Organization will ensure that children and youth are referred to providers who can meet their needs.

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

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.

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.

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.

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.

Specialized Behavioral Health Services

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. These services are managed by the Healthy Louisiana Managed Care Organizations, and may be subject to prior authorization. For youth enrolled in the Coordinated System of Care (CSoc) waiver program, services are managed by the CSoc Contractor, Magellan, and may be subject to prior authorization.

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)
- 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)
- Crisis Stabilization (CS)
- Therapeutic Group Homes (TGH)
- Psychiatric Residential Treatment Facilities (PRTF)**
- Inpatient Hospitalization (mental health and substance use treatment)
- Outpatient and Residential Substance Use Disorder Services
- Medication-Assisted Treatment (MAT)

***The Managed Care Organization's prior authorization unit must pre-approve CPST, PSR, ACT (ages 18-20), FFT/CWFFT, Homebuilders, and MST.** CPST and PSR providers arrange the assessments necessary to obtain prior authorization for rehabilitation services.

****A certificate of need must be complete prior to admission to a PRTF.**

More information on Licensed Practitioner Outpatient Therapy can be found at: laevidencetopractice.com including an EBP Referral Guide which can be found at: <https://laevidencetopractice.com/wp-content/uploads/2020/11/EBP-Referral-Guide.pdf>.

Services are accessed by contacting the Managed Care Organization, or by contacting Magellan for CSoC enrollees. No Primary Care Physician (PCP) referral is required.

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.

School-Based Behavioral Health Services

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 the child's Individualized Education Program (IEP). 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" (page 24).

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

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

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

How to locate a Personal Care Services provider for Legacy Medicaid:

- Personal Care Services must be prior authorized by LDH's Fiscal Intermediary, Gainwell Technologies. Service must be provided by a licensed enrolled PCS provider. A list of providers in your area who offer such services is available through either the Medicaid website or by calling the Specialty Care Resource Line. To obtain the information from the website, go to www.medicaid.la.gov, click on Locate a Provider, click on provider group Personal Care Services, PCS-EPSDT and then the region or parish where the beneficiary resides.
- If you cannot find a PCS provider in your area that is willing to submit a request for prior authorization, call the LDH program staff line at 1-888-758-2220 and tell them that you cannot find a provider. **If a provider cannot be located, LDH must take all reasonable steps to find a willing and able provider within ten days.**
- If the provider is unable to find direct care staff after having received an authorization to provide the service, the support coordinator must notify the LDH PAL.
- Refer to Appendix B – Medicaid Service and Equipment Flyer.

How to locate a Personal Care Services provider for Medicaid Managed Care:

- Personal Care Services must be prior authorized by the beneficiary's Managed Care Organization. Service must be provided by a licensed enrolled PCS provider. A list of providers in your area who offer such services is available via the online provider directory at www.myplan.healthy.la.gov¹, by calling the Member Services Line at each Managed Care Organization to locate a provider in their network, or by accessing the MCO's website to identify providers contracted with the beneficiary's MCO (see *Medicaid Managed Care Appendix B* for Member Services Lines and links to websites). The MCO's web-based provider locator tools have EPSDT Personal Care Service as a listed specialty.
- If you cannot find a PCS provider from the Medicaid Managed Care Program website, or the provider directory, which is willing to submit a prior authorization request call the MCO's member service line which operates from 7am-7pm, M-F, for assistance. The Support Coordinator must fax the Referral to Medicaid Managed Care Case Management (MMCCM) form (*Medicaid Managed Care Appendix Q*) within 3

¹ See p. 67.

days of the date of service request to get assistance from the MCO with locating a provider. **If the MCO is unable to locate a willing provider within 10 days of the Referral to MMCCM, the SC should submit a Referral to LDH PAL – MMC Member using Medicaid Managed Care Appendix S.**

- **The MCO is contractually responsible for ensuring that services are provided for its beneficiary's including finding an in-home provider within 10 business days of the Referral to MMCCM. LDH will reach out to the MCO when a PAL referral is received to ensure that this contractual obligation is met. The MCO may pursue a single case agreement in order to obtain a willing provider.**

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 Legacy Medicaid or to the Managed Care Organization's Prior Authorization Unit for Medicaid Managed Care. 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 Legacy Medicaid:

- 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.
- Support Coordinators should send a Referral to Medicaid Managed Care Case Management form (*Medicaid Managed Care Appendix Q*) to inform the MCO of the beneficiary's desire to change providers.

Home Health Services

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. EHH services must be prior authorized in accordance with the authorizing healthcare provider and home health plan of care.

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. However, these services are subject to post-payment review. If a provider cannot be found call the LDH program staff line at 1-888-758-2220 and tell them that you cannot find a provider.

Some individuals need both PCS and Home Health Services. Refer to *Appendix E* 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.

If you have contacted all of the providers on the current EHH provider list, and cannot find a Home Health Services provider in your area that is willing to submit an application for the services the beneficiary needs (including in-home speech, occupational, or physical therapy), LDH must be notified. Call the LDH program staff line at 1-888-758-2220 and tell them that you cannot find a provider. The support coordinator also must notify the PAL and LDH program staff line if the provider is unable to find staff after having received an authorization to provide the service. **If a provider cannot be located, LDH must take all reasonable steps to find a willing and able provider within ten days.**

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

Refer to the *Medicaid Managed Care Appendices* for Medicaid Managed Care Members.

Pediatric Day Health Care (PDHC)

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.

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

If a child or youth wants rehabilitation services such as Physical, Occupational, or Speech Therapy, Audiology Services, or Psychological Evaluation and Treatment, these services can be provided at school, in Early Childhood Education programs, in an outpatient facility, in a rehabilitation center, at home, or in a combination of settings, depending on the child's needs. For Medicaid to cover these services at school (ages 3 to 21), they must be part of the IEP or IFSP. For Medicaid to cover PT, OT, ST and audiology services through an outpatient facility, rehabilitation center, or home health, they must be ordered by a physician and must be prior

authorized by Medicaid. Refer to “Services Available through School Systems” (page 28) for further information.

For Medicaid to cover such services through a provider outside of an educational setting, they do not need to be part of the IEP, but must be prior-authorized by Medicaid.

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 IEP. The Support Coordinator is to ask the beneficiary/family if they want to request any medically necessary therapies now or if they want to receive therapies on the IEP during the school’s summer break. The Support Coordinator helps the family to determine the setting in which the 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. To locate other therapy providers, call the Specialty Care Resource Line at 1-877-455-9955 for those receiving services in Legacy Medicaid or the beneficiary’s Managed Care Organization Member Services or Medicaid Managed Care Case Manager (MMCCM) for those receiving services in MMC.

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

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

Disposable Incontinence Products

Diapers, pull-on briefs, and liner/guards are covered for 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. Both must also include a completed PA-01. Additional supporting documentation is required for requests that exceed eight units per day. If completed, the BHSF DIP 1 collects this additional information. Refer to *Appendix R-1*.

Providers must provide at a minimum, a moderate absorbency product that will accommodate a majority of the Medicaid recipient’s incontinence needs. Supplying larger quantities of inferior products is not an acceptable practice.

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

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 must request approval for them from Medicaid since this is a prior authorized service.

New technology is being developed every day; therefore, many families and 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 F* for an expanded list of available services. To ask about other available services, contact the **Specialty Care Resource Line (toll free) at 1-877-455- 9955 or TTY 1-877-544-9544 or the beneficiary's Managed Care Organization Member Services line or Medicaid Managed Care Case Manager.** 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 Legacy 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* – Medicaid 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 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.

Refer to *Appendix G* for a list of Local Governing Entities (LGE).

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 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 Local Governing Entity has an **EPSDT Specialist** on staff, who can answer questions about EPSDT services. Refer to *Appendix H* 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. 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 (*Appendix G*).

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. Services include: day and night individualized and family supports; center-based respite services; community life engagement development; environmental accessibility adaptations; specialized medical equipment and supplies as an

extended State Plan service; supported living; substitute family care; day habilitation/community life engagement and transportation for day habilitation; supported employment and transportation for supported employment; prevocational services/community career planning; professional services; personal emergency response system; skilled nursing services; adult companion care services, Monitored In Home Caregiving (MIHC); one-time transitional services; self-direction option; housing stabilization services; housing stabilization transition services; and expanded dental services for adult Waiver beneficiaries.

A fact sheet on the New Opportunities Waiver program is included as *Appendix D-1*.

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. Children's Choice provides funding for medical care, home modifications, care-giving assistance and support, and other specialty services. Funds available through Children's Choice for special additional services are capped at \$20,650 per care plan year. Regular Medicaid services, including EPSDT services, do not count against the cap.

When the family chooses to accept Children's Choice, the child's name is taken off the Developmental Disabilities Request for Services Registry (DD RFSR). Children's Choice is designed for children under age twenty-one (21) with low to moderate needs and whose families provide most of the care and support.

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 transfer into an appropriate waiver for adults as long as they remain eligible for waiver services.
2. **If a crisis situation develops** and additional supports are warranted, the Children's Choice waiver has crisis provisions designed to meet the needs of families on a case-by-case basis. These additional supports must be approved by the Office for Citizens with Developmental Disabilities.

A fact sheet on the Children's Choice waiver program is included as *Appendix D-2*.

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. Services include: support coordination, supported employment, day habilitation/community life engagement, prevocational services/community career planning, respite, habilitation, permanent supportive housing stabilization, permanent supportive housing stabilization transition, personal emergency response systems, and expanded dental services for adult Waiver beneficiaries. Each service is limited based on annual service limits.

A fact sheet on the Supports Waiver program is included as *Appendix D-3*.

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 Residential Options Waiver will only be appropriate for those individuals whose health and welfare can be assured via the Support Plan with a cost limit based on their level of support need and for whom home and community-based waiver services represent a least restrictive treatment alternative. Services include: support coordination, community living supports, companion care, host home, shared living, one-time transitional services, environmental modifications, assistive technology/specialized medical equipment, personal emergency response systems, respite (center-based), nursing, dental, professional (dietary, speech therapy, occupational therapy, physical therapy, social work, psychology), transportation-community access, supported employment, prevocational services/community career planning, day habilitation/community life engagement, housing stabilization, housing stabilization transition services, adult day health care (ADHC), Monitored in Home Caregiving (MIHC), and expanded dental services for adult Waiver beneficiaries.

A fact sheet on the Residential Options Waiver program is included as *Appendix D-4*.

LOCAL GOVERNING ENTITY (LGE) COMMUNITY BEHAVIORAL HEALTH SERVICES

The Louisiana Department of Health, 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 I* for a listing of 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 II - Intake, Assessment and Comprehensive Plan of Care

INTAKE

Linkage: When a beneficiary selects your Support Coordination Agency from the EPSDT Freedom of Choice, you will receive the **Support Coordination Choice and Release of Information Form** (linkage form) from Statistical Resources, Inc. **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 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 N for a sample copy of the Support Coordination Choice and Release of Information form.**

3 Day Contact: The support coordinator must contact the beneficiary within three (3) working days of receipt of the Freedom of Choice (FOC) 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. 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.

Intake: The support coordinator shall use MEVS/REVS to determine if the beneficiary is eligible and remains eligible for Medicaid. The support coordinator shall check for continued eligibility monthly. See page 116 of the Handbook for more information. The support coordinator shall open the case record in LSCIS.

ASSESSMENT

Assessment: The initial assessment must begin within seven (7) calendar days and be completed within 30 calendar days of the referral. The Support Coordinator will need to gather both formal and informal information. Formal information will include medical, psychological, pharmaceutical, social, and educational information, and information from OCDD as described above under Intake. 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.

In addition to contacting OCDD, the SC is to contact 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.

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. 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 Exams and follow-up evaluations. The information provided as a result of these appointments could prove critical in the assessment that will be used to develop the beneficiary's person-centered Comprehensive Plan of Care.

Reassessment: Quarterly review of the CPOC, with the support coordinator and beneficiary to determine if the beneficiary's needs continue to be addressed.

Annual Assessments: Completed and approvable packet to BHSF/SRI no later than 35 calendar days but as early as 90 days prior to the expiration of the CPOC.

COMPREHENSIVE PLAN OF CARE (CPOC)

The completed and approvable CPOC must be submitted and received by BHSF/SRI within thirty-five (35) calendar days from the date of the referral. The CPOC must be revised annually (or as necessary) to meet the needs of the beneficiary and be received by the BHSF/SRI no later than 35 calendar days prior to expiration.

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. 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** (*Appendix U*) 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. **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 the Authorized Representative form (*Appendix U*).

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 an Authorized Representative form (*Appendix U*) or a supported decision-making (SDM) agreement. Refer to page 44, Documentation for Competent Majors for more information.

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. A non-legal custodian affidavit (*Appendix V*) 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.

10 Day Visit: Within 10 calendar days of the referral to the Support Coordination Agency, a face-to-face in-home visit must be conducted. 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 the Medicaid Services Chart (*Appendix C*). 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:

- Explanation and review of the Medicaid Services Chart (*Appendix C*) with special emphasis on medical equipment and supplies, EPSDT-PCS and home health.
- Services Available to Medicaid Eligible Children Under Age 21 (*Appendix F*)
- Rights & Responsibilities (*Appendix K*)
- 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.
- Appeal Process (*Appendix L*)
- Complaint Process for filing a report against support coordinators and/or Legacy Medicaid providers (*Appendix M*)
- Discuss with Chisholm Class Members their right to choose between Legacy Medicaid and the Medicaid Managed Care Program for their physical health services (*Medicaid Managed Care Appendix H*)
- Complaint Process for filing a report against Managed Care Organizations or Medicaid Managed Care Program providers (*MMC Appendix I*)
- HIPAA & Confidentiality Notification
- Referral to EPSDT Screening provider (if requested)
- Availability of formal and non-formal services
- 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.

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!**

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.

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 Medicaid Services Chart (*Appendix C*) 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 O*.

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

Section I. Contact Information / Demographic Information

<i>Contact Information</i> This initial portion of the CPOC is self-explanatory and requires the Support Coordinator to develop current contact information on the individual, including name, mailing and physical address, and good contact numbers. Nothing should be left blank.	
Name: Last, First MI	If the beneficiary's name is spelled or listed incorrectly, there may be a problem with billing. Support Coordination PAs are issued to the name that is on file at Medicaid. If there is a discrepancy in the name provided by the individual and Medicaid, the individual may need assistance in obtaining a correction. If SRI needs to correct the name on file, please send a copy of the e-MEVS to the EPSDT SC Contract Administrator.
Physical MCO Agency Behavioral MCO Agency	Statistical Resources, Inc. (SRI) will populate the Physical MCO Agency and/or the Behavioral MCO Agency based on the datafile SRI receives from Gainwell Technologies. If the Physical MCO Agency is blank, the beneficiary has Legacy Medicaid for their physical health services. If the Behavioral MCO Agency is blank, the beneficiary is enrolled in the Coordinated System of Care (CSoC) and is receiving their specialized behavioral health and CSOC services from the CSOC Contractor, Magellan Health Services of Louisiana.
Legal Guardian Name and Relation	The relationship of the legal guardian must be placed beside their name on the contact page. If someone other than a parent is the guardian, you must obtain the legal guardianship papers from Medicaid, OCDD, or the guardian for the case file.
<i>Demographic Information</i> This initial portion of the CPOC is self-explanatory and requires the Support Coordinator to develop current demographic information on the individual including SSN, Medicaid ID, ICD-10, etc. Nothing should be left blank.	
Case Open	Date of referral to Support Coordination
Legal Status	Once a beneficiary turns 18, they are a competent major unless they have legally been declared incompetent / interdicted. A legal document must be on file if the beneficiary is 18 years of age or older and is not a competent major.
Is able to direct his/her own care	You will only be able to answer if beneficiary is a competent major. If the answer is "no", you must have an Authorized Representative form on file.

ID	Refers to their level of Intellectual Disability. Not ID is an option on the pick list. Review the IEP and other formal information documents for changes in the status.
Adaptive Functioning	Review the IEP and other formal information documents for change in the status.
Residential Placement	If they are living with relatives but in the custody of DCFS (OCS), OCS Foster Care is the correct code to use.
Number of ID/DD/Special Needs in Home (excluding recipient) and Names	Do not count the beneficiary. Enter the number and list the names of any other household members with Intellectual Disability/Developmental Disability diagnoses or special needs.
Current Education/Employment	<p>Homebound: Homebound Service is provided by the School Board. Services are delivered per the IEP.</p> <p>Homeschool: Homeschooling is the parent's choice to provide educational services. The parent is required to apply to the Department of Education for approval. A renewal application must be made annually.</p> <ul style="list-style-type: none"> • More information on the home study application can be found here, http://www.louisianabelieves.com/schools/home-study. • More information on registering as a nonpublic school can be found here, http://www.louisianabelieves.com/schools/nonpublic-schools/registered-nonpublic-schools-(not-seeking-state-approval). • If homeschooling is not registered through the Board of Education, they may be out of compliance with Louisiana's compulsory attendance law, see http://safesupportivelearning.ed.gov/discipline-compendium/choose-type/Louisiana/Attendance%20and%20truancy. <p>Virtual School: is classified as public school (not homebound) so list as Regular / Special Education as applicable. Services are delivered per the IEP if they receive Special Education.</p> <p>Regular and Special Education or Special Education Only: check the IEP to see if they receive Regular and Special Education or Special Education only. If they receive Special Education, they will have an IEP.</p>
Non-Chisholm Reason	SRI will complete this box as needed and label the beneficiary as Non-Chisholm across LSCIS screens.
ICD10 Diagnosis	The ICD-10 code for the diagnosis may have changed since the last submitted CPOC. Make sure the code continues to match the beneficiary's diagnosis.

Section II - Medical/Social/Family History

Provide information about the past and current situations in the beneficiary's life and about their family. Interview those who know the beneficiary best - their family and the people who provide support to the beneficiary, not just those living in the same household. Natural supports should be explored to determine who is involved in the beneficiary's social support network (i.e., what friends/family and community resources are involved in supporting the beneficiary on a daily basis). Information included on this section is relevant to the beneficiary's life today and provides a means of sharing social/family history. Include information that is important to share and relevant to supporting and achieving the goals determined by the beneficiary.

<i>Past</i> Pertinent historical information.	
Pre-Natal health and birth	Provide any significant details regarding the pre-natal health and the birth of the beneficiary.
Nature and cause of beneficiary's disability	Provide any information regarding the approximate date and/or their age when their disability occurred, if a cause is known
Diagnosis	Information on how diagnoses were obtained. Must include when and by whom. What documentation do you have on file to support the diagnoses? If "family states" a diagnosis, has documentation been requested? Each agency is required to have a nurse consultant who may be able to assist in obtaining the documentation.
Early intervention services that were received	Such as EarlySteps.
Placement history	Briefly document any significant details regarding placements with DCFS, psychiatric hospitalizations, other family members, etc.
<i>Legal Guardian-ship documents on file</i>	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. A non-legal custodian affidavit (<i>Appendix V</i>) can be obtained by the caregiver. This affidavit does not require a parent signature. It must be notarized and renewed each year. If this is the only CPOC deficiency, the CPOC will be denied but the approvable CPOC submit date will be honored when the CPOC is resubmitted with the required documentation.

	<p>Document if authorized representative documents on file. If the competent major is unable to sign the CPOC documents, is unable to direct his own care, or requests an authorized representative, Authorized Representative Form (<i>Appendix U</i>) must be on file.</p> <p>Document if a supported decision-making agreement is on file. Supported decision-making (SDM) allows individuals with disabilities to make choices about their own lives with support from a team of people they choose.</p> <p>If in DCFS custody, do 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? If you do not, all monthly contacts must be made with the DCFS guardian, they must sign all documents and they must be present at assessment and reassessment meetings.</p>
Reoccurring situations that impact their care	
Response to past interventions	
Past medical history, past surgeries, etc.	Anything significant that occurred over a year ago.
Other relevant historical information regarding school, family, hospital admits, etc.	
Events that lead to the request for services at this time	<p>Why is EPSDT SC being requested?</p> <p>If there are no services to coordinate, did you inform the beneficiary that SC is optional and declining SC will not affect their eligibility to receive Medicaid services or their placement on the DD RFSR?</p>

<p><i>Present</i></p> <p>Describe current living situation and natural supports.</p>	
Identify all household members	Names and ages of everyone living in the home.
Family situation	<p>How are family members involved or not involved? Must address both parents and if they provide natural or financial support.</p> <p>Who is the primary caregiver?</p> <p>What is the diagnosis of other household members that have special needs? Do they receive any service in the home? Do the needs of other special needs household members affect the beneficiary's needs from being met?</p> <p>Does the family have an understanding of the beneficiary's diagnoses and knowledge of the disability?</p>
Social support network	<p>Who is important to the individual? List friends, natural supports, and other community resources involved in supporting the beneficiary.</p> <p>What does the individual like to do with that person and how often?</p>
Source of household income.	<p>Include economic status and if disability funds are received.</p> <p>Is there a need for referral to financial resources such as family flexible fund, SSI, etc.? If so, was the service offered and response received?</p>
Relevant social, environmental and health factors that impact the beneficiary	<p>Significant life events may include family issues, issues with social/law enforcement agencies, etc. Include if a social services case worker or Probation Officer is assigned and if you will have to interact with that agency/individual.</p> <p>Health of care givers</p> <p>Own home, rental, living with relatives, single family dwelling, etc.</p> <p>Home in rural/urban area</p> <p>Accessibility to resources</p>

	Does home environment adequately meet the needs of the beneficiary or will environmental modifications be required? If the home does not meet their needs due to falling down stairs, not wheelchair accessible, no ramp, needs structural repair (not cosmetic), etc., it is an identified need. How do they manage without the DME or modifications? Problem solve and locate resources. Do they rent the home? Can they relocate to adequate housing? If a beneficiary needs to be carried because they do not have a lift or wheelchair accessible home, how much do they weigh and is it safe for the beneficiary and caregiver to carry them?
Access to community / transportation	Is there a need for NEMT or Gas Reimbursement program? If so, was the service offered and response received?
Desires and requests	What do they want for their future? Address school, employment, leisure, living situation, etc. Preferences, likes and dislikes. What is important to know and do in order to support the individual?
Transition needs	When will the beneficiary graduate? Will they receive a diploma, Certificate of Achievement, or GED? If they are leaving school prior to age 21, do they need to be transitioned to LRS, Supports Waiver, higher education, etc.?
Education needs	School or education should be an identified need unless they have a doctor's statement that it is not appropriate or they have completed an educational program. Contact Child Search if the beneficiary has not had a Special Education Evaluation. A Special Education Evaluation is needed before an IEP can be done to receive school services. Special Education Evaluations should be completed every three years. Review the IEP for information. When documenting placement grade, also document academic functioning level. Some CPOCs give the impression that beneficiary does not meet the eligibility criteria. (Documented the recipient was in the 11 th grade but did not document it was inclusion and they were functioning academically on 3 rd grade level.) Discuss the IEP with the parent/guardian. Are they aware of what services their child is or is not receiving and the frequency of the services? Does the parent need to request another IEP meeting to have the IEP

	<p>services corrected. The School Board is legally obligated to provide the services on the IEP.</p> <p>Contact the parent after Easter to see if the beneficiary qualified for Extended School Year Program (ESYP) and if they will be attending, and if not, what additional needs might need to be met in the summer.</p> <p>If they are receiving homeschooling, is it registered with the Department of Education to be renewed annually?</p> <p>If the child is not in school, is the parent aware of the educational law for school attendance when the child is 7 years old? Does the parent plan to enroll the child next school year or obtain an exemption?</p> <p>If the beneficiary is not attending school, document if they have interaction with friends, participate in leisure and social activities, and get out of the home.</p>
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HEALTH STATUS

Summarize important aspects of the person's health, behavioral and/or psychological concerns. Any pertinent information about the beneficiary that can be provided by the family or gathered from formal information documents should be documented. If there is only sketchy information available in any health status area, remember the beneficiary is eligible for screenings, which can help to determine his/her health needs. It is the Support Coordinator's responsibility to help the beneficiary access those screening services. In some cases, a short term CPOC may need to be developed, setting out the areas that need to be explored towards developing sound and longer term objectives.

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

This portion of the Plan of Care must be addressed initially, and updated as significant change occurs in the beneficiary's life. When significant new information is obtained from a medical appointment or assessment, including a psychological and behavioral services assessment, the CPOC should be updated by adding and/or revising the goals and objectives according to the most recent information available.

Physician and Last Appointment Date	List the name of their primary care provider and the date of their last appointment.
Immunization Current	All information on immunizations should be current. This is extremely important. If immunizations are not up to date, this will need to be addressed in the Medical Diagnoses section.
<i>Medical Diagnosis and Concerns/ Significant Medical History</i> A brief narrative description of the person's health history, current medical condition, including medical diagnoses, hospitalizations and continuing health concerns and medical needs should be included.	
Diagnoses and current formal information documents to support.	<p>List the beneficiary's diagnoses and what current formal documentation you have to support their qualifying developmental disability.</p> <p>It can be documented that a parent states a diagnosis, but also document that you do not have documentation to support this and what you are doing to obtain the documentation. Each agency is required to have a nurse consultant who may be able to assist in obtaining the diagnosis. Does the individual want a referral for an evaluation?</p> <p>Diagnoses can change over time. Update with current information. Use your nurse consultant as a resource for medical information that is not understood or use the internet for information.</p>
Medical specialists – name, specialty, how often they see, last visit, upcoming visits	<p>Are they obtaining physicals at the recommended EPSDT Screening Exam interval? If not, are you encouraging that they do so?</p> <p>Are they receiving the recommended annual dental checkups? If not, are you encouraging that they do so? Also explain to adults that dental is not covered when they turn 21.</p> <p>Are linkages needed?</p> <p>Name, specialty, how often they see, last visit, and upcoming visits? Are they overdue for any appointments?</p>
Findings from the last physical	

Medications	Names of medications and what they are prescribed for (blood pressure, behavior, seizures, etc.)
Current physical abilities	<p>Vision</p> <ul style="list-style-type: none"> • How is their vision? • Need for any screenings, physician referrals or assistive devices? <p>Hearing</p> <ul style="list-style-type: none"> • How is their hearing? • Need for any screenings, physician referrals or assistive devices? <p>Mobility</p> <ul style="list-style-type: none"> • How do they ambulate? • Use of arms, hands and legs? • Concerns with fine or gross motor skills? • Need for assistive devices or DME? • If physical or occupational therapy is an identified need, was it offered and response received?
Communication	<p>Primary language used</p> <p>How does the beneficiary communicate ideas, feelings and desires? Words, sentences, pictures, sign language, gestures, body language, augmentative devices, interpreters?</p> <p>Method of communication if other than speaking?</p> <p>If speech therapy is an identified need, was it offered and response received?</p>
Documentation for Competent Majors	<p>If the beneficiary is a competent major and someone else is being contacted and followed up with instead of the beneficiary or is signing documents on behalf of the beneficiary, there must be documentation that an Authorized Representative form (Appendix U) or a supported decision-making agreement is on file. There must also be documentation to support the beneficiaries request to have the authorized representative contacted <u>or</u> documentation of the beneficiary's inability to self-direct their care.</p> <p>Are they able to self-direct their care? Must match response in demographic information. Are they able to communicate in any form, engage in their life and make choices of what is important to them and what they want in their life? Can they self-direct and have other family members or concerned individuals assist?</p>

	<ul style="list-style-type: none"> • If they are able to self-direct, did they request that the SC contact someone else to assist and communicate on their behalf? Document, "Asks that SC contact ____ to assist and communicate on their behalf." • If they are able to self-direct, did they request that SC speak with someone if they are not available at the time of the SC contact? Document, "Request that SC speak with ____ if they are not available at the time of the SC contact." Service log example if this is documented in CPOC: Phone contact made with Mary on behalf of Liam. Liam is at school. • If unable to self-direct, explain the basis for this, personal observation during the face-to-face meeting, a specific psychological evaluation, IEP, etc. It should not be based only on the parent states they are unable to self-direct. Physical disability does not prevent the ability to self-direct. Who has agreed or is responsible for assisting the beneficiary in obtaining needed services? Document, "____ is unable to direct their own care based on _____. (Name of parent or caregiver) has agreed or is responsible for assisting the beneficiary in obtaining needed services." <p>The SC must attempt to ask all the beneficiaries, regardless of their ability to self-direct, about their preferences.</p> <p>During each Quarterly Review ask and document if they still want representation.</p> <p>The CPOC and Quarterly Reviews are to be signed by competent majors that are able to self-direct their own care.</p> <p>Service log examples when not contacting competent majors:</p> <ul style="list-style-type: none"> • "Phone contact made with Mary Clark as Josh is unable to self-direct his care." • "Phone contact made with Mary Clark per Josh's request." • "Phone contact made with Mary Clark on behalf of Josh. Josh is at school."
Toileting needs	<p>Are they toilet trained? If diapers are needed, is it due to incontinence of bowel or bladder, bedwetting, occasional soiling, working on potty training, etc.?</p>

	<p>If incontinence supplies are an identified need, was it offered and response received? (Note: Diapers are provided by Medicaid beginning at 4 years old and ending on their 21st birthday. PA tracking can begin 60 days prior to the beneficiary's 4th birthday. Instruct the provider to list her 4th birthday as the PA service begin date)</p>
Medical needs	<p>Identify any medical equipment or special procedures such as gastrostomy tube, tracheostomy tube, urinary catheter, or other medical equipment. How often is the special procedure administered?</p> <p>Clarify if EHH (three or more hours of skilled nursing per day) or basic home health visits were offered/requested/received. Document what skilled service is needed that cannot be provided by PCS.</p>
Dietary needs	<p>Formula or nutritional supplements, special diet needs like allergies, pureed food, etc. or funds received for a special diet.</p> <p>If formula or nutritional supplements are an identified need, was it offered and response received?</p>
Therapies	<p>Always offer and document the offer of medically necessary community therapies in addition to the therapies received per the IEP as well as the response received from the individual.</p>
Continuing health concerns and medical needs	
Significant family health risks	
Activities of Daily Living	<p>If a beneficiary meets the criteria for PCS and declines the service, document the recipient/parent declining the service.</p> <p>If the beneficiary is capable of doing Activities of Daily Living or Instrumental Activities of Daily Living, document this.</p> <p>If PCS is received or requested, what two or more Activities of Daily Living (ADL) do they need PCS to assist with?</p> <p>Do they need mentoring, supervision, respite, assistance with homework, etc., which are not provided by PCS? What is the service needed to provide this?</p>

Evaluations	<p>Current formal information must be reviewed to identify needs while developing the CPOC. Information from the documents must be incorporated into the CPOC.</p> <p>Were additional assessments or services recommended? What services are they to receive at school?</p>
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<p><i>Psychiatric/Behavioral Concerns</i></p> <p>A narrative description of the person’s psychiatric status, diagnoses and significant behavior concerns should be provided in the Health Profile. Any relevant history that poses a potential risk for the beneficiary or others should be provided. Also, information on effective behavior interventions, support plan and skills training should be detailed in accompanying information. This information can be obtained from the psychological.</p>	
Describe the behaviors	<p>List the specific behaviors. What exactly does the behavior look like?</p> <p>Address both behaviors at both home and at school. What is reported on the IEP? Home and school may have different concerns.</p> <p>List what is observed by the SC.</p> <p>Ask the beneficiary, not just the guardian, about behaviors and need for services.</p>
Frequency	<p>How often do the behaviors occur?</p> <p>Have they improved or gotten worse?</p> <p>Be specific (i.e., 4 times a day, 2-3 times a week, a few times a month, etc.). Don’t use words like frequently or rarely. The CPOC covers a year and documenting “recently” or “a couple of months ago” is not helpful in determining a time frame. SC will need to know if there has been improvement in behavior or frequency of the events.</p>
Significant behavioral incidents	<p>Document month and year of significant behavioral incidents and what exactly occurred.</p> <p>Clarify any placements. Is the facility a detention center, psychiatric hospital, etc.?</p>
Triggers	<p>Is there something that caused the behavior such as the effect of a medication, beginning of illness, personality clash, antagonized by someone, toy taken away, unknown, etc.?</p>

Strategies	<p>How are the behaviors managed/ what strategies are used such as time out, redirection, positive reinforcement, etc.?</p> <p>Were significant behavior concerns or incidents discussed with or reported to their physician?</p> <p>Does the beneficiary harm himself or others during behavioral episodes, destroy property, etc.? How are siblings protected?</p>
Services	<p>What behavioral health services were offered and which are received/requested? If a service was discontinued, clarify why.</p> <p>For every Chisholm Class Member that has an Autism diagnosis (or related disorder) or has even been labeled, even informally, as having Autism (or related disorder), please make sure you are either:</p> <ul style="list-style-type: none"> • connecting the class member with Applied Behavioral Analysis (ABA), or • referring for testing to assess the need, or • documenting that the family declined these services. If declined, please revisit ABA with the family at least annually. <p>As you know, autism services can be most effective when delivered as early as possible in a child's life. Services usually should begin at ages 2 to 6. The needed early connection is thwarted if support coordinators fail to identify ABA as a possible therapy and arrange it unless declined.</p> <p>Are they taking medications for behavioral or psychiatric issues? If behavior medications are prescribed, they should be listed in the service needs and supports section.</p> <p>Do they have a school behavior plan? List as service need as applicable.</p> <p>If formal information documents, interviews with caretakers, information in the case record, or SC observations identify the need for Psychological and/or Behavioral Services it must be addressed on the CPOC. Any beneficiary with psychological or behavioral concerns (victim of child abuse, loss of parent or close family member, school suspension or expulsion, recent catastrophic injury, acting withdrawn, etc.) should be offered services. Document offer of services and response received. If there is an identified need for a psychological/behavioral health service</p>

	<p>and the family/beneficiary declines the offer of the service it should be placed in the Service Needs Section of the CPOC.</p> <p>Be clear on what service is received or offered. See the additional services in pages 11-17 of this Handbook.</p> <p>Do they belong to an Autism support group or want linkage?</p> <p>If the beneficiary's inability to communicate is causing the frustration, was community ST offered?</p>
Evaluations	Are there any behavioral issues that were not identified or mentioned by the family?
Do not state N/A in this section. These items must be assessed.	
Ask monthly about any behavior concerns or issues.	
<i>Evaluations/Documentation</i> <p>Dates of formal information documents used in the development of the CPOC are to be listed. <u>At least one current formal information document</u> is required in the development of an annual CPOC. <u>Current</u> means that the formal information document was less than a year old at the time of the plan of care meeting.</p>	
Social Evaluation	
Psychological Evaluation	
Psychiatric Evaluation	
Special Education Evaluation	
IEP*	<p>*If receiving Special Education, current IEP is required to be on file.</p> <p>IEPs should be requested from the parent on intake. If the parent does not have a copy, the SC should request a copy from the school or school board office.</p> <p>Obtain the current annual IEP, not just the progress report or Extended School Year Program (ESYP) which do not have all of the assessment information. IEPs are valid for one year. If the IEP is more than a year old, the SC may need to confirm the date of the last IEP with the school</p>

	<p>board. Sometimes parents do not attend the IEP meetings, forget it was renewed, or misplace the IEPs.</p> <p>Obtain the annual IEP as it is renewed and update services with an interim CPOC as needed. If the IEP is obtained as it is renewed, the CPOC submit and approval will not be delayed while the SC tries to obtain the document. School services should be current. (An annual CPOC was randomly selected for monitoring. The current IEP dated 9/18/21 had ST and PT services removed yet the monthly service logs, Quarterly Reviews, and 5/5/22 CPOC that was submitted, wrongly documented the services were still received.)</p> <p>If the child has special health needs, an Individualized Healthcare Plan (IHP) should be attached to the IEP. 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.</p> <p>If the recipient does not have an IEP, do they have a 504 education plan and/or a school health care plan? If so, obtain that document to identify their needs and services.</p>
Behavior Management Plan	
Home Health Plan of Care*	<p>*If receiving EHH, current EHH POC is required to be on file to receive approval on an initial or annual CPOC.</p> <p>EHH Plans of Care must be signed by the Physician every 90 days.</p>
Form 90 or Medical Records	<p>EPSDT-PCS Form 90: If the beneficiary is receiving PCS, an EPSDT-PCS Form 90 can be obtained from the provider or physician.</p> <p>EPSDT Screening Records: The PCP or the PCP's contracted provider is required to do yearly EPSDT Screenings (physicals and assessments) for children age 3-6, and every other year after age 6. These records can be obtained by the beneficiary/guardian, or support coordinator with a signed release of information.</p> <p>Progress Notes or Medical Records: Progress notes or a copy of a physical can be obtained from the physician's office. Mental Health records require a special release of information form. Contact the provider to obtain the release form that is required or obtain one from the LDH website using</p>

	<p>the following link, http://LDH.louisiana.gov/assets/medicaid/MedicaidEligibilityForms/HIPAA402PEng.pdf. The school nurse gathers medical information for the IHP and can be contacted to see if the beneficiary other medical documentation in the school records that could be used for formal information documents.</p>
Pediatric Day Healthcare (PDHC) Plan of Care*	<p>*If receiving PDHC, current PDHC POC is required to be on file to receive approval on an initial or annual CPOC.</p>
<p>Statement of Approval (SOA)*</p> <p>-Enter Expiration date or check Permanent box.</p>	<p>*A valid SOA is required unless they are identified in LSCIS as “Special Needs.”</p> <p>The Support Coordination Choice and Release of Information Form (FOC) 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 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 N for a sample copy of the consent form.</p> <p>The SC should refer a beneficiary to OCDD two months prior to the SOA expiration. You can view all of the SOA expiration dates that you have entered in LSCIS for your beneficiaries by viewing the CPOC Updates Report and referring to Redetermination Due column. BHSF/SRI should not be receiving annual CPOCs that have expired SOAs. SC agencies were instructed to obtain valid SOAs and Beneficiary Recap Sheets from OCDD.</p> <p>The SOA expiration date should not be blank unless a permanent SOA was issued and the permanent box is checked. If there is no SOA expiration date on the SOA or IER or the OCDD Beneficiary Recap Sheet lists the SOA as permanent then you can check the permanent box. If the SOA has expired, contact OCDD and obtain the “Approval for Continued Services and Requested Waiver Date” notice and/or the Beneficiary Recap Sheet.</p>

	<p>If the SOA has expired and a redetermination is required, list the expiration date. The identified need for the OCDD redetermination should be listed in the Service Needs section.</p> <p>A SC is to refer a beneficiary to OCDD for a redetermination if it appears that they no longer meet the eligibility criteria, even if they have a SOA. A short-term PA will be issued while the redetermination process is being completed. If it is determined that they are not eligible for OCDD services, the PA will be extended to allow for an appeal and a review by BHSF for possible identification as "Special Needs."</p>
Other	Enter date and describe what kind of document it is.

Section III - CPOC Service Needs and Supports

This section of the CPOC identifies service needs including the service strategy and a description, how the need was determined, if the individual requests to receive the identified need and any reasons why not, the primary goal, who is providing the support, if the service requires PA tracking, and the amount of service approved. This section of the CPOC will identify the unique personal outcomes envisioned, defined and prioritized by the individual and the agreed upon support strategy needed to achieve or maintain their goals using appropriate natural, community, informal, and formal supports. When designing the goals and objectives of the CPOC, it is important to take into account the strengths and weaknesses of the informal/natural supports. For example, if the primary caregiver has no other supports or has a disability, they may not be able to offer much assistance with physical care, and it may prove beneficial for the individual to use more paid care than may otherwise be provided. It is the Support Coordinator's job to look at and respond to the needs of the beneficiary; however, often the family's needs have a direct impact on the beneficiary's needs. It is important that the Support Coordinator give the caregiver assistance that is dependable and that allows the caretaker to continue to meet the individual's needs over the long-term.

The Support Coordinator must identify all of the services, both Medicaid and non-Medicaid, that the beneficiary needs. 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. The Support Coordinator must use the Medicaid Services Chart (*Appendix C*) to inform the individual of available Medicaid services. 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. Refer to the service strategy pick list for a list of some services.

The Support Coordinator will coordinate all services, Medicaid and non-Medicaid, and ensure that the beneficiary receives the services they need to attain or maintain their personal outcomes. When a service is requested, the Support Coordinator should provide the individual with the medical information forms (EPSDT-PCS Form 90, CMS 485, etc.) that are required for the specific service. The Support Coordinator should assist with scheduling the doctor appointment, transportation, etc. as needed.

The CPOC must include timelines in which the personal outcomes can be met or at least reviewed. The CPOC must be reviewed at least quarterly and revised as needed. The Support Coordinator will have phone contact with the individual at least monthly and meet face-to-face at least quarterly to assure that the CPOC continues to address the beneficiary's needs and maintain their health and well-being and to assure that the services are being provided. It is extremely important for all goals and strategies to be adjusted as the needs of the beneficiary change and as new challenges develop in his/her life, including problems that develop regarding receipt of any services. The Support Coordinator must assure that the individual understands that services and goals may be added at a later date if they do not choose to access them when the need is first identified. The Support Coordinator must document the individual chose not to access a service at the time of the CPOC meeting, and that they will be given an opportunity to add that service during the quarterly CPOC reviews or whenever a request is made. Again, if the beneficiary is 18 or older and has not been legally declared incompetent, the support coordinator should contact the beneficiary unless the support coordinator has documented that the beneficiary is unable to express their preferences or the beneficiary has authorized the support coordinator to contact a family member.

<i>Service Needs</i> What support is needed for the beneficiary to achieve their personal goals? This may reflect training, needed supports, skill acquisitions, or may regard the person's maintenance in the home and community with provided supports. Make sure that you address all issues on IEP and learning disabilities.		
<i>Service Strategy (pick list)</i>		All identified service needs must be listed. Include those that are currently received and those that are requested. Don't forget to include needs such as respite, smoke alarm, behavior medications, cash subsidy, DME maintenance, specialized treatments such as chemotherapy or dialysis, MH services, van lift, etc. If it is not a Medicaid service, the SC is to assist in locating resources to provide the service need. All applicable services that require Prior Authorization must be identified. The drop-down bar will identify a list of Medicaid services that require a PA and other services for identified needs.

<p>Description (blank box)</p>	<p>The description box should clarify the service need that is requested. If there is not enough space, clarify the service in Section IV, Additional Information. Example: Dental Services/ routine care, Dental Services/ tooth decay, Dental Services/locate provider.</p> <p>Do not list the name of the provider in the service description box. The CPOC will be locked after approval and won't allow for this identifier to be edited when a new provider is selected. The provider and/or brand can be identified in Section IV (Additional Information). The CPOC can be revised at any time.</p> <p>Do not list other terms, such as amounts of service, "applying" or "requested" in the description box. These descriptions may change over time without having a change in the need for the service. There is a separate box for amount approved.</p>
<p>Service Strategy Pick List Options:</p>	
<p>Personal Care Services</p>	<p>Personal Care Services is a specific Medicaid program. Use the PCS drop down for EPSDT-Personal Care Services only. PA tracking is required. OCDD does not provide this service.</p> <p>Note: If respite is requested through OCDD family support indicate that need under Other/Respite.</p>
<p>Home Health Services</p>	<p>Indicate Extended Home Health, intermittent nursing, physical therapy, speech-language therapy, occupational therapy, or home health aide services.</p> <p>EHH provides three or more hours per day of skilled nursing care to recipients under 21 years old only. Prior Authorization is required. An EHH Plan of Care (CMS form 485) is required which must be signed by a physician every 90 days. EHH is a Specific Medicaid program.</p> <p>Basic Home Health services are provided in the home under the order of a physician that are necessary for the diagnosis and treatment of the patient's illness or injury, including: skilled nursing, physical therapy, speech-language therapy, occupational therapy, home health aide services. Recipients must</p>

	have a physician's prescription and signed Plan of Care. PT, OT, and ST require a PA.
Medical Equipment and Supplies	<p>DME products for a specific task can be grouped together if they are all ordered from the same provider with the same PA service dates. Gauze, tape, gloves, and saline for wound care can be identified as DME/Wound Care.</p> <p>DME that the individual has and uses should be listed as separate received service needs (DME/Wheelchair, DME/AFO, DME/Walker, etc.) so that the SC can check on the status and ensure the item remains in good working order. PA tracking would be needed if a repair is needed or if the item needs to be replaced.</p>
OT Physical Therapy Speech Therapy	Therapies received at school and in the community should be listed separately. Use OT, Physical Therapy, and Speech Therapy for community therapies and School for IEP services.
Specialized Behavioral Health	<p>Indicate in the description box what service need is identified:</p> <ul style="list-style-type: none"> • Psychiatrist visits • Behavioral medications • Individual, family, and group therapy • Licensed Practitioner Outpatient Therapy <ul style="list-style-type: none"> ○ 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) • Mental Health Rehabilitation Services <ul style="list-style-type: none"> ○ Community psychiatric support and treatment (CPST)*, <ul style="list-style-type: none"> ▪ Multi-Systemic Therapy (MST) (age 0-20)* ▪ Functional Family Therapy (FFT) and Functional Family Therapy-Child Welfare* ▪ Homebuilders®*

	<ul style="list-style-type: none"> ▪ Assertive Community Treatment (ages 18-20 years)* <ul style="list-style-type: none"> ○ Psychosocial Rehabilitation (PSR)*, ○ Crisis Intervention (CI), • Crisis Stabilization (CS); • Therapeutic Group Homes (TGH) • Psychiatric Residential Treatment Facilities (PRTF)** • Inpatient Hospitalization • Outpatient and Residential Substance Use Disorder Services • Medication-Assisted Treatment (MAT) <p>*The Managed Care Organization's prior authorization unit must pre-approve CPST, PSR, ACT (ages 18-20), FFT/CWFFT, Homebuilders, and MST. CPST and PSR providers arrange the assessments necessary to obtain prior authorization for rehabilitation services.</p> <p>**A certificate of need must be complete prior to admission to a PRTF.</p> <p>Note: CSoC enrollees' specialized behavioral health services do not require PA tracking by the SC.</p>
Dental Services	Dental Care – dental checkups are recommended annually.
Eyeglasses	Eyeglasses and/or contact lenses
Transportation Services	NEMT or Gas Reimbursement Program
Diapers	Diapers are provided by Medicaid beginning at 4 years old and ending on their 21st birthday. PA tracking can begin 60 days prior to the beneficiary's 4th birthday. Instruct the provider to list her 4th birthday as the PA service begin date.
School	<p>Identify services that are on the IEP such as School/OT, School/ST, School/Assistive Technology, School/Social Worker, etc.</p> <p>OT/PT/ST consult is not a direct service. They consult with the teacher and parent and may observe the child in the classroom. It may be received only once a semester or once a month. It should be identified as "OT consult," "PT consult," etc.</p> <p>Adaptive Physical Education, A.P.E., is not a therapy. It is provided to a student who is unable to beneficiary in regular physical education (P.E.) and does not need to be listed as a service need.</p>

Vocational	
Employment	
Transition	Must be listed as a service need if the beneficiary is 20 ½ or older during the CPOC service dates. The strategy is to be documented in the Additional Information section. The strategy will be to inform the recipient and family of LT-PCS, OCDD services, how to obtain the services they now receive, link to resources to receive those services, change in Medicaid services on 21st birthday- encourage to obtain dental and eye exams, glasses, DME, etc. prior to aging out.
Pediatric Day H.C.	
Applied Behavioral Analysis	
Home Modifications	
Community Services	
Redetermination	If the SOA will expire during the CPOC year, Redetermination must be added as a service need (example: Redetermination/6.7.22). The SC should refer a beneficiary to OCDD two months prior to the SOA expiration.
OCDD Services	<ul style="list-style-type: none"> • Family Flexible Funds • Family Support • Respite
CSoC	Coordinated System of Care and Wraparound Facilitation <ul style="list-style-type: none"> • Wraparound Facilitation • Parent Support and Training • Youth Support and Training • Short Term Respite Care • Independent Living and Skills Building
Evaluation	
EPSDT Screening Exam	
Hearing Aids	Hearing aids and supplies needed for them
Hospice Services	
Physician/Professional	<ul style="list-style-type: none"> • Doctor's Visits or Referrals • Appointment Scheduling Assistance • Lab and x-ray tests • Family Planning • Podiatry Services • Optometrist Services • Audiological Services • Chiropractic Services

	<ul style="list-style-type: none"> • Prenatal Care • Certified Nurse Midwives • Ambulatory Care Services, Rural Health Clinics, and Federally Qualified Health Centers
Other	Use for any other service that you cannot find from the drop-down box.
<i>How was the need determined?</i>	<ul style="list-style-type: none"> • D&E (Diagnostic and Evaluation) • Family • 1508 • ICAP • IEP • Other • Physician • Psychiatrist • Psychologist • Support Coordinator • Therapist
<i>Requested by beneficiary/family</i>	This column will document the beneficiary/family's choice to access services relating to the identified needs at the time of the CPOC meeting.
<i>If not why not</i>	<p>Carried over-resolved: The service is no longer requested or is no longer an identified need. The service was listed in error or incorrectly identified and is locked on the CPOC. Note: DMEs that need to be maintained or renewed are to remain as Service Needs and should not be marked as carried over – resolved. If it was a one-time PA for a DME you can mark the DME as received and untrack after the item is received and your tracking log is complete. If a new one is needed or repairs are needed, unmark receiving, recheck PA tracking, and bring forward a new tracking log.</p> <p>Family does not want: The need for the service has been identified but the beneficiary/family declines the service.</p> <p>Other - explain next page: The service is an identified need but is placed on hold. This is not appropriate if on a wait list for therapy as they are requesting the service now.</p>

	<p>Example: Has a PA for PT but had a recent surgery and the PT was placed on hold with the intention of returning. Requesting PT but only want it in the summer.</p> <p>Document why the service need was resolved/no longer wanted/on hold in the Additional Information section.</p>
<i>Primary Goal</i>	<ul style="list-style-type: none"> • Natural Supports • Safety • Best Possible Health • Security • Where they live • Choose services • Choose goals • Participate in the community • Have friends
<i>Receiving</i>	Use the check box to indicate if the service need is currently being received.
<i>Will the service be provided by Medicaid, School, Community, Family, or OCDD?</i>	<p>Use the check boxes to identify who and how the person can be supported to achieve his/her personal outcome. This section identifies whether paid staff or natural supports will be utilized to support the strategy.</p> <p>Medicaid - “Medicaid” and “Requires PA Tracked by SC” must be checked in order to generate the required PA Tracking log.</p> <p>Family – if the service is provided by the family or through private insurance check this box.</p>
<i>Requires PA tracked by SC</i>	<p>“Medicaid” and “Requires PA Tracked by SC” must be checked in order to generate the required PA Tracking log.</p> <p>“Requires PA tracked by SC” must be checked for all requested Medicaid services that require a PA, unless both a valid reason and how the SC will ensure the service is received is documented in the Additional Information section. Incorrectly removing the PA tracking requirements on EPSDT CPOCs will cause errors on the EPSDT Quarterly Report and PA Tracking Required Action Report.</p>

<i>Amount Approved</i>	Describe the frequency of service delivery the provider will use to meet the person's need (i.e., 4/day to indicate 4 hours of PCS per day.)
<i>Void</i>	Only void a service need if it was created in error. Otherwise uncheck requested and choose an option from the "If not, why not?" pick list.

No Services to Coordinate

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

Additional Information about Service Needs and Supports and Valid Reasons for not tracking

If a Medicaid service does not have "Requires by PA Tracked by SC" checked, the SC must provide documentation of the valid reason and how the SC will ensure the service need is received. PA tracking starts with the **request for service**, not the choice of provider or receipt of prescription. **Choosing a provider or waiting on a prescription are NOT valid reasons for not tracking.**

The valid reason for not tracking the PA (i.e., PA is issued monthly, the Extended Home Health nurse orders and tracks the supplies, the participant was placed on a wait list after they were referred to the provider, SC unable to obtain PA for community OT but confirmed it is being provided, etc.) **and how the SC will ensure that the service is received must be documented in the "Additional Information" box.** The PA notices must be kept in the case record and the "amount approved" placed in the CPOC service needs and supports section.

These are the only valid reasons for not tracking a requested Medicaid service's prior authorization:

1. A prior authorization is not needed for the Medicaid service.

PA tracking is only required for Medicaid services that require a Prior Authorization from Gainwell or the MCO. Some of the Managed Care Organizations do not require PAs for diapers and therapies (ST, OT, PT). 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 services 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.

The MCOs have PA look-up tools that can be used to determine if a particular service requires a Prior Authorization or not:

- Aetna Better Health
 - <https://www.aetna.com/health-care-professionals/precertification/precertification-lists.html>
- AmeriHealth Caritas
 - <https://www.amerihealthcaritasla.com/provider/resources/prior-authorization-lookup.aspx>
- Healthy Blue
 - <https://provider.healthybluela.com/louisiana-provider/resources/prior-authorization/prior-authorization-lookup-tool>
- Humana Healthy Horizons in Louisiana
 - <https://www.humana.com/provider/medical-resources/authorizations-referrals/preauthorization-lists>
- Louisiana Healthcare Connections
 - <https://www.louisianahealthconnect.com/providers/preauth-check/medicaid-pre-auth.html>
- UnitedHealthcare Community Plan
 - <https://www.uhcprovider.com/content/dam/provider/docs/public/commplan/la/prior-authorization/LA-UHCCP-Prior-Authorization-Effective-7-01-2023.pdf>

2. The PA is issued monthly.

If the PA is issued monthly, PA tracking is not required because a PA tracking log cannot be done due to the quick turnaround. The required provider contact timelines cannot be met since a PA renewal request is submitted by the provider prior to the required 45-day renewal notice being sent by the Support Coordinator. The SC must enter the PA information in the PA Tracking Log documenting the PA begin and end date to show a monthly PA was issued before untracking. Note: Diapers and formula may be delivered or released in monthly increments due to storage when the PA is issued for 6 months. PA tracking would be required in this case.

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

4. The beneficiary is placed on a waitlist and declined offer of other providers. If the participant is placed on a waitlist, the SC must offer alternative providers for whom there might not

be a waiting list. If the participant chooses to stay on the waiting list, PA tracking is not required **after** the SC confirms waitlist placement with the provider and notifies the PAL (Legacy Medicaid) or the MMCCM (Medicaid Managed Care services) of the waitlist placement. Follow these steps:

- 1) Open the tracking log and enter the date of choice of provider and provider name.
- 2) Send Referral to Provider (Legacy Medicaid services), or send Referral to MMCCM (Medicaid Managed Care services) to notify the MCO of choice of provider.
- 3) Complete 15 day Provider contact to confirm waitlist placement.
- 4) Offer the participant alternative providers for whom there might not be a waiting list and document the response received.
- 5) Notify the PAL of waitlist placement via Referral to the PAL (Legacy Medicaid services), or notify the MMCCM of waitlist placement via Referral to MMCCM (Medicaid Managed Care services).
- 6) Enter an Interim CPOC and untrack the service need by unchecking the Requires PA tracked by SC box. Keep requested checked.
- 7) Document the following in Additional Information:
 - a. The SC offered alternative providers for whom there might not be a waiting list and document response received from family,
 - b. the SC confirmed waitlist placement with the provider,
 - c. the SC notified the PAL (Legacy Medicaid) or MMCCM (Medicaid Managed Care) of waitlist placement, and
 - d. how the SC will ensure the participant moves up the waitlist (follow up with provider at least quarterly).
- 8) Continue to follow up the provider at least quarterly on the status of waitlist placement.
- 9) Restart PA tracking when their name comes up on the waitlist by entering an Interim CPOC and rechecking the Requires PA tracked by SC box for the service need.

5. OT, ST, PT provider is providing services without a PA.

Refer to Appendix R-4 – Modification of Rehab Services PA Tracking/PAL Referral. Community therapy providers have up to a year to bill Medicaid for services and some providers are waiting until then to submit the PA request to Gainwell. Some community therapy providers are providing therapy services to EPSDT beneficiaries before they submit PA requests to Gainwell. The PA tracking procedure has been modified for these cases. Prior to completing a 35 or 60 day PAL for therapy services, the SC is to contact the provider to determine if the participant is receiving the service. If the provider confirms the service is being delivered, the family is to be contacted. If BOTH the provider and family confirm the participant is receiving the prescribed therapy, a PAL referral and continued PA tracking would not be needed. If the SC cannot confirm that services are being provided and there is no PA in place, the SC must initiate a PAL referral within the prescribed timelines. If the PAL can confirm with the family and

provider that the services are being delivered and provide them with the date the service began continued PA tracking would not be needed. **If the SC receives a PA notice, it is to be entered on a tracking log and PA Tracking will restart.**

Note: If the MCO does not require a Prior Authorization for OT, ST or PT use reason 01 A prior authorization is not needed for the Medicaid service.

6. The beneficiary is in CSoC and the behavioral service is being authorized by Magellan.
If the beneficiary's behavioral health services are being prior authorized by Magellan while the child is enrolled in CSoC, PA tracking is not required. Once the child leaves CSoC, PA tracking of behavioral health services that require a PA is to resume.

Section IV - CPOC Participants

<i>CPOC Signature Page (paper form)</i> As the Support Coordinator, it is your responsibility to have everyone sign the printed LSCIS CPOC signature page indicating their participation in the meeting.	
Planning Participants	<p>The beneficiary and the legal guardian must be present for the CPOC meeting.</p> <p>Everyone present at the meeting must sign in the Planning Participants box and indicate their Title and Agency Name as applicable. This includes the beneficiary, the legal guardian, the Support Coordinator. Again, if a person is present at the meeting, they should SIGN in the Planning Participant's box.</p> <p>You may also wish to obtain contact information for each person attending, so they can be invited to future meetings, if the beneficiary/family requests assistance with this.</p>
Medicaid Services	<p>The Participant/Guardian is to indicate their response to the questions:</p> <ul style="list-style-type: none"> • SC explained that Medicaid will provide medically necessary therapies in addition to the therapies received at school through the IEP. • SC has reviewed the Medicaid Services Chart with me. • SC has provided me with information on Medicaid EPSDT Services. • SC has provided me with information on EPSDT Screening Services. • EPSDT Screening Services requested.

Participant's/Guardian's Signature	<p>The beneficiary/guardian will sign and date the printed LSCIS CPOC signature page indicating they have reviewed and agree with the services in the CPOC.</p> <p>Beneficiaries age 18 or older must sign all documents if they are able to direct their own care. If they are unable to do this, the reason should be documented. If someone other than the parent or the beneficiary (if they are a competent major) is signing the CPOC as the beneficiary/legal guardian, legal documentation or a Non-Legal Custodian Affidavit (Appendix V) must be in the case record and this must be documented in the CPOC.</p> <p>To complete monthlies or quarterlies with someone other than the parent if the beneficiary is a minor, legal documentation or a Non-Legal Custodian Affidavit (Appendix V) must be in the case record and this must be documented in the CPOC.</p> <p>To complete monthlies with someone other than the beneficiary if the beneficiary is a competent major an Authorized Representative Form or supported decision-making (SDM) agreement must be in the case record and this must be documented in the CPOC.</p>
Support Coordinator's Signature	The SC will sign and date the printed LSCIS CPOC signature page indicating they have reviewed and agree with the services in the CPOC.
Support Coordinator Supervisor's Signature	The SC Supervisor will sign and date the printed LSCIS CPOC signature page indicating they have reviewed and agree with the services in the CPOC.

<i>CPOC Participants (LSCIS)</i>	
Planning Participants / Title and Agency	The individuals listed as Planning Participants in LSCIS must match the Planning Participants on your CPOC signature page (paper form).
Additional Information about Service Needs and Supports	<p>This section is provided to document additional information regarding service needs and supports.</p> <p>The names of all service providers and any additional strategy information are to be placed in this section.</p>

	<p>If there was not enough room in the service need description box clarify what service need is being requested.</p> <p>Support strategy information may be required to clarify what is needed to achieve the Goal, how the support will be delivered / how the service need will be met, who will deliver the support, and where the support will be provided. Example: The service need is “Other/recreational activity” and family and community are checked as providing the service, document the family is taking him to the library and sporting events and he is involved in YMCA activities.</p> <p>Specific EPSDT transition strategies must be listed in this section. Example: Beneficiary will be informed of CCW, ADHC, LT-PCS, OCDD services, how to obtain the services he now receives, link to resources to receive those services, change in Medicaid services on 21st birthday, and will be encouraged to obtain exams, glasses, DME, etc. prior to aging out.</p> <p>If a current service need was requested on the previous CPOC and is not checked as “receiving,” document the barriers and the strategy to obtain the service need now.</p> <p>If any service needs were documented as carried over – resolved or other – explain next page, document why the need was resolved or why the need was placed on hold.</p> <p>If PA tracking is not checked for any Medicaid services that require PAs the valid reason for not tracking must be documented along with how the SC will ensure the service is received. (See Handbook pages 60-62.)</p>
Medicaid Services	<p>This section of the CPOC is to ensure that the beneficiary/family has been made aware of the services available to them through Medicaid. The Support Coordinator must review the Medicaid Services Chart with the beneficiary/family. The Support Coordinator must also provide information on Medicaid EPSDT and EPSDT Screening Services.</p> <p>The SC must document if the following occurred:</p>

	<ul style="list-style-type: none"> • Support Coordinator has explained that Medicaid will provide medically necessary therapies, in addition to the therapies received at school through the IEP. (Yes or No) • Support Coordinator has reviewed Medicaid Services Chart with the participant and family (Yes or No) • Support Coordinator has provided the participant and family with information on Medicaid EPSDT Services. (Yes or No) • Support Coordinator has provided the participant and family with information on EPSDT Screening Services. (Yes or No) • EPSDT Screening Services Requested (Yes or No)
Participant Signature Date	The signature date of the Participants/Guardian's signature on the CPOC Signature Page (paper form) is to be entered into LSCIS.
Signature of SC / SC Signature Date	<p>The goal for Support Coordination is included in section IV and denotes that the CPOC will be reviewed at least quarterly and revised at least annually. The CPOC is to be revised at least annually or sooner if the beneficiary's situation significantly changes.</p> <p>The Support Coordinator must sign and date the CPOC and have their supervisor review and sign the plan prior to submitting an approvable CPOC to BHSE/Statistical Resources, Inc. (SRI).</p>
Ready for Supervisor Review	SC checks this box to submit to Supervisor for review and submittal to BHSE/SRI.

Section V - CPOC Approval

<i>CPOC Approval Information</i>	
Signature of Support Coordinator Supervisor	The SC supervisor's signature denotes that they approve and agree with the content of the CPOC being submitted. The Formal Information documents listed under evaluations/documentation used to develop the CPOC, the prior CPOC, Service Logs, and Quarterly Reviews must be reviewed by the Supervisor for

	identified needs and the status of requested services. The entire CPOC must be reviewed to ensure that all identified needs are addressed, all required information is included, information is edited and updated, and no discrepancies exist.
Submit for review by LDH	SC Supervisor checks this box to submit to SRI for review and approval.
See Service Tickets	This button allows you to review all Service Logs from the prior CPOC year which is required as part of the CPOC approval process.
Approval/Denial Information	<p>BHSF/SRI will review the CPOC to assure that all components of the plan have been identified. If any deficiencies exist, SRI will list them in the Approval/Denial Notes box and return the CPOC for resubmittal. If documents required for initial CPOCs (current formal documents and all assessments/evaluations and supporting documents from the regional OCDD office) or Special Needs CPOCs (current formal documents) or documents required for CPOC monitoring (Appendix X-2) are not submitted as required, the CPOC will be returned to the SC without a review.</p> <p>Review the Approval/Denial Note box on all returned CPOCs. An approved CPOC may have a note to address something on an interim CPOC or information regarding the PA.</p>

Submitting a CPOC to BHSF/Statistical Resources, Inc.

The EPSDT SC signs off with an electronic signature on the CPOC Participants page and checks the Ready for Supervisor Review box.

SC Supervisors must read all of the required formal information documents during the supervisor's CPOC review. A CPOC should not be submitted to SRI for approval if the SC Supervisor did not review all of the listed evaluations/documentation used to develop the CPOC, the service logs, and quarterly reviews for identified needs and the status of requested services. The SC Supervisor is to review the entire CPOC to ensure that all identified needs are addressed, all required information is included, information is edited and updated, and no discrepancies exist.

The SC Supervisor signs off with an electronic signature on the CPOC Approval Information page and checks the Submit for review by LDH box. Documents required for an initial or monitored CPOC should be submitted immediately after the SC Supervisor submits the CPOC for SRI approval.

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.

Approvable CPOC Submit Date:

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 the date the approvable CPOC is submitted will be the approvable CPOC submit date.

Initials: 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.

Annuals: The annual CPOC meeting should not 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 the flat rate billing requirement of a Timely CPOC.

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

CPOC Documents:

For initial CPOCs, *Appendix X-1* and the required documents must be sent to BHSF/SRI including the evaluations and supporting documentation from the regional OCDD office and must be received prior to CPOC approval.

A beneficiary may be identified as “Special Needs” by BHSF/SRI if the beneficiary is not eligible for the waivers or other OCDD services. Special Needs beneficiaries must have *Appendix X-1* submitted to BHSF/SRI with all annual CPOCs and must include current formal information documents to document that they continue to qualify for EPSDT Support Coordination.

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

Annual CPOCs that are not Special Needs and are not selected for monitoring are to have the documents placed in the case record and submitted to BHSF/SRI immediately upon request.

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. Again, the CPOC does not control the services. This process only controls the payment to Support Coordination Agencies.

CPOC Quarterly Review

CPOC Quarterly Review	
This is to be used for the required face to face quarterly review visit. Refer to page 99-101 for documentation requirements regarding the Quarterly Review.	
Status of Service	Provide the current status of the service need.
Screening Questions	Health Changes Safety Issues Changes in Living Situations
Review of the Following Occurred	Medicaid Services Chart Rights and Responsibilities Grievance Policy Abuse Policy Health Standards Provider Complaint Line, Medicaid Managed Care Program Assistance/Complaint Line Are you requesting any medically necessary therapies now or want to receive therapies on the IEP during the school's summer break?
Participant Questions	Ask the individual these questions, document their response, document if a complaint form (<i>Appendix M or MMC I</i>) was completed and any comments.

	<ul style="list-style-type: none"> • Are you receiving the services that you requested? • Are the services at the day/time needed? • Are you pleased with the services that you are receiving? • Are there additional services that you need?
Notes	Include narrative description of quarterly face to face visit, additional explanations as needed, summary of current status, progress for quarter, FOC and information regarding the requirements to obtain a PA for the services requested, and how often goals and support strategies will be reviewed
Names of Attendees	Must match your paper signature form.

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.)

Section VII - Typical Weekly Schedule

Typical Weekly Schedule (paper form only)	
The weekly schedule is a tool that the Support Coordinator uses to assure that services are delivered at appropriate days and times and do not overlap, unless this is medically necessary.	
Services in Place	The weekly schedule should indicate what services are already in place. The schedule should show when the beneficiary is in school, at home or participating in other activities.
Requested Services	Services that are being requested through Medicaid prior authorization or other sources should be indicated.

The schedule can be forwarded to in-home providers and prospective providers to support and clarify prior authorization requests. If prior authorization is denied and not appealed, or if for any other reason the planned services are not delivered, the schedule should be amended to reflect services actually put in place. If the beneficiary wishes to change any of the times for established services, the Support Coordinator shall give the revised schedule to all appropriate providers informing them of the time changes to facilitate the change.

Refer to *Appendix J* CPOC Components for a one-page list of information that must be covered in every CPOC.

COORDINATION OF SERVICES IDENTIFIED IN THE CPOC

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

The Support Coordinator should provide as much assistance as possible to the family to identify and obtain other non-Medicaid services (home modifications, respite, financial assistance, etc.) that are identified in the plan. The CPOC is considered a holistic plan. **Therefore, the Support Coordinator is responsible for coordinating all identified service needs, including paid and un-paid supports as well as non-Medicaid Services.** The Support Coordinator must be knowledgeable of potential community resources, including formal resources such as Supplemental Nutrition Assistance Program, SSI, and housing.

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

Part III – 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, if your name has been included in the prior authorization request.

For beneficiaries in Legacy Medicaid 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 Managed Care Organizations 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 CPST, PSR, ACT (ages 18-20), FFT/CWFFT, Homebuilders, and MST unless they are enrolled in the Coordinated System of Care (CSoC). For children and youth enrolled in CSOC their behavioral health services are authorized by Magellan, except PRTF and substance use residential services.

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, if you are properly identified in the request. 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 Gainwell Technologies 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 period². 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 Legacy Medicaid, and the MCO PALs for all behavioral health services and for physical health needs of beneficiaries who are enrolled in a managed care plan for those services.

² The timeline for continued services will revert from 30 days back to 10 days in March 2025.

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 Legacy Medicaid.

The prior authorization units at Gainwell Technologies (for Legacy Medicaid 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 Legacy Medicaid 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 an able and willing provider of prior authorized services. The LDH PAL must be notified for all recipients, both Legacy Medicaid and managed care recipients, when no provider able and willing 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, 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.

See *Medicaid Managed Care Appendix A* for the Medicaid Managed Care 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 R-1*, 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 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 LOCATING MEDICAID PROVIDERS

Freedom of Choice

When a beneficiary requires a service that must be prior authorized, 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 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 the Choice of Provider Form for EPSDT Medicaid Providers (*Appendix Z*). 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 and have another office employee speak with the family to confirm and witness the Choice of Provider. Make a referral to the provider for Legacy Medicaid or to the Medicaid Managed Care Case Manager for Medicaid Managed Care members 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.

Locating Legacy Medicaid Providers - Physical Health Services

As a Support Coordinator, you can contact the **Specialty Care Resource** to find legacy Medicaid 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 the Medicaid Services Chart (*Appendix C*) for that service. For Personal Care Services and Extended Home Health, call LDH at 1-888-758-2220 and refer to *Appendix B – Medicaid 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 legacy Medicaid providers is also available through the Medicaid website at www.medicaid.la.gov. Click Locate a Provider, select Medicaid under Service Type, choose 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 Legacy Medicaid recipients can be accessed at www.LDH.la.gov. Click Medicaid, click Locate a Provider, click on provider group Personal Care Services, 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 Healthy Plan they are affiliated with. Note: You can search for PCS by selecting Personal Care Attendant and looking for “PCS-EPSDT” listed under PCP/Specialties on the list of providers. You can also find providers by calling the Member Services Line at each Managed Care Organization to locate a provider in their network, or accessing the MCO’s websites to identify contracted providers. Refer to *Medicaid Managed Care Appendix A and B*.

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 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/contacting-your-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 beneficiary's wraparound facilitator can also assist with accessing specialized behavioral health services. Note: PRTF and substance use residential services will be prior authorized by their Managed Care Organization.

Locating Non-emergency Medical Transportation (NEMT) Providers

All beneficiaries can access non-emergency medical transportation (NEMT) through their Managed Care Organization. Non-emergency medical transportation services were integrated into the Medicaid Managed Care Program beginning on December 1, 2015. The transportation phone numbers for each MCO can be found on *Medicaid Managed Care Appendix B*.

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.

For Legacy Medicaid prior authorized services, the SC must notify the LDH PAL of waitlist placement (Appendix S).

For Medicaid Managed Care prior authorized services, the SC must notify the MMCCM (MMC Appendix Q).

The SC must follow up on waitlist placement with the provider at least quarterly to ensure they move up the waitlist.

Unable to Locate a Provider – Legacy Medicaid

If a willing provider cannot be located to submit the request for prior authorization, LDH must take all reasonable steps to find a willing and able provider within ten days. For Legacy Medicaid services, call the LDH program staff line at 1-888-758-2220 and tell them that you cannot find a provider. The Support Coordinator must notify the PAL that the beneficiary has been unable to locate a provider that is willing to submit a request for prior authorization.

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 Y* for a copy of the form that needs to be completed.

Unable to Locate a Provider – Medicaid Managed Care

For Medicaid Managed Care 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, call the MCO's member services line which operates from 7am-7pm, M-F, for assistance and fax the Referral to Medicaid Managed Care Case Management form (*Medicaid Managed Care Appendix Q*) to the MCO to request assistance with locating a provider. If the MCO is unable to locate a willing provider within 10 days of the referral, the Support

Coordinator should submit a referral to the LDH PAL (*Medicaid Managed Care Appendix S*). LDH will forward the referral to the MCO requesting notification upon resolution.

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).

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	
Legacy Medicaid (Fee for Service)	Medicaid Managed Care (Healthy Louisiana)
<ul style="list-style-type: none"> • Beneficiary requests a Medicaid service that requires a prior authorization. • SC adds service need to the CPOC checking the Medicaid and Requires PA tracked by SC boxes. • SC opens an Initial tracking log and enters the date the family requested the service into the date service requested box. • SC offers freedom of choice. • 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. <p>● 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:</p> <ul style="list-style-type: none"> • Contact the LDH Program Staff Line. 	<ul style="list-style-type: none"> • Beneficiary requests a Medicaid service that requires a prior authorization. • SC adds service need to the CPOC checking the Medicaid and Requires PA tracked by SC boxes. • SC opens an Initial tracking log and enters the date the family requested the service into the date service requested box. • SC offers freedom of choice. • 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. • Within 3 calendar days from date of service request <u>if a provider is not already chosen</u>, SC sends 1st Referral to MMCCM to notify MCO that the service is requested (<i>MMC Appendix Q</i>). • Within 15 calendar days from date of Referral to MMCCM, SC contacts MCO to

<ul style="list-style-type: none"> • Send a Referral to LDH PAL (<i>Appendix S</i>). The LDH PAL will take all reasonable and necessary steps to find a willing provider within 10 days of the referral. 	<p>check on status of referral / choice of provider and offer assistance if needed.</p> <ul style="list-style-type: none"> • Within 35 calendar days from date of Referral to MMCCM, SC contacts MCO to check on status of referral / choice of provider and offer assistance if needed. <p>● 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:</p> <ul style="list-style-type: none"> • Contact the Member Service Line of the MCO. • Send a Referral to MMCCM (<i>MMC Appendix S</i>). • If the MCO is unable to resolve the issue within 10 days of the referral, send a Referral to LDH PAL - MMC Member (<i>MMC Appendix S</i>). The MCO is contractually obligated to find a provider within 10 days of Referral to MMCCM. LDH will reach out to the MCO when a PAL referral is received to ensure that this is contractual obligation is met.
Choosing a Provider	
Legacy Medicaid (Fee for Service)	Medicaid Managed Care (Healthy Louisiana)
<ul style="list-style-type: none"> • Beneficiary chooses a provider. Have them list the provider they choose and sign the Choice of Provider Form for EPSDT Medicaid Providers (<i>Appendix Z</i>). • SC enters COP date and Provider name into tracking log. • Within 3 calendar days from date of choice of provider, SC sends Referral to Provider (<i>Appendix Q</i>) – check box 1. • Within 15 calendar days from date of referral to provider, SC completes pro- 	<ul style="list-style-type: none"> • Beneficiary chooses a provider. Have them list the provider they choose and sign the Choice of Provider Form for EPSDT Medicaid Providers (<i>Appendix Z</i>). • SC enters COP date and Provider name into tracking log. • Within 3 calendar days from date of choice of provider, SC sends Referral to MMCCM to notify MCO of choice of provider (<i>MMC Appendix Q</i>). <i>Note: place this date in the Date of 2nd Referral to Provider/MMCCM if that teal box is displayed</i>

<p>vider contact to confirm they are working on the request and see if they need any assistance gathering information.</p> <ul style="list-style-type: none"> • Within 35 calendar days from date of referral to provider, SC completes provider contact to ask if the request has been submitted to Gainwell Technologies or if there are any problems you can assist with. 	<p><i>on your tracking log. 2nd Referral is after provider is known.</i></p> <ul style="list-style-type: none"> • Within 15 calendar days from date of referral to MMCCM, SC completes provider contact to confirm they are working on the request and see if they need any assistance gathering information. 15 day contacts can also be made to the MCO if there are any issues. • Within 35 calendar days from date of referral to MMCCM, SC completes provider contact to ask if the request has been submitted to the MCO or if there are any problems you can assist with. 35 day contacts can also be made to the MCO if there are any issues.
<p style="text-align: center;"> Waitlist Placement</p>	
Legacy Medicaid (Fee for Service)	Medicaid Managed Care (Healthy Louisiana)
<ul style="list-style-type: none"> • SC completes 15 day provider contact and confirms beneficiary was placed on a waitlist. • SC must offer beneficiary alternative providers for whom there may not be a waitlist and document beneficiary's response. 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. • SC sends Referral to LDH PAL to notify LDH PAL of waitlist placement (<i>Appendix S</i>). • 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 	<ul style="list-style-type: none"> • SC completes 15 day provider contact and confirms beneficiary was placed on a waitlist. • SC must offer beneficiary alternative providers for whom there may not be a waitlist and document beneficiary's response. 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 sending a Referral to MMCCM to let them know you are looking for a new provider. • SC sends Referral to MMCCM to notify MCO of waitlist placement (<i>MMC Appendix Q</i>). • 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

<p>following information in order to untrack the service need due to waitlist placement:</p> <ul style="list-style-type: none"> ○ Date of Service Request ○ Date of COP ○ Provider ○ Date of Referral to Provider ○ 15 Day Provider Contact <ul style="list-style-type: none"> • SC must document the following in the Additional Information section of the CPOC: <ul style="list-style-type: none"> ○ SC confirmed waitlist placement with provider. ○ SC offered the beneficiary alternative providers for whom there may not be a waitlist and document beneficiary's response. ○ How the SC will ensure the beneficiary moves up the waitlist (follow up with the provider at least quarterly). ○ Continue to follow up with provider at least quarterly to ensure they move up the waitlist and offer family alternative providers. ○ SC will resume PA tracking when SC is notified that the beneficiary is off of the waitlist. 	<p>information in order to untrack the service need due to waitlist placement:</p> <ul style="list-style-type: none"> ○ Date of Service Request ○ Date of COP ○ Provider ○ Date of Referral to MMCCM ○ 15 Day Provider Contact <ul style="list-style-type: none"> • SC must document the following in the Additional Information section of the CPOC: <ul style="list-style-type: none"> ○ SC confirmed waitlist placement with provider. ○ SC offered the beneficiary alternative providers for whom there may not be a waitlist and document beneficiary's response. ○ How the SC will ensure the beneficiary moves up the waitlist (follow up with the provider at least quarterly). ○ Continue to follow up with provider at least quarterly to ensure they move up the waitlist and offer family alternative providers. ○ SC will resume PA tracking when SC is notified that the beneficiary is off of the waitlist.
PA Packet	
Legacy Medicaid (Fee for Service)	Medicaid Managed Care (Healthy Louisiana)

<ul style="list-style-type: none"> • Enter the date the provider submitted the PA packet to Gainwell into the date packet submitted to FI box on the tracking log. • 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. <p>● If the PA packet is not submitted to Gainwell within 35 calendar days of Referral to Provider:</p> <ul style="list-style-type: none"> • 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 remains the same as previous log). • Send Referral to LDH PAL to notify LDH PAL of the untimely PA packet submission (<i>Appendix S</i>). • Continue to follow up with provider until PA packet is submitted and remind beneficiary, they can switch providers. 	<ul style="list-style-type: none"> • Enter the date the provider submitted the PA packet to the MCO into the date packet submitted to FI box on the tracking log. • 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. <p>● If the PA packet is not submitted to the MCO within 35 calendar days of Referral to Provider:</p> <ul style="list-style-type: none"> • 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 remains the same as previous log). • Seek assistance from MCO. • Continue to follow up with provider and MCO until PA packet is submitted and remind beneficiary, they can switch providers.
Decision Notice	
Legacy Medicaid (Fee for Service)	Medicaid Managed Care (Healthy Louisiana)
<ul style="list-style-type: none"> • When you receive the notice of decision, enter the following information into the tracking log: <ul style="list-style-type: none"> ○ 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 	<ul style="list-style-type: none"> • When you receive the notice of decision, enter the following information into the tracking log: <ul style="list-style-type: none"> ○ 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

<ul style="list-style-type: none"> ● 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 Gainwell (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. ● If a PA notice of decision is not received within 60 calendar days of Referral to Provider: <ul style="list-style-type: none"> • 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 remains the same as previous log). • SC must send Referral to LDH PAL to notify LDH PAL of untimely PA decision notice. • Continue to follow up with provider until a notice of decision is received and the request is approved or denied based on medical necessity. 	<ul style="list-style-type: none"> ● 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 MCO (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. ● If a PA notice of decision is not received within 60 calendar days from date of Choice of Provider: <ul style="list-style-type: none"> • 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 remains the same as previous log). • SC must send Referral to LDH PAL – Medicaid Managed Care Member (<i>MMC Appendix S</i>). Tracking log, service logs, referral forms and e-mails should be faxed with LDH PAL referrals for Medicaid Managed Care Members. LDH will forward the referral to the MCO requesting notification upon resolution.
Notice of Denial	
Legacy Medicaid (Fee for Service)	Medicaid Managed Care (Healthy Louisiana)
<ul style="list-style-type: none"> • Within 4 calendar days from the notice of denial: <ul style="list-style-type: none"> ○ 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 • 20 days from date appeal request filed: 	<ul style="list-style-type: none"> • Within 4 calendar days from the notice of denial: <ul style="list-style-type: none"> ○ Explain appeal rights and offer assistance ○ Explain that the provider can request a peer-to-peer review. • 20 days from date appeal request filed: <ul style="list-style-type: none"> ○ Check on appeal status. • Enter the following information into the tracking log: <ul style="list-style-type: none"> ○ Date Denial of Service Notice Received ○ Approval/Denial Status

<ul style="list-style-type: none"> ○ Check on appeal status and if additional assistance is needed with the appeal. ● 90 days from date appeal request filed: <ul style="list-style-type: none"> ○ Check on final outcome of appeal. ● Enter the following information into the tracking log: <ul style="list-style-type: none"> ○ 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 	<ul style="list-style-type: none"> ○ 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): <ul style="list-style-type: none"> ○ Within 4 calendar days from notice of Appeal Denial from the MCO: <ul style="list-style-type: none"> ▪ Explain DAL State Fair Hearing (SFH) rights and offer assistance. ▪ 60 days from date of SFH request filed: ▪ Check on SFH status and if additional assistance is needed. ○ 120 days from date SFH request filed: <ul style="list-style-type: none"> ▪ Check on final outcome of SFH. ○ Enter the following information into the tracking log: <ul style="list-style-type: none"> ▪ Date Appeal Rights Explained ▪ Date Appeal Brochure Provided ▪ Offered to Help with Appeal Date
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	<ul style="list-style-type: none"> ▪ 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
Issues	
Legacy Medicaid (Fee for Service)	Medicaid Managed Care (Healthy Louisiana)
Provider Referrals <ul style="list-style-type: none"> • If the beneficiary needs a schedule change, send a referral to the provider (<i>Appendix Q</i>) – check box 2. • If the provider needs to submit additional information with the PA request and you received a PAL notice, send a referral to the provider (<i>Appendix Q</i>) – check box 4. LDH PAL Referrals <ul style="list-style-type: none"> • If the provider has not submitted the PA packet to Gainwell within 35 calendar days of Referral to Provider, send a Referral to the LDH PAL (<i>Appendix S</i>) – check box 1. • If you have not received a decision within 60 calendar days of the Choice of Provider date, send a Referral to LDH PAL (<i>Appendix S</i>) – check box 2. • If you have not received a notice of approval from Gainwell Technologies for the renewal and the previous PA expired, send Referral to LDH PAL (<i>Appendix S</i>) – check box 3. 	MMCCM and LDH PAL Referrals <ul style="list-style-type: none"> • If the beneficiary needs a schedule change, send a referral to MCO (<i>MMC Appendix Q</i>) – check box 2. • If the member wants to choose a new provider, send a referral to MCO (<i>MMC Appendix Q</i>) – check box 4. • If the member has selected a new provider, send a referral to MCO (<i>MMC Appendix Q</i>) – check box 5. • If you have not received a notice of approval from the MCO and the previous PA expired, send a referral to MCO (<i>MMC Appendix Q</i>) – check box 6. ● After submitting a Referral to MMCCM, if the MCO is unable to resolve the issue within 10 days send a Referral to the LDH PAL (<i>MMC Appendix S</i>) – check box 2. • If you are unable to locate a provider that is willing to submit a request for a PA, send a referral to MCO (<i>MMC Appendix Q</i>) – check box 7.

<ul style="list-style-type: none"> • If you are unable to locate a provider that is willing to submit a request for a PA, send Referral to LDH PAL (<i>Appendix S</i>) – check box 4. • If the beneficiary was placed on a wait-list, send Referral to LDH PAL (<i>Appendix S</i>) – check box 5. • If service is not provided at the times requested, send Referral to LDH PAL (<i>Appendix S</i>) – check box 6. • If service is not provided in the amount PAed, send Referral to LDH PAL (<i>Appendix S</i>) – check box 7. • If at any time the provider is not working on behalf of the beneficiary, contact the LDH PAL. 	<ul style="list-style-type: none"> ● After submitting a Referral to MMCCM, if the MCO is unable to resolve the issue within 10 days send a Referral to the LDH PAL (<i>MMC Appendix S</i>) – check box 3. • If the provider is not providing services at the times the member requested, send a referral to MCO (<i>MMC Appendix Q</i>) – check box 8. ● After submitting a Referral to MMCCM, if the MCO is unable to resolve the issue within 10 days send a Referral to the LDH PAL (<i>MMC Appendix S</i>) – check box 4. • If the provider is not providing services as prior authorized, send a referral to MCO (<i>MMC Appendix Q</i>) – check box 9. ● After submitting a Referral to MMCCM, if the MCO is unable to resolve the issue within 10 days send a Referral to the LDH PAL (<i>MMC Appendix S</i>) – check box 5. • If the member is placed on a waitlist, send a referral to MCO (<i>MMC Appendix Q</i>) – check box 10. • If at any time the provider is not working on behalf of the beneficiary, contact the MCO. • If the MCO is unable to resolve the issue, contact the LDH PAL.
Renewals	
Legacy Medicaid (Fee for Service)	Medicaid Managed Care (Healthy Louisiana)
<ul style="list-style-type: none"> • 45 - 60 days prior to end of PA period, begin the Renewal process. 	<ul style="list-style-type: none"> • 20 - 60 days prior to end of PA period, begin the Renewal process.

<ul style="list-style-type: none"> ○ Enter the Date Renewal Sent and new tracking started into the current tracking log. ○ Open a Renewal tracking log: <ul style="list-style-type: none"> ▪ Keep the date of service request the same as the previous tracking log. ▪ Enter a new date of COP = the date you started the Renewal and confirmed the beneficiary wants to stay with their current provider. ○ Send the Referral to the Provider to remind the provider to renew the PA (Appendix Q) – check box 3. Enter this date in the Date of Referral to Provider box. <p>● If PA Renewal approval is not received and the previous PA expires:</p> <ul style="list-style-type: none"> • Send a Referral to LDH PAL (<i>Appendix S</i>) – check box 3. 	<ul style="list-style-type: none"> ○ Enter Date Renewal Sent and new tracking started onto the current tracking log. ○ Open a Renewal tracking log: <ul style="list-style-type: none"> ▪ Keep the date of service request the same as the previous tracking log. ▪ Enter a new date of COP = the date you started the Renewal and confirmed the beneficiary wants to stay with their current provider. ○ Send the Referral to MMCCM to remind the MCO to renew the PA (<i>MMC Appendix Q</i>) – check box 3. Enter this date in the Date of Referral to Provider/MMCCM box. <p>● If PA Renewal approval is not received and the previous PA expires:</p> <ul style="list-style-type: none"> • Send a Referral to MCO (<i>MMC Appendix Q</i>) – check box 6. • If the MCO is unable to resolve the issue within 10 days of the referral, send referral to LDH PAL using Referral to LDH PAL – Medicaid Managed Care Member (<i>MMC Appendix S</i>). Note: Tracking log, service logs, referral forms and e-mails should be faxed with LDH PAL referrals for Medicaid Managed Care Members. LDH will forward the referral to the MCO requesting notification upon resolution.
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PA TRACKING NOTES

Do not take verbal PAs from providers. The Support Coordinator can accept a verbal PA from the LDH PAL or directly from the Medicaid Managed Care Plan (MMCCM, MCO PAL, etc.). Document this in the Notes box of the 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.

ABA:

- 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.
- Clinical Diagnostic Evaluation (CDE): The member's MCO is responsible for arranging and finding a CDE provider. 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 a referral has been sent to the Medicaid Managed Care Case Manager, contact the provider and find out what their process is.
- If the beneficiary is placed on a waitlist follow waitlist placement procedures on page 81.

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.

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 legacy Medicaid recipient, 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 Managed Care Organization recipient see *Medicaid Managed Care Appendix A*, 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 oral approval. All emergency requests shall be approved or denied generally within twenty-four (24) hours of the request, but in no case later than the working day following the request.

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

PA NOTICES

You will need to obtain the PA notice from the provider or MMCCM. 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 or MMCCM does not respond, contact the Prior Authorization Liaison (PAL). Follow-up with the family, provider, and/or MMCCM 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 Gainwell Technologies, 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/MMCCM to obtain the information.
- Make sure the information is sent to the PAL.
- 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 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 Gainwell Technologies 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 as to behavioral health services and non-emergency transportation, 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 Legacy Medicaid 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 Legacy Medicaid 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 managed care and Legacy Medicaid, 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. 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 Medicaid Managed Care Appendix T-1 and F.

For beneficiaries with Legacy Medicaid or for those with the Medicaid Managed Care Program 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. A copy of the Appeals Brochure can be found as Appendix L. The Appeals Brochure contains the procedures for filing an appeal request. The following is a more detailed description of the appeal process

Deadlines

For beneficiaries with Legacy Medicaid 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. See *Appendix L*. 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. See *Appendix L*.

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 period³, 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 Medicaid with the request.

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

Gainwell Technologies 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

³ The timeline for continued services will revert from 30 days back to 10 days in March 2025.

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); Disability Rights Louisiana also should have the phone number for a local Legal Services office that might be able to help.

What happens after a fair hearing is requested?

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

Preparing for the fair hearing

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

The 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 legacy Medicaid:

- 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.

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*).

Part IV – Contacts and Documentation

MONTHLY CONTACT

Monthly Contacts assure implementation of requested services and document:

- If the services are 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.
- 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.
- 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.

QUARTERLY FACE-TO-FACE VISIT

The support coordinator must complete a face-to-face visit 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.

Each quarter the Support Coordinator must complete the **EPSDT CPOC Quarterly Review**. The CPOC Quarterly Review form is beneficiary specific and can 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 EPSDT CPOC Quarterly Review provides a forum for discussion with the beneficiary regarding their satisfaction with the services they are receiving.

Quarterly face to face visits can be completed at the location of the beneficiary's or parent/legal guardian's choosing. CPOC meetings must be held at the beneficiary's home.

To generate a CPOC Quarterly Review form:

- Add a CPOC of the appropriate type (Interim or Annual) prior to the quarterly face to face meeting.
- Update any information that you are aware of in the service needs and support section. This will place identified services and supports from the CPOC onto the Quarterly Review form.
- Print out the CPOC with the Quarterly Review form. Service Needs will then be on the form for you to take to the face-to-face meeting.

Conduct the Quarterly Face to Face Visit 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. List the SC as an attendee.

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 form 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 regarding the continuation of IEP services and/or additional services during the summer.
- 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 Legacy Medicaid provider, the beneficiary should be given the Participant Complaint form (Appendix M) to complete and return to Health Standards. If the beneficiary has a complaint against their Managed Care Organization, they should be given MCO Complaint Process (MMC Appendix I) 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 MMC 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 a service log. The service log can state, "Refer to the Quarterly Review on xx/xx/xxxx."
- File the CPOC Quarterly Review signature page.

EPSDT DOCUMENTATION

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.) with a narrative in the form of a progress note.

EPSDT support coordinators are to utilize the service log to document "Progress Notes." **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.

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.”

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.

LSCIS Service Log Coding

Place:

02 Home (*participant’s home*)

12 School (*participant’s school*)

13 Support Coordination Agency

10 Service Provider’s Place of Business (*PCS provider, OT provider, etc.*)

99 Other Community Location (*your/SC’s home, library, etc.*)

Type of Contact:

1 In Person

2 Telephone

3 Written (*e-mail or fax*)

6 Documentation Only (*will automatically put 98 None as service participant. Non-billable services that you want to document anyways.*)

8 Telehealth (*Skype, Facetime, etc.*)

Activity:

- 51 Intake (*3-day contact after linkage*)
- 52 Initial Assessment (*Initial face-to-face visit to complete Initial CPOC*)
- 53 Reassessment (*Quarterly face-to-face Visits*)
- 54 Annual Assessment (*Annual face-to-face CPOC visits*)
- 55 Service Planning (*catch-all*)
- 57 Follow-up Monitoring (*Monthly Contacts*)
- 60 Transition / Closure
- 67 EPSDT PA Tracking (*services related to obtaining a service need or Prior Authorization*)
- 68 EPSDT Provider Follow-up (*15 and 35 day provider contacts*)
- 69 EPSDT PAL Referral (*35 and 60 day PAL Referrals*)
- 70 EPSDT Appeal Follow-up (*20 and 90 day contacts*)
- 78 EPSDT Medicaid Managed Care Case Manager Follow-up (*15 and 35day MMCCM contacts*)
- 80 EPSDT Medicaid Managed Care Appeal Follow-up (*20-day contact*)

Service Participants:

- 01 Recipient
- 02 Parent or Legal Guardian (*including non-legal custodians, authorized representatives, DCFS guardians, foster parents if you have documentation from DCFS authorizing them to be the EPSDT contact, etc.*)
- 03 Other Family Member or Essential Other (*non-legal guardians*)
- 08 Health Care Providers (*doctor's offices*)
- 09 Community Services / Resources
- 10 Program Office (*OCDD, LDH, OBH*)
- 11 Medicaid Eligibility Office
- 13 Medicaid Provider
- 14 Non-Medicaid Other Provider
- 15 PAL (*LDH PAL*)
- 16 Advocacy Representative
- 17 Nurse Consultant
- 18 SRI
- 20 Medicaid Managed Care (*anyone at an MCO – MMCM, MCO PAL, Member Services Line, etc.*)
- 99 Other

Intake

3 business day contact after linkage.

The support coordinator must make contact with the beneficiary and/or legal guardian within 3 business days of the referral to the Support Coordination Agency. At that time, an appointment should be set up to discuss what support coordination is and how it can benefit the individual. 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.

Type of Contact:

Can be completed: 1 In Person, 2 Telephone, 8 Telehealth (Skype/FaceTime)

Activity:

51 Intake

Service Participants:

01 Recipient - If beneficiary is a competent major, contact must be made with 01 Recipient.

02 Parent or Legal Guardian - If beneficiary is a minor, contact must be made with 02 Parent or Legal Guardian.

Initial Assessment

Face-to-face in-home visit conducted within 10 calendar days of linkage.

A face-to-face in-home visit must be conducted within 10 calendar days of the referral to the Support Coordination Agency. 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 the Medicaid Services Chart (*Appendix C*). 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.

Place:

02 Home (participant's home)

Type of Contact:

1 In Person

Activity:

52 Initial Assessment

Service Participants:

01 Recipient must be present.

02 Parent or Legal Guardian must be present if beneficiary is a minor, is legally interdicted, or is a competent major that cannot direct own care.
Code anyone else present at the meeting.

Reassessment

Required face-to-face CPOC Quarterly Review.

*****Must complete the EPSDT CPOC Quarterly Review in LSCIS for each Quarterly Face-to-Face Visit.*****

Type of Contact:

1 In Person

Activity:

53 Reassessment

Service Participants:

01 Recipient must be present.

02 Parent or Legal Guardian must be present if beneficiary is a minor, is legally interdicted, or is a competent major that cannot direct own care.

Code anyone else present at the meeting.

Annual Assessment

Annual CPOC meeting. Cannot be conducted more than 90 calendar days prior to the expiration of the CPOC.

Place:

02 Home (participant's home)

Type of Contact:

1 In Person

Activity:

54 Annual Assessment

Service Participants:

01 Recipient must be present.

02 Parent or Legal Guardian must be present if beneficiary is a minor, is legally interdicted, or is a competent major that cannot direct own care.

Code anyone else present at the meeting.

Service Planning

Type of Contact:

1 In Person, 2 Telephone, 3 Written, 6 Documentation Only, 8 Telehealth (Skype/FaceTime)

Activity:

55 Service Planning (catch-all)

Service Participants:

01 Recipient, 02 Parent or Legal, 08 Health Care Providers, 10 Program Office, 13 Medicaid Provider, 15 PAL, 18 SRI, 20 Medicaid Managed Care, etc.

Follow-up Monitoring / Monthly Contact

Required monthly contact with the beneficiary and/or legal guardian to assure implementation of services identified in the CPOC. *****Do not use this Activity code if you did not complete a monthly contact with the beneficiary/legal guardian regarding the status of implementation of services. If was just a quick contact, code it as 55 Service Planning.*****

Type of Contact:

1 In Person, 2 Telephone, 8 Telehealth (Skype/FaceTime)

Activity:

57 Follow-up Monitoring

Service Participants:

01 Recipient - If beneficiary is a competent major, contact must be made with 01 Recipient unless you have an Authorized Representative form on file.
02 Parent or Legal Guardian - If beneficiary is a minor, is legally interdicted, or is a competent major that cannot direct own care, contact must be made with 02 Parent or Legal Guardian.

Transition / Closure

Contact with the beneficiary and/or legal guardian to ease the transition to other services or care systems.

The transition or closure of support coordination services for beneficiaries in EPSDT target population must occur in response to the request of the beneficiary 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.

Type of Contact:

1 In Person, 2 Telephone, 8 Telehealth (Skype/FaceTime)

Activity:

60 Transition / Closure

Service Participants:

02 Parent or Legal Guardian - If beneficiary is a minor, is legally interdicted, or is a competent major that cannot direct own care, contact must be made with 02 Parent or Legal Guardian.

01 Recipient - If beneficiary is a competent major, contact must be made with 01 Recipient unless you have an Authorized Representative form on file.

EPSDT PA Tracking

Services related to obtaining a service need such as:

- Locating providers
- Freedom of Choice
- Referral to Provider
- Referral to MMCCM
- Any contact with the participant, provider, PAL, LDH Program Staff Line, Gainwell, MCO, physician, etc. related to PA tracking that does not need to go in a pink box on the tracking log.
- The receipt or the approval, denial or reduction of services.
- Notice of Insufficient Documentation: If a Notice of Insufficient Prior Authorization Documentation is received the SC should document the contact with the family and offer to assist with obtaining the additional information and their response, contact with the provider to obtain or have them submit additional information, if no additional information was available, and all SC activities to follow through with the PA request until the PA is either approved or denied based on medical necessity.
- Assisting with appeals: SC must document the required contacts and offer of assistance with the appeals when a PA is totally or partially denied. If assistance is requested, document coordination of documents and filing of the appeal, if documents were sent to the appeal office, or if no documentation was available.

Type of Contact:

1 In Person, 2 Telephone, 3 Written, 8 Telehealth (Skype/FaceTime)

Activity:

67 EPSDT PA Tracking

Service Participants:

01 Recipient, 02 Parent or Legal, 08 Health Care Providers, 10 Program Office, 13 Medicaid Provider, 15 PAL, 18 SRI, 20 Medicaid Managed Care, etc.

Service Need:

Select the appropriate service need from the drop-down box.

EPSDT Provider Follow-up

Contact with a Medicaid Provider to follow-up on the status of prior authorized services.

Legacy Medicaid:

Within 15 calendar days from Referral to Provider to make sure they are working on the request and to see if assistance is needed in obtaining documentation to support the request.
Within 35 calendar days from Referral to Provider to make sure the request has been sent to the Prior Authorization Unit at Gainwell Technologies.

Medicaid Managed Care:

Within 15 calendar days from Referral to MMCCM (Referral to MMCCM or 2nd Referral to MMCCM) to make sure the provider is working on the request and to see if assistance is needed in obtaining documentation to support the request.

Within 35 calendar days from Referral to MMCCM (Referral to MMCCM or 2nd Referral to MMCCM) to ensure the request has been sent to the Prior Authorization Unit at the MCO.

Type of Contact:

1 In Person, 2 Telephone

Activity:

68 EPSDT Provider Follow-up

P/P Contact:

15 - if it's a 15day provider contact or a 2nd 15day provider contact

35 - if it's a 35day provider contact or a 2nd 35day provider contact

Service Participants:

13 Medicaid Provider

Service Need:

Select the appropriate service need from the picklist.

The date of service will be populated into the corresponding tracking log field:

15 Day Provider/ MMCCM Contact Date: / /	35 Day Provider/ MMCCM Contact Date: / /
2nd 15 Day Provider/ MMCCM Contact Date: / /	2nd 35 Day Provider/ MMCCM Contact Date: / /

EPSDT PAL Referral

SC completes *Appendix S – Referral to LDH PAL for Legacy Medicaid or Medicaid Managed Care Appendix S – Referral to LDH PAL for Medicaid Managed Care Member* and faxes it to the LDH PAL single point of contact for Untimely PA Packet Submission (Legacy Medicaid only) or for Untimely PA Notice (Legacy Medicaid or MMC).

Legacy Medicaid:

If after 35 calendar days the provider has not submitted the PA packet, the Support Coordinator must complete the Referral to LDH PAL form (*Appendix S*).

If after 60 calendar days the Support Coordinator has not received a decision, the Support Coordinator must complete the Referral to LDH PAL form (*Appendix S*).

Medicaid Managed Care:

If after 60 calendar days from the Choice of Provider date the Support Coordinator has not received a decision and the MCO has been unable to resolve the issue, the Support Coordinator must complete the Referral to LDH PAL Medicaid Managed Care Member form (*Medicaid Managed Care Appendix S*).

Type of Contact:

3 Written

Activity:

69 EPSDT PAL Referral

P/P Contact:

35 - if it's a 35day LDH PAL Referral

60 - if it's a 60day LDH PAL Referral

Service Participants:

15 LDH PAL

Service Need:

Select the appropriate service need from the picklist.

The date of service will be populated into the corresponding tracking log field:

Date of Referral to PAL
(Untimely PA Packet Submission):

//

Date of Referral to
PAL (Untimely PA Notice):

//

EPSDT Appeal Follow-up

Contact with the beneficiary and/or legal guardian to follow up on the status of the Department of Administrative Law appeal.

EPSDT Appeal Follow Up for Legacy Medicaid services:

If an appeal is requested, the SC must check on the appeal status and see if additional assistance is needed within 20 calendar days from the date the appeal request is filed.

If an appeal is requested, the SC must check the appeal status within 90 calendar days from the date the appeal request is filed.

EPSDT Appeal Follow Up for Medicaid Managed Care services - after the MCO Appeal is exhausted and the family chooses to appeal to the Department of Administrative Law:

The SC must check on the DAL appeal status and see if additional assistance is needed within 20 calendar days from the date the appeal request is filed.

The SC must check the DAL appeal status within 90 calendar days from the date the appeal request is filed.

Type of Contact:

1 In Person, 2 Telephone, 8 Telehealth (Skype/FaceTime)

Activity:

70 EPSDT Appeal Follow-up

P/P Contact:

20 - if it's a 20-day Appeal Follow Up

90 - if it's a 90day Appeal Follow Up

Service Participants:

02 Parent or Legal Guardian - If beneficiary is a minor, is legally interdicted, or is a competent major that cannot direct own care, contact must be made with 02 Parent or Legal Guardian.

01 Recipient - If beneficiary is a competent major, contact must be made with 01 Recipient unless you have an Authorized Representative form on file.

Service Need:

Select the appropriate service need from the picklist.

The date of service will be populated into the corresponding tracking log field:

20 Day Appeal Follow Up: / /	90 Day Appeal Follow Up: / /
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EPSDT Medicaid Managed Care Case Manager Follow-up

Contact with a MCO representative to follow-up on the status of prior authorized services.

Type of Contact:

1 In Person, 2 Telephone

Activity:

78 EPSDT Medicaid Managed Care Case Manager Follow-up

P/P Contact:

15 - if it's a 15day MMCCM contact or 2nd 15day MMCCM contact

35 - if it's a 35day MMCCM contact or 2nd 35day MMCCM contact

Service Participants:

20 Medicaid Managed Care

Service Need:

Select the appropriate service need from the picklist.

The date of service will be populated into the corresponding tracking log field:

15 Day Provider/ MMCCM Contact Date: / /	35 Day Provider/ MMCCM Contact Date: / /
2nd 15 Day Provider/ MMCCM Contact Date: / /	2nd 35 Day Provider/ MMCCM Contact Date: / /

EPSDT Medicaid Managed Care Appeal Follow-up

Contact with the beneficiary and/or legal guardian to follow up on the status of the MCO appeal. If an appeal is requested, the SC must check on the MCO appeal status within 20 calendar days from the date the appeal request is filed.

Type of Contact:

1 In Person, 2 Telephone, 8 Telehealth

Activity:

80 EPSDT Medicaid Managed Care Appeal Follow-up

P/P Contact:

20 - if it's a 20-day Medicaid Managed Care Appeal Follow Up

Service Participants:

01 Recipient - If beneficiary is a competent major, contact must be made with 01 Recipient unless you have an Authorized Representative form on file.

02 Parent or Legal Guardian - If beneficiary is a minor, is legally interdicted, or is a competent major that cannot direct own care, contact must be made with 02 Parent or Legal Guardian.

Service Need:

Select the appropriate service need from the picklist.

The date of service will be populated into the corresponding tracking log field:

20 Day MCO Appeal Follow Up:	/ /
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Assisting with Appeals:

SC must document the required contacts and offer of assistance with the appeals when a PA is totally or partially denied. If assistance is requested, document coordination of documents and filing of the appeal, if documents were sent to the appeal office, or if no documentation was available. (*Appeals section in this Handbook, Appendix L, Appendix T-1, MMC Appendix T-1, LSCIS PA tracking log.*)

Notice of Insufficient Documentation (NOID):

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

Part V - EPSDT Support Coordinator Requirements

The Support Coordination Agency must comply with the Louisiana Department of Health's provider enrollment requirements, the Support Coordination Provider Manual, the Support Coordination Standards of Participation, the Performance Agreement 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.

STAFFING REQUIREMENTS

All staffing requirements for education, experience and training as outlined in the Targeted Case Management Rule must be adhered to.

EPSDT QUARTERLY REPORT

The EPSDT Quarterly Report will be completed for each support coordination agency from information entered into LSCIS. Each agency must have all of the required information entered into LSCIS at the end of each quarter so that the report can be generated. It is the responsibility of the Agency to identify beneficiaries with a PA not issued within 60 calendar days of the beneficiary's request. As part of that identification, the Agency must review all documentation (CPOC, PA Tracking Log, Service Logs, etc.) prior to end of each Quarter. Each Agency must sign and date the Quarterly Report and Record Review (*Appendix W-3*), the Quarterly Report of Revised CPOCs (*Appendix W-2*) 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 the EPSDT Quarterly Report Checklist (*Appendix W-1*) 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

- Beneficiaries with service gaps in the authorization period
- Beneficiaries who submitted requests for appeals within the quarter

The **Record Review for the Quarterly Report** 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. 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 onsite manager and 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.

TRAINING

The Support Coordination agency's designated trainer and supervisors will use the **EPSDT Training Module** in conjunction with this **EPSDT – Targeted Population Support Coordination Training Handbook and Appendices**:

- To train new support coordinators, supervisor and trainers hired to serve the EPSDT – Targeted Population as part of their 16 hours of orientation training.
- To train existing support coordinators, trainers and supervisors as part of the 20 hours of annual training.

All Support Coordinators must receive EPSDT training.

New support coordinators and trainees must receive EPSDT training:

- during orientation (must be included as part of the required 16 hours of orientation training), and
- prior to being assigned an EPSDT caseload.

All support coordinators and trainees must complete the EPSDT training each year. Any support coordinators or trainees that do not attend the annual training at LDH either in person or via webinar must be trained by the agency's designated trainer and

supervisors. All support coordinators and trainees must read the updated EPSDT – Targeted Population Support Coordination Training Handbook and Appendices.

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

New designated Trainers and Supervisors must receive the EPSDT training:

- during orientation (must be included as part of the required 16 hours of orientation training), and
- prior to beginning supervision of EPSDT support coordinators. The training may be provided to supervisors and designated trainers by BHSF/SRI or by a trained supervisor or designated trainer within the agency.

All designated Trainers and Supervisors must complete EPSDT training each year. The designated trainer and the EPSDT specialist must attend the annual training at LDH in person. Any 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 designated trainers and supervisors must read the updated EPSDT – Targeted Population Support Coordination Training Handbook and Appendices.

The agency must submit documentation of EPSDT training to the EPSDT SC Contract Administrator using the Training Log (*Appendix W-4*). **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.**

Refer to the **Targeted Case Management Rule** and the **Case Management Licensing Standard for Participation** for more information on required training.

Refer to the **Trainer Information** found on page 1 of this 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>.

CASELOADS

Support Coordinators should have caseloads of no more than 35 beneficiaries across all populations, and supervisors should supervise no more than 8 support coordinators across all populations. 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.

Number of Support Coordinators 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

PARTICIPANT CALLS

Support Coordination agencies must maintain a toll-free, 24-hour telephone number and the ability to reach someone in an emergency, and must make sure that beneficiaries know this information. Non-emergency calls must be returned within one (1) working day.

PARTICIPANT VISITS

Support coordinators must have a minimum monthly contact with beneficiaries and parent/legal guardian which can be a telephone contact. However, for each quarter there must be a face-to-face visit with beneficiaries and parents/legal guardians along with a review of the CPOC. Refer to page 98-101 of the Handbook and *Appendix T-1* and *Medicaid Managed Care Appendix T-1*.

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 on page 119 of this Handbook.

PARTICIPANT 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 the SRI toll free number and mailing address and must be provided to each recipient annually.

LSCIS REPORTS

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

CPOC Updates Report

Used to track the first date an annual assessment meeting can be held (90 days prior to CPOC expiration), upcoming CPOC due dates (an *approvable* CPOC is due 35 days prior to CPOC expiration), and expiring redeterminations (refer to OCDD 90 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 all monthly contacts, quarterly face-to-face visits and timely CPOCs are completed. 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.

Flat Rate Billing Requirement:

- 1) Monthly Contacts: complete a contact with the beneficiary/legal guardian every month. See pages 98-99 for more information.
- 2) Quarterly Face to Face Visits: complete a face-to-face contact with the beneficiary and legal guardian by the last month of the quarter. See pages 99-100 for more information.

- 3) Timely CPOC: Submit an approvable CPOC within 35 days of CPOC expiration.

EPSDT SCA Prior Authorization

If a contact is not showing up on your Required Action report make sure you have an EPSDT SCA Prior Authorization on file for the date you completed the monthly contact or quarterly face to face 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 participant aging out. A Quarterly Face to Face 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 meeting. 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.

Timely CPOC

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.

An **approvable** initial CPOC must be completed and sent to BHSE/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 should not 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.

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.

Example of a timely CPOC:

<u>Required</u>		Monthly					
Req	Contact	Criterion					
Met	Mnth	Meet	Reported Data		Must Be Between		Actual
Yes	Jan 01/04/22	Yes	Case open	05/20/16	3 Day Contact	NA	NA
Yes	Feb 02/23/22	Yes	CPOC begin	05/24/21	30 Day CPOC	NA	NA
Yes	Mar 03/03/22	Yes	CPOC End	05/23/22	Timely CPOC	02/22/22-04/17/22	02/25/22
Qtr	02/23/22		CPOC submit	02/25/22			

Timely CPOC must be between 2/22/22 – 4/17/22. The Actual approvable CPOC submit was 2/25/22. The CPOC was submitted 2/25/22 so 2/25/22 is the approvable CPOC submit date. Note that the CPOC was approved by BHSF/SRI on 3/11/22.

Example of an untimely CPOC:

<u>Required</u>		Monthly					
Req	Contact	Criterion					
Met	Mnth	Meet	Reported Data		Must Be Between		Actual
Yes	Jan 01/03/22	Yes	Case open	02/29/16	3 Day Contact	NA	NA
Yes	Feb 02/01/22	Yes	CPOC begin	03/04/21	30 Day CPOC	NA	NA
	Mar 03/03/22	No	CPOC End	03/03/22	Timely CPOC	12/03/21-01/26/22	01/28/22<<
Qtr	02/01/22		CPOC submit	01/28/22			

Timely CPOC must be between 12/3/21 – 1/26/22. The Actual approvable CPOC submit date was 1/28/22. It has << next to the date to indicate the requirement was not met and the SCA did not meet the flat rate billing requirement for March as that's when the CPOC ended. The CPOC was first submitted on 1/24/22. It was denied on 1/25/22 and resubmitted on 1/28/22. The CPOC that was submitted on 1/28/22 was approvable so 1/28/22 is the approvable CPOC submit date.

Case Closure: The month that a participant's case is closed becomes the last month of the quarter and all quarterly required services must be completed.

SUPPORT COORDINATION 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.

Closure Criteria

Support Coordination services closure criteria include the following:

01 Recipient moved 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 the EPSDT SC Contract Administrator. 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.

12 Recipient transferred to a new region – The transfer of records to the receiving agency was 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).

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 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. Agencies will be responsible for deficiencies in services if the case is not closed. Beneficiaries 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.

Discharge Summary for Transfers and Closures

All transfers/closures will require a summary of progress prior to final closure. The service log must be used for this documentation. The LSCIS Closure Summary **MUST** be completed. You must inform the beneficiary to contact SRI if they want to access EPSDT SC in the future and give them SRI's toll-free 1-800-364-7828 contact number.

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 or 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 not 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 review/summary (Include any service needs that have not been implemented)
- The most recent 6 months of progress notes
- The current PA tracking logs and PA notices

The 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 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.

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 G*.
- 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) through Medicaid (1-877-456-1146 (TDD 1-855-296-0226)). 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 utilize 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 support coordinator should inform the family to expect notification via phone or mail.
- OAAS Community Choices Waiver and Adult Day Health Care Waiver services Call 1-877-456-1146 (TDD 1-855-296-0226) to be placed on a waiting list. 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.

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 will be closed effective the day prior to the date of waiver certification (18-W Effective Date). 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 the EPSDT services will be adjusted as follows, provided that an approved EPDST plan of care is in place up through the day prior to waiver certification:

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

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 the EPSDT SC Contract Administrator along with current formal information documents such as the current IEP. BHSF/SRI will temporarily stop his SC 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 the EPSDT SC Contract Administrator 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 P* for Special Needs definition.)

Procedure for Closure of Initials

The EPSDT SC Contract Administrator is to be contacted by e-mail or letter before 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. The EPSDT SC Contract Administrator 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 SRIs

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 call SRI to reopen the linkage and have the PAs reissued. When you reopen the file, 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.

If the case has been closed more than 6 months, the beneficiary should be instructed to call SRI to request services again. This will result in a new linkage being sent and you will need to open them under a new case number.

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.