For Your Information
Special Medicaid Benefits for Children and Youth

Developmental Disability (DD) Medicaid Waiver Services

The following services are available to children and youth with developmental disabilities. To apply for services, contact your Local Governing Entity or LGE. Phone numbers are listed on the attachment or on the Louisiana Department of Health website.

For those with developmental disabilities, who are able to live at home and not in an institution, waiver programs are available. To sign up for "waiver programs" that offer Medicaid and additional services to eligible persons, including individuals whose income may be too high for traditional Medicaid, you can request a screening to be added to the Developmental Disabilities Request for Services Registry.

The **New Opportunities Waiver (NOW)** and the **Children's Choice Waiver** both provide services in the home, instead of in an institution, to persons who have intellectual disabilities and/or other developmental disabilities. Both waivers cover family support, center-based respite, environmental accessibility modifications and specialized medical equipment and supplies. In addition, **NOW** covers services to help individuals live alone in the community or to assist with employment and professional and nursing services beyond those that Medicaid usually covers. Expanded dental benefits are available for adult NOW beneficiaries. The NOW is only available to individuals who cannot be supported in another OCDD waiver (Children's Choice, Supports Waiver, or Residential Options Waiver).

The **Children's Choice Waiver** also includes family training services. Children remain eligible for the Children's Choice Waiver until their twenty-first birthday, at which time they are moved to the most appropriate waiver for people with developmental disabilities.

The **Supports Waiver** provides day and employment services rather than continuous custodial care. This waiver offers 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 individuals age 18 and older.

The **Residential Options Waiver (ROW)** is appropriate for those individuals of all ages whose health and welfare can be assured by the support plan with a cost limit based on their level of support need. This waiver offers community living supports, companion care, host home, shared living, 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, monitored in home caregiving and adult day health care (ADHC). Expanded dental benefits are available for adult ROW beneficiaries.

Although not a waiver, services are also available for children ages birth to 3 years. EarlySteps contacts for each parish are listed on this web page:
https://ldh.la.gov/index.cfm/directory/detail/609

Support Coordination

A support coordinator works with you to develop a full list of all the services you need and then helps you get them. This can include things like medical care, therapies, personal care services, equipment, social services and educational services. **If you are a Medicaid recipient under the age of 21 and if support coordination is medically necessary, you may be eligible to receive support coordination services immediately.** Contact Statistical Resources, Inc. (SRI) at 1-800-364-7828. Support coordination is also provided through EarlySteps for eligible children.

Children under age 21 are entitled to receive all medically necessary health care, diagnostic services, treatment, and other measures that Medicaid can cover. This includes many services that are not covered for adults.

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

Transportation

Non-Emergency Medical Transportation (NEMT) is transportation provided to Medicaid eligible children and youth to and/or from a Medicaid covered service, including carved-out services, or value-added benefits when no other means of transportation is available. Medicaid covered transportation is available to Medicaid beneficiaries when the beneficiary is enrolled in a Medicaid benefit program that explicitly includes transportation services. Healthy Louisiana managed care plan recipients should contact the following numbers to schedule NEMT services. NEMT services may be scheduled Monday through Friday from 7am to 7pm. NEMT services should be scheduled at least 48 hours in advance of the requested date of transport, not including Saturday and Sunday.

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

Medicaid beneficiaries, who are eligible for transportation services and are unsure which managed care plan provides those services, should contact Healthy Louisiana at 1-855-229-6848 for assistance.

Medicaid beneficiaries who are eligible for transportation services but do not receive transportation services through a managed care plan, should contact Verida to schedule a ride at 1-855-325-7626.

An attendant shall be required when the beneficiary is under the age of 17.

The attendant must:

- Be a parent, legal guardian, or responsible person designated by the parent/legal guardian; and
- Be able to authorize medical treatment and care for the beneficiary.

Attendants may not:

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

The only exception to the attendant requirements are for all females, regardless of their age, seeking prenatal and/or postnatal care. These females shall not be required to have an attendant.

If a child is to be transported, either as a beneficiary or an additional passenger, the parent or guardian of the child is responsible for providing an appropriate child passenger restraint system. The transportation providers will not transport any child without the appropriate child passenger restraint system.

Applied Behavioral Analysis- Based Therapy Services (ABA)

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

ABA is accessed through your Managed Care Organization. All Medicaid eligible children are enrolled in the Medicaid Managed Care Program for their Specialized Behavioral Health Services even if they may have Legacy Medicaid for their Physical Health Services.

Aetna Better Health	1-855-242-0802
AmeriHealth Caritas	1-888-756-0004
Healthy Blue	1-844-406-2389
Humana Healthy Horizons	1-800-448-3810
Louisiana Healthcare Connections	1-866-595-8133
UnitedHealthcare Community Plan	1-866-658-5499

If you are not sure who your 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 you are covered under.

Mental Health and Substance Use Services

Children and youth may receive mental health and substance use services if it is medically necessary. These services include necessary assessments and evaluations; individual, group and/or family therapy; medication management; crisis services; community psychiatric support and treatment; psychosocial rehabilitation; multi-systemic therapy; functional family therapy; homebuilders; assertive community treatment for youth ages 18-20; therapeutic group home; psychiatric residential treatment facility; inpatient psychiatric treatment; and substance use disorder treatment services. In addition, eligible at-risk children and youth may access specialized services, including peer support, short-term respite, and independent living skills building, through the Coordinated System of Care program.

How to Access Mental Health and Substance Use Care

How a person gets these services depends on the type of coverage they have.

If the member is **enrolled in a Medicaid Managed Care Program,** they can access services toll free by calling their plan using the numbers listed below. All Medicaid eligible children are enrolled in Medicaid Managed Care Program for their Specialized Behavioral Health Services even if they may have Legacy Medicaid for their Physical Health Services.

Aetna Better Health	1-855-242-0802
AmeriHealth Caritas	1-888-756-0004
Healthy Blue	1-844-521-6941
Humana Healthy Horizons	1-800-448-3810
Louisiana Healthcare Connections	1-866-595-8133
UnitedHealthcare Community Plan	1-866-658-5499

If you are not sure who your 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 you are covered under.

If a member is **part of the Coordinated System of Care (CSoC)** that helps at-risk children and youth who have serious behavioral health challenges, they can access services by contacting Magellan at 1-800-424-4489/TTY 1-800-424-4416. CSoC offers services and supports that help children and youth return remain at home. Services include youth support and training; parent support and training; independent living skill building services; and short-term respite, as well as all other Medicaid State Plan behavioral health services. Parents and guardians will be assisted in selecting a provider in their area to best meet the needs of the child or youth and the family. Members may apply for CSoC by contacting their Managed Care Organization and requesting referral to CSoC. The Managed Care Organization will transfer the caller to Magellan for a brief Child and Adolescent Needs Assessment (CANS) screening. If the youth screens positive on the brief CANS assessment Magellan will connect you to the regional Wraparound Agency for further assessment.

EPSDT (Early and Periodic Screening, Diagnostic, and Treatment) Dental Services

The EPSDT Dental Program provides coverage of certain diagnostic; preventive; restorative; endodontic; periodontic; removable prosthodontic; maxillofacial prosthetic; oral and maxillofacial surgery; orthodontic; and adjunctive general services. Specific policy guidelines apply.

Comprehensive Orthodontic Treatment (braces) are paid only when there is a cranio-facial deformity, such as cleft palate, cleft lip, or other medical conditions which possibly results in a handicapping malocclusion. If such a condition exists, the recipient should see a Medicaid-enrolled orthodontist. Patients having only crowded or crooked teeth, spacing problems or under/overbite are not covered for braces, unless identified as medically necessary.

DentaQuest and MCNA Dental administer the dental benefits for eligible Medicaid recipients. Contact your plan toll free by calling the numbers listed below to locate a network provider for questions about covered dental services.

DentaQuest	1-800-685-0143
MCNA Dental	1-855-702-6262

The rest of your medical services will either be accessed through Legacy Medicaid if you have Legacy Medicaid for your physical health services or through your Managed Care Organization if you chose to "opt in" to the Medicaid Managed Care Program for your physical health services.

Chisholm Class Members (Medicaid eligible children who are on the DD Request for Services Registry) are allowed to participate in the Medicaid Managed Care Program if they "opt in." For more information about these options, contact the Medicaid Managed Care Program hotline toll free at 1-855-229-6848.

EPSDT (Early and Periodic Screening, Diagnostic, and Treatment) Exams and Checkups
Medicaid beneficiaries under the age of 21 are eligible for checkups ("EPSDT preventive screening"). These screenings 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 services are needed.

EPSDT preventive screening may help to find problems, which need other health treatment or additional services. Beneficiaries under 21 years of age are entitled to receive all medically necessary health care, screening, diagnostic services, treatment, and other measures covered under federal Medicaid statutes and regulations to correct or improve physical or mental conditions. Services may include those not otherwise covered by Louisiana Medicaid for beneficiaries age 21 and older, unless prohibited or excluded.

EPSDT (Early and Periodic Screening, Diagnostic, and Treatment) Personal Care Services (PCS)
EPSDT Personal Care Services (PCS) are provided by direct service workers (DSWs) and defined as tasks that are medically necessary when physical or cognitive limitations due to illness or injury necessitate assistance with eating, toileting, bathing, bed mobility, transferring, dressing, locomotion, personal hygiene, and bladder or bowel requirements. PCS does not include medical tasks such as medication administration, tracheostomy care, feeding tube or catheter management. The Medicaid Home Health program or Extended Home Health program provides those medical services. PCS must be ordered by a practitioner (physician, advance practice nurse, or physician assistant). The PCS provider must request approval for the service from Medicaid or the Managed Care Organization.

Extended Skilled Nursing Services
Children and youth may be eligible to receive skilled nursing (over 3 hours per day) in the home. These services are provided by a home health agency. An authorizing healthcare provider, which includes a physician, nurse practitioner, clinical nurse specialist, or physician assistant licensed, certified, registered or otherwise authorized to order home healthcare services consistent with state law must order this service. Once ordered by a authorizing healthcare provider, the home health agency must request approval for the service from Medicaid or the Managed Care Organization.

Intermittent Nursing Services
Nursing visits to EPSDT individuals that do not exceed three hours per day may be provided without a prior authorization request unless more than one nursing visit a day is needed. These services must still be ordered by a physician and provided by a home health agency.

Pediatric Day Health Center These centers serve medically fragile individuals under the age of 21, including technology dependent children, who require nursing supervision and possibly therapeutic interventions all or part of the day due to a medically complex condition. These

facilities offer an alternative or supplement to receiving in-home nursing care. PDHC may be provided up to seven days per week and up to 12 hours per day as documented by the beneficiary's Plan of Care.

Physical Therapy, Occupational Therapy, Speech Therapy, and Audiology Services

If a child or youth requires rehabilitation services such as physical, occupational or speech therapy, psychology, or audiology services, these services can be provided at school, through the EarlySteps early intervention program, in an outpatient facility, in a rehabilitation center, at home, or in a combination of settings, depending on the child's needs.

For Medicaid to cover these services at school (ages 3 to 21), or through the early intervention program with EarlySteps (ages birth to 3), the services must be part of the Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP). For Medicaid to cover the services through an outpatient facility, rehabilitation center, or home health, they must be ordered by an authorized healthcare provider and be prior-authorized by Medicaid or the Managed Care Organization.

For information on receiving these therapies contact your school or early intervention center or other providers. EarlySteps contacts for each parish are listed on this web page: https://ldh.la.gov/index.cfm/directory/detail/609. Call the Specialty Care Resource Line for referral assistance at 1-877-455-9955 for Legacy Medicaid or call your Managed Care Organization using the contacts listed above under Mental Health to locate other therapy providers.

Medical Equipment and Supplies

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

If you need a service that is not listed above contact the Specialty Care Resource Line toll-free at 1-877-455- 9955 or TTY 1-877-544-9544 or the participant's Managed Care Organization Member Services or Medicaid Managed Care Case Manager.

How to Locate Legacy Medicaid Services & Medical Equipment for the Home

CAN MEDICAID HELP YOU?

EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) PERSONAL CARE SERVICES

Personal care services (PCS) are defined as tasks that are medically necessary when physical or cognitive limitations due to illness or injury necessitate assistance with eating, toileting, bathing, bed mobility, transferring, dressing, locomotion, personal hygiene, and bladder or bowel requirements. PCS **does not include** medical or nursing tasks, like giving medicine, tube feeding, or suctioning. PCS **is not a substitute** for child care.

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

EXTENDED HOME HEALTH

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

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

MEDICAL EQUIPMENT AND SUPPLIES

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

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

CUSTOMER SERVICE INFORMATION FOR MEDICAID INQUIRIES:

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

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

Medicaid Eligibility Hotline • 1-888-342-6207

Medicaid Services Chart • www.ldh.la.gov/medicaidservices

E-mail • MyMedicaid@la.gov

Medicaid Website • www.medicaid.la.gov

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

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

Appendix C

LOUISIANA DEPARTMENT OF HEALTH

MEDICAID SERVICES CHART

October 2023

Exclusion from this list does not necessarily mean that a service is not covered. Please call one of the appropriate contacts for questions regarding coverage of services not listed on this chart. **NOTE:** The points of contact listed in this document is applicable to Medicaid recipients in the fee-for-service Medicaid program. Healthy Louisiana Plan members should contact their Plan's member services department with questions about how to access care.

MEDICAID SERVICES					
SERVICE	**HOW TO ACCESS SERVICES**	**ELIGIBILITY**	**COVERED SERVICES**	**COMMENTS**	**CONTACT PERSON**
Adult Denture Services	Dentist	Medicaid recipients 21 years of age and older. **(Adults, 21 and over, certified as Qualified Medicare Beneficiary (QMB), Specified Low Income Medicare Beneficiary (SLMB) only, PACE, Take Charge Plus or other programs with limited benefits are not eligible for dental services.)**	Examination, x-rays (are only covered if in conjunction with the construction of a Medicaid-authorized denture) dentures, denture relines, and denture repairs. Only one complete or partial denture per arch is allowed in an eight-year period. The partial denture must oppose a full denture. Two partials are not covered in the same oral cavity (mouth). Additional guidelines apply.	DentaQuest and MCNA Dental administer the dental benefits for eligible Medicaid recipients. Contact your plan to locate a network provider and for questions about covered dental services.	**DentaQuest** 1-800-685-0143 www.DentaQuest.com **MCNA Dental** 1-855-702-6262 www.MCNALA.net **Kevin Guillory** 225-342-7476 **Tiffany Hayes** 225-342-7877
Adult Waiver Dental Services	Dentist	Medicaid recipients 21 years of age and older enrolled in New Opportunities Waiver, Residential Options Waiver or Supports Services Waiver.	The Adult Waiver Dental Program provides coverage of certain diagnostic; preventive; restorative; endodontic; periodontic; removable prosthodontic; maxillofacial prosthetic; oral and maxillofacial surgery; orthodontic; and adjunctive general services. Specific policy guidelines apply.	DentaQuest and MCNA Dental administer the dental benefits for eligible Medicaid recipients. Contact your plan to locate a network provider and for questions about covered dental services.	**DentaQuest** 1-800-685-0143 www.DentaQuest.com **MCNA Dental** 1-855-702-6262 www.MCNALA.net **Kevin Guillory** 225-342-7476 **Tiffany Hayes** 225-342-7877

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MEDICAID SERVICES					
SERVICE	**HOW TO ACCESS SERVICES**	**ELIGIBILITY**	**COVERED SERVICES**	**COMMENTS**	**CONTACT PERSON**
Applied Behavior Analysis (ABA)	Medicaid enrolled ABA provider	Age from birth up to 21 years of age; and 1. exhibit the presence of excesses and/or deficits of behaviors that significantly interfere with home or community activities (examples include, but are not limited to aggression, self-injury, elopement, etc.); 2. 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; 3. have a comprehensive diagnostic evaluation by a qualified health care professional; and 4. have a prescription for ABA-based therapy services ordered by a qualified health care professional.	ABA-based therapy services shall be rendered in accordance with the individual's treatment plan.	All medically necessary services must be prescribed and **Prior Authorized**. The provider of services will submit requests for Prior Authorization.	**Aetna** 1-855-242-0802 www.aetnabetterhealth.com/louisiana **AmeriHealth Caritas** 1-888-756-0004 www.amerihealthcaritasla.com **Healthy Blue** 1-844-521-6941 www.myhealthybluela.com **Humana Healthy Horizons in Louisiana** 1-800-448-3810 www.humana.com/medicaid/louisiana **Louisiana Healthcare Connections** 1-866-595-8133 www.louisianahealthconnect.com **United Healthcare Community Plan** 1-844-253-0667 www.uhccommunityplan.com **Rene Huff** 225-342-3935
Audiological Services	*See: EarlySteps; EPSDT Screening Services; Hospital – Outpatient services; Physician/Professional Services; Rehabilitation Clinic Services; Therapy Services*				

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MEDICAID SERVICES

SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
Behavioral Health Services – Adults	Any Medicaid eligible adult may receive the following behavioral health service if medical necessity is established by a licensed mental health professional (LMHP).	Medicaid eligible adult Adults eligible to receive mental health rehabilitation (MHR) services under Medicaid State Plan include those who meet the following criteria: • Must have a mental health diagnosis and • Must be assessed by an LMHP Members receiving CPST and/or PSR: • Must have at least a level of care of three on the LOCUS. • Must have a rating of three or greater on the functional status domain on the level of care utilization system (LOCUS). Members receiving IPS and PCS must be: • 21 years and older • Transitioned from a nursing facility or been diverted from nursing facility level of care through the My Choice Louisiana program. For more information, please refer to the BHS Provider Manual.	1. Community Psychiatric Support & Treatment (CPST) 2. Psychosocial Rehabilitation (PSR) 3. Crisis Intervention (CI) 4. Assertive Community Treatment (ACT) 5. Crisis Responses Services a. Mobile Crisis Response (MCR) b. Behavioral Health Crisis Care (BHCC) c. Community Based Crisis Service (CBCS) 6. Crisis Stabilization (CS) 7. Individual Placement and Supports (IPS) 8. Personal Care Services (PCS) 9. Peer Support Services (PSS) 10. Outpatient Therapy with Licensed Practitioners (medication management, individual, family, and group counseling) 11. Addiction Services (outpatient, residential, and inpatient) 12. Psychiatric Inpatient Hospital 18-21 years and over 65 years of age	Adult Behavioral Health services are administered by the Healthy Louisiana Plans. CPST, PSR, CI follow-up, ACT, CBCS, CS, IPS, PCS, and PSS must be **Prior Authorized**.	**Aetna** 1-855-242-0802 www.aetnabetterhealth.com/louisiana **AmeriHealth Caritas** 1-888-756-0004 www.amerihealthcaritasla.com **Healthy Blue** 1-844-521-6941 www.myhealthybluela.com **Humana Healthy Horizons in Louisiana** 1-800-448-3810 www.humana.com/medicaid/louisiana **Louisiana Healthcare Connections** 1-866-595-8133 www.louisianahealthconnect.com **United Healthcare Community Plan** 1-844-253-0667 www.uhccommunityplan.com

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MEDICAID SERVICES					
SERVICE	**HOW TO ACCESS SERVICES**	**ELIGIBILITY**	**COVERED SERVICES**	**COMMENTS**	**CONTACT PERSON**
Chemotherapy Services *See also: Hospital-Outpatient Services; Physician/ Professional Services*	Hospital Physician's office or clinic	All Medicaid Recipients.	Chemotherapy administration and treatment drugs, as prescribed by physician.	**NOTE:** The contact person and number provided should not be utilized for making appointments. Members that are enrolled with one of the Healthy Louisiana plans should contact Healthy Louisiana via the information below: **Web** https://www.myplan.healthy.la.gov/en **Phone** 1-855-229-6848 Monday through Friday from 8:00 a.m. to 5:00 p.m. For hearing impaired (TTY) please call 1-855-526-3346. **Mail** Healthy Louisiana P.O. Box 1097 Atlanta, GA 30301-9913 **Fax** 1-888-858-3875	**Crystal Faison** 225-342-8233 (Please utilize the above contact for questions related to Fee For Service coverage.)

Exclusion from this list does not necessarily mean that a service is not covered. Please call one of the appropriate contacts for questions regarding coverage of services not listed on this chart. **NOTE:** The points of contact listed in this document is applicable to Medicaid recipients in the fee-for-service Medicaid program. Healthy Louisiana Plan members should contact their Plan's member services department with questions about how to access care.

MEDICAID SERVICES					
SERVICE	**HOW TO ACCESS SERVICES**	**ELIGIBILITY**	**COVERED SERVICES**	**COMMENTS**	**CONTACT PERSON**
Chiropractic Services	*EPSDT Medical Screening Provider/PCP*	Medicaid recipients 0 through 20 years of age.	Spinal manipulations.	**NOTE:** The contact person and number provided should not be utilized for making appointments. Members that are enrolled with one of the Healthy Louisiana plans should contact Healthy Louisiana via the information below: **Web** https://www.myplan.healthy.la.gov/en **Phone** 1-855-229-6848 Monday through Friday from 8:00 a.m. to 5:00 p.m. For hearing impaired (TTY) please call 1-855-526-3346. **Mail** Healthy Louisiana P.O. Box 1097 Atlanta, GA 30301-9913 **Fax** 1-888-858-3875	**Crystal Faison** 225-342-8233 (Please utilize the above contact for questions related to Fee For Service coverage.)

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MEDICAID SERVICES

SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
Coordinated System of Care (CSoC) Program	To make a referral, contact Magellan directly or the child/youth's Healthy Louisiana Plan. Note that the parent/caregiver must participate in the referral.	Children, youth and families eligible for CSoC include Medicaid members between the ages of 5 and 20 years of age, who have a severe emotional disturbance (SED) or a serious mental illness (SMI) and who are in or at risk of out of home placement. A recipient meet the level of care or level of need through a Child and Adolescent Needs and Strengths (CANS) comprehensive assessment. For more information, please refer to the BHS Provider Manual.	1. Parent Support & Training 2. Youth Support & Training 3. Independent Living/Skills Building 4. Short Term Respite Care 5. Case Conference	CSoC services are administered by Magellan Health Services of Louisiana. **NOTE:** The Healthy Louisiana Plan will connect you with Magellan to complete the referral.	**Magellan Health Services of Louisiana** 1-800-424-4489 **Aetna** 1-855-242-0802 www.aetnabetterhealth.com/louisiana **AmeriHealth Caritas** 1-888-756-0004 www.amerihealthcaritasla.com **Healthy Blue** 1-844-521-6941 www.myhealthybluela.com **Humana Healthy Horizons in Louisiana** 1-800-448-3810 www.humana.com/medicaid/louisiana **Louisiana Healthcare Connections** 1-866-595-8133 www.louisianahealthconnect.com **United Healthcare Community Plan** 1-844-253-0667 www.uhccommunityplan.com
Dental Care Services	*See: Adult Denture Services; Adult Waiver Dental Services; and EPSDT Dental Services*				

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MEDICAID SERVICES

SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
Durable Medical Equipment (DME)	Physician	All Medicaid recipients.	Medical equipment and appliances such as wheelchairs, leg braces, etc. Medical supplies such as ostomy supplies, etc. Diapers and blue pads are -only reimbursable as durable medical equipment items for Medicaid recipients 0 through 20 years of age.	All services must be prescribed by a physician and must be **Prior Authorized**. DME providers will arrange for the **Prior Authorization** request.	**Irma Gauthier** 225-342-5691
EarlySteps (Infant & Toddler Early Intervention Services)		1. Children ages birth to three who have a **developmental delay** of at least 1.5 SD (standard deviations) below the mean in two areas of development listed below: a. cognitive development b. physical development **(vision & hearing)** - communication development c. social or emotional development d. adaptive skills development (also known as self-help or daily living skills) 2. Children with a **diagnosed medical condition** with a high probability of resulting in developmental delay.	**Covered Services (Medicaid Covered)** - Family Support Coordination (Service Coordination) - Occupational Therapy - Physical Therapy - Speech/Language Therapy - Psychology - Audiology **EarlySteps also provides the following services, not covered by Medicaid:** - Nursing Services/Health Services (Only to enable an eligible child/family to benefit from the other EarlySteps services). - Medical Services for diagnostic and evaluation purposes only. - Special Instruction - Vision Services - Assistive Technology devices and services - Social Work - Counseling Services/Family Training - Transportation - Nutrition - Sign language and cued language services.	All services are provided through a plan of care called the Individualized Family Service Plan. Early Intervention is provided through EarlySteps in conformance with Part C of the Individuals with Disabilities Education Act. (IDEA).	**Office for Citizens with Developmental Disabilities (OCDD)** 1-866-783-5553 or 1-866-EARLYSTEP for families **Brenda Sharp** 225-342-8853

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MEDICAID SERVICES

SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
EPSDT Behavioral Health Services	Medicaid eligible youth who meets the medical necessity criteria for behavioral health services as determined by a licensed mental health professional (LMHP).	Meets medical necessity criteria for rehabilitation services for children under the age of 21. Children and youth eligible to receive mental health rehabilitation (MHR) services under Medicaid State Plan include those who meet one of the following criteria and is 21 years and older: • Must be assessed by a licensed mental health professional. Members receiving CPST and/or PSR, ages 6 through 18 years of age, must be assessed using the CALOCUS. Members receiving CPST and/or PSR, ages 19 through 20 years of age, must be assessed using the LOCUS. Members who receive Multi-Systemic Therapy, Homebuilders, Functional Family Therapy and Functional Family Therapy-Child Welfare are not required to be assessed using the CALOCUS.	1. Community Psychiatric Support & Treatment (CPST) 2. Psychosocial Rehabilitation (PSR) 3. Crisis Intervention 4. Crisis Stabilization 5. Outpatient Therapy with Licensed Practitioners (medication management, individual, family, and group counseling) 6. Therapeutic Group Home 7. Psychiatric Residential Treatment Facility (PRTF) 8. Psychiatric Inpatient Hospital 9. Addiction Services (outpatient, residential, and inpatient) 10. Multi-systemic Therapy (MST) 11. Functional Family Therapy (FFT) 12. Homebuilders (HB) 13. Assertive Community Treatment (ACT) 14. Child Parent Psychotherapy (CPP) 15. Parent-child interaction therapy (PCIT) 16. Preschool PTSD Treatment (PPT) and Youth PTSD Treatment (YPT) 17. Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) 18. Eye Movement Desensitization and Reprocessing (EMDR) Therapy 19. Coordinated System of Care (CSoC) (**NOTE:** Please see the CSoC section)	EPSDT Behavioral Health services are administered by the Healthy Louisiana Plans. CPST, PSR, MST, FFT, HB, and ACT must be **Prior Authorized**.	**Aetna** 1-855-242-0802 www.aetnabetterhealth.com/louisiana **AmeriHealth Caritas** 1-888-756-0004 www.amerihealthcaritasla.com **Healthy Blue** 1-844-521-6941 www.myhealthybluela.com **Humana Healthy Horizons in Louisiana** 1-800-448-3810 www.humana.com/medicaid/louisiana **Louisiana Healthcare Connections** 1-866-595-8133 www.louisianahealthconnect.com **United Healthcare Community Plan** 1-844-253-0667 www.uhccommunityplan.com For CSoC Services: **Magellan Health Services of Louisiana** 1-800-424-4489 www.magellanoflouisiana.com

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MEDICAID SERVICES					
SERVICE	**HOW TO ACCESS SERVICES**	**ELIGIBILITY**	**COVERED SERVICES**	**COMMENTS**	**CONTACT PERSON**
EPSDT Dental Services	Dentist	Medicaid recipients 0 through 20 years of age.	The EPSDT Dental Program provides coverage of certain diagnostic; preventive; restorative; endodontic; periodontic; removable prosthodontic; maxillofacial prosthetic; oral and maxillofacial surgery; orthodontic; and adjunctive general services. Specific policy guidelines apply. Comprehensive Orthodontic Treatment (braces) are paid only when there is a cranio-facial deformity, such as cleft palate, cleft lip, or other medical conditions which possibly results in a handicapping malocclusion. If such a condition exists, the recipient should see a Medicaid-enrolled orthodontist. Patients having only crowded or crooked teeth, spacing problems or under/overbite are not covered for braces, unless identified as medically necessary.	DentaQuest and MCNA Dental administer the dental benefits for eligible Medicaid recipients. Contact your plan to locate a network provider and for questions about covered dental services.	**DentaQuest** 1-800-685-0143 www.DentaQuest.com **MCNA Dental** 1-855-702-6262 www.MCNALA.net **Kevin Guillory** 225-342-7476 **Tiffany Hayes** 225-342-7877

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MEDICAID SERVICES					
SERVICE	**HOW TO ACCESS SERVICES**	**ELIGIBILITY**	**COVERED SERVICES**	**COMMENTS**	**CONTACT PERSON**
EPSDT Personal Care Services *For Medicaid recipients ages 65 or older, or age 21 or older with disabilities, see: Long Term – Personal Care Services (LT-PCS)*	Physician and Personal Care Attendant Agencies	All Medicaid recipients 0 through 20 **NOT** receiving Individual Family Support waiver services. However, once a recipient receiving Individual Family Support waiver services has exhausted those services they are then eligible for EPSDT Personal Care Services. Recipients of Children's Choice Waiver can receive both PCS and Family Support Services on the same day; however, the services may not be rendered at the same time.	Basic personal care-toileting & grooming activities. Assistance with bladder and/or bowel requirements or problems. Assistance with eating and food preparation. Performance of incidental household chores, only for the recipient. Accompanying, not transporting, recipient to medical appointments. Does **NOT** cover any medical tasks such as medication administration, tube feedings, urinary catheters, ostomy or tracheostomy care.	The Personal Care Agency must submit the **Prior Authorization** request. Recipients receiving Support Coordination (Case Management Services) must also have their PCS **Prior Authorized** by Gainwell Technology. PCS is *not subject to service limits*. Units approved will be based on medical necessity and the need for covered services. Recipients receiving Personal Care Services must have a practitioner's prescription and meet medical criteria. Does **NOT** include medical tasks. Provided by licensed providers enrolled in Medicaid to provide Personal Care Attendant services.	**Norma Seguin** 225-342-7513
EPSDT Screening Services (Child Health – Preventive Services)	Physician	All Medicaid recipients 0 through 20 years of age.	Medical Screenings (including immunizations and certain lab services). Vision Screenings Hearing Screenings Dental Screenings	Recipients receive their screening services from the primary care provider (PCP) or appropriate health care provider.	**Norma Seguin** 225-342-7513 **Specialty Care Resource Line** 1-877-455-9955
Eyewear	*See: Vision Services*				

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MEDICAID SERVICES					
SERVICE	**HOW TO ACCESS SERVICES**	**ELIGIBILITY**	**COVERED SERVICES**	**COMMENTS**	**CONTACT PERSON**
Family Planning Services (Take Charge Plus)	Any Medicaid provider who offers family planning services. For assistance with locating a provider, call 1-877-455-9955	All Louisiana residents of child bearing age regardless of gender with an income at or below 138% of the Federal Poverty level. Pregnant women are excluded from this program.	Family planning related services and care related to: • Birth control (pills, implants, injections, condoms, and IUDs) • Cervical cancer screening and treatment for most abnormal results • Contraceptive counseling and education • Prescriptions, and follow-up visits to treat STIs • Treatment of major complications from certain family planning procedures • Voluntary sterilization for males and females (over age 21) • Vaccines for both males and females for the prevention of HPV • Transportation to family planning appointments	Take Charge Plus is limited to family planning services and family planning related services. There are no enrollment fees, no premiums, co-payments or deductibles. All Medicaid providers including American Indian "638" Clinics, RHCs and FQHCs are reimbursed at established fee-for-service rates published in the Take Charge Plus fee schedule. **NOTE:** The contact person and number provided should not be utilized for making appointments. Members that are enrolled with one of the Healthy Louisiana plans should contact Healthy Louisiana via the information below: **Web** https://www.myplan.healthy.la.gov/en **Phone** 1-855-229-6848 Monday through Friday from 8:00 a.m. to 5:00 p.m. For hearing impaired (TTY) please call 1-855-526-3346. **Mail** Healthy Louisiana P.O. Box 1097 Atlanta, GA 30301-9913 **Fax** 1-888-858-3875	**Crystal Faison** 225-342-8233 (Please utilize the above contact for questions related to Fee For Service coverage.)

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MEDICAID SERVICES					
SERVICE	**HOW TO ACCESS SERVICES**	**ELIGIBILITY**	**COVERED SERVICES**	**COMMENTS**	**CONTACT PERSON**
Family Planning Services in Physician's Office	*See: Physician/Professional Services*				
Federally Qualified Health Centers (FQHC)	Nearest FQHC The American Indian Clinic	All Medicaid recipients.	Professional medical services furnished by physicians, nurse practitioners, physician assistants, nurse midwives, clinical social workers, clinical psychologists, and dentists Covered benefits include medical, behavioral health, and dental.	There are 3 components that may be provided: 1. Encounter visits; 2. EPSDT Screening Services; and 3. EPDST Dental, and Adult Denture Services.	**Irma Gauthier** 225-342-5691

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MEDICAID SERVICES					
SERVICE	**HOW TO ACCESS SERVICES**	**ELIGIBILITY**	**COVERED SERVICES**	**COMMENTS**	**CONTACT PERSON**
Free Standing Birthing Centers	Certified Nurse Midwife or Licensed Midwife	All Medicaid eligible pregnant women	Vaginal delivery services for females who have had a low risk, normal pregnancy, prenatal care and that are expected to have an uncomplicated labor and normal vaginal delivery.	A Free Standing Birthing Center is a free standing facility, separate from a hospital. Stays for delivery are usually less than 24 hours. Epidural anesthesia is not provided for deliveries at Free Standing Birthing Centers. **NOTE:** The contact person and number provided should not be utilized for making appointments. Members that are enrolled with one of the Healthy Louisiana plans should contact Healthy Louisiana via the information below: **Web** https://www.myplan.healthy.la.gov/en **Phone** 1-855-229-6848 Monday through Friday from 8:00 a.m. to 5:00 p.m. For hearing impaired (TTY) please call 1-855-526-3346. **Mail** Healthy Louisiana P.O. Box 1097 Atlanta, GA 30301-9913 **Fax** 1-888-858-3875	**Crystal Faison** 225-342-8233

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MEDICAID SERVICES

SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
Hearing Aids *See also: Durable Medical Equipment*	Durable Medical Equipment Provider	Medicaid recipients 0 through 20 years of age.	Hearing Aids and any related ancillary equipment such as earpieces, batteries, etc. Repairs are covered if the Hearing Aid was paid for by Medicaid.	All services must be **Prior Authorized** and the DME provider will arrange for the request of **Prior Authorization**.	**Irma Gauthier** 225-342-5691
Hemodialysis Services *See also: Hospital – Outpatient Services*	Dialysis Centers Hospitals	All Medicaid recipients.	Dialysis treatment (including routine laboratory services); medically necessary non-routine lab services; and medically necessary injections.		**Justin Owens** 225-342-6888
Home Health	Physician	All Medicaid recipients. Medically Needy (Type Case 20 & 21) recipients are not eligible for Aide Visits, Physical Therapy, Occupational Therapy, Speech/Language Therapy. EPSDT Home Health is provided to the medically needy if the recipient is under the age of 21.	• Intermittent/part-time nursing services including skilled nurse visits. • Aide Visits • Physical Therapy • Occupational Therapy • Speech/Language Therapy	Recipients receiving Home Health must have an authorized healthcare provider's prescription and signed plan of care. PT, OT, and Speech/Language Therapy require **Prior Authorization**. Crisis Response Team – for Medicaid recipients 0 through 20 AND under a waiver program (Supports, ROW, NOW, Children's Choice) AND not receiving prescribed medically necessary intermittent nursing services for 2 consecutive weeks	**Justin Owens** 225-342-6888 **Crisis Response Team** 1-866-729-0017 crisisresponseteam@la.gov

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MEDICAID SERVICES					
SERVICE	**HOW TO ACCESS SERVICES**	**ELIGIBILITY**	**COVERED SERVICES**	**COMMENTS**	**CONTACT PERSON**
Home Health – Extended	Physician	Medicaid recipients 0 through 20 years of age.	Multiple hours of skilled nurse services. All medically necessary medical tasks that are part of the plan of care can be administered in the home.	Recipients receiving extended nursing services must have a letter of medical necessity and an authorized healthcare provider's prescription. Extended Skilled nursing services require **Prior Authorization**. Crisis Response Team – for Medicaid recipients 0 through 20 AND under a waiver program (Supports, ROW, NOW, Children's Choice) AND not receiving prescribed medically necessary Extended Home Health nursing services for 2 consecutive weeks.	**Justin Owens** 225-342-6888 **Crisis Response Team** 1-866-729-0017 crisisresponseteam@la.gov
Hospice Services	Hospice Provider/ Physician	All Medicaid recipients. Hospice eligibility information: 1-800-877-0666 Option 2	Medicare allowable services.		**Justin Owens** 225-342-6888
Hospital Claim Questions – Inpatient and Outpatient Services, including Emergency Room Services	Physician/ Hospital	All Medicaid recipients. Medically Needy (Type Case 20 & 21) under age 22 are not eligible for Inpatient Psychiatric Services.	Inpatient and Outpatient Hospital Services, including Emergency Room Services	All Questions Regarding Denied Claims and/or Bills for Inpatient and Outpatient Hospital Services, including Emergency Room Services.	Recipients should first contact the provider, then may contact an MMIS Staff Member at 225-342-3855 if the issue cannot be resolved Providers should contact Provider Relations at 1-800-473-2783

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MEDICAID SERVICES					
SERVICE	**HOW TO ACCESS SERVICES**	**ELIGIBILITY**	**COVERED SERVICES**	**COMMENTS**	**CONTACT PERSON**
Hospital – Inpatient Services	Physician/ Hospital	All Medicaid recipients. Medically Needy (Type Case 20 & 21) under age 22 are not eligible for Inpatient Psychiatric Services.	Inpatient hospital care needed for the treatment of an illness or injury which can only be provided safely & adequately in a hospital setting. Includes those basic services that a hospital is expected to provide.		For providers: ProviderRelations@la.gov For members: Healthy@la.gov
Hospital – Outpatient Services	Physician/ Hospital	All Medicaid recipients.	Diagnostic & therapeutic outpatient services, including outpatient surgery and rehabilitation services. Therapeutic and diagnostic radiology services. Chemotherapy Hemodialysis	Outpatient rehabilitation (physical therapy, occupational therapy, and speech therapy) require **Prior Authorization**. Provider will submit request for **Prior Authorization**.	For providers: ProviderRelations@la.gov For members: Healthy@la.gov
Hospital – Emergency Room Services	Physician/ Hospital	All Medicaid recipients.	Emergency Room services.	No service limits.	For providers: ProviderRelations@la.gov For members: Healthy@la.gov
Immunizations	*See: FQHC; EPSDT Screening Services; Physician/Professional Services; Rural Health Clinics*				

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MEDICAID SERVICES					
SERVICE	**HOW TO ACCESS SERVICES**	**ELIGIBILITY**	**COVERED SERVICES**	**COMMENTS**	**CONTACT PERSON**
Laboratory Tests and Radiology Services	Physician	All Medicaid recipients.	Most diagnostic testing and radiological services ordered by the attending or consulting physician. Portable (mobile) x-rays are covered only for recipients who are unable to leave their place of residence without special transportation or assistance to obtain physician ordered x-rays.	All requests for any radiology services requiring prior approval are initiated by the ordering physician. Recipients may follow up with the ordering physician for the status of any ordered radiology service. **NOTE:** The contact person and number provided should not be utilized for making appointments. Members that are enrolled with one of the Healthy Louisiana plans should contact Healthy Louisiana via the information below: **Web** https://www.myplan.healthy.la.gov/en **Phone** 1-855-229-6848 Monday through Friday from 8:00 a.m. to 5:00 p.m. For hearing impaired (TTY) please call 1-855-526-3346. **Mail** Healthy Louisiana P.O. Box 1097 Atlanta, GA 30301-9913 **Fax** 1-888-858-3875	**Crystal Faison** 225-342-8233

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MEDICAID SERVICES					
SERVICE	**HOW TO ACCESS SERVICES**	**ELIGIBILITY**	**COVERED SERVICES**	**COMMENTS**	**CONTACT PERSON**
Long Term – Personal Care Services (LT-PCS) *For Medicaid recipients ages 0 through 20, see: EPSDT Personal Care Services*	Contact Louisiana Options in Long Term Care (Conduent) 1-877-456-1146 for information, eligibility information, assessments and service requirements	All Medicaid recipients age 65 or older, or age 21 or older with disabilities (meets Social Security Administration disability criteria), meet the medical standards for admission to a nursing facility and additional targeting criteria, and be able to participate in his/her care and direct the services provided by the worker independently or through a responsible representative. Applicant must require at least limited assistance with at least one Activity of Daily Living.	- Basic personal care-toileting & grooming activities. - Assistance with bladder and/or bowel requirements or problems. - Assistance with eating and food preparation. - Performance of incidental household chores, only for the recipient. - Accompanying, not transporting, recipient to medical appointments. - Grocery shopping, including personal hygiene items.	Recipients or the responsible representative must request the service. This program is **NOT** a substitute for existing family and/or community supports, but is designed to supplement available supports to maintain the recipient in the community. Once approved for services, the selected PCS Agency must obtain **Prior Authorization**. Amount of services approved will be based on assessment of assistance needed to perform daily living. Provided by PCS agencies enrolled in Medicaid.	**Louisiana Options in Long Term Care (Conduent)** 1-877-456-1146 **Office of Aging and Adult Services (OAAS)** 1-866-758-5035 **Anne Deitch** 225-342-0222
Medical Transportation (Emergency)	Emergency ambulance providers	All Medicaid recipients.	Emergency ambulance service may be reimbursed if circumstances exist that make the use of any conveyance other than an ambulance medically inadvisable for transport of the patient.		**Melanie Doucet** 225-614-3222 **Veronica Gonzalez** 225-342-9566

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MEDICAID SERVICES					
SERVICE	**HOW TO ACCESS SERVICES**	**ELIGIBILITY**	**COVERED SERVICES**	**COMMENTS**	**CONTACT PERSON**
Medical Transportation (Non-Emergency)	Medicaid recipients who **ARE** covered under a Healthy Louisiana managed care plan should contact their call center: **Aetna** 1-877-917-4150 **AmeriHealth Caritas** 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	All Medicaid recipients with full benefits, except some who have Medicaid and Medicare.	Transportation to and from medical appointments. The medical provider the recipient is being transported to, does not have to be a Medicaid enrolled provider but the services must be Medicaid covered services. The dispatch office will make this determination. Recipients under 17 years old must be accompanied by an attendant.	Recipients should call dispatch offices **48 hours** before the appointment. Transportation to out-of-state appointments can be arranged but requires **Prior Authorization.** **Same day transportation can be scheduled when absolutely necessary.**	**Melanie Doucet** 225-614-3222 **Veronica Gonzalez** 225-342-9566

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MEDICAID SERVICES					
SERVICE	**HOW TO ACCESS SERVICES**	**ELIGIBILITY**	**COVERED SERVICES**	**COMMENTS**	**CONTACT PERSON**
Midwife Services	*For* **Certified Nurse Midwife**, *see: FQHC; Physician/Professional Services; Rural Health Clinics* *For* **Licensed Midwife**, *see: Freestanding Birthing Center*				
Nurse Practitioners/ Clinical Nurse Specialists	*See FQHC; Physician/Professional Services; Rural Health Clinics*				
Nursing Facility		Medicaid recipients and persons who would meet Medicaid Long Term Care financial eligibility requirements and who meet nursing facility level of care as determined by OAAS.	Skilled Nursing or medical care and related services; rehabilitation needed due to injury, disability, or illness; health-related care and services (above the level of room and board) not available in the community, needed regularly due to a mental or physical; condition.		**Louisiana Options in Long Term Care (Conduent)** 1-877-456-1146 **Office of Aging and Adult Services (OAAS)** 1-866-758-5035
Occupational Therapy Services	*See: EarlySteps; Home Health; Hospital – Outpatient Services; Rehabilitation Clinic Services; Therapy Services*				

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MEDICAID SERVICES					
SERVICE	**HOW TO ACCESS SERVICES**	**ELIGIBILITY**	**COVERED SERVICES**	**COMMENTS**	**CONTACT PERSON**
Optical Services *For eyewear, see: Vision Services*	Ophthalmologist	All Medicaid recipients.	Recipients 0 through 20 Examinations and treatment of eye conditions, including examinations for vision correction, refraction error. Other related services, if medically necessary. Recipients 21 and over Examinations and treatment of eye conditions, such as infections, cataracts, etc. If the recipient has both Medicare and Medicaid, some vision related services may be covered. The recipient should contact Medicare for more information since Medicare would be the primary payer.	**NON-COVERED SERVICES:** Recipients 21 and over - routine eye examinations for vision correction - routine eye examinations for refraction error **NOTE:** The contact person and number provided should not be utilized for making appointments. Members that are enrolled with one of the Healthy Louisiana plans should contact Healthy Louisiana via the information below: **Web** https://www.myplan.healthy.la.gov/en **Phone** 1-855-229-6848 Monday through Friday from 8:00 a.m. to 5:00 p.m. For hearing impaired (TTY) please call 1-855-526-3346. **Mail** Healthy Louisiana P.O. Box 1097 Atlanta, GA 30301-9913 **Fax** 1-888-858-3875	For ophthalmology: **Crystal Faison** 225-342-8233 For eyewear: **Irma Gauthier** 225-342-5691
Orthodontic Services	*See Dental Care Services*				

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MEDICAID SERVICES					
SERVICE	**HOW TO ACCESS SERVICES**	**ELIGIBILITY**	**COVERED SERVICES**	**COMMENTS**	**CONTACT PERSON**
Pediatric Day Health Care (PDHC)	Physician or PDHC Agencies	Medicaid recipient 0 through 20 who have a medically fragile condition and who require nursing supervision and possibly therapeutic interventions all or part of the day due to a medically complex condition.	Nursing care, Respiratory care, Physical Therapy, Speech-language therapy, occupational, personal care services and transportation to and from PDHC facility	The PDHC facility must submit the Prior Authorization request. In order to receive PDHC, the recipient must have a prescription from their prescribing physician and meet the medical criteria. PDHC may be provided up to seven days per week and up to 12 hours per day for Medicaid recipients as documented by the recipient's Plan of Care. Services are provided by licensed providers enrolled in Medicaid to provide PDHC services. The following services are not covered– before and after school care; medical equipment, supplies and appliances; parenteral or enteral nutrition; infant food or formula. Prescribed medications are to be provided each day by recipient's parent/guardian. PDHC services require Prior Authorization. Provider will submit request for Prior Authorization.	**Norma Seguin** 225-342-7513

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MEDICAID SERVICES					
SERVICE	**HOW TO ACCESS SERVICES**	**ELIGIBILITY**	**COVERED SERVICES**	**COMMENTS**	**CONTACT PERSON**
Program of All-Inclusive Care for the Elderly (PACE) *Program available in New Orleans, Baton Rouge, and Lafayette area.*		Participants are persons age 55 years or older, live in the PACE provider service area, are certified to meet nursing facility level of care and financially eligible for Medicaid long term care. Participation is voluntary and enrollees may disenroll at any time.	ALL Medicaid and Medicare services, both acute and long-term care	- Emphasis is on enabling participants to remain in community and enhance quality of life. - Interdisciplinary team performs assessment and develops individualized plan of care. - Each PACE program serves a specific geographic region. - PACE programs bear financial risk for all medical support services required for enrollees. - PACE programs receive a monthly capitated payment for Medicaid and Medicare eligible enrollees.	**Office of Aging and Adult Services (OAAS)** 1-866-758-5035 **PACE Greater New Orleans** 504-945-1531 **Franciscan PACE Baton Rouge** 225-490-0640 **Franciscan PACE Lafayette** 337- 470-4500

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MEDICAID SERVICES

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Pharmacy Services	Pharmacies	All Medicaid recipients except some who are Medicare/Medicaid eligible. Recipients who are full benefit dual eligible (Medicare/Medicaid) receive their pharmacy benefits through Medicare Part D. Recipients enrolled in an MCO with only behavioral health services receive prescription benefits through the fee-for-service Medicaid program.	Covers prescription drugs Exceptions: • Cosmetic drugs (Except Accutane); • Cough & cold preparations; • Anorexics (Except for Xenical); • Fertility drugs when used for fertility treatment; • Experimental drugs; • Compounded • prescriptions; • Drug Efficacy Study • Implementation (DESI) • drugs; • Erectile Dysfunction (ED) Medications • Over the counter (OTC) drugs with some exceptions;	Co-payments ($0.50-$3.00) are required except for some recipient categories. **NO** co-payments for the following: • Under age 21 • Pregnant women • Long Term Care recipients • American Indians/Alaska Natives • Home and Community Based Waiver • Emergency Services • Family planning services • Preventive medications as designated by the US Preventive Services Task Force A and B Recommendations • Individuals receiving hospice care • Women whose basis of Medicaid eligibility is breast or cervical cancer Prescription limits: 4 per calendar month (The physician can override this limit when medically necessary.) Limits do not apply to recipients under age 21, pregnant women, or those in Long Term Care. **Prior Authorization** is required for *some* drug categories if the medication is not on the Preferred Drug List (PDL). **Children are not exempt from this process.** The PDL can be accessed at www.lamedicaid.com.	**Gabriell Johnson-Stewart** 225-219-4151 **Sue Fontenot** 225-342-2768 **General pharmacy questions** 1-800-437-9101

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MEDICAID SERVICES					
SERVICE	**HOW TO ACCESS SERVICES**	**ELIGIBILITY**	**COVERED SERVICES**	**COMMENTS**	**CONTACT PERSON**
Physical Therapy	*See: EarlySteps; Home Health; Hospital-Outpatient Services; Rehabilitation Clinic Services; Therapy Services*				
Physician Assistants	*See FQHC; Physician/Professional Services; Rural Health Clinics*				

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MEDICAID SERVICES					
SERVICE	**HOW TO ACCESS SERVICES**	**ELIGIBILITY**	**COVERED SERVICES**	**COMMENTS**	**CONTACT PERSON**
Physician/ Professional Services	Physician or Healthcare Professional	All Medicaid recipients.	Professional medical services including those of a physician, nurse midwife, nurse practitioner, clinical nurse specialists, physician assistant. Certain family planning services when provided in a physician's office.	Some services require **Prior Authorization**. Providers will submit requests for **Prior Authorization to Gainwell Technology**. Services are subject to limitations and exclusions. Your physician or healthcare professional can help with this. **NOTE:** The contact person and number provided should not be utilized for making appointments. Members that are enrolled with one of the Healthy Louisiana plans should contact Healthy Louisiana via the information below: **Web** https://www.myplan.healthy.la.gov/en **Phone** 1-855-229-6848 Monday through Friday from 8:00 a.m. to 5:00 p.m. For hearing impaired (TTY) please call 1-855-526-3346. **Mail** Healthy Louisiana P.O. Box 1097 Atlanta, GA 30301-9913 **Fax** 1-888-858-3875	For immunizations: **Norma Seguin** 225-342-7513 For professional services: **Crystal Faison** 225-342-8233

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MEDICAID SERVICES					
SERVICE	**HOW TO ACCESS SERVICES**	**ELIGIBILITY**	**COVERED SERVICES**	**COMMENTS**	**CONTACT PERSON**
Podiatry Services	Podiatrist	All Medicaid recipients.	Office visits. Certain radiology & lab procedures and other diagnostic procedures.	Some **Prior Authorization**, exclusions, and restrictions apply. Providers will submit request for **Prior Authorization to Gainwell Technology**. **NOTE:** The contact person and number provided should not be utilized for making appointments. Members that are enrolled with one of the Healthy Louisiana plans should contact Healthy Louisiana via the information below: **Web** https://www.myplan.healthy.la.gov/en **Phone** 1-855-229-6848 Monday through Friday from 8:00 a.m. to 5:00 p.m. For hearing impaired (TTY) please call 1-855-526-3346. **Mail** Healthy Louisiana P.O. Box 1097 Atlanta, GA 30301-9913 **Fax** 1-888-858-3875	**Crystal Faison** 225-342-8233

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MEDICAID SERVICES					
SERVICE	**HOW TO ACCESS SERVICES**	**ELIGIBILITY**	**COVERED SERVICES**	**COMMENTS**	**CONTACT PERSON**
Pre-Natal Care Services	Physicians or Healthcare Professional	Female Medicaid recipients of child bearing age.	Office visits. Lab and radiology services.	**NOTE:** The contact person and number provided should not be utilized for making appointments. Members that are enrolled with one of the Healthy Louisiana plans should contact Healthy Louisiana via the information below: **Web** https://www.myplan.healthy.la.gov/en **Phone** 1-855-229-6848 Monday through Friday from 8:00 a.m. to 5:00 p.m. For hearing impaired (TTY) please call 1-855-526-3346. **Mail** Healthy Louisiana P.O. Box 1097 Atlanta, GA 30301-9913 **Fax** 1-888-858-3875	**Crystal Faison** 225-342-8233
Psychiatric Hospital Care Services	*See Hospital – Inpatient Services*				
Rehabilitation Clinic Services	Physician	Medicaid recipients 0 through 20 years of age.	Occupational Therapy Physical Therapy Speech, Language and Hearing Therapy	All services must be **Prior Authorized**. The provider of services will submit the request for **Prior Authorization.**	**Justin Owens** 225-342-6888

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MEDICAID SERVICES					
SERVICE	**HOW TO ACCESS SERVICES**	**ELIGIBILITY**	**COVERED SERVICES**	**COMMENTS**	**CONTACT PERSON**
Rural Health Clinics	Rural Health Clinic The American Indian Clinic	All Medicaid recipients	Professional medical services furnished by physicians, nurse practitioners, physician assistants, nurse midwives, clinical social workers, clinical psychologists, and dentists. Covered benefits include medical, behavioral health, and dental.	There are 3 components that may be provided: 1. Encounter visits; 2. EPSDT Screening Services; and 3. EPDST Dental, and Adult Denture Services.	**Irma Gauthier** 225-342-5691
Sexually Transmitted Disease Clinics (STD)	OPH Public Health Units	All Medicaid recipients.	Testing, counseling, and treatment of all sexually transmitted diseases (STD). Confidential HIV testing.		**Public Health Unit Directory** http://ldh.la.gov/index.cfm/directory/category/192
Speech and Language Evaluation and Therapy	*See: EarlySteps; Home Health; Hospital – Outpatient Services; Rehabilitation Clinic Services; Therapy Services*				
Support Coordination Services (Case Management) – Children's Choice Waiver		**Medicaid recipients must be in the Children's Choice Waiver.** There is a Request for Services Registry (RFSR) for those requesting waiver services. To get on the Request for Services Registry, call the Office for Citizens with Developmental Disabilities District/Authority/Local Regional Office contact information is located at: http://ldh.la.gov/index.cfm/page/134/n/137	Coordination of Medicaid and other services. The Support Coordinator (Case Manager) helps to identify needs, access services and coordinate care. Services available through the Waiver are identified in the waiver section of this document.	Services must be **prior authorized** by LDH, Office for Citizens with Developmental Disabilities, Waiver Supports and Services. The support coordinator will submit requests for the **Prior Authorization**.	**Office for Citizens with Developmental Disabilities (OCDD), Waiver Supports and Services** 1-866-783-5553

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MEDICAID SERVICES

SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
Support Coordination Services (Case Management) – Community Choices Waiver		**Medicaid recipients must be in the Community Choices Waiver (CCW).** There is a Request for Services Registry (RFSR) for those requesting CCW Waiver services. Contact Louisiana Options in Long Term Care at 1-877-456-1146.	Coordination of Medicaid and other services. The Support Coordinator (Case Manager) helps to identify needs, access services and coordinate care.	Services must be **prior authorized** by LDH, Office of Aging and Adult Services (OAAS). The provider will submit requests for the **Prior Authorization**.	**Office of Aging and Adult Services (OAAS)** 1-866-758-5035 Participants should call 1-866-758-5035 or 225-219-0643
Support Coordination Services (Case Management) – EPSDT Targeted Populations		**Must be Medicaid eligible and on the DD Request for Services Registry prior to receipt of case management services; or any Medicaid recipient 3 through 20 years of age for whom support coordination is medically necessary.** To get on the Request for Services Registry, call the Office for Citizens with Developmental Disabilities District/Authority/Local Regional Office	Coordination of Medicaid and other services. The Support Coordinator (Case Manager) helps to identify needs, access services and coordinate care.	Support Coordination Services must be prior authorized by LDH, BHSF, and Waiver Compliance Section. The Support Coordination Agency will submit requests for the Prior Authorization to SRI. For other EPSDT services, see that portion of the chart.	**SRI** 1-800-364-7828 Must be on the DD Request for Services Registry. However, if the child is no longer eligible to remain on the registry, the family can appeal the notice that is sent out. LDH will evaluate the recipient's eligibility to receive "special needs" case management.
Support Coordination Services (Case Management) – Infants and Toddlers		Medicaid recipients must be 0 to 3 years of age and have a developmental delay or an established medical condition and eligible for the EarlySteps system. Contact information is located at: http://ldh.la.gov/index.cfm/page/139/n/139	Coordination of Medicaid and other services. The Support Coordinator (Case Manager) helps to identify needs, access services and coordinate care in EarlySteps.	Services must be **authorized** by EarlySteps. Authorizations are approved through the Individualized Family Service Plan (IFSP) process.	**Office for Citizens with Developmental Disabilities (OCDD)** 1-866-783-5553 **Brenda Sharp** 225/342-8853

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

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MEDICAID SERVICES

SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
Support Coordination Services (Case Management) – Supports Waiver		**Medicaid recipients must be in the Supports Waiver.** There is a **Request for Services Registry (RFSR)** for those requesting this waiver. To get on the Request for Services Registry, call the Office for Citizens with Developmental Disabilities District/Authority/Local Regional Office contact information is located at: http://ldh.la.gov/index.cfm/page/134/n/137	Coordination of Medicaid and other services. The Support Coordination (Case Manager) helps to identify needs, access services and coordinate care. Some services available through this waiver are identified in the waiver section of this document.	Services must be **prior authorized** by LDH, Office for Citizens with Developmental Disabilities, Waiver Supports and Services. The support coordinator will submit requests for the **Prior Authorization**.	**Office for Citizens with Developmental Disabilities (OCDD), Waiver Supports and Services** 1-866-783-5553 Complaints Line: 1-800-660-0488
Therapy Services	Recipients have the choice of services from the following provider types: Home Health; Hospital – Outpatient Services; Rehabilitation Clinic Services	Medicaid recipients 0 through 20 years of age.	• Audiological Services (Available in Rehabilitation Clinic and Hospital-Outpatient settings only.) • Occupational Therapy • Physical Therapy • Speech & Language Therapy	Covered services can be provided in the home through Home Health and Rehabilitation Clinics. Services provided by Rehabilitation Clinics can also be provided at the clinic. Services provided through Hospital – Outpatient Services must be provided at the facility/clinic. Covered services may be provided in addition to services provided by EarlySteps/EICs or School Boards if prescribed by a physician and Prior Authorized. All medically necessary services must be prescribed by a physician and **Prior Authorization** is required. The provider of services will submit requests for Prior Authorization.	**Justin Owens** 225-342-6888 **NOTE:** For details on services provided in Home Health, Rehabilitation Clinic, or Hospital – Outpatient settings, please refer to those sections of this Medicaid Services Chart.

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MEDICAID SERVICES					
SERVICE	**HOW TO ACCESS SERVICES**	**ELIGIBILITY**	**COVERED SERVICES**	**COMMENTS**	**CONTACT PERSON**
Therapy Services *(continued)*	EPSDT Health Services – Early Intervention Centers (EIC) or EarlySteps Program	Medicaid recipients under 3 years of age.	• Audiological Services • Occupational Therapy • Physical Therapy • Speech & Language Therapy • Psychological Therapy	All EPSDT Health Services through EICs and EarlySteps must be included in the infant/toddler's Individualized Family Services Plan (IFSP). If services are provided by an EIC or EarlySteps, Prior Authorization requirements are met through inclusion of services on the IFSP.	**Brenda Sharp** 225-342-8932
	EPSDT Health Services – Local Education Agencies (LEA) e.g. School Boards	Medicaid recipients 3 through 20 years of age.	• Audiology Services • Behavioral Health Services • Applied Behavioral Analyst Therapy (ABA) • Occupational, Physical, Speech and Respiratory Therapy • Optometry Services • Personal Care Services • Physician/Nursing Services • Transportation	• Services are performed within schools by Local Education Agencies (LEAs). • EPSDT health services on the Medicaid approved Periodicity Table may be reimbursed when provided by a licensed practitioner within the scope of their practice. All other health services must be included in a completed authorizing document pursuant to 34 C.F.R. § 104.36: - Individualized Education Plan (IEP); - Section 504 Accommodation Plan; - Individualized Health Care Plan; or - Any other medically necessary written plan of care.	**Anissa Young-Ned** 225-342-6885 **Andrea Perry** 225-219-7827

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MEDICAID SERVICES					
SERVICE	**HOW TO ACCESS SERVICES**	**ELIGIBILITY**	**COVERED SERVICES**	**COMMENTS**	**CONTACT PERSON**
Therapy Services *(continued)*	Physician Recipients 21 years of age and older may access Therapy Services through Hospital – Outpatient Services or Home Health Services.	Medicaid recipients 21 years of age and older. Medically Needy (Type Case 20 & 21) recipients are not eligible for Physical Therapy, Occupational Therapy, Speech/Language Therapy in a Home Health setting.	• Physical Therapy • Occupational Therapy • Speech/Language Therapy	PT, OT, and Speech/Language Therapy require a physician's prescription. PT, OT, and Speech/Language Therapy require **Prior Authorization**.	**Justin Owens** 225-342-6888 **NOTE:** For details on services provided in Home Health, Rehabilitation Clinic, or Hospital – Outpatient settings, please refer to those sections of this Medicaid Services Chart.
Transportation	*See: Medical Transportation*				
Tuberculosis Clinics	Office of Public Health Local Health Unit	All Medicaid recipients	Treatment and disease management services including physician visits, medications and x-rays.		TB Control Directory found at: TBControlDirectory.pdf (la.gov)

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MEDICAID SERVICES					
SERVICE	**HOW TO ACCESS SERVICES**	**ELIGIBILITY**	**COVERED SERVICES**	**COMMENTS**	**CONTACT PERSON**
Vision Services (Eyewear)	Optometrist, Ophthalmologist or Optical Supplier		Recipients 0 through 20 Regular eyeglasses when they meet a certain minimum strength requirement. **Medically necessary** specialty eyewear and contact lenses with **prior authorization**. Contact lenses are covered if they are the **only** means for restoring vision. Recipients 21 and over **ONLY** if the recipient receives both Medicare and Medicaid and Medicare covers the required eyewear. In this instance, Medicaid may pick up a calculated portion of the payment as a Medicare cross-over claim.	Recipients 0 through 20 Specialty eyewear and contact lenses, if medically necessary for EPSDT beneficiaries, requires **prior authorization**. The provider will submit requests for the p**rior authorization**. A prior authorization approval does not guarantee patient eligibility. Prescriptions are required for all glasses/contacts. After a prescription is obtained, the recipient may see an optical supplier to receive the glasses/contacts. **NON-COVERED SERVICES:** Recipients 21 and over Eyeglasses	**Irma Gauthier** 225-342-5691
X-Ray Services	*See: Laboratory Tests and Radiology Services*				
WAIVER SERVICES *There is a Request for Services Registry (RFSR) for those requesting any of the waiver services below.*					
Adult Day Health Care (ADHC)		Individuals 65 years of age or older, who meet Medicaid financial eligibility, imminent risk criteria and meet the criteria for admission to a nursing facility; or age 22-64 who are disabled according to Medicaid standards or SSI disability criteria, meet Medicaid financial eligibility and meet the criteria for admission to a nursing facility	- Adult Day Health Care services - Transition Services - Support Coordination - Transition Intensive Support Coordination	This is a home and community-based alternative to nursing facility placement.	**Louisiana Options in Long Term Care (Conduent)** 1-877-456-1146 **Office of Aging and Adult Services (OAAS)** 1-866-758-5035 Participants should call 1-866-758-5035 or 225-219-0643

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MEDICAID SERVICES

SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
Children's Choice (CC)		Child must be on the DD Request for Services Registry, less than 21 years old, disabled according to SSI criteria, require ICF/DD level of care, have income less than 3 times SSI amount, resources less than $2,000 and meet all Medicaid non-financial requirements.	- Center Based Respite - Environmental Accessibility - Adaptation - Specialized Medical Equipment and Supplies - Family Training - Professional Services: Aquatic Therapy, Art Therapy, Music Therapy, Sensory Integration, Hippotherapy/Therapeutic Horseback Riding - Housing Stabilization/ Housing Stabilization Transition -Crisis and Non-Crisis Provisions	There is a $20,200 limit per individual plan year. ($1500 for Case Management balance for other services). Call the Office for Citizens with Developmental Disabilities or local Districts/Authorities for status on the Request for Services Registry.	**Office for Citizens with Developmental Disabilities Districts (OCDD) / Authorities / Local Regional Offices (SYSTEM ENTRY)** http://ldh.la.gov/index.cfm/page/134/n/137 **Tracy Joshua-Guy** 225-342-0943 Complaints Line: 1-800-660-0488
Community Choices Waiver (CCW)		Individuals 65 years of age or older, who meet Medicaid financial eligibility and meet the criteria for admission to a nursing facility; or age 21-64 who are disabled according to Medicaid standards or SSI disability criteria, meet Medicaid financial eligibility, and meet the criteria for admission to a nursing facility	- Support Coordination - Environmental Accessibility Adaptation - Transition Intensive Support Coordination - Transition Service - Personal Assistance Services - Adult Day health Care Services - Assistive Devices and Medical - Supplies - Skilled Maintenance Therapy Services - Nursing Services - Home Delivered Meal Services - Caregiver Temporary Support Services	This is a home and community-based alternative to nursing facility placement.	**Louisiana Options in Long Term Care (Conduent)** 1-877-456-1146 **Office of Aging and Adult Services (OAAS)** 1-866-758-5035 Participants should call 1-866-758-5035 or 225-219-0643

Exclusion from this list does not necessarily mean that a service is not covered. Please call one of the appropriate contacts for questions regarding coverage of services not listed on this chart. **NOTE:** The points of contact listed in this document is applicable to Medicaid recipients in the fee-for-service Medicaid program. Healthy Louisiana Plan members should contact their Plan's member services department with questions about how to access care.

MEDICAID SERVICES

SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
New Opportunities Waiver (NOW)		Individuals three (3) years of age or older, who have a developmental disability which manifested prior to the age of 22, and who meet both SSI Disability criteria and the level of care determination for an ICF/DD.	- Individual Family Support, Day and Night - Shared Supports - Center Based Respite Care - Community Integration Development - Environmental Accessibility Adaptations, Specialized Medical Equipment and Supplies - Substitute Family Care Services - Supported Living - Day Habilitation - Supported Employment - Prevocational Services - Professional Services - One Time Transitional Expense - Skilled Nursing - Housing Stabilization/Housing Stabilization Transition - Personal Emergency Response System, Adult Companion Care.	Call the Office for Citizens with Developmental Disabilities or local Districts/Authorities for status on the Request for Services Registry.	**Office for Citizens with Developmental Disabilities Districts (OCDD) / Authorities / Local Regional Offices (SYSTEM ENTRY)** http://ldh.la.gov/index.cfm/page/134/n/137 **Ed Harris** 225-342-8537 Complaints Line: 1-800-660-0488

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MEDICAID SERVICES					
SERVICE	**HOW TO ACCESS SERVICES**	**ELIGIBILITY**	**COVERED SERVICES**	**COMMENTS**	**CONTACT PERSON**
Residential Options Waiver (ROW)		Individuals, birth to end of life, who have a developmental disability which manifested prior to the age of 22. Must meet the Louisiana definition of DD.	- Support Coordination - Community Living Supports - Host Home Services - Companion Care Services - Shared Living - Respite Care-Out of Home - Personal Emergency Response System - One Time Transition Services - Environmental Accessibility Adaptations - Assistive Technology/Specialized Medical Equipment and Supplies - Transportation – Community Access - Professional Services - Nursing Services - Dental Services - Supported Employment - Prevocational Services - Day Habilitation and Housing Stabilization/Housing Stabilization Transition - Adult Day Health Care - Monitored In Home Caregiving		**Office for Citizens with Developmental Disabilities Districts (OCDD) / Authorities / Local Regional Offices (SYSTEM ENTRY)** http://ldh.la.gov/index.cfm/page/134/n/137 **Office for Citizens with Developmental Disabilities (OCDD), Waiver Supports and Services** 1-866-783-5553 **Denise Boyd** 225-342-0095 Complaints Line: 1-800-660-0488

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MEDICAID SERVICES					
SERVICE	**HOW TO ACCESS SERVICES**	**ELIGIBILITY**	**COVERED SERVICES**	**COMMENTS**	**CONTACT PERSON**
Supports Waiver (SW)		Individuals age 18 and older who have been diagnosed with a Developmental Disability which manifested prior to age 22. Must meet the Louisiana definition of DD.	- Support Coordination - Supported Employment - Day Habilitation - Pre-Vocational Habilitation - Respite - Personal Emergency Response System - Housing Stabilization Transition - Housing Transition - Habilitation		**Office for Citizens with Developmental Disabilities Districts (OCDD) / Authorities / Local Regional Offices (SYSTEM ENTRY)** *http://ldh.la.gov/index.cfm/page/134/n/137* **Rosemary Morales** 225/342-0095 Complaints Line: 1-800-660-0488

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NEW OPPORTUNITIES WAIVER FACT SHEET

What is the New Opportunities Waiver?

The New Opportunities Waiver (NOW) program provides services in the home and in the community to individuals 3 years of age or older who are eligible to receive OCDD waiver services.

The NOW is intended to provide specific activity-focused services rather than continuous custodial care.

Who can qualify?

Individuals who:

- Meet Louisiana Medicaid eligibility **AND**
- Meet the Louisiana definition for developmental disability which manifested prior to age 22 (Revised Statute 28:451.2, Paragraph (11)) **AND**
- Have an OCDD Statement of Approval **AND**
- Meet Intermediate Care Facility-Intellectual Disability (ICF-ID) Level of Care Criteria **AND**
- Are 3 years of age or older **AND**
- Whose needs cannot be met in another OCDD waiver

If I qualify, what services may I receive?

- Individual and Family Support (IFS) for Day, Night, Shared
- Center-Based Respite
- Community Life Engagement Development
- Environmental Accessibility Adaptations
- Specialized Medical Equipment
- Supported Independent Living
- Substitute Family Care
- Day Habilitation/Community Life Engagement and Transportation
- Remote Supports
- Supported Employment (individual or group) and Transportation
- Prevocational/Community Career Planning and Transportation
- Personal Emergency Response System (PERS)
- Skilled Nursing
- One time transitional services
- Housing Stabilization Transition
- Housing Stabilization
- Monitored In Home Care Giving (MIHC)
- Adult Companion Care
- Professional Services
- Expanded Dental Services for Adult Waiver Beneficiaries

Individuals will receive Support Coordination services via state plan.

Individuals who receive the NOW may NOT receive LT-PCS services.

How can I request an OCDD waiver?

Individuals who have a need for services should contact their Local Governing Entity (LGE) in order to go through the eligibility determination process. Once a person is eligible for OCDD services, they may ask to be placed on the Developmental Disability Request for Services Registry (RFSR).

Home and community-based waiver opportunities are provided based on the individual's prioritized need for support, which is identified in their RFSR Screening for Urgency of Need. Individuals with the emergent and urgent need for support will have priority.

For more information on this process, please contact your Local Governing Entity (LGE).

Additional resources and contact information for the New Opportunities Waiver

New Opportunities Waiver Website: https://ldh.la.gov/index.cfm/page/283

OCDD Resources Website: https://ldh.la.gov/index.cfm/page/138

Local Governing Entity (LGE) map: http://ldh.la.gov/index.cfm/page/134

OCDD State Office: 1-866-783-5553 or email at OCDD-hcbs@la.gov

Individuals who are 0-21 years of age may access Early Periodic Screening and Diagnostic Treatment (EPSDT) services: https://ldh.la.gov/index.cfm/page/334

My Place Louisiana: https://ldh.la.gov/index.cfm/page/147

OCDD Employment First Initiative: https://ldh.la.gov/index.cfm/page/1847

Reissued March 15, 2023
Replaces February 1, 2023 issuance

LOUISIANA DEPARTMENT OF HEALTH
Office for Citizens with Developmental Disabilities

CHILDREN'S CHOICE WAIVER FACT SHEET

What is the Children's Choice Waiver?

The Children's Choice Waiver (CC) program provides services in the home and in the community to individuals 0 through 20 years of age, who currently live at home with their families or who will leave an institution to return home. This waiver provides an individualized support package with a maximum cost of $20,650 per year, and is designed for maximum flexibility.

Youth who reach the age of 18 and want to work may choose to transition to a Supports Waiver as long as they remain eligible for waiver services. Please see link below for more information regarding the Supports Waiver.

Youth who continue in the Children's Choice Waiver beyond age 18 will age out of Children's Choice Waiver when they reach their 21st birthday. They will transition to the most appropriate waiver that meets their needs as long as they remain eligible for waiver services.

This program is not intended to provide 24 hours a day support

Youth age 0 to 3 individuals must meet the My Place eligibility requirements.
Youth age 3 to 20 individuals must have an Office for Citizens with Developmental Disabilities Statement of Approval

Who can qualify?

Individuals who:

- Meet Louisiana Medicaid eligibility **AND**
- Meet the Louisiana definition for developmental disability which manifested prior to age 22 (Revised Statute 28:451.2, Paragraph (11)) **AND**
- Have an OCDD Statement of Approval **AND**
- Meet My Place eligibility if age 0-3 **AND**
- Meet Intermediate Care Facility-Intellectual Disability (ICF-ID) Level of Care Criteria **AND** are 0 through 20 years of age

If I qualify, what services may I receive?

- Support Coordination
- Family Support
- Crisis Support
- Center-Based Respite
- Family Training
- Environmental Accessibility Adaptions
- Specialized Medical Equipment
- Permanent Supportive Housing Stabilization and Transition
- Therapy Services
  - Aquatic Therapy
  - Art Therapy
  - Music Therapy
  - Hippo-Therapy/Therapeutic Horseback Riding
  - Sensory Integration

Individuals who receive the CC Waiver may also receive EPSDT personal care services.

How can I request an OCDD waiver?

Individuals who have a need for services should contact their Local Governing Entity (LGE) in order to go through the eligibility determination process. Once a person is eligible for OCDD services, they may ask to be placed on the Developmental Disability Request for Services Registry (RFSR).

Home and community-based waiver opportunities are provided based on the individual's prioritized need for support, which is identified in their RFSR Screening for Urgency of Need. Individuals with the emergent and urgent need for support will have priority.

For more information on this process, please contact your Local Governing Entity (LGE).

Additional resources and contact information for the Children's Choice Waiver

Children's Choice Waiver Website: https://ldh.la.gov/page/218

OCDD Resources Website: https://ldh.la.gov/index.cfm/page/138

Local Governing Entity (LGE) map: http://ldh.la.gov/index.cfm/page/134

OCDD State Office: 1-866-783-5553 or email at OCDD-hcbs@la.gov

Individuals who under 21 years of age may access Early Periodic Screening and Diagnostic Treatment (EPSDT) services: https://ldh.la.gov/index.cfm/page/334

My Place Louisiana: https://ldh.la.gov/index.cfm/page/147

Permanent Supportive Housing Services: https://ldh.la.gov/index.cfm/page/1732

OCDD Employment First Initiative: https://ldh.la.gov/index.cfm/page/1847

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LOUISIANA DEPARTMENT OF HEALTH
Office for Citizens with Developmental Disabilities

SUPPORTS WAIVER FACT SHEET

What is the Supports Waiver?

The Supports Waiver (SW) program provides services in the home and in the community to individuals **18 years of age or older**, who are eligible to receive OCDD waiver services.

This program is not intended to provide 24 hours a day support.

Individuals who are 18-21 years of age may access Early Periodic Screening and Diagnostic Treatment (EPSDT) services
Individuals 21 years of age or older who receive the SW may also receive Long Term-Personal Care Services. (LT-PCS)

Who can qualify?

Individuals who:

- Meet Louisiana Medicaid eligibility **AND**
- Meet the Louisiana definition for developmental disability which manifested prior to age 22 (Revised Statute 28:451.2, Paragraph (11)) **AND**
- Have an OCDD Statement of Approval **AND**
- Meet Intermediate Care Facility-Intellectual Disability (ICF-ID) Level of Care Criteria **AND**

Individuals should contact their Local Governing Entity (LGE) in order to go through the eligibility determination process.

If I qualify, what services may I receive?

- Support Coordination
- Supported Employment (individual or group) and transportation
- Day Habilitation/Community Life Engagement and Transportation
- Prevocational/Community Career Planning and transportation
- Habilitation
- Respite (center-based or in home)
- Permanent Supportive Housing Stabilization and Transition
- Personal Emergency Response System (PERS)
- Expanded Dental Services for Adult Waiver Beneficiaries
- Community Life Engagement Development

For more information on each service, please refer to the Supports Waiver website.

How can I request an OCDD waiver?

Individuals who have a need for services should contact their Local Governing Entity (LGE) in order to go through the eligibility determination process. Once a person is eligible for OCDD waiver services, they may ask to be placed on the Developmental Disability Request for Services Registry (RFSR).

Home and community-based waiver opportunities are provided based on the individual's prioritized need for support, which is identified in their Request for Services Registry Screening for Urgency of Need. Individuals with the most emergent and urgent need for support will have priority.

For more information on this process, please contact your LGE.

Additional resources and contact information for the Supports Waiver

Supports Waiver Website: https://ldh.la.gov/index.cfm/page/1828

OCDD Resources Website: https://ldh.la.gov/index.cfm/page/138

Local Governing Entity (LGE) map: http://ldh.la.gov/index.cfm/page/134

OCDD State Office: 1-866-783-5553 or email at OCDD-hcbs@la.gov

Early Periodic Screening and Diagnostic Treatment (EPSDT) services: https://ldh.la.gov/index.cfm/page/334

Long Term-Personal Care Services (LT-PCS): https://ldh.la.gov/assets/docs/OAAS/publications/FactSheets/LT-PCS_Fact_Sheet.pdf

Permanent Supportive Housing Services: https://ldh.la.gov/index.cfm/page/1732

OCDD Employment First Initiative: https://ldh.la.gov/index.cfm/page/1847

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RESIDENTIAL OPTIONS WAIVER FACT SHEET

What is the Residential Options Waiver?

The Residential Options Waiver (ROW) program provides services in the home and in the community to individuals of all ages who are eligible to receive OCDD waiver services. It is a capped waiver where the person's individual annual budget is based upon the person's assessed support needs.

Supports needs are determined by an Inventory for Client and Agency Planning (ICAP) assessment. Beneficiaries may choose to self-direct all or part of his/her Community Living Supports. This program is not intended to provide 24 hours a day one-to-one support.

Who can qualify?

Individuals birth to end of life who:

- Meet Louisiana Medicaid eligibility **AND**
- Have an OCDD Statement of Approval **AND**
- Meet the Louisiana definition for developmental disability which manifested prior to age 22 (Revised Statute 28:451.2, Paragraph (12)) **AND**
- Meet Intermediate Care Facility-Intellectual Disability (ICF-ID) Level of Care Criteria **AND**
- Meet one of four ROW priority group criteria

If I qualify, what services may I receive?

- Support Coordination
- Community Living Supports
- Host Home Services
- Companion Care Services
- Shared Living
- Adult Day Health Care
- Respite Care-Out of Home
- Personal Emergency Response System (PERS)
- One Time Transitional Services
- Environmental Accessibility Adaptations
- Monitored in Home Caregiving (MIHC)
- Assistive Technology/Specialized Medical Equipment and Supplies
- Community Life Engagement Development
- Remote Supports
- Transportation-Community Access
- Professional Services
- Nursing Services
- Supported Employment (individual or group) and Transportation
- Prevocational/Community Career Planning and Transportation
- Day Habilitation/Community Life Engagement and Transportation
- Housing Stabilization Service
- Housing Stabilization Transition
- Expanded Dental Services for Adult Waiver Beneficiaries

Individuals under 21 years of age must access Early Periodic Screening and Diagnostic Treatment (EPSDT) services.

Individuals who receive the ROW may NOT receive Long Term-Personal Care Services (LT-PCS) when in this program.

How can I request an OCDD waiver?

Individuals who have a need for services should contact their Local Governing Entity (LGE) in order to go through the eligibility determination process. Once a person is eligible for OCDD services, they may ask to be placed on the Developmental Disability Request for Services Registry (RFSR).

Home and community-based waiver opportunities are provided based on the individual's prioritized need for support, which is identified in their RFSR Screening for Urgency of Need. Individuals with the emergent and urgent need for support will have priority.

For more information on this process, please contact your local Human Services District/Authority.

Additional resources and contact information for the Residential Options Waiver

Residential Options Waiver Website: https://ldh.la.gov/index.cfm/page/1875

OCDD Resources Website: https://ldh.la.gov/index.cfm/page/138

Local Governing Entity (LGE) map: http://ldh.la.gov/index.cfm/page/134

OCDD State Office: 1-866-783-5553 or email at OCDD-hcbs@la.gov

Early Periodic Screening and Diagnostic Treatment (EPSDT) services:
https://ldh.la.gov/index.cfm/page/334

Long Term-Personal Care Services (LT-PCS):
https://ldh.la.gov/assets/docs/OAAS/publications/FactSheets/LT-PCS_Fact_Sheet.pdf Permanent

Supportive Housing (PSH) Services: https://ldh.la.gov/index.cfm/page/1732

My Place Louisiana: https://ldh.la.gov/index.cfm/page/147

Reissued March 15, 2023
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LOUISIANA DEPARTMENT OF HEALTH
Office for Citizens with Developmental Disabilities

Fee for Service
EPSDT Personal Care Services vs. Home Health Services
(including Extended Skilled Nursing Services also known as Extended Home Health)

EPSDT Personal Care Services (PCS)

- Services include: Basic personal care, including toileting, grooming, bathing, and assistance with dressing. Assistance with eating and food preparation. Performance of incidental household chores for the beneficiary only.
- Does not cover any medical tasks, medication administration, or NG tube feeding.
- Accompanying, NOT TRANSPORTING beneficiaries to medical appointments.
- EPSDT PCS is not to function as a substitute for childcare arrangements or to provide respite care to the primary caregiver.
- Must be prior authorized by BHSF/Gainwell for beneficiaries with Legacy Medicaid and by the Managed Care Organizations (MCO) for beneficiaries with an MCO for their physical health services. Documentation that must accompany PCS request: PA-14, Daily Time Schedule, EPSDT-PCS Form 90, Plan of care approved by the physician, Social Assessment and any supporting documentation.
- Ages: birth through 20
- Services provided by a Medicaid enrolled Personal Care Services provider.

Home Health

Covered Home Health Services Include:

- **Skilled Nursing** (Intermittent or part-time);
- **Home Health Aide Services** are provided in accordance with the POC as recommended by an authorized healthcare provider;
- **Extended Skilled Nursing Services** is nursing care provided to beneficiaries under the age 21 who are considered "medically fragile." This service is administered by a registered nurse (RN) or a licensed practical nurse (LPN) and provided for over 3 hours a day per visit. It is part of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services and may include services such as tube feeding, catheter maintenance and medication administration. Beneficiaries may be eligible for Extended Skilled Nursing Services even if they attend school outside the home.
- **Rehabilitation Services** are physical, occupational and speech therapies, including
  Audiology services that can be provided in the home, an outpatient facility, an Early Intervention Center, a rehabilitation center and at school.

Prior Authorization

- Extended Skilled Nursing Services must be prior authorized unless the visit is less than 3 hours per day.
- A prescription is needed from the authorizing healthcare provider stating the number of hours requested and a letter of medical necessity justifying the reason for Extended Skilled Nursing Services.
- All rehabilitation services must be prior authorized.

Early and Periodic Screening, Diagnostic and Treatment Personal Care Services

1. Personal care services are defined as tasks that are medically necessary when physical or cognitive limitations due to illness or injury necessitate assistance with eating, toileting, bathing, bed mobility, transferring, dressing, locomotion, personal hygiene, and bladder or bowel requirements.

Beneficiary Qualifications

Conditions for Provision of EPSDT Personal Care Services

1. The person must be an eligible Medicaid beneficiary birth through 20 years of age (EPSDT eligible) and have been prescribed medically necessary, age appropriate EPSDT-PCS by a practitioner (physician, advance practice nurse, or physician assistant). The practitioner shall specify the health/medical condition which necessitates EPSDT – Personal Care Services.
2. EPSDT personal care services **must be prescribed by the beneficiary's attending practitioner initially and every 180 days thereafter (or rolling six months), and when changes in the Plan of Care occur.** The practitioner should only sign a fully completed plan of care which shall be acceptable for submission to BHSF only after the physician signs and dates the form. The physician's signature must be an original signature and not a rubber stamp.

Place of Service

EPSDT – PCS shall be provided **in the beneficiary's home**, or if medically necessary, in another location outside of the beneficiary's home. The beneficiary's own home includes the following: an apartment, a custodial relative's home, a boarding home, a foster home, or a supervised living facility.

Services

EPSDT – Personal Care Services include the following tasks:

- Basic personal care, including toileting, grooming, bathing, and assistance with dressing.
- Assistance with bladder and/or bowel requirements or problems, including helping the beneficiary to and from the bathroom or assisting the beneficiary with bedpan routines, but excluding catheterization.
- Assistance with eating and food, nutrition, and diet activities, including preparation of meals for the beneficiary only.
- Performance of incidental household services, only for the beneficiary, not the entire household, which are essential to the beneficiary's health and comfort in his/her home. This does not include routine household chores such as regular laundry, ironing, mopping, dusting, etc., but instead arises as the result of providing assistance with personal care to the beneficiary.
- Examples of such activities are:
- Changing and washing the beneficiary's soiled bed linens.
- Rearranging furniture to enable the beneficiary to move about more easily in his/her own home.
- Cleaning the beneficiary's eating area after completion of the meal and/or cleaning items used in preparing the meal, for the beneficiary only.
- Accompanying, not transporting, the beneficiary to and from his/her physician and/or medical appointments for necessary medical services.
- Assisting the beneficiary with locomotion in their place of service, while in bed or from one surface to another. Assisting the beneficiary with transferring and bed mobility.

Intent of Services:

- EPSDT PCS shall not be provided to meet childcare needs nor as a substitute for the parent or guardian in the absence of the parent or guardian.

- EPSDT PCS shall not be used to provide respite care for the primary caregiver.
- EPSDT PCS provided in an educational setting shall not be reimbursed if these services duplicate services that are provided by or shall be provided by the Department of Education.

Provider Qualifications

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

To further clarify, the following **persons are prohibited** from serving as the direct service worker for the beneficiary:

- **Father;**
- **Mother;**
- **Sister/brother;**
- **In-law;**
- **Grandparent;**
- **Any individual acting as a parent or guardian of the beneficiary including:**
  - **Curator;**
  - **Tutor;**
  - **Legal guardian;**
  - **Beneficiary's responsible representative;**
  - **or Person to whom the recipient has given Representative and Mandate authority (Power of Attorney).**

Services Available to Medicaid Eligible Children Under 21

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

- Doctor's Visits
- Hospital (inpatient and outpatient) Services
- Lab and X-ray Tests
- Family Planning
- Home Health Care
- Dental Care
- Rehabilitation Services
- Prescription Drugs
- Medical Equipment, Appliances and Supplies (DME)
- Support Coordination
- Speech and Language Evaluations and Therapies
- Occupational Therapy
- Physical Therapy
- Psychological Evaluations and Therapies
- Psychological and Behavioral Health Services
- Podiatry Services
- Optometrist Services
- Hospice Services
- Extended Skilled Nurse Services
- Residential Institutional Care or Home and Community Based (Waiver) Services
- Medical, Dental, Vision and Hearing Screenings, both Periodic and Interperiodic
- Immunizations
- Eyeglasses
- Hearing Aids
- Psychiatric Hospital Care
- Personal Care Services
- Audiological Services
- Necessary Transportation: Ambulance Transportation, Non-ambulance Transportation
- Appointment Scheduling Assistance
- Substance Use Clinic Services
- Chiropractic Services
- Prenatal Care
- Certified Nurse Midwives
- Certified Nurse Practitioners
- Mental Health Rehabilitation
- Mental Health Clinic Services
- Applied Behavioral Analysis (ABA)

and 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.

Medicaid beneficiaries ages 3-20 who are on the Developmental Disabilities Request for Services Registry (DD RFSR) are Chisholm class members. They may choose whether or not they want to get these Medicaid services through regular Medicaid ("Legacy Medicaid") or a managed care plan ("Healthy Louisiana").

If you need a service that is not listed above, call the Medicaid Specialty Care Help Desk at (toll-free) 1-877-455-9955. If they cannot refer you to a provider of the service you need, call 225-342-5774.

Children enrolled in a managed care plan can access the listed services through their individual Health Plan:

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

Chisholm class members are allowed to participate in managed care plans. For beneficiaries under Aetna Better Health, AmeriHealth Caritas, Healthy Blue, Humana Healthy Horizons, Louisiana Healthcare Connections and UnitedHealthcare Community consult the Health Plan to find out how to obtain services other than dental.

If you are a Medicaid beneficiary, under age 21, and are on the Developmental Disabilities Request for Services Registry (DD RFSR), you may be eligible for support coordination services immediately by calling Statistical Resources, Inc. (SRI) toll-free at 1-800-364-7828. To get on the registry (DD RFSR), call the Office for Citizens with Developmental Disabilities District/Authority/Local Regional Office. If the child is no longer eligible to remain on the registry, the family can appeal the notice that is sent out. LDH will evaluate the recipient's eligibility to receive "special needs" case management.

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

Whenever health treatment or additional services are needed, you may obtain an appointment for a screening visit by contacting your primary healthcare provider. Such screening visits also can be recommended by any health, developmental, or educational professional.

To schedule a screening visit, call (toll-free) 1-800-259-4444 (or 928-9683, if you live in the Baton Rouge area). If you have a communication disability or are non-English speaking, you may have someone else call and the appropriate assistance can be provided.

OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES
Local Governing Entity (LGE) Directory

Region 1: Metropolitan Human Services District
Parishes Served: Orleans, Plaquemines, St. Bernard
Executive Director – Dr. Rochelle Dunham
DD Division Director – Carlos Amos
719 Elysian Fields Ave., New Orleans, LA 70117
Phone: (504) 568-3130 Fax: (504) 568-4660
Toll Free: 1-800-889-2975

Region 2: Capital Area Human Services District
Parishes Served: Ascension, East Baton Rouge, East Feliciana, Iberville, Pointe Coupe, West Baton Rouge, West Feliciana
Executive Director – Dr. Janzlean Laughinghouse
DD Division Director – Vacant
7389 Florida Blvd, Ste. 100-C/P.O. Box 66558 Baton Rouge, LA 70806-5817
Phone: (225) 925-1927 Fax: (225) 925-1966
Toll Free: 1-866-628-2133

Region 3: South Central La. Human Services Authority
Parishes Served: Assumption, Lafourche, St. Charles, St. James, St. John, St. Mary, Terrebonne
Executive Director – Kristin Bonner
DD Division Director – Kensie Lasseigne
5593 Highway 311, Houma, LA 70360
Phone: (985) 876-8805 Fax: (985) 876-8905
Toll Free: 1-800-861-0241

Region 4: Acadiana Area Human Services District
Parishes Served: Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin, Vermillion
Executive Director – Brad Farmer
DD Division Director – Troy Abshire
302 Dulles Drive, Lafayette, LA 70506
Phone: (337) 262-5610 Fax: (337) 262-5233
Toll Free: 1-800-648-1484

Region 5: Imperial Calcasieu Human Services Authority
Parishes Served: Allen, Beauregard, Calcasieu, Cameron, Jefferson Davis
Executive Director – Tanya McGee
DD Division Director – James Lewis
3461 5th Avenue, Ste. B., Lake Charles, LA 70607
Phone: (337) 475-3100 Fax: (337) 475-8055
Toll Free: 1-866-698-5304

Region 6: Central Louisiana Human Services District
Parishes Served: Avoyelles, Catahoula, Concordia, Grant, LaSalle, Rapides, Vernon, Winn
Executive Director – Rebecca I. Craig
DD Division Director – Misty Dezendorf
5411 Coliseum Blvd. Alexandria, LA 71303
Phone: (318) 484-2347 Fax: (318) 484-2458
Toll Free: 1-800-640-7494

Region 7: Northwest LA Human Services District
Parishes Served: Bienville, Bossier, Caddo, Claiborne, DeSoto, Natchitoches, Red River, Sabine, Webster
Executive Director – Doug Efferson
DD Division Director – Sharon Doyle
3018 Old Minden Rd., Suite 1211, Bossier, LA 71112
Phone: (318) 741-7455 Fax: (318)741-7445
Toll Free: 1-800-862-1409

Region 8: Northeast Delta Human Services Authority
Parishes Served: Caldwell, East Carroll, Franklin, Jackson, Lincoln, Madison, Morehouse, Ouachita, Richland, Tensas, Union, West Carroll
Executive Director – Dr. Monteic A. Sizer
DD Division Director – Jennifer Purvis
2324 Armand Connector, Monroe, LA 71201
Phone: (318) 362-5188 or (318) 362-3396
Fax: (318) 362-5215 Toll Free: 1-800-637-3113

Region 9: Florida Parishes Human Services Authority
Parishes Served: Livingston, St. Helena, St. Tammany, Washington, Tangipahoa
Executive Director – Richard Kramer
DD Division Director – Janise Monetta
835 Pride Drive, Suite B, Hammond, LA 70401
Phone: (985) 543-4730 Fax: (985) 543-4752
Toll Free: 1-800-866-0806

Region 10: Jefferson Parish Human Services Authority
Parishes Served: Jefferson
Executive Director – Dr. Rosanna DiChiro
DD Division Director – Nicole Green
1500 River Oaks Rd., West, Ste. 200, Jefferson, LA 70123
Phone: (504) 838-5424 Fax: (504) 838-5400

OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES
Local Governing Entity (LGE) EPSDT Specialists

Region 1: Metropolitan Human Services District
Capacine Turner
719 Elysian Fields Ave.
New Orleans, LA 70117
Phone: (504) 568-3130
FAX: (504) 568-4660
Toll Free: 1-800-889-2975

Region 2: Capital Area Human Services District
Alena Bradford
7389 Florida Blvd. Ste. 100-C
Baton Rouge, LA 70806
Phone: (225) 925-1910
FAX: (225) 925-1966
Toll Free: 1-866-628-2133

Region 3: South Central La. Human Services Authority
Danielle Clement
5593 Hwy 311
Houma, LA 70360
Phone: (985) 876-8805
FAX: (985) 876-8905
Toll Free: 1-800-861-0241

Region 4: Acadiana Area Human Services District
Nicole Chapman & Troy Abshire
302 Dulles Dr.
Lafayette, LA 70506
Phone (337) 262-5610
FAX: (337) 262-5233
Toll Free: 1-800-648-1484

Region 5: Imperial Calcasieu Human Services Authority
Doanie Perry
4165 Kirkman St.
Lake Charles, LA 70607
Phone: (337) 475-3100
FAX: (337) 475-8055

Region 6: Central Louisiana Human Services District
Lisa Fontenot
5411 Coliseum Blvd.
Alexandria, LA 71303
Phone: (318) 484-2347
FAX: (318) 484-2458
Toll Free: 1-800-640-7494

Region 7: Northwest LA Human Services District
Nancy Howard
3018 Old Minden Road – Suite 1211
Bossier City, LA 71112
Phone: (318) 741-7455
FAX: (318) 741-7445
Toll Free: 1-800-862-1409

Region 8: Northeast Delta Human Services Authority
Brittany Galloway
2324 Armand Connector
Monroe, LA 71201
Phone: (318) 362-5188 or 362-3396
FAX: (318) 362-5215
Toll Free: 1-800-637-3113

Region 9: Florida Parishes Human Services Authority
Karey Hill & Dawn Riley
835 Pride Drive, Suite B
Hammond, LA 70401
Phone: (985) 543-4370
FAX: (985) 543-4752
Toll Free: 1-800-866-0806

Region 10: Jefferson Parish Human Services Authority
Ciara Ricks
1500 River Oaks Rd. West, Suite 200
Jefferson, LA 70123
Phone (504) 838-5424
FAX: (504) 838-5400

Local Governing Entity (LGE) Community Behavioral Health Services

Metropolitan Human Services District

3100 Gen de Gaulle Dr., New Orleans, LA 70114 | PH: 504.568.3130

Algiers Behavioral Health Center (Adult and Children's Services)
3100 General De Gaulle Avenue, New Orleans, LA 70114 I PH: 504.568.3130

Central City Behavioral Health Center and Access Center
2221 Phillip Street, New Orleans, LA 70113 I PH: 504.568.3130

Chartres-Pontchartrain Behavioral Health Center (Children's and Developmental Disability Services)
719 Elysian Fields Avenue, New Orleans, LA 70117 I PH: 504.568.3130

New Orleans East Behavioral Health Center (Adult and Children's Services)
5630 Read Boulevard, Second Floor, New Orleans, LA 70127 I PH: 504.568.3130

St. Bernard Behavioral Health Center (Adult and Children's Services)
6624 St. Claude Avenue, Arabi, LA 70032 I PH: 504.568.3130

Plaquemines Community C.A.R.E. Center (MHSD Contractor)
115 Keating Drive, Belle Chasse, LA 70337 I PH: 504.568.3130

Capital Area Human Services District

7389 Florida Blvd. Ste. 100-A, Baton Rouge, LA 70806 | PH: 225.922.2700

Children's Behavioral Health (Children & Youth)
422 Colonial Dr., Baton Rouge, LA 70806 I PH: (225) 922-0445 / Toll free 1-800-768-8824

School Based Behavioral Health (Children & Youth) Located in selected schools in Ascension, East & West Baton Rouge, East & West Feliciana, Iberville, and Pointe Coupee I PH: (225) 922-0478 / Toll free 1-800-768-8824

Ascension Behavioral Health & Donaldsonville clinic (Children & Youth and Adults) 1056 E. Worthey St., Suite B, Gonzales LA 70737 I PH: (225) 621-5770 / Toll free 1-800-768-8824

Baton Rouge Behavioral Health & Addiction Recovery Services with Iberville & West Baton Rouge outreach (Adults) 2751 Wooddale Blvd., Suite A, Baton Rouge LA 70805 I PH: (225) 925-1906 / Toll free 1-800-768-8824

North Baton Rouge Behavioral Health with Pointe Coupee & West Feliciana outreach (Adults) 7855 Howell Blvd., Suite 200, Baton Rouge LA 70807 I PH: (225) 359-9315 / Toll free 1-800-768-8824

Capital Area Recovery Program (Social detox & short-term residential addiction treatment services for men, women are referred to contract beds at other facilities) 2455 Wooddale Blvd., Baton Rouge LA 70805 I PH: (225) 922-3169 / Toll free 1-800-768-8824

South Central Louisiana Human Services Authority

521 Legion Avenue, Houma, LA 70364 | PH: 985. 858.2931

Lafourche Behavioral Health Center
157 Twin Oaks Drive, Raceland, LA 70394 I PH:(985) 537-6823 or 1-800-840-7758

River Parishes Behavioral Health Center
1809 West Airline Highway, LaPlace, LA 70068-3336I PH:(985)652-8444

River Parishes Assessment Center
232 Belle Terre Blvd., LaPlace, LA 70068-3336I PH: (985) 651-7064 or 800-256-5508

St. Mary Behavioral Health Center
500 Roderick Street, Suite B, Morgan City, LA 70380I PH:(985) 380-2460,
1-800-481-6882

Terrebonne Behavioral Health Center
5599 HWY 311, Houma, LA 70360 I PH :(985) 857-3615

Acadiana Area Human Services District

302 Dulles Drive, Lafayette, LA 70506-3008 | PH: 337.262-4190

Crowley Behavioral Health Clinic
1822 West 2nd Street, Crowley, LA 70526 I PH:337-788-7511

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

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

Tyler Behavioral Health Clinic
302 Dulles Drive, Lafayette, LA 70506 I PH:337-262-4100

Ville Platte Behavioral Health Clinic
312 Court Street, Ville Platte, LA 70586 I PH:337-363-5525

Imperial Calcasieu Human Services Authority

4105 Kirkman Street, Lake Charles, LA 70607 | PH: 337-475-3100

Allen Behavioral Health Clinic
402 Industrial Dr, Oberlin, La 70655 I PH: 337-639-3001

Beauregard Behavioral Health Clinic
106 W. Port, DeRidder, La 70634 I PH: 337-462-1641

Lake Charles Behavioral Health Clinic and Children & Youth Outreach Center
4105 Kirkman Street, Lake Charles, La 70607 I PH: 337-475-8022

Jefferson Davis Behavioral Health Clinic
437 N Market St., Jennings, LA 70546 I PH: 337-246-7325

Sulphur Behavioral Health Clinic
2651 E. Napoleon St. I Sulphur, LA 70663 I PH: 337-625-6750

Central Louisiana Human Services District

401 Rainbow Drive, #35, Pineville, LA 71360 | PH: 318.487.5191

Caring Choices – Pineville
5411 Coliseum Blvd, Alexandria, LA 71303 I PH: 318-484-6850

Caring Choices – Marksville
694 Government Street, Marksville, La 71351 I PH: 318-253-9638

Caring Choices – Jonesville
200 Third Street, Jonesville, La 71343 I PH: 318-339-8553

Caring Choices – Leesville
102 Belview Road, Leesville, La 71446 I PH: 337-238-6431

Northwest Louisiana Human Services District

1310 North Hearne Avenue, Shreveport, LA 71107 | PH: 318.676.5111

Many Behavioral Health Clinic
265 Highland Drive, Many LA 71449 | PH: (318) 256-4206

Minden Behavioral Health Clinic
502 Nella Street, Minden, LA 71055 | PH: (318) 371-3001

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

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

Northeast Delta Human Services Authority

Administrative Office- 2513 Ferrand Street, Monroe, LA 71201 | PH: 318.362.3020

Bastrop Behavioral Health Clinic (Addiction and Mental Health Clinic)
451 E. Madison Avenue, Bastrop, LA 71220 | PH: (318)-283-0868

Children & Family Services Clinic
2525 Ferrand Street, Monroe, LA 71201 | PH: (318) 362-3153

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

Monroe Behavioral Clinic (Addiction and Mental Health Clinic)
4800 South Grand Street, Monroe, LA 71202 | PH: (318) 362-3339

Ruston Behavioral Health Clinic (Addiction and Mental Health Clinic)
901 White Street, Ruston, LA 71270 | PH: (318) 251-4125

Tallulah Behavioral Health Clinic (Mental Health Clinic)
1012 Johnson Street, Tallulah, LA 71282 | PH: (318) 574-1713

Winnsboro Behavioral Health Clinic (Mental Health Clinic)
1301 Landis Street, Winnsboro, LA 71295 | PH: (318) 435-2146 or (318)-649-2333

Florida Parishes Human Services Authority (FPHSA)

835 Pride Drive, Suite B, Hammond, LA 70401 | PH: 985.543.4333

Rosenblum Behavioral Health Clinic
835 Pride Drive, Ste. B, Hammond, LA 70401 I PH (985) 543-4730

Bogalusa Behavioral Health Clinic
400 Georgia Ave., Bogalusa, LA 70427 I PH (985) 732-6610

Slidell Behavioral Health Clinic
2331 Carey Street, Slidell, LA 70458 I PH: (985) 646-6406

Mandeville Behavioral Health Clinic

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

FPHSA Denham Springs Behavioral Health
1951 Florida Boulevard SW, Denham Springs, LA 70726 | PH: 225-665-0473

Jefferson Parish Human Services Authority

3616 South I-10 Service Road West, Suite 200, Metairie, LA 70001 | PH: 504.838.5215

JeffCare East Jefferson, Federally Qualified Health Center (FQHC)
3616 South I-10 Service Road West, Suite 100, Metairie, LA 70001 | PH: 504.838-5257

JeffCare West Jefferson, Federally Qualified Health Center (FQHC)
5001 West Bank Expressway, Suite 100, Marrero, LA 70072 | PH: 504.349.8833

Find regional behavioral health treatment services and link to additional information at:
http://new.dhh.louisiana.gov/index.cfm/directory/category/100

Past
- Pre-natal Health
- Nature and cause of disability or state unknown
- Age of diagnosis and made by whom or state unknown
- Any early intervention
- Past medical history, surgeries, hospitalizations
- Any placement history outside of current placement
- Why is EPSDT SC being requested? If no services to coordinate is family aware SC is optional and declining will not affect their eligibility to receive Medicaid services or their placement on the Waiver registry?

Present
- Names and ages of all household members
- Primary caregiver and natural supports
- Address mom and dad and if they provide any natural or financial support
- Is the home owned or rented?
- Does the home environment meet their needs?
- Access to transportation and community
- Source of household income

Medical Diagnoses
- List all diagnoses and what documentation you have for each
- If any diagnosis is "parent states" address what you're doing to obtain documentation or if no documentation exists
- List all doctor's names and specialties, how often they see them, last visit/next visit
- List all meds and what they are prescribed for
- Address special procedures -trach, g-tube, etc.
- Vison
- Hearing
- Communication
- Ambulation (fine/gross motor skills, how they ambulate, etc.)
- Toileting needs
- Dietary needs
- Do they need assistance with their ADLs? If so was PCS offered? If PCS is received what ADLs do they need PCS to assist with?
- What therapies do they receive at school and were community therapies offered?

Psych/Behavioral
- Address behaviors at both home and school
- What behaviors do they have / what does it look like?
- Any known triggers?
- How often does it occur? (Don't say rarely, frequently, etc. Be specific)
- What strategies are used to deal with behaviors?
- What behavior services are received or offered?
- Autism or related diagnosis - Was ABA offered? Does family want referral for testing to assess need for ABA? If declined, revisit ABA with family at least annually?

Evaluation/Documentation
- Current formal document that was less than a year old at time of CPOC meeting
- Current IEP if Special Ed
- Current EHH Plan of Care if EHH
- Current PDHC Plan of Care if PDHC
- Current SOA or Redetermination as a service need

Service Needs
- List all requested/received services through Medicaid, school, community, family or OCDD
- List services that require PA tracking like PCS, EHH, PDHC, OT, PT, ST, DME, ABA, etc.
- List services requested from OCDD like Family Flexible Fund, respite, redetermination, family support, etc.
- List services that pertain to mental health like psychiatrist, behavioral meds, counseling, etc.
- List transition as a service need if will be 20.5 this CPOC year or Redetermination if their SOA will expire this CPOC year or is expired

Additional Info
- List chosen providers for each service
- If unclear what a service need is elaborate
- Valid reason for not tracking any service needs and how you will ensure they're received
- If any service needs are marked as "Other – Explain Next Page", document why the service need is on hold
- If any service needs are marked as "Carried Over - Resolved" or "Family Does Not Want" explain why
- If family is checked explain why

Appendix K

Bureau of Health Services Financing
Rights and Responsibilities for Applicants / Participants of EPSDT Targeted Support Coordination

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

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

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

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

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

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

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

Beneficiary Name	
Signature of Beneficiary or Authorized Representative	*Date*
Support Coordinator	*Date*

Can I Appeal a Medicaid Decision?

Yes, you have the right to appeal:

- If all the services you requested were denied
- If part of the services you requested were denied
- If you were offered different services than you requested
- If the service provider did not submit for full amount of services you requested. (In this case, a doctor's note showing the need for the requested services must be included with the appeal.)
- If services are not provided with reasonable promptness

Is There Anything Besides Appealing That I Can Do to Get Services?

The provider that sent in your request for services can request a reconsideration, with additional information. This must be done within 30 days of the denial. You will get a new decision, and if services are denied again, you can appeal then.

How do I appeal?

Complete an appeal request form online at: http://www.adminlaw.state.la.us/HH.htm

or

send a written request for appeal to:
Division of Administrative Law
Health and Hospitals Section
P.O. Box 4189
Baton Rouge, LA 70821-4189
(fax) 225-219-9823

or

call: 225-342-5800 or 225-342-0443
(Telephone appeals are allowed, but are not encouraged)

Use only one method to file your appeal. Do not duplicate the same appeal.

Do I Have to Get Another Doctor's Statement?

To win the appeal, you may need to get your doctor to give a statement with more details about why the services are needed. The doctor's statement should include the number of hours of services needed.

Can my Support Coordinator help with my appeal?

YES! Your Support Coordinator should have received training to assist you with an appeal. He/she can help you gather the necessary information within the allotted time.

What Deadlines Apply?

- The notice of denial will tell you when the appeal must be filed. You must appeal before or by that date.
- Appealing within the 30 day appeal period may keep services you are already receiving from being cut while the appeal is going on.
- You must get a final decision on your appeal within 90 days of the date you file it, unless you request or agree to additional time.

Can Someone Help me with the Appeal?

You can have someone else represent your situation if you choose. That person can be a friend, relative, attorney or other spokesperson. The Disability Rights Louisiana can also help. The Disability Rights Louisiana can be reached at 1-800-960-7705.

*All Legacy Medicaid appeals and MCO appeals after the internal MCO appeal process has been completed.

APPEAL FORM

I want to appeal.

Name of Medicaid Beneficiary appealing: _____.

Social Security Number of Medicaid Beneficiary: _____.

Would you like to request an expedited fair hearing? ☐ Yes ☐ No

If you have an emergency health issue, you can ask for a faster (expedited) fair hearing. If you request an expedited fair hearing, you may be contacted by the Louisiana Department of Health to provide proof of your emergency health.

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

_____

_____

_____

_____

_____ _____

Signature of Beneficiary **Date**

Submit form to:

Division of Administrative Law
Health and Hospitals Section
P. O. Box 4189
Baton Rouge, LA 70821-4189
Fax: (225) 219-9823
Online: http://laserfiche.adminlaw.state.la.us/Forms/hSgLX

Louisiana Division of Administrative Law Contact Info

Physical Address:
1020 Florida Street
Baton Rouge, LA 70802

Phone: 225-342-1800
Fax: 225-342-1812
E-mail: dhaddad@adminlaw.la.gov
Website: www.adminlaw.la.gov

Disability Rights Louisiana Contact Info

Main Office:
8325 Oak Street
New Orleans, LA 70118

Phone: 800-960-7705
E-mail: info@disabilityrightsla.org
Website: www.disabilityrightsla.org

John Bel Edwards
GOVERNOR

Stephen R. Russo, JD
SECRETARY

State of Louisiana

Louisiana Department of Health
Health Standards Section

Complaint Information Form

PROCEDURES FOR FILING A COMPLAINT AGAINST A FACILITY LICENSED BY THE LOUISIANA DEPARTMENT OF HEALTH/HEALTH STANDARDS SECTION:

Please complete the complaint form in its entirety. Please provide the details of your complaint (i.e. exactly what happened). If the complaint involved an incident with a staff member or department of the facility/agency, please be sure to indicate the name of the staff person involved and their title (i.e. R.N., LPN, aide, etc.), date that it occurred, and the name of the particular department that was involved (i.e. radiology, surgery, kitchen, dining room, etc.).

All complaint forms that are received by Health Standards Section are reviewed and a determination made as to the course of action. The Department's jurisdiction is contained in R.S. 40:2009.14, "the Department must review the report and determine whether there are reasonable grounds for an investigation. No report shall be investigated if, in the office's judgment it is not made in good faith, is outdated, or is trivial, or if the report is not within the investigating authority of the office." Once the complaint report is reviewed, the complainant will receive a written notice of the Department's decision.

If a complaint has already been filed in directly with the facility/agency, please allow the facility/agency approximately 30 days to investigate the complaint and provide a response of their findings. After giving the facility approximately 30 days to reply, if no written response is received, contact our office to file a complaint. We request that a copy of the letter that was mailed to the facility/agency be included with the complaint form.

- Nursing Home Abuse & Complaints 1-888-810-1819
- Home Health & Hospice 1-800-327-3419
- Intermediate Care Facility for Developmentally Disabled (ICF/DD) 1-877-343-5179
- Home & Community Based Services 1-800-660-0488
- Case Management 1-800-660-0488
- Hospital, Ambulatory Surgical Center, Dialysis Center & Abortion Facility 1-866-280-7737

Health Standards Section
P.O. Box 3767 • Baton Rouge, Louisiana • 70821-3767
Phone #: (225) 342 • 0138 • Fax #: (225) 342-5073 www.ldh.la.gov

- Adult Day Health Care 1-888-810-1819
- Adult Day Care 1-800-660-0488
- Adult Residential Care Provider 1-225-342-6298
- Others 1-225-342-0138

Complaint Form

(Please complete all sections to the best of your ability)

Complainant's Information	
Date Form was Completed:	**Relationship to Patient Named in this Complaint:**
☐ ***Anonymous*** **(Check if you wish to be anonymous and SKIP to Facility/Agency Information below. *Please note:* *If you choose to remain anonymous and this complaint warrants an investigation, you will not be contacted or receive any follow-up results.***	**Name of Person Filing Complaint:** **If you are staff at the Facility/Agency Named in the Complaint, what is your status now?** ☐Current Employee ☐Former Employee
Complainant's Street Address or P.O. Box:	
City:	
State:	
Zip:	
Phone Home: **Cell:**	**Work:** **Other:**
Email Address:	

Facility/Agency Information
Name of Facility/Agency Primarily Involved:
Street Address of Facility/Agency:
City:
Zip:
If more than one facility/agency was involved, please list additional facilities/agencies along with the address and city:

Patient Whom Complaint is About
Patient's Full Name:
Patient's Age:
Patient's Date of Birth:

Details of the Event:
Admission Date of Patient:
Discharge Date of Patient:
Reason(s) for Admission:
Date(s) of Event(s):
Location Where Event(s) Occurred (i.e. unit, room, department, area, site):
Names of Staff Members Involved in Event(s) (if known):
Event Areas of Concern (check off here and describe in the next section):

☐ **Death**	☐ **Abuse/Neglect**	☐ **Restraints/Seclusion**	☐ **Emergency Services**	☐ **Other**

Details of the event to include names, dates, titles of persons involved, areas of the facility, shifts, room numbers, etc. (Give as much information as possible – you may attach additional pages as needed):

I hereby give permission for the Health Standards Section to forward this complaint to the appropriate agency, if it does not fall under the authority of the Health Standards Section:

Signature of Individual Submitting Complaint **Date**

Did you report this event to anyone at the facility? ☐Yes ☐No

If Yes, please provide the following information:
Name & Title of the person to whom you reported:
Date reported:
Reporting Method (please mark all that apply): ☐Written ☐Telephone ☐In Person ☐Email
☐Other (Describe):

If No, are you considering filing a complaint with the facility/agency? ☐Yes ☐No
If No please provide the reason that you are not filing a complaint with the facility/agency:

Have you received any communication from the facility/agency regarding these concerns?
If so, the method used to contact you was (please mark all that apply): ☐Written ☐Telephone
☐In Person ☐Email ☐Other:

********If possible, please submit a copy of the facility/agency's communication with this complaint********

If your complaint involves:

Billing Issues involving private insurance:	**Please refer this complaint to your individual insurance representative or to the Louisiana Department of Insurance 800-259-5300** or **www.ldi.la.gov** **Louisiana Department of Health/Health Standards Section does not intervene in billing issues.**
Billing Issues involving Medicaid:	**Louisiana Medicaid Hotline at 800-488-2917** **Louisiana Department of Health/Health Standards Section does not intervene in billing issues.**
Billing Issues involving Medicare:	**1-800-Medicare or www.medicare.gov** **Louisiana Department of Health/Health Standards Section does not intervene in billing issues.**
Physician Practices:	**Please refer your complaint to the Louisiana State Board of Medical Examiners** **630 Camp Street** **New Orleans, LA 70130** **Phone: (504) 568-6820; Fax: (504) 568-5754** **http://www.lsbme.la.gov/** **Louisiana Department of Health/Health Standards Section does not have authority over physicians.**

Please mail this form to:

Louisiana Department of Health, Health Standards Section
Complaint Program Desk
P.O. Box 3767
Baton Rouge, LA 70821

You may also fax this form to:
(225) 342-5073

You may also email this form to:

HSSComplaints@LA.GOV

Sample SC FOC: Region number and list of available SC Agencies will vary from region to region.

SUPPORT COORDINATION CHOICE and RELEASE OF INFORMATION FORM
EPSDT Target Population DHH Region 2

To the recipient: Please fill out Sections 1, 2 and 3 of this form and return it as soon as possible to:

Statistical Resources, Inc. Case Management
11505 Perkins Road, Suite H
Baton Rouge, Louisiana 70810
Fax: (225) 767-0502

Recipient's Name: _____ Date of Birth: _____

Physical Address: _____ City: _____

State: _____ Zip code: _____Telephone Number: (_____) _____-_____

Social Security Number: _____-____-_____ Medicaid Number: _____

Population: ☐ EPSDT Targeted Case Management

Recipient currently resides in a Group Home, Developmental Center, or Nursing Home? ☐ Yes ☐ No

---

Section 1: Support Coordination Freedom of Choice - DHH Region 2

The state has contracted with several support coordination providers in your area. Included with this letter are brochures describing the services of each agency.Please choose a provider from among these agencies. We ask that you number your choices.Please write 1 (one) in the box by your first choice and write 2 (two) in the box by your second choice.If your first choice is full, you will be linked to your second choice if they are not full.You will be linked for a 6-month period, after which you have the option of changing agencies if space is available.

[ ] Medical Resources & Guidance
[ ] Community Resource Coordinators

_____ _____
Signature of Recipient / Legal Guardian Date

Section 2: Release of Information

I permit the release of any and all information which may be in the possession of DHH offices that pertain to my application(s) for services, including but not limited to OCDD statement of eligibility, OCDD Request for Services list, plans of support, generic service plans, doctor's reports/evaluations, psychological reports/evaluations, medical/social/educational assessments of any kind, including those provided by schools, other agencies, and /or organizations. This includes all third party information which may be in DHH's possession..

_____ _____
Signature of Recipient / Legal Guardian Date

Section 3: Transfer of Records (For Agency Use Only)

Indicate which of the required documents have been transferred from the following agency: _____

☐ 1. Discharge 148	☐ 4. 51NH	☐ 7. Waiver slot letter (if not certified)	☐ 10. Medical Documentation	☐ 13. _____
☐ 2. Form 142	☐ 5. CPOC (current & approved)	☐ 8. Social Evaluation	☐ 11. IEP	☐ 14. _____
☐ 3. 18 LTC	☐ 6. Six months progress notes	☐ 9. Psych. Evaluation	☐ 12. _____	☐ 15. _____

Signatures by both Transferring Agency and Receiving Agency are required for the Transfer of Records to be finalized.

_____ _____
Transferring Agency (Signature Required) Date Receiving Agency (Signature Required) Date

STATISTICAL RESOURCES, INC. DOES NOT VERIFY MEDICAID ELIGIBILITY NOR DETERMINE IF THE RECIPIENT MEETS THE CRITERIA OF THE TARGET POPULATION. IT IS THE RESPONSIBILITY OF THE PROVIDER TO ENSURE ELIGIBILITY.

Participant Name: Medicaid ID: CPOC: Begin Date: End Date:

Louisiana Department of Health & Hospitals

Comprehensive Plan of Care

EPSDT - Targeted Support Coordination

CPOC Type: _____ Annual, Initial, Interim

Participant's Name:	Participant's DOB:	Region:
Social Security Number	Guardian:	
Medicaid Number:	Relationship:	
Address:	Address (if different) :	
City/State/Zip:	City/State/Zip:	
Home Phone: Other Phone:	Home Phone: Other Phone:	
Support Coordination Agency:	Provider Number:	
Support Coordination Agency's Address:	Contact Person:	
City/State/Zip:	Phone:	
Healthy Lousiana Agency:	Healthy Louisiana Agency Phone:	
Healthy Louisiana Agency:	Healthy Louisiana Agency Phone:	

Sex: ____ 1. Male 2.Female

Race: ____ 1. White 2. Black/African American 3. Asian Pacific Islander 4. American Indian 5. Alaskan 6.Other

Education: ____

01 Early Intervention	05 Regular and Special Education	09 Post-secondary: Colleg	13 Employed	98 N/A
02 Non-Categorical	06 Special Education Only	10 Post-secondary: Vocationa	14 Unemployed	99 Other
03 Regular Kindergarten	07 Homebound Full Time	11 Pre-vocational Trainin	15 Working toward GED	
04 Regular Education Only	08 Graduated	12 Supported Employmen	16 Home Schooled	

Legal Status: ____ 1. Competent Major 2. Minor 3. Interdicted -- Full 4. Interdicted -- Limited 5. Tutorship 6. Commitment 7. Custody 8. O

Is able to direct his/her own care: _____ Yes, No

ID: _____ Mild, Moderate, Severe, Profound, Special Needs

Adaptive Functioning: _____ Mild, Moderate, Severe, Profound, Special Needs

Diagnosis Code (ICD9) : _____

Residential Placement: ____

01 Homeless	07 Community Home with 6 or less beds	13 Lives Independently with Other
02 Incarcerated	08 Supervised Apartment-OCDD Contract	14 Lives Independently
03 Temporary Quarters	09 Supported Living/Residential Habilitation	15 Psychiatric Facility
04 Nursing Home	10 Subsitute Family Care	16 General Medical Facility
05 ICF/DD with 16 or more beds	11 OCS Foster Care	99 other
06 ICF/DD with 7 to 15 beds	12 Lives with Family/Friends	

Number of other individuals in home who are ID/DD/Special Needs who receive Medicaid Services: _____

Names: _____

FOR LDH USE ONLY

CPOC Begin Date: CPOC End Date:

Signature of DHH: Date:

Participant Name: Medicaid ID: CPOC: Begin Date: End Date:

SECTION II: Medical/Social/Family History

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

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

HEALTH STATUS:

Physician Name: _____

Date of Last Appointment: _____

Immunizations Current: Yes No

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

Dates of Evaluations/Documentation used to develop this CPOC

_____ Social
_____ Pyschological
_____ Psychiatric
_____ Special Education
_____ Individual Education Plan
_____ Behavior Management Plan
_____ Home Health Plan of Care
_____ 90 or Medical Records
_____ SOA
_____ Pediatric Day Health Care P
☐ SOA Permanent
_____ Other _____

Psychiatric/Behavioral Concerns:

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

Participant Name: Medicaid ID: CPOC: Begin Date: End Date:

SECTION III: CPOC SERVICE NEEDS AND SUPPORTS

Service Strategy/ Descript	How was need determined?	Requested by participant/family	Why Not	Goal(s)	Receiving Service	Medicaid	School	Community	Family	OCDD	Requires PA	tracked by S. C.	Amount Approved	Reason for not Tracking
Personal Care Service		☐			☐	☐	☐	☐	☐	☐	☐			
Home Health Service		☐			☐	☐	☐	☐	☐	☐	☐			
Medical Equipment & Supplie		☐			☐	☐	☐	☐	☐	☐	☐			
OT		☐			☐	☐	☐	☐	☐	☐	☐			
Physical Therapy		☐			☐	☐	☐	☐	☐	☐	☐			
Speech Therapy		☐			☐	☐	☐	☐	☐	☐	☐			
Specialized Behavioral Heal		☐			☐	☐	☐	☐	☐	☐	☐			
Dental Services		☐			☐	☐	☐	☐	☐	☐	☐			
Eyeglasses		☐			☐	☐	☐	☐	☐	☐	☐			
Transportation Services		☐			☐	☐	☐	☐	☐	☐	☐			
Diapers		☐			☐	☐	☐	☐	☐	☐	☐			
School		☐			☐	☐	☐	☐	☐	☐	☐			
Vocational		☐			☐	☐	☐	☐	☐	☐	☐			
Employment		☐			☐	☐	☐	☐	☐	☐	☐			
Transition		☐			☐	☐	☐	☐	☐	☐	☐			
Pediatric Day H.C.		☐			☐	☐	☐	☐	☐	☐	☐			
Applied Behavior Analysis		☐			☐	☐	☐	☐	☐	☐	☐			
Home Modifications		☐			☐	☐	☐	☐	☐	☐	☐			
Community Services		☐			☐	☐	☐	☐	☐	☐	☐			
Redetermination		☐			☐	☐	☐	☐	☐	☐	☐			
OCDD Services		☐			☐	☐	☐	☐	☐	☐	☐			
CSoC		☐			☐	☐	☐	☐	☐	☐	☐			
Evaluation		☐			☐	☐	☐	☐	☐	☐	☐			
EPSDT Screening Exam		☐			☐	☐	☐	☐	☐	☐	☐			
Hearing Aids		☐			☐	☐	☐	☐	☐	☐	☐			
Hospice Services		☐			☐	☐	☐	☐	☐	☐	☐			
Physician/Professional		☐			☐	☐	☐	☐	☐	☐	☐			
Other		☐			☐	☐	☐	☐	☐	☐	☐			

Participant Name:	Medicaid ID:	CPOC: Begin Date:	End Date:
	☐	☐☐☐☐☐☐☐☐	
	☐	☐☐☐☐☐☐☐☐	

Service Strategy List:

Personal Care Service, Home Health Service, Medical Equipment & Supplies, OT, Physical Therapy, Speech Therapy, Specialized Behavioral Health, Dental Services, Eyeglasses, Transportation Services, Diapers, School, Vocational, Employment, Transition, Pediatric Day H.C., Applied Behavior Analysis , Home Modifications, Community Services, Redetermination, OCDD Services, CSoC, Evaluation, EPSDT Screening Exam, Hearing Aids, Hospice Services, Physician/Professional, Other

Reason for not tracking List:

PA not Required , PA issued monthly, EHH Nurse Tracks (Medical Equipment and Supplies only), Placed on Waitlist, PA from Magellan (Specialized Behavioral Health only), Receiving without PA (OT, PT, ST only)

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

Participant/Guardian's Signature: _____ **Date:** _____

Additional Information about Service Needs and Supports:

SECTION V: CPOC PARTICIPANTS

PLANNING PARTICIPANTS	TITLE & AGENCY NAME

S. C. has explained that Medicaid will provide medically necessary therapies, in addition to the therapies in addition to the therapies received at school through the IEP. Yes No
If not why not:

Support Coordinator has reviewed the Medicaid Services Chart with me: Yes No
If not why not:

Support Coordinator has provided me with information on Medicaid EPSDT Services: Yes No
If not why not:

Support Coordinator has provided me with information on EPSDT Screening Services: Yes No

If not why not:

EPSDT Screening Services requested: _____

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

_____ _____

Participants/Guardian's Signature Date

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

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

_____ _____

Support Coordinator's Signature Date

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

_____ _____

Support Coordinator Supervisor's Signature Date

SECTION VI: CARE PLAN ACTION

Participant Name: _____ Date Approvable CPOC Rec'd by LDH: _____

CPOC Status: _____

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

Approved CPOC: Begin Date: _____ End Date: _____

Signature/Title of LDH Representative: _____

Notes: _____

LOUISIANA DEPARTMENT OF HEALTH **Appendix P**
BUREAU OF HEALTH SERVICES FINANCING
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) –
Targeted Population Support Coordination
FACT SHEET

Description	**EPSDT** targeted support coordination is a Medicaid State Plan Service. Support coordination is a service that can assist beneficiaries with gaining access to the full range of needed services including medical, social, education and other services. This includes all services that beneficiaries under age 21 may be entitled to receive with a Medicaid Card. The support coordinator will review all available services and assist with making referrals for the services they may be eligible to receive. These **MAY** include services such as medical equipment, occupational, physical or speech therapy, Personal Care Service (PCS), Home Health and EPSDT screening. Support coordinators will assure families will also be informed of any new services in the future that may help their children. **EPSDT services are not waiver services.**
Level of Care	Beneficiaries who have multiple medical needs or who meet the definition of a person with special needs. (See eligibility requirements below.)
Population	Age → 3 through 20 years old
Eligibility	• **Individuals on the Developmental Disabilities Request for Services Registry (DD RFSR) or those that meet the definition of a person with special needs;** o Placement on the DD Request for Services Registry on or after October 20, 1997 and have passed the OCDD Diagnosis and Evaluation (D&E) process by the later of October 20, 1997 or the date they were placed on the DD RFSR; o Placement on the DD Request for Services Registry (DD RFSR) on or after October 20, 1997 but who did not have a D&E by the later of October 20, 1997 or the date they were placed on the DD RFSR. Those in this group who subsequently pass or passed the D&E process are eligible for these targeted support coordination services. For those who do not pass the D&E process or who are not undergoing a D&E, they may still receive support coordination services if they meet the definition of a person with special needs; o Medicaid beneficiaries under the age of 21 who are not on the DD RFSR, may still receive support coordination services if it is determined medically necessary, with documentation from Medicaid to substantiate that they meet the definition of a person with special needs (e.g., receipt of special education services through state or local education agency, receipt of regular services from one or more physicians, receipt of or application for financial assistance such as SSI because of medical condition or the unemployment of the parent due to the need to provide specialized care for the child, a report by the beneficiary's physician of multiple health or family issues that impact the participants ongoing care or a determination of developmental delay based upon the Parent's Evaluation of Pediatric Status, the Brignance Screens, the Child Development Inventories, Denver Developmental Assessment, or any other nationally recognized diagnostic tool). • **Under the age of 21; AND** • **Are Medicaid Eligible.**
Follow-up & Monitoring	The support coordinator will follow-up with the beneficiary at least monthly regarding all approved services, to ensure they are receiving services in the amount approved and at the times requested. If the beneficiary is not satisfied, the support coordinator will follow-up with the provider. The support coordinator will meet face-to-face with the beneficiary & family at least one time per quarter. The Health Standards Section (HSS) will conduct complaint investigations for all Support Coordination Agencies. HSS will also conduct annual monitoring for EPSDT Targeted Population Support Coordination Agencies utilizing a 5% sample.

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

For information regarding all Medicaid State Plan Services, visit http://ldh.la.gov/page/319.

Legacy Medicaid
Referral to Provider

EPSDT - Targeted Population

Date:

TO: Provider Name		
FROM: Support Coordination Agency Provider #:	Support Coordinator's Name:	Support Coordinator's Phone #: Fax#:
Address:	City:	State / Zip:
RE: Service Type (if DME be specific):	Service Name: ☐ Initial ☐ Renewal	Amount / # of Hours of Service:
Beneficiary Name:	MID#:	Phone #:
Address:	City:	State / Zip:

This is to inform you that this individual is receiving EPSDT - Targeted Population Support Coordination Services and we are sending this notice to: (Check the following that apply)

	1. Make a referral for the above noted service. We are requesting that you send us a copy of the PA request packet at the same time that it is sent to Medicaid/Gainwell Technologies.
	2. The beneficiary has asked that their schedule for your services be changed as per the attached Typical Weekly Schedule form. If this presents a scheduling problem, please contact the Support Coordinator so that we can all discuss this with the beneficiary/family.
	3. This is a reminder that the above named beneficiary's PA for your service expires on ___/___/___ and the renewal needs to be sent to Medicaid/Gainwell Technologies for continued services.
	4. The Medicaid PAL (Prior Authorization Liaison) has informed us they need the following additional information in order to process the request for the PA packet you submitted:
	5. Other:

Support Coordinator's Signature _____ Date _____

Issued May 30, 2003
BHSF-PF-03-016
Revised March 13,2023

STATE OF LOUISIANA
DEPARTMENT OF HEALTH
Bureau of Health Services Financing Medical Assistance Program

BATON ROUGE, LA. 70898-4919 **REQUEST FOR PRIOR AUTHORIZATION** **P.A. NUMBER**

FAX TO: (225) 216-6481 **CONTINUATION OF SERVICES ____YES ____NO**

(1) PRIOR AUTHORIZATION TYPE:

14 – EPSDT PERSONAL CARE SERVICES

(2) BENEFICIARY 13-DIGIT MEDICAID ID NUMBER OR 16-DIGIT CCN NUMBER

(3) SOCIAL SECURITY #

(4) BENEFICIARY LAST NAME **FIRST NAME** **MI**

(5) DATE OF BIRTH

(6) MEDICAID PROVIDER NUMBER (7- DIGIT)

(7) SERVICE TREATMENT PLAN BEGIN DATE (MMDDYYY) END DATE (MMDDYYY)

(8)IS BENEFICIARY CURRENTLY RECEIVING THESE SERVICES
_____YES _____NO

PRACTITIONER REVIEWER'S SIGNATURE & DATE

(9) DIAGNOSIS:
PRIMARY CODE

SECONDARY CODE

(10) PRESCRIPTION DATE (MMDDYYYY)

STATUS CODES:
2 = APPROVED
3 = DENIED

(11) PRESCRIBING PRACTITIONER'S NAME AND/ OR NUMBER:

DESCRIPTION OF SERVICES

FOR INTERNAL USE ONLY

PROCEDURE CODE	MODIFER	PERSONAL CARE SERVICE EACH 15 MINUTES	REQUESTED UNITS	AUTHORIZED UNITS	STATUS	P.A. MESSAGE/ DENIAL CODE (S)	

(13) PROVIDER NAME: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIPCODE** _____

TELEPHONE: (_____**)** _____ **FAX NUMBER: (**_____**)** _____ _____

Comments:

(14)
PROVIDER SIGNATURE: _____

(15)
DATE OF REQUEST: _____

Revised PA-14 FORM
Revised 5/2019

Instructions for Completing Prior Authorization Form (PA-14)

NOTE: ONLY THE FIELDS LISTED BELOW ARE TO BE COMPLETED BY THE PROVIDER OF SERVICE. ALL OTHER FIELDS ARE TO BE USED BY THE PRIOR AUTHORIZATION DEPARTMENT AT DXC.

FIELD NO. 2 ENTER BENEFICIARY'S 13-DIGIT MEDICAID ID NUMBER OR THE 16-DIGIT CCN NUMBER.

FIELD NO. 3 ENTER THE BENEFICIARY'S SOCIAL SECURITY NUMBER.

FIELD NO. 4 ENTER THE BENEFICIARY'S LAST NAME, FIRST NAME AND MIDDLE INITIAL AS IT APPEARS ON THE BENEFICIARY'S MEDICAID CARD.

FIELD NO. 5 ENTER THE BENEFICIARY'S DATE OF BIRTH IN MMDDYYYY FORMAT (MM=MONTH, DD=DAY, YYYY=YEAR).

FIELD NO. 6 ENTER THE PROVIDER'S 7-DIGIT MEDICAID NUMBER.

FIELD NO. 7 ENTER THE FIRST DAY THE SERVICE IS REQUESTED TO START AND THE LAST DAY OF SERVICE FOR THAT INDIVIDUAL TREATMENT PLAN IN MMDDYYYY FORMAT (MM=MONTH, DD=DAY, YYYY=YEAR.

FIELD NO. 8 PLACE A CHECK MARK IN THE 'YES' OR 'NO' BOX TO INDICATE WHETHER OR NOT THE BENEFICIARY IS CURRENTLY RECEIVING SERVICES.

FIELD NO. 9 ENTER THE DIAGNOSIS CODES (PRIMARY & SECONDARY).

FIELD NO. 10 ENTER THE DAY THE PRESCRIPTION, PRACTITIONER'S ORDERS WAS WRITTEN IN MMDDYYYY FORMAT (MM=MONTH, DD=DAY, YYYY=YEAR)

FIELD NO. 11 ENTER THE NAME OF THE BENEFICIARY'S ATTENDING PRACTITIONER PRESCRIBING THE SERVICES.

FIELD NO. 12 ENTER THE HCPCS CODE.

FIELD NO. 12A ENTER THE CORRESPONDING MODIFIER (WHEN APPROPRIATE).

FIELD NO. 12B ENTER THE HCPCS CODE'S CORRESPONDING DESCRIPTION FOR EACH PROCEDURE REQUESTED. FIELD NO.

12C ENTER THE NUMBER OF TIMES THE REQUESTED PROCEDURE WILL BE PERFORMED DURING THE TREATMENT PLAN. CALCULATE THE TOTAL UNITS REQUESTED BY MULTIPLYING THE NUMBER OF UNITS PER DAY (1 UNIT = 15 MINUTES) TIMES THE NUMBER OF DAYS PER WEEK TIMES THE NUMBER OF WEEKS COVERED IN THE TREATMENT PLAN. THIS WILL GIVE THE TOTAL UNITS REQUESTED. BELOW ARE TWO EXAMPLES ON THE PROPER WAY TO CALCULATE THE TOTAL UNITS REQUESTED:

EXAMPLE 1) REQUESTING FOUR-HOURS PER DAY FOR A SIX MONTH PERIOD:

4 HOURS PER DAY = 16 UNITS PER DAY, 7 DAYS A WEEK, 26 WEEKS =
16 X 7 X 26 = 2912 TOTAL UNITS REQUESTED

EXAMPLE 2) REQUESTING TWO-HOURS PER DAY ON WEEKENDS AND FOUR-HOURS PER DAY ON WEEKDAYS:

2 HOURS PER DAY (WEEKENDS) = 8 UNITS PER DAY, 2 DAYS A WEEK, 26 WEEKS =
8 X 2 X 26 = 416 TOTAL UNITS REQUESTED FOR WEEKENDS

4 HRS. PER DAY (WEEKDAYS) = 16 UNITS PER DAY, 5 DAYS A WEEK, 26 WEEKS =
16 X 5 X 26 = 2080 TOTAL UNITS REQUESTED FOR WEEKDAYS

THE TOTAL UNITS REQUESTED WOULD BE THE COMBINATION OF THE TOTAL WEEKEND UNITS (416) AND WEEKDAY UNITS (2080), WHICH WOULD EQUAL TO 2496 TOTAL UNITS REQUESTED. THIS IS THE NUMBER (2496) TO ENTER IN FIELD NUMBER 12C.

FIELD NO. 13 ENTER THE NAME, MAILING ADDRESS AND TELEPHONE NUMBER OF THE PROVIDER OF SERVICE. FIELD NO.

14 PROVIDER/AUTHORIZED SIGNATURE IS REQUIRED. YOUR REQUEST WILL NOT BE ACCEPTED IF NOT SIGNED. IF USING A STAMPED SIGNATURE, IT MUST BE INITIALED BY AUTHORIZED PERSONNEL.

FIELD NO. 15 DATE IS REQUIRED. YOUR REQUEST WILL NOT BE ACCEPTED IF FIELD IS NOT DATED.

IF YOU HAVE ANY QUESTIONS CONCERNING THE PRIOR AUTHORIZATION PROCESS, PLEASE CONTACT THE PRIOR AUTHORIZATION DEPARTMENT AT DXC.

PRIOR AUTHORIZATION PCS DEPARTMENT TOLL-FREE NO. IS 1-800-807-1320

PRIOR AUTHORIZATION FAX NO. IS 1-225-216-6481

REQUEST FOR MEDICAID EPSDT - PERSONAL CARE SERVICES

(Personal Care Services are to be provided in the home and not in an institution)

I. IDENTIFYING INFORMATION

1. Applicant Name:	**MID#**	
Address:	**Ph#** ( )	
	D **Male** D **Female**	**DOB:**
2. Responsible Party/Curator:	**Relationship:**	
Address:	**Home Phone #** ( )	
	Work or Cell Phone # ( )	

By signing this form I give my consent for my medical information to be released to the Department of Health and Hospitals to be used in determining eligibility for Personal Care Services.

Signature: _____ **Date:** _____

II. MEDICAL INFORMATION

NOTE: The following information is to be completed by the applicant's attending practitioner.

1. Patient Name:

2. Primary Diagnosis:	**Diagnosis Code:**
Secondary Diagnosis:	**Diagnosis Code:**

3. Physical Examination:

General _____ Head and CNS _____ Mouth

and EENT _____ Chest _____ Heart

and Circulation _____ Abdomen _____ Genitalia

Extremities _____ Skin _____ Height

Wt. _____ Pulse _____ Resp

Temp _____ B/P _____ Bowel/Bladder

Control _____

Impaired Vision _____ Impaired Hearing _____

DGlasses DHearing Aid

Lab Results:

HCT _____ HCB _____ U/A

Radiology _____

4. Special Care/Procedures: check appropriate box and give type, frequency, size, stage and site when appropriate

D Trach Care: D Daily D PRN

D Respiratory: D Ventilator D Daily D Other _____

D Suctioning/Oral Care: D Daily D PRN

D Glucose Monitoring: D Insulin Injections D Daily D Other

D Restraints (positioning)

D Dialysis

D Urinary Catheter

D Seizure Precautions

D Ostomy

D IV

D Decubitus/Stage _____

D Diet/Tube Feeding

D Rehab (OT,PT,ST)

Assistive Device:

5. Medications	**Dosage**	**Frequency**	**Route**

II. MEDICAL INFORMATION (Continued)

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

III. LEVEL OF CARE DETERMINATION

Activities of Daily Living:

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

Not Independent at this Age – not age appropriate to perform this task independently
Independent – beneficiary able to perform task **without assistance**
Limited Assistance – beneficiary aids in task, but receives help from other persons **some of the time**
Extensive Assistance – beneficiary aids in task, but receives help from other persons **all of the time**
Maximal Assistance – beneficiary is **entirely dependent** on other persons
Note: An additional 15 minutes can be added to bathing, dressing and toileting if mobility/transfer assistance is required

(EPSDT – PCS Level of Assistance Guide)

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

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

III. LEVEL OF CARE DETERMINATION (Continued)

NOTE: The following information is to be completed by the applicant's attending practitioner. Check the appropriate box using the definitions and EPSDT PCS Level of Assistance Guide to assist with determining the level of care.

Activity	Not Independent at this Age	Independent	Limited Assistance	Extensive Assistance	Maximal Assistance	Comments
Bathing						
Dressing						
Grooming						
Toileting						
Eating						

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

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

D Yes, this individual requires this level of care.

D No, this individual does not require this level of care.

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

Bathing D Yes D No **Dressing** D Yes D No **Toileting** D Yes D No

Medical Appointments:

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

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

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

IV. PRACTITIONER'S ORDER

The above named patient is in need of EPSDT PCS due to his/her current medical condition. I am prescribing

Personal Care Services for _____hours, _____days a week as determined by the level of care determination.

Practitioner's Name (type or print):	Phone: ( )
Address:	

I certify/recertify that I am the attending practitioner for this patient and that the information provided is accurate and correct to the best of my knowledge. I authorize these EPSDT personal care services and will periodically review the plan. In my professional opinion, the services listed on this form are medically necessary and appropriate due to the child's medical condition. I understand that if I knowingly authorize services that are not medically necessary, I may be in violation of Medicaid rules and subject to sanctions described therein. I understand a face to face evaluation must be held between beneficiary and practitioner.

Practitioner's Signature _____ **Date** _____

MAIL TO:
DXC / LA. MEDICAID
P.O. BOX 14919
BATON ROUGE, LA. 70898-4919

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
Bureau of Health Services Financing Medical Assistance Program
REQUEST FOR PRIOR AUTHORIZATION

P.A. NUMBER

FAX TO: (225) 216-6342 **CONTINUATION OF SERVICES _____YES _____ NO**

PRIOR AUTHORIZATION TYPE: (1)	RECIPIENT 13-DIGIT MEDICAID ID NUMBER OR 16-DIGIT CCN NUMBER (2)	Social Security No. (3)
06 - Home Health Services	RECIPIENT LAST NAME FIRST MI (4)	DATE OF BIRTH (5)
MEDICAID PROVIDER NUMBER (7- DIGIT) (6)	SERVICE TREATMENT PLAN (7) BEGIN DATE (MMDDYYYY) / END DATE (MMDDYYYY)	IS RECIPIENT CURRENTLY RECEIVING THESE SERVICES (8) _____ YES _____ NO
DIAGNOSIS : (9) PRIMARY CODE / SECONDARY CODE	PRESCRIPTION DATE (10) (MMDDYYYY)	P. A. NURSE AND / OR PHYSICIAN REVIEWER'S SIGNATURE: & DATE
	PRESCRIBING PHYSICIAN'S NAME AND/ OR NUMBER:	STATUS CODES: 2 = APPROVED 3 = DENIED

DESCRIPTION OF SERVICES **FOR INTERNAL USE ONLY**

PROCEDURE CODE (11)	MODIFIERS (11A) Mod 1	Mod 2	Mod 3	Mod 4	DESCRIPTION (11B)	REQUESTED UNITS (11C)	REQUESTED AMOUNT	AUTHORIZED UNITS	AUTHORIZED AMOUNT	STATUS	P.A. MESSAGE/ DENIAL CODE (S)	

(12)

PROVIDER NAME: _____

ADDRESS: _____

CITY: _____ **STATE:** _____**ZIPCODE** _____

TELEPHONE: (_____**)** _____ _____ **FAX NUMBER: (**_____**)** _____ _____

COMMENTS:

(13)
PROVIDER SIGNATURE: _____

(14)
DATE OF REQUEST: _____

Revised PA-07 Form
Issued 10/1/2015

Instructions For Completing Prior Authorization Form (PA-07)

NOTE: ONLY THE FIELDS LISTED BELOW ARE TO BE COMPLETED BY THE PROVIDER OF SERVICE. ALL OTHER FIELDS ARE TO BE USED BY THE PRIOR AUTHORIZATION DEPARTMENT AT DXC.

FIELD NO. 2 ENTER RECIPIENT'S 13 DIGIT MEDICAID ID NUMBER OR THE 16-DIGIT CCN NUMBER

FIELD NO. 3 ENTER THE RECIPIENT'S SOCIAL SECURITY NUMBER

FIELD NO. 4 ENTER THE RECIPIENT'S LAST NAME, FIRST NAME AND MIDDLE INITIAL AS IT APPEARS ON RECIPIENT'S MEDICAID CARD

FIELD NO. 5 ENTER THE RECIPIENT'S DATE OF BIRTH IN MMDDYYYY FORMAT (MM=MONTH, DD=DAY, YYYY=YEAR)

FIELD NO. 6 ENTER THE PROVIDER'S 7-DIGIT MEDICAID NUMBER

FIELD NO. 7 ENTER THE FIRST DAY THE SERVICE IS REQUESTED TO START AND THE LAST DAY OF SERVICE FOR THAT INDIVIDUAL TREATMENT PLAN IN MMDDYYYY FORMAT (MM=MONTH, DD=DAY, YYYY=YEAR)

FIELD NO. 8 PLACE A CHECK MARK IN THE 'YES' OR 'NO' BOX TO INDICATE WHETHER OR NOT THE RECIPIENT IS CURRENTLY RECEIVING SERVICES

FIELD NO. 9 ENTER THE DIAGNOSIS CODE (PRIMARY & SECONDARY)

FIELD NO.10 ENTER THE DAY THE PRESCRIPTION, DOCTOR'S ORDERS WAS WRITTEN IN MMDDYYYY FORMAT (MM=MONTH, DD=DAY, YYYY=YEAR)

FIELD NO.11 ENTER THE NAME OF THE RECIPIENT'S ATTENDING PHYSICIAN PRESCRIBING THE SERVICES

FIELD NO.12 ENTER HCPCS CODE

FIELD NO.12A ENTER THE CORRESPONDING MODIFIER (WHEN APPROPRIATE)

FIELD NO.12B ENTER THE HCPCS CODE'S CORRESPONDING DESCRIPTION FOR EACH PROCEDURE REQUESTED

FIELD NO.12C ENTER THE NUMBER OF TIMES THE REQUESTED PROCEDURE WILL BE PERFORMED DURING THE TREATMENT PLAN. CALCULATE THE TOTAL UNITS REQUESTED BY MULTIPLYING THE NUMBER OF UNITS PER DAY (4 UNITS = 1 HOUR) TIMES THE NUMBER OF DAYS PER WEEK TIMES THE NUMBER OF WEEKS REQUESTED (TAKEN FROM THE SERVICES TREATMENT DATES (FIELD NO. 7 ABOVE). THIS WILL GIVE THE TOTAL UNITS REQUESTED.

EXAMPLE : 11 HOURS PER DAY , 7 DAYS PER WEEK, 26 WEEKS =

11 X 4 = 44 X 7 X 26 WEEKS = 8, 008

FIELD NO.13 ENTER THE NAME, MAILING ADDRESS AND TELEPHONE NUMBER OF THE PROVIDER OF SERVICE

FIELD NO.14 PROVIDER/AUTHORIZED SIGNATURE IS REQUIRED. YOUR REQUEST WILL NOT BE ACCEPTED IF NOT SIGNED. IF USING A STAMPED SIGNATURE, IT MUST BE INITIALED BY AUTHORIZED PERSONNEL.

FIELD NO.15 DATE IS REQUIRED. YOUR REQUEST WILL NOT BE ACCEPTED IF THIS FIELD IS NOT DATED

IF YOU HAVE ANY QUESTIONS CONCERNING THE PRIOR AUTHORIZATION PROCESS, PLEASE CONTACT THE PRIOR AUTHORIZATION DEPARTMENT AT DXC.

HOME HEALTH TOLL-FREE NO. IS 1-800-807-1320

HOME HEALTH PRIOR AUTHORIZATION FAX NUMBER IS 1-225- 237-3342

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB No. 0938-0357

HOME HEALTH CERTIFICATION AND PLAN OF CARE

1. Patient's HI Claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
		From: To:		

6. Patient's Name and Address

7. Provider's Name, Address and Telephone Number

8. Date of Birth

9. Sex ☐ M ☐ F

10. Medications: Dose/Frequency/Route (N)ew (C)hanged

11. ICD	Principal Diagnosis	Date
12. ICD	Surgical Procedure	Date
13. ICD	Other Pertinent Diagnoses	Date

14. DME and Supplies

15. Safety Measures

16. Nutritional Req.

17. Allergies

18.A. Functional Limitations

1 ☐ Amputation
2 ☐ Bowel/Bladder (Incontinance)
3 ☐ Contracture
4 ☐ Hearing
5 ☐ Paralysis
6 ☐ Endurance
7 ☐ Ambulation
8 ☐ Speech
9 ☐ Legally Blind
A ☐ Dyspnea With Minimal Exertion
B ☐ Other (Specify)

18.B. Activities Permitted

1 ☐ Complete Bedrest
2 ☐ Bedrest BRP
3 ☐ Up As Tolerated
4 ☐ Transfer Bed/Chair
5 ☐ Exercises Prescribed
6 ☐ Partial Weight Bearing
7 ☐ Independent At Home
8 ☐ Crutches
9 ☐ Cane
A ☐ Wheelchair
B ☐ Walker
C ☐ No Restrictions
D ☐ Other (Specify)

19. Mental Status
1 ☐ Oriented
2 ☐ Comatose
3 ☐ Forgetful
4 ☐ Depressed
5 ☐ Disoriented
6 ☐ Lethargic
7 ☐ Agitated
8 ☐ Other

20. Prognosis
1 ☐ Poor
2 ☐ Guarded
3 ☐ Fair
4 ☐ Good
5 ☐ Excellent

21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)

22. Goals/Rehabilitation Potential/Discharge Plans

23. Nurse's Signature and Date of Verbal SOC Where Applicable:

25. Date of HHA Received Signed POT

24. Physician's Name and Address

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

27. Attending Physician's Signature and Date Signed

28. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

Privacy Act Statement

Sections 1812, 1814, 1815, 1816, 1861 and 1862 of the Social Security Act authorize collection of this information. The primary use of this information is to process and pay Medicare benefits to or on behalf of eligible individuals. Disclosure of this information may be made to: Peer Review Organizations and Quality Review Organizations in connection with their review of claims, or in connection with studies or other review activities, conducted pursuant to Part B of Title XI of the Social Security Act; State Licensing Boards for review of unethical practices or nonprofessional conduct; A congressional office from the record of an individual in response to an inquiry from the congressional office at the request of that individual.

Where the individual's identification number is his/her Social Security Number (SSN), collection of this information is authorized by Executive Order 9397. Furnishing the information on this form, including the SSN, is voluntary, but failure to do so may result in disapproval of the request for payment of Medicare benefits.

Paper Work Burden Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0357. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Mailstop N2-14-26, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

BHSF Form DIP1
Revised 10/15

PRESCRIPTION REQUEST FORM FOR DISPOSABLE INCONTINENCE PRODUCTS

Recipient Information

Name: _____ Date of birth: _____ Age: _____

Medicaid ID: _____Height: _____ Weight _____

Recipient's Address _____

Prescribing Provider:

Prescriber's Name: _____ Phone #: _____

Address: _____Fax # _____

➤ Medical Diagnoses causing the urine and/or fecal incontinence (Specify ICD CM code):

Primary: _____ **Secondary:** _____

➤ Specify Urine/Fecal incontinence diagnoses (Specify ICD CM code):

Primary: _____ **Secondary:** _____

➤ Mobility

☐ Ambulatory ☐ Minimal assistance ambulating
☐ Transfer Assistance ☐ Confined to bed or chair

➤ Extraordinary Needs - if you are requesting more than 8 per day ONLY
Complete and provide additional supporting documentation for acute medical condition and/or extenuating circumstances for the increased need for incontinence products

➤ Mental Status/Level of Orientation

☐ Has the ability to communicate needs
☐ Sometimes communicates needs
☐ Unable to communicate needs

Frequency of anticipated change
During Day time (6 AM-10PM) _____.
During Night time (10PM – 6 AM) _____.

➤ Additional supporting Diagnoses (Specific ICD-CM Code)

_____
_____

Indicate current supportive services

☐ Home Health
☐ Skilled Nursing Services
☐ Personal Care Services
☐ Other _____

➤ List any medications and/or nutritional therapy that would increase urine or fecal output:

_____

➤ Specify incontinence supply, size, quantity/24 hours and duration of need:

				Qty per day	Size (S, M, L, XL)
☐ **Diapers (Check one):**	**[ ] child size**	**[ ]☐ youth-sized**	**[ ] adult-sized**	_____	_____
☐ **Pull-ups (Check one):**	**[ ] child size**	**[ ]☐ youth-sized**	**[ ] adult-sized**	_____	_____
☐ **Liner/shield (Check one):**	**[ ] child size**	**[ ]☐ youth-sized**	**[ ] adult-sized**	_____	_____

By my signature I attest that I have seen the patient and the item prescribed is medically necessary. I have personally completed this request and a copy will be maintained in the patient's medical record.

Prescriber's Signature:

_____

Date:

_____

➤ Comments

_____
_____
_____
_____
_____

☐ **Additional documentation attached**

Disposable Incontinence Products (T4521 - T4535 & T4539 & T4543)

Standards of Coverage:

Diapers are covered for individual's age four years through age twenty years when:

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

Pull-on briefs are covered for individual's age four years through age twenty years when:

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

Liners/guards are covered for individual's age four years through age twenty years when:

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

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

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

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

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

To avoid unnecessary delays and need for reconsideration, care should be taken to use the correct HCPC code from among T4521-T4535 & T4539 & T4543.

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

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

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

Approved providers of incontinence products:

- Pharmacy
- Home health agency
- Durable medical equipment provider

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

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

Quantity Limitations:

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

Dispensing and Billing:

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

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

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

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

DATE 08/01/2006 RECIPIENT NAME

PRIOR AUTH. NBR RECIPIENT NUMBER

PROVIDER NUMBER

DEAR PROVIDER,

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

A P P R O V E D .

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

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

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

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

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

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

IN ORDER TO APPEAL, PLEASE WRITE TO:

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

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

THIS AUTHORIZATION IS NOT A GUARANTEE OF RECIPIENT MEDICAID ELIGIBILITY.

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

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

DATE 06/25/2009 RECIPIENT NAME

PRIOR AUTH. NBR RECIPIENT NUMBER 9382978155180

AAA CARE LLC
P O BOX 640402
KENNER LA 70064

PROVIDER NUMBER 1461610

DEAR PROVIDER,

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

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

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

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

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

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

35 MINUTES FOR BATHING

15 MINUTES FOR DRESSING

15 MINUTES FOR GROOMING

15 MINUTES FOR TOILETING

15 MINUTES FOR EATING

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

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

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

THIS INFORMATION SHOULD BE PROVIDED BY YOUR PRIMARY CARE PHYSICIAN.

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

IN ORDER TO APPEAL, PLEASE WRITE TO:

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

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THIS AUTHORIZATION IS NOT A GUARANTEE OF RECIPIENT MEDICAID ELIGIBILITY.

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

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

SINCERELY,

BUREAU OF HEALTH SERVICES FINANCING

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

DATE 06/25/2009 PROVIDER NAME AAA CARE LLC

PRIOR AUTH. NBR 915550960 PROVIDER NUMBER 1461610

****
* THIS IS NOT A BILL *
****

RECIPIENT NUMBER
CCN NUMBER

DEAR

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

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

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

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

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

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

35 MINUTES FOR BATHING

15 MINUTES FOR DRESSING

15 MINUTES FOR GROOMING

15 MINUTES FOR TOILETING

15 MINUTES FOR EATING

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

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

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

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

THIS INFORMATION SHOULD BE PROVIDED BY YOUR PRIMARY CARE PHYSICIAN.

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

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

IN ORDER TO APPEAL, PLEASE WRITE TO:

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

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

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

SINCERELY,

BUREAU OF HEALTH SERVICES FINANCING

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

DATE 06/25/2009 RECIPIENT NAME

PRIOR AUTH. NBR RECIPIENT NUMBER

SHARING AND CARING INC
1986 DALLAS DR/STE 4
BATON ROUGE LA 70806

PROVIDER NUMBER 1464384

DEAR PROVIDER,

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

P A R T I A L L Y D E N I E D .

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

PROCEDURE: T1019 EP PERSONAL CARE SERVICE, EACH 15 MIN
REQUESTED: 2096 APPROVED: 1860
DIFFERENCE: 836
DATES OF SERVICE: 05/14/2009 - 11/13/2009 STATUS: PARTIALLY DENIED

THIS REQUEST IS RE-REVIEWED WITH MD'S LETTER. BASED ON THE NEW INFORMATION WE HAVE APPROVED THIS REQUEST FOR 3 HOURS A DAY, 5 DAYS A WEEK FOR 26 WEEKS OF PERSONAL CARE SERVICES. THIS REQUEST IS APPROVED AS FOLLOWS:

30 MINUTES FOR BATHING

30 MINUTES FOR DRESSING

30 MINUTES FOR GROOMING

30 MINUTES FOR TOILETING

30 MINUTES FOR EATING

30 MINUTES FOR INCIDENTAL HOUSEHOLD SERVICES

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

IN ORDER TO APPEAL, PLEASE WRITE TO:

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

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

THIS AUTHORIZATION IS NOT A GUARANTEE OF RECIPIENT MEDICAID ELIGIBILITY.

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

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

SINCERELY,

BUREAU OF HEALTH SERVICES FINANCING

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

DATE 06/25/2009 PROVIDER NAME SHARING AND CARING I

PRIOR AUTH. NBR PROVIDER NUMBER 1464384

****
* THIS IS NOT A BILL *
****

RECIPIENT NUMBER
CCN NUMBER

DEAR :

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

P A R T I A L L Y D E N I E D .

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

PROCEDURE: T1019 EP PERSONAL CARE SERVICE, EACH 15 MIN
REQUESTED: 2096 APPROVED: 1560
DIFFERENCE: 536
DATES OF SERVICE: 05/14/2009 - 11/13/2009 STATUS: PARTIALLY DENIED

THIS REQUEST IS RE-REVIEWED WITH MD'S LETTER. BASED ON THE NEW INFORMATION WE HAVE APPROVED THIS REQUEST FOR 3 HOURS A DAY, 5 DAYS A WEEK FOR 26 WEEKS OF PERSONAL CARE SERVICES. THIS REQUEST IS APPROVED AS FOLLOWS:

30 MINUTES FOR BATHING

30 MINUTES FOR DRESSING

30 MINUTES FOR GROOMING

30 MINUTES FOR TOILETING

30 MINUTES FOR EATING

30 MINUTES FOR INCIDENTAL HOUSEHOLD SERVICES

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

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

IN ORDER TO APPEAL, PLEASE WRITE TO:

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

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

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

SINCERELY,

BUREAU OF HEALTH SERVICES FINANCING

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

DATE 06/26/2009 RECIPIENT NAME

PRIOR AUTH. NBR RECIPIENT NUMBER

DELAUNES FAMILY DRUG STORE
308 N LEWIS
NEW IBERIA LA 70563

PROVIDER NUMBER 1215210

DEAR PROVIDER,

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

D E N I E D .

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

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

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

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

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

IN ORDER TO APPEAL, PLEASE WRITE TO:

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

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

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

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

DATE 06/26/2009 PROVIDER NAME DELAUNES FAMILY DRUG

PRIOR AUTH. NBR PROVIDER NUMBER 1215210

****
* THIS IS NOT A BILL *
****

RECIPIENT NUMBER
CCN NUMBER

DEAR :

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

D E N I E D .

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

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

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

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

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

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

IN ORDER TO APPEAL, PLEASE WRITE TO:

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

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

SINCERELY,

BUREAU OF HEALTH SERVICES FINANCING

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

SINCERELY,

BUREAU OF HEALTH SERVICES FINANCING

gainwell

Gainwell Technologies
Prior Authorization Liaison

Phone: 800-807-1320
Fax: 225-216-6478

* * NOTICE OF INSUFFICIENT PRIOR AUTHORIZATION DOCUMENTATION * *

RECIPIENT:
CASE MANAGER:
DATE OF REQUEST: 08/22/2023
DATE(S) OF SERVICE REQUESTED:
Begin: 08/22/2023 **End:** 02/22/2024

DATE OF NOTICE: 09/05/2023
PROVIDER: Prentek Romich Company
PA NUMBER: 323455310
SERVICE REQUESTED:
Durable Medical Equipment

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

The following information is needed so a determination can be made for a generating device fo s. Please submit the following item(s).

1. According to the LOUISIANA MEDICAID PROGRAM MANUAL for DURABLE MEDICAL EQUIPMENT, SPECIFIC COVERAGE CRITERIA, Augmentative and Alternative Communication Devices (AAC), Assessment/Evaluation

   b. Sensory Status:

   i. Vision and hearing screening (no more than one year prior to AAC evaluation);
   ii. If vision screening is failed, a complete vision evaluation;
   iii. If hearing screening is failed, a complete hearing evaluation; and
   iv. Description of how vision, hearing, tactile, and/or receptive communication impairments or disabilities affected expressive communication.

   Ask Dr. Chaillie Daniel or Dewana Bobo, FNP to provide a vision screening and a hearing screening that is no more than one year prior to the AAC evaluation. If the screenings were attempted and were unsuccessful, Dr. Daniel or Dewana Bobo, FNP should submit the medical records documenting the attempts and the failure of the attempts.

2. Requests for AAC devices must include a description of the speech language pathologist's qualifications, including a description of the speech-language pathologist's AAC services training and experience.

   Ask Erin Cain, MA, CCC-SLP to provide a description of her AAC services training and experience.

3. According to the LOUISIANA MEDICAID PROGRAM MANUAL for DURABLE MEDICAL EQUIPMENT, SPECIFIC COVERAGE CRITERIA, Augmentative and Alternative Communication Devices (AAC), Assessment/Evaluation:
   h. Identification of AAC Devices Considered for Beneficiaries:

   i. Identification of the significant characteristics and features of the AAC devices considered for the beneficiary;

Ask in, MA, CCC-SLP to identify the significant characteristics and features of other AAC devices considered for Simeon.

Dr. Chaillie Daniel or Dewana Bobo, FNP, Erin Cain, MA, CCC - SLP and Prentke Romich Company can assist the recipient in obtaining the requested information.

The following provider can provide this information:

WE WILL DENY YOUR PRIOR AUTHORIZATION REQUEST UNLESS:

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

WE HAVE RECEIVED ALL NEEDED DOCUMENTATION WITHIN 30 DAYS.

If you need help scheduling an appointment with a health care professional or transportation to the appointment, you can contact your case manager or contact Specialty Care Resource line at 877-455-9955. YOU MUST complete and return the form below to notify the PAL if you make an appointment to provide the necessary information described in this notice.

I HAVE AN APPOINTMENT WITH _____
Provider's Name

THE DATE OF MY APPOINTMENT IS _____ / _____ / 20 ____

_____ _____
Your Name Medicaid ID Number

SEND THIS FORM TO THE PRIOR AUTHORIZATION LIAISON:
Name: Prior Authorization Liaison
Address: P. O. Box 14919 Baton Rouge, LA 70898-4919
Phone: (800) 807-1320/option 2
Fax: (225) 216-6478

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

MEMORANDUM

TO: ESPDT Support Coordination Agencies

FROM: Ellen Bachman

SUBJECT: Modification of Rehab Services PA Tracking/PAL Referral

DATE: March 11, 2011

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

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

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

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

Revised 3/11/11
Revised 3/31/14, 4/27/16

Referral to LDH PAL for Legacy Medicaid Member

EPSDT - Targeted Population

Date:

TO: LDH Prior Authorization Liaison (PAL) · P.O. Box 91030 · Baton Rouge, LA · 70821-9030 **Attn: Nancy Spillman** **Fax 225-389-2749**		
FROM: Provider #:	Support Coordinator's Name:	Support Coordinator's Phone#: Fax#:
RE: Legacy Medicaid Provider:	Provider #:	Phone #:
Address:	City:	State/Zip:
Service Type (if DME be specific):	Service Name: ( ) Initial ( ) Renewal	Amount/# of Hours of Service:
Beneficiary Name: **Responsible Party:**	MID#:	Phone#:
Address:	City:	State/Zip:

This is to inform you that this individual is receiving EPSDT Support Coordination Services and we are having/had the following problem with the Medicaid State Plan Provider identified above (only for services that require Prior Authorization):

	1. The provider has not submitted the PA packet within 35 calendar days of the Referral to Provider date (untimely PA packet submission).
	2. We have not received a decision within 60 calendar days of the Choice of Provider date (untimely PA notice).
	3. We have not received a notice of approval from Gainwell Technologies for the renewal and the previous PA expired on __/__/__.
	4. The beneficiary has been unable to locate a provider that is willing to submit a request for prior authorization. (SC must call the LDH Program Staff Line at 1-888-758-2220.)
	5. The beneficiary was placed on a waitlist. (SC must confirm waitlist placement with provider and offer beneficiary alternative providers. SC must follow up with the provider at least quarterly to ensure they move up the waitlist.)
	6. The provider is not providing services at the times the beneficiary requested and we have been unable to resolve the problem.
	7. The provider is not providing the amount of services prior authorized and we have been unable to resolve the problem.
	8. Other:

____ **I certify that I have attached the EPSDT Prior Authorization Tracking Log and the supporting service logs that document the contacts made regarding the issues identified above to this form.**

Support Coordinator's Signature _____ Date _____

Legacy Medicaid
EPSDT Timeline & Documentation
Participant Contacts

Support Coordination Referrals

Within 3 working days:
Phone contact or Face-to-face Visit for Intake
(Document on EPSDT Service Log)

↓

Within 10 calendar days:
Face-to-face in-home visit for Assessment
(Document on EPSDT Service Log)

↓

Within 35 calendar days:
Complete and submit an approvable CPOC to SRI
(Appendix X-1 EPSDT Checklist)

Case Maintenance

As Needed
Follow up on obtaining information to submit or obtain approval of a PA request, Determine service start date after PA notice received, Assist with identified needs and problems with providers
(Document on EPSDT Service Log & PA Tracking Log as needed)

↓

Monthly Contacts
Assure implementation of requested services listed on the CPOC
(Document on PA Tracking Log and EPSDT Service Log)

↓

Quarterly Contacts
Face-to-face visit
Review CPOC, Status of services & service needs
(Document on LSCIS Quarterly Review/Checklist & Progress Summary and Service Log)

Appeals
(See Medicaid Managed Care Appendices for their Appeals process)

Within 4 calendar days from notice of denial:
Explain appeal rights & offer assistance

Explain that the provider can request a reconsideration

Explain that services can be continued pending appeal if the appeal is filed within the 30 day appeal period.[1]

(Document on PA Tracking Log & EPSDT Service Log)

↓

20 days from date appeal request filed:
Check on appeal status and if additional assistance is needed with the appeal.
(Document on PA Tracking Log & EPSDT Service Log)

↓

90 days from date appeal request filed:
Check on final outcome of appeal
(Document on PA Tracking Log & EPSDT Service Log)

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

Legacy Medicaid
EPSDT Timeline & Documentation
Provider Contacts

Within 3 calendar days from date of choice of provider:
Send referral to provider
(Use Referral to Provider form & Document on PA Tracking Log
and EPSDT Service Log)

↓

Within 15 calendar days from date of referral to provider:
Contact provider to check on status of referral & offer assistance if needed.
(Document on EPSDT Service Log)

↓

Within 35 calendar days from date of referral to provider:
Contact provider to check on status of referral and offer assistance if needed. If PA Packet has not been sent to Gainwell, send referral to PAL and continue to follow up with provider until packet has been submitted.
(Document on EPSDT Service Log)

↓

10 calendar days from date provider sent referral to Gainwell Technologies:
(25 days if a DME request)
If PA or PAL Notice not received contact provider to follow up on status of PA.
Continue to follow up until PA is approved or denied based on medical necessity.
(Document on EPSDT Service Log)

↓

45 – 60 days prior to end of PA period:
Send reminder notice to provider to renew PA.
(Complete Referral to Provider form and Document on PA Tracking Log
and EPSDT Service Log)

Legacy Medicaid
EPSDT Timeline & Documentation
PAL Referrals

35 Day and 60 Day PAL Referrals

35 calendar days from date of referral to provider:
If provider has not sent PA Packet to Gainwell,
Send referral to LDH PAL using Referral to LDH PAL Legacy Medicaid Form *(Appendix S)*
(Document on PA Tracking Log & EPSDT Service Log)

60 calendar days from participant's date of choice of provider:
If PA approval/denial has not been received,
Send referral to LDH PAL using Referral to LDH PAL Legacy Medicaid Form *(Appendix S)*
(Document on PA Tracking Log & EPSDT Service Log)

Other PAL Referrals

If PA Renewal Approval Not Received and PA expired:
Send referral to LDH PAL using Referral to LDH PAL Legacy Medicaid Form *(Appendix S)*
(Document on PA Tracking Log &

Unable to find a provider that is willing to submit a request for a PA*:
Send referral to LDH PAL using Referral to LDH PAL Legacy Medicaid Form *(Appendix S)*
(Document on PA Tracking Log &
EPSDT Service Log)
***Fee for Service - Contact the LDH Staff Line**

The beneficiary was placed on a waitlist*:
Send referral to LDH PAL using Referral to LDH PAL Legacy Medicaid Form *(Appendix S)*
(Document on PA Tracking Log & EPSDT Service Log)

***SC must confirm waitlist placement with provider and document on the CPOC how you will ensure they move up the waitlist. Follow-up with provider must be made at least quarterly. SC must offer alternative providers who may not have a waitlist and document response received from family.**

If Service not provided in the amount PAed or Service not at times requested:
Send referral to LDH PAL using Referral to LDH PAL Legacy Medicaid Form *(Appendix S)*
(Document on PA Tracking Log &
EPSDT Service Log)

John Bel Edwards
GOVERNOR

Stephen R. Russo, JD
SECRETARY

State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

EPSDT BENEFICIARY'S CONSENT FOR AUTHORIZED REPRESENTATION

Beneficiary's Name _____

SSN # _____

ID# _____

I understand that all information gathered, on my behalf and/or for those persons for whom I am responsible, is personal and confidential. I understand that the function of the Authorized Representative is to represent me in the Comprehensive Plan of Care (CPOC) process and to sign CPOC documents on my behalf. I also understand that my authorized representative has the power to make decisions for me concerning all aspects of various Medicaid services administered by the Louisiana Department of Health (LDH). I understand this may require the Department to disclose information to the representative named below that may otherwise be confidential. I hereby waive any rights I may have to prevent disclosure by the Department to the authorized representative named below.

I understand that this authorization is limited solely to the individual named below and is valid until revoked by me. I further understand that I may cancel my appointment of the individual(s) named below as my Authorized Representative at any time upon written notice to the Department.

I understand that while some of the information gathered may have no impact on Medicaid services received, it may affect my liability to a third party should this information be disclosed to the third party by my Authorized Representative. I hereby hold the Louisiana Department of Health (LDH) harmless for any claim resulting from disclosure of information to a third party by my Authorized Representative.

I understand that if this authorization is not signed in the presence of agency staff or a program representative, a confirmation of authenticity may be conducted by agency staff.

NOTE:
If the beneficiary is a competent major and the authorized representative is being contacted and followed up with instead of the beneficiary, there must be documentation to support the beneficiary's request to have the authorized representative contacted or documentation of the beneficiary's inability to self-direct their care.

Authorized Representative Name: _____

Address: _____

Telephone Number (Home): _____ (Work): _____

Authorized Representative Signature: _____

Date: _____

Beneficiary's Signature: _____ Date: _____

Witness' Signature: _____ Date: _____

Support Coordinator's Signature: _____ Date: _____

STATE OF LOUISIANA

PARISH OF _____

Non-legal Custodian's Affidavit

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

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

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

1. Name of child: _____

2. Child's date of birth: _____

3. Name of adult giving authorization: _____

4. Adult's home address: _____

_____

5. [ ] I am a non-legal custodian.

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

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

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

7. Adult's date of birth: _____

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

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

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

Signed: _____

Date: _____

NOTICES:

1. This declaration does not affect the rights of the child's parent or legal guardian regarding the care, custody, and control of the child, and does not mean that the non-legal custodian has legal custody of the child.

2. A person who relies on this affidavit has no obligation to make any further inquiry or investigation.

3. This affidavit is not valid for more than one year from the date on which it was executed.

ADDITIONAL INFORMATION:

TO NON-LEGAL CUSTODIANS:

1. If the child stops living with you, you are required to notify anyone to whom you have given this affidavit as well as anyone of whom you have actual knowledge who received the affidavit from a third party.

2. If you do not have the information in item 8 (Louisiana driver's license or identification card), you must provide another form of identification, such as a social security card.

TO SCHOOL OFFICIALS:

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

TO HEALTH CARE PROVIDERS AND HEALTH CARE SERVICE PLANS:

1. No person who acts in good faith reliance upon a non-legal custodian's affidavit to render educational or medical services, without actual knowledge of facts contrary to those stated in the affidavit, is subject to criminal prosecution or civil liability to any person, or subject to any professional disciplinary action, for such reliance if the applicable portions of the form are completed.

2. This affidavit does not confer dependency for health care coverage purposes.

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

_____

Name of Notary Public:

EPSDT Quarterly Report Checklist

Fax to SRI, Attn: Kim Willems at 225-767-0502 or e-mail to ksalling@statres.com by the 5th day of the month following the end of each quarter.

SC Agency	
Region	

✓	Form
	Quarterly Report (Print Out from LSCIS)
	Number of trackable service needs matches number of service needs being tracked.
	Number of trackings without a date of choice of provider is zero or documentation and explanation is attached to the Quarterly Report.
	Quarterly Report of CPOC Revisions (Appendix W-2 with Print Out from LSCIS attached)
	Service Needs Changes Report attached *(the report does not need to be written onto Appendix W-2; just attached)*
	Record Reviews (Appendix W-3)
	For all PAs not Issued within 60 days
	For all Gaps in PA Authorization Periods
	If deficiencies were found in required contacts, timelines, follow up, documentation, etc. the agency will submit a Corrective Action Plan within 7 days and documentation that the Corrective Action Plan was carried out within 14 days. • CAP Due Date: _____ • Documentation of CAP completed Due Date: _____
	Training Log (Appendix W-4)
	For all new hires or new EPSDT Supervisors for the quarter

Your signature below indicates that the packet has been reviewed by your agency for completeness and that <u>all</u> required information is being submitted for review.

Signature of SCA Representative: _____ Date:_____

Quarterly Report of CPOC Revisions

Complete the following information for your agency for all EPSDT participants and e-mail to BHSF/SRI (ksalling@statres.com) by the 5th day of the month following the end of each quarter. The reporting information should reflect activities that occurred between the first and last day of the quarter. **Attach a print out of the Service Needs Changes report from LSCIS.**

Support Coordination Agency:_____ **Region:_____**

Quarter/Year:_____

Participant	Revision Date	Item, Information, or Service Revised

Issued: 7/19/2007
Revised 3/20/19

Record Review for EPSDT Quarterly Report

SCA/Region: **Quarter/Year:**

Beneficiary: **SC Assigned to Case:**

Service Need: **SC Supervisor:**

(One beneficiary and one service need per record review)

Select One:

- ☐ PA not issued within 60 days
- ☐ Gap in PA Authorization Periods

For PA not issued within 60 days, answer these questions:

1. Was the PA received?	☐ Yes ☐ No If Yes: • Date PA Notice Received: • Date of Decision: • Approval/Denial Status: ☐ Full Approval ☐ Partial Approval ☐ Partial Denial ☐ Denial
2. Provide a summary of the reason the PA was not issued within 60 days:	

For Gap in PA Authorization Periods, answer these questions:

1. PA End Date on the prior PA Tracking Log:	
2. PA Start Date on the current PA Tracking Log:	
3. Gap consisted of how many days?	
4. Was the service provided during the gap?	☐ Yes ☐ No
5. Was the gap due to the family choice?	☐ Yes ☐ No
If yes, explain why:	

6. Was the Referral to the Provider/MMCCM for the PA Renewal sent timely? *(45-60 days prior to the PA expiration for Legacy or 20-60 days prior for Medicaid Managed Care)*	☐ Yes ☐ No

Note: If no gap is found (#3) or the gap was due to the family's choice (#5), remove it from the Quarterly Report and submit page 1 of this Record Review as supporting documentation.
For all PAs Not Issued Within 60 Days and for all Gaps in PA Authorization Periods that are not due to family choice, answer <u>all</u> Required Record Review questions. The agency must review all documentation (CPOC, Quarterly Review, Tracking Log(s), Service Logs, etc.) to answer all Required Record Review Questions. If it's not documented, it didn't happen.

Supporting Document: TL = Tracking Log, SL = Service Log, QR = Quarterly Review.
Example: Service Log #145-1 - 2/1/23, Tracking Log COP 2/15/23, Quarterly Review 1/16/23

Required Record Review Questions	Yes	No	Supporting Document and Date of Service	Comments
1. Is the PA "Type of Request" correctly identified on the PA Tracking log?				☐ Initial ☐ Renewal ☐ Change in Service
2. **Timely PA Tracking:** Does the "Date of Service Request" entered on the Tracking Log match the documentation found in the record? *(Note: Review Service Logs and Quarterly Reviews prior to the "Date of Service Request" listed on the tracking log to ensure it was the initial request date.)*				• "Date of Service Request" on Tracking Log:
3. Is there documentation to support that the family was informed that a prescription was required and given the forms to be completed by the practitioner?				
4. Is there documentation to support that assistance was offered in scheduling an appointment if it is required for the prescription?				
5. Is there documentation to support timely assistance with the FOC and follow up to obtain a Choice of Provider from the beneficiary/guardian?				
6. If a willing provider could not be found, is there documentation of attempts to locate a provider and LDH Staff Line and/or MMCCM or PAL Referral if needed?				

Required Record Review Questions	Yes	No	Supporting Document and Date of Service	Comments
7. **Timely Referrals to Provider/MMCCM:** For MCO Tracking Logs that show 1st and 2nd Referral boxes: a. Was the Referral to MMCCM made within 3 days of the Date of Service Request? (Required for MCO Tracking Logs when provider has not been chosen.) For All Tracking Logs: b. Was the Referral to Provider/MMCCM made within 3 days of the Date of COP?				a. • Date of Service Request: • Date of Referral to Provider/MMCCM: b. • Date of COP: • Date of Referral to Provider/MMCCM:
8. **Timely 15 Day Contact:** Is there documentation of a Provider/MMCCM contact within 15 days of the Referral to Provider/MMCCM to check on the status of the referral and offer assistance if needed?				• Referral to Provider/MMCCM: • Date of 15 Day Provider/MMCCM Contact: • 2nd Referral to Provider/MMCCM: • Date of 2nd 15 Day Provider/MMCCM Contact:
9. Is there documentation to support the SC followed up with the family to see if the provider contacted them and if they contacted the practitioner to obtain the prescription?				

Required Record Review Questions	Yes	No	Supporting Document and Date of Service	Comments
10. **Timely 35 Day Contact:** Is there documentation of a provider/MMCCM contact within 35 days of the referral to the provider/MMCCM to check on the PA status?				• Date of Referral to Provider/MMCCM: • Date of 35 Day Provider/MMCCM Contact: • Date of 2nd Referral to Provider/MMCCM: • Date of 2nd 35 Day Provider/MMCCM Contact:
11. **Timely PA Packet Submission:** Was the PA packet submitted to FI (Fiscal Intermediary = Gainwell or MCO) within 35 days of the Referral to Provider/MMCCM?				• Date of Referral to Provider/MMCCM: • Date Packet Submitted to FI:
If **no**, answer these follow up questions:				
a. Was there a barrier to submitting PA packet timely?				
b. What was the barrier?				
c. Is there documentation to support the SC assisted in identifying and removing the barrier?				
d. **Timely 35 Day PAL:** Was the 35 day PAL Referral completed timely? (Legacy Medicaid service needs only)				• Date of Referral to PAL (Untimely PA Packet Submission):
e. Is there documentation to support the SC offered the family a change in providers?				

Required Record Review Questions	Yes	No	Supporting Document and Date of Service	Comments
12. **PA Packet**: Has the PA packet been submitted to the FI?				
If **yes**, answer these follow-up questions:				
a. Was the "Date Packet Submitted to FI" entered on the tracking log? (*Tracking Log)*				
b. Is there documentation to support the date packet submitted to FI?				
c. Was the "Date Provider PA Request Packet Received" entered or is the "Not Received" box checked?				
d. Is there documentation of a contact with the Provider/MMCCM 10 days after the PA packet was submitted (25 days for DME)?				
13. **Timely 60 Day PAL**: If the PA was not received within 60 days, was the 60 Day PAL Referral timely?				• Date of Referral to PAL (Untimely PA Packet Submission):
14. Is there documentation of ongoing contact with the participant/guardian and provider until the PA notice is received or the service request is resolved?				
15. Did the SC follow up and do planned activities and contacts as documented in the Service Logs, Quarterly Reviews or CPOC? Is there documentation of the planned actions, contacts and follow up?				
16. Was there adequate SC supervision to ensure the required contacts, PA tracking and follow ups were completed timely and to assist the SC with problem solving?				
17. Was the PA notice received?				• Date of Decision: • Date of PA Notice Received:

If PA notice has not been received, submit notification to ksalling@statres.com when the PA is received or the requested service need is resolved. Date submitted to Kim: _____	
If PA notice has not been received, what action will the SC take to obtain the PA? What is the barrier and how will it be removed? Frequent follow up is required.	Plan of Action:
18. **CAP:** Were deficiencies found in the required contacts, timelines, follow-up, documentation, etc.?	☐ Yes ☐ No
If **yes**, the agency will submit a Corrective Action Plan within 7 days. Documentation that the Corrective Action Plan was carried out must be submitted within 14 days.	• CAP due date: • CAP submit date: • Documentation CAP carried out due date: • Documentation submit date:

SC Assigned to the Case*: _____

**If the EPSDT Specialist is the SC assigned to the case, the EPSDT Specialist will not complete the record review or sign below. Their supervisor or the Program Manager will complete the record review.*

EPSDT Specialist Signature, Date: _____

EPSDT Specialist Supervisor's Signature, Date: _____

On-Site Program Manager's Signature, Date: _____

2023 EPSDT Support Coordination Training

Appendix W-4

Project: EPSDT Support Coordination Training

Agency/Region

I viewed the 2023 EPSDT Support Coordination Training Module with the trainer and read the entire 2023 EPSDT Support Coordination Training Handbook and Appendices to complete the required Annual EPSDT Support Coordination training.

Print Name	Signature (Agrees with the above statement	Position	Does the SC have EPSDT cases?	Date Training Module Completed	Date Handbook and Appendices Completed

I certify that training provided contained all necessary information to assure the individual is knowledgeable of the services available to EPSDT eligible individuals.

Date:_____

Signature of Trainer

Please submit a print out of your **Staff List Report from LSCIS with the completed **Training Log**. All **active EPSDT SCs, Supervisors and the Trainer** are to receive the annual EPSDT training following the annual training at LDH.*

All new hires are to receive the training as part of their orientation and prior to be being assigned an EPSDT caseload or prior to beginning supervision of EPSDT Support Coordinators. **Please submit documention of new hire training with the Quarterly Report or as it is completed.*

CHECKLIST FOR EPSDT SUPPORT COORDINATION APPROVAL PROCESS
INITIAL AND SPECIAL NEEDS SUPPORT COORDINATION

BENEFICIARY NAME:	**DATE:**
SUPPORT COORDINATOR AND AGENCY NAME:	

This checklist identifies the forms that are to be sent to BHSF/SRI for review and approval. The documents are to be sent immediately after submission of the plan of care in LSCIS for all Initial plans of care and all plans of care identified as "Special Needs." Documents can be e-mailed to ksalling@statres.com or faxed to 225-767-0502 attention: Kim Willems.

	FORM
	SOA and/or Participant Recap Sheet (if an Initial CPOC)
	CPOC Signature Page • With planning participant's signatures (everyone present signs in the box), participant/guardian's CPOC approval signature, SC signature & SC Supervisor signature.
	Typical Weekly Schedule
	EPSDT Rights & Responsibilities (just the signature sheet)
	Legal Guardianship Document, Supported Decision-Making Agreement, Power of Attorney, Non-Legal Custodian Affidavit, or an Authorized Representative Form • Required if the beneficiary is interdicted, if the beneficiary has given power of attorney to another person, or if the legal guardian is not the parent. An authorized representative form or supportive decision-making agreement needs to be on file if the beneficiary is a competent major and he or she does not sign the CPOC documents or if he or she is not the contact for monthly phone calls.
	Current Formal Information Documents • A current formal document is less than a year old at the time of CPOC meeting. • An initial CPOC requires all assessments/evaluations and supporting documents from the regional OCDD office in addition to current formal documents. • A CPOC flagged as "Special Needs" requires all of the current formal information documents.
	Is the beneficiary receiving **Special Education** services? Yes or No • If yes, must have current **Individualized Education Plan**.
	Is the beneficiary receiving **Extended Home Health** services? Yes or No • If yes, must have current **Extended Home Health Plan of Care**.
	Is the beneficiary receiving **Pediatric Day Healthcare** services? Yes or No • If yes, must have current **Pediatric Day Healthcare Plan of Care**.

Your signature below indicates that the packet has been reviewed by your agency for completeness and that all required information is being submitted for review by LDH-BHSF.

Signature:_____ Date:_____
SUPPORT COORDINATION AGENCY REPRESENTATIVE

CHECKLIST FOR EPSDT SUPPORT COORDINATION APPROVAL PROCESS
CPOC MONITORING CHECKLIST

BENEFICIARY NAME:	**DATE:**
SUPPORT COORDINATOR AND AGENCY NAME:	

This checklist identifies the forms that are to be sent to BHSF/SRI for review and approval if the annual CPOC is selected for CPOC Monitoring after submittal in LSCIS. Documents can be e-mailed to ksalling@statres.com or faxed to 225-767-0502 attention: Kim Willems. (Can check Recently Submitted CPOC report in LSCIS.)

	FORM
	SOA and/or Participant Recap Sheet (if needed to verify a valid SOA)
	CPOC Signature Page • With planning participant's signatures (everyone present signs in the box), participant/guardian's CPOC approval signature, SC signature & SC Supervisor signature.
	Typical Weekly Schedule
	EPSDT Rights & Responsibilities (just the signature sheet)
	Legal Guardianship Document, Supported Decision-Making Agreement, Power of Attorney, Non-Legal Custodian Affidavit, or an Authorized Representative Form • Required if the beneficiary is interdicted, if the beneficiary has given power of attorney to another person, or if the legal guardian is not the parent. An authorized representative form or supportive decision-making agreement needs to be on file if the beneficiary is a competent major and he or she does not sign the CPOC documents or if he or she is not the contact for monthly phone calls.
	Current Formal Information Documents • A current formal document is less than a year old at time of CPOC meeting.
	Is the beneficiary receiving **Special Education** services? Yes or No • If yes, must have current **Individualized Education Plan**.
	Is the beneficiary receiving **Extended Home Health** services? Yes or No • If yes, must have current **Extended Home Health Plan of Care**.
	Is the beneficiary receiving **Pediatric Day Healthcare** services? Yes or No • If yes, must have current **Pediatric Day Healthcare Plan of Care**.

Your signature below indicates that the packet has been reviewed by your agency for completeness and that all required information is being submitted for review by LDH-BHSF.

Signature:_____ Date:_____
SUPPORT COORDINATION AGENCY REPRESENTATIVE

Dear Recipient:

Enclosed is a card to keep that has phone numbers to call for assistance.

This is to let you know that if you feel you need a Medicaid covered service that requires prior approval, but providers of the service have refused to submit your request, you may request a "Review of Possible Eligibility" for the services. This review is available only if two (2) providers have refused to submit your full request, or if there is no other provider from whom to request the service.

To submit your request for a review, simply fill out the bottom of this form and send it to the address listed below. A physician's written statement as to why the services are necessary must be attached to the request. Medicaid will rule on whether you might be eligible for the service you are seeking. If you might be eligible Medicaid will find a provider to submit the request for you.

This option is only available to Medicaid recipients under age 21 who have been on the MR/DD Request for Services Registry on or after October, 1997 (the "*Chisholm*" class).

The enclosed card has a phone number to call if you need additional forms. You can also obtain them from a Medicaid case manager or from Medicaid's Prior Authorization Liaison (PAL), who can be reached at 1-800-807-1320.

Sincerely,

Louisiana Department of Health

- -

Name: ________________________________ Medicaid Identification #: _________________

Social Security #: _______________________ Phone Numbers(s): ______________________

How can we contact you? ____

Service(s) being requested: ____

____

A Doctor's statement as to why the services are necessary must be attached. Below, you must also list the providers that have refused to submit a request for these services:

Provider 1: __________________________ ________________________
Name Phone Number

Provider 2: __________________________ ________________________
Name Phone Number

Mail to: LDH-PAL
Post Office Box 91030 Bin #24
Baton Rouge, Louisiana 70821-9030

CHOICE of PROVIDER FORM
For EPSDT MEDICAID PROVIDERS

This form should be used for all Medicaid services requiring prior authorization

Type of Service (*Check the following service(s) that applies.)*

☐ **Physical Therapy**	☐ **Mental Health Services**
☐ **Occupational Therapy**	☐ **Dental Services**
☐ **Speech Therapy**	☐ **Vision Services**
☐ **Audiology Services**	☐ **Extended Home Health**
☐ **Medical Equipment (DME)**	☐ **Nutritional Services**
☐ **Medical Supplies**	☐ **Applied Behavioral Analysis (ABA)**
☐ **Personal Care Services**	☐ **Other**_____

The participant/family must check the appropriate statement below.

☐ **My support coordinator has explained to me that I have a choice of service providers when there is a choice available. I have reviewed a list of available providers and I understand that this list may not include <u>every</u> available provider. I understand that I may choose a new provider at any time. I have selected the following provider(s).** *(Participant/family may choose to list 1st, 2nd, 3rd choice.)*

1._____

2._____

3._____

☐ **My support coordinator has explained to me that I have a choice of service providers when there is a choice available. I have been informed that there is only one (1) provider available for this service. I understand that I may choose a new provider at any time if another provider is available. I have requested that a referral be made to this provider.** *(List provider.)*

4._____

☐ **I have already chosen the provider that I want. I do not wish to review a list of available providers. I understand that I may choose a new provider at any time. I have requested that a referral be made to this provider.** *(List provider.)*

5._____

Participant/authorized representative must sign and date below.

_____ _____

Participant/Authorized Representative *Date*

_____

Relationship to Participant