List of Appendices to EPSDT Support Coordination Handbook

Bayou Health Appendices

FOR YOUR INFORMATION!
SPECIAL MEDICAID BENEFITS FOR CHILDREN AND YOUTH

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

DD MEDICAID WAIVER SERVICES

To sign up for "waiver programs" that offer Medicaid and additional services to eligible persons (including those whose income may be too high for other Medicaid), ask to be added to the Request for Services Registry (RFSR) for people with Developmental Disabilities (DD). The **New Opportunities Waiver (NOW)** and the **Children's Choice Waiver** both provide services in the home, instead of in an institution, to persons who have intellectual disabilities and/or other developmental disabilities. Both waivers cover Family Support, Center-Based Respite, Environmental Accessibility Modifications, and specialized medical equipment and supplies. In addition, **NOW** covers services to help individuals live alone in the community or to assist with employment, and professional and nursing services beyond those that Medicaid usually covers. The **Children's Choice Waiver** also includes Family Training. Children remain eligible for the Children's Choice Waiver until their nineteenth birthday, at which time they will be transferred to an appropriate waiver for people with Developmental Disabilities (DD). The **Supports Waiver** provides specific, activity focused services rather than continuous custodial care. This waiver offers Supported Employment, Day Habilitation, Pre-Vocational Services, Respite, Habilitation and the Personal Emergency Response System. The **Residential Options Waiver (ROW)** is only appropriate for those individuals whose health and welfare can be assured via the support plan with a cost limit based on their level of support need. This waiver offers Community Living Supports, Companion Care, Host Home, Shared Living, Environmental Modifications, Assistive Technology, Center Based Respite, Nursing, Dental, Professional, Transportation-Community Access, Supported Employment, Pre-Vocational Services and Day Habilitation.

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

SUPPORT COORDINATION

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

THE FOLLOWING BENEFITS ARE AVAILABLE TO ALL MEDICAID ELIGIBLE CHILDREN AND YOUTH UNDER THEAGE OF 21 WHO HAVE A MEDICAL NEED. TO ACCESS THESE SERVICES CALL THE MEMBER'S BAYOU HEALTH PLAN, MEDICAID, OR MAGELLAN at 1-800-424-4489 or TTY 1-800-242-4416

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 evaluation; individual and/or group therapy; medication management; individual and parent/family intervention; supportive and group counseling; individual and group psychosocial skills training; behavior intervention plan development; Multi-Systemic Therapy, Functional Family Therapy, Homebuilders, residential and outpatient substance use treatment; mental health residential treatment in a therapeutic group home; and treatment in a psychiatric residential facility. All services are managed by the member's Bayou Health Plan, Medicaid (for Medicaid eligible children or youth not enrolled in Bayou Health or Magellan) or Magellan (Coordinated System of Care only).

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

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

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

Children enrolled in Bayou Health can access the listed services below by calling their individual health plan. Chisholm Class Members (Medicaid eligible children who are on the DD Request for Services Registry) are allowed to participate in Bayou Health Plans if they "opt in."

EPSDT EXAMS AND CHECKUPS

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

PERSONAL CARE SERVICES

Personal Care Services (PCS) are provided by attendants when physical limitations due to illness or injury require assistance with eating, bathing, dressing, toileting and personal hygiene. PCS do not include medical tasks such as medication administration, tracheostomy care, feeding

tubes or catheters. The Medicaid *Home Health* program or *Extended Home Health* program covers those medical services. PCS must be ordered by a physician. The PCS provider must request approval for the service from Medicaid.

EXTENDED SKILLED NURSING SERVICES

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

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

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

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

APPLIED BEHAVIORAL ANALYSIS-BASED THERAPY SERVICES (ABA)

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

MEDICAL EQUIPMENT AND SUPPLIES

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

TRANSPORTATION

Non-Emergency Transportation to and from medical appointments, if needed, is covered under the Bayou Health program. Even if Medicaid recipients are not covered under Bayou Health for other services, their transportation needs would be authorized and paid under their Bayou Health plan. Arrangements for transportation should always be made at least 48 hours in advance by calling the numbers shown below.

Aetna Better Health	1-877-917-4150
Amerigroup	1-866-430-1101
AmeriHealth Caritas	1-888-913-0364
Louisiana Healthcare Connections	1-855-369-3723
United Healthcare Community Plan	1-866-726-1472

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

If you are in a BAYOU HEALTH PLAN and need a service that is not listed above you can call your individual Bayou Health Plan.

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

HOW CAN MEDICAID HELP YOU?

PERSONAL CARE SERVICES

Personal care services (PCS) are provided by a trained worker. They may be needed if your child has a disability, illness, or injury and needs help with things like eating, bathing, dressing or grooming. PCS **does not include** medical or nursing tasks, like giving medicine, tube feeding, or suctioning. PCS **is not a substitute** for child care.

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

EXTENDED HOME HEALTH

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

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

MEDICAL EQUIPMENT AND SUPPLIES

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

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

(continued on reverse side of flyer)

APPLIED BEHAVIORAL ANALYSIS

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

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

CUSTOMER SERVICE INFORMATION FOR MEDICAID INQUIRIES:

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

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

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

Medicaid Services Chart
http://new.dhh.louisiana.gov/assets/docs/Making_Medicaid_Better/Medicaid_Services_Chart.pdf

E-mail • medicaidweb@la.gov

Medicaid Website • www.medicaid.la.gov

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

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

LOUISIANA DEPARTMENT OF HEALTH & HOSPITALS

MEDICAID SERVICES CHART

March 2016

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

MEDICAID SERVICES

SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
Adult Denture Services	*Dentist*	Medicaid recipients 21 years of age and older. **(Adults, 21 and over, certified as Qualified Medicare Beneficiary (QMB) only, 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.	MCNA Dental administers the dental benefits for eligible Medicaid recipients. Contact MCNA Dental to locate a provider in their network and for questions about covered dental services. Recipients that reside in an Intermediate Care Facility for Developmental Disabilities (ICF/DD) will continue to receive adult denture services through the Fee-For-Service Dental Services Program.	*MCNA Dental* *1-855-702-6262* *Visit online at www.MCNALA.net* Cordelia Clay 225/342-4182

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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*	1. be from birth up to 21 years of age; 2. 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, 3. self-injury, elopement, etc.); 4. be medically stable and does not require 24-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities (ICF/ID); 5. 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; 6. have a comprehensive diagnostic evaluation by a qualified health care professional; and 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 by a physician and **Prior Authorization** is required. The provider of services will submit requests for Prior Authorization.	Rene Huff 1-844-423-4762

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MEDICAID SERVICES					
SERVICE	**HOW TO ACCESS SERVICES**	**ELIGIBILITY**	**COVERED SERVICES**	**COMMENTS**	**CONTACT PERSON**
Audiological Services –*See EarlySteps; EPSDT Screening Services; Hospital-Outpatient services; Physician/ Professional Services; Rehabilitation Clinic Services; Therapy Services*					

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MEDICAID SERVICES

SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
Behavioral Health Services – Adults		Medicaid eligible adult Adults eligible to receive mental health rehabilitation services under Medicaid State Plan include those who meet one of the following criteria and is 21 years and older: Must have a mental health diagnosis, assessed by a licensed mental health professional, and receives LOCUS score of 2	Any Medicaid eligible adult may receive the following behavioral health service if medical necessity is established by a licensed mental health professional (LMHP): 1. Addiction Services (outpatient and residential) 2. Psychiatric Inpatient Hospital The following additional services are available: 1. Treatment Plan Development 2. Psychosocial Rehabilitation 3. Crisis Intervention 4. Community Psychiatric Support & Treatment 5. Assertive Community Treatment 6.Outpatient Therapy Assessment and LOCUS score are not required to receive LMHP services.	Adult Behavioral Health services are administered by the Bayou Health Plans.	Aetna www.aetnabetterhealth.com/louisiana 1-855-242-0802 Amerigroup www.amerigroup.com 1-800-600-4441 AmeriHealth Caritas www.amerihealthcaritasla.com 1-800-756-0004 Louisiana Healthcare Connections www.louisianahealthconnect.com 1-866-595-8133 United Healthcare Community Plan www.uhccommunityplan.com 1-844-253-0667
Chemotherapy Services-*See Hospital-Outpatient Services; Physician/ Professional Services*	*Hospital* *Physician's office or clinic*	All Medicaid Recipients.	Chemotherapy administration and treatment drugs, as prescribed by physician.		

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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.	Medically necessary manual manipulations of the spine when the service is provided as a result of a referral from a EPSDT medical screening provider or Primary Care Provider (PCP).	Kimberly Cezar 225/342-6253
Coordinated System of Care (CSoC)- Home and Community Based Services Waiver		Any child/youth experiencing a serious emotional disturbance who is at risk of out-of home placement. A recipient must be under the age of 22 and meet the level of care or level of need through a Child and Adolescent Needs and Strengths (CANS) comprehensive assessment	1. WRAP Around Planning 2. Parent Support & Training 3. Youth Support & Training 4. Independent Living/Skills Building 5. Short Term Respite Care 6. Crisis Stabilization 7. Case Conference 8. Treatment Planning	CSoC services are administered by Magellan Health Services of Louisiana.	Magellan Health Services of Louisiana 1-800-424-4399 Visit online at www.MagellanofLouisiana.com
Dental Care Services *- See Adult Denture Services; and EPSDT Dental Services*					
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 not reimbursable as durable medical equipment items. **EPSDT RECIPIENTS ARE EXCLUDED FROM THIS LIMITATION.**	All services must be prescribed by a physician and must be **Prior Authorized**. DME providers will arrange for the **Prior Authorization** request.	Sylvia Vinning 225/342-1247

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

MEDICAID SERVICES

SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
EarlySteps *(Infant & Toddler Early Intervention Services)*		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)** c. -- communication development social or emotional development d. adaptive skills development (also known as self-help or daily living skills) 1. 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 1-866-783-5553 or 1-866-earlystep For families Brenda Sharp 225/342-8853

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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.	1. Psychosocial Rehabilitation 2. Crisis Intervention 3. Community Psychiatric Support & Treatment 4. Therapeutic Group Home 5. Addiction Services (outpatient and residential) 6. Inpatient Hospital 7. Psychiatric Residential Treatment Facility (PRTF) 8. Outpatient Therapy (medication management, individual, family, and group counseling) 9. Multi-systemic Therapy 10. Functional Family Therapy 11. Homebuilders 12. Assertive Community Treatment 13. Coordinated System of Care**	EPSDT Behavioral Health services are administered by the Bayou Health Plans. **The Coordinated System of Care (CSoC) is designed to provide services and supports to children and youth who have significant behavioral challenges or co-occurring disorders and are in or at imminent risk of out-of-home placement. Youth must meet medical necessity to receive CSoC services. CSoC services include: Parent Support & Training, Youth Support & Training, Independent Living/Skills Building, Short Term Respite Care and Crisis Stabilization.	Aetna www.aetnabetterhealth.com/louisiana 1-855-242-0802 Amerigroup www.amerigroup.com 1-800-600-4441 AmeriHealth Caritas www.amerihealthcaritasla.com 1-800-756-0004 Louisiana Healthcare Connections www.louisianahealthconnect.com 1-866-595-8133 United Healthcare www.uhccommunityplan.com For CSoC services: Magellan Health Services of Louisiana 1-800-424-4399 Visit online at www.MagellanofLouisiana.com (**For CSoC services ONLY)

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MEDICAID SERVICES

SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
EPSDT Dental Services	*Dentist*	Medicaid recipients 0 to 21 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.	MCNA Dental administers the dental benefits for eligible Medicaid recipients. Contact MCNA Dental to locate a provider in their network and for questions about covered dental services. Recipients that reside in an Intermediate Care Facility for Developmental Disabilities (ICF/DD) will continue to receive dental services through the Fee-For-Service Dental Services Program.	*MCNA Dental* *1-855-702-6262* *Visit online at* *www.MCNALA.net* Cordelia Clay 225/342-4182

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

MEDICAID SERVICES

SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
EPSDT Personal Care Services *(See Long Term – Personal Care Services (LT-PCS)* for Medicaid recipients ages 65 or older, or age 21 or older with disabilities)	*Physician* and *Personal Care Attendant Agencies*	All Medicaid recipients 0 to 21 **not** receiving Individual Family Support waiver services. However, once a recipient receiving Individual Family Support waiver services has exhausted those services they are then eligible for EPSDT Personal Care Services. 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 Molina. 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 physician's prescription and meet medical criteria. Does **not** include medical tasks. Provided by licensed providers enrolled in Medicaid to provide Personal Care Attendant services.	Michelle Renée 225/342-5691 Deloris Young 225/342-1417
EPSDT Screening Services *(Child Health Screenings/Checkups*)	Physician	All Medicaid recipients 0 through 20 years of age.	Medical Screenings (including immunizations and certain lab services). Vision Screenings Hearing Screenings Dental Screenings Periodic and Interperiodic Screenings	Recipients receive their screening services from the primary care provider (PCP) or someone designated by the PCP.	Deloris Young 225/342-1417 *Specialty Care Resource Line* *(877) 455-9955*

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MEDICAID SERVICES

SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
Family Planning Services – *Take Charge Plus*	*Office of Public Health-Family Planning Clinics* *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.	Seven office visits including a well visit and care related to family planning • 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.	Kimberly Cezar 225/342-6253 Jairus Methvin 225/342-6923
Family Planning Services in Physician's Office – *See Physician/ Professional Services*					
Federally Qualified Health Centers (FQHC)	*Nearest FQHC*	All Medicaid recipients.	Professional medical services furnished by physicians, nurse practitioners, physician assistants, nurse midwives, clinical social workers, clinical psychologists, and dentists. Immunizations are covered for recipients under age 21.	There are 3 components that may be provided: 1) Encounter visits; 2) EPSDT Screening Services; and 3) EPDST Dental, and Adult Denture Services.	Kimberly Cezar 225/342-6253

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

MEDICAID SERVICES

SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
Free Standing Birthing Centers	*Certified Nurse Midwife or Licensed Midwife*	All Medicaid recipients	Vaginal delivery services to 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.	Libby Gonzales 225/342-6884
Hearing Aids - *See 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**.	Sylvia Vinning 225/342-1247 Stephanie Young 225/342-1461
Hemodialysis Services - *See 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.		Kimberly Cezar 225/342-6253
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.	• Intermittent/part-time nursing services including skilled nurse visits. • Aide Visits • Physical Therapy • Occupational Therapy • Speech/Language Therapy	Recipients receiving Home Health must have physician's prescription and signed plan of care. PT, OT, and Speech/Language Therapy require **Prior Authorization**.	Sylvia Vinning 225/342-1247

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

MEDICAID SERVICES

SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
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 physician's prescription. Extended Skilled nursing services require **Prior Authorization**.	Sylvia Vinning 225/342-1247 Stephanie Young 225/342-1461
Hospice Services	*Hospice Provider/ Physician*	All Medicaid recipients. Hospice eligibility information: 1-800-877-0666 Option 2	Medicare allowable services.		Deloris Young 225/342-1417 Jairus Methvin 225/342-6923
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
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.	I	Libby Gonzales 225/342-6884

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MEDICAID SERVICES

SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
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 services require **Prior Authorization**. Provider will submit request for **Prior Authorization**.	Libby Gonzales 225/342-6884
Hospital - Emergency Room Services	*Physician/ Hospital*	All Medicaid recipients.	Emergency Room services.	**Recipients 0 to 21 years -** No service limits. **Recipients 21 and older -** Limited to 3 emergency room visits per calendar year (January 1 - December 31).	Libby Gonzales 225/342-6884
Immunizations *See FQHC; EPSDT Screening Services; Physician/Professional Services; Rural Health Clinics*					
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.	Michelle Renee 225/342-5691 Stephanie Young 225/342-1461

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

MEDICAID SERVICES

SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
Long Term - Personal Care Services **(LT-PCS)** *(See EPSDT Personal Care Services* for Medicaid recipients ages 0 to 21)	Contact: Louisiana Options in Long Term Care (XEROX) 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.	Office of Aging and Adult Services (OAAS) Contact: Louisiana Options in Long Term Care (XEROX) 1-877-456-1146 Anne Deitch OAAS Helpline 1-866-758-5035 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.		Jode Burkett 225/342-2094

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

Medical Transportation (Non-Emergency)	*All Medicaid recipients who are NOT covered under a Bayou Health managed care plan should contact* ***Southeastrans at 1-855-325-7565*** *to schedule a ride.* *Medicaid recipients who ARE covered under a Bayou Health managed care plan should contact the call centers as follows:* *Aetna Better Health* *1-877-917-4150* *Amerigroup* *1-866-430-1101* *AmeriHealth Caritas* *1-888-913-0364* *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.**	Jode Burkett 225/342-2094

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MEDICAID SERVICES

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

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MEDICAID SERVICES

SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
Optical Services	*Optometrist, Ophthalmologist or Optical Supplier*	All Medicaid recipients.	**Recipients 0 to 21** Examinations and treatment of eye conditions, including examinations for vision correction, refraction error. 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. 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.	**Recipients 0 to 21** Specialty eyewear and contact lenses, if medically necessary for EPSDT eligibles requires **Prior Authorization**. The provider will submit requests for the **Prior Authorization**. A prior authorization approval does not guarantee patient eligibility. Prescriptions are required for all glasses/contacts. After a prescription is obtained, the recipient may see an optical supplier to receive the glasses/contacts. **Recipients 21 and over** **NON-COVERED SERVICES:** - routine eye examinations for vision correction - routine eye examinations for refraction error - eyeglasses	Sylvia Vinning 225/342-1247 Stephanie Young 225/342-1461 (Eye surgery and Optical services other than eyeglasses and eye exams)
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 to 21 who have a medically fragile condition and who require nursing supervision and possibly therapeutic interventions all or part of the day due to a medically complex condition.	Nursing care, Respiratory care, Physical Therapy, Speech-language therapy, occupational, personal care services and transportation to and from PDHC facility	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.	Jairus Methvin 225/342-6923 Stephanie Young 225/342-1461

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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) Contact: PACE GNO at (504) 945-1531 Franciscan PACE Baton Rouge: (225)490-0640 Franciscan PACE Lafayette (337) 470-4500

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MEDICAID SERVICES

SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
Pharmacy Services	Pharmacies	All Medicaid recipients except some who are Medicare/Medicaid eligible. Recipients who are full benefit dual eligible (Medicare/Medicaid) 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; • Vaccines covered in other programs; • Drug Efficacy Study Implementation (DESI) drugs; • Erectile Dysfunction (ED) Medications • Over the counter (OTC) drugs with some exceptions; Narcotics prescribed only for narcotic addiction	Co-payments ($0.50-$3.00) are required except for some recipient categories. NO co-payments for the following: • Under age 21 • Pregnant women • Long Term Care recipients • American Indians/Alaska Natives • Waiver categories • Influenza immunizations 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.	Melwyn Wendt 225/342-3908 Paul Knecht 225/342-1589 For 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*					
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, audiologist. Immunizations are covered for recipients under age 21. Certain family planning services when provided in a physician's office.	Some services require **Prior Authorization**. Providers will submit requests for **Prior Authorization**. Services are subject to limitations and exclusions. Your physician or healthcare professional can help you with this.	Libby Gonzales 225/342-6884 Immunizations: Deloris Young 225/342-1417 Family Planning Services: Kimberly Cezar 225/342-6253
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**.	Stephanie Young 225/342-1461

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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. Other pre- & post-natal care and delivery. Lab and radiology services.	Some limitations apply.	Kimberly Cezar 225/342-6253
Psychiatric Hospital Care Services - *See Hospital-Inpatient Services*					
Rehabilitation Clinic Services	*Physician*	All Medicaid recipients	Occupational Therapy Physical Therapy Speech, Language and Hearing Therapy	All services must be **Prior Authorized**. The provider of services will submit the request for **Prior Authorization.**	Deloris Young 225/342-1417 Jairus Methvin 225/342-6923
Rural Health Clinics	*Rural Health Clinic*	All Medicaid recipients	Professional medical services furnished by physicians, nurse practitioners, physician assistants, nurse midwives, clinical social workers, clinical psychologists, and dentists. Immunizations are covered for recipients under age 21.	There are 3 components that may be provided: 1) Encounter visits; 2) KIDMED Screening Services; and 3) EPDST Dental, and Adult Denture Services.	Kimberly Cezar 225/342-6253
Sexually Transmitted Disease Clinics (STD)	*Local Health Unit*	All Medicaid recipients.	Testing, counseling, and treatment of all sexually transmitted diseases (STD). Confidential HIV testing.		Deloris Young 225/342-1417
Speech and Language Evaluation and Therapy – *See EarlySteps; Home Health; Hospital-Outpatient Services; Rehabilitation Clinic Services; Therapy Services*					

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MEDICAID SERVICES

SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
Support Coordination Services (Case Management) - **Children's Choice Waiver**		**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://new.dhh.louisiana.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 DHH, 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, Waiver Supports and Services 1-866-783-5553
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 DHH, *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 call 1-866-758-5035 or 225-219-0643

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

MEDICAID SERVICES

SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
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 (Call SRI at 1-800-364-7828).** 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 DHH, BHSF, and Waiver Compliance Section. The Support Coordination Agency will submit requests for the Prior Authorization to SRI. For other EPSDT services, see that portion of the chart.	SRI 1-800-364-7828 Must be on the DD Request for Services Registry
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://www.earlysteps.dhh.louisiana.gov	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

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

MEDICAID SERVICES

SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
Support Coordination Services (Case Management**) - New Opportunities Waiver (NOW)**		**Medicaid recipients must be receiving the NOW.** There is a **Request for Services Registry (RFSR**) for those requesting waiver services. To get on the Request for Services Registry, call the Office for Citizens with Developmental Disabilities District/Authority/Local Regional Office contact information is located at: *http://new.dhh.louisiana.gov/index.cfm/page/134/n/137*	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 DHH, 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, 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://new.dhh.louisiana.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 DHH, 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, Waiver Supports and Services 1-866-783-5553 Complaints Line: 1-800-660-0488

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

MEDICAID SERVICES

SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
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://new.dhh.louisiana.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	Services must be **prior authorized** by DHH, Office for Citizens with Developmental Disabilities, Waiver Supports and Services. The support coordinator will submit requests for the **Prior Authorization**.	Office for Citizens with Developmental Disabilities, Waiver Supports and Services 1-866-783-5553
Therapy Services	*Recipients have the choice of services from the following provider types:* *Home Health;* *Hospital-Outpatient Services;* *Rehabilitation Clinic Services*	Medicaid recipients **birth 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.	Sylvia Vinning 225/342-1247 Stephanie Young 225/342-1461 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.*

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

MEDICAID SERVICES

SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
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.	Sylvia Vinning 225/342-1247 Stephanie Young 225/342-1461
Therapy Services continued	*EPSDT Health Services*- Local Education Agencies (LEA) e.g. School Boards	Medicaid recipients **3 through 20** years of age.	• Audiological Evaluation and Therapy • Occupational Therapy Evaluation and Treatment services • Physical Therapy Evaluation and Treatment services • Speech & Language Evaluation and Therapy • Behavioral Health, Evaluation and Therapy Services • Nursing Services	Services are performed by the Local Education Agencies (LEA) All EPSDT Health Services must be included in the child's Individualized Education Program (IEP). If services are provided by a, LEA Prior Authorization requirements are met through inclusion of services on the IEP.	Ron Johnson 225/342-3881
Transportation *See Medical Transportation*					
Tuberculosis Clinics	*Local Health Unit*	All Medicaid recipients	Treatment and disease management services including physician visits, medications and x-rays.		Deloris Young 225/342-1417
X-Ray Services - *See Laboratory Tests and X-Ray Services*					
WAIVER SERVICES:		There is a Request for Services Registry (RFSR) for those requesting any of the waiver services below.			**See Specific Waiver**

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MEDICAID SERVICES

SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
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.	Office of Aging and Adult Services (OAAS) To Apply Contact: Louisiana Options in Long Term Care 1-877-456-1146 Participants call 1-866-758-5035 or 225/219-0643
Children's Choice		Child must be on the DD Request for Services Registry, less than 19 years old, disabled according to SSI criteria, require ICF/DD level of care, have income less than 3 times SSI amount, resources less than $2,000 and meet all Medicaid non-financial requirements.	- 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 $16,410 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. (See Appendix for telephone numbers)** *Complaints Line: 1-800-660-0488*	Office for Citizens with Developmental Disabilities Districts/ Authorities (SYSTEM ENTRY) contact information is located at: http://new.dhh.louisiana.gov/index.cfm/page/134/n/137 Tanya Murphy 225/342-0095

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

MEDICAID SERVICES

SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
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.	Office of Aging and Adult Services (OAAS) To Apply Contact: Louisiana Options in Long Term Care 1-877-456-1146 Participants call 1-866-758-5035 or 225/219-0643
New Opportunities Waiver (NOW)		Individuals three(3) years of age or older, who have a developmental disability which manifested prior to the age of 22, and who meet both SSI Disability criteria and the level of care determination for an ICF/DD.	An array of services to provide support to maintain persons in the community: Individual Family Support, Day and Night; Shared Supports; Center Based Respite Care; Community Integration Development; Environmental Accessibility Adaptations, Specialized Medical Equipment and Supplies; Substitute Family Care Services; Supported Living; Day Habilitation; Supported Employment; Employment-Related Training; Professional Services; One Time Transitional Expense; Skilled Nursing; Housing Stabilization/ Housing Stabilization Transition and Personal Emergency Response System.	***Call the Office for Citizens with Developmental Disabilities Districts/Authorities/Local Regional Offices for status on the Request for Services Registry. (See Appendix for telephone numbers)** *Complaints Line: 1-800-660-0488*	Office for Citizens with Developmental Disabilities Districts/Authorities SYSTEM ENTRY contact information is located at: http://new.dhh.louisiana.gov/index.cfm/page/134/n/137 Kim Kennedy 225/342-4464

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

MEDICAID SERVICES

SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
Residential Options Waiver (ROW)		Individuals, birth to end of life, who have a developmental disability which manifested prior to the age of 22. (Must meet the Louisiana definition of DD).	Covered services include: Support Coordination, Community Living Supports, Host Home Services, Companion Care Services, Shared Living, Respite Care-Out of Home, Personal Emergency Response System, One Time Transition Services, Environmental Accessibility Adaptations, Assistive Technology/Specialized Medical Equipment and Supplies, Transportation-Community Access, Professional Services, Nursing Services, Dental Services, Supported Employment, Prevocational Services, Day Habilitation and Housing Stabilization/ Housing Stabilization Transition	Complaints Line: 1-800-660-0488	Office for Citizens with Developmental Disabilities Districts/Authorities/Local Regional offices. System Entry contact information is located at: http://new.dhh.louisiana.gov/index.cfm/page/134/n/137 Jeannathan H. Anderson 225/342-5647
Supports Waiver		Individuals age 18 and older who have been diagnosed with a Developmental Disability which manifested prior to age 22. (Must meet the Louisiana definition of DD).	Covered services include: Support Coordination, Supported Employment, Day Habilitation, Pre-Vocational Habilitation, Respite, Personal Emergency Response System, Housing Stabilization Transition, Housing Transition, and habilitation	Complaints Line: 1-800-660-0488	Office for Citizens with Developmental Disabilities Human Services District or Authority Offices System Entry contact information is located at: http://new.dhh.louisiana.gov/index.cfm/page/134/n/137 Rosemary Morales 225/342-0095

*** 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.**

Frequently Asked Children's Choice Questions

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

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

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

3. What services are available through Children's Choice?
- Support Coordination
- Family Support
- Center-based Respite
- Environmental Accessibility Adaptations
- Family Training
- Specialized Medical Equipment and Supplies
- Therapy Services
- Aquatic Therapy
- Art Therapy
- Music Therapy
- Hippotherapy
- Therapeutic Horseback Riding
- Sensory Integration Therapy
- Housing Stabilization Transition Services
- Housing Stabilization
- Medical coverage via the Medicaid program

4. What are some of the things that would be covered by the Medicaid card?
When a child is certified for Children's Choice, they will be entitled to receive medical services and get a Medicaid card.

Some services include physician services, hospital services, Applied Behavioral Analysis-Based Therapy, home health, additional personal care services, durable medical equipment, pharmacy services and many others.

5. What is the New Opportunities Waiver (NOW)?
The NOW is a comprehensive community-based waiver program that serves both children and adults with developmental disabilities. Traditionally, Medicaid pays for and provides services for these individuals in

institutional settings. Through the waiver program, citizens with developmental disabilities have greater flexibility to choose where they want to live, and the services and supports that best suit their needs, while still receiving Medicaid benefits.

The NOW pays for services such as personal care attendants, environmental modifications, assistive devices, respite care and many other services. In addition, day/vocational services and residential alternatives (such as supervised independent living and extended family living) are provided**.**

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

A parent can call Toll Free 1-866-783-5553 or contact their Human Services Authorities or Districts to obtain their child's request date. Registry Dates that are currently being served can be accessed at the OCDD Request for Services Registry web page at http://new.dhh.louisiana.gov/index.cfm/page/155

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

When Children's Choice opportunities are available, letters go out to families. Families who have initially said "no" will not be offered a Children's Choice Waiver again, unless OCDD has gone through the entire DD Request for Services Registry (RFSR) and there are still CC Waiver slots available, they would then be re-offered a CC Waiver by their date of request on the DD RFSR.

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

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

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

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

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

No, families must choose either to accept a slot in the Children's Choice Waiver or to remain on the DDRFSR. This is an individual decision based on a family's current circumstances. A family who chooses Children's Choice may later experience a crisis in circumstances that increases the need for paid supports to a level that cannot be accommodated within the cap on waiver expenditures. At that time a crisis or non-crisis designation request can be made.

11. What are the non-crisis provisions?

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

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

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

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

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

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

When the crisis occurs, the family should contact the support coordination agency to convene the team to evaluate the need and to request approval of the needed services. After all documentation is prepared and sufficient evidence of the need is presented to the State Office Review Committee an urgent request can be approved within two days.

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

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

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

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

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

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

16. How do I choose a support coordination agency?

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

17. Can families who accept Children's Choice for their child receive the funding directly, or through a fiscal intermediary, so they can recruit, hire or fire the in-home supporters? Families can't receive the funding directly**,** but they can hire workers directly and have them paid through a fiscal intermediary that has a contract with the State. This is called the Self-directed option.

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

The process works as follows:

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

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

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

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

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

Yes. The Department of Health and Hospitals (DHH) raised the yearly cap from $7,500 to $15,000 to $17,000 per plan-of-care-year and as a result of a budgetary shortfall service cap was decreased to $16,410.

21. **If I have concerns about my service provider(s) or support coordinator, who should I call?** Call the OCDD toll-free help line at 1-866-783-5553.

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

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

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

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

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

This acceptance should have no effect on other Medicaid state plan services. SSI would need to be contacted to see what effect it would have, as SSI is an individual determination.

25. **What is considered "direct care"?**

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

26. **Will my waiver services be affected if I choose to opt into a Medicaid Bayou Health plan?** Participation in a Bayou Health plan will have no effect on how you will receive your waiver services.

DEPARTMENT OF HEALTH AND HOSPITALS
OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES (OCDD)/
WAIVER SUPPORTS AND SERVICES

NEW OPPORTUNITIES WAIVER (NOW) FACT SHEET

Description	Home and Community-Based Services Waiver programs are based on federal criteria, which allow services to be provided in a home or community-based setting for the recipient who would otherwise require institutional care. Due to the demand for these services, there is a Developmental Disabilities Request for Services Registry (RFSR) that lists individuals who meet the Louisiana definition for developmental disability and their request date. This waiver is offered on a first-come, first-served basis. Persons interested in being added to the Developmental Disabilities Request for Services Registry for this waiver should contact their local Human Services District/Authority. The application process does not begin until a waiver opportunity is available. At that time, medical and financial determinations are completed simultaneously to validate that the individual has a developmental disability and meets the financial and medical/psychological requirements for institutional care in an Intermediate Care Facility for Persons with Developmental Disabilities (ICF/DD). Through freedom of choice, requestors choose their support coordinator and direct service provider(s). The New Opportunities Waiver (NOW) is only appropriate for those individuals whose health and welfare can be assured via an Individual Support Plan and for whom home and communitybased waiver services represent a least restrictive treatment alternative. The NOW is intended to provide specific, activity-focused services rather than continuous custodial care. The following are the services provided under the NOW: Individualized and Family Support (IFS) Service-Day-Night; Center-Based Respite; Community Integration and Development; Environmental Accessibilities Adaptations; Specialized Medical Equipment and Supplies as an Extended State Plan Service; Supported Living; Substitute Family Care; Day Habilitation and Transportation for Day Habilitation; Supported Employment and Transportation for Supported Employment; Employment Related Training; Professional Services; Personal Emergency Response System; Skilled Nursing Services; and One-Time Transitional Services; Self- Direction Option; Housing Stabilization Transition Services; and Housing Stabilization Services.
Level of Care	Requestors **must meet ICF/DD level of care** for medical and/or psychological criteria. Procedures and requirements are the same as ICF/DD facility determination for admission.
Population	Age 3 years and older and have a developmental disability, which manifested prior to age 22. Must meet the Louisiana definition for developmental disability.
Financial	Income - The monthly income can be no greater than 3 times the Supplemental Security Income (SSI) amount. Income of other family members is not considered unless there is a minor child who does not have SSI. Parental income is counted toward minor children for the month of admission only. The income of the minor and the income of the parent(s) with whom the child lived during that month are counted together. * Resources - The income limit for waiver, also known as Special Income Limit is $2,199 for an individual and $4,398 for a couple (when both spouses need long-term care). Individuals with income that exceeds the Special Income Limit may still qualify for coverage of waiver services in Waiver Spend-down. * Waiver Spend-down - An individual may have to pay towards the cost of care in Waiver Spend-down. The individual's liability is based on their income after the income deductions

	are applied. Waiver Spend-down has a standard $20 income deduction. Also $65 and ½ of the remaining income is deducted from all earned income. After the income deductions are applied, the average monthly waiver rate (Currently $6942.96 for NOW) and other allowable incurred medical expenses are used to "spend-down" an individuals' excess income qualifying the individual for Waiver Spend-down. Allowable incurred medical expenses include Medicare and private health insurance premiums, deductibles, coinsurance, or copayment charges, and medical/remedial care expenses incurred by an individual that are not subject to payment by a third party. All individuals are allowed to retain from their income a basic needs allowance which is equal to the SIL ($2199 for 2015) and the amount of the incurred medical expenses not paid by a third party. Any remainder will be the individual's liability for the cost of care in Waiver Spend-down. * The resources limits are subject to change each year.

For Information About Accessing NOW Services,
Please Contact Your Human Services District/Authority.

CHILDREN'S CHOICE WAIVER FACT SHEET

Description	The Children's Choice Waiver began on February 21, 2001 to offer supplemental support to children with developmental disabilities who currently live at home with their families or who will leave an institution to return home. • Children's Choice is an option offered to children on the Developmental Disabilities Request for Services Registry (RFSR) for the New Opportunity Waiver (NOW), as funding permits. • Families choose to either apply for Children's Choice, or remain on the Developmental Disabilities Request for Services Registry for the NOW. • Waiver participants are eligible for all medically necessary Medicaid services, including EPSDT screenings and extended services, and will also receive up to $16,410 per year in Children's Choice services (including required Support Coordination (case management). Services received through the Medicaid State plan will not count against the Children's Choice Waiver cap. • Service package is designed for maximum flexibility. • Children who "age out" (reach their 19th birthday) will transfer into an appropriate waiver for adults as long as they remain eligible for waiver services. The following services are available through the Children's Choice Waiver: Support Coordination, Family Support, Center-Based Respite, Family Training, Environmental Accessibility Adaptations, Specialized Medical Equipment and Supplies. Therapy Services include Aquatic Therapy, Art Therapy, Music Therapy, Hippotherapy/ Therapeutic Horseback Riding and Sensory Integration Therapy. Additional services include Housing Stabilization Services and Housing Stabilization Transition Services for Permanent Supportive Housing participants. • A family choosing Children's Choice may later experience a crisis increasing the need for paid supports to a level, which would be more than the $16,410 cap on Children's Choice expenditures. Crisis designation is time limited, depending on the anticipated duration of the causative event. Each request for crisis designation may be approved for a maximum of three months or the annual POC date, not to exceed 12 months. • A family may also experience a temporary "non-crisis" that could increase the need for additional supports beyond the $16,410 cap and allow the participant's name to be restored to the Developmental Disabilities Request for Services Registry for the NOW. Current Children's Choice Waiver services will not be terminated as a result of restoring the name to the registry. Special provisions have been made to allow someone to be restored to the registry until a NOW opportunity becomes available. Note: Planning of services is crucial for Children's Choice Waiver participants. Over utilization of services does not constitute necessity for crisis support
Level of Care	Recipients **must meet the ICF/DD level of care** for medical and/or psychological criteria. Procedures and requirements for admission to the waiver are the same as for ICF/DD determination.
Population	Age - Birth through age 18 years. Disability – Meets the Louisiana definition for a developmental disability.
Eligibility	**Income** – Up to three times the SSI amount. Income of other family members is not considered. **Needs Allowance** – Three times the SSI amount. **Resources** – Less than $2,000. **Non-Financial** – Meets all Medicaid non-financial requirements (citizenship, residence, Social Security number, etc.) **Other** – Same resource, disability, parental deeming, etc. as ICF/DD.

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

DEPARTMENT OF HEALTH AND HOSPITALS
OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES (OCDD)
WAIVER SUPPORTS AND SERVICES

SUPPORTS WAIVER FACT SHEET	
Description	Home and Community-Based Services Waiver programs are based on federal criteria that allow services to be provided in a home or community-based setting for the participant who would otherwise require institutional care. There is a Developmental Disability (DD) Request for Services Registry (RFSR) that includes individuals who meet the Louisiana definition for developmental disability and their request date, but do not have reserved capacity. Persons interested in being added to the Developmental Disability Request for Services Registry for the Supports Waiver should contact their local OCDD Regional Office/District/Authority. Once a request has been made, the person will be asked to participate in a determination process for system entry will only determine if the person meets the criteria for a developmental disability. The application process for the Supports Waiver will not begin until a waiver opportunity is available. At that time, medical and financial determinations will be completed simultaneously to validate that the individual has a developmental disability and meets the financial and medical/psychological requirements for institutional care in an Intermediate Care Facility for Persons with Developmental Disabilities (ICF/DD). Through freedom of choice, requestors will choose their support coordinator and direct service provider(s). The Supports Waiver will only be appropriate for those individuals whose health and welfare can be assured via the Individual Service Plan and for whom home and community-based waiver services represent a least restrictive treatment alternative. This waiver is intended to provide specific, activity focused services rather than continuous custodial care. Each service is limited based on annual service limits. The following are services offered through the Supports Waiver: Support Coordination, Supported Employment, Day Habilitation, Prevocational, Respite, Habilitation, Permanent Supportive Housing Stabilization, Permanent Supportive Housing Stabilization Transition and Personal Emergency Response System.
Level of Care	Requestors must meet ICF/DD level of care for medical and/or psychological criteria. Procedure and requirements are the same as ICF/DD facility determination for admission.
Population	Age ≡ Age 18 years and older with an intellectual disability or developmental disability which manifested prior to age 22. Must meet the Louisiana definition for developmental disability.
Financial	* Income ≡ The monthly income limit is up to 3 times the SSI amount. * Resources ≡ Countable resources cannot be worth more than $2,000 for an individual or $3,000 for a couple who needs ICF/DD Level of Care. * These income and resources limits are subject to change each year.

For Information About Accessing Supports Waiver Services,
Please Contact Your OCDD Regional Office/District/Authority.

DEPARTMENT OF HEALTH AND HOSPITALS
OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES (OCDD)
WAIVER SUPPORTS AND SERVICES

RESIDENTIAL OPTIONS WAIVER FACT SHEET	
Description	Home and Community-Based Services Waiver programs are based on federal criteria that allow services to be provided in a home or community-based setting for the participant who would otherwise require institutional care. There is a Developmental Disability (DD) Request for Services Registry (RFSR) that includes individuals who meet the Louisiana definition for developmental disability. Persons interested in being added to the Developmental Disability Request for Services Registry should contact their local OCDD Regional Office/Authority/District. Once a request has been made, the person will be asked to participate in a determination process for system entry which will only determine if the person meets the criteria for a developmental disability. The application process for the Residential Options Waiver will not begin until a waiver opportunity is available. At that time, medical and financial determinations will be completed simultaneously to validate that the person has a developmental disability and meets the financial and medical/psychological requirements for institutional care in an Intermediate Care Facility for Persons with Developmental Disabilities (ICF/DD). Using the Freedom of Choice list, participants will choose their support coordinator and direct service provider(s). The Residential Options Waiver will only be appropriate for those individuals whose health and welfare can be assured via the Support Plan with a cost limit based on their level of support need and for whom home and community-based waiver services represent a least restrictive treatment alternative. The following services are available through the Residential Options Waiver: Support Coordination, Community Living Supports, Companion Care, Host Home, Shared Living, One-Time Transitional Services, Environmental Modifications, Assistive Technology/Specialized Medical Equipment, Personal Emergency Response Systems, Respite (Center-Based), Nursing, Dental, Professional (Dietary, Speech Therapy, Occupational Therapy, Physical Therapy, Social Work, Psychology), Transportation-Community Access, Supported Employment, Prevocational Services, Day Habilitation, and Permanent Supported Housing Services.
Level of Care	Requestors **must meet ICF/DD level of care** for medical and/or psychological criteria. Procedure and requirements are the same as ICF/DD facility determination for admission.
Population	Age: Birth through end of life with a developmental disability manifesting prior to age 22. Must meet the Louisiana definition for developmental disability.
Financial	Income - The monthly income limit can be no greater than three (3) times the SSI amount. * Resources - The income limit for waiver, also known as Special Income Limit is $2,199 for an individual and $4,398 for a couple (when both spouses need long-term care). Individuals with income that exceeds the Special Income Limit may still qualify for coverage of waiver services in Waiver Spend-down. * Waiver Spend-down - An individual may have to pay towards the cost of care in Waiver Spend-down. The individual's liability is based on their income after the income deductions are applied. Waiver Spend-down has a standard $20 income deduction. Also $65 and ½ of the remaining income is deducted from all earned income. After the income deductions are

	applied, the average monthly waiver rate (Currently $6,942.96 for NOW) and other allowable incurred medical expenses are used to "spend-down" an individuals' excess income qualifying the individual for Waiver Spend-down. Allowable incurred medical expenses include Medicare and private health insurance premiums, deductibles, coinsurance, or copayment charges, and medical/remedial care expenses incurred by an individual that are not subject to payment by a third party. * All individuals are allowed to retain from their income a basic needs allowance which is equal to the SIL ($2,199 for 2015) and the amount of the incurred medical expenses not paid by a third party. Any remainder will be the individual's liability for the cost of care in Waiver Spend-down. * These income and resources limits are subject to change each year.

For information about accessing Residential Options Waiver services, please contact your OCDD Regional Office/Authority/District.

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)	Home Health (Basic and Extended)
▪ Services include: basic personal care – bathing, dressing and grooming activities. Assistance with bladder and/or bowel requirements or problems. Assistance with eating and food preparation. Performance of incidental household chores for the recipient only. ▪ The recipient's condition includes a need for nursing care to manage a plan of care and/or more assistance with extensive personal care, ambulation, and mobilization. This may include 1) professional nursing care and assessment on a daily basis due to a serious condition which is unstable or 2) rehabilitative therapeutic regime requiring professional staff. ▪ Does not cover any medical tasks, medication administration, or NG tube feeding. ▪ Accompanying, NOT TRANSPORTING recipients to medical appointments. ▪ EPSDT PCS is not to function as a substitute for childcare arrangements or to provide respite care to the primary caregiver. ▪ Must be prior authorized by BHSF/Molina for participants with Legacy Medicaid and by the Bayou Health Plan for participants with Bayou Health 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.	▪ Basic Home Health Services include skilled nurse visits (RN or LPN), Aid visits, Physical Therapy, Occupational Therapy and Speech Therapy. ▪ Recipients may also receive Extended Skilled Nursing Services (Extended HH) which is **multiple hours per day**, several days per week for an extended period of time. Can provide medical tasks such as tube feeding, catheter maintenance and medication administration. ▪ Extended Skilled Nursing Services (Extended HH) and all therapies must be prior authorized. Home Health visits above one per day must be prior authorized by BHSF/Molina for participants with Legacy Medicaid and by the Bayou Health Plan for participants with Bayou Health for their physical health services. Documentation that must accompany HH request: Physician referral on letterhead, home health plan of care, and a completed PA-07. ▪ Children may still be eligible for Extended Skilled Nursing Services even if they attend school outside the home. ▪ For Extended Services, a prescription is needed from the doctor stating the number of hours requested and a letter of medical necessity justifying the reason for extended services and the number of hours requested. ▪ Therapies can be provided by Home Health agencies, an outpatient facility, in an Early Intervention Center, rehabilitation center and at school.

Issued 7/27/06
Revised 6/3/13, 6/16/14, 4/2/15, 5/3/16

Early Periodic Screening, Diagnosis and Treatment Personal Care Services

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

Recipient Qualifications

Conditions for Provision of EPSDT Personal Care Services

1. The person must be a categorically –eligible Medicaid recipient birth through 20 years of age (EPSDT eligible) **and have been prescribed EPSDT PCS as medically necessary by a physician.** To establish medical necessity the parent or guardian must be physically unable to provide personal care services to the child.
2. The recipient's condition includes a need for nursing care to manage a plan of care and/or more assistance with extensive personal care, ambulation, and mobilization. This may include professional nursing care and assessment on a daily basis due to a serious condition which is unstable or rehabilitative therapeutic regime requiring professional staff.
3. When determining whether a recipient qualifies for EPSDT PCS, **consideration must be given not only to the type of services needed, but also the availability of family members and/or friends who can aid in providing such care. EPSDT PCS are not to function as a substitute for childcare arrangements.** A parent or adult caregiver is **no longer required** to be in the home while services are being provided to children age 14 or younger.
4. EPSDT personal care services **must be prescribed by the recipients attending physician initially and every 180 days thereafter (or rolling six months), and when changes in the Plan of Care occur.** The physician should only sign a fully completed plan of care which shall be acceptable for submission to BHSF only after the physician signs and dates the form. The physician's signature must be an original signature and not a rubber stamp.

Place of Service

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

Services

EPSDT personal care services include:

1. basic personal care, toileting and grooming activities, including bathing, care of the hair, and assistance with clothing;
2. assistance with bladder and/or bowel requirements or problems, including helping the client to and from the bathroom or assisting the client with bedpan routines, but excluding catheterization;

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

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

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

Services Available to Medicaid Eligible Children Under 21

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

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

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

All specialized behavioral health services and non-emergency medical transportation services are accessed through your Bayou Health plan. Contact numbers for the Bayou Health plans are below. If the recipient is enrolled in the Coordinated System of Care (CSoC) all specialized behavioral health services will be accessed through Magellan. Magellan can be reached at 1-800-434-4489.

To access specialized behavioral health contact your Bayou Health Plan at:

Aetna Better Health	1-855-242-0802
Amerigroup	1-800-600-4441
AmeriHealth Caritas	1-888-756-0004
Louisiana Healthcare Connections	1-866-595-8133
United Healthcare Community Plan	1-866-675-1607

To access non-emergency medical transportation contact your Bayou Health Plan at:

Aetna Better Health	1-877-917-4150
Amerigroup	1-866-430-1101
AmeriHealth Caritas	1-888-913-0364
Louisiana Healthcare Connections	1-855-369-3723
United Healthcare Community Plan	1-866-726-1472

For participants with Legacy Medicaid for their physical health services, if you need a service that is not listed above you can call the referral assistance coordinator at SPECIALTY RESOURCE LINE (toll free) 1-877-455-9955. If they cannot refer you to a provider of the service you need call 225-342-5774.

Some of these services must be approved by Medicaid in advance. Your medical provider should be aware of which services must be pre-approved and can assist you in obtaining those services. Also, SPECIALTY RESOURCE LINE can assist you or your medical provider with information as to which services must be pre-approved for recipients with Legacy Medicaid for their physical health services. For recipients with Bayou Health for their physical health services contact the Bayou Health Plan.

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

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

OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES
HUMAN SERVICES DISTRICTS and AUTHORITIES

Metropolitan Human Services District

Donna Francis, DD **Dr. Rochelle Dunham,** Ex. Dir.
1010 Common St., Suite 600, N.O., LA 70112
Phone: (504) 568-3130 Fax: (504) 568-4660
Toll Free: 1-800-889-2975

Orleans – Plaquemines – St. Bernard

Central Louisiana Human Services District

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

Avoyelles – Catahoula – Concordia – Grant LaSalle – Rapides – Vernon – Winn

Capital Area Human Services District

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

Ascension – EBR – East Fel. – Iberville Pointe Coupee – WBR – West Fel

Northwest Louisiana Human Services District

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

Bienville – Bossier – Caddo - Claiborne – DeSoto Natchitoches – Red River – Sabine - Webster

South Central La. Human Services Authority

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

Assumption – LaFourche – St. Charles – St. James St. John – St. Mary – Terrebonne

Northeast Delta Human Services Authority

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

Caldwell – East Carroll – Franklin –Jackson – Lincoln Madison- Morehouse – Ouachita – Richland- Tensas – Union – West Carroll

Acadian Area Human Services District

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

Acadia – Evangeline – Iberia – Lafayette St. Landry – St. Martin – Vermillion

Florida Parishes Human Services Authority

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

Livingston – St. Helena – St. Tammany Washington - Tangipahoa

Imperial Calcasieu Human Services Authority

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

Allen - Beauregard – Calcasieu – Cameron Jefferson Davis

Jefferson Parish Human Services Authority

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

Jefferson

OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES
Regional EPSDT Specialists

METROPOLITAN HUMAN SERVICES DISTRICT
Lionel Fascio
1010 Common Street, 6th Floor
New Orleans, LA 70112
Phone: (504) 568-3130
FAX: (504) 568-4660
Toll Free: 1-800-889-2975

CENTRAL LOUISIANA COMMUNITY SERVICES DISTRICT
Nancy Thigpen and Melissa Joyce
429 Murray Street – Suite B
Alexandria, LA 71301
Phone: (318) 484-2347
FAX: (318) 484-2458
Toll Free: 1-800-640-7494

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

NORTHWEST LOUISIANA HUMAN SERVICES DISTRICT
Nancy Howard
3018 Old Minden Road – Suite 1211
Bossier City, LA 71112
Phone: (318) 741-7455
FAX: (318) 741-7445
Toll Free: 1-800-862-1409

SOUTH CENTRAL LOUISIANA HUMAN SERVICES AUTHORITY
Shannon Foret and Freda Green
5593 Hwy 311
Houma, LA 70360
Phone: (985) 876-8805
FAX: (985) 449-5180
Toll Free: 1-800-861-0241

NORTHEAST DELTA HUMAN SERVICES AUTHORITY
Emily Lyle
3200 Concordia Avenue
Monroe, LA 71201
Phone: (318) 362-5188
FAX: (318) 362-5305
Toll Free: 1-800-637-3113

ACADIANA AREA HUMAN SERVICES DISTRICT - Updated
Tina Lyons
302 Dulles Dr
Lafayette, LA 70506
Phone (337) 262-5610
FAX: (337) 262-5233
Toll Free: 1-800-648-1484

FLORIDA PARISHES HUMAN SERVICES AUTHORITY
Crystal Parker and Monique Broussard
835 Pride Drive, Suite B
Hammond, LA 70401
Phone: (985) 543-4730
FAX: (985) 543-4752
Toll Free: 1-800-866-0806

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

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

Local Governing Entities - Community Behavioral Health Centers

Metropolitan Human Services District

1010 Common Street, Suite 600, New Orleans, LA 70112 | 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-Pontchatrain 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
5630 Read Boulevard, Second Floor, New Orleans, LA 70127 I PH: 504.568.3130

St. Bernard Behavioral Health Center
6624 St. Claude Avenue, Arabi, LA 70032 I PH: 504.568.3130

Capital Area Human Services District

4615 Government Street, Building 2, Baton Rouge, LA 70806 | PH: 225.922.2700

Center for Adult Behavioral Health
4615 Government Street, Bldg. 2; Baton Rouge, LA 70806 I PH: (225) 925-1906
Satellite Clinics:
Plaquemine – Iberville Parish Health Unit
24705 Plaza Drive; Plaquemine, LA 70764
Port Allen - West Baton Rouge Parish Health Unit
685 Louisiana Avenue; Port Allen, LA 70767

Children's Behavioral Health Services
4615 Government Street, Bldg. 1; Baton Rouge, LA 70806 I PH: (225) 922-0445

Gonzales Mental Health Center (Children & Adults)
1112 S.E. Ascension Complex Avenue; Gonzales, LA 70737 I PH: (225) 621-5770
Satellite Clinic:
Donaldsonville - Ascension Parish Health Unit
901 Catalpa Street; Donaldsonville, LA 70346

Infant Child & Family Center (Birth to 6 years)
4615 Government Street, Bldg. 1; Baton Rouge, LA 70806 I PH: (225) 922-2654

Margaret Dumas Mental Health Center (Adults)
3843 Harding Boulevard; Baton Rouge, LA 70807 I PH: (225) 359-9315
Satellite Clinics:
Clinton - East Feliciana Parish Health Unit
12080 Marston Street; Clinton, LA 70722
St. Francisville - West Feliciana Parish Hospital Unit
5154 Burnett Road; St. Francisville, LA 70775
New Roads - Point Coupee Human Services Center
282A Hospital Road; New Roads, LA 70760

School-Based Therapy Program
4615 Government Street, Bldg. 1; Baton Rouge, LA 70806 I PH: (225) 922-0478

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

3505 Fifth Avenue, Suite B, 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 West Port Street, DeRidder, La 70634 I PH:337-462-1649

Children and Youth Outreach Services
3505 5th Ave , Suite C1, Lake Charles, La 70607 I PH:337-475-4950

Lake Charles Behavioral Health Clinic
4105 Kirkman Street, Lake Charles, La 70607 I PH:337-475-8022

Central Louisiana Human Services District

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

Caring Choices – Pineville
242 West Shamrock St., Unit 1, Pineville, La 71360 I PH: 318-484-6850

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

Caring Choices – Jonesville
308 Nasif Street, Jonesville, La 71343 I PH: 318-339-6203

Caring Choices – Leesville
102 Belview Road, Leesville, La 71446 I PH: 337-238-6431 or 337-239-2946

Northwest Louisiana Human Services District – Changes Effective May 1st

2924 Knight Street, Suite 350, Shreveport, LA 71105 | PH: 318.862.3085

~~Mansfield Behavioral Health Clinic~~
~~501 Louisiana Avenue, Mansfield, LA 71052 | PH: 318-872-5576~~

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

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

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

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

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

Northeast Delta Human Services Authority

2513 Ferrand Street, Monroe, LA 71201 | PH: 318.362.3020

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

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

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

Monroe - Women and Children's Clinic
3200 Concordia Street, Monroe, LA 71201 | PH: (318)-362-5188

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

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

Winnsboro Outreach

1301 B Landis Street, Suite -B, 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 Mental Health Clinic/Child Services
15785 Medical Arts Plaza, Hammond, LA 70403 I PH: (985) 543-4080

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

Hammond Addictive Disorders Clinic
835 Pride Drive, Ste. B, Hammond, LA 70401 I PH: (985) 543-4730

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

Washington Parish Addictive Disorders Clinic
619 Willis Avenue, Bogalusa, LA 70427 I PH: (985) 732-6610

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

Lurline Smith Mental Health Clinic
900 Wilkinson Street, Mandeville, LA 70448 I PH: (985) 624-4450

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

Jefferson Parish Human Services Authority

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

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

JeffCare, 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

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.)

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?

Send a written request for appeal to:

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

Or call:

225-342-5800 or
225-342-0443

(Telephone appeals are allowed, but are not encouraged)

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 10 days of denial may keep services you are already receiving from being cut while the appeal is going on.
- You must get a final decision on your appeal within 90 days of the date you file it, unless you request or agree to additional time.

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 Advocacy Center (1-800-960-7705) helps with appeals.

APPEAL FORM

I want to appeal.

Name of Medicaid Recipient appealing _____.

Social Security Number of Medicaid Recipient _____.

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

_____

_____

_____

_____

_____ _____

Signature of Recipient **Date**

Submit form to:

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

EPSDT TARGETED POPULATION
PARTICIPANT COMPLAINT FORM

In order to better serve you, the Bureau of Health Services Financing would like to know if you have had any problems with the amount, kind and/or duration of services you received from your direct service provider and/or support coordinator. If you have experienced problems, please fill out this form and return it to:

Bureau of Health Services Financing – Health Standards
P. O. Box 3767
Baton Rouge, LA 70821-3767
OR
You may call your complaint in to 1-800-660-0488

ALL INFORMATION WILL BE KEPT CONFIDENTIAL

Participant's Name:	**Address:**
Phone Number:	**City / State / Zip:**
Name of Person Reporting Complaint:	**Phone Number (if different from participant):**
I have a complaint with my: ❑ **Direct Service Provider/Worker** ❑ **Support Coordination Agency/Support Coordinator**	
Agency Name: **Region:**	**Address:**
Phone Number:	**City / State / Zip:**
Name of Worker/Support Coordinator:	
Nature of Complaint:	
Signature of Person Reporting Complaint:	**Date:**

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. _____

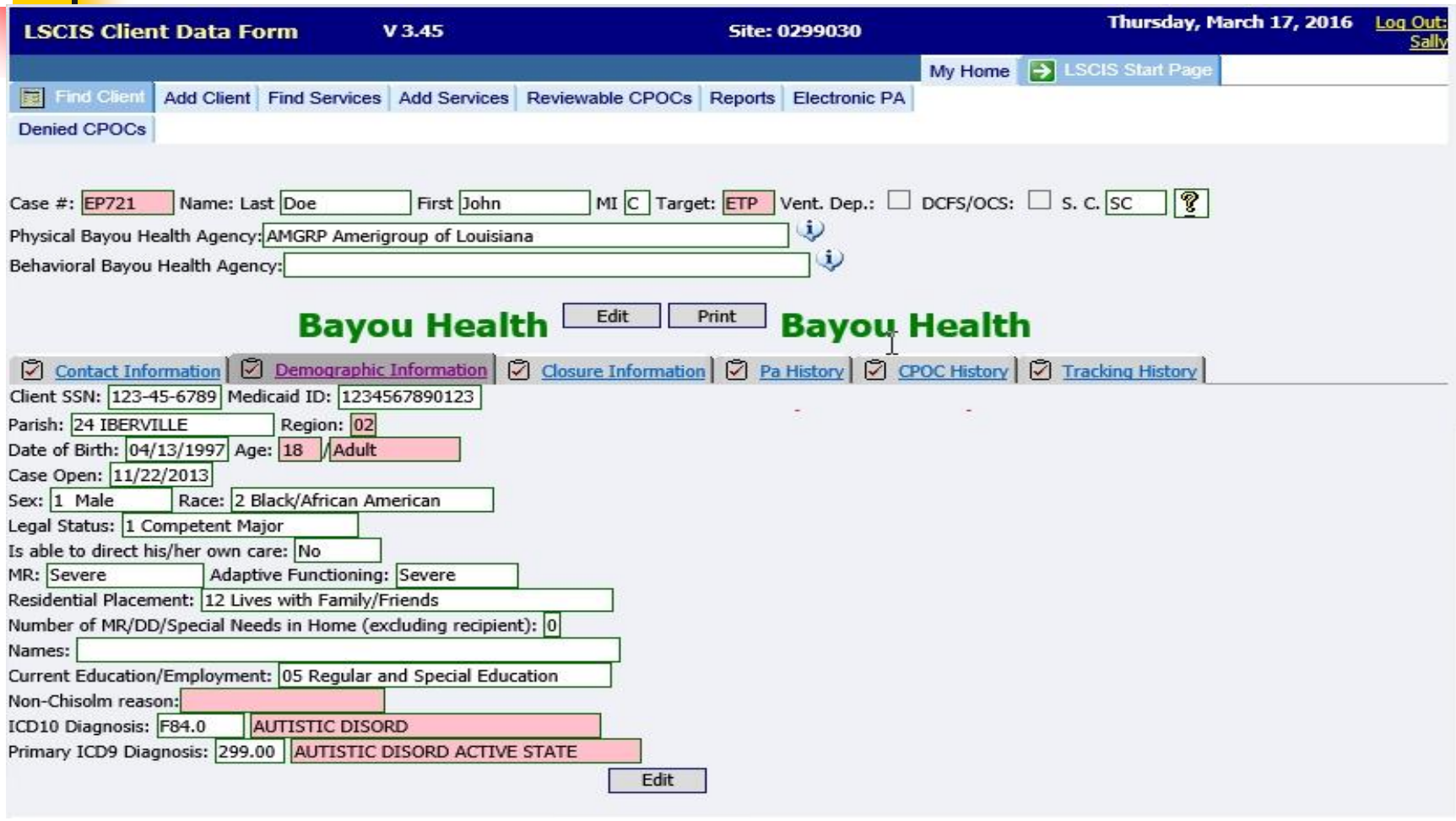
Signatures by both Transferring Agency and Receiving Agency are required for the Transfer of Records to be finalized.

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

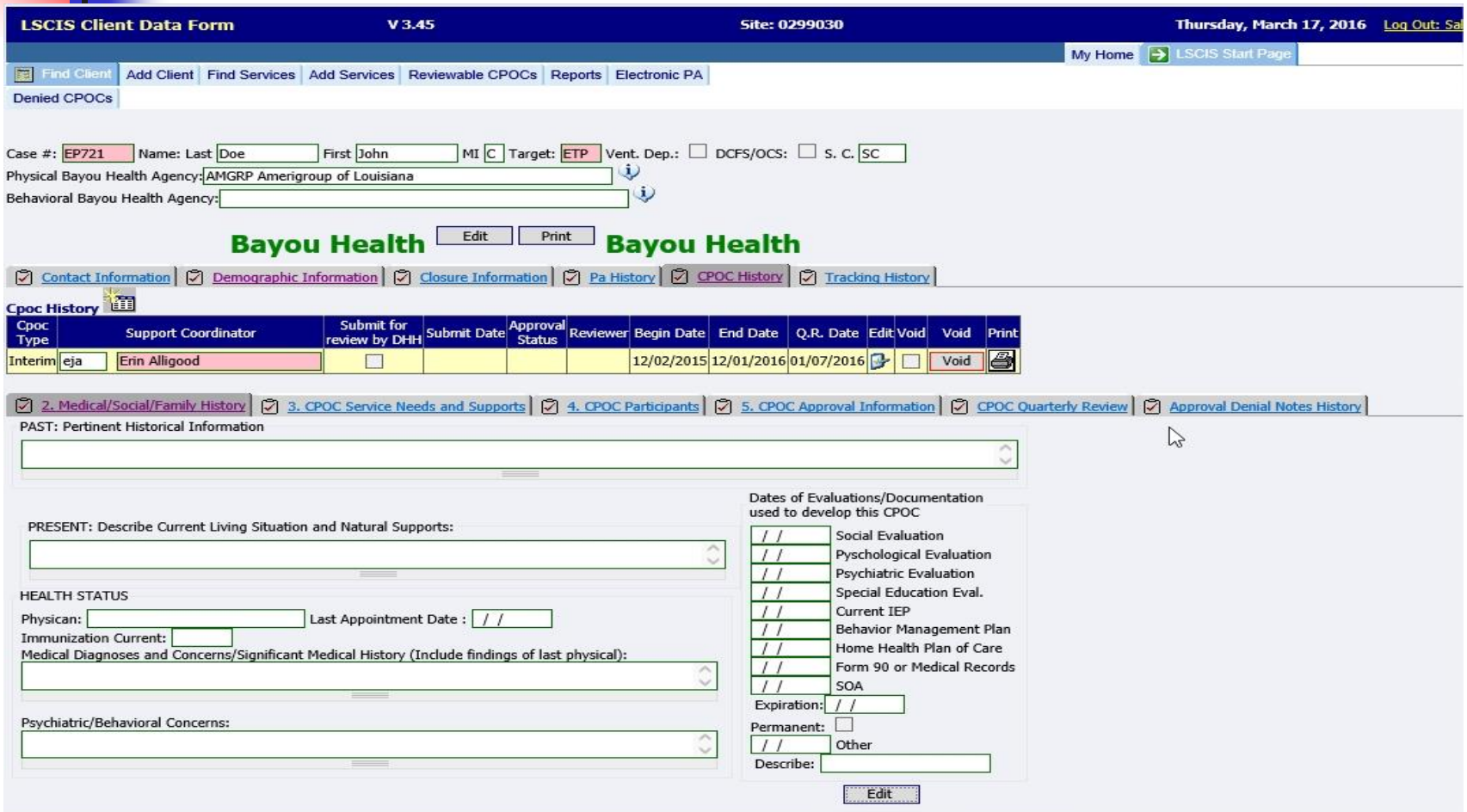
STATISTICAL RESOURCES, INC. DOES NOT VERIFY MEDICAID ELIGIBILITY NOR DETERMINE IF THE RECIPIENT MEETS THE CRITERIA OF THE TARGET POPULATION. IT IS THE RESPONSIBILITY OF THE PROVIDER TO ENSURE ELIGIBILITY.

Appendix O

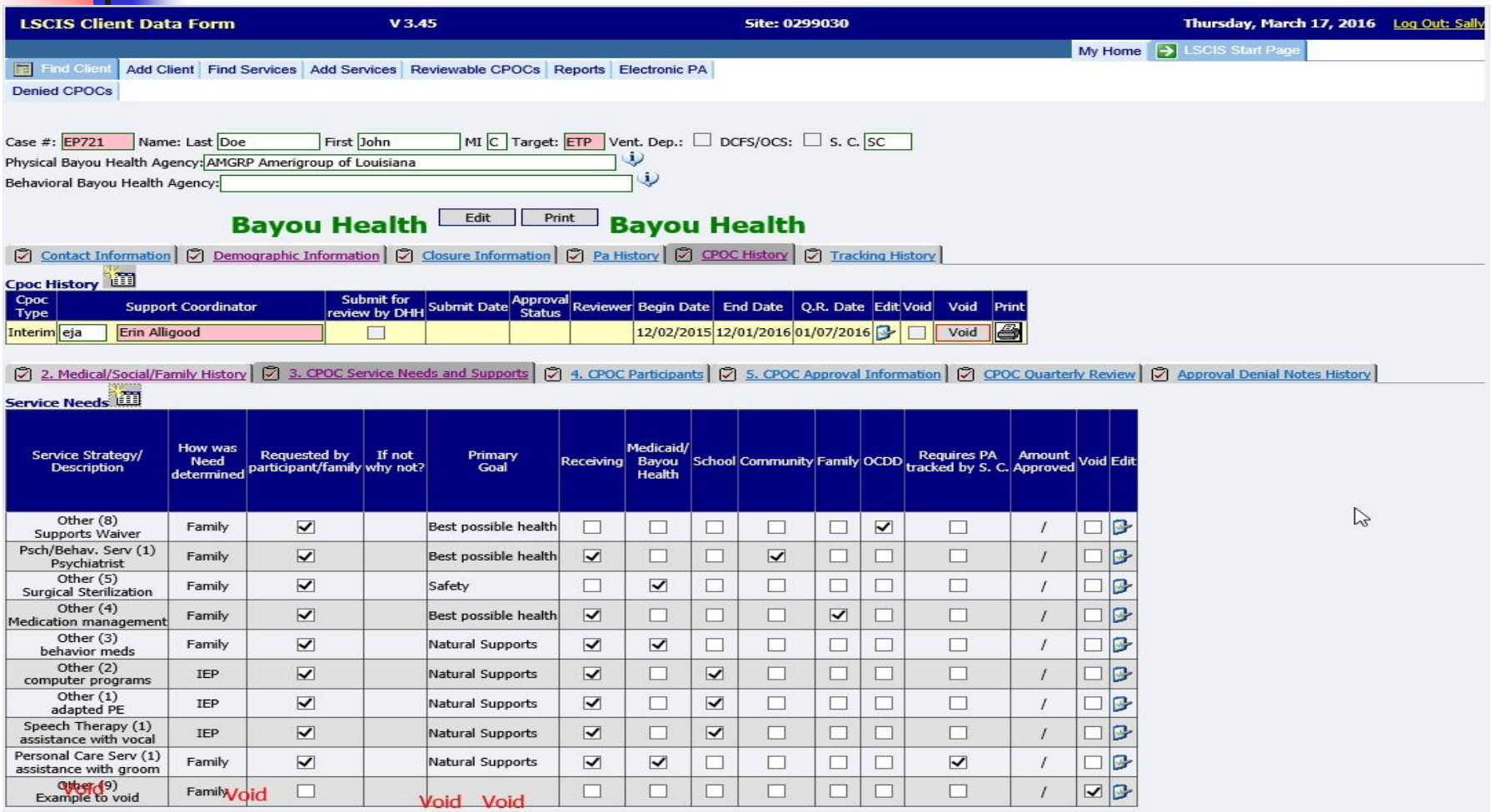
LSCIS CPOC Section 1
Demographics/ Contact Information



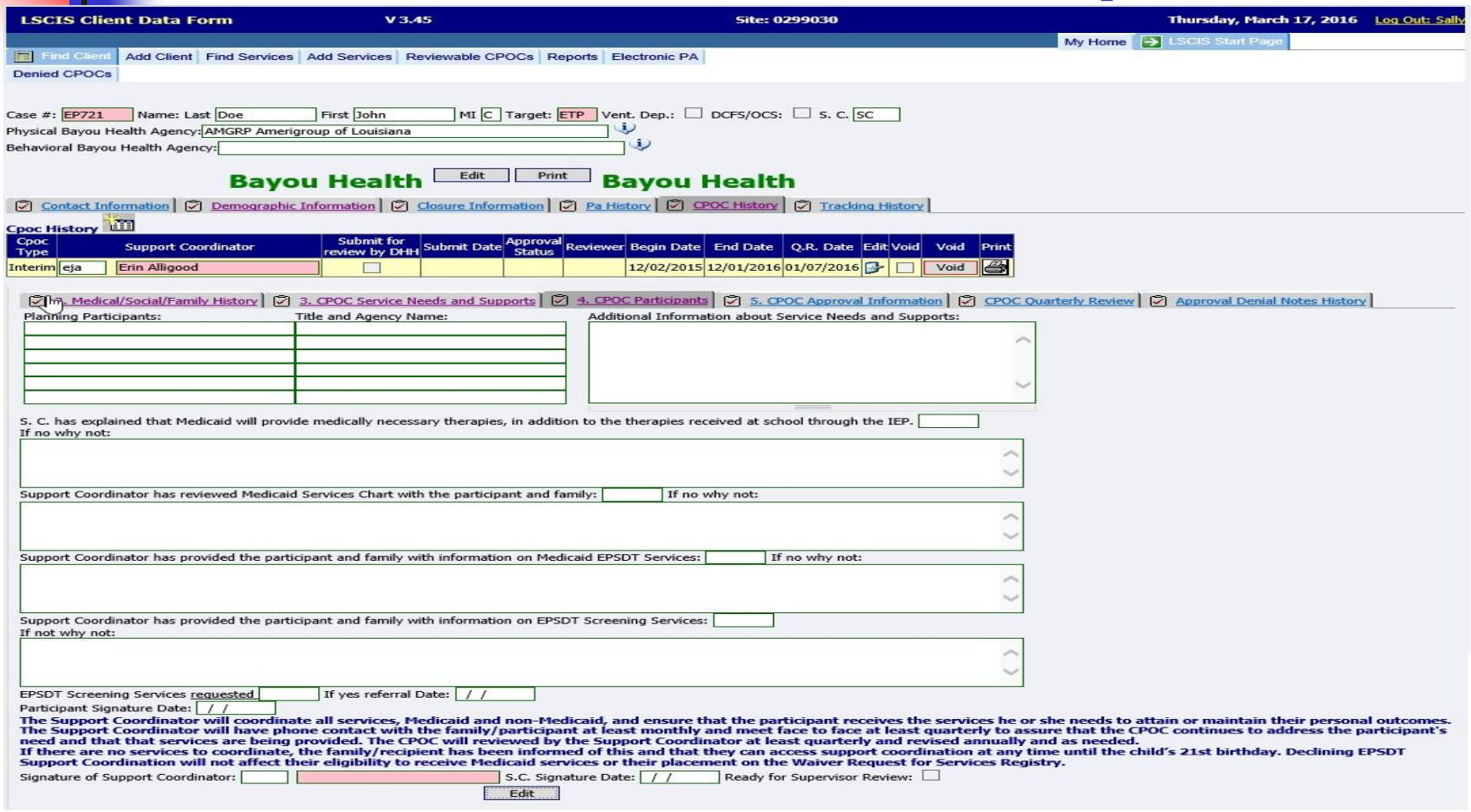
LSCIS CPOC Section 2 – Medical/Social/Family History



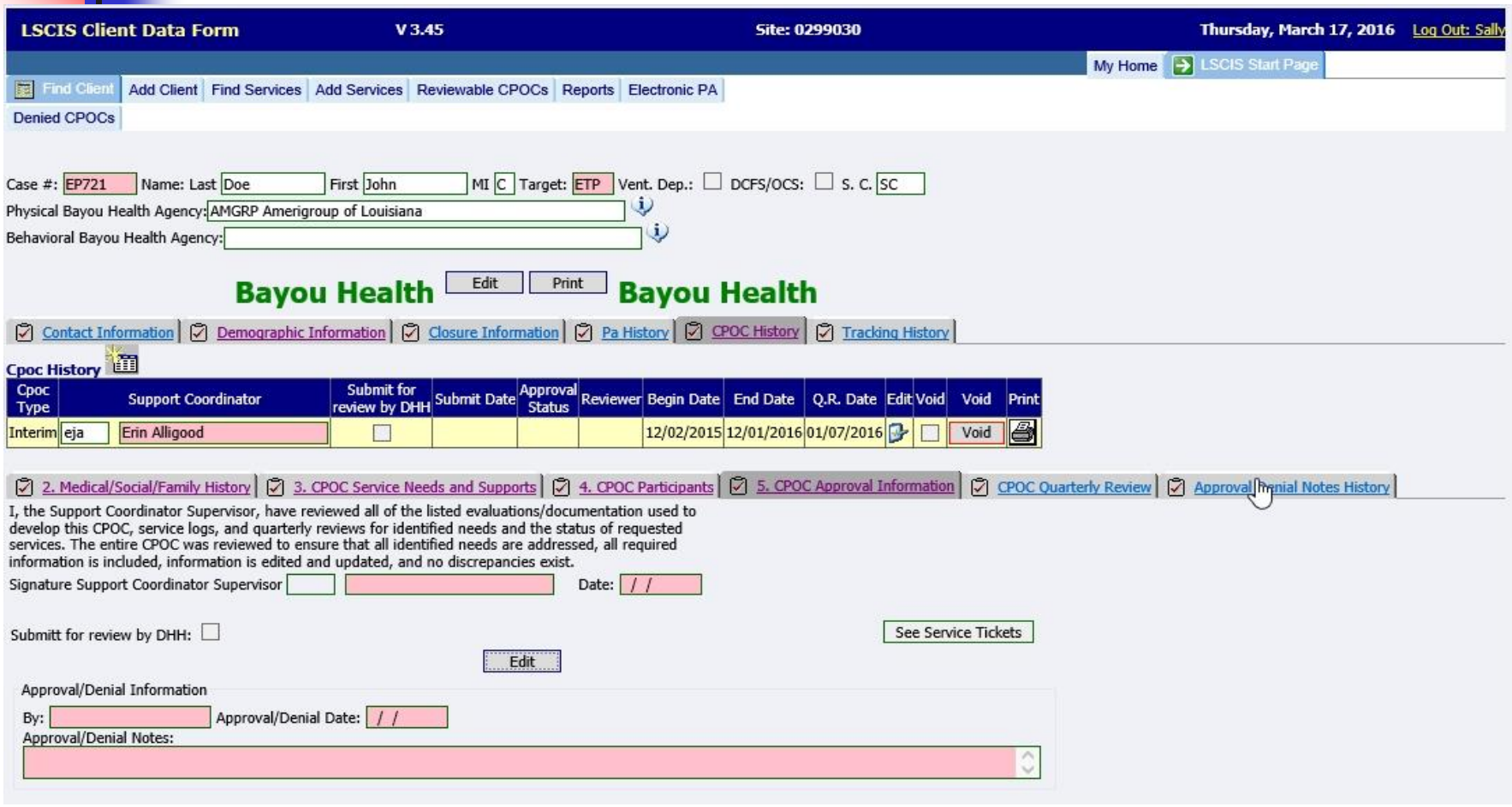
LSCIS CPOC Section 3 – CPOC Service Needs and Supports



LSCIS CPOC Section 4 – Additional Information / CPOC Participants

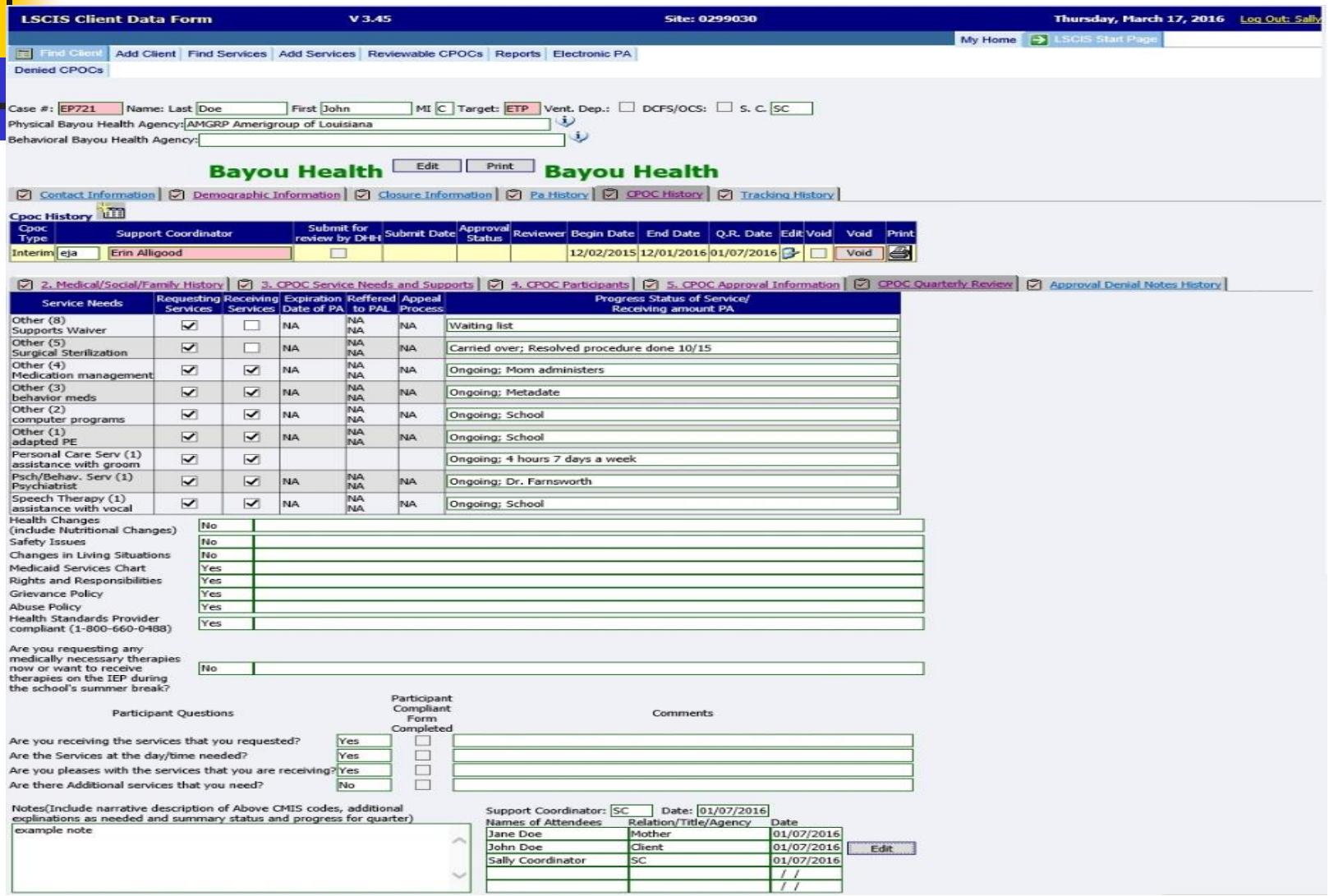


LSCIS CPOC Section 5 – CPOC Approval Information



Appendix O

LSCIS CPOC Quarterly Review



LSCIS Client Data Form V 3.45 Site: 0299030 Thursday, March 17, 2016 Log Out: Sally

My Home | LSCIS Start Page

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

Case #: EP721 Name: Last Doe First John MI C Target: ETP Vent. Dep.: DCFS/OCS: S. C. SC

Physical Bayou Health Agency: AMGRP Amerigroup of Louisiana

Behavioral Bayou Health Agency:

Bayou Health Edit Print Bayou Health

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

Cpoc History

Cpoc Type	Support Coordinator	Submit for review by DHH	Submit Date	Approval Status	Reviewer	Begin Date	End Date	Q.R. Date	Edit	Void	Void	Print
Interim	eja	Erin Alligood				12/02/2015	12/01/2016	01/07/2016			Void	

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

Service Needs	Requesting Services	Receiving Services	Expiration Date of PA	Reffered to PAL	Appeal Process	Progress Status of Service/ Receiving amount PA
Other (8) Supports Waiver	☑	☐	NA	NA NA	NA	Waiting list
Other (5) Surgical Sterilization	☑	☐	NA	NA NA	NA	Carried over; Resolved procedure done 10/15
Other (4) Medication management	☑	☑	NA	NA NA	NA	Ongoing; Mom administers
Other (3) behavior meds	☑	☑	NA	NA NA	NA	Ongoing; Metadate
Other (2) computer programs	☑	☑	NA	NA NA	NA	Ongoing; School
Other (1) adapted PE	☑	☑	NA	NA NA	NA	Ongoing; School
Personal Care Serv (1) assistance with groom	☑	☑				Ongoing; 4 hours 7 days a week
Psch/Behav. Serv (1) Psychiatrist	☑	☑	NA	NA NA	NA	Ongoing; Dr. Farnsworth
Speech Therapy (1) assistance with vocal	☑	☑	NA	NA NA	NA	Ongoing; School

Health Changes (include Nutritional Changes)	No	
Safety Issues	No	
Changes in Living Situations	No	
Medicaid Services Chart	Yes	
Rights and Responsibilities	Yes	
Grievance Policy	Yes	
Abuse Policy	Yes	
Health Standards Provider compliant (1-800-660-0488)	Yes	

Are you requesting any medically necessary therapies now or want to receive therapies on the IEP during the school's summer break? No

Participant Questions		Participant Compliant Form Completed	Comments
Are you receiving the services that you requested?	Yes	☐	
Are the Services at the day/time needed?	Yes	☐	
Are you pleases with the services that you are receiving?	Yes	☐	
Are there Additional services that you need?	No	☐	

Notes(Include narrative description of Above CMIS codes, additional explinations as needed and summary status and progress for quarter)

example note

Support Coordinator: SC Date: 01/07/2016

Names of Attendees	Relation/Title/Agency	Date
Jane Doe	Mother	01/07/2016
John Doe	Client	01/07/2016
Sally Coordinator	SC	01/07/2016
		/ /
		/ /

Edit

Section VI: Typical Weekly Schedule — Confidential

FOR PLANNING PURPOSES ONLY. IF NEEDS CHANGE, I WILL CONTACT MY CASE MANAGER AS SOON AS POSSIBLE.

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

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

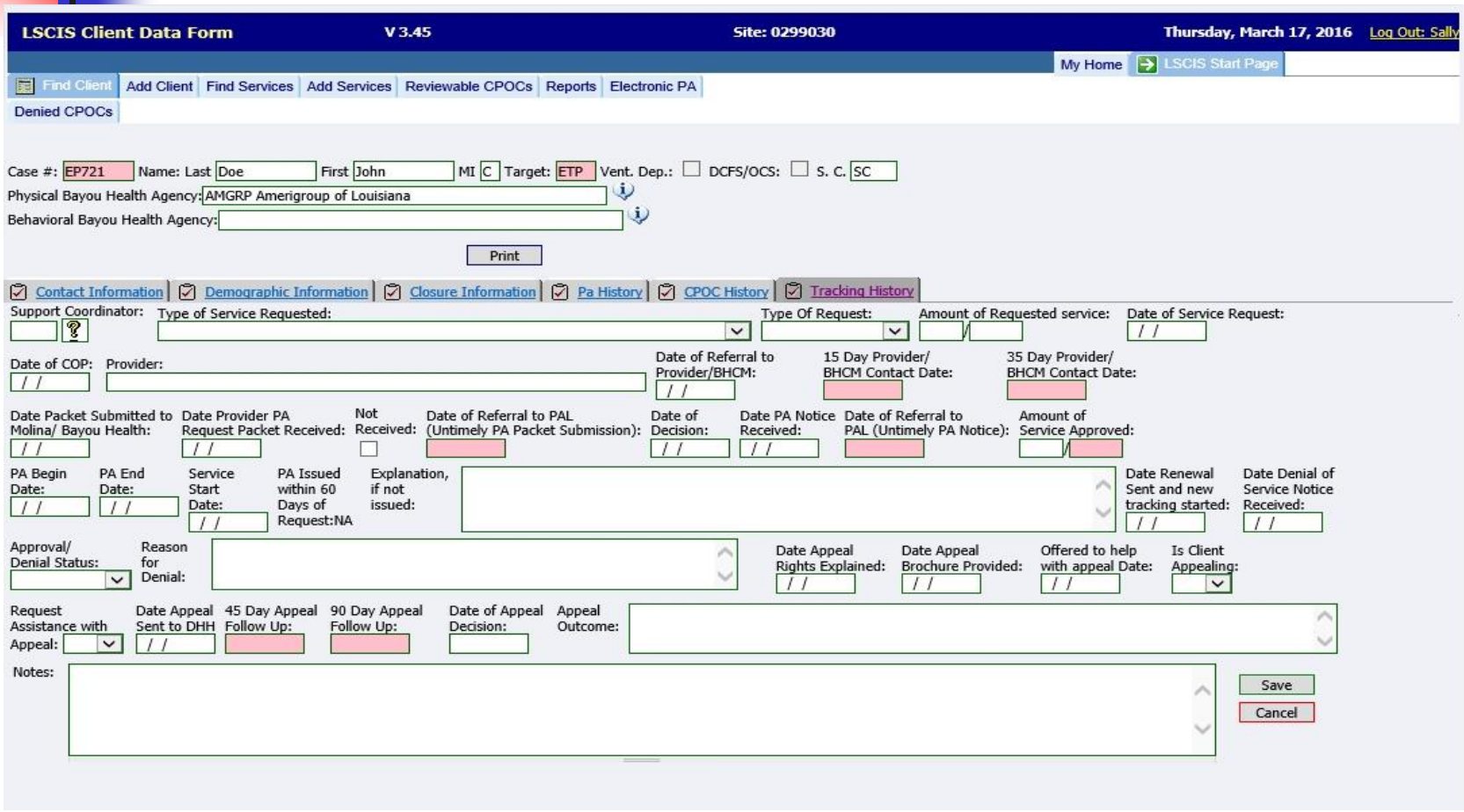
COMMENTS:

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

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

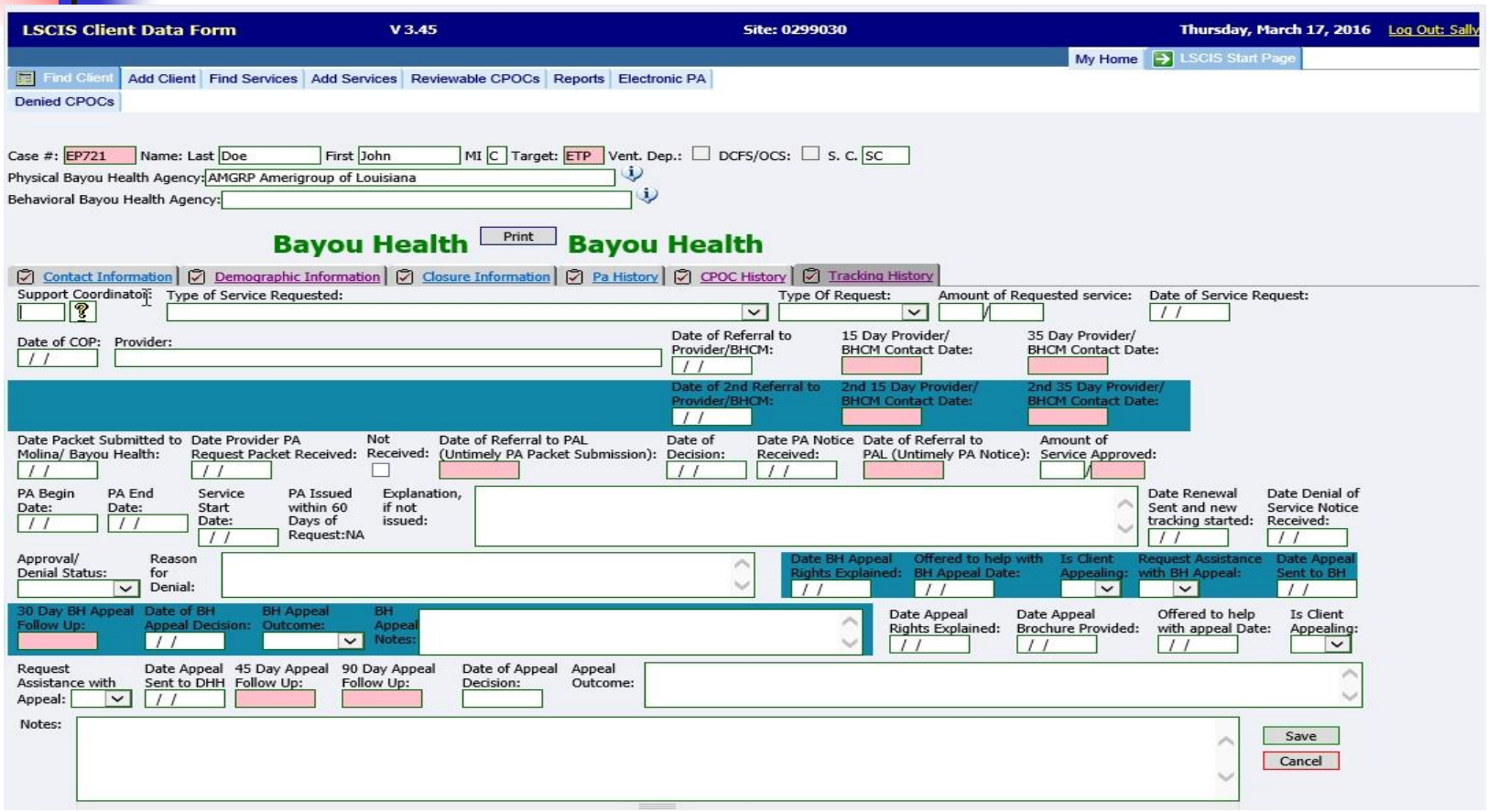
Appendix O

LSCIS Prior Authorization Tracking Log

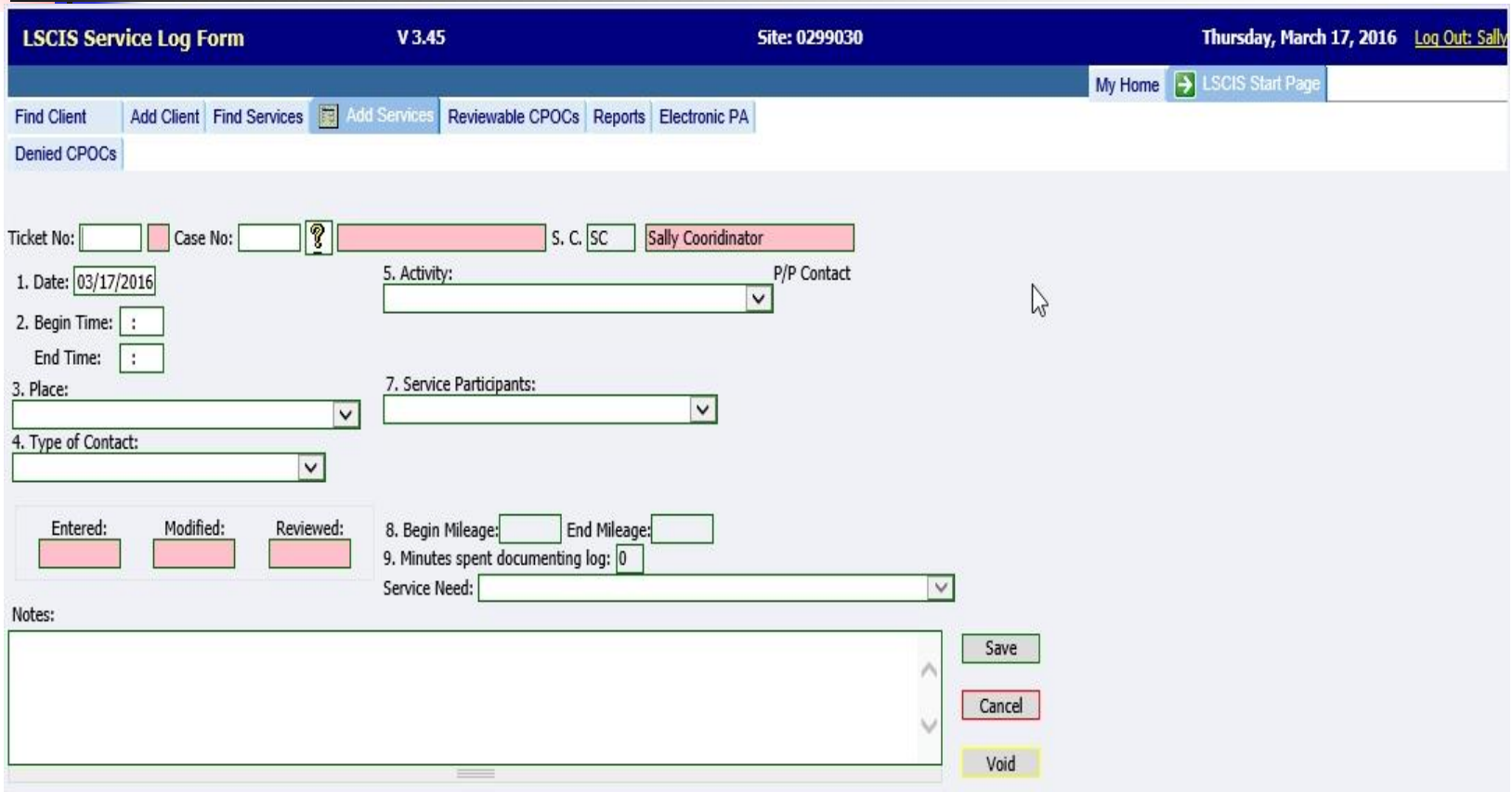


Appendix O

LSCIS Prior Authorization Tracking Log for Bayou Health Services



LSCIS Service Log



CMIS (OCDD) SERVICE LOG CODES

MILITARY TIME CONVERSION TABLE

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

CASE MANAGEMENT SERVICE LOG CODES

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

4. TYPE OF CONTACT
- 1. In person
- 2. Telephone
- 3. Written
- 6. Documentation Only *(does not count for billing requirements)*

5. SERVICE ACTIVITY
(Service activity codes 20-26 are for VACP only)
- 20. Medical Consultation
- 21. Health Management
- 22. Medical Crisis Management
- 23. Medical Crisis Training & Tech. Assistance - School
- 24. Medical Crisis Training & Tech. Assistance - Community
- 25. Intense Informing for Complex Health Needs
- 26. Annual Staffing
- 49. Quarterly Service Provider Monitoring
- 52. Initial Assessment/Initial Contact
- 53. Quarterly Reassessment
- 54. Yearly POC/Annual Assessment
- 55. Service Planning
- 56. Advocacy

5. SERVICE ACTIVITY *(continued)*
- 57. Follow-up Monitoring
- 58. Observation of Services
- 59. In person monitoring of provider records/notes/billing
- 60. Transition / Closure
- 63. Critical Incident into OTIS
- 67. EPSDT PA Tracking
- 68. EPSDT Provider Follow-Up
- 69. EPSDT PAL Referral
- 70. EPSDT Appeal Follow-Up
- 74. Service Note *(does not count for billing requirement)*
- 75. Training *(does not count for billing requirement)*
- 76 SIS / LA Plus
- 78. EPSDT Bayou Health Case Manager Follow-Up
- 80. EPSDT Bayou Health Appeal Follow-Up

7. SERVICE PARTICIPANTS
- 01. Recipient
- 02. Parent or Legal Guardian *(mom, dad, court appointed or ordered legal guardian)*
- 03. Other Family Member or Essential Other *(brother, sister, aunt, uncle, husband, wife, roommate, etc.)*
- 07. Education
- 08. Health Care Providers
- 09. Community Services / Resources
- 10. Program Office (OCDD, OAAS, BHSF, CPS, APS, EPS)
- 11. Medicaid
- 12. Waiver Service Provider
- 13. Medicaid Provider (non-waiver/State Plan)
- 14. Non-Medicaid Other Provider (paid/non-paid)
- 15. PAL
- 16. Advocacy Representative
- 17. Nurse Consultant *(not in the capacity of an S.C.)*
- 18. SRI
- 19. SC Supervisor
- 20. Bayou Health
- 98. None *(used for service note)*
- 99. Other

OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES
CMIS SERVICE LOG

Service Log #: _ _ _ _ _ _ _

Case Number: _ _ _ _ _ _ **Client Name:** _____

Case Manager ID: _ _ _ _

---

1. Date: _ _/_ _/_ _ **5. Activity:** _ _ **Procedure Code:** _ _ _ _ _ _ **8. If this is a travel log:**

Begin Mileage: _ _ _ _ _ _ _ _

2. Begin Time: _ _ : _ _ (hh:mm) **Activity:** _ _ **Procedure Code:** _ _ _ _ _ _ **End Mileage:** _ _ _ _ _ _ _ _

End Time: _ _ : _ _ (hh:mm) **Activity:** _ _ **Procedure Code:** _ _ _ _ _ _ **9. Minutes spent documenting log:** _ _ _ _

3. Place of Service: _ _ **7. Service Participants:** _ _

_ _

_ _

_ _

4. Type of Contact: _ _

Note:

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

Appendix O

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:	
Bayou Health Agency:	Bayou Health Agency Phone:	
Behavioral Bayou Health Agency:	Behavioral Bayou Health 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: College	13 Employed	98 N/A
02 Non-Categorical	06 Special Education Only	10 Post-secondary: Vocational	14 Unemployed	99 Other
03 Regular Kindergarten	07 Homebound Full Time	11 Pre-vocational Training	15 Working toward GED	
04 Regular Education Only	08 Graduated	12 Supported Employment	16 Home Schooled	

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

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

MR: _____ 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 Others
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/MR with 16 or more beds	11 OCS Foster Care	99 other
06 ICF/MR with 7 to 15 beds	12 Lives with Family/Friends	

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

Names: _____

FOR DHH USE ONLY

CPOC Begin Date: CPOC End Date:

Signature of DHH: 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

☐ 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

Appendix O

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

Service Strategy List:

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

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

Appendix O

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 that services are being provided. The CPOC will reviewed by the Support Coordinator at least quarterly and revised annually and as needed.

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

_____ _____
Support Coordinator's Signature Date

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

_____ _____
Support Coordinator Supervisor's Signature Date

SECTION VI: CARE PLAN ACTION

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

CPOC Status: _____

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

Approved CPOC: Begin Date: _____ End Date: _____

Signature/Title of DHH Representative _____

Notes: _____

DEPARTMENT OF HEALTH AND HOSPITALS **Appendix P**
BUREAU OF HEALTH SERVICES FINANCING
Early Periodic Screening Diagnosis and Training (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 families to access the services available to them through Medicaid EPSDT. This includes all services that individuals under age 21 may be entitled to receive with a Medicaid Card. These services may help address the individual's medical, social and educational needs. The Support Coordinator will review all available services and assist with making referrals for the services they may be eligible to receive. These **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	Individuals who have multiple medical needs or who meet the definition of a person with special needs. (See eligibility requirements below.)
Population	Age → 3 to 21 years old
Eligibility	• **Individuals are on the DD Request for Services Registry** ➢ Placement on the DD Request for Services Registry on or after October 20, 1997 and have passed the OCDD Diagnosis and Evaluation (D&E) process by the later of October 20, 1997 or the date they were placed on the RFSR; **OR** ➢ Placement on the DD Request for Services Registry (RFSR) on or after October 20, 1997 but who did not have a D & E by the later of October 20, 1997 or the date they were placed on the DD RFSR. Those in this group who subsequently pass or passed the D & E process are eligible for these targeted support coordination services. For those who do not pass the D & E process or who are not undergoing a D & E, they may still receive support coordination services if they meet the definition of a person with special needs. ➢ Must have documentation from Medicaid to substantiate that the EPSDT recipient meets the definition of special needs for support coordination services (e.g., receipt of special education services through state or local education agency, receipt of regular services from one or more physicians, receipt of or application for financial assistance such as SSI because of medical condition or the unemployment of the parent due to the need to provide specialized care for the child, a report by the participants physician of multiple health or family issues that impact the participants ongoing care or a determination of developmental delay based upon the Parent's Evaluation of Pediatric Status, the Brignance Screens, the Child Development Inventories, Denver Developmental Assessment, or any other nationally recognized diagnostic tool. **AND** • **Under the age of 21, AND** • **Are Medicaid Eligible**
Follow-up & Monitoring	The Support Coordinator will follow-up with the participant at least monthly regarding all approved services, to ensure they are receiving services in the amount approved and at the times requested. (If the participant is not satisfied, the support coordinator will follow-up with the provider.) The support coordinator will meet face-to-face with the participant & family at least one time per quarter. The Health Standards Office will conduct Complaint investigations for all Support Coordination Agencies. They will also conduct monitoring for RFP Contracted Support Coordination Agencies utilizing a 5% sample annually.

****Requests for EPSDT Targeted Population Support Coordination should be directed to the BHSF/SRI toll-free Help Line at 1-800-364-7828**
For information regarding all Medicaid State Plan Services, visit
http://new.dhh.louisiana.gov/index.cfm/page/319.

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:
Participant Name:	MID#:	Phone#:
Address:	City:	State/Zip:

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

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

Support Coordinator's Signature _____ Date _____

Issued May 30, 2003
BHSF-PF-03-016
Reissued August 4, 2006
Revised October 29, 2010
Revised March 26, 2015

Appendix R-1

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

FAX TO: (225) 929-6803

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

P.A. NUMBER

CONTINUATION OF SERVICES ____YES ____NO

PRIOR AUTHORIZATION TYPE: (1)
___ 01-Outpatient Surgery Performed Inpatient Hospital
___ 05 Rehabilitation Therapy
___ 09 DME equipment & Supplies
___ 99 Outpatient Surgery Performed Inpatient (CPT Procedures) & All other specialized CPT Procedures

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

Social Security No. (3)

RECIPIENT LAST NAME | FIRST | MI (4)

DATE OF BIRTH (5)

MEDICAID PROVIDER NUMBER (7-DIGIT) (6)

BEGIN DATE OF SERVICE (7) (MMDDYYYY)

END DATE OF SERVICE (MMDDYYYY)

P. A. NURSE AND / OR PHYSICIAN REVIEWER'S SIGNATURE & DATE

DIAGNOSIS: (8)
PRIMARY CODE & DESCRIPTION

SECONDARY CODE & DESCRIPTION

PRESCRIPTION DATE (9) (MMDDYYYY)

STATUS CODES:
2 = APPROVED
3 = DENIED

PRESCRIBING PHYSICIAN'S NAME AND/ OR NUMBER: (10)

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 (11D)	AUTHORIZED UNITS	AUTHORIZED AMOUNT	STATUS	P.A. MESSAGE/ DENIAL CODE (S)	

(12)
PLACE OF TREATMENT: ____ RECIPIENT'S HOME ____ NURSING HOME ____ ICF-MR FACILITY ____ OUTPATIENT HOSPITAL / CLINIC

(13)
PROVIDER NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIPCODE _____
TELEPHONE: (___) ___ ___ FAX NUMBER: (___) ___ ___

(14) CASE MANAGER INFORMATION:
NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIPCODE _____
TELEPHONE (___) ___ ___ FAX NUMBER: (___) ___ ___

(15)
PROVIDER SIGNATURE: _____

(16)
DATE OF REQUEST: _____

PA-01 FORM

BHSF Form DIP1
Revised 02/09

Appendix R-1

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-9 CM code):**

Primary: _____ **Secondary:** _____

➢ **Specify Urine/Fecal incontinence diagnoses (Specify ICD-9 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-9-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)

Standards of Coverage:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Approved providers of incontinence products:

- Pharmacy
- Home health agency
- Durable medical equipment provider

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

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

Quantity Limitations:

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

Dispensing and Billing:

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

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

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

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

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

Patient Name: _____ Age: _____ Provider Name: _____

BACKGROUND INFORMATION

DATE OF ACCIDENT OR SURGERY: _____

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

REHABILITATION PLAN

PLAN OF SERVICES: _____ INITIAL _____ EXTENSION
IF INITIAL , INITIAL EVALUATION DATA AND MD REFERRAL / PRESCRIPTION MUST BE ATTACHED
IF EXTENSION, PRIOR ATTENDANCE : _____ REGULAR _____ NON-REGULAR. MUST ALSO ATTACH PROGRESS REPORTS

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

PHYSICAL THERAPY: _____

SPEECH THERAPY: _____

OCCUPATIONAL THERAPY _____

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

DATE OF RE - EVALUATION: _____
MONTH DAY YEAR

PROPOSED GOALS / COMMENTS: _____

REQUESTED BY : _____ DATE: _____

P.A 02 FORM (ISSUED 01/91)

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

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

P.A. NUMBER

FAX TO: (225) 216-6342

CONTINUATION OF SERVICES ____YES ____NO

(1) PRIOR AUTHORIZATION TYPE:	(2) RECIPIENT 13-DIGIT MEDICAID ID NUMBER OR 16-DIGIT CCN NUMBER	(3) SOCIAL SECURITY #
14 – EPSDT PERSONAL CARE SERVICES	(4) RECIPIENT 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 RECIPIENT CURRENTLY RECEIVING THESE SERVICES ____YES ____NO
(9) DIAGNOSIS: PRIMARY CODE & DESCRIPTION / SECONDARY CODE & DESCRIPTION	(10) PRESCRIPTION DATE (MMDDYYYY)	(11) PRESCRIBING PHYSICIAN'S NAME AND/ OR NUMBER:

P.A. NURSE AND / OR PHYSICIAN REVIEWER'S SIGNATURE & DATE

STATUS CODES:
2 = APPROVED
3 = DENIED

DESCRIPTION OF SERVICES

FOR INTERNAL USE ONLY

(12) PROCEDURE CODE	(12A) MODIFER	(12B) DESCRIPTION PERSONAL CARE SERVICE EACH 15 MINUTES	(12C) REQUESTED UNITS	AUTHORIZED UNITS	STATUS	P.A. MESSAGE/ DENIAL CODE (S)
T1019	EP	EPSDT-Personal Care Service, each 15 minutes				

(13)

PROVIDER NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIPCODE _____

TELEPHONE: (___) ___ ___ FAX NUMBER: (___) ___ ___

(14) CASE MANAGER INFORMATION:

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIPCODE: _____

TELEPHONE: (___) ___ ___ FAXNUMBER: (___) ___ ___

(15)
PROVIDER SIGNATURE: _____

(16)
DATE OF REQUEST: _____

PA- 14 FORM

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 # ( )	
	☐ Male ☐ Female	DOB:
2. Responsible Party/Curator:	Relationship:	
Address:	Home Phone # ( )	
	Work or Cell Phone # ( )	

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

Signature: _____ Date: _____

II. MEDICAL INFORMATION

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

1. Patient Name:

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

3. Physical Examination:

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 _____ ☐Glasses	Impaired Hearing _____ ☐Hearing 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

- ☐ Trach Care: ☐ Daily ☐ PRN
- ☐ Respiratory: ☐ Ventilator ☐ Daily ☐ Other _____
- ☐ Suctioning/Oral Care: ☐ Daily ☐ PRN
- ☐ Glucose Monitoring: ☐ Insulin Injections ☐ Daily ☐ Other
- ☐ Restraints (positioning)
- ☐ Dialysis
- ☐ Urinary Catheter
- ☐ Seizure Precautions
- ☐ Ostomy
- ☐ IV
- ☐ Decubitus/Stage _____
- ☐ Diet/Tube Feeding
- ☐ Rehab (OT,PT,ST)

Assistive Device:
☐Walker ☐Cane
☐Bed/Chair ☐Lift
☐Other _____

5. Medications	Dosage	Frequency	Route

II. MEDICAL INFORMATION (Continued)

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

III. LEVEL OF CARE DETERMINATION

Activities of Daily Living:

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

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

(EPSDT – PCS Level of Assistance Guide)

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

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

III. LEVEL OF CARE DETERMINATION (Continued)

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

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

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

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

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

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

Bathing ☐ Yes ☐ No **Dressing** ☐ Yes ☐ No **Toileting** ☐ Yes ☐ No

Medical Appointments:

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

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

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

IV. PHYSICIAN'S ORDER

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.

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

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

Physician's Signature _____ **Date** _____

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

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

P.A. NUMBER

FAX TO: (225) 237-3342

CONTINUATION OF SERVICES ____YES ____NO

PRIOR AUTHORIZATION TYPE: (1)

06 - Home Health Services

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

Social Security No. (3)

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

P.A. NURSE AND / OR PHYSICIAN REVIEWER'S SIGNATURE & DATE

DIAGNOSIS : (9)
PRIMARY CODE & DESCRIPTION

SECONDARY CODE & DESCRIPTION

PRESCRIPTION DATE (10) (MMDDYYYY)

STATUS CODES:
2 = APPROVED
3 = DENIED

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

DESCRIPTION OF SERVICES

FOR INTERNAL USE ONLY

PROCEDURE CODE (12)	MODIFIERS (12A) Mod 1	Mod 2	Mod 3	Mod 4	DESCRIPTION (12B)	REQUESTED UNITS (12C)	REQUESTED AMOUNT	AUTHORIZED UNITS	AUTHORIZED AMOUNT	STATUS	P.A. MESSAGE/ DENIAL CODE (S)

(13)
PROVIDER NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIPCODE _____
TELEPHONE: (___) ___ ___ FAX NUMBER: (___) ___ ___

(14) CASE MANAGER INFORMATION:
NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIPCODE: _____
TELEPHONE (___) ___ ___ FAX NUMBER: (___) ___ ___

(15)
PROVIDER SIGNATURE: _____

(16)
DATE OF REQUEST: _____

PA-07 FORM

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

Appendix R-1 CMS 485/EHH
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 From: To:	4. Medical Record No.	5. Provider No.

6. Patient's Name and Address

7. Provider's Name, Address and Telephone Number

8. Date of Birth | 9. Sex ☐M ☐F

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

11. ICD-9-CM	Principal Diagnosis	Date
12. ICD-9-CM	Surgical Procedure	Date
13. ICD-9-CM	Other Pertinent Diagnoses	Date

14. DME and Supplies

15. Safety Measures:

16. Nutritional Req.

17. Allergies:

18.A. Functional Limitations

1 ☐ Amputation
2 ☐ Bowel/Bladder (Incontinence)
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 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 the services on this plan of care and will periodically review the plan.

27. Attending Physician's Signature and Date Signed

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

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

DATE 08/01/2006 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

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

THIS AUTHORIZATION IS NOT A GUARANTEE OF RECIPIENT MEDICAID ELIGIBILITY.

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

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

SINCERELY,

BUREAU OF HEALTH SERVICES FINANCING

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

DATE 06/25/2009 PROVIDER NAME AAA CARE LLC

PRIOR AUTH. NBR 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.

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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
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1. SUBMIT WHAT THE STERILE IV GAUZE IS BEING USED FOR.
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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

MOLINA Medicaid Solutions

Molina Medicaid Solutions
Prior Authorization Liaison

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

NOTICE OF INSUFFICIENT PRIOR AUTHORIZATION DOCUMENTATION

RECIPIENT:

CASE MANAGER:

DATE OF REQUEST: 03/10/2015

DATE OF SERVICE REQUESTED:
Began: 03/09/2015 Ended: 09/06/2015

DATE OF NOTICE: 4/30/2015

PROVIDER: GOLDEN PATIENT CARE SERVICES

SERVICE REQUESTED: Personal Care Services

PA NUMBER: 507057006

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 Personl Care Services for . Please submit the following item(s).

1. The Form 90 is incomplete. Please complete and submit the Form 90. The following sections are incomplete: The Medical Information on the 1st and 2nd page.
2. The Form 90 needs to signed and dated by the physician.

Golden Patient Care Services and Easer Seals Louisiana (case manager) can assist the recipient in obtaining the requested information.

The following provider can provide this information:

(If you need help finding such a provider, contact Specialty Care Resource line toll free at 877-455-9955 for the name, address and phone number of such a provider in your area.)
[This form tells the provider what information is needed. You can give this form directly to him or her.]

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

WE WILL DENY YOUR PRIOR AUTHORIZATION REQUEST UNLESS:

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

WE HAVE RECEIVED ALL NEEDED DOCUMENTATION WITHIN 30 DAYS.

If you need help scheduling an appointment with a health care professional or transportation to the appointment, you can contact your case manager or contact 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 _____, 200__ .

_____ _____
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 Medicaid PAL

EPSDT - Targeted Population

Date:

TO: Medicaid 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: State Plan Provider:	Provider #:	Phone #:
Address:	City:	State/Zip:
Service Type (if DME be specific):	Service Name: ( ) Initial ( ) Renewal	Amount/# of Hours of Service:
Participant 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 those requiring PA): (Check the following that apply.)

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

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

_____ _____

Support Coordinator's Signature Date

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
(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 Bayou Health 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

(Document on PA Tracking Log & EPSDT Service Log)

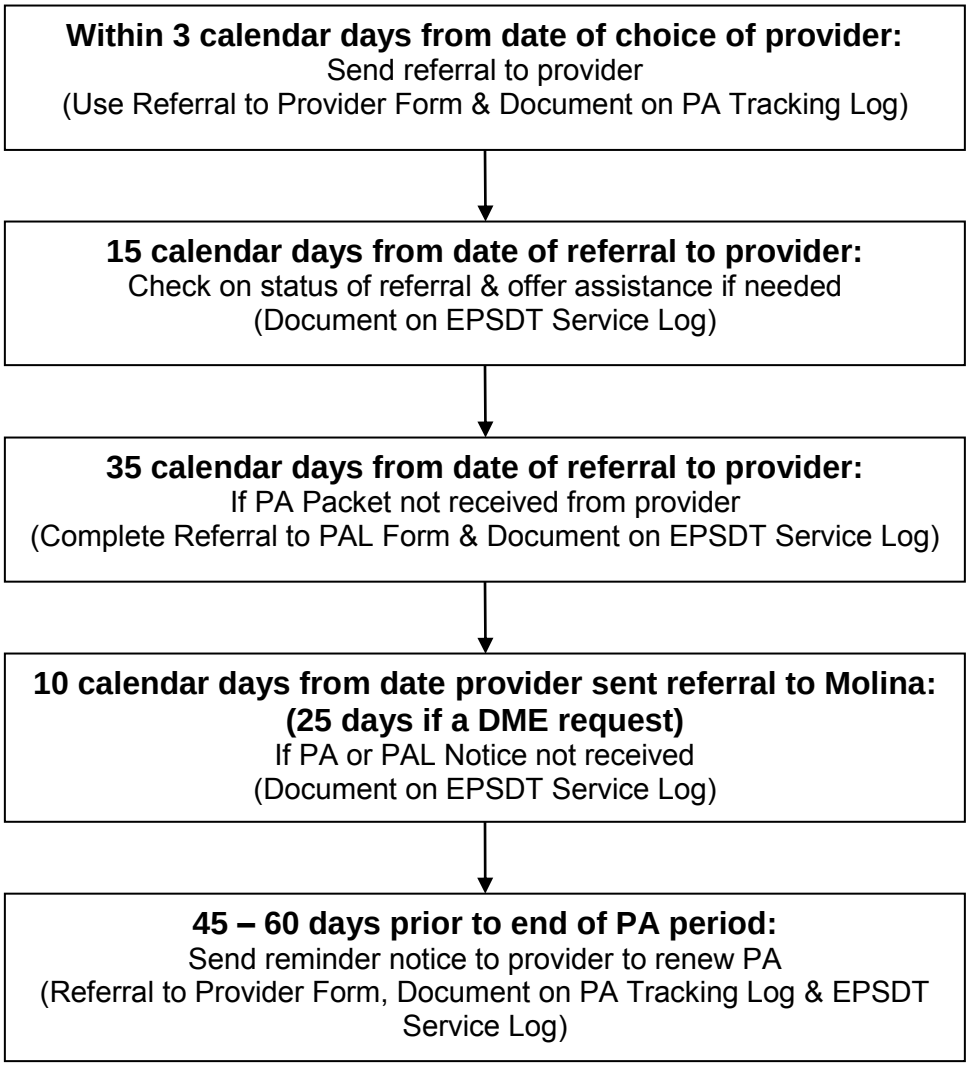
↓

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)

Legacy Medicaid
EPSDT Timeline & Documentation
Provider Contacts



Legacy Medicaid
EPSDT Timeline & Documentation
PAL Referrals

PA Requests

35 calendar days from date of provider referral:
If provider has not sent PA Packet to Molina,
Send referral to PAL using Referral to PAL Form
(Document on PA Tracking Log & EPSDT Service Log)

↓

60 calendar days from participant's date of choice of provider:
If PA approval not received,
Send referral to PAL using Referral to PAL Form
(Document on PA Tracking Log & EPSDT Service Log)

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

Other PAL Referrals

If PA Renewal Approval Not Received:
Complete Referral to PAL Form,
Document on PA Tracking Log &
Document on EPSDT Service Log)

If Participant Chooses a New Provider:
Complete Referral to PAL Form,
Document on PA Tracking Log &
Document on EPSDT Service Log

If Service not provided in the amount in PA or Service not at times according to PA
Complete Referral to PAL Form &
EPSDT Service Log

Unable to find a provider that is willing to submit a request for a PA
Complete Referral to PAL Form &
EPSDT Service Log

***Fee for Service Contact the DHH Staff Line for PCS and EHH**
(Bayou Health Plan Members – contact the Bayou Health case manager)

John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

RECIPIENT'S CONSENT FOR AUTHORIZED REPRESENTATION

Recipient'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 Department of Health and Hospitals (DHH). 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 Department of Health and Hospitals (DHH) 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 participant is a competent major and the authorized representative is being contacted and followed up with instead of the participant, there must be documentation to support the participant's request to have the authorized representative contacted or documentation of the participant's inability to self-direct their care.

Authorized Representative Name: _____

Address: _____

Telephone Number (Home): _____ (Work) _____

Authorized Representative Signature: _____

Date: _____

Recipient'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:

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 3/17/15

Record Review for EPSDT Quarterly Reports

PA not issued within 60 days or Gap in PAs

Agency/Region_____

Participant_____

Service_____

Quarter/Year_____

SC_____

SC Supervisor_____

_____PA not issued within 60 days

_____Gap in PA Authorization Periods

Gap in Authorization Period

Are the "Date of Service Request" and renewal COP dates correct on the PA

1 Tracking Logs?

2 PA end date on the prior PA Tracking _____

3 PA start date on the current PA notice _____

4 Gap consisted of how many days_____

5 Was the service provided during the Gap?

6 Was the gap due to the family choice? If so, explain. (If yes, don't include it on the report.)

7 Was the referral to the provider for the PA renewal sent 45-60 days prior to the PA expiration?

PA Not Issued Within 60 Days

8 Was the PA received?

9 Date Received_____

10 Approval Status: Full Approval_____ Partial Approval_____ Partial Denial_____ Denied_____

	Required review for "PAs not issued within 60 days" and "Gaps in Authorization Periods"	Yes	No	Supporting Document and Service Date	Comments
11	Is the PA "type of request" correctly identified on the PA Tracking Log?				
12	Did PA tracking begin with the initial request date documented in the Service Logs or Quarter Review? (Review Service Logs and Qrt Reviews prior to the request date listed on the tracking log to ensure this is the initial request date.)				
13	Was the family informed that a prescription was required and given the forms to be completed by the physician? Was assistance offered in scheduling appointment if it is required for the prescription?				
14	Is there documentation of timely assistance with the FOC and participant/guardian follow up to obtain a COP?				
15	If a provider could not be found, is there documentation of attempts to locate a provider and DHH Staff Line contact?				
16	Was the Referral to the provider made within 3 days of the COP?				
17	Is there documentation of a provider contact within 15 days of the referral to check on the status of the referral and offer assistance if needed? (Service Log and PA Tracking Log)				
18	Is there documentation that the SC followed up with the family to see if the provider contacted them and if they contacted the physician or obtained the prescription?				
19	Is there documentation of a provider contact within 35 days of the referral to the provider to check on the PA status?				
20	Was the PA packet submitted to Molina or the Bayou Health Plan within 35 days of the referral?				
21	If not, why?				
22	Was there a barrier?				
23	Did the SC assist in identifying and removing the barrier?				
24	Was the 35 day PAL referral completed timely?				
25	Was an offer to switch providers made and documented?				
26	If the PA request was submitted, was the PA packet requested and/or received?				
27	Was the "date packet submitted to Molina/Bayou Health" entered on the PA Tracking Log?				
28	Is there documentation of a follow up with the provider 10 days after the PA request was submitted (25 days for DME)?				

	Required review for "PAs not issued within 60 days" and "Gaps in Authorization Periods"	Yes	No	Supporting Document and Service Date	Comments
29	If the PA was not received, was the 60th day PAL referral timely?				
30	Is there documentation of ongoing contact with the participant/guardian and provider until the PA notice is received or the service request is resolved?				
31	Did the SC follow up and do planned activities and contacts as documented in the Service Logs, Quarter Reviews or CPOC. Is there documentation of the planned actions, contacts and follow up?				
32	Was there adequate SC supervision to ensure the required contacts, PA tracking and follow ups were completed timely and assist the SC with problem solving?				
33	Date of PA decision *If a PA has not been received, submit notification to ksalling@statres.com when the PA is received or the requested service is resolved				
34	**If the PA has not been received, what action will the SC take to obtain the PA?** (What is the barrier and how will it be removed? Frequent follow up is required.)				
35	**Were deficiencies found in the required contacts, timelines, follow up, documentation, etc.? If so, the agency will submit a Corrective Action Plan within 7 days.**				
36	Documentation that the Corrective Action Plan was carried out will be submitted within 14 days.				

EPSDT Specialist Signature_____ Date_____

EPSDT Specialist's Supervisor
Signature_____ Date_____

On-Site Project Manager

Signature_____ Date _____

4/15/09 Revised 8/18/09 8/12/10 3/17/15 4/30/15

CHECKLIST FOR EPSDT SUPPORT COORDINATION APPROVAL PROCESS – INITIALS AND SPECIAL NEEDS SUPPORT COORDINATION

RECIPIENT 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."

	FORM
	Current Formal Information Documents *An initial CPOC requires all assessments/evaluations and supporting documents from the regional OCDD office in addition to current formal documents. These must be sent to SRI to receive approval of an initial CPOC. *A CPOC flagged as "Special Needs" requires all the of the formal information documents to be sent to SRI to receive approval.
	SOA and/or Participant Recap Sheet if needed to verify a valid SOA
	LSICS CPOC Signature Page with participant's signatures, participant/guardian's CPOC approval signature, and the SC & SC Supervisor signature.
	Typical Weekly Schedule
	EPSDT Rights & Responsibilities (just the signature sheet)
	Legal Guardianship Document, Power of Attorney, Non-Legal Custodian Affidavit, or an Authorized Representative Form*
	Extended Home Health Plan of Care (If receiving EHH currently)
	Pediatric Day Healthcare Plan of Care (If receiving PDHC currently)

[*] ***Required if the recipient is interdicted, if the recipient has given power of attorney to another person, or if the legal guardian is not the parent. An authorized representative form needs to be on file if the participant is a competent major and he or she does not sign the CPOC documents or if her or she is not he contact for monthly phone calls.***

The following is a list of common EPSDT Support Coordination CPOC deficiencies:

- ✓ A valid reason for not checking PA tracking is not given in Additional Information for service needs that require a PA.
- ✓ Participant's identified needs are not addressed.
- ✓ Discrepancy in the information documented within the CPOC sections.
- ✓ Formal information document is not current or Evaluation/Documentation dates are not updated.
- ✓ When there are no services identified to coordinate, there is no documentation that the participant/family was informed that SC is optional and can be accessed at any time until the child's 21st birthday.
- ✓ Transition prior to the participant's 21st birthday is not addressed.

YOUR SIGNATURE BELOW INDICATES THAT THE PACKET HAS BEEN REVIEWED BY YOUR AGENCY FOR COMPLETENESS AND THAT ALL REQUIRED INFORMATION IS BEING SUBMITTED FOR REVIEW BY DHH-BHSF.

SIGNATURE:_____ DATE:_____
SUPPORT COORDINATION AGENCY REPRESENTATIVE

EPSDT CPOC MONITORING CHECKLIST

RECIPIENT NAME:	DATE:
SUPPORT COORDINATOR AND AGENCY NAME:	

This checklist identifies the items that are being faxed to SRI if the CPOC is selected for CPOC Monitoring after submittal in LSCIS. The documents must be maintained in the agency's case record.

	FORM
	Current Formal Information Documents
	SOA and/or Participant Recap Sheet if needed to verify a valid SOA
	LSICS CPOC Signature Page with participant's signatures, participant/guardian's CPOC approval signature, and the SC & SC Supervisor signature.
	Typical Weekly Schedule
	EPSDT Rights & Responsibilities (just the signature sheet)
	Legal Guardianship Document, Power of Attorney, Non-Legal Custodian Affidavit, or an Authorized Representative Form*
	Extended Home Health Plan of Care (If receiving EHH currently)
	Pediatric Day Healthcare Plan of Care (If receiving PDHC currently)

* ***Required if the recipient is interdicted, if the recipient has given power of attorney to another person, or if the legal guardian is not the parent. An authorized representative form needs to be on file if the participant is a competent major and he or she does not sign the CPOC documents or if her or she is not he contact for monthly phone calls.***

The following is a list of common EPSDT Support Coordination CPOC deficiencies:

- ✓ A valid reason for not checking PA tracking is not given in Additional Information for service needs that require a PA.
- ✓ Participant's identified needs are not addressed.
- ✓ Discrepancy in the information documented within the CPOC sections.
- ✓ Formal information document is not current or Evaluation/Documentation dates are not updated.
- ✓ When there are no services identified to coordinate, there is no documentation that the participant/family was informed that SC is optional and can be accessed at any time until the child's 21st birthday.
- ✓ Transition prior to the participant's 21st birthday is not addressed.

YOUR SIGNATURE BELOW INDICATES THAT THE PACKET HAS BEEN REVIEWED BY YOUR AGENCY FOR COMPLETENESS AND THAT ALL REQUIRED INFORMATION IS BEING SUBMITTED FOR REVIEW BY DHH-BHSF.

SIGNATURE:_____ DATE:_____
SUPPORT COORDINATION AGENCY REPRESENTATIVE

Appendix Y

Dear Recipient:

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

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

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

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

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

Sincerely,

Department of Health and Hospitals

- -

Name: ________________________________ Medicaid Identification #: _________________

Social Security #: _______________________ Phone 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:

DHH-PAL
Post Office Box 91030 Bin #24
Baton Rouge, Louisiana 70821-9030

CHOICE of PROVIDER FORM
For EPSDT MEDICAID PROVIDERS

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

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

☐ **Physical Therapy**	☐ **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