For Your Information
Special Medicaid Benefits for Children and Youth

Developmental Disability (DD) Medicaid Waiver Services

The following services are available to children and youth with developmental disabilities. To apply for services contact your local Human Services District also referred to as Local Governing Entities or LGEs. Phone numbers are listed on the attachment or on the Louisiana Department of Health website.

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

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

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

The **Supports Waiver** provides specific, activity focused services rather than continuous custodial care. This waiver offers supported employment, day habilitation, prevocational services, respite, habilitation, permanent supportive housing stabilization, permanent supportive housing stabilization transition and personal emergency response systems for individuals age 18 and older.

The **Residential Options Waiver (ROW)** is appropriate for those individuals whose health and welfare can be assured by the support plan with a cost limit based on their level of support need. This waiver offers community living supports, companion care, host home, shared living, one-time transitional services, environmental modifications, assistive technology/specialized medical equipment, personal emergency response systems, respite (center-based), nursing, dental, professional (dietary, speech therapy, occupational therapy, physical therapy, social work, psychology), transportation-community access, supported employment, prevocational services, day habilitation, housing stabilization, housing stabilization transition services and adult day health care (ADHC).

Services are also available for children ages birth to 3 years . Contact EarlySteps at 1-866-327-5978 for eligibility determination

Support Coordination

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

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

Transportation

Non-Emergency Transportation to and from medical appointments, is covered under the Medicaid Managed Care Program. Medicaid recipients that do not get all coverage through the Medicaid Managed Care Program will still get transportation coverage through their Managed Care Organization. Arrangements for transportation should always be made at least 48 hours in advance by calling the numbers shown below.

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

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

Applied Behavioral Analysis- Based Therapy Services (ABA)

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

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

Aetna Better Health	1-855-242-0802

Healthy Blue	1-844-406-2389
AmeriHealth Caritas	1-888-756-0004
Louisiana Healthcare Connections	1-866-595-8133
United Healthcare Community Plan	1-866-658-5499

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

Mental Health and Substance Use Services

Children and youth may receive mental health and substance use services if it is medically necessary. These services include necessary assessments and evaluation; individual, group and/or family therapy; medication management; crisis services; multi-systemic therapy; functional family therapy; homebuilders assertive community treatment for youth ages 18-20; therapeutic group home; psychiatric residential treatment facility including :inpatient and outpatient psychiatric treatment; residential, and inpatient substance use disorder treatment.

How to Access Mental Health and Substance Use Care

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

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

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

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

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

on the brief CANS assessment Magellan will connect you to the regional Wraparound Agency for further assessment.

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

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

EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) Exams and Checkups

Medicaid recipients under the age of 21 are eligible for checkups ("EPSDT screening"). 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 screening 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 direct service workers (DSWs) and defined as tasks that are medically necessary when physical or cognitive limitations due to illness or injury necessitate assistance with eating, toileting, bathing, bed mobility, transferring, dressing, locomotion, personal hygiene, and bladder or bowel requirements. PCS do not include medical tasks such as medication administration, tracheostomy care, feeding tube or catheter management. The Medicaid Home Health program or Extended Home Health program provides those medical services. PCS must be ordered by a physician. The PCS provider must request approval for the service from Medicaid or the Managed Care Organization.

Extended Skilled Nursing Services

Children and youth may be eligible to receive skilled nursing (over 3 hours per day) in the home. These services are provided by a home health agency. A physician must order this service. Once ordered by a physician, the home health agency must request approval for the service from Medicaid or the Managed Care Organization.

Intermittent Nursing Services
Intermittent Nursing services for EPSDT individuals may be provided without a prior authorization request, with the exception of multiple daily visits. These services must still be ordered by a physician and provided by a home health agency.

Pediatric Day Health Center These centers serve medically fragile individuals under the age of 21, including technology dependent children, who require nursing supervision and possibly therapeutic interventions all or part of the day due to a medically complex condition. These facilities offer an alternative or supplement to receiving in-home nursing care. PDHC may be provided up to seven days per week and up to 12 hours per day as documented by the recipient's Plan of Care.

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

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

For information on receiving these therapies contact your school or early intervention center or other providers. EarlySteps can be contacted toll-free at 1-866-327-5978. Call the Specialty Care Resource Line for referral assistance at 1-877-455-9955 for Legacy Medicaid or call your Managed Care Organization using the contacts listed above under Mental Health to locate other therapy providers.

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

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

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

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 medical condition. It also includes necessary dietary or nutritional assistance, and diapers or pull-ups if they are needed because of a medical problem.

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

CUSTOMER SERVICE INFORMATION FOR MEDICAID INQUIRIES:

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

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

Medicaid Eligibility Hotline • 1-888-342-6207

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

E-mail • MyMedicaid@la.gov

Medicaid Website • www.medicaid.la.gov

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

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

NOTE: The points of contact listed in this document is applicable to Medicaid recipients in the fee-for-service Medicaid program. Healthy Louisiana Plan members should contact their Plan's member services department with questions about how to access care.

LOUISIANA DEPARTMENT OF HEALTH

MEDICAID SERVICES CHART

January 2021

* Exclusion from this list does not necessarily mean that a service is not covered. Please call one of the appropriate contacts for questions regarding coverage of services not listed on this chart.

NOTE: The points of contact listed in this document is applicable to Medicaid recipients in the fee-for-service Medicaid program. Healthy Louisiana Plan members should contact their Plan's member services department with questions about how to access care.

MEDICAID SERVICES					
SERVICE	**HOW TO ACCESS SERVICES**	**ELIGIBILITY**	**COVERED SERVICES**	**COMMENTS**	**CONTACT PERSON**
Adult Denture Services	*Dentist*	Medicaid recipients 21 years of age and older. **(Adults, 21 and over, certified as Qualified Medicare Beneficiary (QMB), Specified Low Income Medicare Beneficiary (SLMB) only, PACE, Take Charge Plus or other programs with limited benefits are not eligible for dental services.)**	Examination, x-rays (are only covered if in conjunction with the construction of a Medicaid-authorized denture) dentures, denture relines, and denture repairs. Only one complete or partial denture per arch is allowed in an eight-year period. The partial denture must oppose a full denture. Two partials are not covered in the same oral cavity (mouth). Additional guidelines apply.	DentaQuest and MCNA Dental administer the dental benefits for eligible Medicaid recipients. Contact your plan to locate a network provider and for questions about covered dental services.	*DentaQuest* *1-800-685-0143* *Visit online at* *www.DentaQuest.com* *MCNA Dental* *1-855-702-6262* *Visit online at* *www.MCNALA.net* Kevin Guillory 225/342-7476 Andrea Perry 225/342-7877

* Exclusion from this list does not necessarily mean that a service is not covered. Please call one of the appropriate contacts for questions regarding coverage of services not listed on this chart.

NOTE: The points of contact listed in this document is applicable to Medicaid recipients in the fee-for-service Medicaid program. Healthy Louisiana Plan members should contact their Plan's member services department with questions about how to access care.

MEDICAID SERVICES					
SERVICE	**HOW TO ACCESS SERVICES**	**ELIGIBILITY**	**COVERED SERVICES**	**COMMENTS**	**CONTACT PERSON**
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.); 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 and **Prior Authorized**. The provider of services will submit requests for Prior Authorization.	Aetna www.aetnabetterhealth.com/louisiana AmeriHealth Caritas www.amerihealthcaritasla.com Healthy Blue www.myhealthybluela.com Louisiana Healthcare Connections www.louisianahealthconnect.com United Healthcare Community Plan www.uhccommunityplan.com Rene Huff 225/342-3935

* Exclusion from this list does not necessarily mean that a service is not covered. Please call one of the appropriate contacts for questions regarding coverage of services not listed on this chart.

NOTE: The points of contact listed in this document is applicable to Medicaid recipients in the fee-for-service Medicaid program. Healthy Louisiana Plan members should contact their Plan's member services department with questions about how to access care.

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

* Exclusion from this list does not necessarily mean that a service is not covered. Please call one of the appropriate contacts for questions regarding coverage of services not listed on this chart.

NOTE: The points of contact listed in this document is applicable to Medicaid recipients in the fee-for-service Medicaid program. Healthy Louisiana Plan members should contact their Plan's member services department with questions about how to access care.

Behavioral Health Services – Adults	Any Medicaid eligible adult may receive the following behavioral health service if medical necessity is established by a licensed mental health professional (LMHP).	Medicaid eligible adult Adults eligible to receive mental health rehabilitation services under Medicaid State Plan include those who meet the following criteria and is 21 years and older: • Must have a mental health diagnosis and • Must be assessed by an LMHP Members receiving CPST and/or PSR: • Must have at least a level of care of three on the LOCUS. • Must have a rating of three or greater on the functional status domain on the level of care utilization system (LOCUS). LOCUS score are not required to receive LMHP services. For more information, please refer to the BHS Provider Manual.	1. Community Psychiatric Support & Treatment 2. Psychosocial Rehabilitation 3. Crisis Intervention 4. Assertive Community Treatment 5. Outpatient Therapy with Licensed Practitioners (medication management, individual, family, and group counseling) 6. Addiction Services (outpatient, residential, and inpatient) 7. Psychiatric Inpatient Hospital 18-21 years and over 65 years of age	Adult Behavioral Health services are administered by the Healthy Louisiana Plans. CPST, PSR and ACT must be **Prior Authorized**.	Aetna www.aetnabetterhealth.com/louisiana 1-855-242-0802 AmeriHealth Caritas www.amerihealthcaritasla.com 1-888-756-0004 Healthy Blue www.myhealthybluela.com 1-844-521-6941 Louisiana Healthcare Connections www.louisianahealthconnect.com 1-866-595-8133 United Healthcare Community Plan www.uhccommunityplan.com 1-844-253-0667

* Exclusion from this list does not necessarily mean that a service is not covered. Please call one of the appropriate contacts for questions regarding coverage of services not listed on this chart.

NOTE: The points of contact listed in this document is applicable to Medicaid recipients in the fee-for-service Medicaid program. Healthy Louisiana Plan members should contact their Plan's member services department with questions about how to access care.

MEDICAID SERVICES					
SERVICE	**HOW TO ACCESS SERVICES**	**ELIGIBILITY**	**COVERED SERVICES**	**COMMENTS**	**CONTACT PERSON**
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.		Brandon Bueche 225/384-0460
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 an EPSDT medical screening provider or Primary Care Provider (PCP).	Brandon Bueche 225/384-0460

* Exclusion from this list does not necessarily mean that a service is not covered. Please call one of the appropriate contacts for questions regarding coverage of services not listed on this chart.

NOTE: The points of contact listed in this document is applicable to Medicaid recipients in the fee-for-service Medicaid program. Healthy Louisiana Plan members should contact their Plan's member services department with questions about how to access care.

Coordinated System of Care (CSoC) Program	To make a referral, contact the child/youth's Healthy Louisiana Plan. Note that the parent/caregiver must participate in the referral. The Healthy Louisiana Plan information is as follows: Aetna Better Health: 1-855-242-0802 AmeriHealth Caritas: 1-888-756-0004 Healthy Blue: 1-844-521-6941 Louisiana Healthcare Connections: 1-866-595-8133 United Health Care: 1-866-675-1607 **The Healthy Louisiana Plan will connect you with Magellan to complete the referral**	Children, youth and families eligible for CSoC include Medicaid members between the ages of 5 and 20 years of age, who have a severe emotional disturbance (SED) or a serious mental illness (SMI) and who are in or at risk of out of home placement. A recipient meet the level of care or level of need through a Child and Adolescent Needs and Strengths (CANS) comprehensive assessment. For more information, please refer to the BHS Provider Manual.	1. Parent Support & Training 2. Youth Support & Training 3. Independent Living/Skills Building 4. Short Term Respite Care 5. Case Conference	CSoC services are administered by Magellan Health Services of Louisiana.	Magellan Health Services of Louisiana 1-800-424-4489

* Exclusion from this list does not necessarily mean that a service is not covered. Please call one of the appropriate contacts for questions regarding coverage of services not listed on this chart.

NOTE: The points of contact listed in this document is applicable to Medicaid recipients in the fee-for-service Medicaid program. Healthy Louisiana Plan members should contact their Plan's member services department with questions about how to access care.

MEDICAID SERVICES					
SERVICE	**HOW TO ACCESS SERVICES**	**ELIGIBILITY**	**COVERED SERVICES**	**COMMENTS**	**CONTACT PERSON**
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 -only reimbursable as durable medical equipment items for Medicaid recipients 0 through 20 years of age.	All services must be prescribed by a physician and must be **Prior Authorized**. DME providers will arrange for the **Prior Authorization** request.	Irma Gauthier 225/342-5691

* Exclusion from this list does not necessarily mean that a service is not covered. Please call one of the appropriate contacts for questions regarding coverage of services not listed on this chart.

NOTE: The points of contact listed in this document is applicable to Medicaid recipients in the fee-for-service Medicaid program. Healthy Louisiana Plan members should contact their Plan's member services department with questions about how to access care.

MEDICAID SERVICES

SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
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

* Exclusion from this list does not necessarily mean that a service is not covered. Please call one of the appropriate contacts for questions regarding coverage of services not listed on this chart.

NOTE: The points of contact listed in this document is applicable to Medicaid recipients in the fee-for-service Medicaid program. Healthy Louisiana Plan members should contact their Plan's member services department with questions about how to access care.

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

* Exclusion from this list does not necessarily mean that a service is not covered. Please call one of the appropriate contacts for questions regarding coverage of services not listed on this chart.

NOTE: The points of contact listed in this document is applicable to Medicaid recipients in the fee-for-service Medicaid program. Healthy Louisiana Plan members should contact their Plan's member services department with questions about how to access care.

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

* Exclusion from this list does not necessarily mean that a service is not covered. Please call one of the appropriate contacts for questions regarding coverage of services not listed on this chart.

NOTE: The points of contact listed in this document is applicable to Medicaid recipients in the fee-for-service Medicaid program. Healthy Louisiana Plan members should contact their Plan's member services department with questions about how to access care.

MEDICAID SERVICES

SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
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 through20 **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** byDXC Technology. PCS is *not subject to service limits*. Units approved will be based on medical necessity and the need for covered services. Recipients receiving Personal Care Services must have a 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.	Norma Seguin 225/342-7513
EPSDT Screening Services *(Child Health - preventive services*)	Physician	All Medicaid recipients 0 through 20 years of age.	Medical Screenings (including immunizations and certain lab services). Vision Screenings Hearing Screenings Dental Screenings	Recipients receive their screening services from the primary care provider (PCP) or - appropriate health care provider..	Norma Seguin 225/342-7513 *Specialty Care Resource Line (877) 455-9955*

* Exclusion from this list does not necessarily mean that a service is not covered. Please call one of the appropriate contacts for questions regarding coverage of services not listed on this chart.

NOTE: The points of contact listed in this document is applicable to Medicaid recipients in the fee-for-service Medicaid program. Healthy Louisiana Plan members should contact their Plan's member services department with questions about how to access care.

MEDICAID SERVICES					
SERVICE	**HOW TO ACCESS SERVICES**	**ELIGIBILITY**	**COVERED SERVICES**	**COMMENTS**	**CONTACT PERSON**
Eyewear – *See Vision Services*					
Family Planning Services – *Take Charge Plus*	*Any Medicaid provider who offers family planning services.* *For assistance with locating a provider, call 1-877-455-9955*	All Louisiana residents of child bearing age regardless of gender with an income at or below 138% of the Federal Poverty level. Pregnant women are excluded from this program.	Family planning related services and care related to: • Birth control (pills, implants, injections, condoms, and IUDs) • Cervical cancer screening and treatment for most abnormal results • Contraceptive counseling and education • Prescriptions, and follow-up visits to treat STIs • Treatment of major complications from certain family planning procedures • Voluntary sterilization for males and females (over age 21) • Vaccines for both males and females for the prevention of HPV • Transportation to family planning appointments	Take Charge Plus is limited to family planning services and family planning related services. There are no enrollment fees, no premiums, co-payments or deductibles. All Medicaid providers including American Indian "638" Clinics, RHCs and FQHCs are reimbursed at established fee-for-service rates published in the Take Charge Plus fee schedule.	Becky Mouton 225/342-4722
Family Planning Services in Physician's Office – *See Physician/ Professional Services*					

* Exclusion from this list does not necessarily mean that a service is not covered. Please call one of the appropriate contacts for questions regarding coverage of services not listed on this chart.

NOTE: The points of contact listed in this document is applicable to Medicaid recipients in the fee-for-service Medicaid program. Healthy Louisiana Plan members should contact their Plan's member services department with questions about how to access care.

MEDICAID SERVICES

SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
Federally Qualified Health Centers (FQHC)	*Nearest FQHC* *The American Indian Clinic*	All Medicaid recipients.	Professional medical services furnished by physicians, nurse practitioners, physician assistants, nurse midwives, clinical social workers, clinical psychologists, and dentists Covered benefits include medical, behavioral health, and dental.	There are 3 components that may be provided: 1) Encounter visits; 2) EPSDT Screening Services; and 3) EPDST Dental, and Adult Denture Services.	Irma Gauthier 225/342-5691
Free Standing Birthing Centers	*Certified Nurse Midwife or Licensed Midwife*	All Medicaid eligible pregnant women	Vaginal delivery services for females who have had a low risk, normal pregnancy, prenatal care and that are expected to have an uncomplicated labor and normal vaginal delivery.	A Free Standing Birthing Center is a free standing facility, separate from a hospital. Stays for delivery are usually less than 24 hours. Epidural anesthesia is not provided for deliveries at Free Standing Birthing Centers.	Becky Mouton 225/342-4722
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**.	Irma Gauthier 225/342-5691
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.		Helen Carter 225/342-6888

* Exclusion from this list does not necessarily mean that a service is not covered. Please call one of the appropriate contacts for questions regarding coverage of services not listed on this chart.

NOTE: The points of contact listed in this document is applicable to Medicaid recipients in the fee-for-service Medicaid program. Healthy Louisiana Plan members should contact their Plan's member services department with questions about how to access care.

MEDICAID SERVICES

SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
Home Health	*Physician*	All Medicaid recipients. Medically Needy (Type Case 20 & 21) recipients are not eligible for Aide Visits, Physical Therapy, Occupational Therapy, Speech/Language Therapy. EPSDT Home Health is provided to the medically needy if the recipient is under the age of 21.	• Intermittent/part-time nursing services including skilled nurse visits. • Aide Visits • Physical Therapy • Occupational Therapy • Speech/Language Therapy	Recipients receiving Home Health must have physician's prescription and signed plan of care. PT, OT, and Speech/Language Therapy require **Prior Authorization**. Crisis Response Team – for Medicaid recipients 0 through 20 AND under a waiver program (Supports, ROW, NOW, Children's Choice) AND not receiving prescribed medically necessary intermittent nursing services for 2 consecutive weeks	Helen Carter 225/342-6888 Crisis Response Team 1-866-729-0017
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**. Crisis Response Team – for Medicaid recipients 0 through 20 AND under a waiver program (Supports, ROW, NOW, Children's Choice) AND not receiving prescribed medically necessary Extended Home Health nursing services for 2 consecutive weeks	Helen Carter 225/342-6888 Crisis Response Team 1-866-729-0017
Hospice Services	*Hospice Provider/ Physician*	All Medicaid recipients. Hospice eligibility information: 1-800-877-0666 Option 2	Medicare allowable services.		Helen Carter 225/342-6888

* Exclusion from this list does not necessarily mean that a service is not covered. Please call one of the appropriate contacts for questions regarding coverage of services not listed on this chart.

NOTE: The points of contact listed in this document is applicable to Medicaid recipients in the fee-for-service Medicaid program. Healthy Louisiana Plan members should contact their Plan's member services department with questions about how to access care.

MEDICAID SERVICES

SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
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.		Providers: ProviderRelations@la.gov Members: Healthy@la.gov
Hospital - Outpatient Services	*Physician/ Hospital*	All Medicaid recipients.	Diagnostic & therapeutic outpatient services, including outpatient surgery and rehabilitation services. Therapeutic and diagnostic radiology services. Chemotherapy Hemodialysis	Outpatient rehabilitation (physical therapy, occupational therapy, and speech therapy) require **Prior Authorization**. Provider will submit request for **Prior Authorization**.	Providers: ProviderRelations@la.gov Members: Healthy@la.gov

* Exclusion from this list does not necessarily mean that a service is not covered. Please call one of the appropriate contacts for questions regarding coverage of services not listed on this chart.

NOTE: The points of contact listed in this document is applicable to Medicaid recipients in the fee-for-service Medicaid program. Healthy Louisiana Plan members should contact their Plan's member services department with questions about how to access care.

MEDICAID SERVICES

SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
Hospital - Emergency Room Services	*Physician/ Hospital*	All Medicaid recipients.	Emergency Room services.	No service limits.	Providers: ProviderRelations@la.gov Members: Healthy@la.gov
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.	Becky Mouton 225/342-4722

* Exclusion from this list does not necessarily mean that a service is not covered. Please call one of the appropriate contacts for questions regarding coverage of services not listed on this chart.

NOTE: The points of contact listed in this document is applicable to Medicaid recipients in the fee-for-service Medicaid program. Healthy Louisiana Plan members should contact their Plan's member services department with questions about how to access care.

MEDICAID SERVICES

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

* Exclusion from this list does not necessarily mean that a service is not covered. Please call one of the appropriate contacts for questions regarding coverage of services not listed on this chart.

NOTE: The points of contact listed in this document is applicable to Medicaid recipients in the fee-for-service Medicaid program. Healthy Louisiana Plan members should contact their Plan's member services department with questions about how to access care.

Medical Transportation (Non-Emergency)	*Medicaid recipients who ARE covered under a Healthy Louisiana managed care plan should contact the call centers as follows:* *Aetna Better Health* *1-877-917-4150* *Healthy Blue* *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.**	Melanie Doucet 225/614-3222 Justin Owens 225/342-9566

* Exclusion from this list does not necessarily mean that a service is not covered. Please call one of the appropriate contacts for questions regarding coverage of services not listed on this chart.

NOTE: The points of contact listed in this document is applicable to Medicaid recipients in the fee-for-service Medicaid program. Healthy Louisiana Plan members should contact their Plan's member services department with questions about how to access care.

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

* Exclusion from this list does not necessarily mean that a service is not covered. Please call one of the appropriate contacts for questions regarding coverage of services not listed on this chart.

NOTE: The points of contact listed in this document is applicable to Medicaid recipients in the fee-for-service Medicaid program. Healthy Louisiana Plan members should contact their Plan's member services department with questions about how to access care.

MEDICAID SERVICES

SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
Occupational Therapy Services *See EarlySteps; Home Health; Hospital-Outpatient Services; Rehabilitation Clinic Services; Therapy Services*					
Optical Services – *(See Vision Services for Eyewear)*	*Ophthalmologist*	All Medicaid recipients.	**Recipients 0 through 20** Examinations and treatment of eye conditions, including examinations for vision correction, refraction error. Other related services, if medically necessary. _____ **Recipients 21 and over** Examinations and treatment of eye conditions, such as infections, cataracts, etc. If the recipient has both Medicare and Medicaid, some vision related services may be covered. The recipient should contact Medicare for more information since Medicare would be the primary payer.	**Recipients 21 and over** **NON-COVERED SERVICES:** - routine eye examinations for vision correction - routine eye examinations for refraction error	Ophthalmology: Brandon Bueche 225/384-0460 Eyewear: Irma Gauthier 225/342-5691
Orthodontic Services - *See Dental Care Services*					

* Exclusion from this list does not necessarily mean that a service is not covered. Please call one of the appropriate contacts for questions regarding coverage of services not listed on this chart.

NOTE: The points of contact listed in this document is applicable to Medicaid recipients in the fee-for-service Medicaid program. Healthy Louisiana Plan members should contact their Plan's member services department with questions about how to access care.

MEDICAID SERVICES

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

* Exclusion from this list does not necessarily mean that a service is not covered. Please call one of the appropriate contacts for questions regarding coverage of services not listed on this chart.

NOTE: The points of contact listed in this document is applicable to Medicaid recipients in the fee-for-service Medicaid program. Healthy Louisiana Plan members should contact their Plan's member services department with questions about how to access care.

MEDICAID SERVICES

SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
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

* Exclusion from this list does not necessarily mean that a service is not covered. Please call one of the appropriate contacts for questions regarding coverage of services not listed on this chart.

NOTE: The points of contact listed in this document is applicable to Medicaid recipients in the fee-for-service Medicaid program. Healthy Louisiana Plan members should contact their Plan's member services department with questions about how to access care.

Pharmacy Services	Pharmacies	All Medicaid recipients except some who are Medicare/Medicaid eligible. Recipients who are full benefit dual eligible (Medicare/Medicaid) receive their pharmacy benefits through Medicare Part D. Recipients enrolled in an MCO with only behavioral health services receive prescription benefits through the fee-for-service Medicaid program.	Covers prescription drugs EXCEPTIONS: • Cosmetic drugs (Except Accutane); • Cough & cold preparations; • Anorexics (Except for Xenical); • Fertility drugs when used for fertility treatment; • Experimental drugs; • Compounded prescriptions; • Drug Efficacy Study Implementation (DESI) drugs; • Erectile Dysfunction (ED) Medications • Over the counter (OTC) drugs with some exceptions;	Co-payments ($0.50-$3.00) are required except for some recipient categories. NO co-payments for the following: • Under age 21 • Pregnant women • Long Term Care recipients • American Indians/Alaska Natives • Home and Community Based Waiver • Emergency Services • Family planning services • Preventive medications as designated by the US Preventive Services Task Force A and B Recommendations • Individuals receiving hospice care • Women whose basis of Medicaid eligibility is breast or cervical cancer Prescription limits: 4 per calendar month (The physician can override this limit when medically necessary.) *Limits do not apply to recipients under age 21*, pregnant women, or those in Long Term Care. **Prior Authorization** is required for *some* drug categories if the medication is not on the Preferred Drug List (PDL). **Children are not exempt from this process.** The PDL can be accessed at www.lamedicaid.com.	Sharon Beckwith 225/342-9859 Sue Fontenot 225/342-2768 For general pharmacy questions: 1-800-437-9101

* Exclusion from this list does not necessarily mean that a service is not covered. Please call one of the appropriate contacts for questions regarding coverage of services not listed on this chart.

NOTE: The points of contact listed in this document is applicable to Medicaid recipients in the fee-for-service Medicaid program. Healthy Louisiana Plan members should contact their Plan's member services department with questions about how to access care.

MEDICAID SERVICES

SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
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. Certain family planning services when provided in a physician's office.	Some services require **Prior Authorization**. Providers will submit requests for **Prior Authorization to DXC Technology**. Services are subject to limitations and exclusions. Your physician or healthcare professional can help with this.	Immunizations: Norma Seguin 225/342-7513 Professional Services: Brandon Bueche 225/384-0460 Family Planning: Becky Mouton 225/342-4722
Podiatry Services	*Podiatrist*	All Medicaid recipients.	Office visits. Certain radiology & lab procedures and other diagnostic procedures.	Some **Prior Authorization**, exclusions, and restrictions apply. Providers will submit request for **Prior Authorization to DXC Technology**.	Brandon Bueche 225/384-0460

* Exclusion from this list does not necessarily mean that a service is not covered. Please call one of the appropriate contacts for questions regarding coverage of services not listed on this chart.

NOTE: The points of contact listed in this document is applicable to Medicaid recipients in the fee-for-service Medicaid program. Healthy Louisiana Plan members should contact their Plan's member services department with questions about how to access care.

MEDICAID SERVICES

SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
Pre-Natal Care Services	*Physicians or Healthcare Professional*	Female Medicaid recipients of child bearing age.	Office visits. Lab and radiology services.		Becky Mouton 225/342-4722
Psychiatric Hospital Care Services - *See Hospital-Inpatient Services*					
Rehabilitation Clinic Services	*Physician*	Medicaid recipients 0 through 20 years of age.	Occupational Therapy Physical Therapy Speech, Language and Hearing Therapy	All services must be **Prior Authorized**. The provider of services will submit the request for **Prior Authorization.**	Helen Carter 225/342-6888
Rural Health Clinics	*Rural Health Clinic* *The American Indian Clinic*	All Medicaid recipients	Professional medical services furnished by physicians, nurse practitioners, physician assistants, nurse midwives, clinical social workers, clinical psychologists, and dentists. Covered benefits include medical, behavioral health, and dental.	There are 3 components that may be provided: 1) Encounter visits; 2) EPSDT Screening Services; and 3) EPDST Dental, and Adult Denture Services.	Irma Gauthier 225/342-5691
Sexually Transmitted Disease Clinics (STD)	*OPH Public Health Units*	All Medicaid recipients.	Testing, counseling, and treatment of all sexually transmitted diseases (STD). Confidential HIV testing.		Public Health Unit directory located at: http://ldh.la.gov/index.cfm/directory/category/192

* Exclusion from this list does not necessarily mean that a service is not covered. Please call one of the appropriate contacts for questions regarding coverage of services not listed on this chart.

NOTE: The points of contact listed in this document is applicable to Medicaid recipients in the fee-for-service Medicaid program. Healthy Louisiana Plan members should contact their Plan's member services department with questions about how to access care.

MEDICAID SERVICES					
SERVICE	**HOW TO ACCESS SERVICES**	**ELIGIBILITY**	**COVERED SERVICES**	**COMMENTS**	**CONTACT PERSON**
Speech and Language Evaluation and Therapy – *See EarlySteps;Home Health; Hospital-Outpatient Services; Rehabilitation Clinic Services; Therapy Services*					
Support Coordination Services (Case Management) - **Children's Choice Waiver**		**Medicaid recipients must be in the Children's Choice Waiver.** There is a Request for Services Registry (RFSR) for those requesting waiver services. To get on the Request for Services Registry, call the Office for Citizens with Developmental Disabilities District/Authority/Local Regional Office contact information is located at: http://ldh.la.gov/index.cfm/page/134/n/137	Coordination of Medicaid and other services. The Support Coordinator (Case Manager) helps to identify needs, access services and coordinate care. Services available through the Waiver are identified in the waiver section of this document.	Services must be **prior authorized** by LDH, Office for Citizens with Developmental Disabilities, Waiver Supports and Services. The support coordinator will submit requests for the **Prior Authorization**.	Office for Citizens with Developmental Disabilities, Waiver Supports and Services 1-866-783-5553

* Exclusion from this list does not necessarily mean that a service is not covered. Please call one of the appropriate contacts for questions regarding coverage of services not listed on this chart.

NOTE: The points of contact listed in this document is applicable to Medicaid recipients in the fee-for-service Medicaid program. Healthy Louisiana Plan members should contact their Plan's member services department with questions about how to access care.

MEDICAID SERVICES

SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
Support Coordination Services (Case Management) - **Community Choices Waiver**		**Medicaid recipients must be in the Community Choices Waiver (CCW).** There is a Request for Services Registry (RFSR) for those requesting CCW Waiver services. Contact Louisiana Options in Long Term Care at 1-877-456-1146.	Coordination of Medicaid and other services. The Support Coordinator (Case Manager) helps to identify needs, access services and coordinate care.	Services must be **prior authorized** by LDH, *Office of Aging and Adult Services (OAAS*). The provider will submit requests for the **Prior Authorization**.	Office of Aging and Adult Services (OAAS) 1-866-758-5035 Participants call 1-866-758-5035 or 225-219-0643
Support Coordination Services (Case Management) - **EPSDT Targeted Populations**		**Must be Medicaid eligible and on the DD Request for Services Registry prior to receipt of case management services; or any Medicaid recipient 3 through 20 years of age for whom support coordination is medically necessary (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 LDH, BHSF, and Waiver Compliance Section. The Support Coordination Agency will submit requests for the Prior Authorization to SRI. For other EPSDT services, see that portion of the chart.	SRI 1-800-364-7828 Must be on the DD Request for Services Registry. However, if the child is no longer eligible to remain on the registry, the family can appeal the notice that is sent out. LDH will evaluate the recipient's eligibility to receive "special needs" case management.

* Exclusion from this list does not necessarily mean that a service is not covered. Please call one of the appropriate contacts for questions regarding coverage of services not listed on this chart.

NOTE: The points of contact listed in this document is applicable to Medicaid recipients in the fee-for-service Medicaid program. Healthy Louisiana Plan members should contact their Plan's member services department with questions about how to access care.

MEDICAID SERVICES

SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
Support Coordination Services (Case Management**) - Infants and Toddlers**		Medicaid recipients must be 0 to 3 years of age and have a developmental delay or an established medical condition and eligible for the EarlySteps system. Contact information is located at: http://ldh.la.gov/index.cfm/page/139/n/139	Coordination of Medicaid and other services. The Support Coordinator (Case Manager) helps to identify needs, access services and coordinate care in EarlySteps.	Services must be **authorized** by EarlySteps. Authorizations are approved through the Individualized Family Service Plan (IFSP) process.	Office for Citizens with Developmental Disabilities (OCDD) 1-866-783-5553 Brenda Sharp 225/342-8853
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://ldh.la.gov/index.cfm/page/134/n/137	Coordination of Medicaid and other services. The Support Coordinator (Case Manager) helps to identify needs, access services and coordinate care. Services available through the Waiver are identified in the waiver section of this document.	Services must be **prior authorized** by LDH, Office for Citizens with Developmental Disabilities, Waiver Supports and Services. The support coordinator will submit requests for the **Prior Authorization**.	Office for Citizens with Developmental Disabilities, Waiver Supports and Services 1-866-783-5553 Complaints Line: 1-800-660-0488

* Exclusion from this list does not necessarily mean that a service is not covered. Please call one of the appropriate contacts for questions regarding coverage of services not listed on this chart.

NOTE: The points of contact listed in this document is applicable to Medicaid recipients in the fee-for-service Medicaid program. Healthy Louisiana Plan members should contact their Plan's member services department with questions about how to access care.

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

* Exclusion from this list does not necessarily mean that a service is not covered. Please call one of the appropriate contacts for questions regarding coverage of services not listed on this chart.

NOTE: The points of contact listed in this document is applicable to Medicaid recipients in the fee-for-service Medicaid program. Healthy Louisiana Plan members should contact their Plan's member services department with questions about how to access care.

MEDICAID SERVICES

SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
Therapy Services	*Recipients have the choice of services from the following provider types: Home Health; Hospital-Outpatient Services; Rehabilitation Clinic Services*	Medicaid recipients **0 through 20** years of age.	• Audiological Services (Available in Rehabilitation Clinic and Hospital-Outpatient settings only.) • Occupational Therapy • Physical Therapy • Speech & Language Therapy	Covered services can be provided in the home through Home Health and Rehabilitation Clinics. Services provided by Rehabilitation Clinics can also be provided at the clinic. Services provided through Hospital-Outpatient Services must be provided at the facility/clinic. Covered services may be provided in addition to services provided by EarlySteps/EICs or School Boards if prescribed by a physician and Prior Authorized. All medically necessary services must be prescribed by a physician and **Prior Authorization** is required. The provider of services will submit requests for Prior Authorization.	Helen Carter 225/342-6888 NOTE: *For details on services provided in Home Health, Rehabilitation Clinic, or Hospital-Outpatient settings, please refer to those sections of this Medicaid Services Chart.*
Therapy Services continued	*EPSDT Health Services-Early Intervention Centers (EIC) or EarlySteps Program*	Medicaid recipients **under 3** years of age.	• Audiological Services • Occupational Therapy • Physical Therapy • Speech & Language Therapy • Psychological Therapy	All EPSDT Health Services through EICs and EarlySteps must be included in the infant/toddler's Individualized Family Services Plan (IFSP). If services are provided by an EIC or EarlySteps, Prior Authorization requirements are met through inclusion of services on the IFSP.	Brenda Sharp 225/342-8932

* Exclusion from this list does not necessarily mean that a service is not covered. Please call one of the appropriate contacts for questions regarding coverage of services not listed on this chart.

NOTE: The points of contact listed in this document is applicable to Medicaid recipients in the fee-for-service Medicaid program. Healthy Louisiana Plan members should contact their Plan's member services department with questions about how to access care.

MEDICAID SERVICES

SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
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.	Anissa Young-Ned 225/342-6885
Therapy Services continued	*Physician* *Recipients 21 years of age and older may access Therapy Services through Hospital Outpatient Services or Home Health Services.*	Medicaid recipients 21 years of age and older. Medically Needy (Type Case 20 & 21) recipients are not eligible Physical Therapy, Occupational Therapy, Speech/Language Therapy in a Home Health setting.	• Physical Therapy • Occupational Therapy • Speech/Language Therapy	PT, OT, and Speech/Language Therapy require a physician's prescription. PT, OT, and Speech/Language Therapy require **Prior Authorization**.	Helen Carter 225/342-6888 *For details on services provided in Home Health or Hospital-Outpatient settings, please refer to those sections of this Medicaid Services Chart.*
Transportation *See Medical Transportation*					

* Exclusion from this list does not necessarily mean that a service is not covered. Please call one of the appropriate contacts for questions regarding coverage of services not listed on this chart.

NOTE: The points of contact listed in this document is applicable to Medicaid recipients in the fee-for-service Medicaid program. Healthy Louisiana Plan members should contact their Plan's member services department with questions about how to access care.

MEDICAID SERVICES

SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
Tuberculosis Clinics	*Office of Public Health Local Health Unit*	All Medicaid recipients	Treatment and disease management services including physician visits, medications and x-rays.		TB Control Directory found at: http://ldh.la.gov/assets/oph/Center-PHCH/Center-PH/tuber/TBDirectory2018.pdf
Vision Services (Eyewear)	*Optometrist, Ophthalmologist or Optical Supplier*		**Recipients 0 through 20** Regular eyeglasses when they meet a certain minimum strength requirement. **Medically necessary** specialty eyewear and contact lenses with **prior authorization**. Contact lenses are covered if they are the **only** means for restoring vision. **Recipients 21 and over** ONLY if the recipient receives both Medicare and Medicaid and Medicare covers the required eyewear. In this instance, Medicaid may pick up a calculated portion of the payment as a Medicare cross-over claim.	**Recipients 0 through 20** Specialty eyewear and contact lenses, if medically necessary for EPSDT beneficiaries. Requires **prior authorization**. The provider will submit requests for the p**rior authorization**. A prior authorization approval does not guarantee patient eligibility. Prescriptions are required for all glasses/contacts. After a prescription is obtained, the recipient may see an optical supplier to receive the glasses/contacts. **Recipients 21 and over** **NON-COVERED SERVICES:** eyeglasses	Irma Gauthier 225/342-5691
X-Ray Services - *See Laboratory Tests and X-Ray Services*					

* Exclusion from this list does not necessarily mean that a service is not covered. Please call one of the appropriate contacts for questions regarding coverage of services not listed on this chart.

NOTE: The points of contact listed in this document is applicable to Medicaid recipients in the fee-for-service Medicaid program. Healthy Louisiana Plan members should contact their Plan's member services department with questions about how to access care.

MEDICAID SERVICES					
SERVICE	**HOW TO ACCESS SERVICES**	**ELIGIBILITY**	**COVERED SERVICES**	**COMMENTS**	**CONTACT PERSON**
WAIVER SERVICES:		There is a Request for Services Registry (RFSR) for those requesting any of the waiver services below.			**See Specific Waiver**
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

* Exclusion from this list does not necessarily mean that a service is not covered. Please call one of the appropriate contacts for questions regarding coverage of services not listed on this chart.

NOTE: The points of contact listed in this document is applicable to Medicaid recipients in the fee-for-service Medicaid program. Healthy Louisiana Plan members should contact their Plan's member services department with questions about how to access care.

MEDICAID SERVICES					
SERVICE	**HOW TO ACCESS SERVICES**	**ELIGIBILITY**	**COVERED SERVICES**	**COMMENTS**	**CONTACT PERSON**
Children's Choice		Child must be on the DD Request for Services Registry, less than 21 years old, disabled according to SSI criteria, require ICF/DD level of care, have income less than 3 times SSI amount, resources less than $2,000 and meet all Medicaid non-financial requirements.	- Center Based Respite -Environmental Accessibility Adaptation -Specialized Medical Equipment and Supplies -Family Training - Professional Services: Aquatic Therapy, Art Therapy, Music Therapy, Sensory Integration, Hippotherapy/Therapeutic Horseback Riding - Housing Stabilization/ Housing Stabilization Transition -Crisis and Non-Crisis Provisions	There is a $17,500 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://ldh.la.gov/index.cfm/page/134/n/137* Edward Harris225/342-0095

* 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.

NOTE: The points of contact listed in this document is applicable to Medicaid recipients in the fee-for-service Medicaid program. Healthy Louisiana Plan members should contact their Plan's member services department with questions about how to access care.

MEDICAID SERVICES

SERVICE	HOW TO ACCESS SERVICES	ELIGIBILITY	COVERED SERVICES	COMMENTS	CONTACT PERSON
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

* Exclusion from this list does not necessarily mean that a service is not covered. Please call one of the appropriate contacts for questions regarding coverage of services not listed on this chart.

NOTE: The points of contact listed in this document is applicable to Medicaid recipients in the fee-for-service Medicaid program. Healthy Louisiana Plan members should contact their Plan's member services department with questions about how to access care.

MEDICAID SERVICES					
SERVICE	**HOW TO ACCESS SERVICES**	**ELIGIBILITY**	**COVERED SERVICES**	**COMMENTS**	**CONTACT PERSON**
New Opportunities Waiver (NOW)		Individuals three(3) years of age or older, who have a developmental disability which manifested prior to the age of 22, and who meet both SSI Disability criteria and the level of care determination for an ICF/DD.	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; Prevocational Services; Professional Services; One Time Transitional Expense; Skilled Nursing; Housing Stabilization/ Housing Stabilization Transition and Personal Emergency Response System, Adult Companion Care.	***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://ldh.la.gov/index.cfm/page/134/n/137 Office for Citizens with Developmental Disabilities, Waiver Supports and Services 1-866-783-5553

* Exclusion from this list does not necessarily mean that a service is not covered. Please call one of the appropriate contacts for questions regarding coverage of services not listed on this chart.

NOTE: The points of contact listed in this document is applicable to Medicaid recipients in the fee-for-service Medicaid program. Healthy Louisiana Plan members should contact their Plan's member services department with questions about how to access care.

MEDICAID SERVICES					
SERVICE	**HOW TO ACCESS SERVICES**	**ELIGIBILITY**	**COVERED SERVICES**	**COMMENTS**	**CONTACT PERSON**
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, Adult Day Health Care, Monitored In Home Caregiving	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://ldh.la.gov/index.cfm/page/134/n/137 Office for Citizens with Developmental Disabilities, Waiver Supports and Services 1-866-783-5553 Denise Boyd 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.

NOTE: The points of contact listed in this document is applicable to Medicaid recipients in the fee-for-service Medicaid program. Healthy Louisiana Plan members should contact their Plan's member services department with questions about how to access care.

MEDICAID SERVICES					
SERVICE	**HOW TO ACCESS SERVICES**	**ELIGIBILITY**	**COVERED SERVICES**	**COMMENTS**	**CONTACT PERSON**
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 https://ldh.la.gov/index.cfm/page/1828	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://ldh.la.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 $17,500 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 twenty-one (21) 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 and Screening for Urgency of Need (SUN) score.

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 opportunity again. Their names will be removed from the Developmental Disabilities Request for Services Registry (DD RFSR). Once a recipient's name has been removed from DD Request for Service Registry the individual/family will have to start over again by contacting their Human Services Authorities or Districts to complete the screening process. If there are changes to the program a memo will be sent out to all LGE's and SC agencies describing those changes and the effective date.

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 twenty-one (21) 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 there are inadequate services or there are an increased needs for services, the individual and their family are to notify their Support Coordinator who in turn notifies the LGE. The LGE is responsible for implementing the changes needed. The CCW also provides Crisis Designation services which are sent to OCDD Central Office for approval by the CCW Program Manager. If a child's needs significantly change and a crisis designation is met, the child's name would be returned to the Request for Services Registry with the child's original request date. Additionally, once your child turns age twenty-one (21), 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 twenty-one (21) 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 -crisis designation request can be made.

11. 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.

12. What happens when my child reaches age twenty-one (21) and Children's Choice benefits expire?

Once your child turns age twenty-one (21), and continues to meet the eligibility criteria, your child would transfer to an appropriate adult waiver. Approximately ninety (90) days before your child turns twenty-one (21), this eligibility and transfer process would begin.

13. I've been told that some of the $17,500 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, LDH/OCDD will continue to seek ways to make the support coordination requirement more flexible.

14. 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.

15. 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 has changed? Is this true?

Yes. The Department of Health (LDH) 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. It was then raised to the current cap of $17,500.

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. Accepting Children's Choice has no effect of SSI eligibility.

25. What is considered "direct care"? Direct Care the provision of services to a patient that require some degree of interaction between the patient and the health care provider

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 Healthy Louisiana plan?

Participation in a Healthy Louisiana plan will have no effect on how you will receive your waiver services.

LOUISIANA DEPARTMENT OF HEALTH

Office for Citizens with Developmental Disabilities

New Opportunities Waiver Fact Sheet

WHAT IS THE NEW OPPORTUNITIES WAIVER?

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

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

IF I QUALIFY, WHAT SERVICES MAY I RECEIVE FROM THIS PROGRAM?

- Individual and Family Support (IFS) for Day, Night, Shared
  - Can be Self-Directed
- Center-Based Respite
- Community Integration and Development
- Environmental Adaptations
- Specialized Medical Equipment
- Supported Living
- Substitute Family Care
- Day Habilitation and Transportation
- Supported Employment and Transportation
- Prevocational Services
- Personal Emergency Response
- Skilled Nursing
- One time transitional services
- Housing Stabilization Transition
- Housing Stabilization

Individuals will receive Support Coordination services via state plan.

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

WHO CAN QUALIFY FOR SERVICES?

Individuals who:

- Meet Louisiana Medicaid eligibility **AND**
- Meet the Louisiana definition for developmental disability which manifested prior to age 22 (Revised Statute 25:451.2, Paragraph (11)), **AND**
- Have an OCDD Statement of Approval **AND**
- Meet Intermediate Care Facility- Intellectual Disability (ICF-ID) Level of Care Criteria **AND**
- Are 3 years of age or older, **AND**
- Whose needs cannot be met in another OCDD waiver

Revised November 13, 2019
Replaces September 2018 Issuance

OCDD-RC-19-001

Financials:
Resources are the things people own. When we count resources for this program, we do not count the person's home, the car they drive to medical appointments or other basic resources.

- Single people can have no more than $2,000 in resources. Couples can have no more than $3,000 in resources (when both spouses receive long-term care).

HOW CAN PEOPLE REQUEST AN OCDD WAIVER?

Home and community-based waiver opportunities will now be provided based on the individual's prioritized need for support, which was identified in their Request for Services Registry Screening for Urgency of Need. Instead of being first come, first served, individuals with the most emergent and urgent need for support will have priority.

Individuals who have a need for services should contact their local Human Services District/Authority in order to go through the eligibility determination process

To add your name to the Developmental Disability Request for Services Registry or if you have questions, you can contact the Human Services District/Authority for your area. Listed below is a web link to this information:

http://ldh.la.gov/index.cfm/page/134

If you do not have access to a computer, you may call the OCDD State Office at 866-783-5553 to request the contact information for your local Human Services District/Authority.

LOUISIANA DEPARTMENT OF HEALTH

Office for Citizens with Developmental Disabilities

Children's Choice Waiver Fact Sheet

WHAT IS THE CHILDREN'S CHOICE WAIVER?

The Children's Choice Waiver (CC) program provides services in the home and in the community to individuals 0 through 20 years of age, who currently live at home with their families or who will leave an institution to return home.

This waiver provides an individualized support package with a maximum cost of $17,500 per year, and is designed for maximum flexibility.

Youth who reach the age of 18 and want to work may choose to transition to a Supports Waiver as long as they remain eligible for waiver services.

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

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

Youth age 0 to 3 individuals must meet the My Place eligibility requirements.
Youth age 3 to 20 individuals must have an OCDD Statement of Approval.

IF I QUALIFY, WHAT SERVICES MAY I RECEIVE FROM THIS PROGRAM?

- Support Coordination
- Family Support
- Crisis Support
- Center-Based Respite
- Family Training
- Environmental Accessibility Adaptions
- Specialized Medical Equipment
- Permanent Supportive Housing Stabilization
- Permanent Supportive Housing Stabilization and Transition

Therapy Services

- Aquatic Therapy
- Art Therapy
- Music Therapy
- Hippo-Therapy/Therapeutic Horseback Riding
- Sensory Integration

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

Reissued November 13, 2019
Replaces September 2018 Issuance

OCDD–RC-19-002

WHO CAN QUALIFY FOR SERVICES?

Individuals who:

- Meet Louisiana Medicaid eligibility **AND**
- Meet the Louisiana definition for developmental disability which manifested prior to age 22 (Revised Statute 25:451.2, Paragraph (11)), **AND**
- Have an OCDD Statement of Approval **OR**
- Meet My Place eligibility if age 0-3 **AND**
- Meet Intermediate Care Facility- Intellectual Disability (ICF-ID) Level of Care Criteria **AND**
- Are 0 through 20 years of age

Financial:

Resources are the things people own. When we count resources for this program, we do not count the person's home, the car they drive to medical appointments or other basic resources.

- Single people can have no more than $2,000 in resources. Couples can have no more than $3,000 in resources (when both spouses receive long-term care).

HOW CAN PEOPLE REQUEST AN OCDD WAIVER?

Home and community-based waiver opportunities will now be provided based on the individual's prioritized need for support, which was identified in their Request for Services Registry Screening for Urgency of Need. Instead of being first come, first served, individuals with the most emergent and urgent need for support will have priority.

Individuals who have a need for services should contact their local Human Services District/Authority in order to go through the eligibility determination process.

To add your name to the Developmental Disability Request for Services Registry or if you have questions, you can contact the Human Services District/Authority for your area. Listed below is a web link to this information:

http://ldh.la.gov/index.cfm/page/134

If you do not have access to a computer, you may call the OCDD State Office at 866-783-5553 to request the contact information for your local Human Services District/Authority.

LOUISIANA DEPARTMENT OF HEALTH
Office for Citizens with Developmental Disabilities

Supports Waiver Fact Sheet

WHAT IS THE SUPPORTS WAIVER?

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

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

IF I QUALIFY, WHAT SERVICES MAY I RECEIVE FROM THIS PROGRAM?

- Support Coordination
- Supported Employment-Individual or Group
- Day Habilitation
- Prevocational
- Habilitation
- Respite (center-based or in-home)
- Permanent Supportive Housing Stabilization
- Permanent Supportive Housing Stabilization Transition
- Personal Emergency Response System (PERS)

Individuals under 21 years of age may access Early Periodic Screening and Diagnostic Treatment (ESPDT) services

Individuals who receive the SW may also receive Long Term Personal Care Services.(LTPCS)

WHO CAN QUALIFY FOR SERVICES?

Individuals who:

- Meet Louisiana Medicaid eligibility **AND**
- Meet the Louisiana definition for developmental disability which manifested prior to age 22 (Revised Statute 25:451.2, Paragraph (11)), **AND**
- Have an OCDD Statement of Approval **AND**

Reissued November 13, 2019
Replaces September 2018 Issuance

OCDD-RC-19-003

- Meet Intermediate Care Facility- Intellectual Disability (ICF-ID) Level of Care Criteria **AND**
- Are 18 years of age or older

Financials

Resources are the things people own. When we count resources for this program, we do not count the person's home, the car they drive to medical appointments or other basic resources.

- Single people can have no more than $2,000 in resources. Couples can have no more than $3,000 in resources (when both spouses receive long-term care).

HOW CAN PEOPLE REQUEST AN OCDD WAIVER?

Home and community-based waiver opportunities will now be provided based on the individual's prioritized need for support, which was identified in their RFSR Screening for Urgency of Need. Instead of being first come, first served, individuals with the most emergent and urgent need for support will have priority.

Individuals who have a need for services should contact their local Human Services District/Authority in order to go through the eligibility determination process.

To add your name to the Developmental Disability Request for Services Registry or if you have questions, you can contact the Human Services District/Authority for your area. Listed below is a web link to this information:

http://ldh.la.gov/index.cfm/page/134

If you do not have access to a computer, you may call the OCDD State Office at 866-783-5553 to request the contact information for your local Human Services District/Authority.

LOUISIANA DEPARTMENT OF HEALTH

Office for Citizens with Developmental Disabilities

Residential Options Waiver (ROW) Fact Sheet

WHAT IS THE RESIDENTIAL OPTIONS WAIVER (ROW)?

The Residential Options Waiver (ROW) program provides services in the home and in the community to individuals of all ages who are eligible to receive OCDD waiver services. It is a capped waiver where the person's individual annual budget is based upon the person's assessed support needs.
Supports needs are determined by an Inventory for Client and Agency Planning (ICAP) assessment.

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

IF I QUALIFY, WHAT SERVICES MAY I RECEIVE FROM THIS PROGRAM?

- Support Coordination
- Community Living Supports
- Host Home Services
- Companion Care Services
- Shared Living
- Adult Day Health Care
- Respite Care-Out of Home
- Personal Emergency Response System
- One Time Transition Services
- Environmental Accessibility Adaptations

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

- Assistive Technology/Specialized Medical Equipment and Supplies
- Transportation-Community Access
- Professional Services
- Nursing Services
- Dental Services
- Supported Employment
- Prevocational Services
- Day Habilitation
- Housing Stabilization Service
- Housing Stabilization Transition Services

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

Reissued November 13, 2019
Replaces September 2018 issuance

OCDD-RC-19-004

WHO CAN QUALIFY FOR SERVICES?

Individuals who:

- Meet Louisiana Medicaid eligibility **AND**
- Meet the Louisiana definition for developmental disability which manifested prior to age 22 (Revised Statute 25:451.2, Paragraph (11)), **AND**
- Have an OCDD Statement of Approval **AND**
- Meet Intermediate Care Facility- Intellectual Disability (ICF-ID) Level of Care Criteria **AND**

Meets one of four ROW priority group criteria

Financial:

Resources are the things people own. When we count resources for this program, we do not count the person's home, the car they drive to medical appointments or other basic resources.

- Single people can have no more than $2,000 in resources. Couples can have no more than $3,000 in resources (when both spouses receive long-term care).

HOW CAN PEOPLE REQUEST AN OCDD WAIVER?

Home and community-based waiver opportunities will now be provided based on the individual's prioritized need for support, which was identified in their RFSR Screening for Urgency of Need. Instead of being first come, first served, individuals with the most emergent and urgent need for support will have priority.

Individuals who have a need for services should contact their local Human Services District/Authority in order to go through the eligibility determination process.

To add your name to the Developmental Disability Request for Services Registry or if you have questions, you can contact the Human Services District/Authority for your area. Listed below is a web link to this information:

http://ldh.la.gov/index.cfm/page/134

If you do not have access to a computer, you may call the OCDD State Office at 866-783-5553 to request the contact information for your local Human Services District/Authority.

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. ▪ 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 Healthy Louisiana Plan for participants with Healthy Louisiana 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 for recipients under 21 include skilled nurse visits (RN or LPN) and Home Health Aide visits. If these visits are for less than 3 hours per day, they do not require prior authorization. Physical Therapy, Occupational Therapy and Speech Therapy provided by a home health agency must be prior authorized. ▪ Recipients may also receive Extended Skilled Nursing Services (Extended HH) which is **three of more 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 Healthy Louisiana Plan for participants with Healthy Louisiana 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, 4/27/17, 5/11/18, 4/24/19

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. 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.
3. 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.

Issued June 2009
Mandatory Training
Revised 10/28/10, 2/9/12, 6/16/14, 4/30/15, 4/24/19

- 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 including services not in the published lists.

*All specialized behavioral health services and non-emergency medical transportation services are accessed through your Medicaid Managed Care Program. Contact numbers for the Managed Care Organizations 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 1-800-424-4489.

To access specialized behavioral health contact your Managed Care Organization at:

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

To access non-emergency medical transportation contact your Managed Care Organization at:

Aetna Better Health	1-877-917-4150
AmeriHealth Caritas Louisiana	1-888-913-0364
Healthy Blue	1-866-430-1101
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, the 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 the Medicaid Managed Care Program for their physical health services contact the Managed Care Organization.

Whenever health treatment or additional services are needed, you may obtain an appointment for a screening visit by contacting the SPECIALTY RESOURCE LINE. Such screening visits also can be recommended by any health, developmental, or educational professional. To schedule a screening visit, contact the 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 directly to obtain an appointment for a screening visit if you already have a provider. If you have a communication disability or are non-English speaking, you may have someone else call the SPECIALTY RESOURCE LINE and the appropriate assistance can be provided. For recipients with the Medicaid Managed Care Program for their physical health services, contact the Managed Care Organization.

Louisiana Medicaid encourages you to contact the SPECIALTY RESOURCE LINE office and obtain a 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.
3100 Gen de Gaulle Dr., New Orleans, LA 70114
Phone: (504) 568-3130 Fax: (504) 568-4660
Toll Free: 1-800-889-2975

Orleans – Plaquemines – St. Bernard

Central Louisiana Human Services District

Paxton Oliver II DD **Rebecca Craig** Ex Dir
5411 Coliseum Blvd, Alexandria, LA 71303
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

Corlis Gremillion, DD **Janzlean Laughinghouse,** Ex. Dir.
4615 Government St. Bldg 2, Baton Rouge., 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.
5593 Hwy 311, Houma, LA 70360
Phone: (985) 876-8805 Fax: (985) 876-8905
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

Acadiana Area Human Services District

Troy Abshire, 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 **Richard Kramer,** Dir.
835 Pride Drive, Suite B, Hammond, LA 70401
Phone: (985) 543-4333 Fax: (985) 543-4817

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

Imperial Calcasieu Human Services Authority

James Lewis, DD **Tanya McGee,** Ex Dir
Temporary Mailing Address: 4105 Kirkman St. Lake Charles, LA 70607
Phone: (337) 475-3100 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.
1500 River Oaks Rd. West, Ste. 200, Jefferson, LA 70123
Phone: (504) 838-5424 Fax: (504) 838-5400

Jefferson

OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES
Regional EPSDT Specialists

METROPOLITAN HUMAN SERVICES DISTRICT
Veronica Allen
719 Elysian Fields Ave.
New Orleans, LA 70117
Phone: (504) 599-0245
FAX: (504) 568-4660
Toll Free: 1-800-889-2975

CENTRAL LOUISIANA COMMUNITY SERVICES DISTRICT
Lisa Fontenot
5411 Coliseum Blvd.
Alexandria, LA 71303
Phone: (318) 484-2347
FAX: (318) 484-2458
Toll Free: 1-800-640-7494

CAPITAL AREA HUMAN SERVICES DISTRICT
Polly Rheams
4615 Government St. – Bldg. 2
Baton Rouge, LA 70806
Phone: (225) 925-1910
FAX: (225) 925-1966
Toll Fee: 1-800-768-8824

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
Freda Green and Raymond Menard
5593 Hwy 311
Houma, LA 70360
Phone: (985) 876-8805
FAX: (985) 876-8905
Toll Free: 1-800-861-0241

NORTHEAST DELTA HUMAN SERVICES AUTHORITY
Koren Coleman
2513 Ferrand Street
Monroe, LA 71201
Phone: (318) 362-3396
FAX: (318) 362-5305
Toll Free: 1-800-637-3113

ACADIANA AREA HUMAN SERVICES DISTRICT
Nicole Chapman & Troy Abshire
302 Dulles Dr
Lafayette, LA 70506
Phone (337) 262-5610
FAX: (337) 262-5233
Toll Free: 1-800-648-1484

FLORIDA PARISHES HUMAN SERVICES AUTHORITY
Karey Hill & Dawn Riley
835 Pride Drive, Suite B
Hammond, LA 70401
Phone: (985) 543-4370
FAX: (985) 543-4752

IMPERIAL CALCASIEU HUMAN SERVICES AUTHORITY
Doanie Perry
Temporary Mailing Address:
4105 Kirkman St. Lake Charles, LA 70607
Phone: (337) 475-3100
FAX: (337) 475-8055
Toll Free: 1-800-631-8810

JEFFERSON PARISH HUMAN SERVICES AUTHORITY
Reion Janeau
1500 River Oaks Rd. West, Suite 200
Jefferson, LA 70123
Phone (504) 838-5424
FAX: (504) 838-5400

Local Governing Entities - Community Behavioral Health Centers

Metropolitan Human Services District

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

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

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

Chartres-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 (Adult and Children's Services)
5630 Read Boulevard, Second Floor, New Orleans, LA 70127 I PH: 504.568.3130

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

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

Capital Area Human Services District

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

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

Temporary Mailing Address: 4105 Kirkman St. 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

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

Jefferson Davis Behavioral Health Clinic
1211 N Cutting Ave, Jennings, LA 70546 I PH: 337-246-7325

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

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

Northwest Louisiana Human Services District

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

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

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

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

Northeast Delta Human Services Authority

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

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

Bogalusa Behavioral Health Clinic
2106 Avenue F, Bogalusa, LA 70427 I PH (985) 732-6610

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

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

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

Jefferson Parish Human Services Authority

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

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

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

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

Past

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

Present

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

Medical Diagnoses

- List all diagnoses and what documentation you have for each (ICD10 must have current documentation to support)
- If any diagnosis is "parent states" and you don't have documentation to back it up address that and address what you're doing to obtain documentation or if no documentation exists
- List all doctor's names and specialties, how often they see them, last visit/next visit
- List all meds and what they are prescribed for
- Address special procedures -trach, g-tube, etc.
- Ambulation
- Communication
- Vison
- Hearing
- Toileting needs
- Dietary needs
- Do they need assistance with their ADLs? If so was PCS offered? If PCS is received, what ADLs do they need PCS to assist with?
- What therapies do they receive at school and were community therapies offered?

Psych/Behavioral

- Address behaviors at both home and school
- What behaviors do they have / what does it look like?
- How often does it occur?
- Any triggers?
- What strategies are used to deal with behaviors?
- What behavior services are received or offered?

Evaluation/Documentation

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

Service Needs

- List all school therapies
- List services that require PA tracking like PCS, EHH, PDHC, OT, PT, ST, DMEs, ABA, BHR, etc.
- List services requested from OCDD like Family Flexible Fund, respite, redetermination, family support, etc.
- List services that pertain to behavioral health like psychiatrist, behavioral meds, counseling, etc.
- List services requested through the community
- List Transition as a service need if will be 20.5 years old this CPOC year
- List Redetermination if their SOA will expire this CPOC year or is expired

Additional Info

- List chosen providers for each service
- If unclear what a service need is elaborate here
- If any services that typically require PA tracking are not checked as "requires PA tracking" document the valid reason for not tracking the service need
- If any service needs are marked as "Other – Explain Next Page", document why the service need is on hold
- If any service needs are marked as "Carried Over - Resolved" or "Family Does Not Want" explain why
- If family is checked state why

Appendix K

Bureau of Health Services Financing

Rights and Responsibilities for Applicants / Participants of EPSDT Targeted Support Coordination

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

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

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

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

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

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

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

Applicant/Participant Name	
Signature of Applicant/Participant or Authorized Representative	*Date*
Support Coordinator	*Date*

Can I Appeal a Medicaid Decision?

Yes, you have the right to appeal:

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

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:
Director
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)

Or complete and submit the online Recipient Appeal Request form:
www.adminlaw.state.la.us/forms.htm

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 or before the services stop (whichever is longer) 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. Disability Rights Louisiana (1-800-960-7705) helps with appeals.

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

APPEAL FORM

I want to appeal.

Name of Medicaid Recipient appealing: _____.

Social Security Number of Medicaid Recipient: _____.

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

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

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

_____

_____

_____

_____

_____ _____

Signature of Recipient **Date**

Submit form to:

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

Department of Administrative Law Contact Info

Physical Address:
1020 Florida Street
Baton Rouge, LA 70802

Phone: 225-342-1800
Fax: 225-342-1812
E-mail: dhaddad@adminlaw.state.la.us
Website: http://www.adminlaw.state.la.us/index.htm

Disability Rights Louisiana Contact Info

Main Office:
8325 Oak Street
New Orleans, LA 70118

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

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:**

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

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

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

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

Recipient's Name: _____ Date of Birth: _____

Physical Address: _____ City: _____

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

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

Population: ☐ EPSDT Targeted Case Management

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

---

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

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

[ ] Medical Resources & Guidance
[ ] Community Resource Coordinators

_____ _____
Signature of Recipient / Legal Guardian Date

Section 2: Release of Information

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

_____ _____
Signature of Recipient / Legal Guardian Date

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

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

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

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

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

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

Louisiana Department of Health & Hospitals

Comprehensive Plan of Care

EPSDT - Targeted Support Coordination

CPOC Type: _____ Annual, Initial, Interim

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

Sex: _____ 1. Male 2.Female

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

Education: _____

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

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

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

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

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

Diagnosis Code (ICD9) : _____

Residential Placement: _____

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

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

Names: _____

FOR LDH USE ONLY

CPOC Begin Date: CPOC End Date:

Signature of DHH: Date:

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

SECTION II: Medical/Social/Family History

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

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

HEALTH STATUS:

Physician Name: _____

Date of Last Appointment: _____

Immunizations Current: Yes No

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

Dates of Evaluations/Documentation used to develop this CPOC

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

Psychiatric/Behavioral Concerns:

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

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

SECTION III: CPOC SERVICE NEEDS AND SUPPORTS

Service Strategy/ Descript	How was need determined?	Requested by participant/family	Why Not	Goal(s)	Receiving Service	Medicaid	School	Community	Family	OCDD	Requires PA tracked by S. C.	Amount Approved
Personal Care Serv												
Extended Hme Serv												
DME												
OT												
Physical Therapy												
Speech Therapy												
Behavioral Health 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, Behavioral Health 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:

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

SECTION V: CPOC PARTICIPANTS

PLANNING PARTICIPANTS	TITLE & AGENCY NAME

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

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

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

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

If not why not:

EPSDT Screening Services requested: _____

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

_____ _____

Participants/Guardian's Signature Date

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

_____ _____

Support Coordinator Supervisor's Signature Date

SECTION VI: CARE PLAN ACTION

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

CPOC Status: _____

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

Approved CPOC: Begin Date: _____ End Date: _____

Signature/Title of LDH Representative: _____

Notes: _____

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							

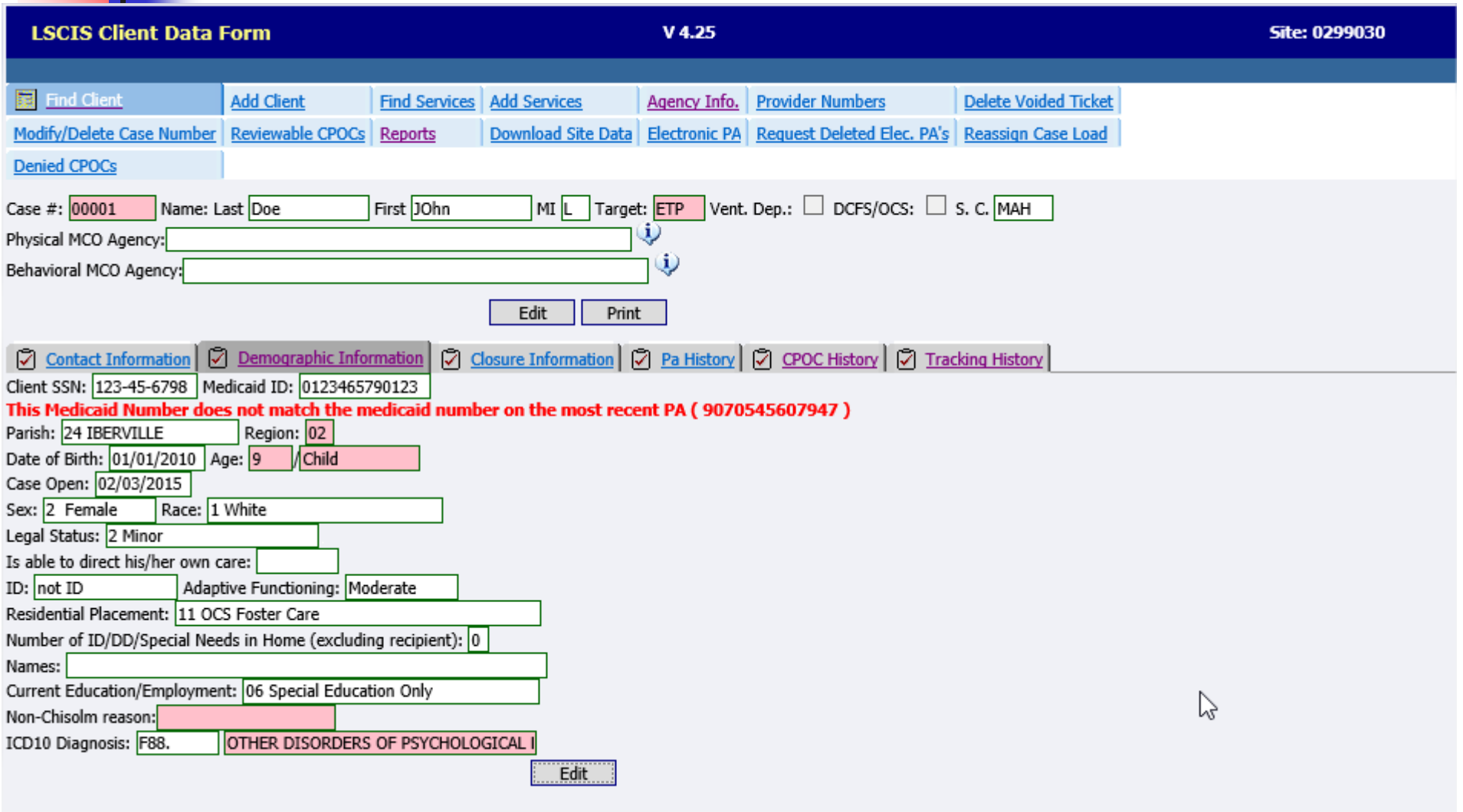
CODE
F = Family/Friends
S = Self
Sc = School
ST = Speech Therapy
OT = Occupational Therapy
PCS = EPSDT Personal Care Services
EHH = Extended Home Health
PT = Physical Therapy

COMMENTS:

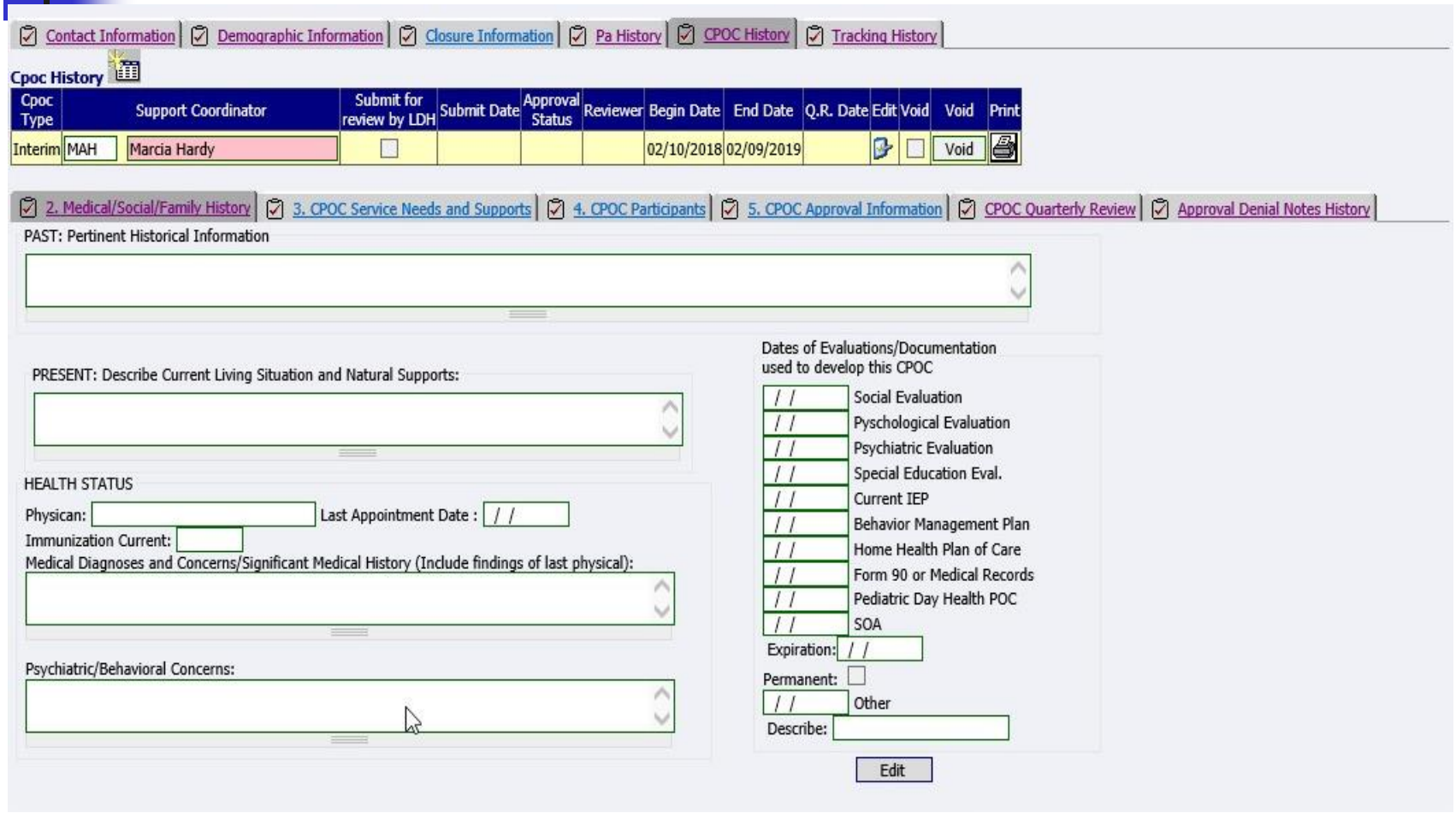
Above is the schedule of services requested by the individual and should be provided at these times. PCS can be provided at the same time as skilled nursing or therapy services as long as the PCS worker is performing duties that do not require one-on-one contact with the participant such as meal preparation 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 provisions 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: _____

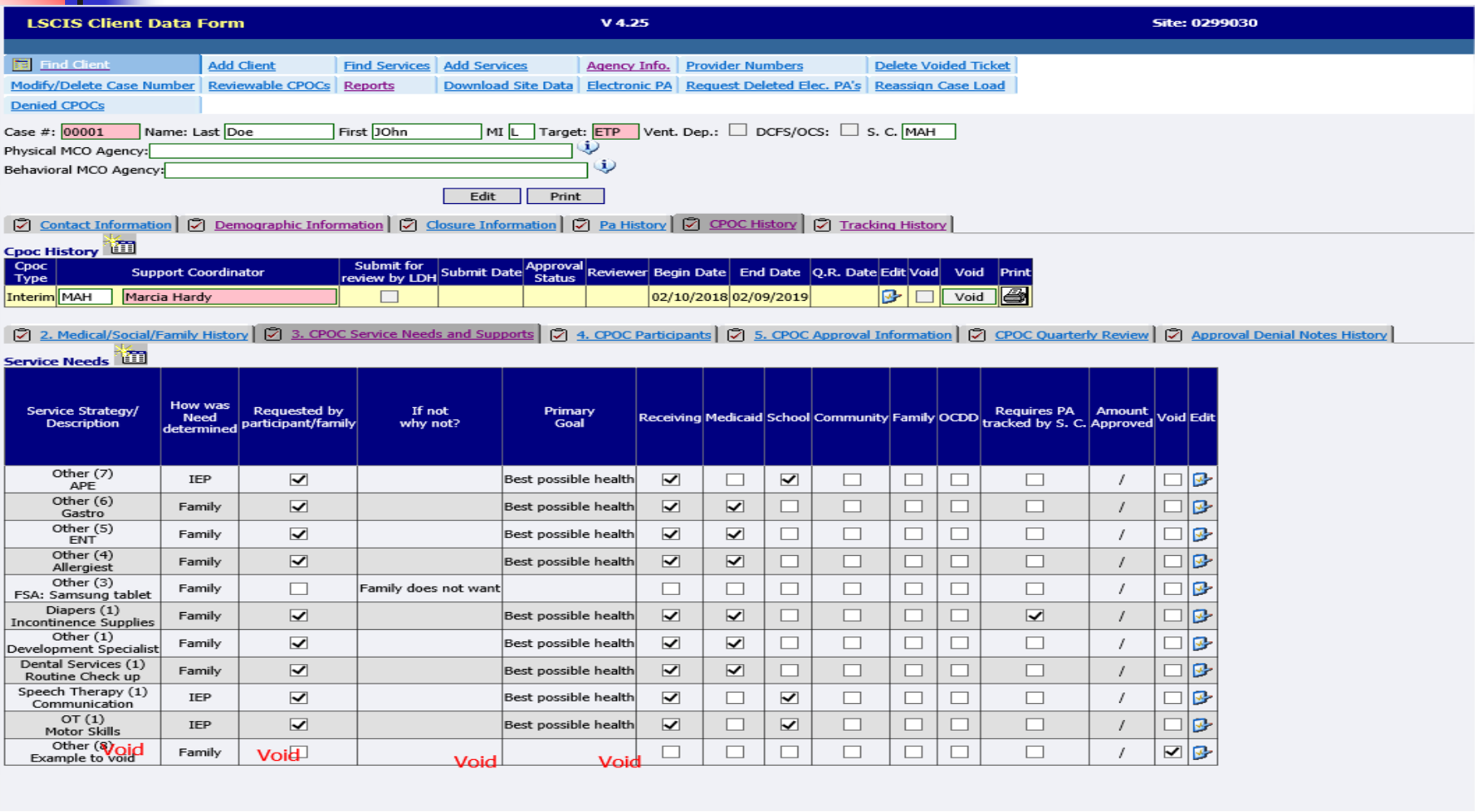
LSCIS CPOC Section 1
Demographics/ Contact Information



LSCIS CPOC Section 2 – Medical/Social/Family History



LSCIS CPOC Section 3 – CPOC Service Needs and Supports



LSCIS Client Data Form V 4.25 Site: 0299030

Find Client | Add Client | Find Services | Add Services | Agency Info. | Provider Numbers | Delete Voided Ticket
Modify/Delete Case Number | Reviewable CPOCs | Reports | Download Site Data | Electronic PA | Request Deleted Elec. PA's | Reassign Case Load
Denied CPOCs

Case #: 00001 Name: Last Doe First JOhn MI L Target: ETP Vent. Dep.: DCFS/OCS: S. C. MAH
Physical MCO Agency:
Behavioral MCO Agency:
Edit Print

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

Cpoc History

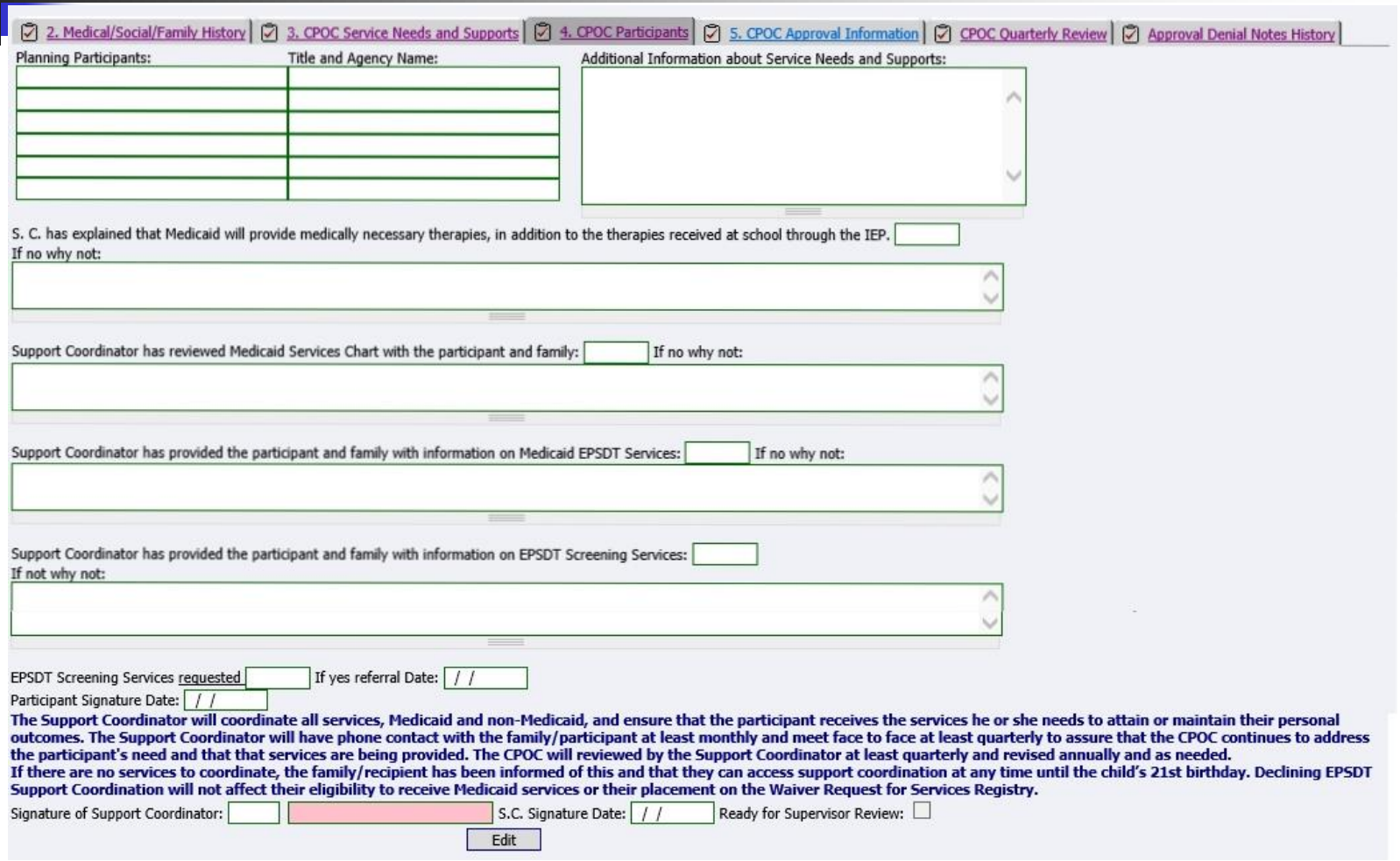
Cpoc Type	Support Coordinator		Submit for review by LDH	Submit Date	Approval Status	Reviewer	Begin Date	End Date	Q.R. Date	Edit	Void	Void	Print
Interim	MAH	Marcia Hardy					02/10/2018	02/09/2019				Void	

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

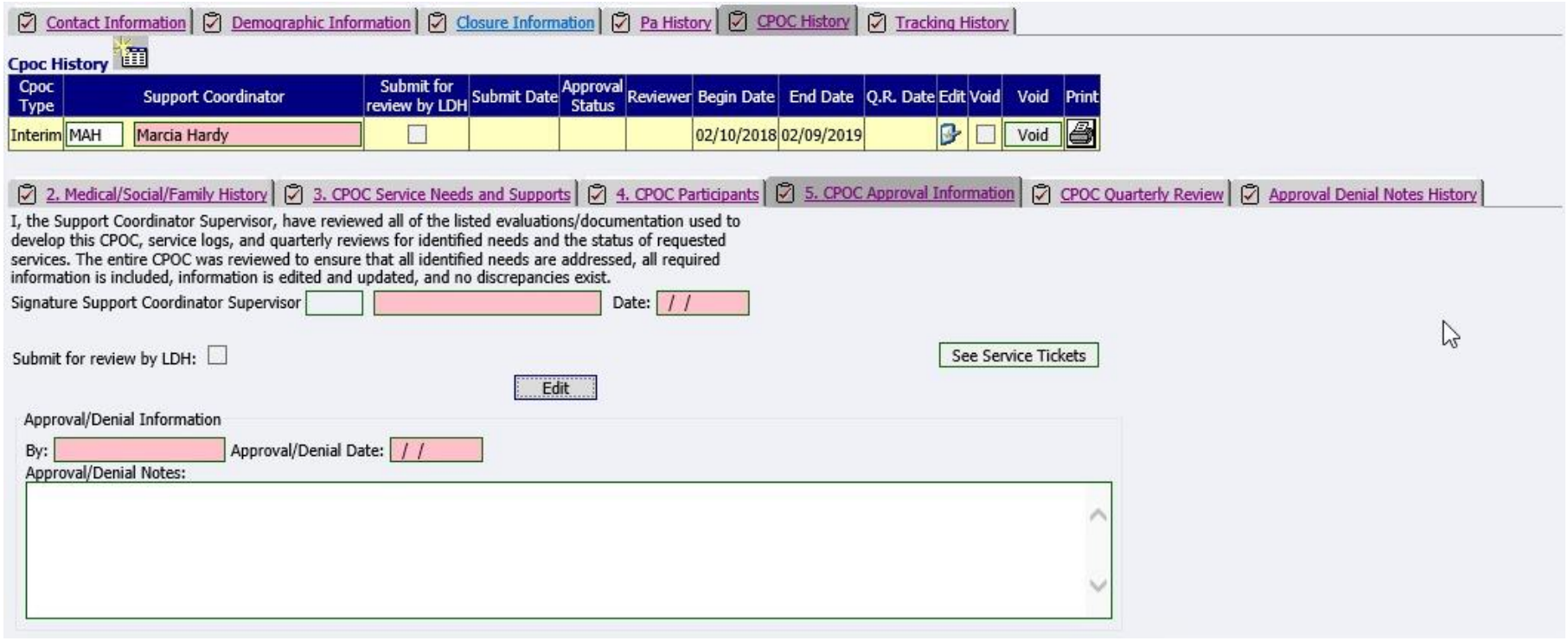
Service Needs

Service Strategy/ Description	How was Need determined	Requested by participant/family	If not why not?	Primary Goal	Receiving	Medicaid	School	Community	Family	OCDD	Requires PA tracked by S. C.	Amount Approved	Void	Edit
Other (7) APE	IEP	☑		Best possible health	☑	☐	☑	☐	☐	☐	☐	/	☐	
Other (6) Gastro	Family	☑		Best possible health	☑	☑	☐	☐	☐	☐	☐	/	☐	
Other (5) ENT	Family	☑		Best possible health	☑	☑	☐	☐	☐	☐	☐	/	☐	
Other (4) Allergiest	Family	☑		Best possible health	☑	☑	☐	☐	☐	☐	☐	/	☐	
Other (3) FSA: Samsung tablet	Family	☐	Family does not want		☐	☐	☐	☐	☐	☐	☐	/	☐	
Diapers (1) Incontinence Supplies	Family	☑		Best possible health	☑	☑	☐	☐	☐	☐	☑	/	☐	
Other (1) Development Specialist	Family	☑		Best possible health	☑	☑	☐	☐	☐	☐	☐	/	☐	
Dental Services (1) Routine Check up	Family	☑		Best possible health	☑	☑	☐	☐	☐	☐	☐	/	☐	
Speech Therapy (1) Communication	IEP	☑		Best possible health	☑	☐	☑	☐	☐	☐	☐	/	☐	
OT (1) Motor Skills	IEP	☑		Best possible health	☑	☐	☑	☐	☐	☐	☐	/	☐	
Other (8) Example to void	Family	Void ☐	Void	Void	Void ☐	☐	☐	☐	☐	☐	☐	/	☑	

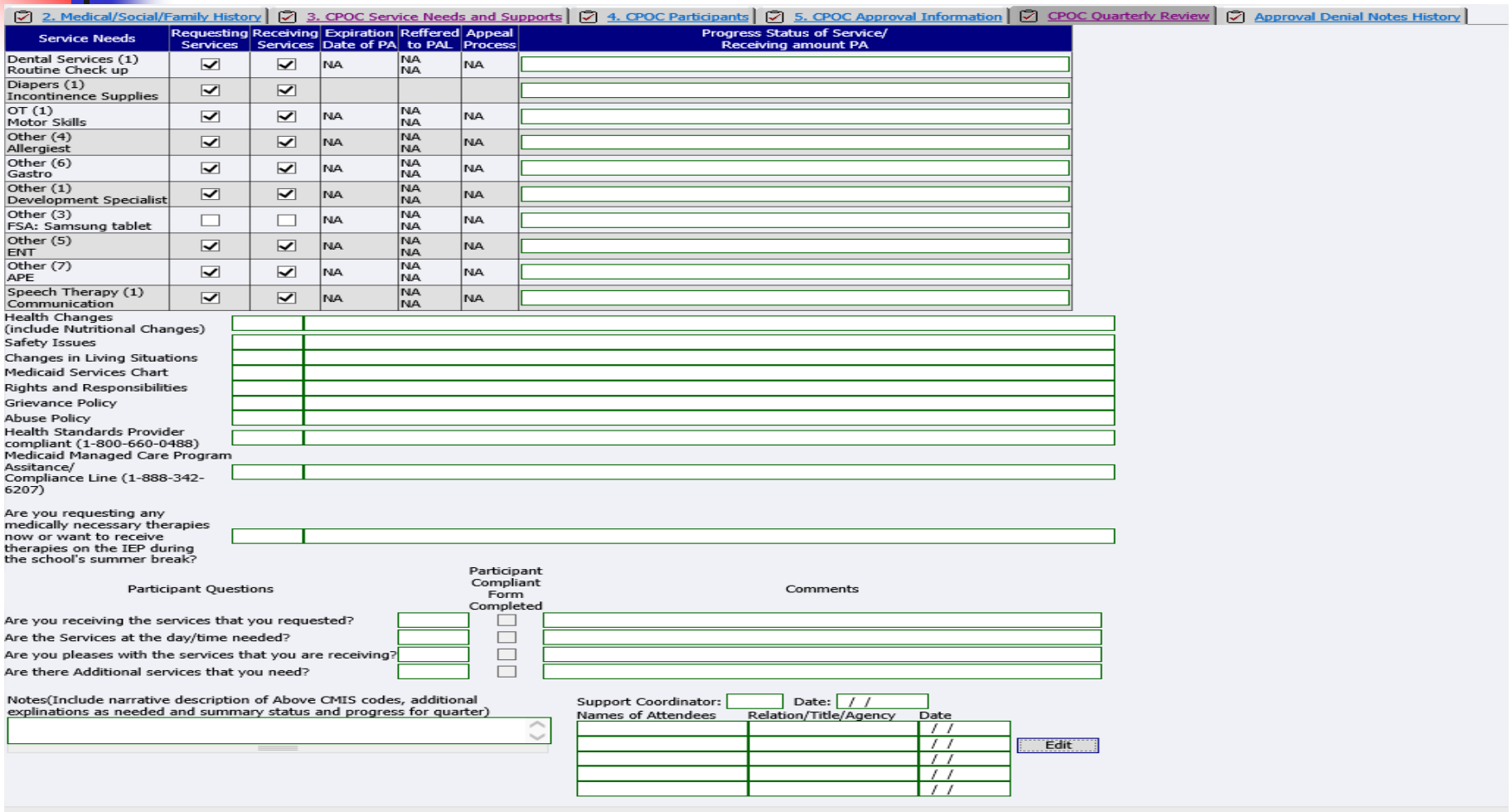
LSCIS CPOC Section 4 – Additional Information / CPOC Participants



LSCIS CPOC Section 5 – CPOC Approval Information



LSCIS CPOC Quarterly Review



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
Dental Services (1) Routine Check up	☑	☑	NA	NA NA	NA	
Diapers (1) Incontinence Supplies	☑	☑				
OT (1) Motor Skills	☑	☑	NA	NA NA	NA	
Other (4) Allergiest	☑	☑	NA	NA NA	NA	
Other (6) Gastro	☑	☑	NA	NA NA	NA	
Other (1) Development Specialist	☑	☑	NA	NA NA	NA	
Other (3) FSA: Samsung tablet	☐	☐	NA	NA NA	NA	
Other (5) ENT	☑	☑	NA	NA NA	NA	
Other (7) APE	☑	☑	NA	NA NA	NA	
Speech Therapy (1) Communication	☑	☑	NA	NA NA	NA	

Health Changes (include Nutritional Changes)		
Safety Issues		
Changes in Living Situations		
Medicaid Services Chart		
Rights and Responsibilities		
Grievance Policy		
Abuse Policy		
Health Standards Provider compliant (1-800-660-0488)		
Medicaid Managed Care Program Assitance/ Compliance Line (1-888-342-6207)		
Are you requesting any medically necessary therapies now or want to receive therapies on the IEP during the school's summer break?		

Participant Questions		Participant Compliant Form Completed	Comments
Are you receiving the services that you requested?		☐	
Are the Services at the day/time needed?		☐	
Are you pleases with the services that you are receiving?		☐	
Are there Additional services that you need?		☐	

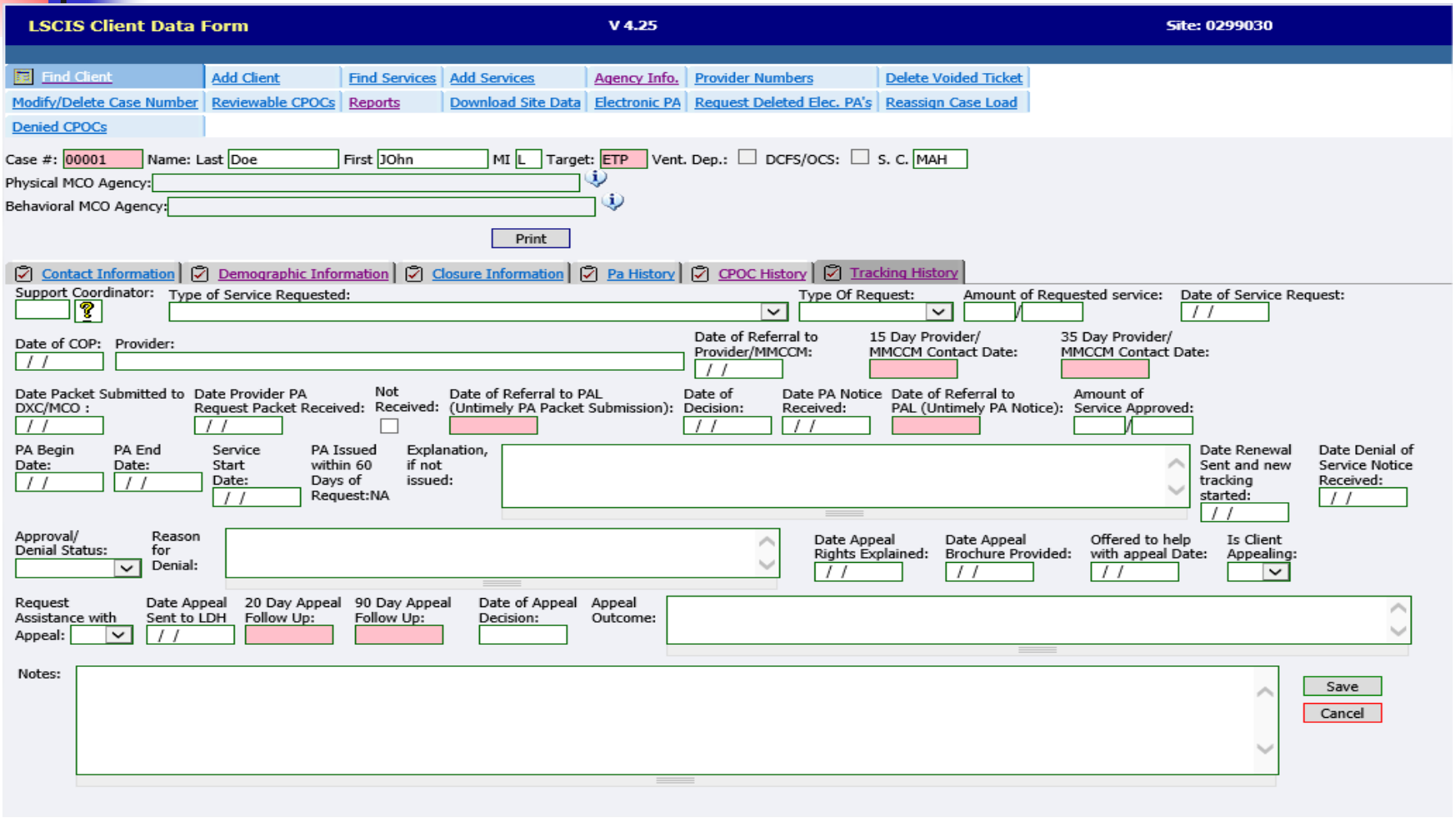
Notes(Include narrative description of Above CMIS codes, additional explinations as needed and summary status and progress for quarter)

Support Coordinator: Date: / /

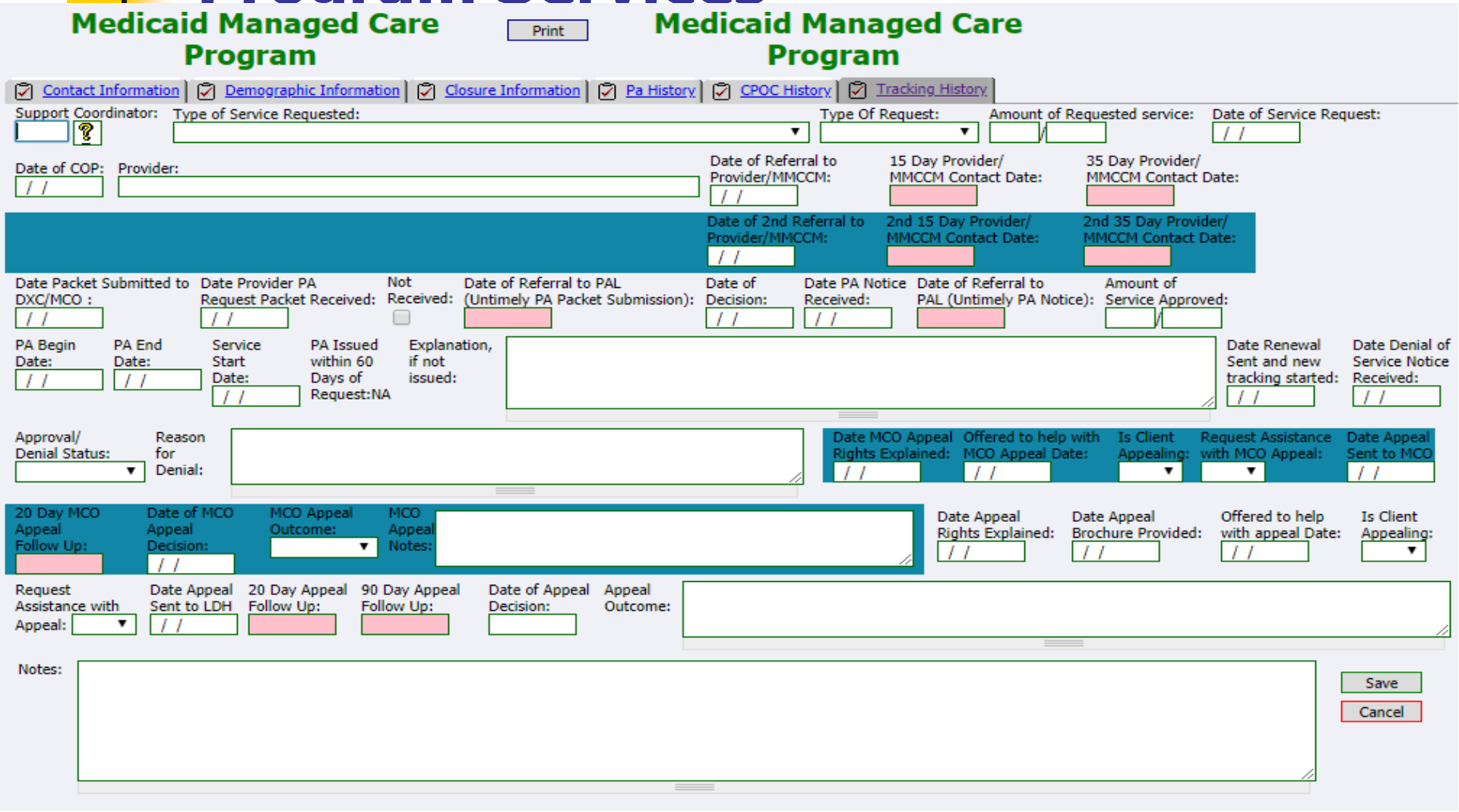
Names of Attendees	Relation/Title/Agency	Date
		/ /
		/ /
		/ /
		/ /
		/ /

Edit

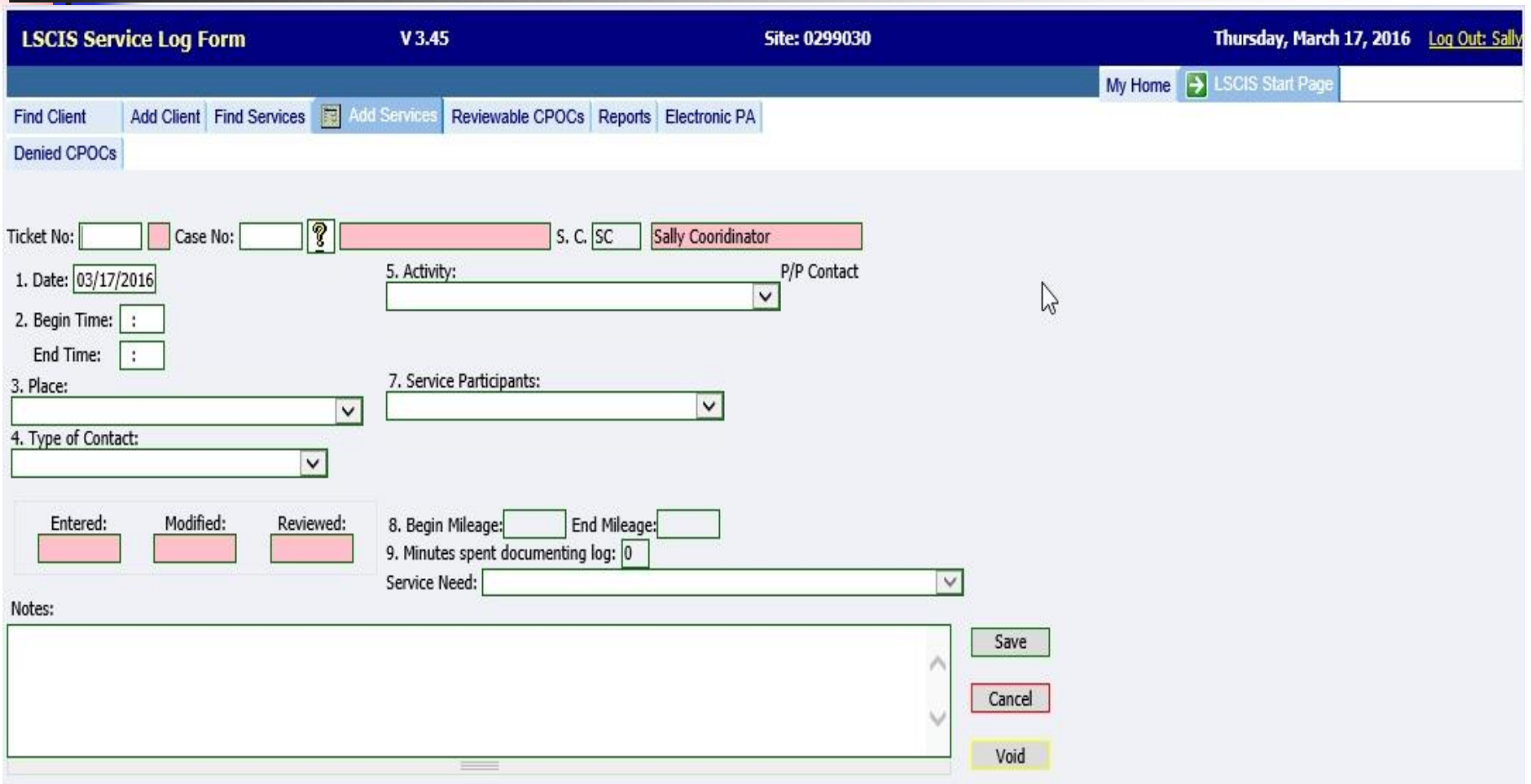
LSCIS Prior Authorization Tracking Log



LSCIS Prior Authorization Tracking Log for Medicaid Managed Care Program Services



LSCIS Service Log



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
https://ldh.la.gov/assets/docs/Making_Medicaid_Better/Medicaid_Services_Chart.pdf

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

STATE OF LOUISIANA
Louisiana Department of Health
Bureau of Health Services Financing
REQUEST FOR PRIOR AUTHORIZATION

PA Number

Molina Medicaid Solutions
FAX TO: (225) 216-6481

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)	P. A. NURSE AND / OR PHYSICIAN REVIEWER'S SIGNATURE: & DATE STATUS CODES: 2 = APPROVED 3 = DENIED
	(11) PRESCRIBING PHYSICIAN'S NAME AND/ OR NUMBER:	

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: (**_____**)** _____ _____

COMMENTS:

CASE MANAGEMENT AGENCY:_____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

(14)
PROVIDER SIGNATURE: _____

(15)
DATE OF REQUEST: _____

Instructions For Completing Prior Authorization Form (PA-14)

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

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

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

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

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

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

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

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

FIELD NO. 9 ENTER THE NUMERIC ICD-10 -DIAGNOSIS CODE (PRIMARY & SECONDARY) AND THE CORRESPONDING DESCRIPTION.

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

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

FIELD NO. 12 ENTER THE HCPCS CODE.

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

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

FIELD NO. 12C ENTER THE NUMBER OF TIMES THE REQUESTED PROCEDURE WILL BE PERFORMED DURING THE TREATMENT PLAN. CALCULATE THE TOTAL UNITS REQUESTED BY MULTIPLYING THE NUMBER OF UNITS PER DAY (1 UNIT = 15 MINUTES) TIMES THE NUMBER OF DAYS PER WEEK TIMES THE NUMBER OF WEEKS COVERED IN THE TREATMENT PLAN. THIS WILL GIVE THE TOTAL UNITS REQUESTED. BELOW ARE TWO EXAMPLES ON THE PROPER WAY TO CALCULATE THE TOTAL UNITS REQUESTED:

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

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

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

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

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

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

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

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

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

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

PRIOR AUTHORIZATION PCS DEPARTMENT TOLL-FREE NO. IS: 1-800-807-1320, then press Option 1

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

REQUEST FOR MEDICAID EPSDT - PERSONAL CARE SERVICES

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

I. IDENTIFYING INFORMATION

1. Applicant Name:	**MID#**	
Address:	**Ph #** ( )	
	☐ **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 _____ Impaired Hearing_____

☐Glasses ☐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** _____

STATE OF LOUISIANA
Louisiana Department of Health
Bureau of Health Services Financing
REQUEST FOR PRIOR AUTHORIZATION

P.A. NUMBER

Molina Medicaid Solutions
FAX TO: (225) 216-6481

CONTINUATION OF SERVICES _____YES _____ NO

PRIOR AUTHORIZATION TYPE: (1)	**RECIPIENT 13-DIGIT MEDICAID ID NUMBER OR 16-DIGIT CCN NUMBER (2)**	**Social Security No. (3)**
06 - Home Health Services	**RECIPIENT LAST NAME FIRST MI (4)**	**DATE OF BIRTH (5)**

MEDICAID PROVIDER NUMBER (7- DIGIT) (6)	**SERVICE TREATMENT PLAN (7)** BEGIN DATE **(MMDDYYYY)** / END DATE **(MMDDYYYY)**	**IS RECIPIENT CURRENTLY RECEIVING THESE SERVICES (8)** _____ **YES** _____ **NO**	**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
Revised 5/11/2018

Instructions For Completing Prior Authorization Form (PA-07)

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

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

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

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

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

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

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

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

FIELD NO. 9 ENTER THE NUMERIC ICD 10-DIAGNOSIS CODE (PRIMARY & SECONDARY) AND THE CORRESPONDING DESCRIPTION

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

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

FIELD NO.12 ENTER HCPCS CODE

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

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

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

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

FIELD NO 14 ENTER THE NAME, MAILING ADDRESS AND TELEPHONE NUMBER OF THE RECIPIENT'S CASE MANAGER, IF AVAILABLE .

FIELD NO.15 PROVIDER/AUTHORIZED SIGNATURE IS REQUIRED. YOUR REQUEST WILL NOT BE ACCEPTED IF NOT SIGNED. IF USING A STAMPED SIGNATURE, IT MUST BE INITIALED BY AUTHORIZED PERSONNEL.

FIELD NO.16 DATE IS REQUIRED. YOUR REQUEST WILL NOT BE ACCEPTED IF THIS FIELD IS NOT DATED

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

HOME HEALTH TOLL-FREE NO. IS 1-800-807-1320, then press Option 1

HOME HEALTH PRIOR AUTHORIZATION FAX NUMBER IS 1-225-216-6481

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

Form Approved
OMB No. 0938-0357

HOME HEALTH CERTIFICATION AND PLAN OF CARE

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

6. Patient's Name and Address

7. Provider's Name, Address and Telephone Number

8. Date of Birth

9. Sex ☐ M ☐ F

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

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

14. DME and Supplies

15. Safety Measures

16. Nutritional Req.

17. Allergies

18.A. Functional Limitations

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

18.B. Activities Permitted

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

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

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

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

22. Goals/Rehabilitation Potential/Discharge Plans

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

25. Date of HHA Received Signed POT

24. Physician's Name and Address

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

27. Attending Physician's Signature and Date Signed

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

Privacy Act Statement

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

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

Paper Work Burden Statement

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

BHSF Form DIP1
Revised 10/15

PRESCRIPTION REQUEST FORM FOR DISPOSABLE INCONTINENCE PRODUCTS

Recipient Information

Name: _____ Date of birth: _____ Age: _____

Medicaid ID: _____Height: _____ Weight _____

Recipient's Address _____

Prescribing Provider:

Prescriber's Name: _____ Phone #: _____

Address: _____Fax # _____

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

Primary: _____ **Secondary:** _____

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

Primary: _____ **Secondary:** _____

➤ Mobility

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

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

➤ Mental Status/Level of Orientation

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

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

➤ Additional supporting Diagnoses (Specific ICD-CM Code)

_____
_____

Indicate current supportive services

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

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

_____

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

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

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

Prescriber's Signature:

_____

Date:

_____

➤ Comments

_____
_____
_____
_____
_____

☐ **Additional documentation attached**

Disposable Incontinence Products (T4521 - T4535 & T4539)

Standards of Coverage:

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

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

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

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

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

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

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

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

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

- Diagnosis (specific ICD-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 & T4539.

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

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

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

Approved providers of incontinence products:

- Pharmacy
- Home health agency
- Durable medical equipment provider

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

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

Quantity Limitations:

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

Dispensing and Billing:

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

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

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

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

DATE 08/01/2006 RECIPIENT NAME

PRIOR AUTH. NBR RECIPIENT NUMBER

PROVIDER NUMBER

DEAR PROVIDER,

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

A P P R O V E D .

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

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

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

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

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

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

IN ORDER TO APPEAL, PLEASE WRITE TO:

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

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

THIS AUTHORIZATION IS NOT A GUARANTEE OF RECIPIENT MEDICAID ELIGIBILITY.

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

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

DATE 06/25/2009 RECIPIENT NAME

PRIOR AUTH. NBR RECIPIENT NUMBER 9382978155180

AAA CARE LLC
P O BOX 640402
KENNER LA 70064

PROVIDER NUMBER 1461610

DEAR PROVIDER,

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

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

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

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

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

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

35 MINUTES FOR BATHING

15 MINUTES FOR DRESSING

15 MINUTES FOR GROOMING

15 MINUTES FOR TOILETING

15 MINUTES FOR EATING

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

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

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

THIS INFORMATION SHOULD BE PROVIDED BY YOUR PRIMARY CARE PHYSICIAN.

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

IN ORDER TO APPEAL, PLEASE WRITE TO:

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

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.

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

IN ORDER TO APPEAL, PLEASE WRITE TO:

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

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

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

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

DATE 06/26/2009 PROVIDER NAME DELAUNES FAMILY DRUG

PRIOR AUTH. NBR PROVIDER NUMBER 1215210

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

RECIPIENT NUMBER
CCN NUMBER

DEAR :

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

D E N I E D .

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

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

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

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

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

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

IN ORDER TO APPEAL, PLEASE WRITE TO:

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

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

SINCERELY,

BUREAU OF HEALTH SERVICES FINANCING

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

SINCERELY,

BUREAU OF HEALTH SERVICES FINANCING

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 DXC Technologies 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. The participant has been unable to locate an in-home service provider (PCS or EHH).
	9. 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 Medicaid Managed Care Appendices for their Appeals process)

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

Explain that the provider can request a reconsideration

(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

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

↓

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

↓

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

↓

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

↓

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

Legacy Medicaid
EPSDT Timeline & Documentation
PAL Referrals

---

35 Day and 60 Day PAL Referrals

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/denial has not been received,
Send referral to PAL using Referral to PAL Form
(Document on PA Tracking Log & EPSDT Service Log)

Other PAL Referrals

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

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

Unable to find a provider that is willing to submit a request for a PA*
Complete Referral to PAL Form
(Document on PA Tracking Log &
EPSDT Service Log)

***Fee for Service Contact the LDH Staff Line for PCS and EHH**

John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health
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 Louisiana Department of Health (LDH). I understand this may require the Department to disclose information to the representative named below that may otherwise be confidential. I hereby waive any rights I may have to prevent disclosure by the Department to the authorized representative named below.

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

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

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

NOTE:
If the 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:

EPSDT Quarterly Report Checklist

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

SC Agency	
Region	

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

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

Signature of SCA Representative:_____ Date:_____

Quarterly Report of CPOC Revisions

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

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

Quarter/Year:_____

Participant	Revision Date	Item, Information, or Service Revised

Record Review for EPSDT Quarterly Reports - Gap in PA Periods or PA not Issued within 60 Days

Appendix W-3

Agency/Region_____ Quarter/Year_____

Participant_____ SC Assigned to Case _____

Service_____ SC Supervisor_____

_____Gap in PA Authorization Periods
_____PA not issued within 60 days

Gap in Authorization Period

Are the "Date of Service Request" and renewal "Choice of Provider" dates correct on the PA Tracking Logs?

1 PA end date on the prior PA Tracking _____

2 PA start date on the current PA notice _____

3 Gap consisted of how many days_____

4 Was the service provided during the Gap?

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

6 Was the referral to the provider/MMCCM for the PA renewal sent 45-60 days prior to the PA expiration for Legacy or 20-60 days prior for Medicaid Managed Care?

PA Not Issued Within 60 Days

7 Was the PA received?

8 Date Received _____

9 PA Decision Date _____

10 Approval Status: Full Approval_____ Partial Approval_____ Partial Denial_____ Denied_____

11 Summary of Reason PA was not Issued Within 60 Days:

	Required review for "PAs not issued within 60 days" and "Gaps in Authorization Periods"	Yes	No	Supporting Document and Service Date	Comments
12	Is the PA "type of request" correctly identified on the PA Tracking Log?				
13	Did PA tracking begin with the initial request date documented in the Service Logs or Quarterly Review? (Review Service Logs and Quarterly Reviews prior to the request date listed on the tracking log to ensure this is the initial request date.)				
14	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?				
15	Is there documentation of timely assistance with the FOC and participant/guardian follow up to obtain a COP?				
16	If a provider could not be found, is there documentation of attempts to locate a provider and LDH Staff Line/PAL contact if needed?				
17	Was the Referral to the Provider/Medicaid Managed Care Case Manager(MMCCM) made within 3 days of the COP/Date of Service Request?				
18	Is there documentation of a provider/MMCCM 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)				
19	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?				
20	Is there documentation of a provider/MMCCM contact within 35 days of the referral to the provider/MMCCM to check on the PA status?				
21	Was the PA packet submitted to Molina or the MCO within 35 days of the referral?				
22	If not, why?				
23	Was there a barrier?				
24	Did the SC assist in identifying and removing the barrier?				
25	Was the 35 day PAL referral completed timely? (Not required for Medicaid Managed Care Program)				
26	Was an offer to switch providers made and documented?				
27	If the PA request was submitted, was the PA packet requested and/or received?				
28	Was the "date packet submitted to Molina/MCO" entered on the PA Tracking Log?				

	Required review for "PAs not issued within 60 days" and "Gaps in Authorization Periods"	Yes	No	Supporting Document and Service Date	Comments
29	Is there documentation of a follow up with the provider/MMCCM 10 days after the PA request was submitted (25 days for DME)?				
30	If the PA was not received, was the 60th day PAL referral timely?				
31	Is there documentation of ongoing contact with the participant/guardian and provider until the PA notice is received or the service request is resolved?				
32	Did the SC follow up and do planned activities and contacts as documented in the Service Logs, Quarterly Reviews or CPOC. Is there documentation of the planned actions, contacts and follow up?				
33	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?				
34	Date of PA decision	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	
35	**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.**				
36	**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.**				
37	**Documentation that the Corrective Action Plan was carried out will be submitted within 14 days.**				

EPSDT Specialist Signature *Cannot be the SC assigned to the case

_____ Date_____

EPSDT Specialist's Supervisor Signature

_____ Date_____

On-Site Program Manager's Signature

_____ Date_____

Revised 3/13/19

2020 EPSDT Training

Appendix W-4

Project: EPSDT Support Coordination Training

Agency/Region

I viewed the 2020 EPSDT Support Coordination Training Module with the trainer and read the entire 2020 EPSDT Support Coordination Training Handbook and Appendices to complete the required Annual EPSDT Support Coordination training.

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

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

Date:_____

Signature of Trainer

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

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

CHECKLIST FOR EPSDT SUPPORT COORDINATION APPROVAL PROCESS – 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." Documents can be e-mailed to ksalling@statres.com or faxed to 225-767-0502 attention: Kim Willems.

	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 of the current formal information documents be sent to SRI to receive approval.
	SOA and/or Participant Recap Sheet (if an Initial CPOC)
	LSCIS CPOC Signature Page (With planning 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 (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 he or she is not the contact for monthly phone calls.)
	Individualized Education Plan (If receiving Special Education currently)
	Extended Home Health Plan of Care (If receiving EHH currently)
	Pediatric Day Healthcare Plan of Care (If receiving PDHC currently)

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

- It is not noted in the CPOC what current formal documentation you have to support the ICD-10 diagnosis. (Example: must state, "3.13.19 IEP documents developmental delay.")
- For services that typically require PA tracking, a valid reason is not given for why the service need is not being tracked or how the SC will ensure the service continues to be received.
- Participant's identified needs are not addressed.
- Discrepancy in the information documented within the CPOC sections. Remove information that is no longer accurate.

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

SIGNATURE:_____ DATE:_____
SUPPORT COORDINATION AGENCY REPRESENTATIVE

EPSDT CPOC MONITORING CHECKLIST

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 if the annual CPOC is selected for CPOC Monitoring after submittal in LSCIS. Documents can be e-mailed to ksalling@statres.com or faxed to 225-767-0502 attention: Kim Willems.

	FORM
	Current Formal Information Documents
	SOA and/or Participant Recap Sheet (If needed to verify a valid SOA)
	LSCIS CPOC Signature Page (With planning 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 (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 he or she is not the contact for monthly phone calls.)
	Individualized Education Plan (If receiving Special Education currently)
	Extended Home Health Plan of Care (If receiving EHH currently)
	Pediatric Day Healthcare Plan of Care (If receiving PDHC currently)

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

- It is not noted in the CPOC what current formal documentation you have to support the ICD-10 diagnosis. (Example: must state, "3.13.19 IEP documents developmental delay.")
- For services that typically require PA tracking, a valid reason is not given for why the service need is not being tracked or how the SC will ensure the service continues to be received.
- Participant's identified needs are not addressed.
- Discrepancy in the information documented within the CPOC sections. Remove information that is no longer accurate.

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

SIGNATURE:_____ DATE:_____
SUPPORT COORDINATION AGENCY REPRESENTATIVE

Dear Recipient:

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

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

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

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

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

Sincerely,

Louisiana Department of Health

- -

Name: ________________________________ Medicaid Identification #: _________________

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

How can we contact you? ____

Service(s) being requested: ____

____

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

Provider 1: __________________________ ________________________

Name Phone Number

Provider 2: __________________________ ________________________

Name Phone Number

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

CHOICE of PROVIDER FORM
For EPSDT MEDICAID PROVIDERS

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

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

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

The participant/family must check the appropriate statement below.

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

1._____

2._____

3._____

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

4._____

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

5._____

Participant/authorized representative must sign and date below.

_____ _____

Participant/Authorized Representative *Date*

_____

Relationship to Participant