

EPSDT – Targeted Population Support Coordination Training Handbook

TRAINER INFORMATION

There are four major sections to this training taken directly from the Support Coordinator's handbook that should flow sequentially.

Part I - Services

Part II - Intake, Assessment and CPOC

Part III - Prior Authorization

Part IV - Other

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

There will be different forms/flyers/brochures discussed in each section. These are mandatory forms that should help the Support Coordinator to serve the participant better. If at any time a Support Coordinator has a suggestion on how to change a form to make it more useful, that information will gladly be accepted. Suggestions can be sent to Kim Willems at SRI via e-mail at ksalling@statres.com.

As each form is discussed, an overhead or PowerPoint slide of the form should be used to enhance understanding and discussion. The Support Coordinator should have a full understanding of the use and importance of each form. It is especially crucial to explain to the Support Coordinators how the use of each form will benefit the participant in the end. The forms were not developed simply to create work for Support Coordinators, but in response to needs identified within service provision.

If the training consists of a small group, there is no need to use an overhead projector, but be sure that each trainee has a copy of the form being discussed.

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

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EPSDT – Targeted Population Support Coordination Training Handbook

Support Coordination is a service provided by Louisiana Medicaid through contracts with agencies to serve different groups of Medicaid participants. This handbook provides information on services available to individuals under 21 years of age who have developmental disabilities or chronic health needs. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Support Coordination is available to all Medicaid eligibles under the age of 21 who are on the Developmental Disabilities Request for Services Registry (DD RFSR) or for whom the service is determined medically necessary or have documentation from Medicaid to substantiate that the EPSDT participant meets the definition of special needs (*Appendix P*).

Legacy Medicaid

This is for people who are not enrolled in a Managed Care Organization for most of their health services.

Medicaid Managed Care Program

Five private companies contract with the state to manage the health needs of individuals who are enrolled. Some of these Managed Care Organizations (MCO) have a different network of doctors, hospitals, and other providers than traditional Medicaid.

Chisholm class members (CCM) are children up to age 21 who currently receive or are eligible for Medicaid, and who are on the Developmental Disabilities Request for Services Registry. Members included in Chisholm and Home and Community Based Services (HCBS) waivers are required to enroll in a Managed Care Organization for specialized behavioral health services and Non-Emergency Medical Transportation (NEMT). Coordinated System of Care (CSoC) enrollees will receive most of their behavioral health services from Magellan and will not have a Managed Care Organization for specialized behavioral health.

Members included in Chisholm and HCBS waiver participants who do not have Medicare have the opportunity to proactively opt-in for physical health services as well. Chisholm class members can return to Legacy Medicaid for their physical health services at any time effective the earliest possible month the action can be administratively taken, but will have to stay enrolled in the Medicaid Managed Care Program for their behavioral health services and for non-emergency medical transportation. Chisholm class members who have previously returned to Legacy Medicaid for all state plan services other than Specialized Behavioral Health and NEMT may return to the Medicaid Managed Care Program for other state plan services only during the annual open enrollment period.

Part I – Services Available to EPSDT Participants

(Refer to *Appendix A - Service Description Brochure*)

Parents of children and young adults with developmental disabilities are sometimes unaware of the services that may be available to assist them. Therefore, it is important for the Support Coordinator to be knowledgeable of these services and how to access them. As the Support Coordinator, it is part of your responsibility to make suggestions for these services. Do not wait for the family to request a service. If you see a need for one of these services, inform the family. If the child may need additional services, but it is not clear, suggest and document appropriate evaluations to determine whether there is a need. If the family states they aren't interested in the service, accept that. However, feel free to remind the parent of the service again when the opportunity presents.

Children and young adults receiving targeted EPSDT Support Coordination are eligible to receive **all medically necessary Medicaid services** that are available to people under the age of 21. In addition, because of their disabilities and being on the DD RFSR, they are eligible for services through the **Louisiana Developmental Disabilities services system**, administered by OCDD through the Human Services Districts and Authorities. Further, they may be able to receive services through the **school system** or through **Early Childhood Education programs**.

MEDICAID SERVICES

Through Medicaid, children under 21 are entitled to receive all necessary health care, diagnostic services and treatment and other measures coverable by Medicaid to correct or improve physical or mental conditions, *even if these are not normally covered as part of the state's Medicaid program*. This includes a wide range of services not covered by Medicaid for participants over the age of 21. For a listing of Medicaid services, consult the **Medicaid Services Chart** (*Appendix B*). *But even if a service is not on the Medicaid services chart, it must still be covered if it is a service permitted by federal Medicaid law and is necessary to correct or ameliorate a physical or mental condition of a recipient who is under age 21.*

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

- Support Coordination (only adults who receive Waiver services can get these services)
- Psychological evaluations and therapy
- Psychiatric residential care
- Medical, dental, vision and hearing screenings
- Audiology services
- Speech and language evaluations and therapies
- Occupational therapy

- Physical therapy
- Personal Care Services
- Extended Home Health visits
- Pediatric Day Health Care
- Dental care
- Hearing aids and supplies needed for them
- Eyeglasses and/or contact lenses
- Disposable Incontinence Products
- Nutritional supplements needed for their growth or sustenance
- Applied Behavioral Analysis
- Any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice

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

Medicaid's offered services may be more comprehensive than services offered through schools as part of a child's Individualized Educational Plan (IEP). IEPs only cover services that help with a child's *education*. Medicaid, outside of the IEP process, should cover services needed to help any other aspect of a child's life, as well.

Some Medicaid services must be "prior authorized" (PA) before the service can be received. (Prior Authorization is discussed in Part III of this handbook.) Typically, a Medicaid-enrolled provider of the service develops and submits an application for authorization to provide the service. Once the request has been reviewed, a notice of decision is sent to the participant, the provider, and to the Support Coordination agency. These are not waiver services and **the prior authorization process for these services is a separate process from the approval of the CPOC.**

If prior authorization for any legacy Medicaid service is denied in whole or in part, the participant can appeal to the Division of Administrative Law (DAL). Medicaid Managed Care enrollees must appeal first to their Managed Care Organization. If the decision is upheld or not resolved within the contractual timeframes, a request for a State Fair Hearing can be made to the DAL. The Support Coordinator must offer to assist with the appeal and State Fair Hearing.

The following services are often used by and are very important to children and young adults with disabilities and/or chronic health conditions:

Support Coordination

Individuals under the age of 21 with disabilities and/or chronic health conditions typically need more Medicaid services than do their peers without disabilities or health concerns. A Support Coordinator should help in identifying and coordinating these necessary services. Parents often do not understand aspects of the Medicaid system. Therefore, the Support Coordinator should provide assistance in this area. The Support Coordinator can and should make referrals for these services and then follow-up to assure they are being delivered.

One of the primary responsibilities of the Support Coordinator is to follow through with requests for services until the PA is either approved or denied based on medical necessity.

EPSDT Screening Exams and Checkups

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

The EPSDT Screenings are the responsibility of the Primary Care Physician (PCP) to perform. The PCP can contract with EPSDT Screening providers and bill Medicaid. The PCP will reimburse the EPSDT Screening provider.

EPSDT Screenings are recommended at the following ages:

•Newborn	•12 Months	•4 Years
•2 Months	•15 Months	•5 Years
•4 Months	•18 Months	•6 Years
•6 Months	•2 Years	•After Age 6: Every Two Years
•9 Months	•3 Years	

Dental checkups are recommended yearly.

In addition, an **interperiodic screen** can be obtained whenever one is requested by the parent or is recommended by a health, developmental, or educational professional (including a Support Coordinator), in order to determine a child's need for health treatment or additional services.

Medical conditions such as lead poisoning, sickle cell anemia, developmental delays, nutritional deficiencies, and behavioral disorders consistently result in successful outcomes and cost effective treatment plans when detected early.

Home and Community Based Waivers

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

Most children currently receiving EPSDT Support Coordination services are on the Developmental Disabilities Request for Services Registry for these waiver programs. For children with similar needs, it is important to have their name added to the list as soon as possible since the registry is arranged by urgency of need and date of application for developmentally disabled waiver services. To find the participant's date of request on the Registry refer to the Statement of Approval or call 1-866-783-5553 or the Human Services Authorities/ Districts (*Appendix G*).

New Opportunities Waiver

The New Opportunities Waiver (NOW) provides services for individuals who can benefit from home and community based services, but who qualify for care in an intermediate care facility for persons with developmental disabilities, and who cannot be supported in one of the other OCDD waivers. The individual must be 3 years of age or older, and the age of the disability onset must occur prior to age 22. Services include: day and night individualized and family supports; center-based respite services; community integration development; environmental accessibility adaptations; specialized medical equipment and supplies as an extended State Plan service; supported living; substitute family care; day habilitation and transportation for day habilitation; supported employment and transportation for supported employment; prevocational services; professional services; personal emergency response system; skilled nursing services; adult companion care services, one-time transitional services; self-direction option; housing stabilization services; and housing stabilization transition services.

Children's Choice Waiver

Children's Choice Waiver opportunities shall be offered to individuals under the age of 21 who are on the registry, have the highest level of need and the earliest registry date as slots become available. Children's Choice provides funding for medical care, home modifications, care-giving assistance and support, and other specialty services. Funds available through Children's Choice for special additional services are capped at \$17,500 per care plan year. Regular Medicaid services, including EPSDT services, do not count against the cap.

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

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

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

1. **When a Children's Choice participant reaches the age of 21**, he/she will transfer into an appropriate waiver for adults as long as they remain eligible for waiver services.
2. **If a crisis situation develops** and additional supports are warranted, the Children's Choice waiver has crisis provisions designed to meet the needs of families on a case-by-case basis. These additional supports must be approved by the Office for Citizens with Developmental Disabilities.

A fact sheet on the Children's Choice waiver program and "Frequently Asked Questions about Children's Choice" are included as *Appendix D-2* and *Appendix C*.

Supports Waiver

The Supports Waiver is available for those individuals age 18 and older whose health and welfare can be assured via the Individual Service Plan and for whom home and community-based waiver services represent a least restrictive treatment alternative. This waiver is intended to provide specific, activity focused services rather than continuous custodial care. Services include: support coordination, supported employment, day habilitation, prevocational services, respite, habilitation, permanent supportive housing stabilization, permanent supportive housing stabilization transition, and personal emergency response systems. Each service is limited based on annual service limits (Refer to *Appendix D-3*).

Residential Options Waiver

The Residential Options Waiver (ROW) offers a choice of expanded services for individuals who can benefit from home and community based services, but who qualify for care in an intermediate care facility for persons with intellectual or developmental disabilities. The Residential Options Waiver will only be appropriate for those individuals whose health and welfare can be assured via the Support Plan with a cost limit based on their level of support need and for whom home and community-based waiver services represent a least restrictive treatment alternative. Services include: support coordination, community living supports, companion care, host home, shared living, one-time transitional services, environmental modifications, assistive technology/specialized medical equipment, personal emergency

response systems, respite (center-based), nursing, dental, professional (dietary, speech therapy, occupational therapy, physical therapy, social work, psychology), transportation-community access, supported employment, prevocational services, day habilitation, housing stabilization, housing stabilization transition services and adult day health care (ADHC).

Coordinated System of Care (CSoC) and Wraparound Facilitation

The Coordinated System of Care (CSoC) helps Louisiana's at-risk children ages 5 through age 20 who have serious behavioral health challenges and their families. It offers services and supports that help these children and youth return to or remain at home while they are being helped.

This service is available in all regions of the State. Youth in out-of-home placement or at risk of out-of-home placement who are enrolled in the Coordinated System of Care (CSoC) receive Wraparound facilitation, and may also receive these additional services: Youth Support and Training, Parent Support and Training, Independent Living Skill-Building Services, and Short-Term Respite.

A parent or primary caregiver can make a referral for CSoC by calling the participant's Managed Care Organization. The Managed Care Organization will ask the caller a series of three risk questions. If the caller answers 'yes' to any one questions, the caller will be transferred to the CSoC contractor, who will conduct a Brief CANS (Child and Adolescent Needs and Strengths Assessment) which will determine if the child or youth is presumptively eligible for CSoC. The caller will be given this information at the time of the call. If the child/youth is determined to be presumptively eligible for CSoC and the caller agrees, the CSoC Contractor will make a referral to the regional Wraparound Agency for a more comprehensive assessment which will confirm the child/youth's eligibility for CSoC. Parents/caregivers and family members have a key role in CSoC. They help Magellan decide the best services for their child. Every youth and family getting care in CSoC will have the chance to work with a person who coordinates their care. This is called "wraparound." Wraparound Agencies (WAAs) in each region support the family in planning and directing their care. The WAAs develop a plan of care and provide lots of help for children in the CSoC.

CSoC also has Family Support Organizations (FSO) to help families. FSOs make sure families are involved and have a voice in their care. Families can call 1-800-424-4489 or the TTY number at 1-800-424-4416 for information about the Wraparound Agency and Family Support Organization in their region.

Behavioral Health Rehabilitation Services

[Community Psychiatric Support and Treatment (CPST), Crisis intervention (CI), Crisis Stabilization (CS) and Psychosocial Rehabilitation (PSR)] Medicaid participants under age 21 with mental illness or emotional/behavioral disorders who meet the program's medical

necessity criteria may receive Behavioral Health Rehabilitation Services. Chisholm class members are required to enroll in the Medicaid Managed Care Program for their specialized behavioral health services so they will access these services through their Managed Care Organization with the exception of Coordinated System of Care (CSoC) enrollees. CSoC enrollees will access these services through Magellan. These services include: individual and group skills training, individual counseling, crisis intervention, crisis stabilization, psychosocial rehabilitation, goal setting, and service coordination. Services are accessed by contacting a Rehabilitation Service provider agency or contacting the class member's Managed Care Organization. No Primary Care Physician (PCP) referral is required. The Managed Care Organization's prior authorization unit must pre-approve CPST and PSR rehabilitation services.

Behavioral Health Rehabilitation providers arrange the assessments necessary to obtain prior authorization for mental health rehabilitation services required for adults. To find a Behavioral Health Rehabilitation Provider in your area, call the Managed Care Organization of the enrollee.

Remember these services offer family intervention, which could help a family struggling with the symptoms of their child's mental health diagnosis. Services may be provided in the home, school, community or at the provider's office. A support coordinator can work with the family and the Behavioral Health Rehabilitation Provider to assure the participant and family are receiving all necessary services from the provider.

As with any service, support coordinators should work with providers and in this case, with the class member's Managed Care Organization on coordination of services.

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

Applied Behavioral Analysis-Based Therapy Services (ABA)

ABA therapy is the design, implementation, and evaluation of environmental modification using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the direct observation, measurement, and functional analysis of the relations between environment and behavior. ABA-based therapies teach skills through the use of behavioral observation and reinforcement or prompting to teach each step of targeted behavior. ABA therapy uses therapeutic techniques to increase useful behavior (including communication) and reduce harmful behavior. ABA-based therapies are based on reliable evidence of their success in alleviating autism and are not experimental. This service is available through Medicaid for persons 0-21. For Medicaid to cover ABA services through a

licensed provider the person must meet ALL of the following guidelines, as published in the May 2015 Rule (LAC 50: XV. Chapters 1-7).

The person must:

- Be under 21 years of age;
- Exhibit the presence of excesses and/or deficits of behaviors that significantly interfere with home or community activities (examples include, but are not limited to: aggression, self-injury, elopement, etc.);
- Be diagnosed by a qualified health care professional with a condition for which ABA-based therapy services are recognized as therapeutically appropriate, including autism spectrum disorder; and
- Have a comprehensive diagnostic evaluation by a qualified health care professional and have a prescription for ABA-based therapy services ordered by a qualified health care professional.

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

School-Based Behavioral Health Services

Medicaid also funds behavioral health services provided through schools or early childhood educational settings such as regular kindergarten classes; public or private preschools; Head Start Centers; child care facilities; or home instruction. To be funded by Medicaid, these services must be included in the child's IEP. Behavioral Health services, treatment, and other measures to correct or ameliorate an identified mental health or substance abuse diagnosis may be provided by licensed mental health practitioners or Louisiana Certified School Psychologists and Counselors.

Personal Care Services

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

Assistance is provided with meal preparation if the recipient is on a restricted diet that differs from the rest of the household members and no family member is preparing the meals.

PCS does not include medical tasks such as medication administration, tracheostomy care, feeding tubes or indwelling catheters. Assistance with these tasks can be covered through Medicaid's Home Health program.

Personal Care Services are not intended as a substitute for child care needs or to provide respite care to the primary caregiver. A parent or adult caregiver is **no longer required** to be in the home while services are being provided to children.

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

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

How to obtain Personal Care Services for Legacy Medicaid:

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

How to obtain Personal Care Services for Medicaid Managed Care Enrollees:

- Personal Care Services must be prior authorized by the recipient's Managed Care Organization. Service must be provided by a licensed enrolled PCS provider. A list of providers in your area who offer such services is available via the online provider directory at www.myplan.healthy.la.gov¹, by calling the Enrollee Services Line at each Managed Care Organization to locate a provider in their network, or by accessing the

¹ See p. 48.

MCO's website to identify contracted providers (see *Medicaid Managed Care Appendix B* for links to websites).

- If you cannot find a PCS provider from the Medicaid Managed Care Program website, or the provider directory, which is willing to submit a prior authorization request call the MCO's member service line which operates from 7am-7pm, M-F, for assistance. SCs should fax the Referral to Medicaid Managed Care Case Management form (*Medicaid Managed Care Appendix Q*) to the MCO when a service is requested by the participant to request assistance with locating a provider. **If the MCO is unable to locate a willing provider within 10 days of the Referral, the SC should submit a referral to the LDH Medicaid PAL using *Medicaid Managed Care Appendix S-1, S-2, S-3*.**
- **The MCO is contractually responsible for ensuring that services are provided for its enrollees including finding an in-home provider within 10 business days of the Referral to MMCCM. LDH will reach out to the MCO when a PAL referral is received to ensure that this contractual obligation is met. The MCO may pursue a single case agreement in order to obtain a willing provider.**

How to obtain prior authorization:

- To obtain prior authorization, the provider must send in a completed prior authorization request to the DXC prior Authorization unit for Legacy Medicaid or to the Managed Care Organization's Prior Authorization Unit for Medicaid Managed Care enrollees. The request must include an EPSDT-PCS Form 90 (prescription is included on the form) completed by the participant's attending physician, a completed plan of care that has been signed by the attending physician, a Social Assessment form, an EPSDT PCS Daily Time Schedule, and any other supporting documentation or independent assessment information.
- There are no set limits to the number of service hours a participant under age 21 can receive. The number of hours approved is based on the participant's need for assistance with his/her personal care tasks that are covered through this program. The participant must be of an appropriate age to receive PCS meaning that they are old enough to do the tasks themselves if they did not have a disability or illness.
- The Support Coordinator should provide the family with an EPSDT-PCS Form 90 and inform them of the need to have it completed. This should be done when PCS is requested by the participant/family. The Support Coordinator should assist with scheduling the doctor appointment, transportation, etc., as needed. The Support Coordinator should assist the family to provide all critical information to the physician before he writes the orders requesting the service. All requests should include the necessary documentation to ensure that needed services can be approved.

Changing PCS Providers within an authorization period for Legacy Medicaid:

- If a recipient is changing PCS providers within an authorization period, the current agency must send a letter to the DXC Prior Authorization Unit notifying them of the recipient's discharge so a new PA can be issued to the new PCS provider that has been selected.
- If the earlier provider fails or refuses to promptly send in a letter, the Support Coordinator can work with the new provider to obtain a letter from the recipient/family asking DXC to terminate the prior services. The letter should include the name of the provider being discharged and, if known, the prior authorization number from the last approval notice for the service at issue. The new provider is to send this letter to DXC with their PA request.
- The new provider must submit an initial request for prior authorization to the PA Unit using current documentation. The new provider must submit all required documentation necessary for an initial PA request.
- **Units approved for one provider CANNOT be transferred to another provider.**

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

- Enrollees have the right to change providers at any time; however, **approved authorizations are not transferred between agencies.** If an enrollee elects to change providers within an authorization period, the current agency must notify the Managed Care Organization of the enrollee's discharge, and the new agency must obtain their own authorization through the usual authorization process. Enrollees may contact their Managed Care Organization directly for assistance in locating another provider.
- Support Coordinators are responsible for assisting CCMs with switching service providers.
- Support Coordinators should send a Referral to Medicaid Managed Care Case Management form (*Medicaid Managed Care Appendix Q*) to inform the MCO of the enrollees desire to change providers.

Home Health Services

Children and youth may be eligible to receive multiple hours of skilled nurse service per day through Extended Home Health (EHH) services if it is determined to be medically necessary for the recipient to receive at least three hours per day of nursing services. These services are provided by a Home Health Agency, and **cover medically necessary home care that can require more skills than Personal Care Services.**

Unlike services for adults, Home Health Services for children and youth are **not limited in terms of frequency or duration.** EHH services must be prior authorized in accordance with the certifying physician's orders and home health plan of care. Recipients who require

fewer than three hours per day of nursing services can be prescribed by a doctor do not need to obtain prior authorization. However, these services are subject to post-payment review. If a provider cannot be found call the LDH program staff line at 1-888-758-2220 and tell them that you cannot find a provider.

Some individuals need both PCS and Home Health Services. **(Refer to *Appendix E* for a comparison of PCS and Home Health Services.) Services must not overlap.** The best practice is to develop a detailed schedule of all in-home providers, which can be used to show that multiple services do not overlap.

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

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

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

Pediatric Day Health Care Facility (PDHC)

A pediatric day health care (PDHC) facility serves medically fragile individuals under the age of 21, including technology dependent children who require close supervision. These facilities offer an alternative health care choice to receiving in-home nursing care. A PDHC facility may operate 7 days a week and may provide up to 12 hours of services per day per individual served. Care and services to be provided by the pediatric day health care facility shall include but shall not be limited to: (a) Nursing care, including but not limited to tracheotomy and suctioning care, medication management, IV therapy, and gastrostomy care. (b) Respiratory care. (c) Physical, speech, and occupational therapies. (d) Assistance with activities of daily living. (e) Transportation services. (f) Socialization. (g) Education and training. If the PDHC facility provides services for which a school district is responsible, the PDHC facility may enter into a Memorandum of Understanding (MOU) with the school district. (Refer to LAC 48:1.Chapters 52 and 125 and LAC 50:XV.27503 July 2015 (pg. 211-237))

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

If a child or youth wants rehabilitation services such as Physical, Occupational, or Speech Therapy, Audiology Services, or Psychological Evaluation and Treatment, these services can be provided at school, in Early Childhood Education programs, in an outpatient facility, in a rehabilitation center, at home, or in a combination of settings, depending on the child's needs. For Medicaid to cover these services at school (ages 3 to 21) or EarlySteps (ages 0 to 3), they must be part of the IEP or IFSP. For Medicaid to cover PT, OT, ST and audiology services through an outpatient facility, rehabilitation center, or home health, they must be ordered by a physician and be prior-authorized by Medicaid. Refer to "Services Available through School Systems" (page 25) for further information.

Community Therapies: The PT, OT, ST and audiology services cited above can be provided in the community in addition to being provided in the school. For Medicaid to cover such services through a provider outside of an educational setting, they do not need to be part of the IEP or IFSP, but must be prior-authorized by Medicaid.

The Support Coordinator is to explain to the family/participant that Medicaid will provide medically necessary therapies in addition to the therapies received at school through the IEP. The Support Coordinator is to ask the family/participant if they want to request any medically necessary therapies now or if they want to receive therapies on the IEP during the school's summer break. The Support Coordinator helps the family to determine the setting in which the child will receive the greatest benefit, and also helps the family by making the appropriate referral and coordinating the days and times of this service with other services the participant is receiving.

For information on receiving these therapies in schools, contact the child's school. To locate other therapy providers call the Specialty Care Resource Line at 1-877-455-9955 for those enrolled in Legacy Medicaid or the participant's Managed Care Organization Enrollee Services or Medicaid Managed Care Case Manager (MMCCM).

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

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

Disposable Incontinence Products

Diapers, pull-on briefs, and liner/guards are covered for individual's age four years through age twenty years if they have a medical condition resulting in bowel/bladder incontinence and meet other LDH criteria. A Prescription Request Form for Disposable Incontinence Products (BHSF Form DIP1) may be completed, or a physician's prescription along with required documentation can be submitted. Both must also include a completed PA-01. Additional supporting documentation is required for requests that exceed eight units per day. If completed, the BHSF DIP 1 collects this additional information. Refer to *Appendix R-1*.

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

PA tracking can begin 60 days prior to the child's fourth birthday. Instruct the provider to use the child's fourth birthday as the PA service begin date.

Medical Equipment and Supplies

Participants under age 21 can obtain any medically necessary medical supplies, equipment and appliances needed to correct, improve, or assist in dealing with physical or mental conditions. This includes lifts and other devices to help the family deal with a child's circumstances such as communication devices, and also some medically necessary dietary or nutritional assistance. **Medical Equipment and Supplies must be prescribed by a physician.** Once prescribed, the supplier of the equipment or supplies must request approval for them from Medicaid since this is a prior authorized service.

New technology is being developed every day; therefore, many families and participants are unaware of equipment and medical supplies available, or do not realize that Medicaid can pay for items deemed medically necessary. As the Support Coordinator, it is your responsibility to investigate if equipment can help families with difficulties they are facing. You can also help to arrange any appointment needed to get the prescription from the doctor.

Alternate approved items: Sometimes, the Medicaid prior authorization unit will not grant prior authorization for the specific equipment or supplies indicated, but will approve **less expensive items** that it believes will meet a participant's needs. If so, the notice of denial should identify the items. You can then consult with the participant and the provider to see if the identified item might work. **The participant can accept the less costly item and still appeal the denial of the item originally requested;** however, they must not dispose of, destroy, or damage (beyond normal wear and tear) the less expensive item while the appeal is pending.

Transportation

Refer to *Medicaid Managed Care Appendix B*. Non-emergency medical transportation (NEMT) to and from medical appointments, if needed, is covered under the participant's Managed Care Organization. Even if Medicaid recipients are not covered under the Medicaid Managed Care Program for other services, their transportation needs would be authorized and paid for under their Managed Care Organization. Children under 17 must be accompanied by an attendant. Arrangements for non-emergency transportation should be made at least 48 hours in advance by calling the enrollee's Managed Care Organization at the numbers shown below. The Support Coordinator can assist the parent(s) in arranging transportation services for the participant.

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

Fee for Service members can contact 1-855-325-7565 to schedule transportation.

Special arrangements: If special arrangements need to be made due to there not being a Medicaid funded transportation service in the participant's parish, or if none of the providers have lift-equipped vehicles needed by the participant, or due to the long distance of a trip, the support coordinator can call the enrollee's Managed Care Organization at the numbers shown above. If a situation arises and the MCO is unable to assist, the enrollee can contact Melanie Doucet with the LDH Medicaid Transportation Unit at 225-614-3222 or via e-mail at melanie.doucet@la.gov. Fee for Service members can contact 1-855-325-7565 to schedule transportation.

"Gas Reimbursement" program: Support Coordinators should also be aware that Louisiana Medicaid will allow family members/friends to become Medicaid funded transportation providers for specific family members, through the "Gas Reimbursement" transportation program. To assist someone you are serving that may benefit from this arrangement, call the enrollee's Managed Care Organization at the numbers shown above.

Other Medicaid Services Not Listed

Refer to *Appendix F* for an expanded list of available services. To ask about other available services, contact the **Specialty Care Resource Line (toll free) at 1-877-455- 9955 or TTY 1-877-544-9544 or the participant's Managed Care Organization Enrollee Services or Medicaid**

Managed Care Case Manager. Although a service may not be listed, if it is a service permitted by federal Medicaid law, and is necessary to correct or ameliorate a physical or mental condition of a recipient who is under age 21, it must be covered. Persons under age 21 are entitled to receive all equipment that is medically necessary or items that Medicaid can cover. This includes many items that are not covered for adults. These services may be subject to the restrictions allowable under Federal Medicaid law.

Arrangements to tailor additional coverage for children's needs are taken by Louisiana Medicaid staff at **1-888-758-2220** or the participant's Managed Care Organization Case Manager. They should be contacted only once it is clear that existing offerings will not meet the child's needs, that there is a specific service to meet the need, and potential providers of the service. Medical justification for the service will be required.

MEDICAID MANAGED CARE PROGRAM

Five private companies contract with the state to manage the acute and behavioral health needs of individuals who are enrolled. Some of these Managed Care Organizations (MCO) have a different network of doctors, hospitals, and other providers than traditional Medicaid.

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

Members included in Chisholm and Home and Community Based Services (HCBS) waivers are required to enroll in the Medicaid Managed Care Program for specialized behavioral health services and Non-Emergency Medical Transportation (NEMT). CSoC enrollees will receive their behavioral health services from Magellan and will not have a Managed Care Organization for behavioral health. Members included in Chisholm and HCBS waiver participants who do not have Medicare have the opportunity to proactively opt-in for physical health services as well. **Chisholm class members can return to Legacy Medicaid for their physical health services at any time effective the earliest possible month the action can be administratively taken, but will have to stay enrolled in the Medicaid Managed Care Program for their behavioral health services and for non-emergency medical transportation.** Chisholm class members who have previously returned to Legacy Medicaid for all state plan services other than Specialized Behavioral Health and NEMT may return to the Medicaid Managed Care Program for other state plan services only during the annual open enrollment period.

Individuals who are currently enrolled in the Medicaid Managed Care Program and get placed on the DD Request for Services Registry by being found eligible for OCDD services become Chisholm class members. Chisholm class members have the option to return to legacy Medicaid for their physical health services at any time effective the earliest possible month that the action can be administratively taken. This means that they can request to return to traditional Medicaid for their physical health services whenever they want. However, they should keep in mind that the change will not go into effect until the 1st of the following month and they may be required to resubmit requests or prescriptions and they will not be able to return to the Medicaid Managed Care Program until the next open enrollment period.

It's very important that individuals and their families look closely at the potential advantages and disadvantages of enrolling in the Medicaid Managed Care Program before making this decision.

Benefits may include access to a different set of medical providers. In addition, some plans offer incentives for successfully meeting certain outcomes.

To learn more about the specific benefits that each plan offers, visit <https://www.myplan.healthy.la.gov/choose/compare-plans>

Things to consider before selecting a Managed Care Organization:

- Access to your current doctors and other healthcare providers. Not all doctors and healthcare providers are enrolled in all the managed care plans. If you want to keep your doctors, it's important to confirm that they are all enrolled in the plan you choose.
- Access to prescription medications. It's important to check that you can access needed medications on the new plan. A common preferred drug list can be found at: http://new.dhh.louisiana.gov/assets/docs/BayouHealth/Pharmacy/HealthyLouisianaCommonPDL_3.1.17.pdf. It is important to check any medications not listed on the common preferred drug list with each of the plans to see if it is covered. Each plan covers different drugs and has different prior authorization and step therapy procedures.
 - **Aetna Better Health:**
 - <http://www.aetnabetterhealth.com/louisiana/providers/pharmacy>
 - **Amerihealth Caritas:**
 - <http://www.amerihealthcaritasla.com/pharmacy/index.aspx>
 - **Healthy Blue:**
 - <https://www.myhealthybluela.com/la/benefits/pharmacy-benefits.html>
 - **Louisiana Healthcare Connections:**
 - <https://www.louisianahealthconnect.com/providers/pharmacy/preferred-drug-list-info.html>

- **UnitedHealthcare:**
 - <https://www.uhccommunityplan.com/la/medicaid/healthy-louisiana/lookup-tools.html#view-drug>
 - **Legacy Medicaid:**
 - <http://new.dhh.louisiana.gov/assets/HealthyLa/Pharmacy/PDLandNPDL.pdf>.
- Access to services. The Managed Care Organization will be determining the services, amounts, and duration of services to be received. The Managed Care Organization has to provide the same amount, duration, and scope as traditional Medicaid.

To enroll or dis-enroll in the Medicaid Managed Care Program, call 1-855-229-6848 or TTY: 1-855-LAMed4Me (1-855-526-3346).

See *Medicaid Managed Care Appendices*.

OCDD SERVICES

The **Office for Citizens with Developmental Disabilities** (OCDD), through human services districts and authorities in each region, provides a variety of state-funded services to individuals with developmental disabilities, including children and youth. EPSDT support coordination participants may already have contacted OCDD in order to be assessed and placed on the Request for Services Registry; however, their families may not be aware of all the services and supports OCDD has to offer.

Refer to *Appendix G* for a list of **Human Services Districts and Authorities**.

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

Flexible Family Funds (Cash Subsidy)

A monthly stipend to families of eligible children with severe or profound developmental disabilities from birth to age 18 to help families meet the extraordinary costs associated with maintaining their child in the home. There is a waiting list, and stipends are awarded to eligible children on a first come, first served basis.

Individual and Family Support

This service provides supports which are administered by OCDD Regional Offices with state general fund dollars that are not available from any other source. Individual and Family Supports include, but are not limited to: respite care, personal assistance services, specialized clothing, such as diapers and adult briefs, dental and medical services not covered by other sources, equipment and supplies, communication services, crisis intervention, specialized utility costs, specialized nutrition, and family education. Requests for Family Support funding are reviewed each year or when a person's needs change.

Human Services District / Authorities Support Coordinators

Provide information about supports and services available through OCDD and other sources; make referrals; assess the need for support and services; develop an individualized Plan of Support which identifies formal and natural supports; and provide ongoing coordination of the person's support plan.

In addition, each Human Services District and Authority has an **EPSDT Specialist** on staff, who can answer questions about EPSDT services. Refer to *Appendix H* for a list of the EPSDT Specialists.

LOCAL GOVERNING ENTITIES (LGE) – COMMUNITY BEHAVIORAL HEALTH SERVICES

The Department of Health and Hospitals, Office of Behavioral Health, ensures children and youth with serious emotional disturbances are provided with **outpatient mental health services** through the operation of licensed Local Governing Entities (LGE) and their satellite outreach clinics. The LGE facilities may provide an array of services: screening and assessment; emergency crisis care; individual evaluation and treatment; medication administration and management; clinical casework services; specialized services for children and adolescents; specialized services for criminal justice; specialized services for the elderly; and pharmacy services. LGEs provide services to Medicaid and non-Medicaid individuals, so inability to pay does not preclude services.

Refer to *Appendix I* for a listing of LGE and Community Behavioral Health Services.

Child-Adolescent Response Team (CART)

Crisis services for children are accessible in every LGE (Local Governing Entity) of the state. Some LGE's provide this crisis service by utilizing CART services. These can be accessed through the mental health clinics in the LGEs. They are available through the mental health clinics 24 hours a day, 7 days a week, in **crisis situations** (situations in which a child's

behavior is unmanageable and threatens harm to the child or others). They provide crisis counseling and intervention to children and youth under age 18 and their immediate family. CART assists the family in the stabilization of the crisis and provides the family with advocacy, referral, and support.

SERVICES AVAILABLE THROUGH SCHOOL SYSTEMS

From **birth to age three**, children with disabilities and developmental delays are served by a program called **EarlySteps** which is run by the Office of Citizens with Developmental Disabilities. EarlySteps services are typically provided in child care or Head Start settings or in the home. More information on EarlySteps can be found at <http://new.dhh.louisiana.gov/index.cfm/page/139/n/139>.

Local school systems are responsible for serving students with disabilities beginning at age three. Children who were served in EarlySteps may transition into other services provided by the school system including the school system's **Early Childhood Education** programs. Each school system in Louisiana has a Child Search Coordinator who can arrange for evaluations of children to determine whether or not the child has a disability and requires special educational services. For more information about Child Search and Early Childhood Education programs, contact your school district or:

Ivy Starns or Patsy Palmer
LA Dept. of Education/Office of District Support
Early Childhood Education
Ivy.Starns@la.gov or Patsy.Palmer@la.gov
(225) 342-7290 or 225-342-1129
1-877-453-2721

"The Early Childhood Transition Process" booklet is a guide for helping families prepare for the transition and can be requested from the above contacts. It is available in English and Spanish versions. They can be found on the internet at:

English:

<http://www.louisianabelieves.com/docs/default-source/early-childhood/brochure---early-childhood-transition-process---english-version.pdf?sfvrsn=7>

Spanish:

<http://www.louisianabelieves.com/docs/default-source/early-childhood/brochure---early-childhood-transition-process---spanish-version.pdf?sfvrsn=9>

Regardless of age, **each child who is suspected of needing special education and related services has the right to be evaluated** by the special education department of his local school system. The child will be professionally evaluated through test results, interviews, observations, and other relevant information. Reevaluation should be completed every 3 years. **The evaluation results in a final written report** on the child's level of functioning, strengths and weaknesses, needs, and conditions that qualify the child for special educational services. This report can be useful to the Support Coordinator in developing a CPOC and in supporting any need for Personal Care Services.

The services that will be provided to the child by the school system are determined at a meeting called an **Individualized Education Program (IEP) meeting**. The IEP team includes the parent, the child's special education teacher, regular education teacher (if the child is or may be participating in regular education), a representative of the school system, and other individuals who have knowledge or experience about the child (as determined by the parent or the school). The meeting results in a **written plan ("IEP")** that should address all of the child's educational goals, needs, and services.

In addition to addressing educational methods and goals, the IEP may include **"related services"**--such services as transportation, speech pathology and audiology, psychological services, physical and occupational therapy, orientation and mobility services, recreation, counseling services, and school health services. The IEP can also include **assistive technology devices and services**. Examples of such devices are adapted toys and computer games, remote control switches, electronic communication devices, and standers and walkers. Such devices may be taken home if use in other settings is included in the IEP.

An Individualized Healthcare Plan (IHP) is completed by the school nurse for children with special health care needs. It is usually attached to the IEP, but may be in the child's school record file. The school nurse gathers medical information and develops the IHP with input from the parent, student, physician and/or others. The IHP documents health concerns, goals and interventions required to ensure the health needs of the student are met in the school setting.

Children with disabilities are not limited to the services they may be able to receive at school. **Even though a child with a disability may receive therapy or use assistive devices at school, they can also receive those services in other settings including their homes through Medicaid, if this is medically necessary.**

Before age 16, the child's IEP should start to address the transition the child will make from school to post-secondary education, employment, or other post-high school activities. If employment will be sought at some point, Louisiana Rehabilitation Services should be

contacted to see if they can provide services after high school. Louisiana Rehabilitation Services (LRS) office can be found at:

http://www.laworks.net/workforcedev/lrs/lrs_regionaloffices.asp

The Louisiana Department of Education maintains a **toll-free hotline** that parents can call for information and referrals regarding school services: 1-877-453-2721.

Part II - Intake, Assessment and Comprehensive Plan of Care

INTAKE

Once the referral has been made to the support coordination agency, the participant's family or caretaker should be contacted within three working days of the referral. At that time, an appointment should be set up to discuss what support coordination is and how it can benefit the participant. A face-to-face in-home interview must be conducted within 10 calendar days of the referral.

The Support Coordinator should begin performing the participant's assessment and gathering information within seven calendar days of the referral to the Support Coordination Agency. The Support Coordination Choice and Release of Information Form (FOC) can be used to obtain all plans, evaluations, assessments, and documents that OCDD has developed or used in connection with its determination that the participant is eligible for services through the developmental disability services system as well as the Statement of Approval (SOA). The Individual Entry Review (IER) and supporting documents, Eligibility Recap Sheet, I-CAP, DD-SNAP, psychological evaluation, Screening for Urgency of Need (SUN) tool, and the OCDD Plan of Support can be obtained from OCDD. Allow OCDD a five work day turnaround. Refer to *Appendix N* for a sample copy of the Consent form. Formal information will be needed for the assessment and CPOC completion. The family can also be asked about formal information documents they may have or can obtain prior to the CPOC assessment.

At the face to face visit, the Support Coordinator should explain his/her responsibilities to the family and give specific examples about how these services can benefit the participant. This must include a review of the Medicaid Services Chart (*Appendix B*). By reviewing the Medicaid Services Chart, the Support Coordinator can begin to obtain additional information as to the participant's need for services and help the participant and his/her family become aware of the support systems available and how to access them. In addition, the Support Coordinator should explain all contact requirements, including the required face-to-face meetings. Once the participant and his/her family have been given all of the information, they should be asked again if they want support coordination services.

During this meeting, the Support Coordinator should inform the participant of:

- Support Coordination Responsibilities
- Rights & Responsibilities (*Appendix K*)
- HIPAA & Confidentiality
- Appeal Process (*Appendix L*)
- Availability of formal and non-formal services
- Complaint process for filing a report against support coordinators and/or providers (*Complaint Form – Appendix M*)
- Health Standards Provider Complaint Line (1-800-660-0488)
- Medicaid Managed Care Program Assistance Line (1-888-342-6207) which can be used to make a complaint against a Managed Care Organization. Complaints can also be e-mailed to healthy@la.gov.
- Medicaid Services Chart (*Appendix B*)
- Discuss with Chisholm Class Members their right to choose between Legacy Medicaid and the Medicaid Managed Care Program for their physical health services (*Medicaid Managed Care Appendix H*)

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

ASSESSMENT

To adequately perform an assessment, the Support Coordinator will need to gather both **formal and informal information**.

Formal information will include medical, psychological, pharmaceutical, social, and educational information, and information from OCDD as described above under Intake. Examples of formal information include the IEP and other assessments by professionals such as EPSDT-PCS Form 90, Home Health Plan of Care, LRS evaluations, Special Education Evaluations, behavior plans, psychological evaluations, etc.

Again the Support Coordination Choice and Release of Information Form (FOC) can be used to obtain all plans, evaluations, assessments, and documents that OCDD has developed or used in connection with its determination that the participant is eligible for services through the developmental disability services system as well as the Statement of Approval (SOA). The family can also be asked about formal information documents they may have or can obtain prior to the CPOC assessment.

Individualized Educational Plans (IEP) and Special Education Evaluations can be obtained from the parent, school, or the School Board's Special Education Department with the parent's written consent. It may be easier to obtain the IEP or records from the school by having the parent request that the information be sent home with the participant. Even if the participant is not attending school or receiving Special Ed Services, they should have a Special Education Evaluation to assess their needs. If the child is receiving Special Ed Services, it is required that the IEP be done annually and Special Education Re-evaluations should be completed every three years. Vision and hearing screenings are done at school if the student is able to cooperate with the testing. This required with the Special Education Evaluation and Re-Evaluation. If the child has special health needs, an Individualized Healthcare Plan (IHP) should be attached to the IEP. The school nurse gathers medical information for the IHP and the school nurse can be contacted to see if the participant has an IHP or other medical documentation in the school records. You can look on the current IEP under Supporting Documentation to see what documents are included with the IEP such as IHP, Behavior Intervention Plan, etc.

A current formal information document is required to be on file to receive approval on an initial or annual plan of care. Current means that the formal information document was less than a year old at the time of the plan of care meeting.

- If the child is receiving Extended Home Health, a current EHH Plan of care is required to be on file to receive approval on an initial or annual plan of care.
- If the child is receiving Pediatric Day Healthcare, a current PDHC plan of care is required to be on file to receive approval on an initial or annual plan of care.
- If the child is receiving Special Education Services, a current IEP is required to be on file to receive approval on an initial or annual plan of care. If the school has not completed a new IEP and the current IEP is expired you can obtain a letter from the school or school board indicating that the expired IEP is the most current one available and documentation on the status of the new IEP. Another current formal information document will be required.
- If the child is not receiving Special Education Services, the following formal information documents can serve as the current formal information document:
 - EPSDT-PCS Form 90: If the participant is receiving PCS, an EPSDT-PCS Form 90 can be obtained from the provider or physician.
 - EHH Plan of Care (CMS form 485): If the participant is receiving Extended Home Healthcare an EHH Plan of Care is signed by the physician every 60 days.
 - EPSDT Screening Records: The PCP or the PCP's contracted provider is required to do yearly EPSDT Screenings (physicals and assessments) for children age 3-6, and every other year after age 6. These records can be obtained by the participant/guardian, or support coordinator with a signed release of information.

- Progress Notes or Medical Records: Progress notes or a copy of a physical can be obtained from the physician's office. Mental Health records require a special release of information form. Contact the provider to obtain the release form that is required or obtain one from the LDH website using the following link,
 - <http://LDH.louisiana.gov/assets/medicaid/MedicaidEligibilityForms/HIPAA402PEng.pdf>

Informal information will include information gathered in discussions with the family and the participant, and it may also include information gathered from talking to friends and extended family.

All of this information is vital to performing a good assessment of the participant's needs. The information gathered in the assessment is to be incorporated into the CPOC.

The process of gathering formal information should occur prior to the CPOC meeting. The SC is to obtain all assessments/evaluations and documents that OCDD used to determine eligibility, the current IEP and any other assessments by professionals (EPSDT-PCS Form 90, Home Health Plan of Care, LRS and Special Education Evaluations, behavior plans, psychological and other evaluations, etc.) that are required to obtain CPOC approval. The SC is to contact OCDD, schools, Pupil Appraisal and health care professionals for necessary records, ask the participant/guardian about documents they may have or can obtain from their school, and follow up on requests for records.

The Support Coordinator may need to assist the participant with arranging professional evaluations and appointments including EPSDT Screening Exams and follow-up evaluations. The information provided as a result of these appointments could prove critical in the assessment that will be used to develop the participant's person-centered Comprehensive Plan of Care.

COMPREHENSIVE PLAN OF CARE (CPOC)

The Comprehensive Plan of Care is the Support Coordinator's blueprint for assisting the participant. The CPOC is developed using all information gathered during the assessment process and **MUST** be completed in a face-to-face in home meeting with the participant and others they wish to have present. Because the people at the CPOC meeting are those who know the participant best, more information to be incorporated into the CPOC can be gathered at this meeting. If for some reason the CPOC cannot be completed at the meeting, the participant/guardian must sign the CPOC after it is completed and prior to submittal to SRI. If the participant is 18 years of age or older, has not been declared incompetent (interdicted), and is able to express his preferences, the Support Coordinator should talk directly to the

participant or an Authorized Representative form (Appendix U) must be obtained. If they are unable to express their preferences due to a disability for which an accommodation cannot bridge the gap, the coordinator should document this in the file. Refer to page 38, Documentation for Competent Majors.

CPOC Planning is the process whereby an **analysis of information from the formal and informal evaluations is utilized**. The CPOC is developed based on the identified needs and the unique personal outcomes envisioned, defined and prioritized by the participant and his/her family. It is important that everyone desired by the participant who can offer valuable information in the development of the CPOC be at the meeting. The CPOC is developed through a collaborative process involving the participant, family, friends or other support systems, the Support Coordinator, direct service providers and others that know the participant best.

The CPOC must be specifically designed to meet the participant's goals and objectives, and should include timelines in which the goals can be met or at least reviewed. The plan must include strategies (agreed upon by all) to achieve or maintain the desired outcomes that rely on informal, natural, community supports and appropriate formal paid services.

The Support Coordinator should provide the participant complete and clear information regarding service options to assure the participant makes informed choices. During the CPOC meeting, the Support Coordinator should have the Medicaid Services Chart (*Appendix B*) available to discuss the available Medicaid services. The most current Medicaid Services Chart can be found on the Internet, at:

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

The services discussed in Part I of this handbook should be highlighted in the discussions with the participant and his/her family.

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

The Support Coordinator must be very familiar with all parts of the CPOC and assure that information from each section is used to determine the Goals and Objectives of the Plan that will lead to the requested services. In addition to understanding the importance of each section, it is very important that the Support Coordinator use the most current CPOC provided to the support coordination agencies by LDH/Bureau of Health Services Financing. **(Review a blank copy of the CPOC in LSCIS and the instructions before conducting each CPOC.)** Refer to *Appendix O*.

The CPOC is comprised of the following six sections:

Section I. Contact Information / Demographic Information

This initial portion of the CPOC is self-explanatory and requires the Support Coordinator to provide current information on the person, including name, address, Medicaid number, ICD-10, and contact information. Be sure that all information is provided. Nothing should be left blank.

If the EPSDT participant is enrolled in a Managed Care Organization, the MCO and contact information will be listed on the LSCIS screen if the SC agency has an active Support Coordination PA and the participant is a Chisholm Class Member (CCM). The SC can manually add or remove the Managed Care Organization as needed if the participant does not have an active Support Coordination PA, is not a CCM or if the information is found to be incorrect during the required monthly MEVS/REVS check. There are two boxes: one to list the MCO Agency for their physical health services and one to list the MCO agency for their specialized behavioral health services.

Contact Information

- Review all of the information and update as necessary.
- If the participant's name is spelled or listed incorrectly, there may be a problem in resolving the PAs from Medicaid. PAs are issued to the name that is on file at Medicaid. If there is a discrepancy in the name documented by the family and Medicaid, the family may need assistance in obtaining a correction.
- Legal guardian: The relationship of the legal guardian must be placed beside their name on the contact page. If someone other than a parent is the guardian, you must obtain the legal guardianship papers from Medicaid, OCDD, or the guardian. The legal guardianship document must be in the SC agency case record.

Demographic Information

- Legal status: Once a participant turns 18 they are a competent major unless they have legally been declared incompetent / interdicted, a legal document must be on file if the participant is 18 years of age or older and is not a competent major.
- Ability to self-direct care: Only answer if participant is a competent major.
- ID Status: Not ID is an option on the dropdown bar. Do not select this option unless it is valid. Review the IEP and other formal information documents for changes in the status.
- Adaptive functioning: Review the IEP and other formal information documents for change in the status.
- Residential Placement: If they are living with relatives but in the custody of DCFS (OCS), OCS Foster Care is the correct code to use.
- Number of ID/DD/Special Needs in Home / Names: Do not count the participant. Enter the number and list their names of any other household members with ID/DD diagnoses or special needs.
- Current Education/Employment:
 - **Homebound:** Homebound Service is provided by the School Board. Services are delivered per the IEP.
 - **Homeschool:** Homeschooling is the parent's choice to provide educational services. The parent is required to apply to the Department of Education for approval. A renewal application must be made annually.
 - More information on the home study application can be found here, <http://www.louisianabelieves.com/schools/home-study>.
 - More information on registering as a nonpublic school can be found here, [http://www.louisianabelieves.com/schools/nonpublic-schools/registered-nonpublic-schools-\(not-seeking-state-approval\)](http://www.louisianabelieves.com/schools/nonpublic-schools/registered-nonpublic-schools-(not-seeking-state-approval)).
 - If homeschooling is not registered through the Board of Education, they may be out of compliance with Louisiana's compulsory attendance law, see <http://safesupportivelearning.ed.gov/discipline-compendium/choose-type/Louisiana/Attendance%20and%20truancy>.
 - **Virtual School:** is classified as public school (not homebound) so list as Regular / Special Education as applicable. Services are delivered per the IEP if they receive Special Education.
 - **Regular and Special Education / Special Education Only:** check the IEP to see if they receive Regular and Special Education or Special Education only. If they receive Special Education they will have an IEP.
- The ICD-10 code for the diagnosis may have changed since the last submitted CPOC. Make sure the code continues to match the participant's diagnosis.

Section II - Medical/Social/Family History

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

Past

- Nature and cause of participant's disability, the date and/or their age when this occurred, and significant details regarding the prenatal health and the birth of the participant. If not known, document unknown.
- Information on how diagnoses were obtained, when and by whom. Note if you have documentation to support or if it's family states. It can be documented that family states a diagnosis, but also document that you do not have documentation to support this. If you do not have documentation to support a diagnosis, has it been requested? Each agency is required to have a nurse consultant who may be able to assist in obtaining the diagnosis.
- Any early intervention services that were received
- Briefly document the placement history.
- Reoccurring situations that impact their care.
- Response to past interventions.
- Past medical history, past surgeries, etc.
- Other relevant historical information regarding school, family, hospital admits, etc.
- Events that lead to the request for services at this time / why EPSDT SC is being requested

Present/Natural Supports

- Names and ages of all household members.
- Current family situation. How family members are involved/not involved. Who is the primary care giver?
- Description of complete social support network - list friends, natural supports, and other community resources involved in supporting the individual on a daily basis.
- Address both parents and whether they are in the picture or if the family chose not to disclose that information to you.

- What is the diagnosis of other household members that have special needs? Do they receive any service in the home? Do the needs of other special needs household members affect the participant's needs from being met? If another household member receives SSI, what disability are they are receiving it for?
- Does the family have an understanding of the participant's diagnoses and knowledge of the disability?
- Source of household income, economic status and if disability funds are received.
- Relevant social environmental and health factors that impact individual such as:
 - Health of care givers
 - Home in rural/urban area
 - Accessibility to resources
 - Own home, rental, living with relatives, single family dwelling, etc.)
- Does home environment adequately meet the needs of individual or will environmental modifications be required? If the home does not meet their needs due to falling down stairs, not wheelchair accessible, no ramp, needs structural repair (not cosmetic), etc., it is an identified need. How do they manage without the DME or modifications? Problem solve and locate resources. Do they rent the home? Can they relocate to adequate housing? Family does not want?
- If a participant needs to be carried because they do not have a lift or wheelchair accessible home, how much do they weigh and is it safe for the participant and caregiver to carry them?
- Access to community / transportation. Is there a need for NEMT or Family and Friends Transportation? If so, was the service offered and response received?
- Significant life events which may include family issues, issues with social/law enforcement agencies, etc. Include if a social services case worker or Probation Officer is assigned and if you will have to interact with that agency/individual.
- Address the competent major's desires and requests, not just parental input. What do they want for their future? School, employment, leisure, living situation, etc.
- Legal guardianship documents on file. If the caregiver is not the parent, it must be documented on the CPOC that the legal guardianship document is in the SC agency's case record. The demographic sheet from OCDD documenting the caregiver or a letter documenting the SSI payee is not a legal guardianship document. A non-legal custodian affidavit (*Appendix V*) can be obtained by the caregiver. This affidavit does not require a parent signature. It must be notarized and renewed each year. **If this is the only CPOC deficiency, the CPOC will be denied but the approvable CPOC submit date will be honored when the CPOC is resubmitted with the required documentation.**

- Authorized representative documents on file. If the competent major is unable to sign the CPOC documents, is unable to direct his own care, or requests a representative to be the SCs contact, an authorized representative form must be on file.
- If in DCFS custody, do you have a letter from the DCFS guardian authorizing the foster parent to make medical and educational decisions, sign the documents and be the EPSDT SC contact in the case record?
- When will the participant graduate? Will they receive a diploma, Certificate of Achievement, or GED? If they are leaving school prior to age 21, do they need to be transitioned to LRS, Supports Waiver, higher education, etc.?
- If they are receiving homeschooling, is it registered with the Department of Education to be renewed annually? If the child is not in school, is the parent aware of the educational law for school attendance when the child is 7? Does the parent plan to enroll the child next school year or obtain an exemption?
- School or education should be an identified need unless they have a Doctor's statement that it is not appropriate or they have completed an educational program.
- If child/young adult is not attending school, document if they have interaction with friends, participate in leisure and social activities, and get out of the home.
- Discuss the IEP with the parent/guardian. Are they aware of what services their child is or is not receiving and the frequency of the services? Does the parent need to request another IEP meeting to have the IEP services corrected. The School Board is legally obligated to provide the services on the IEP.
- Review the IEP for information. When documenting placement grade, also document academic functioning level. Some CPOCs give the impression that participant does not meet the eligibility criteria. (Documented the recipient was in the 11th grade but did not document it was inclusion and they were functioning academically on 3rd grade level.)
- Always offer and document the offer of medically necessary community therapies in addition to the therapies received per the IEP.
- Contact the parent after Easter to see if the participant qualified for Extended School Year Program (ESYP) and if they will be attending, and if not, what additional needs might need to be met in the summer.
- Contact Child Search if the participant has not had a Special Education Evaluation. A Special Education Evaluation is needed before an IEP can be done to receive school services. Special Education Evaluations should be completed every three years.

HEALTH STATUS

Summarize important aspects of the person's health, behavioral and/or psychological concerns. Any pertinent information about the individual that can be provided by the family or gathered from formal information documents should be documented. If there is only sketchy information available in any health status area, remember the participant is eligible for

screenings, which can help to determine his/her health needs. It is the Support Coordinator's responsibility to help the participant access those screening services. In some cases, a short term CPOC may need to be developed, setting out the areas that need to be explored towards developing sound and longer term objectives.

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

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

Physical

- List the name of the participant's physician and the date of the participant's last appointment. Are they obtaining physicals at the recommended EPSDT Screening Exam interval? If not, are you encouraging that they do so?

Immunizations

- All information on immunizations should be current. This is extremely important. If immunizations are not up to date, this will need to be addressed.

Medical Diagnosis and Concerns/ Significant Medical History

A brief narrative description of the person's health history, current medical condition, including medical diagnoses, hospitalizations and continuing health concerns and medical needs should be included.

- Findings from the last physical.
- Participant's diagnoses and what documentation you have to support the diagnosis. It can be documented that Mom states a diagnosis, but also document that you do not have documentation to support this. If you do not have documentation to support a diagnosis, has it been requested? Each agency is required to have a nurse consultant who may be able to assist in obtaining the diagnosis. Diagnoses can change over time. Update with current information. Don't automatically list Intellectual Disability; obtain the formal information documents to support this. Pervasive Developmental Disorder (PDD) is not Autism. Developmental Delay is not a form of Intellectual Disability (ID).

Use your nurse consultant as a resource for medical information that is not understood or use the internet for information.

- Participant's medications and what the medications are for, i.e. allergies, blood pressure, behavior, etc.
- Medical specialists that the participant is required to see for follow up/routine appointments; list the name and specialty of all medical providers. Are they receiving the recommended annual dental checkups? Are linkages needed? Are they overdue for any appointments?
- Participant's current physical abilities (if not addressed in the previous section) in the areas of vision, hearing, mobility, use of arms, hands and legs and any need for assistive devices or DME?
- How the participant communicates (assistive technology, PECS, sign language, point or grunts, etc.)
- Are they toilet trained? Why are diapers a need, i.e. due to incontinence of bowel or bladder, bedwetting, occasional soiling, etc.?
- Gastrostomy tube, tracheostomy tube, urinary catheter, or other medical equipment. How often is a special procedure administered?
- Formula, special diet needs, or funds received for a special diet.
- Therapies.
- Continuing health concerns and medical needs.
- Any significant family health risk.
- PCS is not PCA. List the correct service need. Be clear on what the identified service need is and what is requested. What two or more Activities of Daily Living (ADL) do they need PCS to assist with? Do they need mentoring, supervision, respite, assistance with homework, etc., which are not provided by PCS? What is the service needed to provide this?
- If an individual meets the criteria for PCS and declines the service, document the recipient/parent declining the service. If the individual is capable of doing Activities of Daily Living or Instrumental Activities of Daily Living, document this.
- Clarify if it is EHH (three or more hours of skilled nursing per day) or basic home health skilled nurse visit that is requested/received. Document what skilled service is needed that cannot be provided by PCS.
- **Documentation Required for Competent Majors** – If the participant is a competent major and the parent or caregiver is being contacted and followed up with instead of the participant, there must be documentation to support the participants request to have the parent or caregiver contacted or documentation of the participants inability to self-direct their care and an Authorized Representative form (Appendix U) must be on file.

- Are they able to self-direct their care? Must match response in demographic info. Are they able to communicate in any form, engage in their life and make choices of what is important to them and what they want in their life? Can they self-direct and have other family members or concerned individuals assist?
- If they are able to self-direct, did they request that the SC contact someone else to assist and communicate on their behalf?
 - Document, “Asks that SC contact _____ to assist and communicate on their behalf.”
- If they are able to self-direct, did they request that SC speak with someone if they are not available at the time of the SC contact?
 - Document, “Request that SC speak with _____ if they are not available at the time of the SC contact.” Service log example if this is documented in CPOC: Phone contact made with Mary on behalf of Liam. Liam is at school.
- If unable to self-direct, explain the basis for this. (Personal observation during the face to face meeting, a specific psychological evaluation, IEP, etc. Should not be based only on the parent states they are unable to self-direct.) Physical disability does not prevent the ability to self-direct. Who has agreed or is responsible for assisting the participant in obtaining needed services?
 - Document, “_____ is unable to direct their own care based on _____. (Name of parent or caregiver) has agreed or is responsible for assisting the participant in obtaining needed services.”
- The SC must attempt to ask all the participants, regardless of their ability to self-direct, about their preferences.
- During each Quarterly Review ask and document if they still want representation.
- The CPOC and Quarterly Reviews are to be signed by competent majors that are able to self-direct their own care.
- Service log examples when not contacting competent majors:
 - “Phone contact made with Mary Clark as Josh is unable to self-direct his care.”
 - “Phone contact made with Mary Clark per Josh’s request.”
 - “Phone contact made with Mary Clark on behalf of Josh. Josh is at school.”
- Authorized Representative documents on file. If the competent major is unable to sign the CPOC documents, is unable to direct his own care, or requests a representative to be the SCs contact, an Authorized Representative form (Appendix U) must be on file.

Psychiatric/Behavioral Concerns

A narrative description of the person’s psychiatric status, diagnoses and significant behavior concerns should be provided in the Health Profile. Any relevant history that poses a potential risk for the individual or others should be provided. Also, information on effective behavior

interventions, support plan and skills training should be detailed in accompanying information. This information can be obtained from the psychological.

- List the specific behaviors and what is observed by the SC.
- Ask the participant, not just the guardian, about behaviors and need for services.
- How often do the behaviors occur? Have they improved or gotten worse? Be specific (i.e. 4 times a day, 2-3 times a week, a few times a month, etc.)
- Document month and year of significant behavioral incidents. The CPOC covers a year and documenting “recently” or “a couple of months ago” is not helpful in determining a time frame. SC will need to know if there has been improvement in behavior or frequency of the events.
- Clarify if any reported behavioral incidents are new and frequency of occurrences.
- Is there something that caused the behavior such as the effect of a medication, beginning of illness, personality clash, antagonized by someone, toy taken away, unknown, etc.?
- How are the behaviors managed/ what strategies are used such as time out, redirection, positive reinforcement, etc.?
- Were significant behavior concerns or incidents discussed with or reported to their physician?
- Does the participant harm himself or others during behavioral episodes, destroy property, etc.? How are siblings protected?
- What is reported on the IEP? Home and school may have different concerns.
- Do they have a school behavior plan? List as service need as applicable.
- What behavioral health services were offered and which are received/requested? If a service was discontinued, clarify why.
- Are they taking medications for behavioral or psychiatric issues? If behavior medications are prescribed, they should be listed in the service needs and supports section.
- Clarify any placements. Is the facility a detention center, psychiatric hospital, etc.?
- If formal information documents, interviews with caretakers, information in the case record, or SC observations identify the need for Psychological and/or Behavioral Services it must be addressed on the CPOC. Any participant with issues (victim of child abuse, loss of parent or close family member, school suspension or expulsion, recent catastrophic injury, acting withdrawn, etc.) should be offered services. Document offer of services and response received. If there is an identified need for a psychological behavioral health service and the family/participant declines the offer of the service it should be placed in the Service Needs Section of the CPOC.
- Be clear on what service is received or offered. See the additional services in pages 11-13 and 24-25 of this Handbook.

- Do they belong to an Autism support group or want linkage?
- If the participant's inability to communicate is causing the frustration, was community ST offered?
- Don't state N/A in this section. These items must be assessed. Documenting "none" instead, would indicate that it was assessed.
- Ask monthly about any behavior concerns or issues.

Evaluations/Documentation

- You should have the Statement of Approval (SOA) and all assessments/evaluations that OCDD used to determine DD eligibility, the current IEP and any other assessments by professionals (Form 90, Home Health Plan of Care, etc.) that would be current. Contact BHSF/SRI if OCDD does not provide their documents. OCDD should release the documents within 5 working days of the request. You can make the request by faxing the Consent and FOC/*Appendix N* with your request for records.
- **At least one current formal information document is required in the development of an annual CPOC.** Current means that the formal information document was less than a year old at the time of the plan of care meeting.
- If the participant is receiving Extended Home Health, a current EHH Plan of care is required to be on file to receive approval on an initial or annual plan of care. EHH Plans of Care must be signed by the Physician every 90 days.
- If the participant is receiving Special Education Services, a current IEP is required to be on file to receive approval on an initial or annual plan of care.
- If the participant is not receiving Special Education Services, the following formal information documents can serve as the current formal information document:
 - **EPSDT-PCS Form 90:** If the participant is receiving PCS, an EPSDT-PCS Form 90 can be obtained from the provider or physician.
 - **EHH Plan of Care (CMS form 485):** If the participant is receiving Extended Home Healthcare an EHH Plan of Care is signed by the physician every 60 days.
 - **EPSDT Screening Records:** The PCP or the PCP's contracted provider is required to do yearly EPSDT Screenings (physicals and assessments) for children age 3-6, and every other year after age 6. These records can be obtained by the participant/guardian, or support coordinator with a signed release of information.
 - **Progress Notes or Medical Records:** Progress notes or a copy of a physical can be obtained from the physician's office. Mental Health records require a special release of information form. Contact the provider to obtain the release form that is required or obtain one from the LDH website using the following link, <http://LDH.louisiana.gov/assets/medicaid/MedicaidEligibilityForms/HIPAA402P>

Eng.pdf. The school nurse gathers medical information for the IHP and can be contacted to see if the participant other medical documentation in the school records that could be used for formal information documents.

- Current formal information must be reviewed to identify needs while developing the CPOC. Information from the documents must be incorporated into the CPOC. Were additional assessments or services recommended? What services are they to receive at school? Are there any behavioral issues that were not identified or mentioned by the family?
- Formal information documents used in the development of the CPOC are to be listed. On initial CPOCs, this documentation is to be sent to SRI along with the assessments/evaluations and supporting documentation from the regional OCDD office and must be received prior to CPOC approval.
- A participant may be identified as “Special Needs” by BHSF/SRI if the participant is not eligible for the waivers or other OCDD services. Special Needs participants must have Appendix X and current formal information documentation submitted to BHSF/SRI with the annual CPOC to document that they continue to qualify for EPSDT Support Coordination.
- If the CPOC is randomly selected for monitoring when it is submitted to LDH/SRI for approval, Appendix X-2 and the required documents must be submitted to SRI. Annual CPOCs are to have the documents placed in the case record and submitted to BHSF/SRI immediately upon request.
- Information gathered from the family is informal information and should not be listed as an evaluation/document.
- **SOA: Statement of Approval**
 - A valid SOA is required unless they are identified in LSCIS as “Special Needs.”
 - The SC should refer a participant to OCDD two months prior to the SOA expiration. You can view all of the SOA expiration dates that you have entered in LSCIS for your participants by viewing the CPOC Updates Report and referring to Redetermination Due column. BHSF/SRI should not be receiving annual CPOCs that have expired SOAs. SC agencies were instructed to obtain valid SOAs and Participant Recap Sheets from OCDD.
 - The SOA expiration date should not be blank unless a permanent SOA was issued and the permanent box is checked. If there is no SOA expiration date on the SOA or IER or the OCDD Participant Recap Sheet lists the SOA as permanent then you can check the permanent box.
 - If the SOA has expired, contact OCDD and obtain the “Approval for Continued Services and Requested Waiver Date” notice and/or the Participant Recap Sheet.

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

➤ **Individualized Educational Plan (IEP)**

- IEPs should be requested from the parent on intake. If the parent does not have a copy, the SC should request a copy from the school or school board office.
- Obtain the current annual IEP, not just the progress report or Extended School Year Program (ESYP) which do not have all of the assessment information. IEPs are valid for one year. If the IEP is more than a year old, the SC may need to confirm the date of the last IEP with the school board. Sometimes parents do not attend the IEP meetings, forget it was renewed, or misplace the IEPs.
- Obtain the annual IEP as it is renewed and update services with an interim CPOC as needed. If the IEP is obtained as it is renewed, the CPOC submit and approval will not be delayed while the SC tries to obtain the document. School services should be current. (An annual CPOC was randomly selected for monitoring. The current IEP dated 9/18/08 had ST and PT services removed yet the monthly service logs, Quarter Reviews, and 5/5/09 CPOC that was submitted, wrongly documented the services were still received.)
- If the child has special health needs, an Individualized Healthcare Plan (IHP) should be attached to the IEP. You can look on the current IEP under Supporting Documentation to see what documents are included with the IEP such as IHP, Behavior Intervention Plan, etc.
- If the recipient does not have an IEP, do they have a 504 education plan and/or a school health care plan? If so, obtain that document to identify their needs and services.

Section III - CPOC Service Needs and Supports

This Section requires that the Support Coordinator review the Medicaid Services Chart (*Appendix B*) with the participant/guardian regardless of whether or not the participant is receiving these specific services. The Medicaid Services Chart is first reviewed during the face to face visit and should be kept handy and revisited as many times as necessary during the development of the CPOC.

This section identifies goals, what the individual wants in the future for himself/herself, and the support strategy needed to meet the goals. These are unique **personal outcomes** envisioned, defined, and prioritized by the participant/family. This is the section that will identify the services (Medicaid and non-Medicaid) that the participant needs. **It is important that the family know what Medicaid services are available to them before beginning this part of the CPOC. Refer to the drop down bar in this section for a list of some services that require prior authorization.** In addition, this section of the CPOC identifies how the need was determined, if the participant/family requests to receive the identified need and reason why not, personal outcome, who is providing the support, and amount of service approved.

When designing the goals and objectives of the CPOC, it is important to take into account the strengths and weaknesses of the informal/natural supports. For example, if the primary caregiver has no other supports or has a disability, he/she may not be able to offer much assistance with physical care, and it may prove beneficial for the participant to use more paid care than may be otherwise provided. It is the Support Coordinator's job to look at and respond to the needs of the participant; however, often the family's needs have a direct impact on the participant's needs. It is important that the Support Coordinator give the caregiver assistance that is dependable and that allows the caretaker to continue to meet the child's needs over the long-term.

The CPOC must be reviewed at least quarterly to assure that the service being provided is adequate to meet the participant's needs and it remains necessary to his/her health and well-being. It is extremely important for all goals and strategies to be adjusted as the needs of the participant change and as new challenges develop in his/her life, including problems that develop regarding receipt of any services.

The Support Coordinator must assure that the recipient/family understands that services and goals may be added at a later date if they do not choose to access them when the need is first identified. The Support Coordinator must document the participant/family chose not to access a service at the time of the CPOC meeting, and they will be given an opportunity to add that service during the quarterly CPOC reviews or whenever a request is made.

When a service is requested, the Support Coordinator should provide the family with the medical information forms (EPSDT-PCS Form 90, CMS 485, etc.) that are required for the specific service. The Support Coordinator should assist with scheduling the doctor appointment, transportation, etc. as needed.

The Support Coordinator will coordinate all services, Medicaid and non-Medicaid, and ensure that the participant receives the services he/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 needs and that services are being provided. Again, if the participant is 18 or older and has not been declared incompetent, the coordinator should contact the participant unless the coordinator has documented that the participant is unable to express his preferences or the participant has authorized the coordinator to contact a family member. The CPOC will be reviewed at least quarterly and revised annually and as needed.

Service Strategy / Description

- All identified service needs must be listed. Don't forget to include all identified needs such as, respite, smoke alarm, behavior medications, cash subsidy, DME maintenance, specialized treatments such as chemotherapy or dialysis, MH services, van lift, etc. If it is not a Medicaid service, the SC is to assist in locating resources to provide the service need.
- Therapies:
 - Therapies received at school and in the community should be listed separately. Their amounts approved and PA tracking requirement differ.
 - Identify services that are on the IEP.
 - OT/PT/ST consult is not a direct service. They consult with the teacher and parent and may observe the child in the classroom. It may be received only once a semester or once a month. It should be identified as "OT consult," "PT consult," etc.
 - Adaptive Physical Education, A.P.E., is not a therapy. It is provided to a student who is unable to participate in regular physical education (P.E.).
- EHH vs. Basic Home Health Services:
 - EHH provides three or more hours per day of skilled nursing care to recipients under 21 years old only. Prior Authorization is required. An EHH Plan of Care (CMS form 485) is required which must be signed by a physician every 90 days. EHH is a Specific Medicaid program. Use the EHH drop down for Extended Nursing Home Health only.
 - Basic Home Health Services are provided in the home under the order of a physician that are necessary for the diagnosis and treatment of the patient's illness or injury, including: skilled nursing, physical therapy, speech-language therapy, occupational therapy, home health aide services or medical supplies, equipment and appliances suitable for use in the home (with approved Prior Authorization). Recipients must have a physician's prescription and signed Plan of Care. PT, OT, and ST require a PA. If they are requesting or receiving basic home health services, Other/Skilled nurse visits or Other/Home Health PT, etc. should be listed.
- EPSDT Transition must be listed as a service need if the participant is 20 ½ or older during the CPOC service dates. The strategy is to be documented in the Additional Information section. The strategy will be to inform the recipient and family of LT-PCS,

OCDD services, how to obtain the services they now receive, link to resources to receive those services, change in Medicaid services on 21st birthday- encourage to obtain dental and eye exams, glasses, DME, etc. prior to aging out.

- If the participant is homeschooled, is homeschooling registered with the LA Department of Education to be renewed annually or is this a need?
- Behavioral Health Rehabilitation is a specific Medicaid program. Review the service information on page 12 of this Handbook. Behavioral Health Rehab includes Community Psychiatric Support and Treatment (CPST), Crisis Intervention (CI), Crisis Stabilization (CS) and Psychosocial Rehabilitation (PSR). These services usually require a PA. If you confirm with the Managed Care Organization or the provider that the Managed Care Organization does not require a PA you can stop tracking but you must document how you will ensure the service continues to be received. Make sure you select Behavioral Health Rehab from the drop down box so LSCIS knows to always mark the tracking log as Medicaid Managed Care Program. Do not use the term Behavioral Health Rehab unless it is the service being requested/received. Other/Behavior Meds, Other/Psychologist, Other/Psychiatrist, Other/Social Worker, etc. can be used if that is the service need that is requested/received.
- PCS is a specific Medicaid service that cannot be provided by the family. OCDD does not provide this service. Other/Assist with ADL, Other/PCA contract, Other/Respite, etc., should be used for non-PCS services.
- Diapers are provided by Medicaid beginning at 4 years old and ending on their 21st birthday. PA tracking can begin 60 days prior to the participants 4th birthday. Instruct the provider to list her 4th birthday as the PA service begin date.
- If the SOA will expire during the CPOC year, Other/Month & Year Redetermination, (Other/4/16 Redetermination) should be listed as an identified need. The SC should refer a participant to OCDD two months prior to the SOA expiration. LDH/SRI should not be receiving annual CPOCs that have expired SOAs. SC agencies were instructed to obtain valid SOAs and Participant Recap Sheets from OCDD.
- Unless the SC checked with the contact person listed on the Medicaid Services Chart, never state that Medicaid does not cover a service. Medicaid must cover items that are medically necessary. Examples: Aquatic therapy may be covered under an OT provider. A liquid thickener may be medically necessary to prevent choking. Will the physician write a prescription?
- Do not list SC as a service need in this section. The service strategy for Support Coordination is included in section IV and denotes that the CPOC will be reviewed quarterly and revised at least annually.
- **No Services to Coordinate:** If there are no services to coordinate, the Support Coordinator is to inform the family/participant of this and that they can access support coordination at any time until the child's 21st birthday. Declining EPSDT Support Coordination

will not affect their eligibility to receive Medicaid services or their placement on the Waiver Request for Services Registry. The family can choose to continue EPSDT Support Coordinator service, but they must be informed.

- Service Strategy/Description:
 - What support is needed for the individual to achieve his/her personal goals? This may reflect training, needed supports, skill acquisitions, or may regard the person's maintenance in the home and community with provided supports. Make sure that you address all issues on IEP and learning disabilities.
 - All applicable services that require Prior Authorization must be identified. The drop down bar will identify a list of Medicaid services that require a PA and other services for identified needs. Additional needed services can be added to this list.
 - The description box should clarify the service need that is requested. If there is not enough space, clarify the service in Section IV, Additional Information. Example: Dental Services/ routine care, Dental Services/ tooth decay, Dental Services/locate provider.
 - Do not list the name of the provider in the service description box. The CPOC will be locked after approval and won't allow for this identifier to be edited when a new provider is selected. The provider and/or brand can be identified in Section IV (Additional Information). The CPOC can be revised at any time.
 - Do not list other terms, such as amounts of service, "applying" or "requested" in the description box. These descriptions may change over time without having a change in the need for the service. There is a separate box for amount approved.
 - DME products for a specific task can be grouped. Gauze, tape, gloves, and saline for wound care can be identified as DME/wound care if all of the products are ordered from the same provider with the same PA service dates.
- How was the need determined: i.e. by family, physician, IEP, Support Coordinator, etc.
- Requested by participant/family: This column will document the participant/family's choice to access services relating to the identified needs at the time of the CPOC meeting.
- If not why not:
 - **Carried over-resolved:**
 - The service is no longer requested or is no longer an identified need.
 - The service was listed in error or incorrectly identified and is locked on the CPOC.
 - Document why service need was resolved in the Additional Information section.

- Note: DMEs that need to be maintained or renewed are to remain as Service Needs and should not be marked as carried over – resolved. If it was a one-time PA for a DME you can mark the DME as received and untrack after the item is received and your tracking log is complete. If a new one is needed or repairs are needed, unmark receiving, recheck PA tracking, and bring forward a new tracking log.
 - **Family does not want:**
 - The need for the service has been identified but the participant/family declines the service.
 - **Other - explain next page:**
 - The service is an identified need but is placed on hold. Must explain in the Additional Information section. Example: Has a PA for PT but had a recent surgery and the PT was placed on hold with the intention of returning. This is not appropriate if on a wait list for therapy; they are requesting the service now.
- Primary Goal: i.e. best possible health, security, have friends, etc.
- Who and How: Use the check boxes to identify who and how the person can be supported to achieve his/her personal outcome. This section identifies whether paid staff or natural supports will be utilized to support the strategy. Will the service be provided by Medicaid, School, Community, Family, or OCDD? If the service is provided through private insurance, check Family.
- Requires PA Tracked by SC:
 - “Medicaid” and “Requires PA Tracked by SC” must be checked in order to generate the required PA Tracking log.
 - **“Requires PA tracked by SC” must be checked for all requested Medicaid services that require a PA, unless a valid reason and how the SC will ensure the service is received is documented in the Additional Information section. Incorrectly removing the PA tracking requirements on EPSDT CPOCs will cause errors on the EPSDT Quarterly Report and PA Tracking Required Action Report.**
 - If a service is covered by private insurance, check “Family” and PA tracking will not be required.
 - Valid reasons for not tracking:
 - If the PA is issued monthly, PA tracking is not required because a PA tracking log cannot be done due to the quick turnaround. The required provider contact timelines cannot be met since a PA renewal request is submitted by the provider prior to the required 45 day renewal notice being sent by the Support Coordinator. The SC must enter the PA infor-

mation in the PA Tracking Log documenting the PA begin and end date to show a monthly PA was issued before untracking.

- If the EHH nurse is the person ordering and tracking the supplies, PA tracking is not required.
- If the participant is on a waitlist for therapies or ABA, PA tracking is not required after the SC confirms placement on the wait list with the provider and the PAL is notified of the wait list placement.
- For community OT, PT, and ST:
 - Prior to completing a 35 or 60 day PAL, the SC is to contact the provider to confirm if the participant is receiving the service. If the provider confirms the service is being delivered, the family is to be contacted. If both the provider and family confirm the participant is receiving the prescribed therapy, a PAL referral and continued PA tracking would not be needed.
 - If the SC cannot confirm that services are being provided and there is no PA in place, the SC must initiate a PAL referral within the prescribed timelines. If the PAL can confirm with the family and provider that the services are being delivered and provide them with the date the service began. Continued PA tracking would not be needed.
 - **If the SC receives a PA notice, it is to be entered on a tracking log and PA Tracking will restart.**
- *If the Managed Care Organization does not require a PA for the service, PA tracking cannot be completed. Some of the Managed Care Organizations do not require PAs for diapers or therapies (ST, OT, PT). Document that you confirmed with the MMCCM or provider that a PA is not required for the service on a service log and on the notes section of the PA tracking log. You can then uncheck PA tracking and enter the reason for untracking in the Additional Information section of the CPOC. Also document in Additional Info how the SC will ensure the service continues to be received. The SC is still responsible for ensuring the services are received and may need to assist with obtaining the prescription or letter of medical necessity, scheduling assistance, choice of provider, etc.*
- If the participant's behavioral health services are being prior authorized by Magellan while the child is enrolled in CSoC, PA tracking is not required. Once the child leaves CSoC, PA tracking of behavioral health services that require a PA is to resume.

- Diapers and formula may be delivered or released in monthly increments due to storage when the PA is issued for 6 months. PA tracking would be required in this case.
- For Applied Behavioral Analysis (ABA) PA tracking:
 - ABA is managed by the Medicaid Managed Care Program so PAs will be issued by the MCO. Make you sure you select Applied Behavioral Analysis from the service needs drop down box so LSCIS knows to mark the tracking log as Medicaid Managed Care Program.
 - Once the service is requested you are to begin PA tracking. Once a COP has been made and a referral has been sent, contact the provider and find out what their process is.
 - If a Clinical Diagnostic Evaluation (CDE) is required before the provider will place the participant on a waiting list then you can add the CDE as a service need and place ABA on hold by marking it as Other–Explain Next Page and document why in the Additional Information section of the CPOC and on the tracking log. PA tracking for the CDE is not required. Once the CDE is completed and it is determined that the participant qualifies for services you can restart ABA tracking. *Note: The enrollee’s Managed Care Organization is responsible for arranging and finding a CDE provider.
 - If the participant is placed on a waitlist for ABA, complete the PAL referral to notify the PAL of the waitlist placement and PA tracking would not be required until their name comes up on the waitlist.
 - PA tracking is not required for ABA plan development.
- PA tracking starts with the **request for service**, not the choice of provider or receipt of prescription. **Choosing a provider or waiting on a prescription are NOT valid reasons for not tracking.**
- **The valid reason for not tracking the PA** (i.e. PA is issued monthly, the Extended Home Health nurse orders and tracks the supplies, the participant was placed on a wait list after they were referred to the provider, SC unable to obtain PA for community OT but confirmed it is being provided, etc.) **and how the SC will ensure that the service is received must be documented in the “Additional Information” box. If the participant is on a waitlist, document how the SC will ensure they move up the waitlist.** The PA notices must be kept in the case record and the “amount approved” placed in the CPOC service needs and supports section.
- The Amount Approved: In this column, describe the frequency of service delivery the provider will use to meet the person's need (i.e. 4 / day to indicate 4 hours of PCS per day.)

Section IV - CPOC Participants

CPOC Participants

As the Support Coordinator, it is your responsibility to have everyone sign (especially the participant, parent/guardian) the printed LSCIS CPOC signature page indicating their participation. The support coordinator present shall sign the CPOC. The individuals listed as Planning Participants in LSCIS must match the Planning Participants on your signature page. The participant and the parent/guardian must be present for the CPOC meeting so they must be listed as planning participants both in LSCIS and on the signature page. You may also wish to obtain contact information for each person attending, so they can be invited to future meetings, if the participant/family requests assistance with this.

The participant/guardian will sign and date the printed LSCIS CPOC signature page indicating they have reviewed and agree with the services in the CPOC. Participants age 18 or older must sign all documents if they are able to direct their own care. If they are unable to do this, the reason should be documented. This signature date is to be entered in this section of LSCIS. **If someone other than the parent or the participant (if they are a competent major) is signing the CPOC as the participant/legal guardian, legal documentation or a Non-Legal Custodian Affidavit (Appendix V) must be in the case record and this must be documented in the CPOC. To complete monthlies or quarterlies with someone other than the parent if the participant is a minor, legal documentation or a Non-Legal Custodian Affidavit (Appendix V) must be in the case record and this must be documented in the CPOC. To complete monthlies with someone other than the participant if the participant is a competent major an Authorized Representative Form must be in the case record and this must be documented in the CPOC.**

Additional Information

This section is provided to document additional information regarding service needs and supports.

- The names of all service providers and any additional strategy information are to be placed in this section.
- If there was not enough room in the service need description box, clarify what service need is being requested.
- Support strategy information may be required to clarify **what** is needed to achieve the Goal, **how** the support will be delivered / **how** the service need will be met, **who** will deliver the support, and **where** the support will be provided. Example: The service need is "Other/recreational activity" and family and community are checked as providing the service, document the family is taking him to the library and sporting events and he is involved in YMCA activities.

- **Specific EPSDT transition strategies must be listed in this section. Example: Participant will be informed of CCW, ADHC, LT-PCS, OCDD services, how to obtain the services he now receives, link to resources to receive those services, change in Medicaid services on 21st birthday, and will be encouraged to obtain exams, glasses, DME, etc. prior to aging out.**
- If a current service need was requested on the previous CPOC and is not checked as “receiving,” document the barriers and the strategy to obtain the service need now.
- If any service needs were documented as carried over – resolved or other – explain next page, document why the need was resolved or why the need was placed on hold.
- If PA tracking is not checked for any Medicaid services that require PAs the valid reason for not tracking must be documented along with how the SC will ensure the service is received. Example: The participant was placed on a wait list after they were referred to the provider for community PT. The SC will follow-up with the family and the provider monthly to ensure they move up the waitlist.

Medicaid Services

This section of the CPOC is to ensure that the participant/family has been made aware of the services available to them through Medicaid. The Support Coordinator must review the Medicaid Services Chart with the individual/family. The Support Coordinator must also provide information on Medicaid EPSDT and EPSDT Screening Services.

Review/Resolution

The minimum requirement for a review of the plan is quarterly. The goal for Support Coordination is included in section IV and denotes that the CPOC will be reviewed at least quarterly and revised at least annually. The review will determine whether the person's needs have been adequately met and whether the services continue to be necessary. Identify if the goal was met (carried over – resolved), if the service is on hold (other – explain next page) or if the participant/family no longer wants the service (family does not want), on the Quarterly Review/Interim CPOC. For Medicaid services that require a PA, the SC is to work with the family and provider to obtain the PA and requested service or to resolve the request for the service. The CPOC is to be revised at least annually or sooner if the individual's situation significantly changes.

Section V - CPOC Approval

An **approvable** initial CPOC must be completed and sent to BHSF/SRI within 35 calendar days of the date of referral to the Support Coordination agency.

The annual CPOC meeting should not be held more than 90 calendar days prior to the expiration of the current CPOC. The **approvable** annual CPOC must be completed and submitted to SRI within 35 calendar days of the CPOC expiration date.

An initial CPOC or a CPOC for participants that are not on the DD RFSR but are identified as Special Needs must have all formal information evaluations and documents listed on *Appendix X* submitted. This is to be sent to SRI and must be received prior to CPOC approval. All information as required on the Checklist for EPSDT Support Coordination Approval Process must be maintained in the participant's file. It must be available and submitted to BHSF/SRI immediately upon request.

The supervisor submitting the CPOC to BHSF/SRI for review will be notified by LSCIS when the CPOC is randomly selected for monitoring. The required documents and the Monitoring Checklist (*Appendix X-2*) must be sent to BHSF/SRI. If the documents are not received within the required two working day timeline, the CPOC will not be approved and it will be returned to the agency.

BHSF/SRI will review the CPOC to assure that all components of the plan have been identified. If any part of the CPOC is not completed by the Support Coordinator, the plan will be returned to the Support Coordinator without an approval.

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

The Support Coordinator is responsible for requesting and coordinating all services identified in the CPOC immediately upon completion of the CPOC and prior to approval from BHSF/SRI. Since approval of Medicaid state plan services is through the prior authorization unit, there is no reason for the Support Coordinator to await BHSF/SRI approval of the CPOC before making referrals for necessary services.

Signature Support Coordinator Supervisor

- The Support Coordinator must sign and date the CPOC and have their supervisor review and sign the plan prior to submitting an approvable CPOC to BHSF/Statistical Resources, Inc. (SRI). The supervisor's signature denotes that they approve and agree with the content of the CPOC being submitted. The Formal Information documents, prior CPOC, Service Logs, and Quarterly Reviews must be reviewed by the Supervisor for identified needs and the status of requested services. The entire CPOC must be reviewed to ensure that all identified service needs are addressed, all required information is included, the information from the prior approved CPOC has been updated with current information, outdated information has been edited, and no discrepancies exist.

Approval/Denial Notes

- BHSF/SRI will review the CPOC to assure that all components of the plan have been identified. If any deficiencies exist, SRI will list them in the Approval/Denial Notes box and return the CPOC for resubmittal. If documents required for initial CPOCs (current formal documents and all assessments/evaluations and supporting documents from the regional OCDD office) or Special Needs CPOCs (current formal documents) or documents required for CPOC monitoring (Appendix X-2) are not submitted as required, the CPOC will be returned to the SC without a review.
- Review the Approval/Denial Note box on all returned CPOCs. An approved CPOC may have a note to address something on an interim CPOC or information regarding the PA.

CPOC Quarterly Review

This is to be used for the required face to face quarterly review visit. Refer to page 79 for documentation requirements regarding the Quarterly Review.

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

Section VII - Typical Weekly Schedule (Paper form only)

The weekly schedule is a tool that the Support Coordinator uses to assure that services are delivered at appropriate days and times and do not overlap, unless this is medically necessary.

- The weekly schedule should indicate what services are already in place and the services that are being requested through Medicaid prior authorization or other sources. The schedule should show when the participant is in school, at home or participating in other activities.
- The schedule can be forwarded to in-home providers and prospective providers to support and clarify prior authorization requests.
- If prior authorization is denied and not appealed, or if for any other reason the planned services are not delivered, the schedule should be amended to reflect services actually put in place.
- If the participant wishes to change any of the times for established services, the Support Coordinator shall give the revised schedule to all appropriate providers informing them of the time changes to facilitate the change.

COORDINATION OF SERVICES IDENTIFIED IN THE CPOC

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

The Support Coordinator should provide as much assistance as possible to the family to identify and obtain other non-Medicaid services (home modifications, respite, financial assistance, etc.) that are identified in the plan. The CPOC is considered a holistic plan. Therefore, the Support Coordinator is responsible for coordinating all identified service needs, including paid and un-paid supports as well as non- Medicaid Services.

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

Part III – Prior Authorized Services

The following forms/brochures/flyers will be covered in this section:

- Referral to Provider (*Appendix Q*)
- Referral to Medicaid Managed Care Case Manager (*Medicaid Managed Care Appendix Q*)
- Referral to Provider Authorization Liaison "PAL" (*Appendix S and Medicaid Managed Care Appendix S-1, S-2, S-3*)
- EPSDT Prior Authorization Tracking Log (*Appendix O and Appendices T, R-5 and Medicaid Managed Care Appendix T* for information)
- EPSDT LSCIS Service Log (*Appendix O*)
- EPSDT Quarterly Review/ Checklist and Progress Summary (*Appendix O*)
- Appeals Brochure (*Appendix L*)
- Prior Authorization Requests(*Appendix R*)
- Review of Possible Eligibility request (*Appendix Y*)

OVERVIEW OF THE PRIOR AUTHORIZATION PROCESS

Some Medicaid services such as Personal Care Services, Rehabilitation Services, Home Health, and Durable Medical Equipment (DME) require prior authorization before they can be provided. Typically, a Medicaid-enrolled provider of the service develops and submits an application for the service to the prior authorization unit. A notice of authorization or denial of the service will be sent to the participant, the provider, and to you, the Support Coordinator, if your name has been included in the prior authorization request.

For recipients in legacy Medicaid for their physical health services, prior authorization requests are acted on by the Prior Authorization Unit of DXC, a company that contracts with the Department of Health and Hospitals to perform this function. For recipients in Managed Care Organizations for their physical health services, prior authorization is handled by the individual plan. Specialized behavioral health services are authorized by the participant's Managed Care Organization unless they are enrolled in the Coordinated System of Care (CSoC). For children and youth enrolled in CSOC most of their behavioral health services are authorized by Magellan. Requests may be denied if the item or service requested is not medically necessary, or if it is outside the scope of services covered by Medicaid. A notice of denial will be sent to the participant, the provider, and you, the Support Coordinator, if you are properly identified in the request. The participant then has the right to appeal the denial.

If services are approved, the provider and the participant are notified and services can begin. If services are authorized for a period of time, it will be necessary to file another request near the end of the period for which they are authorized. **If the request for reauthorization is received by DXC at least 25 calendar days before the end of the period, services may not be discontinued until the request has been ruled upon.** If the requested services are denied, the services may continue while awaiting a ruling on the appeal, *if* the request was submitted 25 calendar days ahead of the end of the authorization period *and* the appeal was filed within 10 calendar days of the denial notice. Participants have 30 calendar days to file an appeal request after the notice of denial of services, but in order to continue receiving the services during the appeal process, the appeal must be filed within 4 calendar days of the denial notice.

For participants under age 21 who are on the Developmental Disabilities Request for Services Registry, **if there is insufficient information for DXC (or the Managed Care Organization for Medicaid Managed Care enrollees) to make a decision as to whether an item or service should be approved or denied, the request will be referred to the Prior Authorization Liaison (PAL),** whose function is to communicate with providers, Support Coordinators, and participants in order to develop and obtain the necessary documentation. If there is no response within 30 calendar days after a Notice of Insufficient Documentation goes out, the recipient's request will be denied, for not having enough information. No decision will be reached as to the medical necessity for the service. This can be avoided by notifying the PAL of an upcoming doctor's appointment unless the recipient failed to keep the appointment. The PAL shall then follow up with the doctor to get all necessary information.

Support Coordinator Role - General

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

- assisting participants in identifying services they will request (discussed previously);

- providing the specific medical information forms, that the physician must complete, for the requested services (Refer to *Appendix R-1*, LaMedicaid.com or the LDH website);
- assisting with the scheduling of physician appointments, transportation, etc., to have the forms required for a PA request completed;
- locating providers willing to submit the request;
- assisting, if necessary, in assembling documentation needed to support the PA request;
- making sure providers submit requests timely and tracking the status of the request;
- communicating with the PAL, notifying them of any upcoming doctor's appointment, and helping to supply any missing documentation of medical need;
- follow through with requests for services until the PA is either approved or denied based on medical necessity; and
- assisting the participant with making a decision about whether to appeal any denials of services, and assisting with the appeal if the participant decides to appeal and wants assistance.

Support Coordinator Role - Locating Medicaid Providers

As a Support Coordinator, you can contact the **Specialty Care Resource Line for those enrolled in legacy Medicaid only** to find medical providers of various types and specialties for referral of your participants. The Specialty Care Resource Line can even help you find a needed source for referrals that, otherwise, may be difficult to find. For those enrolled in a Managed Care Organization you can contact the Managed Care Organization's Enrollee Services or the Medicaid Managed Care Case Manager. All participants can access non-emergency medical transportation (NEMT) through their Managed Care Organization. For dental, always consult the Specialty Care Resource Line as those services are excluded from the Medicaid Managed Care Program.

The Specialty Care Resource Line is supported by an **automated resource directory** of all Medicaid-enrolled providers of medical services, including physicians, dentists, mental health clinics, and many other health care professionals. The database is updated regularly.

For assistance, call the toll-free Referral Assistance Hotline at 1-877-455-9955. When you call this number, you will reach a Referral Administrator who will be glad to assist you.

If the Specialty Care Resource Line has no provider listed, call the contact person listed on the Medicaid Services Chart (*Appendix B*) for that service. To obtain the most recent Medicaid Services Chart please visit this website:

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

For Personal Care Services and Extended Home Health, call LDH at 1-888-758-2220.

NOTE: Specialized behavioral health services and non-emergency medical transportation services were integrated into the Medicaid Managed Care Program beginning on December 1, 2015. Participants now access behavioral health services and non-emergency transportation services through their Managed Care Organization with the exception of Coordinated System of Care (CSoC) enrollees. CSoC enrollees will receive most of their behavioral health services from Magellan and will not have a Managed Care Organization for behavioral health. For participants with the Medicaid Managed Care Program for their behavioral health services contact the Managed Care Organization to find out how to obtain behavioral health services. (<https://www.myplan.healthy.la.gov/contacting-your-plan>)

When a participant requires a service that must be prior authorized, you must refer the participant to the appropriate provider of his/her choice. Unless the participant already has a provider he or she is satisfied with, you must give the participant a list of agencies where the service they need is offered. From that list, the participant will choose the provider they prefer. The EPSDT Provider list for Personal Care Services (PCS) for Legacy Medicaid recipients can be accessed at www.LDH.louisiana.gov click Medicaid, click Locate a Provider, click on provider group Personal Care Services, and the region or parish where the participant resides. For Medicaid Managed Care enrollees, the list of providers can be accessed via the online provider directory at <http://myplan.healthy.la.gov>. Select Choose > Find a Provider. Choose between Behavioral Health and Medical Health Providers. Indicate if you know the provider's name or phone number. You can look up a specific provider to see what MCO they are affiliated with by selecting "Yes" and then entering the Doctor/Provider's name. If you select "No" you can search by Provider Location and then select the Provider Specialty and narrow the results down further by provider gender (for doctors), provider language or which Healthy Plan they are affiliated with. Note: You can search for PCS by selecting Personal Care Attendant and looking for "PCS-EPSDT" listed under PCP/Specialties on the list of providers. You can also find providers by calling the Enrollee Services Line at each Managed Care Organization to locate a provider in their network, or accessing the MCO's websites to identify contracted providers. Refer to Medicaid Managed Care Appendix A and B. The Support Coordinator cannot tell the participant which provider to choose. However, the Support Coordinator may recommend to the participant/family that a list of interview questions may help them in selecting the appropriate provider for their identified needs. The Support Coordinator must have the participant/family list the provider they choose and sign the **Choice of Provider Form for EPSDT Medicaid Providers (Appendix Z)**. The support coordinator may also need to assist the participant in contacting prospective providers and finding out if they are willing to submit prior authorization requests.

The family can give a verbal Choice of Provider (COP) to the Support Coordinator per phone if it is needed for a timely referral to the provider. In order to do this, the family must have a list of providers or know who they want. The Support Coordinator may not give a partial list of providers to the family to choose from. The Support Coordinator must complete the Choice

of Provider Form documenting the participant's choice of provider and have another office employee speak with the family to confirm and witness the Choice of Provider. Make a referral to the provider for Legacy Medicaid or to the Medicaid Managed Care Case Manager for Medicaid Managed Care enrollees and mail a copy of the verbal COP to the participant/family.

As noted previously, if you cannot find a provider in your area that is willing to submit an application for the services the participant needs, LDH (or the Managed Care Organization, for a Medicaid Managed Care enrollee) must help you find a provider who is willing and able to provide the services. Call the LDH program staff line at 1-888-758-2220 and tell them that you cannot find a provider. For Medicaid Managed Care enrollees, call the Enrollee Services Line at their Managed Care Organization. The Support Coordinator must notify the PAL if the provider is unable to find staff for the service after the service has been approved. **If an EHH, PCS, PT, ST or OT provider cannot be located, LDH must take all reasonable steps to find a willing and able provider within ten days. If two providers have refused to submit a request for the needed item or service (other than PCS or EHH), or if there is no willing provider of the service in the area, participants can request a review of possible eligibility for the service directly from Medicaid.** They must first obtain a written statement from a physician as to why the services or items are necessary. If Medicaid finds that the participant may be eligible for the services, Medicaid will find a provider to submit the request or otherwise take steps to obtain a prior authorization decision. Refer to *Appendix Y* for a copy of the form that needs to be completed. Contact the LDH program staff line for PCS and EHH services.

TRACKING PRIOR AUTHORIZATION REQUESTS for LEGACY MEDICAID

PA Tracking begins with the request for the service, not when the choice of provider or prescription is received or when the CPOC is approved. **Please make sure you are using the most recent versions of the Referral forms.**

Complete the Referral to Provider form

Once the participant has chosen a provider, the Support Coordinator must complete the **Referral to Provider** (*Appendix Q*) form and submit it to the provider. It is extremely important that the Support Coordinator fill in the name of the support coordination agency and request that their name and contact information be placed on the **Request for Prior Authorization** form.

Referral to providers should be made within 3 calendar days of CPOC completion, or within 3 calendar days of the date the family selects the direct service provider - Choice of Provider date (if the date of provider selection is later than the CPOC meeting).

Obtain a copy of the Request for Prior Authorization Form

In addition to requesting that your name be placed on the form, it is equally important that you request a copy of the Request for Prior Authorization Form for the appropriate service that is submitted by the provider to DXC (for legacy Medicaid recipients) or to the Managed Care Organization (for Medicaid Managed Care enrollees). Receiving a copy will give you a better opportunity to track the service from your referral to the provider to the prior authorization decision and will also document in your file your active participation in the prior approval process.

Tracking Activities and Contacts for Legacy Medicaid

Document in LSCIS all contacts with the provider regarding the request on the EPSDT Prior Authorization Tracking Log and the EPSDT Service Log. Also document all contacts with the participant/family regarding the requested service. Contacts must be, at a minimum, on a monthly basis.

It is the Support Coordinator's responsibility to track all prior authorization requests on behalf of their participant. To track each prior authorization request, the Support Coordinator must use the **EPSDT Prior Authorization Tracking Log**. On this form the Support Coordinator will document the nature and the specific amount of each service being sought, provider and PAL referrals, and information about approval, denial and appeals. (Refer to *Appendix R-2*)

- A separate **EPSDT Prior Authorization Tracking Log** is completed for each service that requires prior authorization. A new log is used for renewals and changes in existing services (i.e., additional hours of service requested). (Note: DME supplies relating to a specific activity may be grouped as one Service Need entered on one tracking log if the provider and PA service dates are the same.)
- The log provides space for ongoing tracking information relating to the status of the prior authorization/service:
 - Type of Service and Amount: Specify the item or services sought, and the amount. For services that are expressed in hours, the total hours per week should be indicated.
 - Date of Service Request and Date of COP (Choice of Provider)
 - Provider Name
 - Date of Referral to Provider (within 3 calendar days of date of COP)
 - Provider Contacts (within 15 calendar days of Referral to Provider and within 35 calendar days of Referral to Provider)
 - Referral to PAL (if required)
 - Reminder Notice to Provider for Renewal: **45 - 60 calendar days prior to the date the services are scheduled to expire**, you should remind the provider to renew the prior authorization request.

- Date of the PA Decision and the Date PA Notice Received by the agency (If a partial approval is received, enter this information and also enter in the Note Box that a Partial Approval was received. The Partial Approval will be followed by a Full Approval or Partial Denial notice.)
- PA Approval and Dates: The outcome of the request for prior authorization should be recorded. Because the Support Coordinator is listed on the **Request for Prior Authorization** form, you should receive the notices that the Prior Authorization Unit or the PAL sends to the provider and the participant. If services are approved, record the specific number of hours and/or services approved and follow up with the participant to make sure that services begin and enter the service start date. If services are denied or partially denied, record the reason for denial. If the PA was not issued within 60 calendar days of the request, complete the explanation box.
- Appeal Information: The SC should contact the recipient within 4 calendar days of the notice of denial to review the appeals brochure with the participant, record the date the appeal rights were explained, whether or not the participant requests assistance with the appeal, and the date the appeal request was sent to LDH. If an appeal is requested, the SC should check on the appeal status and see if additional assistance is needed within 20 calendar days from the date the appeal request is filed.
- When the reminder notice for renewal is sent to the provider, a new EPSDT Prior Authorization Tracking Log should be started for the next PA cycle. The date the reminder notice is sent is the date of referral for a new tracking log. The date the participant chose to renew the PA with the provider is the COP date on the renewal. A new Tracking Log should also be started when there are requests for changes to existing services or a change in the choice of provider.

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

- It will help you assure the participant is receiving the services requested;
- It will serve as a reminder to contact the provider if you have not received a copy of the Request for Prior Authorization form;
- It will serve as a reminder to make required PAL referrals;
- It will allow you to know at a glance when, and if, services were/were not approved;
- It will serve as a reminder of when the notice should be sent to the provider to renew services;
- It will allow you to document information about the PA decision notice;
- It will allow you to document that you offered/provided appeal assistance to the participant and provided the **Appeals Brochure**.

Review the form and instructions completely before using them. If you have questions about this form, ask your trainer or your supervisor.

The **EPSDT LSCIS Service Log** should be used to provide a narrative of activities related to the request for EPSDT services including each activity and contact with the provider, the participant, and the PAL. A separate service log should be used when possible to document activity related to a specific requested prior authorized service as identified on the EPSDT Prior Authorization Tracking Log.

The EPSDT LSCIS Service Log should be used for documenting all contacts with the participant, provider and PAL. This log should also be used to document the receipt or the approval, denial or reduction of services, the monthly contact with the participant/family regarding the status of implementation of services, and all support coordination activities.

- **Participant contacts:** The support coordinator must make contact with the participant at **least monthly and as needed** until each service included on the CPOC is fully implemented, including receipt of all prior authorized services. **Monthly contacts** are to assure implementation of the services requested on the CPOC. Additional, **as needed contacts** may be required to determine a service start date after the PA is received, assist with identified needs and problems with providers, to follow up on obtaining information to complete a PA request, or to offer assistance with an appeal. (Refer to *Appendix T-1* for the contact flow sheet.)
- **Provider contacts:** The support coordinator must contact the provider as needed, but at a minimum:
 - **Within 15 calendar days from referral** to make sure they are working on the request and to see if assistance is needed in obtaining documentation to support the request;
 - If the support coordinator does not receive a copy of the Request for Prior Authorization form **within 35 calendar days of referral**; contact should be made with the provider again at that time to ensure the request has been sent to the Prior Authorization Unit;
 - If a notice of decision has not been received **10 calendar days after the date the provider said they submitted the request** or a call from the PAL has been received;
 - **45 – 60 calendar days prior to the date the services are scheduled to expire**, you should remind the provider to renew the prior authorization request. The provider must submit the renewal request at least 25 calendar days prior to expiration to assure uninterrupted services. (Refer to *Appendix T-2* for the contact flow sheet.)
- **PAL contacts:** All contacts with the PAL must be documented. (Refer to *Appendix T-3* for the contact flow sheet)

The Support Coordinator must document on the *EPSDT Prior Authorization Tracking Log* that a referral was made to the provider. If after 35 calendar days the provider has not submitted the PA packet, the Support Coordinator should complete the **Referral to Medicaid PAL** form. Refer to *Appendix S* for a copy of this form. (The role of the Prior Authorization Liaison or PAL will be discussed in more detail later in this document.) Other reasons this form can be used are:

- When you have not received a decision within 60 calendar days from the Choice of Provider date;
- To alert the PAL of situations where the participant has chosen a new provider;
- To alert the PAL of situations where the participant was placed on a wait list for rehabilitative therapies;
- To alert the PAL that a renewal approval has not been received and the previous PA has expired; or
- To alert the PAL that a provider is not providing services at the time the participant requested and/or the amount of services prior authorized and the problem cannot be resolved

If a decision has not been received for any prior authorized Medicaid service 60 calendar days following the selection of the service provider or renewal request, the participant's name and the type of service will be included on the **EPSDT Quarterly Report**.

TRACKING PRIOR AUTHORIZATION REQUESTS for MEDICAID MANAGED CARE ENROLLEES

PA Tracking begins with the request for the service, not when the COP or prescription is received or when the CPOC is approved. **Please make sure you are using the most recent Referral forms.**

Complete the Referral to Medicaid Managed Care Case Management Form

Once the participant has requested a service the Support Coordinator must complete the **Referral to Medicaid Managed Care Case Management** (*Medicaid Managed Care Appendix Q*) form and submit it to the Medicaid Managed Care Case Manager (MMCCM). It is extremely important that the Support Coordinator fill in the name of the support coordination agency and request that their name and contact information be placed on the **Request for Prior Authorization** form.

Referral to Medicaid Managed Care Case Management should be made within 3 calendar days of CPOC completion, or within 3 calendar days of the date of service request (if the date of service request is later than the CPOC meeting).

Obtain a copy of the Request for Prior Authorization Form

In addition to requesting that your name be placed on the Request for Prior Authorization form, it is equally important that you request a copy of the Request for Prior Authorization Form for the appropriate service that is submitted by the provider to the Managed Care Organization. Receiving a copy will give you a better opportunity to track the service from your referral to the MMCCM to the prior authorization decision and will also document in your file your active participation in the prior approval process. The MMCCM will ensure this information is given to the provider agency.

Tracking Activities and Contacts for Managed Care Organization Enrollees

Document in LSCIS all contacts with the MMCCM and provider regarding the request on the EPSDT Prior Authorization Tracking Log and the EPSDT Service Log. Also document all contacts with the participant/family regarding the requested service. Contacts must be, at a minimum, on a monthly basis. It is the Support Coordinator's responsibility to track all prior authorization requests on behalf of their participant. To track each prior authorization request, the Support Coordinator must use the **EPSDT Prior Authorization Tracking Log**. On this form the Support Coordinator will document the nature and the specific amount of each service being sought, MMCCM and PAL referrals, and information about approval, denial and appeals. (Refer to *Medicaid Managed Care Appendices D, E, F, T-1, T-2, T-3 and Appendix R-5*)

- A separate **EPSDT Prior Authorization Tracking Log** is completed for each service that requires prior authorization. A new log is used for renewals and changes in existing services (i.e., additional hours of service requested). (Note: DME supplies relating to a specific activity may be grouped as one Service Need entered on one tracking log if the provider and PA service dates are the same.)
- The log provides space for ongoing tracking information relating to the status of the prior authorization/service.
 - Type of Service and Amount: Specify the item or services sought, and the amount. For services that are expressed in hours, the total hours per week should be indicated.
 - Date of Service Request and Date of COP (Choice of Provider)
 - Provider Name
 - Date of Referral to MMCCM (within 3 calendar days of the date of service request and within 3 calendar days of the date of COP, if the COP is later than the date of service request; if they are the same date only one Referral to MMCCM is needed)
 - MMCCM/Provider Contacts (Before the COP, the required contacts must be made with the MMCCM. Following the COP, the required MMCCM/Provider contacts can be made with either the MMCCM or the Provider or both; refer to *Medicaid Managed Care Appendix T-2.*)

- Date Packet Submitted to MCO
 - Date Provider Packet received
 - Referral to PAL (if required)
 - Date of the PA Decision and the Date PA Notice Received by the agency (If a partial approval is received, enter this information and also enter in the Note Box that a Partial Approval was received. The Partial Approval will be followed by a Full Approval or Partial Denial notice.)
 - PA Approval and Dates: The outcome of the request for prior authorization should be recorded. Because the Support Coordinator is listed on the **Request for Prior Authorization** form, you should receive the notices that the Managed Care Organization or the PAL sends to the provider and the participant. If services are approved, record the specific number of hours and/or services approved and follow up with the participant to make sure that services begin and enter the service start date. If services are denied or partially denied, record the reason for denial. If the PA was not issued within 60 calendar days of the request, complete the explanation box.
 - Reminder Notice to MMCCM for Renewal: **20 - 60 calendar days prior to the date the services are scheduled to expire**, you should remind the MMCCM that the prior authorization needs to be renewed.
 - MCO Appeal Information: Within 4 calendar days from the notice of denial from the Managed Care Organization, the SC should contact the recipient to explain appeal rights and offer assistance; explain to the family that the provider can request a peer to peer review; record the date the appeal rights were explained, whether or not the participant is appealing or requests assistance with the appeal, and the date the appeal request was sent to the Managed Care Organization. Within 20 calendar days from the date the appeal request is filed check on the status of the appeal and record the decision and outcome. If the decision is upheld an appeal can be made to the Department of Administrative Law (DAL).
 - DAL Appeal Information: Within 4 calendar days from the notice of appeal denial from the Managed Care Organization, the SC will contact the recipient to review the appeals brochure with the participant; record the date the appeal rights were explained, whether or not the participant requests assistance with the appeal, and the date the appeal request was sent to LDH.
- When the reminder notice for renewal is sent to the MMCCM, a new EPSDT Prior Authorization Tracking Log should be started for the next PA cycle. The date the reminder notice is sent is the date of referral for a new tracking log. The date the participant chose to renew the PA with the provider is the COP date on the renewal. A

new Tracking Log should also be started when there are requests for changes to existing services or a change in the choice of provider.

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

- It will help you assure the participant is receiving the services requested;
- It will serve as a reminder to contact the provider/MMCCM if you have not received a copy of the Request for Prior Authorization form;
- It will serve as a reminder to make required PAL referrals;
- It will allow you to know at a glance when, and if, services were/were not approved;
- It will serve as a reminder of when the notice should be sent to the MMCCM to renew services;
- It will allow you to document information about the PA decision notice;
- It will allow you to document that you offered/provided appeal assistance to the participant and provided the **Appeals Brochure**.

Review the form and instructions completely before using them. If you have questions about this form, ask your trainer or your supervisor.

The **EPSDT LSCIS Service Log** should be used to provide a narrative of activities related to the request for EPSDT services including each activity and contact with the provider, the MMCCM, the participant, and the PAL. A separate service log should be used when possible to document activity related to a specific requested prior authorized service as identified on the EPSDT Prior Authorization Tracking Log.

The EPSDT LSCIS Service Log should be used for documenting all contacts with the participant, provider, the MMCCM and PAL. This log should also be used to document the receipt or the approval, denial or reduction of services, the monthly contact with the participant/family regarding the status of implementation of services, and all support coordination activities.

- **Participant contacts:** The support coordinator must make contact with the participant at **least monthly and as needed** until each service included on the CPOC is fully implemented, including receipt of all prior authorized services. **Monthly contacts** are to assure implementation of the services requested on the CPOC. Additional, **as needed contacts** may be required to determine a service start date after the PA is received, assist with identified needs and problems with providers, to follow up on obtaining information to complete a PA request, or to offer assistance with an appeal. (Refer to *Medicaid Managed Care Appendix T-1* for the contact flow sheet.)
- **Medicaid Managed Care Case Manager / Provider contacts:** The support coordinator must contact the MMCCM and/or Provider as needed, but at a minimum:

- **Within 15 calendar days from referral** to make sure they are working on the request and to see if assistance is needed in obtaining documentation to support the request;
 - If the support coordinator does not receive a copy of the Request for Prior Authorization form **within 35 calendar days of referral**; contact should be made with the provider/MMCCM again at that time to ensure the request has been sent to the Prior Authorization Unit;
 - Contact should be made if a notice of decision has not been received **10 calendar days after the date the provider submitted the request** or a call from the PAL has been received;
 - **20 – 60 calendar days prior to the date the services are scheduled to expire**, you should remind the MMCCM to renew the prior authorization request. (Refer to *Medicaid Managed Care Appendix T-2* for the MMCCM/Provider contact flow sheet.)
- **PAL contacts:** All contacts with the PAL must be documented. (Refer to *Medicaid Managed Care Appendix T-3* for the PAL contact flow sheet)

The Support Coordinator must document on the *EPSDT Prior Authorization Tracking Log* that a referral was made to the MMCCM. The Support Coordinator should complete the **Referral to Medicaid PAL Medicaid Managed Care Program** form (refer to *Medicaid Managed Care Appendix S-1, S-2, S-3* for a copy of this form) for the following reasons:

- When you have not received a decision within 60 calendar days from the Choice of Provider date;
- To alert the PAL of situations where the participant has chosen a new provider;
- To alert the PAL of situations where the participant has decided to stay with the provider and wait until the PA packet is submitted;
- To alert the PAL that a renewal approval has not been received and the previous PA has expired; or
- To alert the PAL that a provider is not providing services at the time the participant requested and/or the amount of services prior authorized and the problem cannot be resolved

Prior to sending the **Referral to LDH Medicaid PAL Medicaid Managed Care Program** (*Medicaid Managed Care Appendix S-2*), the Support Coordinator should document all contacts and all attempts to contact the MCO PAL and Medicaid Managed Care Case Manager on the **MCO PAL/Medicaid Managed Care Case Management Contact Form** (*Medicaid Managed Care Appendix S-3*). The Support Coordinator must attach the completed Referrals to Medicaid Managed Care Case Management (*Medicaid Managed Care Appendix Q*) along with all logs, referral forms, and e-mails related to resolving the issue with the MCO PAL.

If a decision has not been received for any prior authorized Medicaid service 60 calendar days following the selection of the service provider or renewal request, the participant's name and the type of service will be included on the **EPSDT Quarterly Report**.

QUARTERLY FACE TO FACE VISIT

The support coordinator must complete a face-to-face visit with the participant and parent/legal guardian each quarter in order to identify:

- Service needs and status through review of the CPOC
- Additional services requested
- Scheduling issues (update the Typical Weekly Schedule)
- Completion of the EPSDT CPOC Quarterly Review/ Checklist and Progress Summary located in LSCIS.

Each quarter the Support Coordinator must complete the **EPSDT CPOC Quarterly Review/ Checklist and Progress Summary in LSCIS**. The CPOC Quarterly Review form is participant specific and can be printed from LSCIS prior to the visit. A new Quarterly Review form can be obtained by entering an interim or an annual CPOC. This form is a reminder to the Support Coordinator about each service the person requested and provides assurance the services are being delivered for the correct amount of time and on the agreed upon days. More importantly, the **EPSDT CPOC Quarterly Review/Checklist and Progress Summary** provides a forum for discussion with the participant regarding their satisfaction with the services they are receiving. If any complaints are detected as a result of the **EPSDT CPOC Quarterly Review/Checklist and Progress Summary**, the participant should be given the **Participant Complaint** form (*Appendix M*) to complete and return to Health Standards. If the Support Coordinator detects the participant has any dissatisfaction with a service provider, it is the Support Coordinator's responsibility to assist the participant in resolving any problem and let the participant know of his/her right to change providers. If the participant has a complaint against their Managed Care Organization they should be given the Medicaid Managed Care Program Assistance Line at 1-888-342-6207 or the complaint can be e-mailed to healthy@la.gov. The Quarterly face to face visit can be completed at the location of the participant's or parent/legal guardian's choosing. CPOC meetings must be held at the participant's home.

EPSDT QUARTERLY REPORT

The EPSDT Quarterly Report will be completed for each support coordination agency from information entered into LSCIS. Each agency must have all of the required information entered into LSCIS at the end of each quarter so that the report can be generated. It is the responsibility of the Agency to identify participants with a PA not issued within 60 calendar days of the participant's request. As part of that identification, the Agency must review all

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

- The report will include the names of the participants and the services for the following:
 - Participants with PAs not issued within 60 calendar days
 - Participants with service gaps in the authorization period
 - Participants who submitted requests for appeals within the quarter
- The **Record Review for the Quarterly Report** is to be completed for each participant/service listed on the LSCIS Quarterly Report as not having a PA issued within 60 calendar days or a Gap in Authorization Period. If no gap is found or the gap was due to the family's choice fill out page one of the Record Review to document this and then remove it from the Quarterly Report.
- Either the number of trackings without a choice of provider must be zero or documentation and explanation must be attached for each participant and service without a choice of provider.
- The EPSDT Specialist, if they are not the Support Coordinator involved, is to complete the form. If the Support Coordinator involved in these cases is the EPSDT Specialist, the onsite manager and supervisor are to complete the form.
- BHSF/SRI and the LDH attorney will review the information to assure that the participants are receiving the services they need and the assistance they need to access the services. BHSF/SRI will request supporting documentation and information from the support coordination agencies as needed.

PRIOR AUTHORIZATION LIAISON

The Prior Authorization Liaison (PAL) was established to assure that requests for prior authorization are not denied simply because of a lack of documentation. The prior authorization unit, which is at DXC (for legacy Medicaid recipients) and at each Managed Care Organization (for Medicaid Managed Care enrollees), should not deny a request that has a technical error such as overlapping dates of services, missing or incorrect diagnosis codes, incorrect procedure codes, or having a prescription that is not signed by the doctor. These requests for prior authorization are given to the PAL.

The PAL contacts the provider, Support Coordinator and participant when attempting to gather the correct information for resubmission to DXC (for legacy Medicaid recipients) and at

each Managed Care Organization (for Medicaid Managed Care enrollees), so a final decision regarding approval or denial of service can be made.

The first of these contacts may be by phone or fax. If the problem is not resolved in a few days, the PAL will send a Notice of Insufficient Documentation to the provider, participant, and Support Coordinator. This notice advises of the specific documentation needed and the type of provider that can supply it. The participant has 30 calendar days to either supply the needed documentation, or notify the PAL with the appointment date that has been made with the health professional to obtain it. The Support Coordinator should assist the participant in this process.

The provider submitting the request is instrumental in gathering the required information when contacted by the PAL. However, the Support Coordinator should work very closely with the provider and offer any assistance possible to assure that DXC receives all necessary information to make the decision that is in the participant's best interest.

The Legacy Medicaid PAL can be reached at 1-888-758-2220 or 225-342-6711. See *Medicaid Managed Care Appendix A* the Medicaid Managed Care PAL contact information.

EMERGENCY PRIOR AUTHORIZATION REQUESTS

Louisiana Medicaid has provisions and procedures in place for emergency authorization requests. *A request is considered an emergency if a delay of 25 calendar days in obtaining the medical equipment or supplies would jeopardize the health of the recipient.*

The items listed below are examples of medical equipment and supplies considered for emergency approval. However, other equipment will be considered on a case by case basis through the Prior Authorization Unit (PAU).

- Apnea monitors
- Breathing equipment
- Enteral therapy
- Parenteral therapy (must be provided by a pharmacy)
- Suction pumps
- Wheelchair rentals for post-operative needs and items needed for hospital discharge

To submit an emergency request for PA for a legacy Medicaid recipient, the provider may call the Prior Authorization Unit (PAU) at 1-800-488-6334. NOTE: Emergency requests cannot be submitted via e-PA. To submit an emergency request for a PA for a Managed Care Organization recipient see *Medicaid Managed Care Appendix A*, escalation contacts.

In the event of an **emergency medical need where a delay of twenty-five (25) calendar days would jeopardize the health of the recipient**, a request for prior approval shall be permitted orally or by telephone and the item shall be supplied upon oral approval. All emergency requests shall be approved or denied generally within twenty-four (24) hours of the request, but in no case later than the working day following the request.

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

APPEALS

For services authorized by the Medicaid Managed Care Program that are denied or partially denied, the participant/family, provider, and the Support Coordinator will receive notice of denial. The MCO PAL shall contact by phone the participant/family, provider, and the Support Coordinator to explain the documentation needed and possible sources of that documentation. If 10 calendar days passes after the MCO PAL phone call, the MCO PAL shall provide written notice to the participant/family, provider, and the Support Coordinator that:

- Describes the missing information, how to obtain it, the suggested type of provider(s) it can be obtained from, and an explanation of how it can be submitted and how to contact the MCO PAL with questions.
- Provides the timeline to submit the missing information.
- Includes a form to return to the PAL with date of appointment and name of provider.
- The notice will explain how any provider can contact the PAL to find out what information is needed.
- Each plan must: Provide the enrolled a reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing. The MCO must inform the enrollee for the limited time available for this in the case of expedited resolution (i.e. if you have an emergency health issue you can ask for a faster fair hearing); and provide the enrollee and his or her representative opportunity before and during the appeals process to examine the enrollee's case file including medical records, and any other documents and records considered during the appeals process.

The Managed Care Organization's prior authorization unit may deny the request for any prior authorized services if no additional information is received nor notice that the enrollee has made an appointment with a provider to obtain the needed documentation within 30 calendar days of the issuance of the notice described above. If services are denied or partially denied, the participant/family may appeal the decision by following the appeals procedures sent to them, the provider, and the Support Coordinator by the Managed Care Organization

following the denial or partial denial. The participant may appeal the denial of part of the requested services, and still receive the amount that was approved. The participant should be assured that the fact that he or she files an appeal will not result in losing the services that were approved. The support coordinator must inform the participant of his/her Appeal rights, go over the Appeals Brochure that both parties received from the Managed Care Organization, and offer to assist the participant with the appeal process/fair hearing if the participant decides to request an appeal. If the internal Managed Care Organization appeal decision is upheld, the participant/family has the right to appeal to the Department of Administrative Law. See *Medicaid Managed Care Appendix T-1 and F*.

For participants with Legacy Medicaid or for those with the Medicaid Managed Care Program after the internal appeal process has been exhausted: If services are denied or partially denied, the participant/family may appeal the decision by mailing or faxing a written request for a fair hearing to the Division of Administrative Law (“DAL”), Health and Hospitals Section. The participant/family can also complete an online form on the Division of Administrative Law’s website “Medicaid & Health Cases” section via: <http://www.adminlaw.state.la.us/HH.htm>. Telephone appeals are also allowed, but are not encouraged. The denial notice will need to be included with the appeal. They can scan it and attach it to the online submission form, fax it to (225) 219-9823, mail it to the DAL, or e-mail it to: LDHProcessing@adminlaw.state.la.us. If they filed the request on the DAL website and are sending the notice by means other than scanning and attaching, they should indicate that the appeal request was filed online. The participant may appeal the denial of part of the requested services, and still receive the amount that was approved. The participant should be assured that the fact that he or she files an appeal will not result in losing the services that were approved. The support coordinator must inform the participant of his/her Appeal rights, provide the participant with an Appeals Brochure, and offer to assist the participant with the appeal process/fair hearing if the participant decides to request an appeal. A copy of the Appeals Brochure can be found as *Appendix L*. The Appeals Brochure contains the procedures for filing an appeal request. The following is a more detailed description of the appeal process.

Deadlines

For participants with Legacy Medicaid or for those with the Medicaid Managed Care Program after the internal appeal process has been exhausted, appeals with the Department of Administrative Law must be filed within 30 calendar days of the denial notice or the agency will not consider them. Because of this deadline, you should discuss denial notices and partial denial notices with the participant as soon as they are received. Appeals are filed via phone call, fax, online submission or by sending a letter to the DAL. See *Appendix L*. If a recipient chooses to appeal, the SC should follow-up with the participant within 20 calendar days of the appeal being filed to check on the status and see if any assistance is needed.

Continued services while awaiting a decision

For services to be continued pending the outcome of the appeal, a participant must file an appeal on or before the effective date of the action or within 10 days, whichever is longer. However, if the 30-calendar-day deadline for filing an appeal lapses before the effective date of the action, services are continued when the appeal is filed within the 30 calendar day period.

For services to be continued, all of the following must be true:

- The service is one the participant had been receiving.
- A request for renewal of the service is denied (or fewer services are approved than were in place before).

If a person continues to receive services during the appeal, and the appeal is lost, the CCM could be responsible for paying the cost of the services received while the appeal was pending.

Reconsideration

An alternative to requesting a fair hearing is for the provider that submitted the request for services to submit for “reconsideration” of a denial or partial denial.

The request for reconsideration has to be based on some *new documentation* that the provider submits to Medicaid with the request.

Requests for reconsideration are especially appropriate when a denial or partial denial is based on Medicaid not having enough documentation showing the necessity for a service. (This includes instances where Medicaid sent a letter requesting more documentation and no one responded to the letter within 30 calendar days. Any time such a notice is sent, if further information is not provided, the request for prior approval *will* be denied.)

To request a Reconsideration (Recon), providers should submit the following:

- A copy of the denial notice with the word “RECON” written across the top of the notice and the reason for requesting the reconsideration written at the bottom of the letter.
- All of the original documentation attached as well as any additional information or documentation which supports medical necessity.

DXC physician consultant(s) will review the reconsideration request for medical necessity. When a decision is made on the reconsideration request, a new appealable notice is issued.

Representation

It can be helpful to have an attorney experienced in these types of hearings to represent the participant regarding his/her appeal. Because the attorney may need to collect medical documents or may want to negotiate ahead of time with the agency, it is important to seek an attorney as early as possible in the process. Free representation by an attorney may be

available through the Disability Rights Louisiana (1-800-960-7705); Disability Rights Louisiana also should have the phone number for a local Legal Services office that might be able to help.

What happens after a fair hearing is requested?

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

Preparing for the fair hearing

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

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

The participant and anyone helping the participant should start seeking any medical records or other documents that could help show their situation and need, as soon as possible, even before receiving the Summary of Evidence.

They should also be talking to people, especially health professionals, who can speak at the hearing or send documents on behalf of the participant.

The participant should contact DAL (1-225-342-0443) if they need to make arrangements to fax in exhibits or for witnesses to call in to the hearing.

The participant or their representative can review all documents Medicaid and DXC have in their possession. Arrangements should be made through staff at the DAL (1-225-342-0443), if documents need to be reviewed.

What happens at the fair hearing?

If it is a telephone hearing, the Administrative Law Judge will be listening by speaker phone. (Some other witnesses may also participate by phone, for instance, prior approval staff from Baton Rouge.) If the hearing is held in person, it is held in a hearing room at the DAL.

At the hearing the Administrative Law Judge tape records the hearing, and begins by swearing in all who have facts to offer to help him/her reach a decision, and will summarize what seems to be at issue. Then the agency presents its side, typically by reading into the record the Summary of Evidence that it mailed out. The agency occasionally will offer

testimony from DXC staff including one of their physicians, to explain their rationale of the decision.

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

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

The participant may ask his/her doctor or a nurse to participate, if the medical necessity of a service is at issue. Doctors are often allowed to testify by phone if this is arranged in advance with the Administrative Law Judge.

The Administrative Law Judge and LDH staff can ask questions of anyone who speaks for the participant.

If arrangements were not made in advance, and a document you have not seen seems pertinent at the hearing, a request to see it can be made then, and the Administrative Law Judge should arrange access to it. Similarly, if at the hearing you realize something else should be submitted for the Administrative Law Judge to see, you can ask that he or she allow you additional time to mail it in.

Remember that just because someone says something, does not make it true. If you or the participant say something, it is best to back it up with other records, such as medical records, if possible.

The Administrative Law Judge does not usually announce his or her decision at the hearing. Occasionally, he or she may encourage the people at the hearing to work out a solution to a problem in advance of any decision. The Administrative Law Judge will mail his or her written decision, which will also summarize what was said at the hearing. These decisions can be appealed to court.

Regardless of whether or not the support coordinator is assisting with the appeal, the support coordinator must follow-up with the participant within 20 calendar days of the appeal request to see if he/she has received a response, and/or needs additional assistance. The support coordinator should follow-up again with the participant at least 90 calendar days after the appeal was sent to check on the final decision regarding the appeal.

The Support Coordinator's File

If a participant's service is denied or partially denied, the Support Coordinator's files (EPSDT Prior Authorization Tracking Log and EPSDT LSCIS Service Log) should document:

- that the participant was informed of appeal rights;

- that the participant was given the appeals brochure;
- that the Support Coordinator offered to assist with an appeal;
- if assistance was given on the appeal:
 - the coordination of documents;
 - the submission of documents to the appeals office or if no documentation was available;
 - the date the appeal was filed;
- if the Support Coordinator did not assist with the appeal, the reason assistance was not provided; and
- if an appeal was filed, the response to the appeal and the final decision.

IDENTIFICATION OF CHRONIC NEEDS

As request for prior authorization is reviewed, the participant requesting the service may be deemed as eligible for Chronic Needs status. If this occurs, providers, participants and Support Coordinators will receive an approval letter with the following codes for legacy Medicaid:

- 822 – Participant has been deemed as a “Chronic Needs case.” Write “Chronic Needs” on top of the next P.A. Request.
- 823 – Submit only P.A. form & doctor’s statement stating condition of patient has not changed.

Once a situation has been deemed a chronic needs case, the provider must submit future packets according to the instructions provided by the above codes. This determination only applies to the services approved where requested services remain at the approved level. Requests for an increase in these services will be treated as a traditional PA request and will be subject to full review.

If “Chronic Needs Case” is not written on the P.A. form, the packet will be reviewed as routine and must have new and complete supporting documentation. Unless these codes were included, do not assume DXC will know *anything* about the documentation submitted during earlier times that prior approval was requested for the same service.

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

ADJUSTMENTS TO THE CPOC

The CPOC should be updated to reflect the changes if prior approval of a requested service is denied (and not successfully challenged through a fair hearing request or other advocacy).

Changes to the CPOC should also be made when:

- Strategies are needed to deal with problems with services or providers. Resolving problems and overcoming barriers to participants' receiving services is a key goal of the CPOC process.
- Significant new information is obtained from a medical appointment or assessment, including a psychological and behavioral services assessment. The CPOC should be updated and goals and objectives should be added and/or revised according to the most recent information available. The Typical Weekly Schedule should also be revised to reflect the changes

A list with the names of participants that have a revised/updated CPOC must be submitted to SRI with the Quarterly Report for each quarter that significant changes are made to the CPOC (Refer to *Appendix W*).

Part IV – Other

EPSDT DOCUMENTATION

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

Progress notes must be of sufficient content to reflect descriptions of activities and cannot be so general that a complete picture of the services and progress cannot be drawn from the content of the note, i.e., general terms such as "called the participant" or "supported participant" or "assisted participant" is not sufficient and does not reflect adequate content. Check lists alone are not adequate documentation.

Service logs must support the activity that is billed and provide enough narrative documentation/information to clearly identify the activity and the participants. BHSF allows the support coordinators of EPSDT services to utilize the service log to document required "progress notes" and "progress summaries."

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

All notes, summaries and service log entries in a participant's record should include:

- Name of author/person making entry

- Signature of author/person making entry
- Functional title of person making entry
- Full date of documentation
- Signature or Initials indicating review by supervisor, if required
- **If electronic, strongly prefer you do not use all caps.** Must be legible and if hand written, in ink.
- Narrative that follows definition for the type of documentation used.

Service Logs: Chronology of events and contacts which support justification of critical support coordination elements for Prior Authorization (PA) of services in the LSCIS system.

- All contacts with participant, provider, PAL, LDH Program Staff Line, etc. should be documented on a service log.
- Identify who the contact was with (i.e. participant, guardian, provider, etc.)
- Each service contact is to be briefly defined (i.e. telephone call, face to face visit) with a narrative in the form of a progress note.
- EPSDT support coordinators are to utilize the service log to document “Progress Notes.” **Progress Notes:** Narrative that reflects each entry into the service log and elaborates on the substance of the contact.

Monthly Contacts: Assure implementation of requested services and document:

- If the services are received.
- If the participant/family is satisfied with the services and their provider. If not satisfied, document the offer of FOC and response. Offer to switch providers if service not received or if not received in the amount PA’ed or at the times desired.
- Any assistance provided with identified needs and problems with providers.
- Offer of services for identified needs.
- The Freedom of Choice.
- Information regarding the requirements to obtain a PA for the services requested was given to the family/participant.
- Follow up on obtaining information to obtain the PA request.
- Assistance with appeals.
- Determination of service start date after the PA is received.
- If the participant is progressing with the current services and/or IEP services.
- Meetings/discussions about continuing to receive additional services during the school year, over and above what the IEP required.
- Meetings/discussions about continuing to receive the IEP services during the summer months. If summer therapies are requested, they are to be entered in the CPOC Service Needs section. PA tracking is to begin 60-45 calendar days prior to the last day of

school. (If the service is requested prior to this, the parent should be obtaining the Rx so it can be submitted with the referral.) SC is to document if the Rx is not obtained due to physician refusal, parent did not schedule a required doctor visit, etc. SC is to document any barriers to obtaining the Rx and SC attempt to remove them.

- Any behavior concerns or issues.

Quarterly Review/Progress Summary: Summary that includes the synthesis of all activities for a specified period which addresses significant activities, summary of progress/lack of progress toward desired outcomes and changes to the social history. This summary should be of sufficient detail and analysis to allow for evaluation of the appropriateness of the current CPOC, allow for sufficient information for use by other support coordinators or their supervisors, and allows for evaluation of activities by program monitors. (Note: The service log and LSCIS Quarterly Review Form must be used for this documentation.)

- Completion of the LSCIS Quarterly Review Form and narrative is required.
- Add a CPOC of the appropriate type (Interim or Annual) before doing the quarterly review. Note: The Annual CPOC meeting cannot be conducted more than 90 calendar days prior to the expiration of the CPOC (refer to CPOC Updates Report for First CPOC Meeting Date and Next CPOC Due date). **A Quarterly Review will not be counted on the required action report if the participant does not have a PA for SC at the time of the quarterly meeting.** (Example: If the CPOC was submitted late, either on an initial or an annual, your PA will start or pick up the date the approvable CPOC was submitted. If the case transfer of record was not signed at the time of the face to face visit, you will not have a PA.)
- Update any information that you are aware of in the service needs and support section. This will place identified services and supports from the CPOC onto the Quarterly Review form.
- Print out the CPOC with the Quarterly Review form. Service Needs will then be on the form for you to take to the face to face meeting.
- Conduct the Quarterly Review using the information from the printed copy of the CPOC and Quarterly Review. A service strategy list is printed below the service needs section to assist in identifying additional service needs.
- Individuals participating in the meeting are to sign and date the paper copy. List the SC as an attendee.
- When entering the information into LSCIS update the CPOC information and enter any newly requested services on the new CPOC before completing the LSCIS Quarterly Review. The modified and newly requested services will then appear on the LSCIS Quarterly Review form so that they can be addressed.

- Complete the LSCIS Quarterly Review. All sections of the Quarterly Review form must be completed including the progress/status of each service need and the narrative. One complete document is required for monitoring, rather than two partial records.
- The service needs section of the Quarterly Review should document if services are received and if the participant/family is satisfied with their services and their providers.
- Address if the participant is receiving the amount of services as Prior Authorized, service needs and status, additional service requests, scheduling issues, etc.
- Document if the participant is progressing with the current services and/or IEP services.
- Document the FOC and information regarding the requirements to obtain a PA for the services requested was given to the family/participant.
- Document discussion with the family/participant regarding the continuation of IEP services and/or additional services during the summer.
- The SC date is the date of the meeting, not the date the log was entered.
- Complete a service log. The service log can state, "Refer to the Quarterly Review on xx/xx/xxxx."
- File the CPOC Quarterly Review signature page.
- Do not write over a previous CPOC Quarterly Review. Each Quarterly Review document must be maintained in LSCIS.

Assisting with Appeals:

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

Notice of Insufficient Documentation (NOID):

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

Service logs regarding PA Tracking:

- When entering a service log for a **15 day or 35 day MMCCM/Provider contact**:
 - Activity code is either:
 - 78 EPSDT Medicaid Managed Care Case Manager Follow-up

- 68 EPSDT Provider Follow-up
 - When you enter one of these activity codes a PP box (Provider/PAL) will pop-up next to it and you need to select either 15 or 35 to indicate if it was the 15 day or 35 day Provider/MMCCM Contact.
 - The Service Participant code is either:
 - 20 Medicaid Managed Care Program
 - 13 Medicaid Provider
 - Select the appropriate service need from the drop down box.
 - For **Legacy Medicaid**, the date will be populated into the appropriate tracking log in the pink boxes, either “15 Day Provider/MMCCM Contact Date” or “35 Day Provider/MMCCM Contact Date.”
 - For a **Medicaid Managed Care enrollee** if the COP date was after the Date of Service Request and the type of request is Initial or Change in Service:
 - If the 15 day and 35 day contacts are made before there is a COP, the contacts will need to be made with the MMCCM and LSCIS will display those dates in the pink boxes labeled “15 Day Provider/MMCCM Contact Date” and “35 Day Provider/MMCCM Contact Date.”
 - If the 15 day and 35 day contacts are made after the Date of COP, the contacts can be made with either the MMCCM or the provider and LSCIS will display those dates in the teal area in the pink boxes labeled “2nd 15 Day Provider/MMCCM Contact Date” and “2nd 35 Day Provider/MMCCM Contact Date.”
 - For a **Medicaid Managed Care enrollee** if the type of request is Renewal or if the COP date is the same as the Date of Service Request and the type of request is Initial or Change in Service:
 - The 15 day and 35 day contacts will be made after the COP so the contacts can be made with either the MMCCM or the provider and LSCIS will display those dates in the pink boxes labeled “15 Day Provider/MMCCM Contact Date” and “35 Day Provider/MMCCM Contact Date.”
 - Note for **Medicaid Managed Care Enrollees**: Once you have the COP date entered LSCIS will ignore the 1st set of referral/contacts and prompt you to complete the “2nd Referral” within 3 calendar days of the Date of COP followed by the 2nd 15 day and 35 day contacts. Once you know the COP you can stop where you are on the 1st set of referral/contacts and move on to the 2nd set.
- When entering a service log for a **EPSDT PAL Referral**:
- Activity code is 69 EPSDT PAL Referral
 - When you enter that code, a PP box will pop-up next to it and you need to select either 35 or 60 to indicate if it was the 35 or 60 day PAL.

- Service participant code is 15 PAL.
- Select the appropriate service need from the drop down box.
- The date will be populated into the appropriate tracking log in the pink boxes, either the “Date of Referral to PAL (Untimely PA Packet Submission)” if 35 was selected or in the “Date of Referral to PAL (Untimely PA Notice)” if 60 was selected.

***35 day PALs for untimely PA packet submission are not required for Medicaid Managed Care services. Follow up with the MMCCM and provider if you have not received the PA packet within 35 calendar days of the referral notifying MMCCM of the COP.

***PALs for Medicaid Managed Care enrollees are sent to the LDH PAL – not the MCOPAL.

- When entering a service log for **EPSDT Appeal Follow-up**:
 - Activity code is 70 EPSDT Appeal Follow-up
 - When you enter that code, a PP box will pop-up next to it and you need to select either 20 or 90 day to indicate if it was the 20 or 90 Appeal Follow-up.
 - Service participant code is either:
 - 01 Recipient
 - 02 Parent or Legal Guardian
 - Select the appropriate service need from the drop down box.
 - The date will be populated into the appropriate tracking log in the pink boxes, either the “20 Day Appeal Follow Up” or “90 Day Appeal Follow Up.”

PA Tracking Log:

- Documents the coordination process of services that require Prior Authorization. Entries must be up to date to verify services and PA information. Refer to the Tracking Prior Authorization Requests for Legacy Medicaid or for Medicaid Managed Care Enrollees section of this handbook for additional information (page 59 and 63, respectively).
- Complete all required boxes as applicable (Refer to *Appendix O* for a screenshot of the LSCIS PA Tracking Log to see all boxes):
 - **Type of Service Requested** – the service must be listed on the CPOC under service needs; Medicaid/and Requires PA Tracked by SC must be checked to enter a tracking log.
 - **Type of Request:**
 - Initial – means the service has never been PAed before
 - Change in Service – the participant/family is requesting a change in provider or other change like change in hours requested

- **Renewal** – means the service has a prior PA and a renewal / new PA is being requested
- **Amount of Requested Service** – can be obtained from the PA packet or from the PAL after the packet has been submitted.
- **Date of Service Request** – this is the date the participant/family informed you that they wanted the service. On renewals, this date will remain the same as the previous tracking log.
- **Date of COP** – this is the date the participant/family informed you of their chosen provider for the requested service. On renewals, this is the date the family informed you they wanted to continue services with their current provider.
- **Date of Referral to Provider/MMCCM** – For Legacy Medicaid, this is the date you sent the Referral to Provider (Appendix S) to the provider. For the Medicaid Managed Care Program, this is the date you sent the Referral to MMCCM (Medicaid Managed Care Appendix Q) to the MMCCM.
- **15 Day and 35 Day Provider/MMCCM Contact** – these dates are auto-populated from your service logs. Refer to EPSDT Documentation section of this Handbook, page 77-78 for additional information. For the Medicaid Managed Care Program, once you know the COP you can complete the 15 day and 35 day contacts with either the provider or MMCCM.
- If participant is with the Medicaid Managed Care Program and the COP date is after the Date of Service Request the “2nd Referral” and 2nd 15 Day and 35 Day Contacts” will pop-up on all Initial and Change in Service tracking logs:
 - **Date of 2nd Referral to Provider/MMCCM:** date you sent the Referral to MMCCM (Medicaid Managed Care Appendix Q) to the MMCCM notifying them of the request for service and the COP. Refer to EPSDT Documentation section of this Handbook, page 80-81 for additional information.
 - **2nd 15 Day and 2nd 35 Day Provider/MMCCM Contact Date** - these dates are auto-populated from your service logs. Refer to EPSDT Documentation section of this Handbook, page 80-81 for additional information.
- **Date Packet Submitted to DXC/MCO** – this is the date the provider or MMCCM informed you the PA Packet was submitted to DXC or MCO.
- **Date Provider PA Request Packet Received** – if you received the PA Packet from the provider, enter the date here. If you did not receive the PA packet, check the “Not Received” box next to this space.
- **Date of Referral to PAL (Untimely PA Packet Submission)** - this date is auto-populated from your service log. Refer to EPSDT Documentation section of this Handbook, page 81-82 for additional information.
- **Date of Referral to PAL (Untimely PA Notice)** – this date is auto-populated from your service log. Refer to EPSDT Documentation section of this Handbook, page 81-82 for additional information.

- Obtain the following information from the PA notice. If the PA notice is not received, the PAL can give you the following information over the phone. Do not take verbal information from providers.
 - **Date of Decision**
 - **Date PA Notice Received** – this is the date you receive the hard copy of the PA notice or the date you received the verbal PA from the PAL.
 - **Amount of Service Approved**
 - **PA Begin Date**
 - **PA End Date**
- **Service Start Date** – this is the date the provider or family reports services began.
- **PA Issued within 60 day of Request** – LSCIS will automatically enter Yes or No.
- **Explanation, if not issued** – use this note box to document why the notice wasn't received, barriers and strategies to obtain.
- **Date Renewal Sent and new tracking started** – For Legacy Medicaid, this is the date you sent the Referral to Provider (Appendix Q) to the provider notifying them of the need for a renewal. For the Medicaid Managed Care Program, this is the date you sent the Referral to MMCCM (Medicaid Managed Care Appendix Q) to the MMCCM for participants with the Medicaid Managed Care Program notifying the MMCCM of the need for a renewal.
- **Approval/Denial Status** – document if the participant received a full or partial approval or a full or partial denial.
- **Reason for Denial** – use this note box to document why the denial was issued.
- **If Medicaid Managed Care Program:**
 - **Date MCO Appeal Rights Explained**
 - **Offered to help with MCO Appeal Date**
 - **Is Participant Appealing**
 - **Request Assistance with MCO Appeal**
 - **30 Day MCO Appeal Follow Up**
 - **Date of MCO Appeal Decision**
 - **MCO Appeal Outcome**
 - **MCO Appeal Notes**
- **Date Appeal Rights Explained**
- **Date Appeal Brochure Provided**
- **Offered to help with Appeal Date**
- **Request Assistance with Appeal**
- **Date Appeal Sent to LDH**
- **45 Day / 90 Day Appeal Follow Up** - these dates are auto-populated from your service logs. Refer to EPSDT Documentation section of this Handbook, page 82 for additional information.
- **Date of Appeal Decision**
- **Appeal Outcome**

- **Notes-** Use the comment box on the PA Tracking Log to leave a trail of what has occurred. If PA tracking is unchecked, it's helpful to leave a note as to why in this box in addition to the Additional Info section of the CPOC.
- If a Partial Approval is received:
 - Enter the Partial Approval in the PA tracking Log.
 - Document in the Tracking Log note box that a partial approval was received.
 - Document if the Support Coordinator and family are working with the PAL.
- Only void a PA Tracking Log if it was entered in error. Otherwise,
 - Uncheck PA Tracking in the Service Needs section if the tracking is not required. When this is done, the tracking required actions will no longer show up on your Tracking Required Action report.
 - Enter a PA tracking log and it will replace the prior tracking log.

Medicaid Managed Care Program PA Tracking Logs:

There are four different scenarios for Medicaid Managed Care Program PA Tracking Logs that will determine what actions you are prompted to complete and what boxes are displayed on the tracking log:

- 1) On Initial and Change of Service PA Tracking Logs when the Date of Service Request and the Date of Choice of Provider (COP) are the same:
 - a. You will complete one Referral to Medicaid Managed Care Case Management Form and input that date in the Date of Referral to Provider/MMCCM cell. The 2nd Referral teal boxes will not be displayed.
 - b. LSCIS will then prompt you, "Must make 15 Day Provider/MMCCM contact to check on PA packet status" and "Must make 35 Day Provider/MMCCM contact to check on PA packet status." You can complete these contacts with either the provider or the MMCCM or both using codes 68 EPSDT Provider Follow-up or 78 EPSDT Medicaid Managed Care Case Manager Follow-up.
- 2) On Initial and Change of Service PA Tracking Logs when the Date of Service Request is entered but, there is no Choice of Provider (COP):
 - a. A set of teal colored boxes will be displayed which have the following cells: "Date of 2nd Referral to Provider/MMCCM", "2nd 15 Day Provider/MMCCM Contact Date", and "2nd 35 Day Provider/MMCCM Contact Date."
 - b. LSCIS will prompt you that a Choice of Provider must be made until a Date of COP is entered.
 - c. LSCIS will prompt you to **complete the 1st Referral to Provider/MMCCM within 3 calendar days of the Date of Service Request** to notify the MMCCM that the participant wants a particular service and LSCIS will prompt you to complete the 15 day and 35 day contacts using the same prompts as above. Since you do not know the provider, the 15 day and 35 day contacts will be completed with the MMCCM using code 78 EPSDT Medicaid Managed Care Case Manager Follow-up.

- d. **Once a COP date is entered**, the first set of Referral/15 day/35 day contacts do not need to be completed if you have not done so already as you will move on and LSCIS will prompt you to **complete the 2nd Referral to Provider/MMCCM within 3 days of the COP** to notify the MMCCM that the participant chose a provider and to complete the 2nd 15 day and 2nd 35 day contacts. If the 15 day and 35 day contacts are made after the Date of COP, LSCIS will display those dates in the pink boxes labeled “2nd 15 Day Provider/MMCCM Contact Date” and “2nd 35 Day Provider/MMCCM Contact Date.” Since you now know the provider, you can complete these contacts with either the provider or the MMCCM or both using codes 68 EPSDT Provider Follow-up or 78 EPSDT Medicaid Managed Care Case Manager Follow-up.
- 3) On Initial and Change of Service PA Tracking Logs when the Choice of Provider date is later than the Date of Service Request:
 - a. Once you have the COP date entered LSCIS will ignore the 1st set of referral/contacts and prompt you to complete the “2nd Referral” within 3 days of the Date of COP followed by the 2nd 15 day and 35 day contacts. Once you know the COP you can stop where you are on the 1st set of referral/contacts and move on to the 2nd set. Since you now know the provider, you can complete these contacts with either the provider or the MMCCM or both using codes 68 EPSDT Provider Follow-up or 78 EPSDT Medicaid Managed Care Case Manager Follow-up.
 - 4) On Renewals: The Date of Service Request will remain the same as the previous tracking log and the Choice of Provider date will be a later date when you confirmed with the family that they wanted to stay with their current provider. The 2nd Referral teal boxes will not be displayed.
 - a. You will complete one Referral to Medicaid Managed Care Case Management Form to remind the MMCCM to renew the PA and input that date in the Date of Referral to Provider/MMCCM cell.
 - b. LSCIS will then prompt you, “Must make 15 Day Provider/MMCCM contact to check on PA packet status” and “Must make 35 Day Provider/MMCCM contact to check on PA packet status.” You can complete these contacts with either the provider or the MMCCM or both using codes 68 EPSDT Provider Follow-up or 78 EPSDT Medicaid Managed Care Case Manager Follow-up.

PA NOTICES

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

Types of PA Notices:

1) Notice of Insufficient Documentation

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

2) Partial Approval

- Partial Approval means there is enough documentation to approve some of the request. The rest is sent to the PAL to notify that more documentation is required.
- A final Partial Denial will be issued if the information is not received or if the service is not medically necessary or a Full Approval will be issued if additional information is received to support the medical necessity. If a partial denial is received as a final decision it can be appealed.
- Partial Approvals do not need to be appealed if the family can get the additional information to get an Approval.
- Partial Approvals are done so that the family can start receiving some of the service.
- If the participant asks for 8 hours and DXC has enough documentation to partial approve 4 hours, the participant can get the 4 hours without accepting the decision. They can appeal for the other 4 hours later, if a Partial Denial occurs. They do not need to do anything to receive the hours that are partial approved.
- If the participant/family does not want to work with the PAL or submit additional information, they can do an appeal now.
- Why was the full approval denied? What was denied? Was it due to a dollar amount but the correct product amount was received?

- If the PA is for PCS, exactly what help does the family need or want? Is it PCS for ADLS or IADLs, respite, homework assist, someone to take in the community, do they want family to be paid for services provided, etc.?
- Discuss what was approved and what needed tasks are not included in the PA. Are additional hours still requested?
- Offer to assist the family in obtaining the information from the provider.

3) Partial Denial/Full Denial

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

*Assisting with Appeals – See Appeals Section in this Handbook page 71, Appendix L, Appendix T-1, Medicaid Managed Care Appendix T-1, and LSCIS PA Tracking log.

WHAT HAPPENS AT AGE 21?

When participants turn 21, they become ineligible for some of the services they had qualified for under Medicaid, including support coordination, EPSDT Personal Care Services, Extended Home Health Services, Disposable Incontinence Products, and other items or services that are not part of Medicaid offerings for adults.

It is very important, therefore, for the Support Coordinator to learn about the services that will be available at age 21, and to make arrangements to transition participants to receive all services they may need in order to continue to live in the most integrated setting that is appropriate for them.

The Support Coordinator should begin making arrangements for transition at least 6 months prior to the participant's 21st birthday.

Available services may include:

- OCDD services, including (in addition to those listed above) extended family living, supported independent living, and vocational and habilitative services. Contact the local District/Authority to request ID/DD supports. Local District/Authority contacts can be found on *Appendix G*.

- Behavioral Health Rehabilitation Services - The provider agency may need to be changed if the current provider only services children.
- Long Term - Personal Care Services (LT-PCS) through Medicaid (1-877-456-1146 (TDD 1-855-296-0226)). A representative from Conduent will be contacting the participant a couple of months before the participant turns age 21 to assist him/her with the LT-PCS application process. All efforts will be made to utilize the existing medical information on file when determining the participant's eligibility for this service; however, the participant may be asked to have his/her doctor complete a medical assessment form. The support coordinator should inform the family to expect notification via phone or mail.
- OAAS Community Choices Waiver and Adult Day Health Care Waiver services Call 1-877-456-1146 (TDD 1-) 855-296-0226 to be placed on a waiting list. Only individuals without a Statement of Approval for Developmental Disability services through OCDD can be added to the OAAS waiting lists such as those participants receiving Special Needs Support Coordination.
- Louisiana Rehabilitation Services may provide assistance with services needed to pursue short or long-term employment goals including higher education.

SUPPORT COORDINATION TRANSITION/CLOSURE

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

Closure Criteria

Support Coordination services closure criteria include but are not limited to the following:

- The participant/family requests termination of services;
- The participant/family chooses to transfer to another support coordination agency;
- The participant/family refuses services and/or refuses to comply with support coordination;
- Death of the participant;
- The participant is no longer Medicaid eligible;
- Permanent relocation of the participant out of the service area;
- If the participant is institutionalized for a period not considered temporary. The support coordinator must provide information as to whether this is a permanent or temporary placement such as the need for rehabilitation services;
- Participant refuses to comply with support coordination and BHSF requirements;
- The support coordination agency closes (transfer procedures must be followed);

- Participant no longer meets the criteria for EPSDT support coordination services.
- The participant has a change in target population.

Note: If the participant/family refuses to comply with support coordination requirements, the support coordinator must document all instances appropriately.

Required Transition/Closure Procedures by the Support Coordinator

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

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

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

The support coordination agency must close the case immediately and enter the closure in LSCIS no later than seven days after closure. Agencies will be responsible for deficiencies in services if the case is not closed. Participants will continue to be included in reports (Aging, Quarterly Report, Timely CPOC, Tracking, etc.) until they are closed in LSCIS.

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

Relocation to a different region: If the participant relocates within the state but out of their current region, the support coordinator must assist them with linkage to an agency in the new region **prior to closure**. The support coordinator must obtain the participant's new address and contact information and enter it in LSCIS. **The LSCIS closure report, participant contact information, and documentation of actions taken to link/transfer the participant are to be sent to SRI.**

Institutionalized: Inform the participant/family to request a SUN assessment from their local Human Services Authority if their circumstances have changed.

Unable to locate or contact: If the support coordinator is unable to locate the participant/family or have them respond to phone calls, a notification is to be mailed to the last known address which gives them a deadline to contact you by and informs them that if they do not meet the deadline their case will be closed. You must inform them to contact SRI if they want to access EPSDT SC in the future and give them SRI's 800-364-7828 contact number. LDH requires a toll free number for the participants. This must all be documented in the case closure or service logs.

Aging Out: The support coordinator must begin making arrangements for transition six months prior to the participant's 21st birthday. At closure and/or 90 days prior to the participants reaching their 21st birthday, the support coordinator must complete a final written reassessment identifying any unresolved problems or needs. The support coordinator is to discuss with the participant/family methods of negotiating their own service needs.

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

Closure of Initials: The EPSDT SC Program Manager is to be contacted by e-mail or letter before a participant that has not had an initial face to face assessment or issued a PA is closed. Documentation to support the closure must be found in LSCIS to have the linkage closed. If this is not done they will remain linked to the agency and will continue to show up on reports. When closing initial linkages document why they requested and then declined SC. EPSDT SC is not just for individuals with a need for PCS. The recipient/family made the effort to receive the service by completing and submitting a FOC for the linkage. The EPSDT SC Program Manager may have additional information regarding referrals from OCDD, DCFS, social worker, etc. The closure must document that the participant/guardian was instructed to contact SRI if they want to access EPSDT SC in the future and was given SRI's 800-364-7828 contact number. LDH requires a toll free number for the participants. This must be documented in the case closure or service logs.

Transition of the Participant into a Waiver

If the participant becomes eligible for a waiver, a FOC will be provided to the participant/family by SRI to request services under the waiver.

The FOC form will be sent to SRI for linkage.

If SRI sees that the participant is currently receiving EPSDT services it will be noted on the linkage form.

The participant will be linked as per the established contract guidelines on agency capacity. The support coordination agency is responsible for ensuring that an approved EPSDT plan of care is in place until the waiver certification is issued. The EPSDT case will remain open until receipt of the waiver certification. The EPSDT case will then be closed effective the day prior to the date of waiver certification.

The participant/family may choose a different agency for waiver services. The receiving agency is required to obtain any existing documentation from the previous EPSDT- Targeted Populations provider. The FOC Transfer of Records form shall be used. If the participant changes agencies, the participant will be linked to the receiving agency for both EPSDT and waiver support coordination services. See procedures For Changing Providers below.

The EPSDT Support Coordination cases are to remain open until the waiver certification is issued. The PA for the EPSDT Support Coordination will temporarily end on waiver linkage. When the waiver certification is received, the PA for the EPSDT services will be adjusted as follows, provided that an approved EPDST plan of care is in place up through the day prior to waiver certification:

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

If an approved EPSDT plan of care is not in place for the entire waiver linkage period up through the day prior to waiver certification, the EPSDT PA will end on the day of waiver linkage.

EPSDT Support Coordination is to be closed in LSCIS with the code “change in target population” when the waiver certification is issued. The closure date is the last day of the revised PA once issued.

Procedure for Reopening a Case

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

- If it has been less than 6 months since the closure, the support coordination agency can call SRI to reopen the linkage and have the PAs reissued. When you reopen the file,

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

- If the case has been closed more than 6 months, the participant should be instructed to call SRI to request services.
- The CPOC must be revised if there are significant changes in the services needed but the CPOC date will not change.
- If the CPOC expired, and a new CPOC was not approved before closure, then a new CPOC with a new begin and end date must be completed and approved.

Procedure for Changing Support Coordination Agencies

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

- The participant moves to a different LDH Administrative Region.
- The participant is offered a waiver slot.
- The participant and support coordination agency have unresolved difficulties and mutually agree to transfer. This transfer must be approved by the EPSDT SC Program Manager.
- The participant has another family member living in the same home receiving support coordination from another agency.

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

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

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

- The LSCIS Annual CPOC will be transferred when the receiving agency sends the completed Transfer of Records form to the EPSDT SC Program Manager. The PA will also be transferred at this time.

The transferring support coordination agency shall provide services through the last day of the prior authorization month for which they are eligible to bill. The transfer of records shall be completed by the last week of the month prior to the transfer effective date. The receiving support coordination agency shall begin services within three calendar days after the effective date of the prior authorization. The receiving support coordination agency must submit the completed Transfer of Records form to SRI to begin prior authorization immediately. The CPOC dates will not change.

Discharge Summary for Transfers and Closures: All transfers/closures will require a summary of progress prior to final closure. The service log must be used for this documentation. The LSCIS Closure Summary MUST be completed. Refer to the Support Coordination Transition/Closure section of this Handbook for additional information (page 89).

EPSDT SUPPORT COORDINATOR REQUIREMENTS

Training

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

- To train new support coordinators, supervisor and trainers hired to serve the EPSDT – Targeted Population as part of their 16 hours of orientation training.
- To train existing support coordinators, trainers and supervisors as part of the 40 hours of annual training.

All Support Coordinators must receive EPSDT training.

- New support coordinators and trainees must receive EPSDT training:
 - during orientation (must be included as part of the required 16 hours of orientation training), and
 - prior to being assigned an EPSDT caseload.
- All support coordinators and trainees must complete the EPSDT training each year. Any support coordinators or trainees that do not attend the annual training at LDH either in person or via webinar must be trained by the agency's designated trainer and supervisors. All support coordinators and trainees must read the updated EPSDT – Targeted Population Support Coordination Training Handbook and Appendices.

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

- New designated Trainers and Supervisors must receive the EPSDT training:
 - during orientation (must be included as part of the required 16 hours of orientation training), and
 - prior to beginning supervision of EPSDT support coordinators. The training may be provided to supervisors and designated trainers by BHSF/SRI or by a trained supervisor or designated trainer within the agency.
- All designated Trainers and Supervisors must complete EPSDT training each year. The designated trainer and the EPSDT specialist must attend the annual training at LDH in person. Any supervisors that do not attend the annual training at LDH either in person or via webinar must be trained by a trained supervisor or designated trainer within the agency. All designated trainers and supervisors must read the updated EPSDT – Targeted Population Support Coordination Training Handbook and Appendices.

The agency must submit documentation of EPSDT training to the EPSDT SC Program Manager using the Training Log (*Appendix W-4*). **Documentation of annual training must be submitted one time each year following the annual training at LDH, and documentation of training for new staff must be submitted by the last day of each quarter.**

Refer to the **Targeted Case Management Rule**:

- Orientation Training:
 - A minimum of 16 hours of orientation must be provided to all EPSDT staff within one week of employment. A minimum of eight hours of the orientation training must address the target population including, but not limited to, specific service needs, available resources and other topics. In addition to the required 16 hours of orientation, all new employees who have no documentation of previous training must receive a minimum of 16 hours of training during the first 90 calendar days of employment related to the target population and the skills and techniques needed to provide case management to that population.
- Annual Training:
 - Support coordinators and supervisors must satisfactorily complete a minimum of 40 hours of case management-related training annually which may include updates on subjects covered in orientation and initial training. The 16 hours of orientation training required for new employees are not included in the annual training requirement of at least 40 hours.
- Documentation of Training:
 - All training required during orientation and annually must be evidenced by written documentation and provided to the department upon request.

Refer to the **Case Management Licensing Standard for Participation** for more information on required training including what topics should be covered during orientation and annual training.

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

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

Caseloads

Support Coordinators should have caseloads of no more than 35 participants, and supervisors should supervise no more than 8 support coordinators. Additional job duties should result in a reduction in caseload size and supervisory ratio.

Participant Calls

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

Medicaid Eligibility Verification

Support coordinators are required to validate Medicaid eligibility through MEVS/REVS or e-MEVS at the beginning of every month. If the participant becomes ineligible for Medicaid, they are no longer eligible for Support Coordination and closure procedures shall be followed. Refer to the Closure Section on page 89 of this Handbook.

Participant Visits

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

Participant Satisfaction Survey

Participants must be given a satisfaction survey asking if they are satisfied or dissatisfied with the type, quantity, and/or quality of services identified in the CPOC. The survey must include the SRI toll free number and mailing address and must be provided to each recipient annually.

LSCIS Reports

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

Special emphasis should be placed on the following LSCIS reports:

- CPOC Updates Report
 - Used to track the first date an annual assessment meeting can be held (90 days prior to CPOC expiration), upcoming CPOC due dates (an *approvable* CPOC is due 35 days prior to CPOC expiration), and expiring redeterminations (refer to OCDD 90 days before SOA expires).
- Required Action Report
 - Used to ensure all monthly contacts, quarterly face to face visits and timely CPOCs are completed.
- Aging Report
 - Used to track initial CPOCs. An *approvable* CPOC must be submitted within 35 calendar days of linkage.
- Tracking Required Action Report
 - A negative number of days out indicates that the tracking required action is overdue. A positive number of days out indicates how many days the support coordinator has to complete the tracking required action.