State of California-Health and Human Services Agency
Department of Health Services

California Department of Health Services
SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

June 13, 2005

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TO: ALL COUNTY CALIFORNIA CHILDREN'S SERVICES (CCS) ADMINISTRATORS, MEDICAL CONSULTANTS, AND STATE CHILDREN'S MEDICAL SERVICES (CMS) BRANCH STAFF

SUBJECT: DELEGATION OF AUTHORITY TO AUTHORIZE EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SUPPLEMENTAL SERVICES (EPSDT SS) TO COUNTY CCS PROGRAMS AND CMS REGIONAL OFFICES

PURPOSE

The purpose of this numbered letter is to provide policy and procedures for the review and authorization of services that are not within the scope of regular benefits of the Medi-Cal program for CCS/Medi-Cal, CCS-Only, and CCS/Healthy Families (HF) clients. These services require authorization as EPSDT SS for CCS clients who are full scope, no share of cost Medi-Cal beneficiaries, and as CCS benefits for CCS-only and CCS/HF clients. Hereinafter, these benefits, without regard to funding source, will be described as EPSDT SS.

BACKGROUND

EPSDT SS are defined as those services that are beyond the scope of the benefits of the Medi-Cal program, but which must be available to Medi-Cal beneficiaries under the age of 21 regardless of whether or not the services are available to all other Medi-Cal beneficiaries. Authorization of most EPSDT SS has been centralized at the CMS Branch since the EPSDT SS concept was established in the mid-1990's.
Providers of EPSDT SS services must be enrolled as Medi-Cal providers. They include:

- Physicians, hospital outpatient clinics, CCS Special Care Centers, etc. for which the requested services are within the provider's scope of practice.

- Other health care professionals who are members of the healing arts professions, described in the Business and Professions Code, as long as the requested services are within the provider's scope of practice. Examples of these professionals include registered dietitians, registered nurses, marriage and family therapists and licensed clinical social workers. These providers can become enrolled as EPSDT SS Medi-Cal providers and are issued Medi-Cal provider numbers beginning in "EPS."

POLICY

A. Effective the date of this letter, authority for review and authorize of services, that are either not Medi-Cal benefits or are required to be provided at frequencies that exceed the frequency limitations of the Medi-Cal program, for CCS clients is delegated to the independent county CCS programs, CMS Branch Regional Offices, and dependent county CCS programs participating in Level III of the Case Management Improvement Project (CMIP). Exceptions to this delegation include:

1. Cochlear implants
2. Medical foods
3. Ketogenic diets
4. Weight management programs
5. Investigational services
6. New treatment modalities
7. New medical procedures

B. CCS programs in counties in which a County Organized Health System (COHS) with carved in CCS services is the Medi-Cal managed care contractor shall continue to function under their current agreement with the health plan on the authorization of EPSDT SS for CCS clients who are COHS enrollees.

C. The requested service:

1. Must be medically necessary to the treat the CCS client's eligible medical condition.
2. Must not be a Medi-Cal benefit or must be required to be provided at frequencies that exceed the frequency limitations of the Medi-Cal program.
3. Must be requested or prescribed by a CCS paneled physician.
4. Must be provided by a CCS approved provider, if appropriate.
5. Must be provided by a provider who is enrolled as a Medi-Cal provider or who is eligible for enrollment by Medi-Cal as an "EPS" provider.

IMPLEMENTATION

A. Prior to authorizing a service as an EPSDT SS, CCS county program or CMS Branch Regional Office case management staff shall:

1. Verify that the requested service is not a Medi-Cal benefit or that it must be provided at a frequency that exceeds the frequency limitations of the Medi-Cal program. The scope of Medi-Cal benefits can be determined by checking the following references:

    - The Medi-Cal provider manual at www.medi-cal.ca.gov; or
    - The Medi-Cal procedure master file.

2. Verify that the provider of service has provided medical documentation of the medical necessity for the service and has completed any required supporting documentation, such as:

    - A Requests for Non-Conventional Hearing Aids and Assistive Listening Devices.
    - A Medical Nutrition Assessment.

3. Verify that the request and/or prescription is from a CCS approved provider.

4. Submit requests for non-delegated services to the CMS Branch for review and approval. Submissions to the Branch must include the following:

    - An EPSDT SS Worksheet (Attached)
    - documentation of medical necessity for the services
    - Completed supporting documentation, if appropriate
    - Prescription from a CCS paneled physician, if appropriate
    - Documentation that the provider of the service, if not already a Medi-Cal provider or not eligible to become a regular Medi-Cal provider, meets the criteria to become enrolled by Medi-Cal as an "EPS" provider,

    Such requests should be submitted by FAX to the CMS Branch at:

Main FAX number:	(916) 327-1144
FAX for cochlear implants:	(916) 327-1010

B. Denials

1. When a service, considered to be an EPSDT SS, is denied by the CCS program for a client who is a full scope, no share of cost Medi-Cal beneficiary, the denial shall be sent on behalf of both the Medi-Cal program and the CCS program. The EPSDT SS NOA includes the right for the CCS client/applicant who is a Medi-Cal beneficiary to directly request a Fair Hearing.

2. Any request that is considered for denial shall be discussed with the county CCS program medical consultant who shall seek consultation with the CMS Regional Office medical consultant before issuing a denial. When there is agreement that the request should be denied, a NOA is sent, in accordance with CCS regulations. Please refer to Attachment 3 for the format and the required specific language for an EPSDT NOA. The citations listed should be included in the NOA, as well as any other section that would be applicable to the requested service.

   A copy of the NOA is sent to the requesting provider, prescribing physician (if different), the Regional Office Medical Consultant and the State CMS Branch.

3. Examples of EPSDT SS denials that may require an NOA include:

   a. The item or services is requested for the treatment of the CCS eligible but is not medically necessary.
   b. There is no documentation of medical necessity.
   c. The requested services are duplication of other provided services.
   d. The item or service is not within the provider's scope of practice.

If you have any questions regarding this numbered letter or EPSDT SS, please contact the CMS Branch EPSDT SS consultant or your CMS Branch Regional Office medical consultant.

Original Signed by Marian Dalsey, M.D., M.P.H.

Marian Dalsey, M.D., M.P.H., Acting Chief
Children's Medical Services Branch

Attachments

1. EPSDT SS Worksheet
2. EPSDT SS Worksheet instructions
3. Template Notice of Action (NOA) and First Level Appeal Decision

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

Department of Health Services
Children's Medical Services Branch

CHILDREN'S MEDICAL SERVICES (CMS) BRANCH
CALIFORNIA CHILDREN'S SERVICES (CCS) PROGRAM

EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT-SUPPLEMENTAL SERVICES (**EPSDT-SS**) **WORKSHEET**

Date S.A.R.:_____ Pended Service Authorization #:_____ County:_____
(**S**ervice **A**uthorization **R**equest)

Last Name:_____ First Name:_____ M.I.:_____ Date of Birth:_____

Social Security #/ MEDS ID:_____ CCS #:_____ Medi-Cal #:_____

Is child enrolled in a **M**edi-Cal **M**anaged **C**are **P**lan (MMCP)? Y or N (Please circle) If Yes: Name of MMCP:_____

CCS Eligible Condition Related to EPSDT-SS Request:_____ Primary ICD9 Code: _____

Secondary Condition Related to EPSDT-SS Request:_____

Requested EPSDT-SS:_____ Medi-Cal Benefit? Y or N (Please circle)
(Include frequency and duration if applicable)

Has County authorized **THIS** request prior to submission as an EPSDT-SS? Y or N (Please circle) Estimated Cost: $ _____

Request for Renewal? Y or N (Please circle) Foster Care Client? Y or N (Please circle) I.H.O. Client? Y or N (Please circle)

Requesting Vendor:_____ Medi-Cal Enrolled Vendor? Y or N (Please circle)
(The vendor who will provide the requested service)
CCS Approved (if appropriate) Y or N (Please circle)

Prescribing Provider:_____ CCS Approved? Y or N (Please circle)

Type of Special Care Center (SCC):_____ Tertiary Hospital:_____
(i.e. craniofacial)

Service/Billing Code: Modifier:

The person submitting this EPSDT-SS request has consulted with the County medical consultant.

Person submitting EPSDT-SS request:_____ Date:_____

E-mail address:_____
(Please print legibly)

Phone #: FAX #:

Please include the required documents listed below:

- EPSDT-SS worksheet
- Supporting documentation that describes how the EPSDT-SS request meets the definition of section 51340(e), Title 22.
- Form(s) for specific EPSDT-SS category completed by providers for audiology, DME, medical foods, and nutrition.

Please FAX **requests** to:

CMS Branch-EPSDT- SS
EPSDT-SS Coordinator
(916) 327-1144

Please FAX **Audiology** requests only to:

CMS Branch-EPSDT-SS
Audiology (916) 327-1010

Attachment #2

EPSDT SUPPLEMENTAL SERVICES WORKSHEET INSTRUCTIONS

Instructions for completion of the Early and Periodic Screening, Diagnostic, and Treatment Supplemental Services (EPSDT SS) Worksheet for Children's Medical Services (CMS) California Children's Services (CCS)

General Instructions

1. The County CCS Program or CMS Regional Office staff has the responsibility to complete the EPSDT SS Worksheet.
2. The EPSDT SS Worksheet must be completed in entirety.
3. One request per EPSDT SS Worksheet.
4. The EPSDT SS request must be reviewed with the county CCS program medical consultant or for the dependent counties the CMS Regional Office medical consultant before submitting the request.
5. Please type or print legibly. Information can become illegible when faxed.

EPSDT SS Worksheet Instructions

1. **Date of SAR:** Enter the date the provider requested the EPSDT SS item or service on the Service Authorization Request (SAR).
2. **Pended Services Authorization #:** Enter the Service Authorization Request Number (SAR Number) from the web-based CMSNET System.
3. **County:** Enter the name of the County requesting the EPSDT SS item or service.
4. **Last Name:** Enter the last name of the CCS eligible client for whom the EPSDT SS request is submitted.
5. **First Name:** Enter the first name of the CCS eligible client for whom the EPSDT SS request is submitted.
6. **M.I.:** Enter the middle initial of the CCS eligible client, if available.
7. **Date of Birth:** Enter the date of birth of the CCS eligible client.
8. **Social Security Number/Meds ID:** Enter the MEDS identification number of the CCS eligible client. The CCS County/Regional Office must verify that the Medi-Cal eligibility is current, and is full scope, no share of cost.
9. **CCS#:** Enter the child's State CCS number.
10. **Medi-Cal #:** Enter the Medi-Cal number including the Aid and County code. Client Identification Number (CIN) is acceptable as long as the Aid and County codes precede the CIN. The CCS County/Regional Office must verify that the Medi-Cal eligibility is current, and is full scope, no share of cost.

11. **Is child enrolled in a Medi-Cal Managed Care Plan (MMCP)? Yes or No:** Circle "Yes" if the child is enrolled in a MMCP and enter the name of the plan in field number 12. If the child is not enrolled in a MMCP, please circle "No."
12. **If Yes: Name of MMCP:** Enter the name of the MMCP the child is enrolled in if "Yes" was circled in field number 11.
13. **CCS Eligible Condition Related to EPSDT SS Request:** Enter the CCS medically eligible condition that specifically relates to the requested EPSDT SS item or service.
14. **Primary ICD9 Code:** Enter the ICD9 code for the CCS medically eligible condition listed in field number 13.
15. **Secondary Condition Related to EPSDT SS Request:** Enter a second CCS medically eligible condition that specifically relates to the requested EPSDT SS item or service, if applicable.
16. **Requested EPSDT SS:** Enter the specific EPSDT SS item or service that is requested, including frequency and duration if applicable. For example: speech therapy twice a week for six months. Please note <u>one</u> item or service per EPSDT SS Worksheet.
17. **Medi-Cal Benefit? Y or N:** Circle "No" if the requested item or service is not a Medi-Cal benefit. Circle "Yes" if the requested item or service is a Medi-Cal Benefit (this should be circled only if the requested item or service is a Medi-Cal benefit that is beyond the current benefit limitation; for example, speech therapy or occupational therapy).
18. **Has County authorized <u>THIS</u> request prior to submission as an EPSDT SS? Y or N:** Enter "Yes" if the County CCS program or the CMS Regional Office authorized this specific EPSDT SS request prior to submission. Enter "No" if the County CCS program or CMS Regional Office has not authorized this request and is waiting for the decision from the EPSDT SS Unit. Please note, Medical food products should never be authorized before an EPSDT SS decision is rendered.
19. **Estimated Cost $:** Enter the estimated cost of the item or service, as provided by the rendering provider, if applicable. Services such as speech pathology, medical nutritional therapy, or occupational therapy, have an established Medi-Cal reimbursement rate and do not need to be entered.
20. **Request for Renewal? Y or N:** Enter "Yes" if the requested item or services is an extension/renewal or a previously authorized EPSDT SS request. Enter "No" if this specific EPSDT SS request has not been approved by the EPSDT SS Unit previously.
21. **Foster Care Client? Y or N:** Enter "Yes" is a foster care client. Enter "No" if the child is not a foster care client.

22. **I.H.O. Client? Y or N:** Enter "Yes" if the child is receiving services through In-Home Operations. Enter "No" if the child is not receiving services through In-Home Operations.
23. **Requesting Vendor:** Enter the name of the provider who will be providing the EPSDT SS item or service. For example; XXX DME Company, or Abcdef H.
24. **Medi-Cal Enrolled Vendor? Y or N:** Circle "Yes" if the provider listed in field number 23 is an enrolled Medi-Cal provider. Circle "No" if the provider is listed in the field number 23 is NOT an enrolled Medi-Cal provider. If "No" is circled, is the provider willing and able to enroll as a Medi-Cal provider?
25. **CCS Approved (If appropriate):** Circle "Yes" or "No" if the provider listed in field number 23 is an approved CCS provider.
26. **Prescribing Provider:** Enter the name of the physician prescribing the EPSDT SS item or service.
27. **CCS Approved? Y or N:** Circle "Yes" if the prescribing provider is an approved provider. Enter "No" if the prescribing provider is not paneled or approved.
28. **Special Care Center (SCC):** If applicable, enter the name/type of the Special Care Center that follows the child and is related to the EPSDT SS requested item or service.
29. **Tertiary Hospital:** Enter the name of the tertiary hospital that follows the child, if appropriate.
30. **Billing Code:** Enter the Service Code (HCPCS or CPT) billing code provided by the provider.
31. **Modifier:** Enter the appropriate modifier when requesting Durable Medical Equipment.
32. **The person submitting this EPSDT SS request has consulted with the County CCS program medical consultant.** All EPSDT SS request are to be discussed with the county CCS program medical consultant or for dependent counties the CMS Regional Office medical consultant, and agree that the requested item or services is medically necessary to treat the CCS medically eligible condition.
33. **Person submitting EPSDT SS request:** Type or print the name of the County CCS program or CMS Regional person submitting the request. This person will receive the EPSDT SS response. For example, the county case manager.
34. **Date:** Enter the date the EPSDT SS Worksheet is completed.

35. **Email address:** Enter the email address of the person submitting the EPSDT SS request as listed in #33. This is the person identified to receive information from the EPSDT SS Unit. Please print legibly.
36. **Phone Number:** Enter the phone number of the County CCS program or CMS Regional Office person submitting the EPSDT SS request as listed in #33.
37. **Fax Number:** Enter the fax number of the County CCS program or CMS Regional Office person submitting the EPSDT SS request as listed in #33.
38. **Please include the required documents listed below:** Refer to Title 22, California Code of Regulations, Section 51340(e) for documentation that meets the criteria listed in this section, such as medical reports that specifically mention the item or service and the need. Please include any provider form that the provider is responsible to complete.
39. **Please fax requests to:** For EPSDT SS request (except Audiology) fax to the main EPSDT SS Fax Number as listed (916) 327-1144.
40. **Please fax <u>Audiology</u> requests <u>only</u> to:** Fax only Audiology or EPSDT SS requests to this fax number as listed (916) 327-1010.

Date:

Name:
Address:
City, State Zip

Dear:

NOTICE OF ACTION (NOA) AND FIRST LEVEL APPEAL DECISION

CHILD'S NAME:
DATE OF BIRTH:
CCS NUMBER:
MEDI-CAL NUMBER:
COUNTY:

This letter is to inform you that the **(item or service requested)** requested for **(Child's Name)** by **(Provider's Name)** has been denied. This letter constitutes a California Children's Services (CCS) Program NOA and first level appeal decision and a Medi-Cal Program NOA mandated by California Code of Regulations (CCR), Title 22, Sections 42701, 42703, 51014.1 and 51003.

The CCS Program is responsible for case management and prior authorization of services for those Medi-Cal beneficiaries under 21 years of age with a CCS-eligible medical condition. When a requested service and/or eligibility for the program is denied, CCS is required to provide you with written notification of the denial.

The Department of Health Services, Children's Medical Services (CMS) Branch/CCS Program staff, in conjunction with the Medi-Cal Program's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Supplemental Services Program staff, has determined that the services requested for your child do not meet either program's criteria for medically necessary services. Specifically, **(ex: there is no documentation of medical necessity for, and/or is not medically necessary) – (Refer to any other programs as appropriate)**. **(Offer another option, if appropriate – a lesser costly item that has not been tried and would meet the medical needs of the child)**.

The CCS Program's authority in reaching this decision is contained in the following law and regulations: Sections 123830 and 123850 of the Health and Safety Code and CCR, Title 22, Sections 41510, 41518 and 51013. The Medi-Cal Program's authority is contained in the following regulations: Sections 51003, 51184 and 51340 of CCR, Title 22.

You may appeal the denial of the requested item/service through the CCS Program by requesting a fair hearing. The appeal process requires that a written

request for a fair hearing be submitted within 14 calendar days of the date of this letter.

Please be advised that when requesting a CCS Program fair hearing you may:

1. Request an interpreter (to be provided by the State at no cost to you).
2. Request to view your child's medical record.
3. Appoint a representative to represent you.

To request a fair hearing, in accordance with Section 42705, CCR, Title 22, direct your written request along with a copy of this letter to:

Director
Department of Health Services
Office of Administrative Hearings and Appeals
1501 Capitol, Suite 601
Mail Stop 0000
Sacramento, CA 95814-5050

You must make your request for a fair hearing in writing. Also, please provide the following information with your fair hearing request:

1. Patient's name;
2. Date of Birth;
3. CCS Number;
4. Address;
5. Telephone number where you can be reached; and
6. A copy of this letter.

The request must be received within 14 calendar days of the date of this letter.

You may obtain detailed information and assistance on the CCS Program appeal process by contacting Ms. Candie Saldana, at (916) 327-1915.

Sincerely,

Marian Dalsey, M.D., M.P.H., Acting Chief
Children's Medical Services Branch

cc: **Requesting Provider**
Prescribing Physician
Regional Office Medical Consultant

cc: Candie Saldana, Administrative Analyst
Children's Medical Services Branch
MS 8104
P.O. Box 997413
Sacramento, CA 95899-7413

Galynn Plummer-Thomas, R.N., NC III
Program Case Management Section
Children's Medical Services Branch
MS 8105
P.O. Box 997413
Sacramento, CA 95899-7413

bcc: Patient's Medical Records
Chron File
Author