July 28, 1998

MMCD ALL PLAN LETTER 98-06

TO: All Managed Care Plans

SUBJECT: CALIFORNIA CHILDREN SERVICES NUMBERED LETTERS 01-0298 AND 09-0598

Please **find** enclosed for your information two California Children Services (CCS) numbered letters (NL) which are directed to County CCS programs.

NL 01-0298 describes CCS’ policy for authorization of automobile orthopedic positioning devises for CCS eligible children. NL 09-0598 describes CCS’ policy for authorization of Early and Periodic Screening, Diagnosis and Treatment Supplemental Services request, including hourly nursing.

These letters are being sent for your information only to help you remain current regarding CCS authorization procedures and to facilitate care coordination efforts between managed care plans and CCS.

Sincerely,

[Signature]

Ann-Louise Kuhns, Chief
Medi-Cal Managed Care Division

Enclosure
TO: All California Children Services (CCS) County Program Administrators, Medical Consultants, Chief/Supervising Therapists, Medical Therapy Units, State Regional Office Administrators, Medical and Therapy Consultants

SUBJECT: DURABLE MEDICAL EQUIPMENT (DME) GUIDELINES ADDENDUM: AUTOMOBILE ORTHOPEDIC POSITIONING DEVICES (XOPDS)

Introduction

CCS authorizes purchase of DME items that are medically necessary to treat a child’s CCS-eligible medical condition. If the child is a Medi-Cal-eligible beneficiary, the CCS program authorizes DME that is deemed medically necessary and is a benefit of the general Medi-Cal program; or if the DME is not a general Medi-Cal program benefit, may request authorization as an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) supplemental service.

The CCS DME Guidelines were established in 1997 to provide criteria for purchase of DME-Rehabilitation items that are considered medically necessary benefits of the CCS program. In those guidelines, AOPDs, or non-standard (commercially available) car seats and harness/vests, were categorized as items that could be useful for the family, but were not considered medically necessary CCS benefits. CCS now recognizes there are instances when these items would be medically necessary to treat the child’s CCS-eligible condition.

Policy

Effective the date of this letter, AOPDs are a benefit of the CCS program when they meet the criteria applicable to the item listed in the enclosed addendum to the DME guidelines. CCS will not authorize the purchase of standard, commercially available car seats or vests/harnesses that are required by California state law for children are under 4 years of age and under 40 pounds. If the child is Medi-Cal eligible, the request must be submitted as an EPSDT supplemental services request in order for the equipment to be reimbursable by Medi-Cal.
Requests for AOPDs must be reviewed and approved by the county CCS program medical consultant or designee or the state CCS regional office therapy consultant prior to authorization. Request for authorizations must be accompanied by a current prescription, a current medical report that justifies the medical necessity of the item, and a physical therapy and/or occupational therapy assessment that addresses the criteria in the DME guidelines for the item.

If you have any questions regarding this change in policy, please contact Jeff Powers at (916) 657-0834. Thank you for your attention to this matter.

Maridee A. Gregory, M.D., Chief
Children’s Medical Services Branch

Enclosure
<table>
<thead>
<tr>
<th>Equipment</th>
<th>Medical Necessity</th>
<th>Criteria</th>
<th>Related Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Automobile Orthopedic Positioning Devices (AOPD)</strong></td>
<td></td>
<td></td>
<td>* CCS will purchase only AOPD over a lifetime.</td>
</tr>
<tr>
<td>Car seats</td>
<td>Requires maximal to moderate postural support to maintain a safe sitting position during transportation</td>
<td>Child must be over 4 years of age and either over 40 pounds or over 40 inches in length, and must meet one of the following criteria: 1) Has moderate-minimal trunk control sitting ability, moderate to minimal lateral head control and requires total postural support 2) At risk for breathing complications as a result of poor trunk control or alignment 3) Presence of a skeletal deformity requiring total postural support for safe transportation</td>
<td>* The child's length, width or physical deformity precludes use of a commercially available car seat  A harness or vest will not provide the child with enough stability to remain in proper alignment or allow for safe transport  Child cannot be transported in wheelchair because the family does not own appropriate vehicle to allow this</td>
</tr>
<tr>
<td>Harnesses, Vests</td>
<td>Same as car seats</td>
<td>Child must be over 4 years of age and either over 40 pounds or over 40 inches in length and meets one of the three criteria for car seats. or due to deformity or surgical corrections must be transported in other than an upright position</td>
<td>* The child's physical deformity or trunk instability precludes use of a standard seat belt or commercially available vest or harness  A standard seat belt or commercially available vest harness will not provide the child with enough stability to remain in proper alignment or allow for safe transport  Child cannot be transported in wheelchair because the family does not own appropriate vehicle to allow this</td>
</tr>
</tbody>
</table>
TO: California Children Services (CCS) Program Administrators, Medical Consultants, CCS Regional Office Medical Consultants, and CCS State Program Consultants, and Nurse Consultants

SUBJECT: EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) SUPPLEMENTAL SERVICES (SS)

The purpose of this numbered letter is to clarify the procedure for EPSDT SS requests for those CCS medically-eligible children who are Medi-Cal, full scope, no share of cost.

ALL EPSDT SS REQUESTS EXCEPT HOUfially NURSING SERVICES

ALL EPSDT SS requests for a CCS-eligible child with Medi-Cal, full scope, no share of cost, with the exception of requests for long term hourly nursing services in the home, are to be sent to:

EPSDT SS Coordinator
Children’s Medical Services Branch
714 P Street, Room 350
P.O. Box 942732
Sacramento, CA 94234-7320
Office: (916) 6544499
FAX: (916) 654-0501

Enclosed are all the forms necessary to submit an EPSDT SS request. Please remember that the EPSDT SS WORKSHEET must accompany each request. The check-off lists are for CCS staff to use in preparing the request. The other forms are provider forms and must be completed by the provider and returned to the local county CCS program. When preparing an EPSDT SS request, please refer to California Code of Regulations, Title 22, Division 3, Health Care Services, Sections 51184, 51340, 51242, and 51013. Section 51340(e) specifically addresses the type of documentation that must be submitted with a request. When the CCS program has gathered all the necessary information to support the EPSDT SS request, the request may be submitted to the EPSDT SS Coordinators at the State CMS office.
EPSDT SS HOURLY NURSING SERVICE REQUESTS

All requests for EPSDT SS long term hourly or shift nursing services in the home are to be submitted by the provider on the format prescribed by Medi-Cal to:

In-Home Operations intake Unit
1801 Seventh Street
P.O. Box 942732
Sacramento, California
94234-7320
(916) 324-5940
FAX (916) 324-0297

The In-Home Operations Unit does the review and determination for EPSDT Supplemental Services long-term hourly nursing services in the home and continues to do case evaluation for the Waiver Services such as the In-Home Medical Care Waiver, Nursing Facility Waiver, and the Model Waiver.

If you have any questions, please contact Sally Paswaten, R.N., at (916) 653-8784, or Galynn Plummer-Thomas, R.N., at (916) 6533480.

Enclosures
Enclosures

A. EPSDT SS WORKSHEET (which must accompany each EPSDT SS request)
B. EPSDT SUPPLEMENTAL BENEFITS REQUEST FOR AUDIOLOGY SERVICES
C. EPSDT SUPPLEMENTAL SERVICES REQUEST FOR MEDICAL FOODS
D. EPSDT SUPPLEMENTAL SERVICES REQUEST FOR MEDICAL NUTRITION ASSESSMENT.
E. EPSDT SUPPLEMENTAL SERVICE REQUEST FOR MEDICAL NUTRITION THERAPY
F. PULSE OXIMETER PROVIDER FORM
G. PULSE OXIMETER CHECK LIST
H. OCCUPATIONAL THERAPY REQUEST DOCUMENTATION CHECKLIST
I. DURABLE MEDICAL EQUIPMENT REQUEST DOCUMENTATION CHECKLIST
J. REQUEST FOR MENTAL HEALTH ASSESSMENT ONLY and the REQUEST TO PROVIDE TREATMENT
K. MEDICAL OPERATIONS DIVISIONS DEFER THE TAR TO REFER TO CCS
L. MEDI-CAL OPERATIONS DIVISION HEADS UP LETTER TO CCS THAT A PROVIDER HAS BEEN REFERRED TO OBTAIN THE SERVICES FROM CCS
**CHILDREN'S MEDICAL SERVICES (CMS) BRANCH**  
CALIFORNIA CHILDREN SERVICES (CCS) PROGRAM

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

| Patient Name: ___________________________ | DOB: ___________________________ |
| CCS County/or Regional Office: __________ | CCS Number: ____________________ |
| Social Security Number: _________________ | Medi-Cal Number: ________________ |
| CCS Medically Eligible Condition Related to EPSDT SS Request: ___________________________ |

**EPSDT SS Requested:**

If Applicable, Include Frequency and/or Duration of EPSDT SS: ___________________________.

If Applicable, Indicate Cost of Supply, Product, or Equipment: ___________________________.

Date This EPSDT SS Request Was Received in Your CCS Office: ___________________________.

Has County already authorized this request? Yes ☐ No ☐ Dates: ___________________________.

Is This Request a Renewal of a Previously Authorized EPSDT SS? Yes ☐ No ☐

Name of the Provider and/or Facility Providing EPSDT SS: ___________________________.

1. EPSDT SS request is to treat a CCS-eligible condition/or complication thereof? Yes ☐ No ☐

   If no, attach justification of EPSDT SS request.

2. EPSDT SS is a Medi-Cal benefit? ☐ Yes ☐ No ☐

3. EPSDT SS is a CCS benefit? ☐ Yes ☐ No ☐

4. Provider requesting to provide EPSDT SS is an enrolled Medi-Cal provider? ☐ Yes ☐ No ☐

5. Provider requesting to provide EPSDT SS is a CCS paneled provider? ☐ Yes ☐ No ☐

6. Provider requesting to provide EPSDT SS is employed by an enrolled Medi-Cal provider? ☐ Yes ☐ No ☐

7. Is there alternative care which is less costly than the EPSDT SS? Yes ☐ No ☐

   If yes, identify alternative care and its cost: ___________________________.

8. Is patient an In-Home Operations client? Yes ☐ No ☐

---

**County Recommendation(s):** ___________________________.

By: ___________________________.

Phone #: ___________________________.

FAX #: ___________________________.

Date: ___________________________.

**Central Office Decision:** ___________________________.

By: ___________________________.

Phone #: ___________________________.

Date: ___________________________.

---

**To Be Filled in By CMS Central Office**

Committee (Coma) Code: ___________________________.

Date Presented to Comm: ___________________________.

Comm Decision Code: ___________________________.

Comm Decision Date: ___________________________.

Date County Notified: ___________________________.

Consultant Code: ___________________________.

---

Mail or Fax the required documents listed below to:  
- EPSDTSS Worksheet  
- Supporting documentation that describes how the EPSDT SS request meets the definition of Section 51340(e), TITLE 22.  
- Form for specific EPSDT SS category, completed by providers, for nutrition, pulse oximeter, mental health, dental, and audiology services.

Children's Medical Services Branch  
EPSDT Coordinator  
714 P Street, Room 350  
P.O. Box 942732  
Sacramento, CA  95814  
Office: (916) 654-0499 or (916) 654-0832  
(916) 6640601
MEDICAL EPSDT SUPPLEMENTAL SERVICES REQUEST  
(Audiology services, cochlear implant, ALDs and nonconventional hearing aids) 
(CCS NOTE: Include this form with the CCS EPSDT request form.) 
DATE OF REQUEST: ________________

NAME: ___________________________ DOB: __________ MEDICAL#: __________

SUMMARY OF CONDITIONS FOR THIS REQUEST:

Primary diagnosis: ____________________________________________________________
Other dx: _____________________________________________________________________
Age of onset: __________________ Etiology: _______________________________________
Functional impairment(s): _____________________________________________________

CURRENT STATUS: Physical health: ____________________________________________
Otological: __________________________
Audiological: __________________________
Amplification: __________________________
Education Placement: __________________________
Communication level and mode: ________________________________________________
Cognitive ability/cooperation: _________________________________________________
Describe all current program/treatment enrollment: ________________________________

PATIENT/FAMILY EXPECTATIONS: ______________________________________________

PRIOR TREATMENT FOR THIS CONDITION: ______________________________________

WHY ARE SUPPLEMENTAL SERVICES NEEDED?: ______________________________________

TREATMENT PLAN:
Specific services or device requests: ____________________________________________

________________________
Long and short term goals: ________________________________

________________________________________________________________________

This plan differs from previous treatment because... __________________________

________________________________________________________________________

Expected outcomes: ________________________________

________________________________________________________________________

How will this supplemental treatment augment current treatment? ______________

________________________________________________________________________

ENCLOSURES REQUIRED:

1. Medical clearance or referral for services (if old CCS case). 2. Audiological report to support request. 3. Speech and language reports to support request. 4. Previous treatment progress reports. 5. Audiogram. 6. Other useful information for EPSDT review. 7. Any other data to support your request.

(Name) ________________________________

(Facility) ________________________________

(Requested By. and Facility Name) ________________________________

(Medi-Cal Provider Number to be authorized)

FOR OFFICIAL USE:

<table>
<thead>
<tr>
<th>DATE RECEIVED:</th>
<th>DATE REVIEWED:</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADDITIONAL INFO NEEDED:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RESPONSE DATE:</th>
<th>BY:</th>
</tr>
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<tbody>
<tr>
<td>EPSDT REVIEWER</td>
<td></td>
</tr>
</tbody>
</table>

REVISED
PRE-COCHLEAR IMPLANT QUESTIONNAIRE FOR REFERRAL SOURCE

CHILD'S NAME:

Diagnosis of bilateral deafness, established by audiologic and medical evaluation:

Enclose current reports of audio-logical evaluation, current audiogram, the make and model of hearing aid(s), electro-acoustic hearing aid data, and hearing aid performance (unaided vs. aided) thresholds.

ANSWER (YES/NO) to the following:

___ Is hearing loss greater than 90-95 dB HTL in the better ear?
___ Are aided better ear hearing thresholds above 1000 Hz poorer than 50 dB HTL?
___ Are hearing aids used consistently? All waking hours?
___ Is speech discrimination for simple sentences and words less than 30%?

Cognitive ability to use auditory cues:

___ Does the child cooperate during clinic visits?
___ Does child comprehend speech/signing used during your interaction?
___ Does child understand and respond to commands?
___ Does child-use situational cuing for understanding?
___ Is child aware of speech as communication medium?
___ Does child include expression (facial or body language) in communication?
___ Does child use voice without signs for communication?
___ Does child attempt to use oral communication?
___ Does child interactively with other children and/or family members?
___ Is child considered Immature, dependent on others to initiate action?
___ Do parents comply with clinical recommendations for carry over in the home to obtain maximum use of amplification and for keeping appointments?
___ Are parents aware that there is an external device worn with cochlear implant unit?
___ Are parents informed of all options available to deaf children?

Comment:

Provider's assessment of: Motivation of candidate and/or commitment of family/care giver(s) to undergo a program of prosthetic fitting and long-term rehabilitation.

Provider's assessment of: Realistic expectations of the candidate and/or family/caregiver(s) for post implant educational/vocational rehabilitation as appropriate.

Provider's assessment of the child's educational program:

Provider's assessment of the child's individual aural (re)habilitation program:
Additional Comments:

Name, address and telephone number of child's educational program:

Teacher's Name:

Name of private setting and clinician and telephone number (if appropriate):
Early, Periodic Screening, Diagnosis or 3 Treatment Supplemental Services

PROVIDER REQUEST FOR MEDICAL FOODS (as defined on the back)

Provider: Please complete the following information and attach readable copies of current history and physical, progress notes, laboratory reports, anthropometric data/growth grids, or any other information that supports the request. Omission of information may result in a deferral or denial of the request.

DATE OF YOUR REQUEST: / /

PROVIDER OF MEDICAL NUTRITION THERAPY:
Registered Dietitian
Address
Phone
Medi-Cal Provider Number (ii billed through the RD)

PRESCRIBED BY:
Health Care Provider
Address
Phone
Medi-Cal Provider Number (ii billed to outpatient clinic)

PATIENT INFORMATION

Patient Name
Date of Birth
County of Residence

Medi-Cal Number (or Social Security Number)
CCS Number

SERVICE REQUEST AND JUSTIFICATION (attach additional pages as needed)

☐ A written prescription signed by a CCS paneled physician for the specific Medical Foods is attached.

☐ A copy of the nutritional assessment and treatment plan done by a CCS paneled registered dietitian (RD) is attached.

☐ Attach either a CCS Request for Service form, or a Treatment Authorization Request (TAR) if you are a Medi-Cal provider requesting fee-for-service.

Principle Diagnosis
Significant Associated Diagnosis
Date of Onset, Etiology if known

Prognosis

Clinical significance or functional impairment(s)

Significant Medical History (remember to attach appropriate medical records to support your request. Describe what services are being provided by the physician)

Medical justification for specific dietary management of a disease or condition for which specific nutritional requirements exist (guidelines on the back):

☑ Provide documentation that includes: ☑ type of medical food(s), ☑ cost of each medical food, ☑ total amount of each medical food to be provided for the specific period to be covered by this authorization, ☑ name of the pharmacy which will dispense the medical food, and ☑ percentage of medical food products which are snack foods (< 10% of the total cost limit)

Submit to the local CCS program or Medi-Cal field office.

If you have questions about using this form, please call the local CCS program or Medi-Cal field office.

CMS 11/96 c:\penn\epsd1.f00
Medical foods are replacement food products which are:

- Specially formulated to be consumed or administered enterally;
- Intended for the specific dietary management of a disease or condition for which specific nutritional requirements exist;
- Prescribed as medically necessary by a California Children's Services paneled physician;
- Purchasable only through a pharmacy;
- Required in place of food products used by the general population;
- Are safe for the individual EPSDT-eligible beneficiary and are not experimental;
- Generally accepted by the professional medical community as effective and proven treatments for the condition for which they are proposed to be used (scientific evidence published in peer-review journals).

When justifying the medical necessity for specific dietary management of a disease or condition for which specific nutritional requirements exist, include in your statement:

- The necessity for the medical foods to treat or ameliorate the beneficiary's medical condition;
- The reason food products used by the general population cannot be used for the medical condition;
- Documentation that the food products are specially formulated for the specific dietary management of a disease or condition for which specific nutritional requirement exist;
- Documentation that they are not requested solely for the convenience of the beneficiary, family, physician, or other provider of services.
- Documentation that the medical food products are the most cost-effective, medically accepted mode of treatment available and that they improve the overall health outcome as much as, or more than, the established alternatives.

Here is a sample list for medical food products for a child with phenylketonuria (PKU):

<table>
<thead>
<tr>
<th>Medical Food Product</th>
<th>Product Code</th>
<th>Package Amt</th>
<th>Unit Cost</th>
<th># of Unik for 6 mo</th>
<th>TOTAL COS</th>
</tr>
</thead>
<tbody>
<tr>
<td>dp Baking Mix</td>
<td>DPBM0604</td>
<td>4 lb bag</td>
<td>$15.00</td>
<td>4</td>
<td>$60.00</td>
</tr>
<tr>
<td>Low pro cookies</td>
<td>xxxxxxxxxx</td>
<td>160zbox</td>
<td>55.00</td>
<td>1</td>
<td>55.00</td>
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Snack foods are 7% of the Total Cost (√ 10 %) TOTAL COST $65.00
Early Periodic Screening, Diagnosis and Treatment Supplemental Services

PROVIDER REQUEST FOR MEDICAL NUTRITION ASSESSMENT

Provider: Please complete the following information and attach readable copies of current history and physical, progress notes, laboratory reports, anthropometric data/growth grids, or any other information that supports the request. Omission of information may result in a deferral or denial of the request.

<table>
<thead>
<tr>
<th>PROVIDER OF SERVICES:</th>
<th>PRESCRIBED BY:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered Dietitian</td>
<td>Health Care Provider</td>
</tr>
<tr>
<td>Address</td>
<td>Address</td>
</tr>
<tr>
<td>Phone</td>
<td>Phone</td>
</tr>
<tr>
<td>Medi-Cal Provider Number (if billed through the RD)</td>
<td>Medi-Cal Provider Number (if billed to outpatient clinic)</td>
</tr>
</tbody>
</table>

PATIENT INFORMATION

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Date of Birth</th>
<th>County of Residence</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medi-Cal Number (or Social Security Number)</td>
<td>CCS Number</td>
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</table>

SERVICE REQUEST AND JUSTIFICATION (attach additional pages as needed)

- A written, signed request by the patient’s physician for medical nutrition assessment is attached.
- Attach either a CCS Request for Service form, or a Treatment Authorization Request (TAR) if you are a Medi-Cal provider requesting fee-for-service.

<table>
<thead>
<tr>
<th>Principal Diagnosis</th>
<th>Significant Associated Diagnosis</th>
<th>Date of Onset, Etiology if known</th>
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Prognosis

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<tr>
<th>Clinical significance or functional impairment(s)</th>
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Significant Medical History (remember to attach appropriate medical records to support your request. Describe what services are being provided by the physician)

Medical Justification for Providing Nutrition Assessment

<table>
<thead>
<tr>
<th>Anticipated Frequency and Duration of the Nutrition Assessment (e.g. number of visits and amount of time per visit).</th>
<th>TOTAL UNITS</th>
</tr>
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When complete, submit your request to the local CCS program or Medi-Cal field office.

If you have questions about using this form, please call the local CCS program or Medi-Cal field office.

CMS 11/96 c:\penn\epstf.ass
Early, Periodic Screening, Diagnosis and Treatment Supplemental Services

**PROVIDER REQUEST FOR MEDICAL NUTRITION THERAPY**

Provider: Please complete the following information and attach readable copies of current history and physical progress notes, laboratory reports, anthropometric data/growth grids, or any other information that supports the request. Omission of information may result in a deferral or denial of the request.

<table>
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<tr>
<th>DATE OF YOUR REQUEST:</th>
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**PROVIDER OF SERVICES:**
Registered Dietitian

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**PRESCRIBED BY:**
Health Care Provider

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**SERVICE REQUEST AND JUSTIFICATION**
(attach additional pages as needed)

- A written, signed prescription by the physician for mediil nutrition therapy is attached.
- Attach either a CCS Request for Service form, or a Treatment Authorization Request (TAR) if you are a Medical provider requesting fee-for-service.
- A copy of the nutritional assessment done by a registered dietitian (RD) is attached.
- A nutritional plan of treatment, including therapeutic goals and anticipated time for achievement, is attached.
- **Parent/legal** guardian and/or patient agree(s) to cooperate with the proposed medical nutrition therapy.

<table>
<thead>
<tr>
<th>Principle Diagnosis</th>
<th>Significant Associated Diagnosis</th>
<th>Date of Onset, Etiology if known</th>
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**Clinical significance of functional impairment(s)**

**Significant Medical History** (remember to attach appropriate medical records to support your request. Describe what services are being provided by the physician.)

**Mediil Justification for Providing Medical Nutrition Therapy**

**Anticipated Frequency and Duration of the Medical Nutrition Therapy for a Period of (6) Cix Months:**

<table>
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<tr>
<th>(1/2 hour = 1 unit) Total Units</th>
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Submit to the local CCS program or Medi-Cal field office.

If you have questions about using this form, please call the local CCS program or Medi-Cal field office.

CMS 11/96 c:\penniepsd\the
Date: __________

**OXIMETER INFORMATION**

Patient Name: ____________________________  D.O.B.: __________  Age: __________

TO BE COMPLETED BY M.D.

Diagnosis (List all pertinent, be specific):

__________________________________________________________________________

Hospital *admissions past year* - give dates, hospital, diagnosis:

__________________________________________________________________________

O₂ requirement - %, flow, duration, etc.:

__________________________________________________________________________

Give recent oximeter readings. include range, average, and dates. Describe fluctuation(s):

__________________________________________________________________________

List other monitors or alarms to be used. Explain why these are not sufficient:

__________________________________________________________________________

Explain what intervention caregiver will provide based on oximeter readings:

__________________________________________________________________________

Estimate length of need for oximeter:

__________________________________________________________________________

Physician’s Signature ____________________________  Print Name & License ____________________________  Date & Physician’s signature ____________________________

Attach MD’s recent outpatient evaluations and notes, or a narrated summary. Also, attach a copy of H. & P. and discharge summary of most recent hospitalization, or a progress summary if currently an inpatient. These RECORDS ARE MANDATORY for consideration of request.

Model requested: ____________________________  Brand: ____________________________

Monthly rental: $ _________  Provider’s actual invoice purchase cost: $ _________

List the least expensive model available on the market:

__________________________________________________________________________

Cost of rental or purchase of this model: ____________________________

Explain why this model is not adequate for this child: ____________________________
EPSDT SS PULSE OXIMETER REQUEST CHECK LIST

☐ EPSDT SS Worksheet

☐ Pulse Oximeter form filled out (preferably by a Pulmonologist).

☐ Signed physician’s prescription for pulse oximeter.

☐ History and physical or current discharge summary. Include full center report that specifically justifies the request for a pulse oximeter.

☐ Documentation of significant respiratory or cardiopulmonary disease requiring continuous in-home monitoring (include frequency and readings) (basically instability).

☐ Documentation of variable oxygen needs - requiring immediate changes by caregiver.

☐ Oxygen settings and duration.

☐ Is child on a ventilator in the home? If yes, how many hours per day-

☐ Current 02 saturations if machine already in the home.

☐ What other related equipment in the home, i.e., Apnea monitor.

☐ Explanation of why just monitoring signs and symptoms is not enough.

☐ Explanation why periodic outpatient monitoring would not be effective.

☐ Explanation of what interventions the caregiver will provide based on oximeter readings.

☐ Rental vs. purchase.

☐ Anticipated length of need.

☐ Documentation that parent has been trained in the use of, and interpretation of reading from the pulse oximeter.

☐ Is the child receiving licensed nursing services in the home? If so how many hours per day? Waiver or EPSDT Supplemental Nursing Services?
The purpose of the EPSDT Supplemental Services Request Documentation Checklist is to assist county CCS programs and State CCS Regional Offices in assembling legible information required for processing of an EPSDT Supplemental Services request by the designated EPSDT Supplemental Services subcommittee. Use of the checklist may prevent either delays in processing caused by the subcommittee’s deferral of a request for more information or denial. Omission of applicable information on the checklist may also cause the request to be deferred or denied.

---

**General**

0 OT services requested exceed 2x per month

0 Patient is not receiving OT through the Medical Therapy Program

---

**Current Physician’s Prescription**

0 **Specific** for service to be provided (by discipline)

0 Frequency and duration of prescription identified

---

**Current Physician’s Report**

0 Physical findings

0 Addresses need for therapy intervention

0 Identifies condition that therapy will correct or ameliorate

0 Treatment plan identifies functional goal(s) for therapy intervention

---

**Current Occupational Therapy Report**

0 Physical findings

0 Summary of functional deficits to be addressed by therapy

0 Patient’s **functional** status in each area of deficit to be addressed

0 Treatment plan includes **functional** goals to address deficits targeted by therapy assessment, and anticipated time required to achieve these goals

0 **Patient/Caregiver** input into the treatment plan

0 Functional outcomes/benefits of any previous therapy services

---

FOR CCS USE ONLY (4/3/96)
The purpose of the EPSDT Supplemental Services Request Documentation Checklist is to assist county CCS programs and State CCS Regional Offices in assembling legible information required for processing of an EPSDT Supplemental Services request by the designated EPSDT Supplemental Services subcommittee. Use of the checklist may prevent either delays in processing caused by the subcommittee’s deferral of a request for more information or denial. Omission of applicable information on the checklist may also cause the request to be deferred or denied.

General
- DME item **is not** a benefit of the regular Medi-Cal program
- DME item **is** a benefit of the CCS program or treats CCS eligible condition
- Provider information (provider name, address, phone number, and Medi-Cal provider status/number)
- Catalog listing, prices, description/photo of item(s)

Current Physician’s Prescription
- Specific for DME item
- Identifies significant modifications/additions to basic item

Current Physician’s Report
- Physical findings
- Addresses needs for specific DME item

Current Physical Therapy/Occupational Therapy Report
- Physical findings
- Functional status related to DME item requested
- Home/School/Community Accessibility Assessment (if applicable)

The following items must be addressed in either the MD’s or PT/OT report:

Justification (initial item)
- Medical necessity of basic DME item
- Each addition/modification/accessory to basic DME item

Justification (new/replacement/upgrade)
- Why current item no longer meets patient needs
- Functional opportunities new item/upgrade provides
- Medical necessity of basic DME item
- Each addition/modification/accessory to basic DME item

Comparisons (if applicable)
- What other similar DME items were considered?
- Why this particular DME item was chosen over others considered.
- Is this the most cost effective method of meeting patient needs?

Trial Period (if applicable)

Follow-Up Training (if applicable)

Meets all requirements of CCS DME Guidelines

FOR CCS USE ONLY (4/3/96)
CALIFORNIA CHILDREN SERVICES/EPSDT MENTAL HEALTH SERVICES REQUEST
DATE OF INITIAL REQUEST: / /9 DATE OF ADDED REQUEST / /9

I. CLIENT IDENTIFICATION:

<table>
<thead>
<tr>
<th>CLIENT NAME</th>
<th>DATE OF BIRTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>MED-CAL NUMBER</td>
<td></td>
</tr>
<tr>
<td>(14 digits)</td>
<td></td>
</tr>
<tr>
<td>MED-CAL NUMBER</td>
<td>COUNTY/CCS#</td>
</tr>
</tbody>
</table>

II. PROVIDER INFORMATION

<table>
<thead>
<tr>
<th>PROVIDER NAME</th>
<th>EPSDT #/MC#</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHONE NUMBER</td>
<td>LICENSE TYPE</td>
</tr>
<tr>
<td>ADDRESS</td>
<td>LICENSE #</td>
</tr>
<tr>
<td>CITY</td>
<td>ZIP</td>
</tr>
</tbody>
</table>

III. SERVICE REQUEST AND JUSTIFICATION (ATTACH ADDITIONAL SHEETS IF NEEDED)

| INDICATE NUMBER OF SESSIONS REQUESTED: | INDIVIDUAL | FAMILY |
| (INDICATE GOALS FOR EACH TYPE OF SERVICE REQUESTED IN SECTION IX) | GROUP      | REQUESTED, INDICATE |
|                                             |            | NAMES AND          |
|                                             |            | RELATIONSHIPS OF PERSONS TO BE INCLUDED |
| Other:                                      |            | Family therapy will include: |
| TIME NEEDED TO COMPLETE ABOVE SESSIONS =  |
| WEEKS                                       |            |

| HOW WAS CHILD REFERRED AND WHY (INCLUDE AS MUCH AS IS KNOWN ABOUT PRESENTING PROBLEM—FREQUENCY CIRCUMSTANCES, ETC.) |

| OTHER AGENCIES INVOLVED WITH CLIENT/FAMILY |

| YOUR EXPERIENCE PROVIDING SERVICE REQUESTED TO PERSONS THE AGE OF THE CLIENT |

IV. FUNCTIONAL IMPAIRMENTS

| [ ] HOME |
| [ ] SCHOOL/WORK |
| [ ] SOCIAL |
| [ ] COMMUNITY |
| [ ] MEDICAL/OTHER |

Attach psychosocial reports if any available.
You may stop here if no more than 3 evaluation sessions are requested.
VI. PREVIOUS TREATMENT FOR PROBLEM & OUTCOME(S):

<table>
<thead>
<tr>
<th>FROM</th>
<th>TO</th>
<th>SERVICES PROVIDED/PROVIDED BY</th>
<th>RESULTS OF SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

VII. SIGNIFICANT FAMILY HISTORY/FAMILY FUNCTIONING

VIII. DSM DIAGNOSIS: (Give code & describe symptoms that justify diagnoses)

AXIS 1: CLINICAL

AXIS 2: PERSONALITY

AXIS 3: MEDICAL

AXIS 4: PSYCHOSOCIAL AND ENVIRONMENTAL PROBLEMS

AXIS 5: GLOBAL ADAPTIVE FUNCTIONING-BEST

CURRENT GAF
### IX. TREATMENT PLAN/GOALS

**NAME OF CLIENT**

#### GOALS FOR INDIVIDUAL THERAPY

#### GOALS FOR (CHECK ONE): GROUP / FAMILY THERAPY [ ]

<table>
<thead>
<tr>
<th>TIMELINE</th>
<th>BASELINE/CURRENT STATUS</th>
<th>SHORT TERM GOALS/OBJECTIVES: If family therapy is requested some goals should be for changes in family functioning</th>
</tr>
</thead>
<tbody>
<tr>
<td>IN _____ MONTHS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IN _____ MONTHS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IN _____ MONTHS</td>
<td></td>
<td></td>
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<tr>
<td>IN _____ MONTHS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IN _____ MONTHS</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### TREATMENT METHODS/EXPLANATION OF TREATMENT PLAN:

I CERTIFY THAT THE CLIENT’S PARENT(S) OR CLIENT, IF OVER 18 AGREES TO THE TREATMENT PLAN:

**SIGNATURE OF THERAPIST**
TO REQUEST EXTENSIONS OF PREVIOUS AUTHORIZATIONS FOR TREATMENT

Please send copies of pages 1-3 with this page to extend previously authorized treatment.

PROGRESS MADE DURING PREVIOUS TREATMENT:

REASONS FURTHER TREATMENT IS NEEDED:

CHANGES IN GOALS/OBJECTIVES

<table>
<thead>
<tr>
<th>NEW TARGET DATE</th>
<th>CURRENT BASELINE</th>
<th>NEW OBJECTIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## I. CLIENT IDENTIFICATION:

<table>
<thead>
<tr>
<th>CLIENT NAME</th>
<th>SMITH, Nancy</th>
<th>DATE OF BIRTH</th>
<th>7-15-84</th>
</tr>
</thead>
<tbody>
<tr>
<td>MED-CAL NUMBER</td>
<td>59-90-966666-6-66</td>
<td>COUNTY CCS/NA</td>
<td>55555555</td>
</tr>
</tbody>
</table>

## II. PROVIDER INFORMATION

<table>
<thead>
<tr>
<th>PROVIDER NAME</th>
<th>Ima Goodworker, LCSW</th>
<th>AGENCY</th>
<th>LCSW</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHONE NUMBER</td>
<td>(777)777-7777</td>
<td>LICENSE TYPE</td>
<td>LCSW</td>
</tr>
<tr>
<td>ADDRESS</td>
<td>P.O.Box 66666</td>
<td>LICENSE NUMBER</td>
<td>LCS 00000</td>
</tr>
<tr>
<td>CITY</td>
<td>Anytown</td>
<td>CALIFORNIA ZIP</td>
<td>95888</td>
</tr>
</tbody>
</table>

## III. SERVICE REQUEST AND JUSTIFICATION

<table>
<thead>
<tr>
<th>INDICATE NUMBER OF SESSIONS REQUESTED:</th>
<th>4 INDIVIDUAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>(INDICATE GOALS FOR EACH TYPE OF SERVICE REQUESTED IN SECTION IX)</td>
<td>4 FAMILY</td>
</tr>
<tr>
<td>GROUP</td>
<td>Other:</td>
</tr>
<tr>
<td>TIME NEEDED TO COMPLETE ABOVE SESSIONS=8-10WEEKS</td>
<td></td>
</tr>
</tbody>
</table>

HOW WAS CHILD REFERRED AND WHY (INCLUDE AS MUCH AS IS KNOWN ABOUT PRESENTING PROBLEM-FREQUENCY CIRCUMSTANCES, ETC.)

This is an almost 12 year old child with diabetes requiring insulin injections and asthma. The request is for an eight session extension of treatment. Nancy's mother's work schedule had changed which reduced mother's availability to the child just as treatment was ending, and Nancy regressed. She had a depressive episode which included increased lethargy, she quit doing homework, and she stopped drawing and preparing her injections.

OTHER AGENCIES INVOLVED WITH CLIENT/FAMILY

U. C. Medical Center–Jane Do, MD

YOUR EXPERIENCE PROVIDING THE TYPE OF SERVICE REQUESTED TO PERSONS THE AGE OF THE CLIENT

Many years experience working with children and certified by Play Therapy Assn.

ATTACH ANY RELEVANT MEDICAL OR PSYCHOSOCIAL HISTORY (ATTACHED: Yes No X)

*YOU CAN STOP HERE IF THE REQUEST IS FOR AUTORIZATION OF NO MORE THAN THREE EVALUATION SESSIONS

## IV. DSM DIAGNOSIS:

Give code and descriptions with date of onset, if known

<table>
<thead>
<tr>
<th>AXIS I CLINICAL</th>
<th>309.0 Adjustment disorder with depressed mood</th>
</tr>
</thead>
<tbody>
<tr>
<td>AXIS 2 PERSONALITY</td>
<td>No DX</td>
</tr>
<tr>
<td>AXIS 3 MEDICAL</td>
<td>Insulin dependent Diabetes and Asthma</td>
</tr>
<tr>
<td>AXIS 4 PSYCHOSOCIAL AND ENVIRONMENTAL PROBLEMS (Describe)</td>
<td>Change in single, working mother's hours, social isolation, with no supports for mom or Nancy</td>
</tr>
<tr>
<td>AXIS 5 GLOBAL ADAPTIVE FUNCTIONING– BEST</td>
<td>70</td>
</tr>
<tr>
<td>CURRENT GAF</td>
<td>60</td>
</tr>
</tbody>
</table>

CONTINUED ON REVERSE
V. HISTORY OF PROBLEM

Nancy talked of suicide at the beginning of treatment and no longer does so. She began to comply with her medical regimen, became less lethargic and began to take interest in her studies and friends at school. Her grades improved from failing to passing. Nancy experienced increased asthma symptoms and medical compliance problems but has improved in both. She lives in a very bad neighborhood and her mother has been overwhelmed, finding it easier to give Nancy shots than teach Nancy to draw and give her own.

VI. PREVIOUS TREATMENT FOR PROBLEM & OUTCOME(S)

<table>
<thead>
<tr>
<th>FROM</th>
<th>TO</th>
<th>SERVICES PROVIDED</th>
<th>RESULTS OF SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>3/1/96</td>
<td>Present</td>
<td>13 sessions to be completed June 1996</td>
<td>Improving but setback see sections III and V, above.</td>
</tr>
</tbody>
</table>

VII. SIGNIFICANT FAMILY HISTORY

Poverty, single mother with history of being the victim of abuse. She is distrustful and very isolated. The mother is overwhelmed and has no supports for herself. The neighborhood is dangerous but the mother refuses to consider moving if she cannot have a house or duplex/halfplex, and is probably too overwhelmed to contemplate the added stress of moving, in the event.

VIII. FUNCTIONAL IMPAIRMENT-PROGRESS TO DATE

[X] HOME
- Improved, with less defiance of medical regimen. Her allergies are well controlled for the first time, but she is still not fully compliant with her diabetes Tx. She is afraid of her shots and resists even drawing the insulin from the bottle-lethargic at home.

[X] SCHOOL/WORK
- Grades improved from failing and she shows improved interaction wrtn other children.

[X] SOCIAL
- Isolated family in a bad neighborhood, with few friends at home.

[X] COMMUNITY
- Mother trusts few people and maintains isolation.

[X] OTHER
- Nancy's diabetes is a real challenge in this family that would be struggling without this medical problem. She has begun to draw her own shots intermittently.

IX. GOALS: PLEASE STATE GOALS FOR EACH TYPE OF SERVICE REQUESTED; IN MEASURABLE OR OBSERVABLE TERMS THAT WILL ALLOW EVALUATION OF THE EFFICACY OF THE TREATMENT: EG: REDUCING ANXIETY ABOUT SCHOOL ATTENDANCE CAN BE STATED AS "MISSING SCHOOL WILL BE REDUCED FROM ONE UNEXCUSED ABSENCE PER WEEK TO LESS THAN ONE PER MONTH" WHAT THE CLIENT WILL VERBALIZE THAT INDICATES PROGRESS. USE ADDITIONAL PAGES IF NEEDED

LONG TERM GOAL(S):1. Individ: Maintain school performance gains. 2. Family: Mother will be supported to use her authority as a parent, and encouraged to teach Nancy and insist that Nancy draw and give her own insulin shots.

3. Both: Decrease depression. 4. Increase Nancy's expression of her needs and wants verbally. 5. Increase Nancy's self esteem and support Nancy's feelings of self efficacy concerning self care, peers, and school.

TARGET DATE SHORT TERM GOALS/OBJECTIVES

Summer 96
- Nancy will give her own shots two days per week, on the days when mother is home from work. She will attend camp for children with Diabetes, in August 1996.

June 96
- Nancy will prepare all shots. Nancy will state one need/wish verbally each day. Nancy will converse with one peer each day.

I CERTIFY THAT THE CLIENT'S PARENT(S) OR CLIENT, IF OVER 18 AGREES TO THE TREATMENT

PLAN: SIGNATURE OF THERAPIST
Children’s Medical Services  
California Children’s Services Program

__________________________

__________________________

TAR#: ______________________
RE: ___________________________ Medi-Cal#: ______________________
DOB: ________________________

Dear Children’s Medical Services Representative:

The enclosed request was received by the Medi-Cal Operations Division, Early & Periodic Screening, Diagnosis and Treatment (EPSDT) Unit and appears to be a Children’s Medical Services (CMS), California Children’s Services (CCS) eligible condition. The provider has been asked to forward the request to you. We appreciate your review of the request and return of this form indicating the action taken:

☐ Case Management will be provided by CCS.
☐ Diagnosis is not a CCS eligible condition and we are returning the Treatment Authorization Request (TAR).
☐ Services requested will not treat a CCS eligible condition and we are returning the TAR.
☐ Services requested are not documented to be medically necessary and we are returning the TAR.
☐ Provider is not a CCS panel provider.
☐ Other: __________________________________________________________

Signature of CCS Representative

__________________________________________

Date

Please return this form to:

Department of Health Services
Medi-Cal Field Office

__________________________________________

Thank you for your cooperation.

Enclosure

ReplyCCSLu 08/14/95
RE: ____________________________

Medi-Cal #. ____________________________

Dear ____________

The enclosed Treatment Authorization Request (TAR) # ____________________________ was received by on for the beneficiary named above. The Medi-Cal Program is required to refer to the California Children’s Service (CCS) program, any beneficiary under age 21 who has a medical or surgical condition which would qualify for services through CCS according to title 22 California Code of Regulations section 51013. Please submit your request for services to the address indicated below.

Children’s Medical Services (CMS)
California Children’s Services Program

In order to expedite review, do not send a TAR instead, your request should contain copies of the TAR and this letter, as well as any supporting documentation.

Thank you for your cooperation. If you have any additional questions, please contact the CMS county representative identified above at (____) ____________________________

Sincerely,

______________________________

Enclosure

cc: Children’s Medical Services (CMS)
California Children’s Services (CCS) Program