STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY GRAY DAVIS, *Governor*

DEPARTMENT OF HEALTH SERVICES
714 / 744 P STREET
P.O. BOX 942732
SACRAMENTO, CA 94234-7320
(916) 654-0499

October 20, 1999

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N.L. 12-0999
Index: Benefits

TO: California Children's Services (CCS) Program County Administrators and Medical Directors, Children's Medical Services (CMS) Branch Central Office and Regional Office Staff

SUBJECT: REQUESTS FOR AUDIOLOGY SERVICES

It is essential that the pool of audiology providers be maintained by assuring appropriate and timely authorizations and payments for their services provided to CCS-eligible children. Therefore, it is imperative that CCS programs adhere to the following guidelines.

All requests for audiology services and amplification devices for full-scope Medi-Cal beneficiaries with no Share of Cost that exceed the general Medi-Cal benefits MUST be referred to the CMS Branch as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Supplemental Services (SS) requests. Examples of such requests **include** programmable hearing aids, digital hearing aids, FM systems, vibrotactile devices, and aural rehabilitation services.

Medi-Cal will NOT reimburse any claim for audiology services that exceeds the general scope of benefits established by Medi-Cal, even if the services have been authorized by the local CCS program. It will not reimburse for medically necessary, non-conventional hearing aids beyond the price limitations identified with Medi-Cal regulations. In order that providers are reimbursed appropriately and adequately, these requests for services must be submitted, reviewed, and approved as EPSDT SS.

EPSDT SS requests are submitted to:

EPSDT SS Coordinator
Children's Medical Services
Branch 714 P Street, Room 350
P.O. Box 942732
Sacramento, CA 94234-7320
(916) 654-0499
FAX (916) 654-0501

Requests must be submitted with:

1. EPSDT SS Worksheet (dated 3/98) -- completed by the county program staff.

2. Medi-Cal EPSDT SS Request two-sided form (dated March 1997) completed by the provider.

3. Current audiology report, including audiograms (or for children under one year of age, a summary of the results of specific audiological testing procedures).

It is increasingly clear that the need for the services identified above is not reflected in the number of requests reviewed as EPSDT SS for audiology and amplification devices. This reminder, therefore, is necessary as the requests are only being submitted from a few county CCS programs.

If you have any questions about EPSDT SS please contact Galynn Plummer-Thomas, R.N., at (916) 653-3480. For questions regarding audiology services, please contact Jennifer Sherwood, M.A., CCS-A, at (415) 904-9678.

Original Signed By

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

Enclosures

State of California-Health and Welfare Agency

Department of Health Services
Children's Medical Services Branch

CHILDREN'S MEDICAL SERVICES (CMS) BRANCH
CALIFORNIA CHILDREN SERVICES (CCS) PROGRAM
EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) SUPPLEMENTAL SERVICES (SS) WORKSHEET

ID#_____
TO BE FILLED IN BY CMS CENTRAL OFFICE

Patient Name: _____ DOB:_____
(Last) (First) (Middle Initial)

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:_____

	Yes	No
1. EPSDT SS request is to treat a CCS-eligible condition/or complication thereof? If no, attach justification of EPSDT SS request.	❑	❑
2. EPSDT SS is a Medi-Cal benefit?	❑	❑
3. EPSDT SS is a CCS benefit?	❑	❑
4. Provider requesting to provide EPSDT SS is an enrolled Medi-Cal provider?	❑	❑
5. Provider requesting to provide EPSDT SS is a CCS paneled provider?	❑	❑
6. Provider requesting to provide EPSDT SS is employed by an enrolled Medi-Cal provider?	❑	❑
7. Is there alternative care which is less costly than the EPSDT SS? If yes, identify alternative care and its cost:_____	❑	❑
8. Is patient an In-Home Operations client?	❑	❑

County Recommendation(s):	Central Office Decision:	To Be Filled in By CMS Central Office
By:_____ Phone #:_____ FAX #:_____ Date:_____	By:_____ Phone #:_____ Date:_____	Committee (Comm) 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:

- EPSDT SS Workslieet
- **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
FAX: (916)654-0501

MEDI-CAL EPSDT SUPPLEMENTAL SERVICES REQUEST

(Audiology services, cochlear implant, Aills and nonconventional hearing aids)

(CCS NOTE: Include this form with the CCS EPSDT request form.)

NAME:_____DOB:_____MEDI-CAL#_____

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: _____

_____

_____

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)_____

(Facility Name)_____

(Medi-Cal Provider Number to be authorized)_____

FOR OFFICIAL USE:

DATE RECEIVED:_____ DATE REVIEWED:_____

ADDITIONAL INFO NEEDED:

RESPONSE DATE:_____ BY:_____

ESPDT REVIEWER