

**DEPARTMENT OF HEALTH SERVICES**

714 / 744 P STREET  
P.O. BOX 942732  
SACRAMENTO, CA 94234-7320

(916) 654-0499

October 20, 1999



**REVISED**  
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

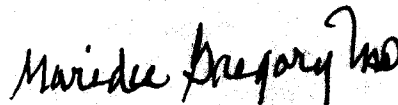
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Requests must be submitted with:

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.



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

Enclosures



**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: \_\_\_\_\_ (Last, First, Middle Initial) 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: \_\_\_\_\_

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

County Recommendation(s):  By: _____ Phone #: _____ FAX #: _____ Date: _____	Central Office Decision:  By: _____ Phone #: _____ Date: _____	<b><u>To Be Filled in By CMS</u></b> <b><u>Central Office</u></b>  Committee (Comm) Code: _____ Date Presented to Comm: _____ Comm Decision Code: _____ Comm Decision Date: _____ Date County Notified: _____ Consultant Code: _____
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- Mail or Fax the required documents listed below to:**
- ◆ EPSDT SS 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  
 FAX: (916) 654-0501

**MEDI-CAL 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: \_\_\_\_\_ 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:** \_\_\_\_\_

**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:**

DATE RECEIVED:	DATE REVIEWED:
ADDITIONAL INFO NEEDED:	
RESPONSE DATE: _____	BY: _____
EPSDT REVIEWER	