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

October 20, 1999

REVISED
N.L. 12-0999
Index: Benefits

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.


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

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? ☐

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

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 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

EPSDT.FR.M (Rev. 3/94)
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:

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

RESPONSE DATE: ___________________ BY: ___________________

EPSDT REVIEWER 4/97 REVISED