

DEPARTMENT OF HEALTH SERVICES

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December 3, 1996



MMCD Letter No. 96-10

- TO:**
- Prepaid Health Plans (PHP)
 - County Organized Health Systems (COHS)
 - Geographic Managed Care Plans
 - Primary Care Case Management Plans (PCCM)

SUBJECT: Medi-Cal Managed Care Plans Whose Contracts Exclude California Children's Services (CCS)

PURPOSE:

The goal of the Medi-Cal Managed Care program is to insure that Plan members with emerging or identified CCS eligible conditions receive timely, appropriate, and coordinated care leading to optimum clinical outcomes.

BACKGROUND:

The CCS program provides medically necessary care and case management to children with physically handicapping conditions who meet program eligibility requirements pursuant to Health and Safety Code Section 123800, et seq., and Title 22, Sections 41000, et seq. CCS services are delivered by paneled providers and approved tertiary care medical centers in the local communities who meet CCS program standards (see Enclosure I for a more complete program description). Pursuant to legislation Welfare and Institutions Code, Section 14094.3(a), CCS covered services are excluded from the Medi-Cal managed care contracts entered into after August 1, 1994.

This policy applies to Medi-Cal managed care plans (referred to henceforth as the Plans) whose contracts exclude medical services for children eligible under the CCS program. The following Plans' contracts specify CCS SERVICE CARVE-OUT while the member remains enrolled in the Plan:

1. PHPs, including the Local Initiatives and Mainstream Plans in the Two-Plan Model, and most PHPs in the Sacramento Geographic Managed Care (GMC) program.
2. PCCM Plans operating in the Sacramento GMC program.
3. COHS (Cal-Optima and Santa Cruz).

Members of the above-listed Plans whose condition is authorized for treatment by the CCS program will remain enrolled in the Plans for purposes of receiving primary care and services unrelated to the CCS condition(s).

PCCMs operating outside of the Sacramento GMC program have contracts that require the disenrollment of a member with an approved CCS condition(s) (CCS MEMBER CARVE-OUT).

POLICY:

Plans must develop procedures for identifying children with CCS eligible conditions, and arrange for their timely referral to the county CCS program. For Plans whose contracts specify CCS service CARVE-OUT, they must continue to provide case management of all services (primary care and specialty care) until eligibility has been established with the CCS program. When eligibility has been established, the CCS program assumes case management responsibility of the CCS eligible condition and authorizes medically necessary care to be reimbursed on a fee-for-service basis by the Medi-Cal program. Plans continue to provide primary care case management, coordination of services, and health care service other than those required for the CCS condition. For PCCMs whose contracts allow for disenrollment of a member with a CCS eligible condition, the Plan must ensure the orderly transfer of care to the CCS program.

I. PRIMARY CARE

Plans must provide children with CCS eligible conditions, primary care and all other services unrelated to the CCS eligible condition, including EPSDT supplemental services (EPSDT supplemental services related to the CCS eligible condition are excluded from the contract). Plans must also ensure that their primary care providers provide complete baseline health assessment and diagnostic evaluations sufficient to ascertain the evidence or suspicion of a CCS eligible condition, including but not limited to: specific physical findings,

laboratory test results, etc., (see Enclosure II for specific requirements). Plans must implement procedures to ensure transfer of medical documentation from the PCP to the county CCS program.

II. PROVIDER TRAINING

Plans must ensure that network providers delivering care to children, as well as the support staff, are knowledgeable about CCS eligibility criteria, provider standards, and CCS program services by training the plan's providers and administrative staff. Plans must also distribute to its providers the list of potentially eligible CCS conditions (see Enclosure III) and updated CCS program policies and procedures transmitted to the Plan by the county CCS program.

III. REFERRAL, PRIMARY CARE CASE MANAGEMENT, AND COORDINATION

Plans must develop and implement procedures to ensure the timely referral of children with CCS eligible conditions to the county CCS program. With respect to conditions covered by CCS, Plans remain responsible for the care of the enrolled child until the CCS program eligibility is determined. Plans shall ensure that providers are informed of CCS paneled providers and approved hospitals within the plan's network to ensure continuity of care during the time it takes to determine eligibility. CCS services are covered only from the time the referral is made to the county CCS program, except for emergency services or services rendered after office hours. Referrals for emergency or after-hours care must be made to the county CCS program on the next business day and must include appropriate documentation substantiating emergency or urgent care. Plans must also implement procedures for primary care case management and coordination of services between the primary care providers, the CCS specialty providers, and the county CCS program.

IV. CCS CHILDREN IDENTIFICATION AND TRACKING

Plans must develop and implement procedures to identify current and new enrollees with CCS conditions and provide timely information to the county CCS program regarding these children (see Enclosure IV for a list of the county CCS programs). In addition, Plans must develop and implement procedures for tracking the identified children and the services provided to them to assure coordination and continuity of care.

V. PROBLEM RESOLUTION

Plans must also establish procedures to coordinate problem resolution with the local CCS program. For the Two-Plan Model plans, a memorandum of understanding (MOU) with the local health department is required. The MOU will specify the scope and responsibilities of both parties (the Plan and the County CCS program), including but not limited to referrals, medical information transmittals, and coordination of services. Plans not in the Two-Plan Model are encouraged to explore this as an option for their own coordination procedures.

The MOU must also address procedures to coordinate problem resolution between the two parties. Disagreements with regards to CCS program eligibility, payments for treatment services of the CCS eligible condition and associated or complicating conditions, must be resolved cooperatively between the Plan and the county CCS program. If these are not resolved at the local level, the Plan must notify the Medi-Cal Managed Care contract manager, and the county CCS program must notify the State CCS Regional Office. The State Children's Medical Services (CMS) program and Medi-Cal Managed Care Division will ultimately render a joint decision if the problem is not resolved at the lower levels.

DISCUSSION:

For Medi-Cal managed care plans whose contract excludes CCS services (both service CARVE-OUT and member CARVE-OUT), the county CCS program has the sole authority to make CCS program eligibility decisions. CCS decisions will be based upon the review of appropriate medical documentation and other evidence submitted with the referral and request for services. Once CCS eligibility is determined, the county CCS program assumes case management (including prior authorization) of all services related to the CCS condition, including condition-related EPSDT supplemental services. A CCS authorization for specialty services to a CCS paneled provider indicates that these services are eligible for Medi-Cal fee-for-service reimbursement with claims being authorized directly through local CCS offices.

Plans may wish to make CCS application forms readily available in providers' offices to assist families in the completion and submission of necessary paperwork to establish full CCS eligibility. Completion of the application forms will entitle the CCS eligible plan enrollee to extended benefits covered only by the CCS programs and not currently available from the Medi-Cal program.

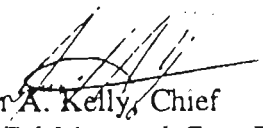
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In order to ensure that children with CCS eligible conditions receive appropriate care and achieve the optimum clinical outcome, the Plan and the county CCS program must establish a close working relationship. Some of the responsibilities of the county CCS program include assisting the Plan in the following:

1. Prompt determination of CCS eligibility upon receipt of Plan's referral and medical documentation.
2. Training and consultation to the Plan's providers on various aspects of the CCS program.
3. On-going coordination with Plan's providers, including authorization of appropriate CCS services for Plan's enrollees and provision of information as to CCS approved providers and services authorized.
4. Periodic transmittal to the Plans of CCS eligible patients who are known to be Plan enrollees, when such information is known to CCS.
5. Provision of a list of current CCS approved specialists, hospitals and special care centers in the county and/or surrounding areas, with updates of the list on a periodic basis.
6. Designation of a liaison to the Plan to ensure transmittal of program information to the Plan and Plan providers and assist with problem resolution.

Should there be any questions regarding these policies, please contact your contract manager.

Sincerely,


Joseph A. Kelly, Chief
Medi-Cal Managed Care Division

Enclosures

CALIFORNIA CHILDREN SERVICES PROGRAM

A Brief Summary

GOAL

The California Children Services (CCS) Program's goal is to assure that children with physically handicapping conditions receive necessary and appropriate health care to treat their eligible conditions at the appropriate time and place by CCS paneled health care practitioners. The program performs these assurance functions by defining those handicapping conditions requiring multispecialty, multidisciplinary care and by determining program eligibility. The program also performs other services which usually include:

- assessing the qualifications of and selecting the most appropriate providers and sites for care;
- case management activities;
- determining the appropriateness of treatment plans and
- authorizing funding for the services.

Frequently, working with families and children with multiple problems may identify the need for extended services in the home and coordination with other community agencies.

STATE AND COUNTY PARTNERSHIP

The organization of the state's CCS programs have been a partnership between the local county health departments and the State of California. When Medi-Cal does not provide services for the CCS eligible condition, but the patient meets the other program eligibility criteria, the services are then funded equally between the state and the county.

In the counties with populations of greater than 200,000 (independent counties), county staff perform all case management activities for eligible children residing in the counties. This includes determining all phases of program eligibility, evaluating needs for specific services and authorizing and paying for medically necessary care. For the smaller counties who do not have the staff available to provide case management and eligibility and benefits determination, the state assumes this role in the three Regional Offices. The latter "dependent" counties interact directly with the families and make decisions on financial and residential eligibility.

The Regional Offices provide consultation, technical assistance and oversight to independent counties, individual CCS paneled providers, hospitals and the special care centers within their region.

PROGRAM COMPONENTS

The CCS program has four components, which are the following:

Diagnosis and Treatment Program

The Diagnosis and Treatment Program provides medically necessary care and case management to infants, children, and adolescents meeting program eligibility requirements. This care is delivered by providers who meet program standards in tertiary care medical centers and in local communities.

Medical Therapy Program

The Medical Therapy Program provides medically necessary physical therapy (PT).

occupational therapy (OT) and medical therapy conference (MTC) services to children who are medically eligible for the program. There are no financial eligibility requirements for the MTP. The MTC team physician(s) are specialists (usually an orthopedist or physiatrist and a pediatrician) in the treatment of chronically handicapped children. The team performs examinations and prescribes PT, OT, durable medical equipment (DME), and any other necessary medical interventions required to treat the child's eligible diagnosis. PTs and OTs work for the county in medical therapy units (MTUs) that are located on public school grounds as part of an interagency agreement with the California Department of Education. PTs and OTs evaluate and treat patients as prescribed by the physician, participate as members of the MTC team, and provide consultative services to all entities involved with providing care for the child.

High Risk Infant Followup Program

The High Risk Infant Followup Program provides follow up to infants discharged from a CCS Neonatal Intensive Care Unit (NICU) who are at risk of developing a CCS eligible condition. These services include developmental testing, neurological, ophthalmological and audiological evaluations.

The Human Immunodeficiency Virus (HIV) Children's Screening Program

HIV Children's Screening Program provides a structured system for screening and monitoring infants, children, and adolescents, under the age of 21, at risk for HIV infection. Children at risk for, or suspected of having HIV infection, are eligible for screening, diagnostic evaluation or medical monitoring and follow-up services regardless of family income. The program is administered through a coalition between state, county, and community based providers.

AUTHORITY

Using regulatory and statutory authority and CCS program policies and procedures, professional program staff determine medical eligibility through the review of medical documentation submitted for an individual child.

CCS FINANCIAL ELIGIBILITY

Children who may subsequently lose their Medi-Cal eligibility may continue to retain CCS eligibility and access to necessary health care services as long as their families and/or legal guardians apply to the CCS program and maintain financial and residential eligibility. Financial eligibility for CCS is up to an Adjusted Gross Income of to \$40,000. The program may also authorize care for children medically eligible for the CCS program, but who have other third party insurance coverage or no insurance benefits at all. In the case of the former, the insurance is billed first and CCS may pay beyond the insurance coverage, up to Medi-Cal reimbursement rates, but the provider cannot bill the family for any balance.

DELIVERY SYSTEM

The CCS program implements its statutory mandate to assure that eligible children receive appropriate high quality care by limiting authorization of such care to physicians, dentists and other health care providers with documented training and experience in either pediatrics and/or one of its subspecialties or in the care of children by other specialists, such as surgeons. The state CCS program enrolls, maintains and updates the lists of specialists that it authorizes. This process is called paneling. It also maintains a list of hospitals that have been reviewed and found to have met CCS program standards. These hospitals are described by the

level of, and types of services, provided to children. Local county CCS programs provide a listing of paneled providers in their community for the appropriate specialties and services. Likewise, information about hospitals which are CCS approved providers can be obtained by contacting your local CCS program.

CCS PROGRAM SPECIAL CARE CENTER SERVICES

The CCS program's rationale for the development of Special Care Centers is that children with complex, handicapping conditions receive improved care and achieve better long-term outcomes when services are provided in a timely fashion and coordinated through special care centers. These centers are a construct of multidisciplinary, multispecialty teams who evaluate, treat and plan comprehensive, coordinated care for groups of illnesses, generally grouped by organ system. Such centers are usually located at tertiary medical centers throughout the state and their approval indicates review by the state program as having met CCS program standards.

The program requires that children with the following conditions be referred to a CCS approved special care center for evaluation and recommendation:

- congenital heart disease
- inherited metabolic disorders
- chronic renal disease
- chronic lung disease
- malignant neoplasms
- hemophilia and other coagulopathies
- hemoglobinopathies
- craniofacial anomalies
- myelomeningocele
- endocrine disorders, including diabetes

In addition, other children should be referred to CCS special care centers if the CCS client has another condition that:

- impacts the management of the CCS eligible condition,
- the family is unable to provide care for the client and/or the family system is not able to provide support;
- or the CCS program or the approved CCS special care center identifies that the patient is in need of center services.

Historically in CCS, program professional staff performed the case management functions. The CCS staff review proposed treatment plans generated by the centers and/or individual practitioners to determine the appropriateness of the requests to meet the specific needs of the child. Questions of medical necessity for specific services and care are discussed with the requesting practitioner, and if after review, staff feels other referrals and/or care might be needed, such requests are initiated, whether to a health care practitioner or a community agency.

AUTHORIZATION OF SERVICES

Authorization of requested care is another component of the case management activities performed by CCS program staff. As per Title 22, Section 51013, the CCS program provides case management services for Medi-Cal-eligible beneficiaries with CCS-eligible conditions. Such activities included those previously identified, as well as the authority to authorize the payment of Medi-Cal funds for Medi-Cal services provided to these eligible children. The CCS program may authorize and pay for those necessary services that are CCS benefits, but not Medi-Cal benefits to Medi-Cal beneficiaries from CCS funds (a combination of state

general fund monies and local county allocations and appropriations).

The program requires prior authorization for ALL services, per Section 42180, Title 22, regardless of the eventual source of payment. It is most important that children with potentially eligible conditions be referred as soon as possible to the CCS program. Program policy is that services can only be authorized starting from the DATE OF REFERRAL, with specific criteria for referral of conditions arising from an emergency or services provided when the program offices are closed.

ROUTINE FLOW OF PATIENT SPECIFIC ACTIVITIES

The following descriptions attempt to define terms and clarify the way in which services are initiated and provided as a routine within the CCS program. Naturally emergency services for new and continuing patients will alter this pattern.

- Referral: The CCS program accepts referrals for eligibility determination from any source (health care provider, Child Health and Disability Prevention (CHDP) program, teacher, Regional Center or parent are examples); receipt of a referral by the county program triggers the sending of an
- CCS program Application: A form to be filled out by the client, parent and/or legal guardian, indicating an interest in participating in the CCS program and receiving all CCS program benefits (this would include non-Medi-Cal benefits for Medi-Cal-eligible clients); upon receipt of a completed application the CCS program completes
- Eligibility Determination: The CCS program determines whether there is there a medically eligible condition, whether the family is financially eligible; whether the child a resident of the county in which he/she applies for services; and when found eligible for the program, the client, parent and/or legal guardian signs a
- CCS Program Agreement: a document indicating the willingness to abide by CCS program policies and procedures and offering Medi-Cal recipients the full range of CCS program benefits beyond those available through the Medi-Cal program.

After determination of CCS program eligibility,

- Requests for services: are reviewed by the CCS program for the determination of medical necessity and appropriateness, as all services are to be prior authorized. If a request is found to be medically necessary for the treatment of the CCS-eligible condition and/or for the treatment of an associated or complicating condition, then the CCS program issues an
- Authorization: document sent to a provider indicating that the provider can deliver and will be reimbursed for the approved medically necessary and appropriate services for the treatment of the client's CCS-eligible condition.

Contingencies for the authorization of emergency services for patients with CCS eligible conditions are available and necessarily do not follow the routine patient flow of services.

***This brief summary document has been developed solely for the convenience and use of contractors in understanding the general characteristics of the CCS program. It is not an authoritative statement of, and may not be cited as authority, for any decisions, determinations or interpretations under the CCS program. Managed Care Contractors and others should refer to the applicable provisions of the California Health and Safety Code, Title 22 of the California Code of Regulations and formal CCS policy documents of the Department of Health Services. The County or Regional CCS Office can provide you with assistance in this regard.*

REFERRALS TO THE CALIFORNIA CHILDREN SERVICES PROGRAM

The California Children Services Program (CCS) requires that at the time of referral there be sufficient medical documentation to ascertain the evidence or suspicion of a CCS eligible condition, (e.g., specific physical findings, laboratory results). Primary care providers and plan medical administrators may consult with the county CCS program staff if there are any questions regarding potential eligibility and need for referral. Most suspected conditions should be referred upon recognition that there is some evidence or suspicion that a CCS eligible condition is present in a child. However, for children suspected of having the following conditions, the following steps should be undertaken by the referring provider before referral to the CCS program:

I. Cardiac Condition

If a heart murmur was detected upon routine examination, steps such as having the child examined by a pediatrician, should be undertaken to ensure that the heart murmur is not a functional murmur and that it requires evaluation by a CCS approved pediatric cardiologist.

II. Strabismus

If strabismus was detected upon routine examination, the child should be referred by the Plan to an ophthalmologist for evaluation. Referral to the CCS program is only necessary if surgery is required.

III. Scoliosis

If scoliosis is detected upon routine examination, the primary care provider must obtain an x-ray examination of the spine. Referral to the CCS program should be done if the x-ray confirms a spinal curvature of greater than 20%.

IV. Cerebral Palsy

A detailed physical examination including a complete neurological examination, documenting physical findings consistent with the diagnosis of cerebral palsy, must be completed prior to referral to the CCS program.

V. Hearing Loss

For children who are at an age appropriate for testing, referral to the CCS program is appropriate only after the following have occurred:

1. two separate audiometric evaluations performed six weeks apart, documenting hearing loss; and
2. evaluation and treatment by the primary care provider of any treatable conditions contributing to the hearing loss.

Referral for evaluation of hearing loss in younger children maybe made without test results.

VI. Growth Hormone Deficiency

Referral to the CCS program should occur only if the child's growth chart shows a height of more than three standard deviations below the mean for age or a linear growth rate less than the third percentile for age.

OVERVIEW OF CCS MEDICAL ELIGIBILITY

Infectious and Parasitic Diseases (ICDA 000-136)

In general, these conditions are eligible when they:

- 1) involve the CNS and produce disabilities requiring surgical and/or rehabilitation services;
- 2) involve bone;
- 3) involve eyes, may lead to blindness and constitute a medically treatable condition;
- 4) are congenitally acquired which may result in physical disability, and for which postnatal treatment is available and appropriate.

Neoplasms (ICDA 140-208, 210-228)

- 1) All malignant neoplasms, including those of the blood and lymph systems;
- 2) Benign neoplasms when they constitute a significant disability or significantly interfere with function.

Endocrine, Nutritional, and Metabolic Diseases (ICDA 240-279)

In general, these conditions are eligible. Examples of eligible conditions include diseases of the pituitary, thyroid, parathyroid, adrenal, pancreas, ovaries and testes; growth hormone deficiency when certain specific criteria are met; diabetes mellitus when it is uncontrolled (per CCS criteria) and/or complications are present; varied inborn errors of metabolism; cystic fibrosis.

Nutritional disorders such as failure to thrive and exogenous obesity are not eligible.

Diseases of Blood and Blood-Forming Organs (ICDA 280-289)

In general, these conditions are eligible. Common examples of eligible conditions are: Sickle cell anemia, hemophilia and aplastic anemia.

Iron or vitamin deficiency anemias are only eligible when there are life-threatening complications.

Mental Disorders (ICDA 290-315)

Conditions of this nature are not eligible except when the disorder is associated with or complicates an existing CCS-eligible condition. (Diagnosis and treatment under these conditions is limited.)

Diseases of the Nervous System and Sense Organs (ICDA 320-359)

Diseases of the nervous system are, in general, eligible when they produce physical disability (e.g., paresis, paralysis, ataxia) that significantly impair daily function.

Idiopathic epilepsy is eligible when the seizures are uncontrolled, per CCS criteria. Treatment of seizures due to underlying organic disease (e.g. brain tumor, Cerebral Palsy, inborn error of metabolism) is based on the eligibility of the underlying disease.

Specific conditions not eligible are self-limited and include acute neuritis and neuralgia; and meningitis that does not produce sequelae or physical disability. Learning disabilities are not eligible.

Sense Organs (ICDA 360-389)

A. Eyes

Strabismus is eligible when surgery is required.

Chronic infections or diseases of the eye are eligible when they may produce visual impairment and/or require complex management or surgery.

B. Ears

Hearing loss, as defined per CCS criteria.

Perforation of the tympanic membrane requiring tympanoplasty.

Mastoiditis.

Cholesteatoma.

Diseases of the Circulatory System (ICDA 390-458)

Conditions involving the heart, blood vessels, and lymphatic system are, in general, eligible.

Diseases of the Respiratory System (ICDA 460-519)

A. Upper respiratory tract conditions are eligible if they are chronic, cause significant disability, and respiratory obstruction; or complicate the management of a CCS-eligible condition.

B. Lungs: chronic pulmonary disease is eligible (as per CCS criteria).

Diseases of the Digestive System (ICDA 520-577)

Diseases of the liver, chronic inflammatory disease of the gastrointestinal tract and congenital abnormalities of the GI system are eligible; and gastroesophageal reflux, as per CCS criteria.

Malocclusion is eligible when there is severe impairment of occlusal function and is subject to CCS screening and acceptance for care.

Diseases of the Genitourinary System (ICDA 580-629)

Chronic genitourinary conditions and renal failure are eligible. Acute conditions are eligible when complications are present.

Complications of Pregnancy, Childbirth, and Puerperium (ICDA 630-678)

Prenatal care and delivery may be provided if the pregnancy complicates the management of the CCS-eligible chronic disease (e.g., cystic fibrosis, diabetes, chronic renal or cardiac disease.)

Diseases of the Skin and Subcutaneous Tissue (ICDA 680-709)

These conditions are eligible if they are disfiguring, disabling and require plastic or reconstructive surgery and/or prolonged and frequent hospitalizations.

Diseases of the Musculoskeletal System and Connective Tissue (ICDA 710-738)

These conditions are eligible if they are disabling. Minor orthopedic conditions such as toeing-in, knock knees, flat feet are not eligible. However these conditions may be eligible if expensive bracing, multiple casting, and/or surgery is required.

Congenital Anomalies (ICDA 740-759)

Congenital anomalies of the various systems are eligible if the condition is disabling or disfiguring, amenable to correction and requires surgery.

Certain causes of Perinatal Morbidity and Mortality (ICDA 760-779)

- A. Neonates who have a CCS eligible condition and require care in a neonatal intensive care unit
- B. Critically ill neonates who do not have an identified CCS eligible condition but who between 0-28 days develop a disease or condition which requires one or more of the following services in a neonatal intensive care unit:
 1. Ventilatory assistance.
 2. CPAP (continuous positive airway pressure), including nasal CPAP.
 3. FiO_2 greater than 30%
 4. UA (umbilical artery), UV (umbilical vein), PAC (Peripheral arterial catheter), or central lines.
 5. Apneic and/or bradycardic spells requiring stimulation ten times per day or more often.

6. Chest tube in place.
7. Multiple and frequent procedures, defined as two or more of the following:
 - - Frequent vital signs (every two hours or more often).
 - - Frequent PVS (percussion, vibration, suction), PPDS (percussion, postural drainage, suction), CPT (chest physiotherapy).
 - - Maintenance of IV line for medication.
 - - Hyperalimentation.
 - - Frequent suction (every hour or more frequently).
 - - Frequent and/or lengthy feedings.

When conditions in A. and B. above are not applicable, the neonate is not eligible.

Accidents, Poisonings, Violence, and Immunization Reactions (ICDA 800-999)

These conditions are, in general, eligible when: they are of a serious nature, lead to significant deformity or disability, and/or require surgery.

Acute, self-limiting poisoning due to drugs/alcohol are not eligible. Similarly, simple fractures requiring casting are not eligible.

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