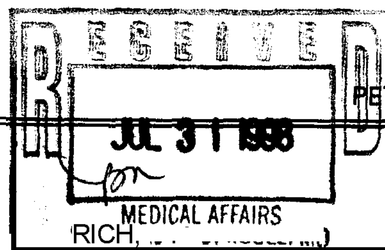
STATE OF CALIFORNIA HEALTH AND WELFARE AGENCY



PETE WILSON, *Governor*

DEPARTMENT OF HEALTH SERVICES

141744 P Street
P. 0. Box 942732
Sacramento, California 94234-7320
(916) 654-8076

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,

Susanne Hughes for

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

Enclosure

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

DEPARTMENT OF HEALTH SERVICES
P STREET
BOX 942732
SACRAMENTO CA 94234-7320
(916) 654-0832
(916) 654-0476 TDD Relay

February 11, 1998

N.L.: 01-0298
Index: Durable Medical Equipment

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 199 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.

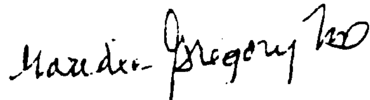
Policy

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 senices request in order for the equipment to be reimbursable by Medi-Cal.

Poiicv Guidelines

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

Equipment	Medical Necessity	Criteria	Related Considerations
Automobile Orthopedic Positioning Devices (AOPD)			• CCS will purchase only 1 AOPD over a lifetime.
Car seats	Requires maximal to moderate postural support to maintain a safe sitting position during transportation	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	• 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.
Harnesses Vests	Same as car seats	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.	• The childs' 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

STATE OF CALIFORNIA-HEALTH AND WELFARE AGENCY

PETE WILSON, Governor

. DEPARTMENT OF HEALTH SERVICES
1/744 P STREET
J. BOX 942732
SACRAMENTO, CA 94234-7320

(916) 653-3480
(916) 654-0476 TDD/Relay

May 26, 1998

N.L. : 09-0598
Index: EPSDT Supplemental Services
Subject: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Supplemental Services (SS)

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 FXCEPT HOURI Y 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 **Cocrdinators** at the State CMS office.

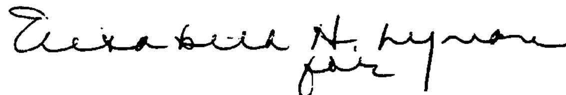
EPSDT SS HOURLY NURSING SERVICE REQUESTS

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.



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

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-CALOPERATIONS DIVISION HEADS UP LETTER TO CCS THAT A PROVIDER HAS BEEN REFERRED TO OBTAIN THE SERVICES FROM CCS

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

ID #: ________
TO BE FILLED IN BY CMS CENTRAL OFFICE

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

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 ad/or Duratior 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
		Committee (Comm) Code: ________
		Date Presented to Comm: ________
By: ________	By: ________	Comm Decision Code: ________
Phone #: ________	Phone #: ________	Comm Decision Date: ________
FAX #: ________		Date County Notified: ________
Date: ________	Date: ________	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) 6640601

EPSDT.FRM (Rev. 3/98)

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

1/97 REVISED

PRE-COCHLEAR IMPLANT QUESTIONNAIFE FOR REFERRAL **SOURCE**
CHILD'S **NAME:**______________________________

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

Enclose current reports of audiological 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 play **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 thild's **cducational** program: ______________________________
____
____
____

Rovider'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 ar 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	PRESCRIBED BY: Health care Provider
Address	Address
Phone	Phone
Medi-Cal Provider Number (ii billed through the RD)	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 beck):

☐ 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 thii authorization, ✔ name of the pharmacy which will dispense the medical food, and ✔ percentage of medical food products which are snack foods ($\leq$ 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.

Early, Periodic Screening, Diagnosis and Treatment Supplemental Services

INFORMATION ABOUT REQUESTING MEDICAL FOODS

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 requiremenk 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):

Medical Food Product	Product Code	Package Amt	Unit Cost	# of Unik for 6 mo	TOTAL COS
dp Baking Mix	DPBM0604	4 lb bag	$ 15.00	4	$60.00
Low pro cookies .	xxxxxxxxx	160zbox	55.00	1	55.00 *
. 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.

DATE OF YOUR REQUEST: / /

PROVIDER OF SERVICES: Registered Dietitian	**PRESCRIBED BY:** Health Care Provider
Address	Address
Phone	Phone
Medi-Cal Provider Number (ii billed through the RD)	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, 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.

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

Prognosis

Clinical significance or functional impairment(s)

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

Medical Justificabon for Providing Nutrition Assessment

Anticipated Frequency and Duration of the Nutrition Assessment (e.g. number of visits and amount of time per visit). (¼ hour = 1 unit)

TOTAL UNITS ______

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.

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.

DATE OF YOUR REQUEST: / /

PROVIDER OF SERVICES: Registered Dietitian	PRECRIBED BY: Health Care Provider
Address	Address
Phone	Phone
Medi-Cal Provider Number (if billed through the RD)	Medi-Cal Provider Number (if 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, signed prescription by the physician for medical 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.

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 Providing Medical Nutrition Therapy

Anticipated Frequency and Duration of the Medical Nutrition Therapy for a Period of (6) Six Months: (½ hour = 1 unit)

Total Units ______

Submit to the local CCS prog... ...edi-Cal field office.

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

STATE OF CALIFORNIA-HEALTH AND WELFARE AGENCY

PETE WILSON, Governor

DEPARTMENT OF HEALTH SERVICES

714/744 P STREET
P. 0. Box 942732
SACRAMENTO, CALIFORNIA 94234-7320
(916) 654-0521

Initial Request ? ____
Renewal ? ____

Date: ________

OXIMETER INFORMATION

Patient Name: ____________________ D.OB.: ________ **Age:** ________

TO BE COMPLETED BY M.D.

Diagnosis (List all pertinent, **be** specific): ____________________

Hospital *admissions past* **year** • *give* ***dates, hospital, diagnosis:*** ____________________

O_2 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 of Physicians 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.**

DME PROVIDER

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 **ouise** 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?

EPSDT Supplemental Services Occupational Therapy Request Documentation Checklist

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
- o OT services requested exceed 2x per month
- o Patient is not receiving OT through the Medical Therapy Program

___ Current Physician's Prescription
- o Specific for service to be provided (by discipline)
- o Frequency and duration of prescription identified

___ Current Physician's Report
- o Physical findings
- o Addresses need for therapy intervention
- o Identifies condition that therapy will correct or ameliorate
- o Treatment plan identifies functional goal(s) for therapy intervention

___ Current Occupational Therapy Report
- o Physical findings
- o Summary of functional deficits to be addressed by therapy
- o Patient's functional status in each area of deficit to be addressed
- o Treatment plan includes functional goals to address deficits targeted by therapy assessment, and anticipated time required to achieve these goals
- o Patient/Caregiver input into the treatment plan
- o Functional outcomes/benefits of any previous therapy services

FOR CCS USE ONLY (4/3/96)

EPSDT Supplemental Services Durable Medical Equipment Request Documentation Checklist

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

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

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

Current Physical Therapy/Occupational Therapy Report
- o Physical findings
- o Functional status related to DME item requested
- o 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)
- o Medical necessity of basic DME item
- o Each addition/modification/accessory to basic DME item

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

Comparisons (if applicable)
- o What other similar DME items were considered?
- o Why this particular DME item was chosen over others considered.
- o 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

CALIFORNIA CHILDREN SERVICES/EPSDT MENTAL HEALTH SERVICES REQUEST
DATE OF INITIAL REQUEST: / /9 DATE OF ADDED REQUEST / /9

I. CLIENT IDENTIFICATION:

CLIENT NAME		DATE OF BIRTH	
MED-CAL NUMBER (14 digits)		COUNTY/CCS#	

II. PROVIDER INFORMATION

PROVIDER NAME		EPSDT #/MC#	
PHONE NUMBER		LICENSE TYPE	
ADDRESS		LICENSE #	
CITY		ZIP	

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

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

V. HISTORY OF PROBLEM

Name of Client

VI. PREVIOUS TREATMENT FOR PROBLEM & OUTCOME(S):

FROM	To	SERVICES PROVIDED/PROVIDED BY	RESULTS OF SERVICES

VII. SIGNIFICANT FAMILY HISTORY/FAMILY FUNCTIONING

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

AXIS I 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________________ Pg 3

GOALS FOR INDIVIDUAL THERAPY

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

TIMELINE	BASELINE/CURRENT STATUS	SHORT TERM GOALS/OBJECTIVES: If family therapy is requested some goals should be for changes in family functioning)
IN_____ MONTHS		
IN_____ MONTHS		
IN_____ MONTHS		
IN_____ MONTHS		
IN_____ MONTHS		
IN_____ MONTHS		

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 [EPSDTREQ.REV]

Date: - / ./9___ Name of Client______________________

TO REQUEST EXTENSIONS OF PREVIOUS AUTHORIZATIONS FOR TREATMENT

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

PROGRESS NADE DURING PREVIOUS TREATMENT:

REASONS FURTHER TREATMENT IS NEEDED:

CHANGES IN GOALS/OBJECTIVES

NEW TARGET DATE	CURRENT BASELINE	NEW OBJECTIVE

EPSDT SUPPLEMENTAL SERVICES MENTAL HEALTH SERVICES REQUEST DATE OF REQUEST: 5/7/96

I. CLIENT IDENTIFICATION:

CLIENT NAME	SMITH, Nancy	DATE OF BIRTH	7-15-84
MED- CAL NUMBER	59-90-9666666-6-66	COUNTY CCS/NA	55555555

II. PROVIDER INFORMATION

PROVIDER NAME	Ima Goodworker, LCSW	AGENCY	
PHONE NUMBER	(777)777-7777	LICENSE TYPE	LCSW
ADDRESS	P.O.Box 66666	LICENSE NUMBER	LCS 00000
CITY	Anytown	CALIFORNIA ZIP	95888

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

INDICATE NUMBER OF SESSIONS REQUESTED: (INDICATE GOALS FOR EACH TYPE OF SERVICE REQUESTED IN SECTION IX)	4 INDIVIDUAL 4 FAMILY ___ GROUP ___ Other: TIME NEEDED TO COMPLETE ABOVE SESSIONS=8-10WEEKS	IF FAMILY TEERAPY REQUESTED, INDICATE NAMES AND RELATIONSHIPS OF INDIVIDUALS TO BE INCLUDED	Family therapy will include Nancy and her mother CONTINUED ON ATTACHED SHEET: Yes ___ No x

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 TEE REQUEST IS FOR AUTHORIZATION OF NO MORE THAN THREE EVALUATION SESSIONS

IV, DSM DIAGNOSIS: Give code and descriptions with date of onset, if known

AXIS I CLINICAL	309.0 Adjustment disorder with depressed mood		
AXIS 2: PERSONALITY	No DX		
AXIS 3: MEDICAL	Insulin dependent Diabetes and Asthma		
AXIS 4: PSYCHOSOCTAL AND ENVIRONMENTAL PROBLEMS (Describe)	Change in single, working mother's hours, social isolation, with no supports for mom or Nancy		
AXIS 5: GLOBAL ADAPTIVE FUNCTIONING- BEST	70	CURRENT GAF	60

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)

FROM	TO	SERVICES PROVIDED	RESULTS OF SERVICES
3/1/96	Present	13 sessions to be completed June 1996	Improving but setback see sections III and V, above.

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 any 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 with 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 CA&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 patent, 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

psdtsmp.FRM

DEPARTMENT OF HEALTH SERVICES

7141744 P STREET
P. O. Box 942732
SACRAMENTO, CALIFORNIA 94234-7320
(916) 667-I 604

Children's Medical Services
California Children's Services Program

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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** thii form to:

Department of Health Services
Medi-Cal Field **Office**

____

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Thank you for your cooperation.

Enclosure

DEPARTMENT OF HEALTH SERVICES

714/744 P STREET
P. 0. Box 942732
SACRAMENTO, CALIFORNIA 94234-7320
(916) 657-1604

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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 Caliiomia 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

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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

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