EPSDT – PCS PRIOR AUTHORIZATION

EPSDT – personal care services must be prior authorized by the BHSF or its designee. Services shall not be authorized for more than a six month period. A face-to-face medical assessment must be completed by the physician. The recipient's choice of a personal care services provider may assist the physician in developing a plan of care which shall be submitted for review/approval by BHSF or its designee. Recipients may contact the BHSF directly for assistance in locating a provider to submit a prior authorization request for medically necessary personal care services. (See Appendix H for contact information.)

Initial and Subsequent Prior Authorization Requests

All initial and subsequent prior authorization requests for EPSDT – PCS must be accompanied by the following documents:

- Copy of the recipient's Medicaid Eligibility Card,
- Physician's referral for PCS,
    - EPSDT – PCS **must be prescribed** by the recipient's attending physician initially and every 180 days after that (or rolling six months), and when changes in the Plan of Care occur. The prescription does not have to specify the number of hours being requested, but must specify PCS and not PCA.
    - The physician's signature must be an original signature or a computer generated electronic signature. Rubber stamped signatures will not be accepted.
    - Signatures by nurse practitioners and registered nurses on the referrals are not acceptable.
- Plan of Care prepared by the PCA agency with physician approval,
    - The provider may not initiate services or changes in services under the Plan of Care prior to approval by BHSF.
- EPSDT – PCS Form 90,
    - Completed by the attending physician,
    - Completed within the last 90 days,
    - Documents the recipient requires/would require institutional level of care equal to an Intermediate Care Facility 1, and

- Documents a face-to-face medical assessment was completed.

- EPSDT – PCS Daily Schedule Form,

- EPSDT Personal Care Services - Social Assessment Form,

  - Specifies the personal care activities which the parent or other caregiver is providing and requires assistance with, and
  - States the reason the parent cannot provide the assistance.

- Request for Prior Authorization Form (PA-14), and

- Other documentation that would support medical necessity (i.e., other independent evaluations).

NOTE: Information about forms used with a prior authorization request can be found in Appendix I.

Requests for prior approval of EPSDT – Personal Care Services should be submitted by mail, by fax or electronically (e-PA) to the Prior Authorization Unit. (See Appendix H for contact information.)

The request shall be reviewed by BHSF's physician consultant and a decision rendered as to the approval of the service. A letter will be sent to the recipient, the provider and the support coordination agency, if available, advising of the decision.

Chronic Needs Case

Recipients who have been designated by DHH as a "Chronic Needs Case" are exempt from the standard prior authorization process. A new request for prior authorization must still be submitted every 180 days; however, the provider shall only be required to submit a PA-14 form accompanied by a statement from the recipient's primary physician verifying that the recipient's condition has not improved and the services currently approved must be continued. The provider must indicate "Chronic Needs Case" on the top of the PA-14 form. This determination only applies to the services approved where requested services remain at the approved level.

Requests for an increase in these services will be subject to a full review requiring all documentation used for a traditional PA request.

NOTE: Only DHH or its designee will be allowed to grant the designation of a "chronic needs case" to a recipient.

Plan of Care

The Plan of Care must be written on the current version of the EPSDT PCS POC – 1 Form which can be downloaded from the Louisiana Medicaid website. (See Appendix I) The form must be completed in its entirety and must specify the personal care task(s) to be provided (i.e., activities of daily living for which assistance is needed) and the frequency and duration required to complete each of these tasks.

Dates of care not included in the Plan of Care or services provided before approval of the Plan of Care by BHSF are not reimbursable.

The recipient's attending physician shall review and/or modify the Plan of Care and sign and date it prior to the Plan of Care being submitted to BHSF.

The Plan of Care shall include the following information:

- Recipient name, Medicaid ID number, date of birth and address, phone number,
- Date EPSDT personal care services are requested to start,
- Provider name, Medicaid provider number and address of personal care agency,
- Name and phone number of someone from the provider agency that may be contacted, if necessary for additional information,
- Medical reasons supporting the need for PCS (must be accompanied by appropriate medical documentation for recipient and parent/caregiver, if parent/caregiver is disabled),
- Other in-home services the recipient is receiving,
- Specific personal care tasks (bathing, dressing, eating, etc.) with which PCS provider is to assist the recipient,
- Goals for each activity,
- Number of days services are required each week,
- Time requested to complete each activity,
- Total time requested to complete each activity each week,

- Child care arrangements specified for children 14 years of age or younger, (parent/relative/paid caregiver), and

- Signature of parent/primary caregiver, provider representative and the recipient's primary physician.

Changes in Plan of Care

Amendments or changes in the Plan of Care should be submitted as they occur and shall be treated as a new Plan of Care which begins a new six-month service period. Revisions of the Plan of Care may be necessary because of changes that occur in the recipient's medical condition which warrant an additional type of service, an increase or decrease in frequency of service or an increase or decrease in duration of service.

Documentation for a revised Plan of Care is the same as for a new Plan of Care. Both a new "start date" and "reassessment date" must be established at the time of reassessment. The provider may not initiate services or changes in services under the Plan of Care prior to approval by BHSF.

Subsequent Plans of Care

A new Plan of Care must be submitted at least every 180 days (rolling six months). The subsequent Plan of Care must:

- Be approved by the recipient's attending physician,

- Reassess the recipient's need for EPSDT – PCS,

- Include any updates to information which has changed since the previous assessment was conducted, and

- Explain when and why the change(s) occurred.

The physician shall only sign and date a fully completed Plan of Care that is acceptable for submission to BHSF.

The physician's signature must be an original signature or a computer generated electronic signature. Rubber stamped signatures will not be accepted.

Reconsideration Requests

If the prior authorization request is not approved as requested, the provider may submit a request for a reconsideration of the previous decision. When submitting a reconsideration request, providers should include the following:

- A copy of the prior authorization notice with the word "Recon" written across the top and include the reason the reconsideration is being requested written across the bottom,
- All original documentation submitted from the original request, and
- Any additional information or documentation which supports medical necessity.

The reconsideration request packet should be sent to the Prior Authorization Unit via fax, mail, or e-PA. After the reconsideration request has been reviewed, a new notification letter with the same prior authorization number will be generated and mailed to the provider, recipient, and support coordinator, if the recipient has a case manager.

Changing PCS Providers

Recipients have the right to change providers at any time; however, approved authorizations are not transferred between agencies. If a recipient elects to change providers within an authorization period, the current agency must notify the Prior Authorization Unit of the recipient's discharge, and the new agency must obtain their own authorization through the usual authorization process.

NOTE: Recipients may contact the Bureau of Health Services Financing directly for assistance in locating another provider.

Prior Authorization Liaison

The Prior Authorization Liaison (PAL) was established to facilitate the authorization process for EPSDT recipients who are part of the Request for Services Registry. The PAL assists by contacting the provider, recipient, and support coordinator (if the recipient has one) when a request cannot be approved by the Prior Authorization Unit because of a lack of documentation or a technical error.