EPSDT – PCS PRIOR AUTHORIZATION

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) – Personal Care Services (PCS) are subject to prior authorization (PA) by the Bureau of Health Services Financing (BHSF) or its designee. Services shall not be authorized for more than a six month period. A face-to-face medical assessment shall be completed by the practitioner. The beneficiary's choice of a PCS provider may assist the practitioner in developing a plan of care (POC) which shall be submitted for review/approval by BHSF or its designee. Beneficiaries may contact the BHSF directly for assistance in locating a provider to submit a prior authorization request for medically necessary PCS. (See Appendix H for contact information).

Initial and Subsequent Prior Authorization Requests

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

1. Copy of the beneficiary's Medicaid eligibility card;

2. Practitioner's referral for PCS:

    a. EPSDT – PCS **shall be prescribed** by the beneficiary's attending practitioner initially and every 180 days after that (or rolling six months), and when changes in the POC occur. The prescription does not have to specify the number of hours being requested, but shall specify PCS and not Personal Care Attendant (PCA);

    b. The practitioner's signature shall be an original signature or a computer generated electronic signature. Rubber stamped signatures will not be accepted; and

    c. Signatures by registered nurses on the referrals are not acceptable.

3. POC prepared by the PCS agency with practitioner's approval. The provider may not initiate services or changes in services under the POC prior to approval by BHSF;

4. EPSDT – PCS Form 90:

    a. Completed by the attending practitioner;

    b. Completed within the last 90 days;

c. Documents the beneficiary requires assistance with at least two (2) activities of daily living (ADL); and

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

5. EPSDT – PCS Daily Schedule Form;

6. EPSDT - PCS - Social Assessment Form;

7. Request for PA Form (PA-14); and

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

Information about forms used with a PA request can be found in Appendix I.

Requests for prior approval of EPSDT –PCS should be submitted by fax or electronically (e-PA) to the PA 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 beneficiary, the provider and the support coordination agency, if available, advising of the decision.

Chronic Needs Case

Beneficiaries who have been designated by BHSF as a "Chronic Needs Case" are exempt from the standard PA process. A new request for PA shall still be submitted every 180 days; however, the EPSDT-PCS provider shall only be required to submit a PA-14 form accompanied by a statement from the beneficiary's primary practitioner verifying that the beneficiary's condition has not improved and the services currently approved must be continued. The provider shall 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 BHSF or its designee will be allowed to grant the designation of a "chronic needs case" to a beneficiary.

Plan of Care

The POC shall 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 shall be

completed in its entirety and shall 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 service not included in the POC or services provided before approval of the POC by BHSF or its designee, are not reimbursable.

The beneficiary's attending practitioner shall review and/or modify the POC and sign and date it prior to the POC being submitted to BHSF or its designee.

The POC shall include the following information:

1. Beneficiary name, Medicaid ID number, date of birth and address, phone number;
2. Date EPSDT PCS are requested to start;
3. Provider name, Medicaid provider number and address of personal care agency;
4. Name and phone number of someone from the provider agency that may be contacted, if necessary, for additional information;
5. Medical reasons supporting the beneficiary's need for PCS;
6. Other in-home services the beneficiary is receiving;
7. Specific personal care tasks (bathing, dressing, eating, etc.) with which PCS provider is to assist the beneficiary;
8. Goals for each activity;
9. Number of days services are required each week;
10. Time requested to complete each activity;
11. Total time requested to complete each activity each week; and
12. Signature of parent/primary caregiver, provider representative and the beneficiary's primary practitioner.

Changes in Plan of Care

Revisions to the POC shall be submitted as they occur and shall be treated as a new POC which begins a new six month service period. Revisions to the POC may be necessary because of changes

that occur in the beneficiary's medical condition which warrant an additional type of service, change in frequency of service, or an increase or decrease in duration of service.

Documentation required for a revised POC is the same as for a new POC. Both a new "start date" and "reassessment date" shall be established at the time of reassessment. The EPSDT-PCS provider may not initiate services, or changes in services, under the POC prior to approval by BHSF or its designee.

Subsequent Plans of Care

A new POC shall be submitted at least every 180 days (rolling six months). The subsequent POC shall:

1. Be approved by the beneficiary's attending practitioner;

2. Reassess the beneficiary's need for EPSDT–PCS;

3. Include any updates to information which has changed since the previous assessment was conducted; and

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

The POC shall be acceptable only after the practitioner signs and dates the completed form. The practitioner's signature shall be an original signature and not a rubber stamp.

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:

1. 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;

2. All original documentation submitted from the original request; and

3. Any additional information or documentation which supports medical necessity.

The reconsideration request packet should be sent to the PA Unit via fax 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, beneficiary, and support coordinator, if the beneficiary has a case manager.

Changing PCS Providers

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

Beneficiaries may contact the BHSF directly for assistance in locating another provider.

Prior Authorization Liaison

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