Covering Related Services

through the

Medicaid EPSDT Program

A Community Outreach Program will ensure that all New York State children enrolled in Medicaid receive the Speech, OT, PT and Counseling Services they Need and are Entitled to Under Federal and State Medicaid Law

Prepared for

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1. Summary: What is Medicaid Early and Periodic Screening Diagnosis and Treatment (EPSDT) Program and why it's an option for parents to consider using for the cost of related services?

Medicaid **Early and Periodic Screening Diagnosis and Treatment (EPSDT)** is a program that is potentially available to pay for a broad range of the related services that are required by special needs children in families enrolled in Medicaid. Enacted into law in 1967, EPSDT is a comprehensive program of medical services designed to ensure that poor children are not held back in life because of a health related issue.

> EPSDT can best be thought of as the pediatric component of Medicaid. The EPSDT service is essentially a bundled benefit governed by a pediatric coverage standard and supported by a series of administrative services. The EPSDT benefit definition contains both classes of items and services, as well as a preventive standard of medical necessity that is directly embedded in the definition. The benefit classes span the entire spectrum of health care for children, from primary pediatric to advanced, while the medical necessity definition, which applies to all aspects of coverage, specifies the provision of "early" services that "correct or ameliorate" both physical and mental health conditions found as a result of "comprehensive" assessments. Source: EPSDT at 40: Modernizing a Pediatric Health Policy to Reflect a Changing Health Care System. 2008

EPSDT begins with preventive based screenings and diagnosis. For every diagnosis that identifies a medical illness or condition, an appropriate medical treatment is also covered by Medicaid. Treatment can include speech, physical therapy, occupational therapy and counseling.

1. **Medicaid EPSDT funds are used by school districts to cover the cost of Related Services:** Currently, any special education child attending a public school in the United States is entitled under the Individuals with Disabilities Act (IDEA) to a Free and Appropriate Public Education (FAPE). Under FAPE, New York State offers every public school child a full range of special education and related services (speech, physical, occupational and counseling). NYS also offers almost the same group of special education and related services to parentally placed in private school children. In NYS, a school district can bill Medicaid for the cost of related services for a Medicaid eligible child, regardless if the child is enrolled in public or private school.

2. **Related Services option:** In New York State and New York City, 112,000 children attend private school through scholarships. In New York City alone, 76,000 children private school children are either enrolled in or eligible to enroll in Medicaid. Within this group are special needs children that attend either mainstream or special education private schools (schools with only self-contained classes). For the special education private schools, many of the children attend based on a request for a Free and Appropriate Public Education (FAPE). Under this arrangement, the school district agrees that best interest of the child will be served by a placement in a private special education school. The school district reimburses the parent for all or part of the tuition and the cost of Related Services. For the parents with a child enrolled in Medicaid and seeking FAPE based tuition reimbursement from the school

district, they should consider the option available to them of accessing Related Services from their Managed Care Organization (also known as an HMO) primary care provider (instead of the school district). The primary care provide, usually the pediatrician, can make a referral to a therapist for the provision of services. The cost of the Related Services can be covered through the Medicaid EPSDT program. It is available as of right based on medical necessity.

2. Federal legal basis for using the Medicaid *Early Periodic Screening Diagnostic and Treatment* (EPSDT) for covering the cost of Related Services (OT, PT, Speech and Counseling) for Medicaid enrolled families

The Social Security Act, as codified at **42 U.S.C.§ 1396d(r) and [1905(r) of the Social Security Act]** requires state Medicaid programs to provide Early and Periodic Screening, Diagnostics, and Treatment (EPSDT) for recipients under 21 years of age. Within the scope of EPSDT benefits under the federal Medicaid law, the states are required to cover any service that is "medically necessary" to "correct or ameliorate a defect, physical or mental illness, or a condition identified by screening," whether or not the service is covered under the State Medicaid Plan. The services covered under EPSDT are limited to those within the scope of the category of services listed in 42 U.S.C. § 1396d(a).

With this broad coverage, covers most of the treatments a recipient under 21 years of age needs to stay as healthy, and the State Medicaid must provide or arrange for (directly or through referral to appropriate agencies, organizations, or individuals) necessary corrective treatment as identified or disclosed by a child health screening services. More specifically, the term "**ameliorate"** means to improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Even if the service will not cure the recipient's condition, it must be covered if the service is medically necessary to improve or maintain the recipient's overall health. Source: adapted from North Carolina EPSDT Policy Instructions Update 1/11/2010 and Neighborhood Legal Services **MEDICAID AND EPSDT** by Maureen O'Connell & Sidney Watson ,March 2001

For full legal citation and list of covered Medicaid EPSDT services covered under 42 U.S.C.§ 1396d(r) and 42 U.S.C. § 1396d (a) Medical assistance. See appendix 1.

3. What is the Medicaid EPSDT Program definition of "Medical Necessity"?

The most critical language in the Federal Social Security law that covers Medicaid is devoted to illnesses and conditions that constitute "medical necessity". Federal law prohibits states from watering down the types of medical conditions that can be covered by Medicaid EPSDT program.

> **Medical necessity:** The Medicaid Act contains a federal definition of medical necessity that all states must apply. The Act requires coverage of "necessary health care, diagnostic services, treatment, and other measures . . . to correct or ameliorate defects and physical and mental illnesses and conditions[.]"

In sum, if a health care provider determines that a service is needed, it should be covered to the extent needed and allowed under the federal Medicaid Act. For example, if a child needs personal care services to ameliorate a behavioral health problem, then EPSDT should cover those services to the extent the child needs them — even if the state places a quantitative limit on personal care services or does not cover them at all for adults. Recent court decisions have consistently affirmed the broad EPSDT scope of benefits and the medical necessity definition outlined above.

Source: Medicaid Early and Periodic Screening, Diagnosis and Treatment. Fact Sheet by Jane Perkins, October 2008. National Help Law Project.

4. EPSDT Program specific language from the New York State Official Medicaid Plan and Manual with HMO Providers:

Below are excerpts from the New York State Contract with Medicaid HMO Providers 2012 and the New York State Department of Health EPSDT Provider Manual:

- **Source: EPSDT/CTHP Provider Manual for Child Health Plus A (Medicaid) 2005 version.** NEW YORK STATE DEPARTMENT OF HEALTH OFFICE OF MEDICAID MANAGEMENT:

  The New York State Child Health Plus A (Medicaid) general scope of services includes but is not limited to the following

  - EPSDT/CTHP health services for screening, diagnosis and treatment
  - Speech-language pathology therapy
  - Physical and occupational therapy
  - Psychiatry and psychology services

- **Source: New York State MEDICAID MANAGED CARE AND FAMILY HEALTH PLUS MODEL CONTRACT March 1, 2011**

  10.20 Children with Special Health Care Needs

  a) Children with special health care needs are those who have or are suspected of having a serious or chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally. The Contractor will be responsible for performing all of the same activities for this population as for adults as described in Section 10.19 a) ii) A-D) and Section 10.19 a) iii).

  In addition, the Contractor will implement the following for these children:

i) Satisfactory methods for interacting with school districts, preschool services, child protective service agencies, early intervention officials, behavioral health, and developmental disabilities service organizations for the purpose of coordinating and assuring appropriate service delivery.

ii) An adequate network of pediatric providers and sub-specialists, and contractual relationships with tertiary institutions, to meet such children's medical needs.

iii) Satisfactory methods for assuring that children with serious, chronic, and rare disorders receive appropriate diagnostic work-ups on a timely basis.

iv) Satisfactory arrangements for assuring access to specialty centers in and out of New York State for diagnosis and treatment of rare disorders.

v) A satisfactory approach for assuring access to allied health professionals (Physical Therapists, Occupational Therapists, Speech Therapists,

POPULATIONS WITH SPECIAL HEALTH CARE NEEDS STANDARD FOR COMPLIANCE

The Contractor will have satisfactory methods for identifying persons at risk of, or having, chronic disabilities and determining their specific needs in terms of specialist physician referrals, durable medical equipment, medical supplies, home health services, etc. The Contractor will have satisfactory systems for coordinating service delivery and, if necessary, procedures to allow continuation of existing relationships with out-of-network provider for course of treatment.

SUGGESTED METHODS FOR COMPLIANCE

1. Procedures for requesting standing referrals to specialists and/or specialty centers, specialist physicians to function as PCP, out-of-network referrals, and continuation of existing relationships with out-of-network providers for course of treatment

2. Linkages with behavioral health agencies, disability and advocacy organizations, etc.

3. Adequate network of providers and sub-specialists (including pediatric providers and sub-specialists) and contractual relationships with tertiary institutions

4. Procedures for assuring that these populations receive appropriate diagnostic work-ups on a timely basis

5. Procedures for assuring that these populations receive appropriate access to durable medical equipment on a timely basis

6. Procedures for assuring that these populations receive appropriate allied health professionals (Physical, Occupational and Speech Therapists, Audiologists) on a timely basis

7. State designation as a Well Qualified Plan to serve the OMRDD population and look-alikes

5. How many private children are enrolled in Medicaid or eligible for Medicaid in New York City and New York State?

If families were encouraged to consider the option of using Medicaid EPSDT program for covering the cost of Related Services, how many children would be affected? While Medicaid enrollment data is not maintained by school attendance, there are other reliable sources of data from the New York State Education Department (NYSED) that can be used to determine how many private school children could potentially benefit from this option.

Formula for determining number of private school children enrolled in Medicaid: There are currently a total of 230,400 children attending private schools for grades K to 12 in New York City. Most of these children, 86%, attend parochial schools (Catholic, Jewish, Islamic, Greek Orthodox, Lutheran and Independent Christian). To be eligible for Medicaid, household income can be no higher than 133% of the Federal Poverty level. To be eligible for the Federal Department of Agriculture-School Free Lunch Program (administered in New York State by New York State Education Department), a household income can be no higher than 130% of the Federal Poverty Level. Therefore, the Free Lunch Program is a very accurate indicator of Medicaid eligibility.

County/service area	Total Student Enrollment	NYSED School Free Lunch Program Private School Participants
Bronx	880	445
Manhattan	3377	2,156
New York Archdiocese (covers Bronx and Manhattan)	20732	15,530
Brooklyn	78088	54078
Queens	10,772	3315
Staten Island	681	408
Total New York City	**114,530**	**75,932**
Rest of New York State	**67782**	**36486**
Total (New York City and New York State)	**182,312**	**112,418**

The above chart only includes private and parochial schools that participate in the New York State Education Department School Free Lunch Program. There are hundreds of private schools that do not offer the Free Lunch Program; none of these schools are included in the above chart. In New York City alone, there are an estimated 4,000 children who attend private and parochial

schools that are Free Lunch eligible but the schools do not operate an NYSED lunch program. Below is the total number of children that could potentially benefit from Medicaid EPSDT option for accessing Related Services:

- **New York City:** Based on NYSED data, a total of around 112,418 children attending private schools could benefit from the Medicaid EPSDT option.

- **New York State:** Based on NYSED data, a total of around 112,418 children attending private schools could benefit from the Medicaid EPSDT option.

6. Do New York HMO Medicaid Member Plans contain language that clearly explains how families can access Medicaid EPDST benefits?

Yes and no. The HMO Medicaid Member Plans do contain a sentence that tells parents that their children are entitled to the EPSDT Program. However, none of the Plans explain what the EPSDT program is and how it can help their child in general or specifically if they need related services. For a parent to understand that they are entitled to EPSDT benefits, very clearly written language must be available. This language could also be disseminated through a brochure. An internet search resulted in no such brochure. Here are several samples of the only language found in a Member Plan booklet:

Based on a random search of Medicaid Managed Plans offered in New York City, it appears that each company uses the exact same language for EPSDT and related services.

Affinity, Fidelis, WellCare,:

On page 11. "access to Early, Preventive, Diagnostic and Treatment (EPSDT) program for enrollees from birth until age 21years".

On page 15, Specialty Care: Includes the services of other practitioners, including

- occupational, physical and speech therapists—Limited to twenty visits per therapy per calendar year, except for children under 21, or if you have been determined to be developmentally disabled by the office of People with Developmental Disabilities or is you have a traumatic brain injury.

On page 20, Prior Authorization, (included on the list), "Physical, Occupational, and Speech Therapy (no authorization for the initial visit, subsequent visits require prior authorization".

Based on the few times EDPST and OT, PT, Speech and Counseling are mentioned, it would be next to impossible for a parent to understand that their HMO provided coverage of Related Services.

7. Is there a Federal regulation regarding how many hours of treatment services a provider will be reimbursed through Medicaid.

No. For each of the related services (OT, PT Speech), there is no set number of visits or hours of treatment that Medicaid will reimburse for per child. Treatment must be provided as per child's need to improve their condition. Below are three separate sources of documentation:

- Services under EPSDT must be sufficient in amount, duration, or scope to reasonably achieve their purpose. The amount, duration, or scope of EPSDT services to recipients may not be denied arbitrarily or reduced solely because of the diagnosis, type of illness, or condition. Appropriate limits may be placed on EPSDT services based on medical necessity. Source: HHS-Centers for Medicare and Medicaid Services (CMS) THE STATE MEDICAID MANUAL.

- While states are required to cover screening services, they are granted flexibility in establishing how frequently these services must be provided. As a result of this flexibility, the frequency and timing of required screening services vary considerably across states.

  Once physical or mental health conditions are discovered, the EPSDT benefit covers necessary health services to correct or ameliorate them, whether or not these services are otherwise covered by the state's Medicaid program. This requirement that states cover all mandatory and optional Medicaid services for children reflects the broader definition of medical necessity that Medicaid applies to children. Source: Kaiser Commission on Medicaid Facts. EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT SERVICES Oct. 2005.

- Federal Medicaid law also requires that coverage must be sufficient in amount, duration, and scope to reasonably achieve its purpose. Yet, while states have the authority to limit the amount, duration and scope of services based on medical necessity, such limits generally need to be determined case-by-case. For example, one child's condition may require weekly speech therapy over a period of years, while another child may need only three visits while adapting to a new hearing aid device. Source: Managing the "T" in EPSDT Services. 2010 National Academy for State Health Policy.

8. Who can make the referral? Whose Medicaid Reimbursement number is used?

The Primary Care Physician (PCP) makes the referral to the therapist (OT, PT, Speech or counseling). All Medicaid HMO's maintain lists of PT, OT, Speech and Counseling therapists that participate in their plan network (these lists can be found on the website of the HMO). Also, a licensed therapist can request Prior Authorization from the Managed Care Provider. Billing is under the Medicaid number of the primary care physician or clinic.

9. Does the Related Services referral need to have prior authorization by the HMO managed care provider company?

Yes and no. It depends on the HMO and which plan. For most HMO plans, only a referral from the Primary Care Provider (PCP) is needed. Check first with your PCP. As long as the request meets Medicaid specified conditions for treatment, approval must be granted by the HMO.

10. Who can provide the OT, PT, Speech and Counseling services? What licensing authorities in New York State are involved with regulating provision of related services through Medicaid?

The following professional requirements were taken from the New York State Official Medicaid Plan. A Medicaid EPSDT qualified practitioner is:

- **Speech therapist:** a licensed and registered speech-language pathologist qualified in accordance with 42CFR Section 440. 110 c and applicable state and federal laws and regulations, acting within his or her scope of practice under New York State law: or a teacher certified to provide screech and language services, under the documented direction of such a qualified licensed and registered speech language pathologist (ASHA Certified or equivalent), acting within his or her scope of practice under New York State

- **Physical therapist:** a New York State licensed and registered physical therapist qualified in accordance with 42 CFR 440,110(a) and with applicable state and federal laws and regulations acting within his or her scope of practice under New York State Law; or a certified physical therapy assistant "under the direction of" such a qualified licensed and registered physical therapist acting within his or her scope of practice under New York State Law.

- **Occupational therapist** shall mean a person who is registered with the American Occupational Therapy Association, or either a graduate of a program in occupational therapy approved by the Council on Medical Education of the American Medical Association in collaboration with the American Occupational Therapy Association or a graduate of a curriculum in occupational therapy which is recognized by the World Federation of Occupational Therapists and is eligible for a registration with the American Occupational therapy Association. The state assures the provision of occupational therapy services will be provided in accordance with 42 CFR 440.110(b)(2)(i) and 440.110(b)(2) (ii).

- **Psychological counseling:**
  - a New York State licensed and registered psychiatrist qualified in accordance with 42 CFR Section 440.50(a) and other applicable state and federal law or regulation, acting within his or her scope of practice under New York State Law:

  - a New York State licensed and registered psychologist qualified In accordance with 42 CFR Section 440.60(a) and other applicable state and-federal law or regulations, acting within his or her scope of practice under New York State Law;

  - a New York State licensed clinical social worker (LCSSW), qualified in accordance 42 CFR Section 440.60(a) and other applicable state and federal law or regulations, acting within his or her scope of practice Under **N**YS law; or

  - a licensed master social worker (LMSW) qualified In accordance with 42 CFR Section 440.600) and other applicable state and federal law or regulations. acting within his or her scope of practice under New York State Law, under the supervision of such a qualified licensed clinical social worker, a qualified licensed and registered psychologist or a qualified licensed and registered psychiatrist as described above,

11. How does the Primary Care Provider (PCP) or licensed therapist provider get paid by Medicaid through the HMO?

Just as with any medical procedure or service, there is billing code number and related Medicaid claim form. OT, PT, all have code numbers. A 194 page manual is available from Wisconsin Medicaid that includes clear instructions on how a PCP can bill for OT, PT, using the standard code system. 'All diagnosis codes indicated on claims and prior authorization (PA) requests submitted to Wisconsin Medicaid must be from the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD- 9-CM) coding structure." Source: Physical Therapy, Occupational Therapy, and Speech and Language Pathology Services Wisconsin Medicaid.

12. Are there ready to use community outreach brochures and other literature on the Medicaid ESPDT Program?

Yes, there are several national organizations and states that have prepared literature for the purpose of increasing usage of the Medicaid EPSDT program. The **Kaiser Foundation** (affiliated with Kaiser, one of the largest health insurance companies in the country) has prepared community outreach materials for the purpose of educating low income families about the EPSDT program. Many state legal services organizations have also developed excellent fact sheets and brochures. **Wisconsin** has a very good eight page brochure as well a 190 page comprehensive manual on how children and adults can receive OT, PT, Speech and Counseling Services with Medicaid ***(The eight page Wisconsin brochure can be found in this Memo in Appendix II.)***. **Maryland** has a two page outreach brochure that lists Related Services. Other states with official community education Medicaid EPSDT literature include Oklahoma, Iowa, Rhode Island, Florida, Connecticut and Tennessee. These materials can be easily adapted and used by Lakewood BOE, clinics and CBO's. I have not been able to find any New York State or New York City specific community outreach brochures.

13. Are there examples of technical manuals from other states that explain how Primary Care Providers can make referrals for PT, OT, Speech and Counseling and bill Medicaid?

Other states with printed information on how primary care providers should use EPSDT for covering the cost of OT, PT, Speech and Counseling treatment services include **Alabama, North Carolina, Kentucky, Florida and Texas. Below is a list of examples of state publications with information on how Medicaid can be used for coverage for speech, occupational and physical therapy through EPSDT:**

- Physical Therapy, Occupational Therapy, and Speech and Language Pathology Services Handbook. Wisconsin Medicaid and Badger Care. Department of Health and Family Services. January 2006

- North Carolina Division of Medical Assistance Medicaid and Health Choice Outpatient Specialized Therapies Clinical Coverage Policy No: 10A Revised Date: June 1, 2012

- Florida Medicaid Therapy Services Coverage and Limitations Handbook Agency for Health Care Administration 2008

14. Program operating procedures can be adapted from the New York State Department of Health School Supportive heatlh Services program (SSHSP)

The procedures for the day to day operations have been fully specified in the 82 page *NYS-DOH PRESCHOOL/SCHOOL SUPPORTIVE HEALTH SERVICES PROGRAM (SSHSP) MEDICAID-IN-EDUCATION PROVIDER POLICY AND BILLING HANDBOOK (UPDATE 7) ISSUED APRIL 2012*. While this manual was written for school districts, Section schools and counties, the procedures can easily be adapted to a private school operation. The only difference is that the clinic will be billing Medicaid and not the school. The importance of the IEP in the NYS-DOH can be carry over to the private school. The primary care provider and the therapist can also rely on the IEP. Procedures relating to privacy, disclosure of information, session notes and other documentation, are all described in this manual. The manual also covers how to prevent duplication of services (which is against the law and will result in claims not being paid).

15. Coordination of Activities with Local School Districts

The following guidance discusses how school districts that operate a School Based Health Service Program should coordinate services with local primary care providers, their HMO's and clinics that participate in Medicaid. All information below was taken from: **Medicaid School-Based Administrative Claiming Guide MAY 2003 U.S. HHS Center for Medicare and Medicaid Services.**

There are many situations in which a Medicaid-eligible child with special needs receives IEP services from the school, and well-child, primary, preventive and acute care services from a managed care organization (MCO). (MCO services can be provided at a school-based, school-linked clinic, a doctor's office, or elsewhere.) In those situations where the same Medicaid-eligible child receives IEP services from both a school and an MCO, there must be a concerted effort to ensure that Medicaid is not paying for the same services twice, once to the MCO and again to the school.

5. Coordination of Activities

In addition to avoiding duplicate payments, as discussed above in Principle 4., duplicate performance of activities should also be avoided. Under Principle 1. allowable administrative activities must be necessary "for the proper and efficient administration of the [Medicaid] state plan," as well as for the operation of all governmental programs. Therefore, it is important in the design of school-based administrative claiming programs that the school not perform activities that are already being offered or should be provided by other entities, or through other programs. As appropriate, this calls

for close coordination between the schools, the state Medicaid agency, state education agencies, for for close coordination between providers, community and non-profit organizations, and other entities related to the activities performed.

States must ensure that appropriate coordination occurs among providers. States can include these kinds of assurances in the language implementing their Medicaid managed care contracts. In addition, since schools are required under IDEA to provide services listed in a child's IEP, many Medicaid managed care contracts contain provisions that specifically exclude these services from the capitation rate paid to cover the costs of providing other medical services to Medicaid eligible children.

The following are examples of activities that should be coordinated:

- Activities performed by an MCO for Medicaid enrollees, such as case management functions. To avoid duplication of these functions by school personnel, coordination mechanisms should be established between the school and appropriate entities, such as the MCO and state Medicaid agency.

- Payment rate setting mechanism. State Medicaid agencies and schools need to coordinate with respect to their activities, payments to providers, third party payers, and rate setting mechanisms in order to ensure that duplicate payments are not made and that medical services and administrative activities are provided as efficiently and effectively as possible. For example, MCO payment rates may need to be adjusted to reflect the activities and services being furnished in the school setting.

- An activity that is provided/conducted by another governmental component. For example, it is not necessary for EPSDT educational materials, such as pamphlets and flyers, which have already been developed by the state Medicaid agency, to also be developed by schools. It would be inefficient in the allocation of Medicaid program and school resources to do so. In order to avoid this, school districts/schools should coordinate and consult with the state Medicaid agency to determine the appropriate activities related to EPSDT and to determine the availability of existing materials.

16. Are children enrolled in New York State Child Health Plus (CHP) Program eligible for Related Services through EPDST?

No. The New York State Child Health Plus (CHP) offers a significantly less generous menu of related services than the Medicaid EPSDT Program. Children enrolled in CHP are not eligible to the menu of benefits available from the Medicaid EPSDT program. Special education children enrolled in NYS-CHP would be much better offer getting Related Services from the local school district. NYS-CHP provides insufficient coverage for most of the needs of special education children.

Related Services	New York State CHP Requirement for maximum annual hours of service
Speech	Covered speech therapy services are those required for a condition amenable to significant clinical improvement within a two-month period, beginning with the first day of therapy.
Occupational therapy	Short term physical and occupational therapies will be covered when ordered by a physician.
Physical therapy	
Mental health counseling	A combined 60 outpatient visits per calendar year. Visits may include family therapy for alcohol, drug and/or mental health as long as such therapy is directly related to the enrolled child's alcohol, drug and/or mental health treatment.

Source: New York State Department of Health, Child Health Plus Program, Contract for Services, 2008- 2012.

17. What can be done to encourage neighborhood primary care physicians (PCP's) to offer children related services as per the New York State Medicaid Plan?

See Section II for recommended next steps.

18. How will the *Patient Protection and Affordable Care Act (PPACT)* Law affect the Medicaid EPSDT Program, Related Services and Child Enrollment?

The new Federal Health Care Act, formally known as Patient Protection and Affordable Care Act (PPACT), will not affect the EPSDT program. The program has been left intact. Certain provisions of the PPACT will result in an increase in Medicaid enrollment and the expansion of school based health clinics.

Section II. Recommended Next Steps

1. **Encourage parents with special needs children to discuss with their primary care physician how their child could benefit from Medicaid EPSDT covered related services.**

2. **Convene meeting with the main Medicaid HMO's that service New York City's 1.3 million Medicaid enrollees.**

NYC Medicaid HMO's	Contact Information	Catchment Area	enrollment
Affinity Health Plan, Inc.	866) 247-5678 www.affinityplan.org	Citywide	86,000
AMERIGROUP Community Care	(800) 600-4441 www.amerigroupcorp.com	Citywide	226,000
Fidelis Care New York	(888) 343-3547 www.fideliscare.org	Citywide	149,000
Healthfirst PHSP	(800) 404-8778 www.healthfirstny.com	Citywide	279,955
HIP	(800) 542-2412 www.hipusa.com	Citywide	93,742
MetroPlus	(800) 475-6387 www.metroplus.org	Manhattan, Bronx, Brooklyn, Queens	249,000
Neighborhood Health Providers	800-826-6240 www.getnhp.com	citywide	111,000
United health Care	(800) 493-4647 www.americhoice.com	citywide	117,000
WellCare of New York	(800) 992-6095 www.wellcare.com	Man, Bronx, Brooklyn, Queens	24,994
Total			1,336,691

3. **Convene meeting with a group of Medicaid HMO primary care providers (usually pediatricians).**

4. **Convene meeting with licensed therapists working in a HMO network plan**

5. **Convene meeting with community based social service organizations**

6. **Secure funding for a community outreach campaign and hotline for parents to call.** a part time community worker should be hired to get the word out, act as a resource for parents to call**,** help parents navigate the access of related services, interface with primary care providers and their HMO's.

Appendix I:

Sampling of OT, PT and Speech therapists that accept Medicaid billing.

http://www.metroplus.org/docs/provider_directory.pdf

Appendix II:

LISTING OF EPSDT SERVICES FOUND IN 42 U.S.C. § 1396d (r)

(r) Early and periodic screening, diagnostic, and treatment services

The term "early and periodic screening, diagnostic, and treatment services" means the following items and services:

(1) Screening services—
(A) which are provided—
(i) at intervals which meet reasonable standards of medical and dental practice, as determined by the State after consultation with recognized medical and dental organizations involved in child health care and, with respect to immunizations under subparagraph (B)(iii), in accordance with the schedule referred to in section 1396s(c)(2)(B)(i) of this title for pediatric vaccines, and **(ii)** at such other intervals, indicated as medically necessary, to determine the existence of certain physical or mental illnesses or conditions; and

(B) which shall at a minimum include—
(i) a comprehensive health and developmental history (including assessment of both physical and mental health development),
(ii) a comprehensive unclothed physical exam,
(iii) appropriate immunizations (according to the schedule referred to in section 1396s (c)(2)(B)(i) of this title for pediatric vaccines) according to age and health history,
(iv) laboratory tests (including lead blood level assessment appropriate for age and risk factors), and
(v) health education (including anticipatory guidance).

(2) Vision services—
(A) which are provided—
(i) at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and
(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and
(B) which shall at a minimum include diagnosis and treatment for defects in vision, including eyeglasses.

(3) Dental services—
(A) which are provided—
(i) at intervals which meet reasonable standards of dental practice, as determined by the State after consultation with recognized dental organizations involved in child health care, and
(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and
(B) which shall at a minimum include relief of pain and infections, restoration of teeth, and maintenance of dental health.

(4) Hearing services—
(A) which are provided—

(i) at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and
(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and
(B) which shall at a minimum include diagnosis and treatment for defects in hearing, including hearing aids.

(5) Such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.

Nothing in this subchapter shall be construed as limiting providers of early and periodic screening, diagnostic, and treatment services to providers who are qualified to provide all of the items and services described in the previous sentence or as preventing a provider that is qualified under the plan to furnish one or more (but not all) of such items or services from being qualified to provide such items and services as part of early and periodic screening, diagnostic, and treatment services. The Secretary shall, not later than July 1, 1990, and every 12 months thereafter, develop and set annual participation goals for each State for participation of individuals who are covered under the State plan under this subchapter in early and periodic screening, diagnostic, and treatment services.

42 U.S.C. § 1396d (a) Medical assistance

The term "medical assistance" means payment of part or all of the cost of the following care and services or the care and services themselves, or both (if provided in or after the third month before the month in which the recipient makes application for assistance or, in the case of medicare cost-sharing with respect to a qualified medicare beneficiary described in subsection (p)(1) of this section, if provided after the month in which the individual becomes such a beneficiary) for individuals, and, with respect to physicians' or dentists' services, at the option of the State, to individuals (other than individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1396a (a)(10)(A) of this title) not receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI of this chapter, or part A of subchapter IV of this chapter, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter, who are—
(i) under the age of 21, or, at the option of the State, under the age of 20, 19, or 18 as the State may choose,
(ii) relatives specified in section 606 (b)(1) 1 of this title with whom a child is living if such child is (or would, if needy, be) a dependent child under part A of subchapter IV of this chapter,
(iii) 65 years of age or older,
(iv) blind, with respect to States eligible to participate in the State plan program established under subchapter XVI of this chapter,
(v) 18 years of age or older and permanently and totally disabled, with respect to States eligible to participate in the State plan program established under subchapter XVI of this chapter,
(vi) persons essential (as described in the second sentence of this subsection) to individuals receiving aid or assistance under State plans approved under subchapter I, X, XIV, or XVI of this chapter,

(vii) blind or disabled as defined in section 1382c of this title, with respect to States not eligible to participate in the State plan program established under subchapter XVI of this chapter,
(viii) pregnant women,
(ix) individuals provided extended benefits under section 1396r–6 of this title,
(x) individuals described in section 1396a (u)(1) of this title,
(xi) individuals described in section 1396a (z)(1) of this title,
(xii) employed individuals with a medically improved disability (as defined in subsection (v) of this section),
(xiii) individuals described in section 1396a (aa) of this title,
(xiv) individuals described in section 1396a (a)(10)(A)(i)(VIII) or 1396a (a)(10)(A)(i)(IX) of this title,
(xv) individuals described in section 1396a (a)(10)(A)(ii)(XX) of this title,
(xvi) individuals described in section 1396a (ii) of this title, or
(xvii) individuals who are eligible for home and community-based services under needs-based criteria established under paragraph (1)(A) of section 1396n (i) of this title, or who are eligible for home and community-based services under paragraph (6) of such section, and who will receive home and community-based services pursuant to a State plan amendment under such subsection, but whose income and resources are insufficient to meet all of such cost—

(1) inpatient hospital services (other than services in an institution for mental diseases);

(2) (A) outpatient hospital services, **(B)** consistent with State law permitting such services, rural health clinic services (as defined in subsection (l)(1) of this section) and any other ambulatory services which are offered by a rural health clinic (as defined in subsection (l)(1) of this section) and which are otherwise included in the plan, and **(C)** Federally-qualified health center services (as defined in subsection (l)(2) of this section) and any other ambulatory services offered by a Federally-qualified health center and which are otherwise included in the plan;

(3) other laboratory and X-ray services;

(4) (A) nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older; **(B)** early and periodic screening, diagnostic, and treatment services (as defined in subsection (r) of this section) for individuals who are eligible under the plan and are under the age of 21; **(C)** family planning services and supplies furnished (directly or under arrangements with others) to individuals of child-bearing age (including minors who can be considered to be sexually active) who are eligible under the State plan and who desire such services and supplies; and
(D) counseling and pharmacotherapy for cessation of tobacco use by pregnant women (as defined in subsection (bb));

(5) (A) physicians' services furnished by a physician (as defined in section 1395x (r)(1) of this title), whether furnished in the office, the patient's home, a hospital, or a nursing facility, or elsewhere, and **(B)** medical and surgical services furnished by a dentist (described in section 1395x (r)(2) of this title) to the extent such services may be performed under State law either by a doctor of medicine or by a doctor of dental surgery or dental medicine and would be described in clause (A) if furnished by a physician (as defined in section 1395x (r)(1) of this title);

(6) medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law;

(7) home health care services;

(8) private duty nursing services;

(9) clinic services furnished by or under the direction of a physician, without regard to whether the clinic itself is administered by a physician, including such services furnished outside the clinic by clinic personnel to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address;

(10) dental services;

(11) physical therapy and related services;

(12) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;

(13) other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level;

(14) inpatient hospital services and nursing facility services for individuals 65 years of age or over in an institution for mental diseases;

(15) services in an intermediate care facility for the mentally retarded (other than in an institution for mental diseases) for individuals who are determined, in accordance with section 1396a (a)(31) of this title, to be in need of such care;

(16) effective January 1, 1973, inpatient psychiatric hospital services for individuals under age 21, as defined in subsection (h) of this section;

(17) services furnished by a nurse-midwife (as defined in section 1395x (gg) of this title) which the nurse-midwife is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider, and without regard to whether or not the services are performed in the area of management of the care of mothers and babies throughout the maternity cycle;

(18) hospice care (as defined in subsection (o) of this section);

(19) case management services (as defined in section 1396n (g)(2) of this title) and TB-related services described in section 1396a (z)(2)(F) of this title;

(20) respiratory care services (as defined in section 1396a (e)(9)(C) of this title);

(21) services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner (as defined by the Secretary) which the certified pediatric nurse practitioner or certified family nurse practitioner is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not the certified pediatric nurse practitioner or certified family nurse practitioner is under the supervision of, or associated with, a physician or other health care provider;

(22) home and community care (to the extent allowed and as defined in section 1396t of this title) for functionally disabled elderly individuals;

(23) community supported living arrangements services (to the extent allowed and as defined in section 1396u of this title);

(24) personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are **(A)** authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State, **(B)** provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and **(C)** furnished in a home or other location;

(25) primary care case management services (as defined in subsection (t) of this section);

(26) services furnished under a PACE program under section 1396u–4 of this title to PACE program eligible individuals enrolled under the program under such section;

(27) subject to subsection (x) of this section, primary and secondary medical strategies and treatment and services for individuals who have Sickle Cell Disease;

(28) freestanding birth center services (as defined in subsection (l)(3)(A)) and other ambulatory services that are offered by a freestanding birth center (as defined in subsection (l)(3)(B)) and that are otherwise included in the plan; and

(29) any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary, except as otherwise provided in paragraph (16), such term does not include— **(A)** any such payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution); or **(B)** any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases. For purposes of clause (vi) of the preceding sentence, a person shall be considered essential to another individual if such person is the spouse of and is living with such individual, the needs of such person are taken into account in determining the amount of aid or assistance furnished to such individual (under a State plan approved under subchapter I, X, XIV, or XVI of this chapter), and such person is determined, under such a State plan, to be essential to the well-being of such individual. The payment described in the first sentence may include expenditures for medicare cost-sharing and for premiums under part B of subchapter XVIII of this chapter for individuals who are eligible for medical assistance under the plan and **(A)** are receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI of this chapter, or part A of subchapter IV of this chapter, or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter, or **(B)** with respect to whom there is being paid a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1396a (a)(10)(A) of this title, and, except in the case of individuals 65 years of age or older and disabled individuals entitled to health insurance benefits under subchapter XVIII of this chapter who are not enrolled under part B of subchapter XVIII of this chapter, other insurance premiums for medical or any other type of remedial care or the cost thereof. No service (including counseling) shall be excluded from the definition of "medical assistance" solely because it is provided as a treatment service for alcoholism or drug dependency.

Definitions of the above federal Medicaid services can be found in the Code of Federal Regulations 42 CFR 440.1-440.170 at http://www.access.gpo.gov/nara/cfr/waisidx_06/42cfr440_06.html.

Appendix III. How are PT, OT, Speech and Counseling services actually provided by the PCP

Below is language regarding how a PCP and a referral provider should work together to ensure appropriate treatment for speech, developmental or mental health needs. The New York State Official Provider Manual for the Medicaid EPSDT Program. All of the excerpts below come from the New York State EPSDT/CTHP Provider Manual for Child Health Plus A (Medicaid) 2012.

DIAGNOSIS

When a screening examination indicates the need for further evaluation of an individual's health, provide diagnostic services or refer when appropriate. Any necessary referrals and follow-up should be made without delay to make sure that the Child Health Plus A (Medicaid) child/adolescent receives a complete diagnostic evaluation.

TREATMENT

Provide treatment or other measures (or refer when appropriate) to correct or ameliorate defects and physical and mental illness or conditions discovered by the screening services.

Primary care providers (PCP) include physicians (such as pediatricians, family practitioners and internists), nurse practitioners, and physician's assistants. The partnership between the PCP, other providers, and the child and family--whether birth parents or adoptive parents, foster parents or guardians--is central to the medical home concept. Therefore, health providers other than the PCP, and other relevant service providers (e.g. social service, school) should consult as necessary with the PCP, and obtain permission of the legally responsible adult (or youth where applicable) to share a copy of their findings with the PCP, in order to facilitate comprehensive, coordinated care. This will promote maintenance of a central record containing all pertinent information at the medical home. This is particularly important when the PCP refers youth to subspecialists for diagnostic evaluations and/or treatment (e.g. mental and developmental health care professionals, neurologists, audiologists), and when the PCP orders services that will be performed in other settings (e.g. home health care; physical, occupational and/or speech-language pathology therapy).

Medicaid Managed Care

In most New York State counties, Medicaid families are required, or may choose to enroll in Medicaid managed care plans. For policy governing EPSDT covered services, health care referrals, orders and prescriptions, you must follow the child's managed care plan's procedures and use plan network providers.

Many services covered by **Medicaid managed care plans** must be provided by plan providers. Many services require primary care physician referral or plan authorization.

Please refer to the Medicaid managed care model contract on the department's website for the list of managed care covered services. Contact the Medicaid managed care plan for specific details concerning approval and authorization procedures.

Medicaid Managed Care Plans

- Provide consumer and provider outreach and education to assure access to health care services. Managed care plans educate pregnant women, families with children, and young adults up until age 21 about EPSDT and its importance to their health.
- Provide members with information about services covered, patient costs, how to obtain referrals, and how to file complaints and appeals.
- Educate network providers about the program and their responsibilities under EPSDT.
- Maintain a list of participating Medicaid providers and provide assistance with scheduling appointments for EPSDT services, if requested.
- Provide access to medical services to their members through the plan's network of primary care providers and obstetricians/gynecologists on a 24-hour-a-day, 7-days-a-week basis.
- Follow-up to see that all appropriate diagnostic and treatment services, including referrals, are furnished pursuant to findings from an EPSDT screening examination.

Accessing Mental Health System and Practitioners (Referrals)

Making Referrals

Successful referrals of a child, adolescent, family to a mental health practitioner by a primary care physician require thought and planning. The following outline should be used as a guide:

a. Conduct psychiatric evaluation of child/teen.

b. Option - Discuss case with mental health colleague.

c. Option - Counsel the patient and/or parent(s) yourself.

d. Anticipate the child, adolescent and parents' concerns (worries, resistance, etc.) about the referral.

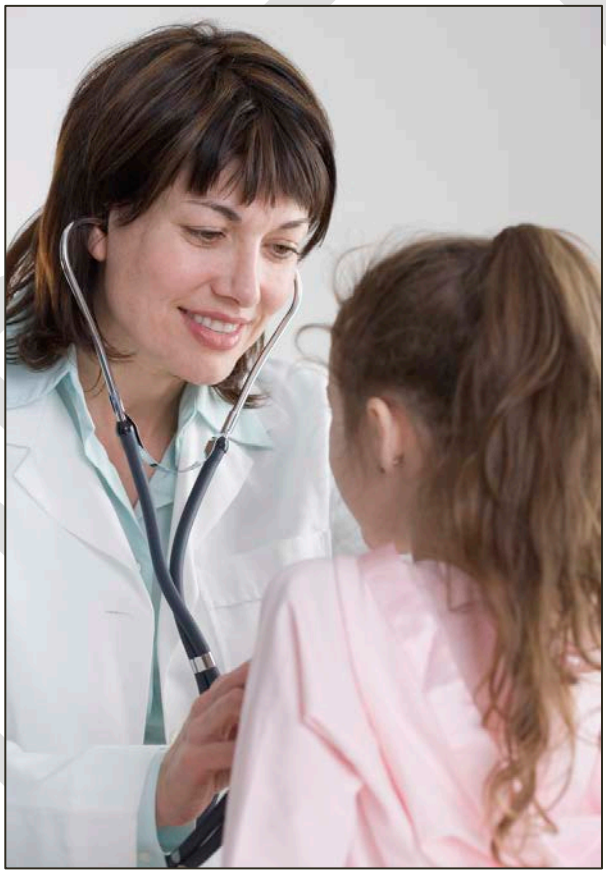
e. Present the referral to the patient and parent(s) and discuss their concerns.

f. Do not make the first appointment with the mental health professional - it is very important that the parent(s) are responsible and make the appointment.

g. Discuss the mental health referral and treatment at future visits or by phone.

Appendix III: Sample Brochure

Medicaid Therapy Services for Children



Wisconsin Department of Health and Family Services
Division of Health Care Financing

PHC 1794 (Rev. 06/05)

Medicaid Therapy Services for Children

The information in this brochure is for children in the BadgerCare and Wisconsin Medicaid programs. The term “Wisconsin Medicaid” will be used to represent both programs. Contact your county/tribal social or human services agency or your local W-2 agency for more information on applying for Wisconsin Medicaid, BadgerCare, or Healthy Start.

This brochure is for recipients and their families considering occupational therapy, physical therapy, and/or speech and language therapy services provided in the community with coverage by Wisconsin Medicaid. Wisconsin Medicaid covers medically necessary services that meet state and federal guidelines.

This brochure does not address therapy services provided by schools or Medicaid HMOs.

What is Medicaid?

Medicaid is a joint federal/state program formed in 1965 under Title XIX of the Social Security Act. Wisconsin Medicaid pays for medical services for people with disabilities, people 65 years and older, children and their caretakers, and pregnant women who meet the program’s financial requirements and are enrolled in the program. Wisconsin Medicaid is also known as the Medical Assistance Program, MA, Title XIX, or T19.

What is BadgerCare?

BadgerCare extends Medicaid coverage to uninsured children and parents with incomes at or below 185 percent of the Federal Poverty Level and who meet other program requirements. The goal of BadgerCare is to fill the gap between Wisconsin Medicaid and private insurance without “crowding out” private insurance.

What are the Katie Beckett, Healthy Start, and SSI programs?

Katie Beckett, Healthy Start, and Supplemental Security Income (SSI) are special eligibility programs that allow certain individuals to become eligible for Wisconsin Medicaid.

Who can provide therapy services to my child?

Your child can get therapy services from any licensed therapist. If you want Wisconsin Medicaid to pay for therapy services, the therapist must be Medicaid certified. You should ask your child's therapist if he or she is Medicaid certified before your child receives services. Medicaid-certified therapists can practice:

- Individually.
- In therapy clinics and rehabilitation agencies.
- In hospitals and nursing homes.
- In home health agencies.

How do I get therapy services for my child? Whom do I contact?

If your child needs therapy services, contact your child's doctor. Your child's doctor needs to write a prescription for therapy services. Your child's doctor is able to refer you to a *Medicaid certified* occupational therapist, physical therapist, or speech language therapist. The therapist will then assess your child to see if therapy may help him or her.

When do you need a prior authorization request for therapy services?

If the therapist thinks your child needs therapy, the therapist will complete and send a prior authorization request to Wisconsin Medicaid. There is a separate prior authorization process for children enrolled in the Birth to 3 Program.

What does the prior authorization request include?

The prior authorization request for children who are older than age 3 or not enrolled in the Birth to 3 Program includes:

- The therapy evaluation of your child by the therapist.
- The therapy plan of care.
- The Individualized Education Program (IEP), if applicable.

The prior authorization request for children under age 3 who are enrolled in the Birth to 3 Program includes an affidavit signed by the provider indicating that he or she will follow the rules and regulations of Wisconsin Medicaid. For more information about the Birth to 3 Program, contact your county Birth to 3 Program or call (800) 642-STEP (7837).

Plan of Care

A therapy plan of care includes goals of the therapy treatment, how the treatment will be delivered, how long the therapy will last, and how often treatments will be provided. The plan of care must be reviewed and signed by the doctor prescribing therapy. You and your family are encouraged to participate in the development of the plan of care. For children older than age 3, the plan of care will include the school IEP and team reports, if available. For more information on a school IEP, contact your local school district.

Prior Authorization Process

After the prior authorization materials are ready, the therapist will send them to Wisconsin Medicaid. You have the right, and are encouraged, to review the prior authorization request before it is sent to Wisconsin Medicaid. The prior authorization request is being submitted on your child's behalf. A Medicaid therapy consultant reviews each request to make sure it meets Wisconsin Medicaid requirements. In some cases, the prior authorization request is returned to your child's requesting therapist for more information. When a prior authorization decision is delayed because more information is needed, your therapist is expected to notify you of the reason for the delay.

When all of the needed information is sent in, the Medicaid therapy consultant approves, modifies, or denies the request. The approval includes the number of therapy sessions and the start and end dates of the approval. Before the end date of the current prior authorization, your child's therapist should submit a new prior authorization request if services need to be continued.

If the prior authorization request is modified or denied, you will receive a letter telling you the reasons for the decision and your right to appeal that decision. You are encouraged to always review the prior authorization decision with the requesting therapist. There is an optional line on the prior authorization request for you to sign to indicate that you have read it and agree. Remember, you have the right to:

- Review the prior authorization request before it is sent to Wisconsin Medicaid.
- Review the prior authorization decision.
- Know the start and end dates of the prior authorization.

Frequently Asked Questions What is looked at for approval of a prior authorization request?

Prior authorization requests are reviewed on an individual basis. If the requested services do not meet the Medicaid requirements, they are denied. Some of the factors taken into consideration are:

- The medical necessity of the service.
- The appropriateness of the service.
- The cost of the service.
- The frequency of the service.
- The quality and timeliness of the service.
- The extent to which less expensive alternative services are available.
- The utilization practices of the providers and recipients.
- The limitations imposed by federal and state statutes, rules, regulations, or interpretation, including Medicare or private insurance guidelines.

Some of the reasons that a prior authorization request for therapy might not be approved are:

- The skills of a therapist are not needed to perform the activity with the child.
- Another provider or caregiver is working on the same activity.
- No functional progress is documented as a result of therapy.
- The services are experimental.
- The needs of the child can be met without therapy.

What can I do if Wisconsin Medicaid modifies or denies a prior authorization request?

If the prior authorization request is denied or modified, you will receive a letter. You may wish to discuss the decision with your child's therapy provider to understand the reasons for Wisconsin Medicaid's decision. You may also want to make sure that the agency or the individual provider sent in all the necessary information. If more information is needed, your child's provider may contact Wisconsin Medicaid to determine if additional information should be submitted at this time. The letter will also give you information about how to appeal the decision and request a fair hearing before an administrative hearing officer.

If a prior authorization request was denied or modified, will future prior authorization requests also be denied or modified?

Not necessarily. If your child's condition or situation changes, a new prior authorization request for therapy services with current information may be submitted.

If my child receives therapy or special education services through his or her school, may my child receive additional therapy services outside the school through Wisconsin Medicaid?

Each case is reviewed on an individual basis. Wisconsin Medicaid approves requests that meet Medicaid regulations and guidelines. Wisconsin Medicaid

does not base approval or denial of prior authorization requests on whether the school seeks payment through the Medicaid school-based services (SBS) benefit. Medicaid consultants do not review SBS billing information. When making a decision on a prior authorization request, Wisconsin Medicaid considers the medical necessity of services and other criteria including (but not limited to) whether the service is appropriate, cost-effective, and not duplicative of other services. As part of the prior authorization process, therapists submit each child's IEP with their prior authorization request. Medicaid therapy consultants review the prior authorization request and IEP in addition to all other required materials and records to determine if a child is receiving other services that meet the child's needs.

What if I have other health insurance?

You will be expected to see therapists and other health care providers who accept your child's other health insurance as well as Wisconsin Medicaid. This is because your child's other health insurance will be billed first, before Wisconsin Medicaid. This is not always true for Birth to 3 services. You should talk to your child's therapist or Birth to 3 coordinator for more information about billing other health insurance.

What if I or my children are enrolled in a Medicaid HMO?

You should contact your Medicaid HMO for more information on how to receive therapy services from your HMO's providers.

Wisconsin Department of Health and Family Services
Division of Health Care Financing
PHC 1794 (Rev. 06/05)

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