PURCHASE OF SERVICE GUIDELINE

7/8/2015	HEALTH SERVICES (MEDICAL/DENTAL)	FINAL

I. DEFINITION

ELARC will consider the purchase of health services which are specialized (i.e. specialized services meaning services, supports and adaptations of generic services directed at the alleviation of a developmental disability) [WIC 4512 (b), WIC 4685(c)(1)], under certain exceptional circumstances, as needed for assessment or treatment. Ordinarily, emergency room treatment, and routine health services are not included; however, exceptional circumstances may occur and will be reviewed on a case-by-case basis.

II. CRITERIA

ELARC will consider the purchase of specialized health services only when no other source of payment is available. ”Regional center funds shall not be used to supplant the budget of any agency which has a legal responsibility to serve all members of the general public and is receiving public funds for providing those services” WIC section 4648, subd. (a)(8)]. Therefore, consumers and families are first expected to pay for health care services, utilize County Department of Health Services facilities, other available generic resources and/or low cost services.

ELARC shall consider funding specialized health (medical / dental) services once the regional center is provided with the documentation of a Medi-Cal, private insurance or health care service plan denial and the regional center (ELARC) determines that an appeal by the consumer or family of the denial does not have merit [WIC 4659(d)].

ELARC may pay for health (medical / dental services) during the following periods:

1. While coverage is being pursued, but before a denial is made.

2. Pending a final administrative decision on the administrative appeal if the family provides proof that an appeal is being pursued.

3. Until the commencement of services by Medi-Cal, private insurance, or a health care service plan WIC section 4659, subd. (d)(1)(A)(B)(C)].

If ELARC identifies the health service as a need in the IPP, then it may also consider funding the copayment, coinsurance or deductible associated with the private or generic health plan which accepts responsibility for coverage of the service and for which the parent, guardian or

caregiver is responsible for; if all of the following conditions are met: (1) The consumer is covered by his or her parent's, guardian's, or caregiver's health care service plan or health insurance policy. (2) The family has an Annual Gross Income (AGI) that does not exceed 400 percent of the Federal Poverty Level (FPL). The Family Cost Participation Program Schedule shall be used to determine AGI not exceeding 400% FPL for the family. (3) There is no other third party having liability for the cost of the service.

ELARC may make an exception to fund for co-payments, coinsurance and deductible for a consumer whose family income exceeds 400 percent of the federal poverty level, when the service is necessary to successfully maintain the child at home or the adult consumer in the least- restrictive setting, and the parents or consumer demonstrate one or more of the following: (1) The existence of an extraordinary event that impacts the ability of the parent, guardian, or caregiver to meet the care and supervision needs of the child or impacts the ability of the parent, guardian, or caregiver, or adult consumer with a health care service plan or health insurance policy, to pay the copayment, coinsurance or deductible. (2) The existence of catastrophic loss that temporarily limits the ability to pay. (3) Significant unreimbursed medical costs associated with the care of the consumer or another child who is also a regional center consumer.

Per WIC 4648(a)(16), effective July 1, 2009, ELARC shall not purchase experimental treatments, therapeutic services, or devices that have not been clinically determined or scientifically proven to be effective or safe or for which risks and complications are unknown.

III. AMOUNT OF SERVICE

A. For an applicant in the assessment process (Status 0), diagnostic health services may be considered for purchase if evaluations are determined to be needed for eligibility determination by the Assessment & Special Services Division (A & SSD).

B. For a consumer at risk of a developmental delay /early intervention (Status 1), specialized health services may be considered for purchase if “necessary to enable a child to benefit from the other early intervention services . . . during the time that the child is receiving the other early intervention services.” (Title 34, C.F.R. 303.16(a). These services must be standard of practice, necessary for care and not experimental.

C. For an active consumer (Status 2), specialized health services may be considered for purchase if the requested service is included, per the planning team, in an objective on the IPP [WIC § 4648)] and is standard of practice medically necessary to alleviate a developmental disability and not experimental.

IV. ALTERNATIVE FUNDING SOURCES

Ability to Pay programs at county medical facilities and clinics, Medi-Cal, Medicare, HMO's, CCS, and EPSDT; private health plans, private insurance, CHAMPUS, Veteran's Administration Benefits, etc.

In addition, per WIC 4659(c) effective July 1, 2009, ELARC shall not purchase any service that would otherwise be available from Medi-Cal, Medicare, the Civilian Health and Medical Program for Uniform Services, In Home Support Services, California Children's Services, private insurance, or a health care service plan when a consumer or a family meets the criteria of this coverage but chooses not to pursue coverage.

V. PROCESS FOR PURCHASE OF SERVICE

A. After discussion with the consumer or legally authorized representative regarding a service request as part of the planning team process, the Service Coordinator completes a R1-11 with as much detail as possible, signs it, obtains his/her supervisor's signature and submits it with the chart to the Special Services secretary. Documentation from consumer's health service providers should be current within 6 months, and written denials/ documentation should be provided that all other resources for payment have been exhausted. All requests should be submitted to the Special Services Secretary at least four weeks in advance of the expected date of service, agreed to by the planning tea, as no retroactive funding requests will be considered for purchase of service.

B. The request will be reviewed by the appropriate clinical consultant for input and recommendations on whether the service request is clinically indicated and the submitted documentation is adequate to support this request. If so, the appropriate clinical consultant will sign the R1-11 and it will be returned to the Service Coordinator through the Special Services Secretary, for scheduling of appointments and processing by the respective unit office assistant. Payment will be at the SMA or vendor rate.

   If the appropriate clinical consultant has concerns and recommends changes in the request, this will be reflected in an I.D. Note/Memo/Record Review Form which will be returned along with the R1-11 to the Service Coordinator to share with the planning team.

C. Upon planning team agreement to proceed with the health service changes as recommended by the applicable clinical consultant, the service coordinator will note this in a memo, attach the R1-11 and a copy of the I.D. Note/Memo/Record Review Form originally completed by the clinician and route through the Special

Services Secretary for signature by the clinical consultant. The R1-11 will be returned to the service coordinator for scheduling of appointments and processing by the respective unit office assistant. Payment will be at the SMA or vendor rate.

VI. EVALUATION OF SERVICE

Feedback from the consumer/family, information obtained through the person centered planning process, and review of evaluation reports, treatment plans and progress by appropriate clinical consultant, are the mechanisms for evaluating service effectiveness.