PURCHASE OF SERVICE GUIDELINE

10/24/2016	PRESCRIPTION DRUGS SERVICES	FINAL

I. DEFINITION

Prescription drugs are those which are prescribed by a licensed physician and dispensed by a licensed pharmacy and are of such type or dosage that prohibits their purchase over-the-counter. As further defined by this policy, the usage of these medications is related to the developmental disability, such as anti-epileptic medications for seizure control or anti-anxiety medications to reduce behavioral challenges, and must be deemed medically necessary to maintain the consumer's health/mental health status.

II. CRITERIA

The Eastern Los Angeles Regional Center (ELARC) may consider the purchase of prescription medications when all other alternative funding sources have been exhausted. "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 4648, subd. (a)(8)]

Prescriptions must be supported by medical evaluation and lab reports which indicate the diagnoses and symptoms for which the drugs are being prescribed, substantiate the need for medication intervention and provide monitoring of therapeutic medication levels. Prescriptions must be filled by a pharmacy vendored by ELARC and drugs must be on the Medi-Cal Formulary. Generic medications must be utilized first and medical documentation is required for prescriptions for brand-name medications, which states the reasons why generic drugs are not being prescribed (i.e., generic has been tried and has produced unacceptable side effects; generic has proven to be ineffective in controlling symptoms).

ELARC shall consider funding specialized health (medical prescription drugs) 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 specialized health (medical prescription drugs) during the following periods:

1. While coverage is being pursued and documentation of this has been provided to ELARC, but before a denial is made.

2. Pending a final administrative decision on the administrative appeal and the family provides proof to ELARC 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 prescription drug 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.

III. AMOUNT OF SERVICE

Prescription drugs are to be dispensed in the amounts and dosages ordered by the licensed physician as indicated on the written prescription. If the duration of use of a prescription drug will exceed one year, the prescription must be evaluated and updated annually based upon current medical and lab reports.

IV. ALTERNATIVE FUNDING SOURCES

Private insurance, private trusts, Medi-Cal, California Children’s Services, EPSDT, CHAMPUS, Medicare, County Health Clinics, Veteran’s Benefits, Department of

Rehabilitation and other sources of public health care available to the general public. Effective July 1, 2009, WIC 4659(c) was revised to include that regional centers 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. The service coordinator completes the 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 the consumer's physician should be current within 6 months, and written denials/documentation should be provided indicating that all other resources for payment have been exhausted.

B. All R1-11 requests should be submitted in advance of the dispensing of prescription drugs.

C. The request will be reviewed by the physician consultant for input and recommendations on whether the service request is clinically indicated and the submitted documentation is adequate to support this request. If the physician consultant has concerns and recommends changes in the request, this will be reflected in an ID Note/Memo/Record Review form which will be provided to the service coordinator to share with the planning team.

    1. If approved, the physician consultant will sign the R1-11 and return it with the chart to the service coordinator for processing by the respective unit office assistant and submission to the ELARC Fiscal/Administration Division.

    2. If denied, the physician consultant will return the R-1-11 and chart to the service coordinator with an ID Note/Memo/Record Review Form indicating the reason for denial.

D. ELARC fiscal/administration division processes the R1-11 for funding.

V. EVALUATION OF SERVICE EFFECTIVENESS

Information obtained through the person-centered planning process, physician reports, review by the appropriate consultant and consumer/family feedback will serve as the mechanisms for evaluating the effectiveness of the service.