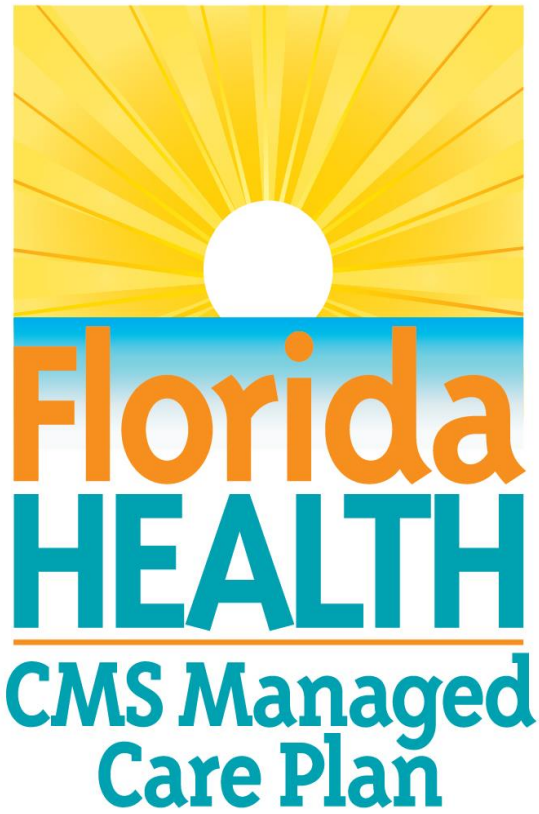

TITLE XIX, TITLE XXI & SAFETY NET
UTILIZATION MANAGEMENT PROVIDER HANDBOOK
FEBRUARY 2016

Children's Medical Services Managed Care Plan
Title XIX, Title XXI and Safety Net
Utilization Management Provider Handbook

Thank you for participating as a Children's Medical Services (CMS) provider. This Utilization Management Provider Handbook is a guide to the policies and procedures for the Service Authorization Utilization Management Process. These requirements are for all Title XXI and Title XIX enrollees.

As a reminder ALL services for the Safety Net enrollee population must be prior authorized and are limited health services. Authorization for services for the Safety Net program is the responsibility of the local CMS Area Office utilization management staff. The available health services are limited to Specialty Physician services, pharmacy, diagnostics for the selected primary and secondary qualifying conditions, and dental services for those clients who have selected cleft lip/ cleft palate diagnosis.

For Title XIX enrollees in Children's Medical Services Managed Care Plan, the Florida Medicaid Handbooks, prior authorization rules and fee schedules apply and can be located on the following website: http://portal.flmmis.com/FLPublic/Provider_ProviderSupport/Provider_ProviderSupport_ProviderHandbooks/tabId/42/Default.aspx/

Prior authorization is a condition of reimbursement for identified services included in this handbook. Payment is contingent upon receipt of prior authorization for identified services and members must be eligible on the date service is provided. Prior authorization is not a guarantee of payment. Prior authorization for these services may be requested by the member's primary care provider, a treating specialist, or a treating facility.

The Early Steps program authorizes services through the Individualized Family Support Plan (IFSP) process. Services for this program are excluded from this handbook. Please contact your local Early Steps provider with any questions.

A copy of this handbook can be found at http://www.floridahealth.gov/programs-and-services/childrens-health/cms-plan/index.html **Please refer to this site regularly to ensure you are accessing the most updated copy of this document.**

CMS has partnered with **Ped-I-Care** and **South Florida Community Care Network (SFCCN)** to authorize the services described in this handbook when provided to **CMS** enrollees**.** These partners will make the determination to provide a service based on review of submitted information and a determination of medical necessity. **Ped-I-Care** and **SFCCN** each support CMS in different areas of the state. **Please see the child's member ID card if you would like to know which entity will review your requests.**

Providers may also call **1-800-664-0146** or email **FI-CustomerService@Med3000.com** with any questions or concerns regarding **claims payment** of authorized services.

CMS requests that all Specialty Providers communicate their clinical findings to the referring provider by providing documentation of visits and consultations.

Table of Contents

Section 1.0 Coverage and Services Limitations and Services Requiring Prior Authorization

1.0.1. Coverage and Services Limitations for CMS

- Children's Medical Services will follow the Medicaid Coverage and Service Limitations and authorization requirements established by the Florida Medicaid program.

- For a list of these limitation guidelines, refer to the appropriate Medicaid Coverage and Limitation Provider Handbooks found at the following web site:

  http://portal.flmmis.com/FLPublic/Provider_ProviderSupport/Provider_ProviderSupport_ProviderHandbooks/tabId/42/Default.aspx

1.0.2. Services Requiring Prior Authorizations

- Children's Medical Services will follow Florida Medicaid policy related to procedures with utilization limitations and services requiring prior authorization.

- For a list of the services requiring prior authorization please refer to the appropriate Florida Medicaid Coverage and Limitations Provider Handbook, and the Florida Medicaid Provider Fee Schedules found at the following link;

  http://portal.flmmis.com/FLPublic/Provider_ProviderSupport/Provider_ProviderSupport_FeeSchedules/tabId/44/Default.aspx

- Procedures requiring prior authorization are listed in the fee schedule and are indicated by a "PA" or "BR" located in the "Spec" column for the associated procedure code.

- Requests for prior authorization must be submitted to the appropriate Integrated Care System (ICS) serving your area.

- If unsure whether a specific procedure/service/facility requires an authorization, contact the utilization management department listed on the child's member ID card.

- For the services prior authorized, an authorization number will be assigned for the requested service and must be on the claim for payment.

Services Requiring Authorization for CMS Title XXI and Title XIX

Call or fax the CMS UM Department assigned to the member or enter your request via the Provider Portal https://cms.einfosource.med3000.com Ped-I-Care Phone 800-492-9634 Fax (866) 256-2015 SFCCN Phone T21: 1-866-202-1132, Fax (954)7675491 or T19 MMA: 1-866-209-5022, Fax (954) 767-5649
Prior Authorization – *supporting clinical documentation is required* ***Prior*** *authorization requests require the submission of supporting clinical documentation for medical review. Failure to provide clinical information can result in a delay or denial of the request.*
Applied Behavioral Analysis (therapy) *Services will be authorized by the local Area Medicaid Offices for TXIX. ICS's will authorize services for TXXI*
By Report items per the Medicaid Fee Schedule
Durable Medical Equipment *For services that have a PA indicator per the Medicaid Fee Schedule*
Elective Surgical Procedures (including cosmetic and Plastic/Reconstructive procedures per Medicaid Physician Fee Schedule)
Experimental / Investigational Treatment (See Definition Below) *Those newly developed procedures undergoing systematic investigation to establish their role in treatment or procedures that are not yet scientifically established to provide beneficial results for the condition for which they are being used.*
Hearing Services / Hearing Aids / Augmentative or Alternative Communicative Systems *For services that have a PA indicator per the Medicaid Fee Schedule*
Home Health Care services (including Home Health Aids, Nursing Visits, Respite Care {skilled and non-skilled} and Infusion Services)
Inpatient Admissions (including Mental Health and Skilled Nursing Facilities) In and Out of Network
Mental Health Day Treatment Programs
PET scans
MRIs, CTs No PA required if diagnosis code is listed in Appendix D of the Practitioner Services Coverage and Limitations Handbook. For diagnoses not listed, PA is required.
Nutritional Supplements / Enteral & Parenteral Nutrition (Includes Enteral Feedings) *For services that have a PA indicator per the Medicaid Fee Schedule*
Orthotics and Prosthetics *For services that have a PA indicator per the Medicaid Fee Schedule*
Orthodontia *For services that have a PA indicator per the Medicaid Fee Schedule*

Out of network / Out of State Services
PPEC (Signed Plan of Care Needed) *Services will be authorized by eQHealth for TXIX. ICS's will authorize services for TXXI.*
Private Duty Nursing
Request that Exceeds Medicaid Limits
Therapy Services (PT, OT, Speech and Respiratory) (Signed Plan of Care Needed) *This requirement includes Therapy Services for Dually Enrolled Children in Early Steps*
Transplants and Related Care *Professional services rendered in the office for participating providers would not require prior authorization*
Therapeutic Foster Care, Therapeutic Group Care and Crisis Intervention
Vision Services (Contact Lenses Specialty (non-standard) Glasses) *For services that have a PA indicator per the Medicaid Fee Schedule*
Notification Required – service does not require prior authorization just notification that that service was rendered for coordination of care purposes only
Emergency Room Visit - Notification Only **Observation Stays – Notification Only**

1.0.3. Exceptional Service Requests

- **Authorization is required when the requested service meets any of the following conditions**
    - is not a covered benefit,
    - exceeds Medicaid covered allowable limits, or
    - is to be provided by an Out of Network provider.

- CMS may pay for services that are not a covered benefit or are beyond the Medicaid allowable limits, based on determination of medical necessity. Providers must submit detailed medical documentation supporting the need and benefit of these services. Please use the form in Appendix I to submit these special exception requests.

- CMS does not pay for experimental/ investigational procedures.

- If approved, an authorization number will be assigned for the requested service and must be on the claim for payment.

1.0.4. Authorization for Services to Children Enrolled in CMS Safety Net Program

- Children enrolled in CMS Safety Net are only eligible for a limited selection of services.

- Every service must be prior authorized for children enrolled in CMS Safety Net program.

- Each child can be authorized to receive care for a primary and secondary qualifying condition. If a child has more than two qualifying conditions, the family determines which conditions will be covered under CMS Safety Net program.

- Eligible services include
    - specialty physician services to treat the qualifying conditions,
    - diagnostic services needed to treat the qualifying conditions,
    - pharmacy services needed to treat the qualifying conditions, and
    - dental services only for children with a cleft lip/cleft palate diagnosis.

- Primary care, durable medical equipment, emergency room, and inpatient hospital care are not covered services for this program.

- Each family must meet a sliding-fee participation requirement before CMS can be authorized to pay for any service.

- If you are unsure if a service can be provided under this program, please contact your local CMS office.

- Authorizations for services for the Safety Net program are the responsibility of the local CMS Area Office utilization management staff.

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Section 2.0. Process for Requesting Prior Authorization

2.0.1. Submitting Prior Authorization Requests

- You may submit prior authorization requests through the **CMS-KIDS Web portal at: https://cms.einfosource.med3000.com or by contacting the UM department listed on the child's member ID card. Clinical documentation supporting the request cannot be submitted through einfosource. Clinical documentation must be faxed to the appropriate ICS.**

- For services that are special exceptions (outside the Medicaid benefit package or over Medicaid coverage limits), please use the special exception form in Appendix I.

    - The local CMS area office may only submit prior authorization requests on behalf of providers who provide clinic services or who otherwise do not have a stand-alone office and support staff.

- For children enrolled in CMS Safety Net Program, if submitting the authorization by fax, please contact the intended recipient at the local CMS Area Office of the request prior to faxing to ensure availability of staff to receive the information.

- Each request must include a signed physician order and supporting documentation. The physician order must specify the units of service, hours per day, or time period for which authorization is being requested. Requests for services that lack sufficient information or documentation to make a determination may be denied if the requested information is not supplied within seven (7) business days.

- A new request must be submitted for any continuation of services beyond the initial authorized time period. These requests may be submitted up to 60 days prior to the expiration of the current authorization.

- If an expedited request is needed after normal business hours, the provider should process the request following the urgent and expedited processes outlined in section 2.0.2. below.

- CMS will not be responsible for payment of services requiring authorization that have not been prior approved or a service rendered outside the authorization date span.

- An authorization number will be assigned for the requested service and required on the claim for payment.

2.0.2. Response Time for Prior Authorization Requests

TITLE XIX

- Routine Request or Non-Urgent Request
  The ICS will process ninety-five percent (95%) of all routine or non-urgent authorizations within fourteen (14) calendar days. The ICS's average turnaround time for routine requests shall not

exceed seven (7) days. The timeframe for authorization decisions can be extended up to seven (7) additional calendar days if the enrollee or provider requests an extension or the ICS justifies the need for additional information and how the extension is in the enrollee's interest.

- Urgent Request or Expedited Requests
  The ICS will process ninety-five percent (95%) of all urgent requests within three (3) business days. The ICS's average turnaround time for urgent or expedited requests will not exceed (2) business days. The ICS may extend the timeframe for urgent or expedited requests up to two (2) additional business days if the enrollee or the provider requests an extension or if the ICS justifies the need for additional information and how the extension is in the enrollee's interest.

TITLE XXI

- Routine Request or Non-Urgent Request
  A determination will be made for all non-urgent requests for authorization within fourteen (14) calendar days of obtaining all necessary information. This timeframe can be extended up to fourteen (14) additional calendar days if the member or the provider requests an extension, or if the ICS needs additional information to make a decision and it determines that an extension is in the member's interest. Providers will be notified of approval or denial within one (1) calendar day of making the decision.

- Urgent Request or Expedited Requests
  A determination will be made for all urgent care requests within seventy-two (72) hours. Upon determination, the requesting provider will be notified by telephone immediately with a letter to follow.

2.0.3. Appeal Process for Denied, Reduced, Suspended, or Termination of Services

- When an authorization request is denied, the enrollee or provider has the right to appeal the decision. There is not an appeals process for non-covered services for Safety Net enrollees.

- An appeal may be filed orally or in writing within thirty (30) calendar days of the date of the notice of action and, except when an expedited resolution is required, must be followed with a written notice within ten (10) calendar days of any oral filing. The initial date of receipt of either an oral or written appeal shall constitute the date of receipt.

- The following information will be required for each appeal

  - enrollee's full name and date of birth,
  - enrollee's individual identification number,
  - complainant's name, if not the enrollee,
  - name of provider who ordered the health service,
  - name of provider requesting the appeal, if applicable,
  - type of action in dispute (e.g., delay, denial, reduction, suspension or termination)
  - duration and frequency of the disputed health service, if applicable,
  -

- medical necessity of the health service to include additional documentation as needed to support the request,
- if the provider is out of network, documentation to substantiate that the health service cannot be performed by a CMS provider,
- a copy of the original notice of action in dispute, and
- if a continuation of disputed health services is being requested.

2.0.4. Appeal Process for Failure to Approve, Furnish, or Provide Payment for Health Services

- An explanation of all claims submitted from providers will be documented on the Explanation of Benefits (EOB) sent to the provider. Each claim submitted is noted as paid or will include an explanation of the reason for non-payment.

- If the provider believes there has been an error in the payment denial or has any questions about the interpretation of or disagrees with the adjudication, they should first attempt to resolve the issue through the fiscal agent's customer service at 1-800-664-0146 or by email Fl-CustomerService@Med3000.com

- If unsuccessful with this first level appeal, the provider should contact Ped-I-Care or SFCCN as identified on the member ID card.

- **Please see the member's ID card** for assistance or request information on submission of a written formal appeal.

- If a provider submits an appeal, Ped-I-Care or SFCCN will provide a written response within 45 days of receipt of the appeal.

- Examples of reasons for payment denial for actively enrolled members include but are not limited to:
  - no prior authorization where one was required,
  - incorrect enrollee information,
  - use of Out of Network provider without prior authorization,
  - incomplete claims information, or
  - insurance paid the maximum allowable for the service or the benefit limits have been met
  - member not eligible on the date of service

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Section 3.0. Summary for Selected Services for Referral, Authorization, and Notification

Authorization

3.0.1. Applied Behavior Analysis

- Prior authorization is required for Applied Behavior Analysis services necessary for the treatment of autism spectrum disorders.
    - **For Title XXI enrollees request for ABA services are submitted to the appropriate ICS.**
    - **For Title XIX enrollees requests for ABA services are submitted to the local Area Medicaid Office.**
    - **ABA services are not included in the Safety Net limited services package.**
- Treating providers must meet Medicaid qualifications and may submit a prior authorization request for medically necessary services for a child diagnosed with any of the following ICD-10 diagnosis codes: F84.0, F84.3, F84.5, F84.8, or F84.9
- For Title XXI enrollees contact the utilization management department listed on the child's member ID card for provider requirements and covered services.
- Or refer to the Medicaid Coverage and Prior Authorization of ABA for Children under 21 with Autism Provider Alert at this location: http://ahca.myflorida.com/Medicaid/childhealthservices/chc-up/index.shtml

3.0.2. By Report Special Procedures

- By report procedures require documentation of medical necessity for the procedure performed or information is needed in order to review and price the procedure correctly. This requires a written report to be submitted with the claim.
- Please see the most current version of the Medicaid Practitioner Services Coverage and Limitations Handbook, Section 3 for more detailed information. http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/CL_12_12-12-01_Practitioner_Services_Handbook.pdf

3.0.3. Durable Medical Equipment

- Prior authorization for certain services is required and must include a signed written order by the treating physician/PA/ARNP or treating podiatrist. See Medicaid DME and Medical Supply Services Coverage and Limitation Handbook.

  http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/CL_10_100601_DME_ver1_0.pdf

- For children receiving on-going DME who require renewals, the ordering physician or primary care provider must evaluate the member face-to-face at a minimum of every six (6) months.

- Services will not be reauthorized without documentation of a physician face-to-face evaluation.

3.0.4. Elective Surgical Procedures - Hospitalization

- Prior authorization is required for all elective hospitalizations.

- Elective procedures performed in the outpatient setting must follow the prior authorization requirements established for the procedure being performed.

- Any post-discharge services requiring authorization must be communicated through the normal authorization process described above.

- CMS Safety Net program is a limited service package and does not cover inpatient hospital care services.

3.0.5. Home Health Services

- A request for home health services is generally made in two phases, the initial assessment and the treatment plan.

    - The primary care or specialty physician will submit a prior authorization request for the initial assessment.
    - If approved, the home health agency will conduct the assessment and develop a proposed treatment plan.
    - Once the treatment plan is approved and signed by the requesting provider, the plan must be submitted for authorization of services.

- Initial requests for home health care will be authorized for no more than 60-day duration to allow for any reevaluation.

- For enrollees funded by Title XIX and Title XXI, requests are submitted to the appropriate ICS

- For enrollees funded by Title XIX, eQHealth Solutions will partner with CMS to provide care coordination. Recommended home health care services requests are submitted to the appropriate ICS for authorization.

- Continuing private duty home health care services will be authorized for no more than six (6) month duration and will require a medical consultation by the ordering or attending physician.

- During the approval period, if there is a change in the member's status or a change in hours necessary to care for the member, a new request for authorization must be submitted along with documentation of the changes in the member's condition that necessitates the requested change.

3.0.6. Hospice/Palliative Care Services

Hospice

- Although Hospice services do not require prior authorization the primary care provider is required to complete necessary hospice referral documentation to verify client meets the requirements for hospice care and meets the standard definition for hospice eligibility.

Partners In Care: Together for Kids (PIC:TFK) / Florida's Program for All-Inclusive Care (PACC)

- For children with life-threatening illnesses, but who have a life expectancy of greater than six (6) months, the primary care provider can submit the Physician Authorization/Recertification form to refer a child to receive PIC:TFK services. This form is submitted to the Area Office PIC Liaison. These services are for members with a life threatening illness that would benefit from specialized palliative care services. Annual Physician Re-Certification will be required. This form, unique to the palliative care program, is in Appendix II.

- Upon receipt of the Physician Authorization/Recertification form, the CMS office will process the referral to the PIC:TFK provider for evaluation and potential admission into the program.

- The PIC:TFK provider will collaborate with the CMS office on the initial Plan of Care identifying service needs, frequency of service, the family's goals and the planned interventions.

- Although the services provided by the PIC:TFK program do not require authorization, the physician must complete necessary documents in order for the child to be referred and enrolled in the PIC:TFK program.

- **For Title XIX enrollees** PIC:TFK services are billed directly to Medicaid as these services are included in the list of services that are billed outside of the CMS Plan.

- **For Title XXI enrollees** PIC:TFK services are billed to the CMS Plan.

- Services provided have specified limitations that can be found in the PIC:TFK Program Guidelines.

3.0.7. Inpatient Hospitalization – including Mental Health and Skilled Nursing Care

- All non-emergent inpatient hospitalizations require prior authorization approval.

- Services must be medically necessary.

- For inpatient mental health needs, CMS will reimburse providers for therapeutic group care during a hospitalization or mental health inpatient or crisis stabilization placement if the setting is not an Institution for Mental Diseases. CMS will also reimburse for services designed for children that are provided in a licensed residential group home setting.

-

- For Title XXI children enrolled in the Behavioral Health Network (BNET) program, please contact the child's BNET liaison in the local CMS Area Office.

- Children being considered for skilled nursing care (nursing facility services) must have a staffing with the Children's Multidisciplinary Assessment Team (CMAT) to determine the most appropriate level of care needed, in consideration of medical needs and family request.

- See: Hospital services coverage and Limitations Handbook
  http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/Hospital_Services_Handbook_December_2011.pdf

  Community and Behavior Heath Services Coverage and Limitations Handbook

  http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/Community_Behavioral_HealthHB.pdf

  Nursing Facility Services Coverage and Limitations Handbook

  http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/CL_06_040701_Nursing_ver1_0.pdf

3.0.8. Out-of-Network and Out-of-State Providers

- Prior authorization is required for ALL non-emergency out-of-network and out-of-state services. Contact the utilization management department listed on the child's member ID card for any out-of-network service request.

3.0.9. Private Duty Nursing

- Requests for private duty nursing must be prior authorized and services may be reimbursable if determined medically necessary. CMS follows the Florida Medicaid Home Health Services Coverage and Limitations Handbook at this location
  http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/Home_Health_Services_Handbook_March_2013.pdf

- For enrollees funded by Title XIX and Title XXI, requests are submitted to the appropriate ICS

- For enrollees funded by Title XIX, eQHealth Solutions will partner with CMS to provide care coordination. Recommended private duty nursing requests are submitted to the appropriate ICS for authorization.

- During the approval period, if there is a change in the member's status or a change in hours necessary to care for the member, a new request for authorization must be submitted along with documentation of changes in member's condition that necessitates the requested change.

3.0.10. Therapy Services (PT, OT, Speech and Respiratory)

- Therapy services (physical, occupational, speech/language or respiratory therapy) are generally performed in two phases under **one** authorization.

    - The primary care or specialty physician will submit an order /prescription, along with supporting documentation for evaluation and treatment.
    - The evaluating therapist will perform the initial evaluation and develop a proposed plan of care to include, amount, scope and duration of services, and any other requirements set by Medicaid
    - Once the treatment plan is approved and signed by the requesting provider it must be submitted for authorization of services to the appropriate ICS.

- Services may be requested up to sixty (60) days in advance. The authorization period for these services may not exceed six months (180 days).

- Therapy services included on a child's Individual Family Support Plan through the Early Steps program does not need a separate authorization request.

3.0.11. Therapeutic Foster Care, Therapeutic Group Home and Crisis Intervention

- Coverage for therapeutic foster care, therapeutic group home and crisis intervention require prior authorization.

- The authorization forms are attached to this handbook as Appendix IV, Appendix V and Appendix VI. These authorization forms are completed by the behavioral health contracted provider. Supporting document for these services is submitted to the appropriate ICS.

- CMS follows the Medicaid guidelines specified in the Specialized Therapeutic Services Coverage and Limitations Handbook.

  http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/Specialized_Therapeutic_Services_Coverage_and_Limitations_Handbook_Adoption.pdf

Notifications

3.0.12. Emergency Services

- Emergency services do not require prior authorization and are to be provided to all members in accordance with state and federal laws.

- If an emergency condition is determined to exist, the care, treatment, or surgery for a covered service by a physician that is necessary to relieve or eliminate the emergency medical condition within the service capability of a hospital will be a covered service.

- No later than the following business day after an emergency occurrence, the provider is required to notify the utilization management department listed on the child's member ID card of the member's demographics, facility name, and admitting diagnosis.

- Member's shall not be sent to the Emergency Department during a primary care provider's normal office hours for the following:

- routine follow-up care,
- follow-up for suture or staple removal, or
- non-emergent care.

- The CMS Safety Net program is a limited service package and does not cover emergency services.

3.0.13. Admissions through the Emergency Room – Hospitalizations

- Prior authorization is NOT required for emergent admissions. However, by the following business day, the hospital must notify the utilization management department listed on the member's ID card and provide member demographics, facility name and admitting diagnosis.

- Any post-discharge services requiring authorization must be communicated through the normal authorization process described above.

- The CMS Safety Net program is a limited service package and does not cover Inpatient hospital care services.

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4.0.1. Appendix I - Special Exemption Form for Title XXI and Title XIX

Request for Children's Medical Services Coverage of Medically Necessary Non-Covered Services for a Child Under Age 21

Patient Name: _____ Date of Birth: _____ Medicaid ID: _____

This section must be completed by a physician, licensed clinician, or other provider

Requesting Provider Name: _____ National Provider ID: _____Telephone: _____ Fax: _____

Requesting Provider Name_____ National Provider ID: _____Telephone: _____ Fax: _____

Provider Type/Specialty: _____ This request is for a Product: ○ Procedure: ○ Service: ○

CPT/HCPCS Code, *(if none, please describe)*: _____ Expected Frequency/Duration of Treatment:

_____

Is the request experimental or investigational? _____ Yes: ○ No: ○

(If yes, provide name and protocol)

_____

Is the request considered to be safe? _____ Yes: ○ No: ○

(If no, please explain why necessary)

_____

Is the request proved effective? _____ Yes: ○ No: ○

(If no, please explain why necessary)

_____

Is the request furnished in a manner primarily for the convenience of the provider, child, or parent/caregiver? Yes: ○ No: ○

(If yes, please explain why necessary) _____

_____

Please provide a description of how the requested procedure, product or service will correct or ameliorate the patient's defect, physical or mental illness, or condition. *(If more space is needed, please attach additional comments)*

_____

_____

Requester's Signature and Credentials: _____ License #: _____ Date: _____

Please attach <u>all related</u> medical records and evidence-based literature

This section must be completed by the Medical Consultant

Comments: Approved: Denied: Duration:

_____

_____

_____

_____

_____

_____

Signature: _____ Date: _____

This section must be completed by the Utilization Manager

Program Assigned: _____ Name/Title: _____ Date: _____

CPT/HCPCS Code: _____ Provider Type: _____ Duration: _____

Comments: _____

_____

4.0.2. Appendix II Palliative Care Program: Partners In Care: Together for Kids

Forms Include:

- Partners in Care Electronic Form
- Physician Authorization/Re/Certification Form

Forms should be sent to the CMS Area Office PIC/TFK Liaison.

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PARTNERS IN CARE:TOGETHER FOR KIDS (PIC:TFK) FAX REFERRAL

Section 1: Demographics:

Child's name: **SS#:** **DOB:** **Gender:** ☐ **M** ☐ **F**

School child attends: **Grade:** **ESE:** ☐ **Yes** ☐ **No**

Adult living with child: **Relationship:**

Adult living with child: **Relationship:**

Parent's marital status: **Legal guardian:**

Home address:

Home phone: **Work phone:** **Cell phone:**

Siblings living at home	DOB/Age	School attends

Other involved family members & relationship:

Section 2: Medical and Insurance Information

Primary Diagnosis: **Date of onset:**

Secondary Diagnosis: **Date of onset:**

Primary Care MD: **Phone:**

Address of Primary Care MD:

Other involved MDs, Specialty, and Phone #:

Medicaid Waiver/State Plan Services Form attached: ☐ **Yes** ☐ **N/A (child has Title XXI)**

Insurance: ☐ Medicaid/ Title XIX ☐ Title XXI

Current Trajectory of Illness: ☐New (dx within last 3 mo, may/may not be in curative care) ☐Mid-Stage (at least 4 mo post-dx & on active treatment/intervention) ☐End Stage (4 mo or more post-dx & not responding to a normal course of treatment/interventions, future options limited)

Suggested Services (Check all that apply): ☐ Psychosocial Counseling ☐ Palliative Care Nurse Consult/Assessment

☐Personal Care ☐ Respite ☐ Pain & Symptom Management ☐ Spiritual Counseling

☐ Bereavement Counseling ☐ Volunteer Services

CMS staff making referral: **Date faxed to PIC:TFK Provider:** **Phone:**

CMS care coordinator (if not same as referring staff): **Phone:**

Section 3: Disposition of Referral

PIC:TFK provider: **Phone:**

If more than 1 PIC:TFK provider available, choice made by family: ☐ Yes ☐ N/A—only 1 PIC:TFK provider available

Date referral completed: **Date faxed to PIC:TFK provider:**

Date & time referral received: **Patient enrolled:** ☐ Yes—Date: ☐ No

Contact Attempt dates: 1 **2** **3**

Reason if not enrolled:

PIC:TFK provider signature: **Date:** **Phone:**

PHYSICIAN AUTHORIZATION/ RE-CERTIFICATION

Instructions:

- **New patients**: This form must be signed by the child's Children's Medical Services primary care physician prior to discussing PIC:TFK with a parent/ caregiver.

- **PIC:TFK enrolled patients**: The Child's primary care physician must sign this form every twelve months (annually).

- **Please sign the form and fax back the Area Office Children's Medical Services (CMS).**

(Check one)

☐ Initial Certification

☐ Annual Re- Certification

CHILD'S NAME DOB

DIAGNOSIS:

I certify that , a CMS enrolled child is diagnosed with a potentially life limiting condition.

_____

Physician's Signature

_____

Date

INSTRUCTIONS FOR THE PARTNERS IN CARE: TOGETHER FOR KIDS

PHYSICIAN AUTHORIZATION/ RE- CERTIFICATION

NOTE: The Partners in Care: Together for Kids (PIC:TFK) Physician Authorization/Re-certification form contains confidential information and should only be used by authorized personnel as part of the medical and administrative record for the PIC:TFK participant. This form is designed to obtain written initial authorization and annual re-certification for services provided by the PIC:TFK provider. This form must be signed prior to inviting the family to participate in the PIC:TFK program and before Medicaid can be billed for services.

When the form is completed and signed by the primary care physician (PCP) or specialty physician, it means they have authorized PIC:TFK services and have certified that the child has a potentially life limiting condition.

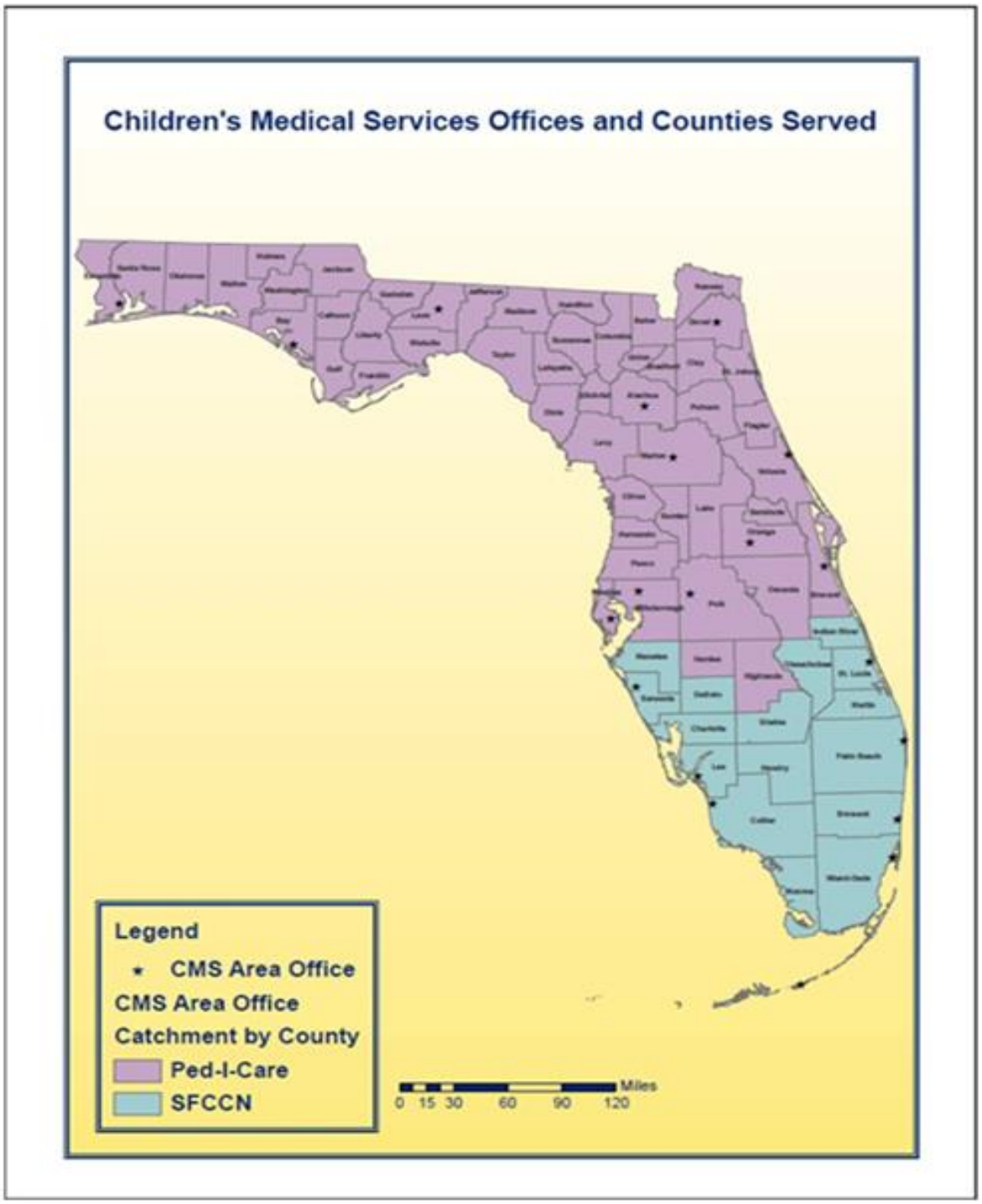
A completed and signed authorization/re-certification forms meets the following program Access Indicators and Performance Measures:

- Access Indicator 2
- Access Indicator 4
- Organizational and Administrative Structure

The CMS staff must enter the fax number prior to sending to the PCP or specialty physician.

A copy of this form must be included in the CMS electronic health record (EHR).

Appendix III- ICS Coverage Area



Appendix IV-Authorization Form for Specialized Therapeutic Foster Care

Form must be completed by the entity determining eligibility for these services

Authorization For Specialized Therapeutic Foster Care

This is to certify that:

Recipient's Name: _____ Date: _____

Medicaid Number: _____ Date of Birth:_____

has been screened and recommended by a multidisciplinary team for specialized therapeutic foster care and has been determined to require the following level of service:

_____ Level I Specialized Therapeutic Foster Care

_____ Level II Specialized Therapeutic Foster Care

These services are to be provided by: _____ (provider agency), as authorized by:

The recipient is eligible for Specialized Therapeutic Foster Care as follows:

_____ The recipient meets eligibility criteria for service.

_____ Multidisciplinary team has determined the child is in need of the service.

_____ _____

Behavioral Health Medical Director Date

Services will be reviewed and reauthorized by the multidisciplinary team prior to: _____

Date

Refer to policy in the Florida Medicaid Specialized Therapeutic Services Coverage and Limitations Handbook for instructions on what must be completed for the specific service.

Copy of form to be placed in recipent's clinical record at CMS and in the servicing provider's clinical record. Medicaid Reimbursement covers only dates of service authorized on this form.

***Form and supporting documentation must be sent to the ICS for Prior Authorization after the MDT.**

Appendix V-Authorization Form for Therapeutic Group Care Services

Form must be completed by the entity determining eligibility for these services

Authorization for Therapeutic Group Care Services

This is to certify that:

Recipient's Name: _____ Date: _____

Medicaid Number: _____ Date of Birth: _____

has been determined by a multidisciplinary team as appropriate for therapeutic group care placement by a licensed clinical psychologis,t per section 490, Florida Statues (F.S.), or a board certified psychiatrist in compliance with section 394.4781 or 39.407, F.S., and has an emotional disturbance or serious emotional disturbance.

These services are to be provided by: _____

_____ _____

Behavioral Health Medical Director Date

Services will be reviewed and reauthorized by the multidisciplinary team prior to: _____

Date

Refer to policy in the Florida Medicaid Specialized Therapeutic Services Coverage and Limitations Handbook for instructions on what must be completed for the specific service

Copy of form must be placed in recipient's CMS clinical record and in the servicing provider's clinical record. Medicaid will reimburse services only for the dates of service authorized on this form.

***Form and supporting documentation must be sent to the ICS for Prior Authorization after the MDT.**

Appendix VI-Authorization for Crisis Intervention

Form must be completed by the entity determining eligibility for these services

Authorization for Crisis Intervention

This is to certify that:

Recipient's Name: _____ Date: _____

Medicaid Number: _____ Date of Birth: _____

has been screened and recommended for Crisis Intervention by the multidisciplinary team.

This service will be provided by: _____ (provider agency) as authorized by:

The recipient is eligible for Specialized Therapeutic Foster Care as follows:

_____ The recipient meets eligibility criteria for service.

_____ Multidisciplinary team has determined the child is in need of the service.

_____ _____

Behavioral Health Medical Director Date

Services will be authorized by the multidisciplinary team from: _____

Date

Services must be reviewed and reauthorized by the multidisciplinary team prior to: _____

Date

Refer to the policy in the Florida Medicaid Specialized Therapeutic Services Coverage and Limitations Handbook for instructions on what must be completed for the specific service.

Copy of form must be placed in recipient's CMS clinical record and in the servicing provider's clinical record. Medicaid will reimburse services only for the dates of service authorized on this form.

***Form and supporting documentation must be sent to the ICS for Prior Authorization after the MDT.**