PURCHASE OF SERVICE GUIDELINE

010/04/2018	HEALTH SERVICES EARLY INTERVENTION (0-3)	FINAL

I. DEFINITION

Health services means services necessary to enable an otherwise child to benefit from the other early intervention services under this part during the time that the child is eligible to receive early intervention services. 34 C.F.R § 303.16(a);

The term includes –

1. Such services as clean intermittent catheterization, tracheostomy care, tube feeding, the changing of dressings or colostomy collection bags, and other health services; and
2. Consultation by physicians with other service providers concerning the special health care needs of infants and toddlers with disabilities that will need to be addressed in the course of providing other early intervention services.

The term does not include –

1. Services that are -
   - (i) Surgical in nature (such as cleft palate surgery, surgery for club foot, or the shunting of hydrocephalus);
   - (ii) Purely medical in nature (such as hospitalization for management of congenital heart ailments, or the prescribing of medicine or drugs for any purpose); or
   - (iii) Related to the implementation, optimization (***e.g.,*** mapping), maintenance, or replacement of a medical device that is surgically implanted, including a cochlear implant.

     (A) Nothing in this part limits the right of an infant or toddler with a disability with a surgically implanted device (*e.g.,* cochlear implant) to receive the early intervention services that are identified in the child's IFSP as being needed to meet the child's developmental outcomes.

     (B) Nothing in this part prevents the EIS provider from routinely checking that either the hearing aid or the external components of a surgically implanted device (***e.g.,*** cochlear implant) of an infant or toddler with a disability are functioning properly;

(2) Devices (such as heart monitors, respirators and oxygen, and gastrointestinal feeding tubes and pumps) necessary to control or treat a medical condition; and

(3) Medical-health services (such as immunizations and regular “well-baby” care) that are routinely recommended for all children 34C.F.R. & 303.16 (b)(1)(2)(c)(1)(2)(3).

II. CRITERIA

The IFSP team for RC eligible infants and toddlers may determine, when exploring utilization of generic services and supports that a medical services identified in the IFSP is not available through the family’s private health insurance policy or health care service plan and that ELARC will fund the service to ensure compliance with the timely provision of service requirements contained in the Code of Federal Regulations, Title 34, Part 303 (commencing with Section 303.1).

If it is determined by the planning team that a health service is needed in the IFSP 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 or deductibles 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 can 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 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.

Any financial hardship information submitted by a parent should be immediately shared with Manager / Supervisor so that an exceptional review can be completed.

Per WIC §4648(a)(16); and, 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 and assessments are determined to be needed for eligibility determination.

B. Health services refers to services necessary to enable an otherwise eligible child to benefit from the other early intervention services under this part during the time the child is eligible to receive early intervention services. 34 C.F.R. 303.16(a).

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.

A State may not use the public benefits or insurance of a child or parent to pay for part C services unless the State provides written notification, consistent with §303.520(a)(3), to the child's parents, and the State meets the no-cost protections identified in paragraph (a)(2) of this section. (2) With regard to using the public benefits or insurance of a child or parent to pay for part C services, the State—(i) May not require a parent to sign up for or enroll in public benefits or insurance programs as a condition of receiving part C services and must obtain consent prior to using the public benefits or insurance of a child or parent if that child or parent is not already enrolled in such a program [34 C.F.R.303.520 (a)(1)(2)]

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 team, 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 provided to the Service Coordinator to share with the planning team. The R1-11 will be returned to the service coordinator to review 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 the 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.