PURCHASE OF SERVICE GUIDELINE

10/04/2018	MEDICAL SUPPLIES	FINAL

I. DEFINITION

Medical supplies include, but are not limited to, dressing supplies, ostomy supplies, catheters and nutritional supplements. Medical supplies must be prescribed by an appropriately licensed physician.

ELARC may assist consumers with the purchase of medical supplies as related to the developmental disability, when it is deemed medically necessary to maintain the consumer's health status or allow the individual greater independence.

II. CRITERIA

ELARC may purchase medical supplies for consumers of any age who require the supplies in order to maintain their health status or to allow them greater independence.

The purchase of medical supplies may be considered when all alternative funding sources have been exhausted [WIC § 4648, subd. (a)(8)].

Effective July 1, 2009, a regional center shall not purchase Health (medical or dental) supplies/ services for a consumer three years of age or older unless the regional center is provided with the documentation of a Medi-Cal, private insurance or health care service plan denial and the regional center determines that an appeal by the consumer or family of the denial does not have merit.

The regional center may pay for medical supplies / services only 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 that an appeal is being pursued.

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

If a service or support provided pursuant to a consumer's IPP/IFSP is paid for, in whole or in part, by the health care service plan or health insurance policy of the consumer's parent, guardian, or caregiver, the regional center may, when necessary to ensure that the consumer receives the service or support, pay any applicable copayment, coinsurance, or deductible associated with the service or support for which the parent, guardian, or caregiver is responsible 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 that does not exceed 400 percent of the federal poverty level.

(3) There is no other third party having liability for the cost of the service or support, as provided in subdivision (a) of Section 4659 and

Article 2.6 (commencing with Section 4659.10).(b) If a service or support provided to a consumer 18 years of age or older, pursuant to his or her IPP, is paid for in whole or in part by the consumer's health care service plan or health insurance policy, the regional center may, when necessary to ensure that the consumer receives the service or support, pay any applicable copayment, coinsurance, or deductible associated with the service or support for which the consumer is responsible if both of the following conditions are met:

(1) The consumer has an annual gross income that does not exceed 400 percent of the federal poverty level.

(2) There is no other third party having liability for the cost of the service or support, as provided in subdivision (a) of Section 4659 and Article 2.6 (commencing with Section 4659.10).

A regional center may pay a copayment, coinsurance, or deductible associated with the health care service plan or health insurance policy for a service or support provided pursuant to a consumer's IPP/IFSP if the family's or consumer's income exceeds 400 percent of the federal poverty level, the service or support 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 of the parent, guardian, or caregiver, or adult consumer with a health care service plan or health insurance policy and creates a direct economic impact on the family or adult consumer. For purposes of this paragraph, catastrophic loss may include, but is not limited to, natural disasters and accidents involving major injuries to an immediate family member.

(3) Significant unreimbursed medical costs associated with the care of the consumer or another child who is also a regional center consumer.

(d) The parent, guardian, or caregiver of a consumer or an adult consumer with a health care service plan or health insurance policy shall self-certify the family's gross annual income to the regional center by providing copies of W-2 Wage Earners Statements, payroll stubs, a copy of the prior year's state income tax return, or other documents and proof of other income.

(e) The parent, guardian, or caregiver of a consumer or an adult consumer with a health care service plan or health insurance policy is responsible for notifying the regional center when a change in income occurs that would result in a change in eligibility for coverage of the health care service plan or health insurance policy copayments, coinsurance, or deductibles.

(f) Documentation submitted pursuant to this section shall be considered records obtained in the course of providing intake, assessment, and services and shall be confidential pursuant to Section 4514.

(g) This section shall not be implemented in a manner that is inconsistent with the requirements of Part C of the federal Individuals with Disabilities Education Act (20 U.S.C. Sec. 1431 et seq.).

ELARC will consider co-pays, co-insurance, and/or deductible, only up to the Schedule of Maximum Allowance (SMA) Rate for the actual service.

Per WIC 4648(a)(15), 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

The amount of service will be based on evaluation results and review of appropriateness of recommendations. In some cases, more than one estimate or alternative types of supplies may be explored. The service shall also be reviewed by the physician consultant.

IV. ALTERNATIVE FUNDING

Private insurance, private trusts, Medi-Cal, Medicare, California Children's Services, EPSDT, CHAMPUS, private health plans, HMOs, Veteran's Benefits, Department of Rehabilitation, Ability to Pay programs at county medical facilities and clinics, etc.

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 that coverage [WIC 4659 (c).

The cost of providing services or supports of comparable quality by different providers, if available, shall be reviewed, and the least costly available provider of comparable service, including the cost of transportation, who is able to accomplish all or part of the consumer's individual program plan, consistent with the particular—needs of the consumer or family as identified in the IPP shall be selected [WIC Section 4648 subd. (a)(6)(D].

V. PROCESS FOR THE 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 and all applicable documentation to the Special Services secretary. Documentation from consumer's medical services providers should be current within 6 months, and written denials/documentation should be provided that all other resources for payment have been exhausted. All R1-11 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 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 so, the physician consultant will sign the R1-11 and return it to the Service Coordinator for scheduling of appointments and processing by the respective unit office assistant. Payment will be at the Schedule Maximum Allowance or vendor rate.

   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 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 changes to service as recommended by the physician consultant, the service coordinator will note that in a memo, attach the R1-11 and a copy of the I.D. Note/Memo/Record Review Form originally completed by the physician consultant and route through the Special Services Secretary to the physician consultant for signature. 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 Schedule Maximum Allowance or vendor rate.

V. EVALUATION OF SERVICE EFFECTIVENESS

The planning team, therapist reports, review by the appropriate consultant, and consumer/family feedback will serve as the mechanism for evaluating the effectiveness of the service. If the duration of use will exceed one year, the supply purchases will be evaluated on an annual basis, based upon updated medical reports and recommendations.