PURCHASE OF SERVICE GUIDELINE

7/8/2015	COUNSELING/THERAPY SERVICES	FINAL

I. DEFINITION

ELARC may assist consumers with the purchase of short-term counseling/therapy services when it is deemed necessary to maintain or improve the consumer's status or preferred living situation or to allow the individual greater independence. Counseling/therapy services are to be provided by qualified and licensed professionals, which includes licensed clinical psychologists, licensed clinical social workers (LCSW), and marriage and family therapists (MFT).

II. CRITERIA

ELARC may purchase counseling/therapy services for consumers of any age who require the counseling/therapy service in order to improve their mental health status or to allow them greater independence and maintain their preferred living situation.

The purchase of counseling/therapy services may only be considered when all alternative funding sources and generic services have been exhausted. ELARC will consider the purchase of specialized health care (counseling/therapy) 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 § 4648, subd. (a)(8)]. Therefore, consumers and families are first expected to pay for health care (counseling/therapy) services, utilize County Department of Health Services facilities, other available generic resources and/or low cost services.

ELARC shall consider funding specialized health (counseling/therapy) 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 (counseling/therapy services) during the following periods:

1. While coverage is being pursued and family has provided documentation of this to ELARC, 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 4659, subd. (d)(1)(A)(B)(C)].

If ELARC identifies the counseling/therapy service as a need in the IPP, then it may also consider funding the copayment, coinsurance or deductibles 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

The amount and duration of service may vary and will be based on current evaluations and recommendations. An evaluation or qualified recommendation should be requested prior to the funding of this service to determine the appropriate amount and duration of the service. The request for service may also be reviewed by the regional center psychology consultant.

IV. ALTERNATIVE FUNDING

A. Private insurance, private trusts, Medi-Cal, Department of Mental Health, school/school district (AB 3632), other sources of public health care available to the general public. The Lanterman Act has been revised to further include that 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).

V. PROCESS FOR THE 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 packet to the Special Services secretary. Documentation from the consumer's psychological /psychiatric services providers 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 at least four weeks in advance of the expected date of service, as no retroactive funding requests will be considered for purchase of service.

C. The request will be reviewed by the psychology consultant to determine if the service request is clinically indicated and the submitted documentation is adequate to support this determination.

    1. If indicated, the reviewing consultant will sign the R1-11 and return it with the packet 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.

    2. If not indicated and/or submitted documentation is not adequate to make a determination, the consultant will return the R-1-11 and the packet to the service coordinator with an ID note/memo/Record Review Form indicating the reason(s).

D. ELARC fiscal/administration unit processes the R1-11.

VI. EVALUATION OF SERVICE

The planning team and consumer/family input, and specialist consultant review of the evaluations and treatment plans and progress reports will serve as the mechanism for evaluating the effectiveness of the service.