

# PHYSICIAN GUIDE TO NAVIGATING THE MEDICAID MANAGED CARE SYSTEM FOR MEDICAID ELIGIBLE PEDIATRIC PATIENTS

*Prepared by Disability Rights Ohio and the Miami Valley Medical-Legal Partnership for Children.*

On July 1, 2013, the Department of Job and Family Services launched a new state-wide Medicaid Managed Care system. Medicaid eligible children and families were asked to choose from one of five state-wide Medicaid Managed Care Plans: Buckeye Community Health Plan, Care Source, Molina Healthcare of Ohio, Paramount Advantage, and United HealthCare Community Plan of Ohio. Families that did not choose a plan were placed in a plan by the Ohio Department of Medicaid. This means that many of your Medicaid eligible patients have new Managed Care Plans and you are navigating new policies and procedures. This guide seeks to answer questions related to Medicaid eligible pediatric patients' right to care, regulations governing managed care plans, and physician strategies to ensure continuous appropriate coverage for services, prescriptions, transportation, and durable medical equipment.



## Do different Medicaid Managed Care Plans offer different coverage to children?

All Medicaid Managed Care Plans are required to provide coverage for medically necessary care to children in accordance with EPSDT. However, each plan may have different policies for determining medical necessity for specific services. These policies, however, must conform to the federal requirements under EPSDT and must consider the individual needs of each eligible child.

## What is EPSDT?

EPSDT is the Federal Medicaid Act's Early and Periodic Screening, Diagnosis and Treatment benefit available to children under the age of 21. In Ohio, we call this Healthchek. EPSDT requires that states cover any federal Medicaid services necessary to "correct or ameliorate" a child's physical or mental illness or condition. 42 U.S.C. § 1396d(r)(5).

## What does "ameliorate" mean?

To improve or maintain the child's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

## What does Medicaid for Children Cover?

- » Early and Periodic screening services – well child visits
- » Vision, dental, and hearing screenings and services
- » Other necessary health care identified through screening including:
  - » Rehabilitative services for developmental disabilities;
  - » PT and OT services;
  - » In-home nursing, personal care, specialized therapies;
  - » Mental health and substance abuse services;
  - » Transportation to medical appointments;
  - » Medical and adaptive equipment – glasses, helmets, wheelchairs, communication devices;
  - » Speech pathology services;
  - » Out-of-home residential, facility and hospital services;
  - » Other medically necessary care.

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## Are there limits on treatment services for children?

Under EPSDT/Healthchek, a child can receive medically necessary services or equipment that would be covered by federal Medicaid whether or not the service is covered by Ohio Medicaid. Children can get more of a service or treatment than would be provided to an adult. For example, a child can get more physical therapy than would be provided to an adult or more dental care than an adult would receive. This means that a child can get the type (e.g., therapy, nursing, personal care, etc.), amount (how much of the service) and duration (how long the service will be provided) of a service that is recommended as medically necessary by a Medicaid provider.

## What does “medically necessary” mean?

Under EPSDT/Healthchek, children can receive services or equipment needed to correct or ameliorate physical or mental illnesses and conditions. This is a different standard than the standard of medical necessity used for adults. Any Medicaid provider can make a recommendation regarding what is medically necessary for a child. Medicaid providers include doctors, nurses, dentists, physical therapists, occupational therapists, speech therapists, psychologists, psychiatrists and other health care professionals. Other considerations in determining “medical necessity” include:

- » Must be determined to be medical in nature;
- » Must be generally recognized as an accepted method of medical practice or treatment;
- » Must not be experimental, investigational.

## How does a child get medically necessary services?

A Medicaid provider must make a recommendation that a service or piece of equipment is medically necessary. Some services must be approved by Ohio Medicaid before they are provided to a child. If a child needs a service that must be pre-approved, the physician or health care professional must submit a preauthorization request for the service. Only a Medicaid provider may make the request for medically necessary treatment or services. If a child is enrolled in a Medicaid managed care plan, the provider should contact the plan’s prior authorization department to request treatment or services. If a child is not enrolled in a Medicaid managed care plan, the Medicaid provider will submit a request for the treatment or services to Ohio Medicaid.

## What happens if a request for prior authorization is denied?

If a Medicaid managed care plan denies a prior authorization request for a service, prescription or medical equipment, it must send a written notice to the patient and the provider. If you disagree with the denial, you can request a peer to peer review by contacting the plan. This peer to peer review typically involves a consultation with a plan physician and an opportunity to explain why the prescribed treatment is medically necessary. A patient also has the right to appeal any denials of coverage for Medicaid services. A health care provider can file an appeal directly with the managed care plan on behalf of the patient. The patient or patient’s parent or guardian can also appeal the denial by filing an appeal with the managed care plan or directly with the Department of Job and Family Services. An appeal, also known as a hearing request, must be requested within 90 days from the date of the notice. The notice explains how to request a hearing. If an appeal is filed with DJFS, a hearing will be scheduled and a hearing officer will listen to evidence regarding the reasons the prescribed treatment is necessary. Clear medical documentation regarding why the treatment, equipment, etc. is medically necessary and appropriate under EPSDT will support any preauthorization requests, peer to peer reviews and appeals.

## Can a Managed Care Plan ask me to consider less expensive treatment options for my patients?

Yes, a medically necessary service must be the lowest cost alternative that effectively addresses and treats the medical problem. A managed care plan may ask a provider to consider a lower cost alternative treatment. However, if a lower cost treatment would not effectively address the medical problem, Medicaid must pay for the higher cost alternative if it is otherwise medically necessary.

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## When do I need to request prior authorization?

There are many types of medical services and equipment that require prior authorization. There is not a comprehensive list, but some examples are:

- » Some home health services, including private duty nursing;
- » Some durable medical equipment, such as wheelchairs, speech generating devices, hearing aids, orthopedic shoes, compression garments, hospital beds, and some repairs to previously purchased equipment;
- » Some brand name prescriptions;
- » Dentures and braces;
- » Specialty optical items, including contact lenses, tinted lenses, prosthetic eyes, and low-vision aids, and non-shattering lenses;
- » Services for children under Early Periodic Screening, Diagnosis, and Treatment (EPSDT or Healthchek) in excess of the amount of services that adults can receive, such as speech therapy or physical therapy;
- » Some mental health services;
- » Some surgical procedures, including organ, bone marrow, or stem cell transplants.

If you do not know whether a service or equipment requires prior authorization, you should contact Ohio Medicaid. Managed care plans often require prior authorization for additional services or equipment, such as home health services. The member handbook or managed care organization can tell you which services or equipment require prior authorization.

## How do I request prior authorization?

If you are recommending a service or equipment that requires prior authorization, you must submit a request for prior authorization to the managed care plan or the Medicaid agency. Sometimes plans require the completion of specific forms and you may need to contact the plan or any medical equipment providers to ensure that the appropriate and most up to date forms are being completed and submitted timely. This will help to avoid the hassle of having to resubmit forms and long delays in processing.

## How will I know if my prior authorization request has been approved or denied?

If the prior authorization request is approved, you will be notified that the service or equipment has been approved. If the Medicaid agency needs more information in order to approve or deny the request, then you should be notified that additional information is needed.

If the prior authorization request is denied, you will receive a notice in the mail. The notice will tell you that the request has been denied, the reason for the denial, and how you can appeal if you disagree. If no response is provided in a timely manner, you can assume that the request has been denied and proceed with appeal procedures.

## How can I appeal the denial of a prior authorization request?

If your request for prior authorization is denied, the patient can appeal the denial through the state hearing process. If a managed care plan denies your prior authorization request, then you also have the option of appealing through the managed care organization's appeal process. Your denial notice will provide you with information about your appeal options, and the timeline for requesting an appeal. You must request an appeal within 90 days of the mailing date of the denial notice.

Before the hearing, review the notice of denial to determine the reason for the denial. You should try to cure any defects in paperwork submitted, including providing additional information about medical necessity or changing incorrect coding. Additional information about medical necessity can be presented at the hearing.

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## Physician Strategies to Increase Patient Access to Healthcare:

Write a detailed prescription/coverage recommendation describing the child's condition and need for the service, medicine or equipment. Explain any alternatives that have been tried and/or rejected and why they failed or will fail to address the underlying condition. If lower cost alternatives have been considered and rejected, document that in your recommendation. Make sure that correct coding is used in your recommendation. If you are unsure of the code that should be used, contact the managed care plan or Medicaid prior authorization section for assistance.

- » Explain how the services will correct or ameliorate the child's physical or mental condition.
- » Be prepared to request a peer-to-peer review and argue for coverage.
- » Obtain information about the peer reviewer's credentials and area of expertise. You may need to request review by someone with a specific specialty background.
- » Be prepared to argue why the particular services are medically necessary and covered by EPSDT.
- » Be prepared to file an appeal or advise the patient/parent to file.
- » Appeals can be filed directly with the managed care plan and/or with the Department of Job and Family Services (file within 15 days to maintain coverage, 90 day appeal deadline).
- » If the appeal filed with managed care plan is denied, another appeal can be filed with the Department of Job and Family Services (90 day deadline).
- » For urgently needed care, make sure to request an expedited appeal.
- » Refer the family for legal assistance with appeals and provide family with documentation in support of the medical necessity of the service.

## Medicaid Managed Care EPSDT Coordinators:

Each managed care plan has an EPSDT coordinator who is charged with ensuring that the managed care plan follows federal requirements in the provision of services to children. You can contact the managed care plan member/provider services number to speak with the coordinator about questions specific to Healthcheck/EPSDT.

Buckeye Community Health Plan	(866) 246-4358	<a href="http://www.bchpohio.com">www.bchpohio.com</a>
Care Source	(800) 488-0134	<a href="http://www.caresource.com">www.caresource.com</a>
Molina Healthcare of Ohio	(800) 642-4168	<a href="http://www.molinahealthcare.com">www.molinahealthcare.com</a>
Paramount Advantage	(800) 462-3589	<a href="http://www.paramounthealthcare.com">www.paramounthealthcare.com</a>
UHC Community Plan of Ohio	(800) 895-2017	<a href="http://www.uhcommunityplan.com">www.uhcommunityplan.com</a>

## For concerns regarding a Medicaid managed care plan's practices, contact the Ohio Department of Medicaid at:

[medicaid.ohio.gov/PROVIDERS/EnrollmentandSupport/ProviderAssistance.aspx](http://medicaid.ohio.gov/PROVIDERS/EnrollmentandSupport/ProviderAssistance.aspx) or (800) 686-1516

*Prepared by the Miami Valley Medical-Legal Partnership for Children (MLPC) and Disability Rights Ohio.*

### [mlpc.ablelaw.org/miamivalley](http://mlpc.ablelaw.org/miamivalley)

The Miami Valley MLPC is a collaboration among Dayton Children's Hospital, Five Rivers Health Centers, Community Health Centers of Greater Dayton (CHCGD), and two law firms serving low-income clients: Advocates for Basic Legal Equality, Inc. (ABLE), and Legal Aid of Western Ohio, Inc. (LAWO).

### [www.disabilityrightsohio.org](http://www.disabilityrightsohio.org)

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