# CHAPTER 41-000 MEDICAL SERVICES COVERED BY CHILD WELFARE FUNDS

41-001 Introduction: This chapter deals with medical services that are covered by child welfare funds.

For Medicaid services, see Chapters 1-000 through 31-000 of Title 471.

41-001.01 Legal Basis: Title IV, Part B of the Social Security Act authorizes the states to provide child welfare services. Section 43-284, Reissue Revised Statutes of Nebraska, authorizes the Nebraska Department of Social Services to provide medical and psychiatric services to Department wards. The children may be removed from their homes or placed in their own homes with the provision of services and supervision.

The Department of Social Services provides all services in accordance with the Family Policy Act, Sections 43-532 through 43-534, R.R.S., 1943.

41-001.02 Purpose: The program ensures proper authorization and delivery of medical services to a child, and the child's family when services will benefit the child, when -

1. The child is committed to the custody of the Nebraska Department of Social Services by virtue of a court order entered by a court of competent jurisdiction;
2. The child's guardianship is surrendered to the Department by a properly executed voluntary relinquishment; or
3. The child's custody is transferred to the Department through a "Voluntary Placement Agreement" (see 474 NAC 5-021.22 ff.).

41-001.03 Administration: The program is administered by the Nebraska Department of Social Services in accordance with state laws and with rules, regulations, and procedures established by the Director of the Nebraska Department of Social Services.

41-001.04 Definitions: For use within this program, the following definitions of terms will apply unless the context in which the term is used denotes otherwise.

Child Welfare Funds: State funds that may be used to meet the needs of -

1. Department wards;
2. Former wards;
3. Children who are eligible for adoption assistance; and
4. Subsidized guardians.

Child welfare funds may be used to provide services to members of the child's family when the services will benefit the child (e.g., family counseling services).

Contracted (Non-Medicaid) Provider: An individual or entity that does not have a provider agreement with NMAP but has a contract with the Department to provide services covered by child welfare funds.

Drug and Chemical Diagnosis: An identified drug or chemical dependent condition as determined by a certified drug and alcohol counselor who has a contract with the Department of Social Services.

Educational Assessment: The summary of a child's educational needs as determined by -

1. The local school district;
2. The Area Educational Service Unit; or
3. The Nebraska Diagnostic and Resource Center, Cozad.

Family Assessment: An assessment of the family's level of functioning, while considering the child's physical, emotional, and social needs, and the family's ability to meet those needs.

Medicaid Provider: Any individual or entity which furnishes Medicaid services under an approved provider agreement with the Nebraska Medical Assistance Program (NMAP).

Mental Health Review Team (MHRT): A team consisting of representatives of the Medical Services, Human Services, Client Services Delivery, and Legal Divisions with expertise in psychiatric care who will consult with local workers on use of inpatient services for mental health, chemical dependency, eating disorders, or behavioral treatment. The team will approve/disapprove inpatient services based on information supplied by the worker, who is part of the team.

Psychiatric Assessment: An evaluation provided by a psychiatrist using testing and evaluation which can be expected to contribute to a psychiatric diagnosis and plan of care.

Psychiatric Second Opinion: An evaluation provided by a psychiatrist other than the original psychiatrist as deemed necessary by the Department.

Psychological Assessment: An evaluation provided by a licensed and certified clinical psychologist using testing and evaluation which can be expected to contribute to a psychiatric diagnosis and plan of care.

State Ward Medical Unit: A unit in the Medical Services Division which processes claims for services covered by child welfare funds under this chapter.

Third Party Liability: Any source from which payment for a service could be made before being paid by NMAP or child welfare funds. This may include private insurance, other available benefits, parents (either voluntarily or by court order), or the ward herself/himself from personal assets or earnings.

41-001.05 Summary of Forms: The following forms are addressed in this chapter. Examples and instructions for these forms are contained in the appendix.

| Form # | Form Title | Appendix Reference |
|---|---|---|
| CWI-10 | | 471-000--___ |
| DA-100 | Aplication for Assistance | 471-000-1 |
| EPSDT-3 | EPSDT Follow-Up | 471-000-39 |
| EPSDT-3FC | EPSDT Request and Treatment | 471-000-___ |
| EPSDT-4FC | EPSDT Treatment Follow-Up | 471-000-___ |
| HCFA-1500 | Health Insurance Claim Form | 471-000-52 through 471-000-65 |
| MC-5 | Periodic Screening Report and Claim Statement | 471-000-83 |
| MC-13 | Dentist's Pre-Treatment Plan and Service Statement | 471-000-88 |
| MC-83 | Psychiatric Acute Care Report | 471-000-96 |
| PDS-110 | Income Maintenance Client Data | 471-000-___ |

## 41-002 Billing and Payment

41-002.01 Plan for Payment: The worker shall use the following priorities to determine a plan for payment of services:

1. A provider who is paid through the parents' insurance or by the parents (whether at full cost or reduced cost), or a no-cost provider;
2. A Medicaid provider, when the client is Medicaid-eligible and the service is covered by Medicaid;
3. A Department contractor; and
4. Another provider of service when none of the above are available or able to reimburse.

Payment of services in item 4 must be at or below Medicaid rates. If there is no Medicaid rate or Medicaid-comparable rate (e.g., chemical dependency treatment), the Medical Services Division and the Human Services Division shall jointly establish the rate. Information regarding the establishment of a rate may be requested through the Medical Services Division.

41-002.01A Identification of Need for Contracted (Non-Medicaid) Provider: When the placement worker identifies a medical or mental health need which cannot be met through a Medicaid source, the worker shall -

1. Document the need;
2. Gather all medical history which supports the medical or mental health need;
3. Develop an initial plan for services with the provider;
4. Obtain the prior approval of Medical Services staff in conjunction with Human Services staff;
5. Obtain approval from the MHRT for inpatient services for mental health, chemical dependency, eating disorders or behavioral treatment; and
6. File a copy of the approved plan in the service file and forward a copy to the State Ward Medical Unit.

(Also see 474 NAC 4-009.32C1.)

41-002.01B Use of Medicaid/Non-Medicaid Providers: The worker shall explain to the foster parent(s) that a non-Medicaid provider may be used only with approval (prior to provision of the service) of Medical Services staff in conjunction with Human Services staff. Use of a non-Medicaid provider may be approved only if there is no Medicaid provider available to provide the particular services and/or to allow the physician caring for the child at the time of initial placement to continue to provide services to the child.

41-002.01C Services Not Covered by Medicaid: The physician or the worker shall send all requests for services not covered by Medicaid (e.g., plastic surgery, scar or tatoo removal, breast reduction, or nasal reconstruction) to the Central Office, Medical Services Division to the state ward program specialist. The request must include a physician's statement which must include the following:

1. History of condition/illness;
2. Physical findings and other signs and symptoms, including appropriate laboratory data;
3. Recommended service/procedure; and
4. Expected outcome.

Risks and benefits will be weighed.

The Medical Services Division in consultation with the Medical Director shall make a decision on each request in consultation with Human Services staff. A decision will be made within 30 days of the receipt of complete information. A copy of the decision is sent to the child's worker and the State Ward Medical Unit.

If the request is denied, the worker may provide additional information to the Human Services and Medical Services Divisions for review and reconsideration.

41-002.02 Billing Procedures: Medical billings for children must be submitted on Medicaid forms with appropriate documentation as required in 471 NAC.

41-002.02A Contracted (Non-Medicaid) Providers: All contracted (non-Medicaid) providers shall submit billings to the State Ward Medical Unit. The local office shall provide the non-Medicaid provider with proper forms (or information on how to obtain forms), procedure codes, and billing procedures.

41-002.02B Medicaid Providers: For Medicaid eligible wards, Medicaid providers shall first bill NMAP. If a claim is denied, NMAP sends it to the State Ward Medical Unit. If a denied claim is inadvertently returned to the provider, the provider shall resubmit the claim along with the Medicaid denial to the State Ward Medical Unit for review and processing.

41-002.02C Inquiries: The worker may direct inquiries regarding rates, procedure codes, and dollar limitations to the appropriate Medical Services Division program specialist for the specific service being provided.

41-002.03 Payment by Foster Parent: Foster parents should not pay a medical provider for services rendered to a Department ward. The foster parent will not be reimbursed unless there has been written prior authorization signed by the worker and service supervisor, except in emergency situations where the foster parent is required to pay for a medical expense. The worker shall send a copy of any written authorization to the State Ward Medical Unit.

41-003 Family and Child Welfare Mental Health Services: Also see 471 NAC 20-000 ff. regarding Medicaid-covered mental health services and 474 NAC 4-003 ff. regarding mental health services.

41-003.01 Funding: The worker shall use the following priorities to establish a plan for payment for mental health services:

1. A provider paid through parents' insurance, by parents (whether at full cost or reduced cost), or a no-cost provider;
2. Medicaid provider when the client is Medicaid-eligible and the service is reimbursable through Medicaid;
3. Department contractor;
4. Another provider of service when none of the above are available or able to reimburse.

Payment of services in item 4 must be at or below Medicaid rates. If there is no Medicaid or Medicaid-comparable rate (e.g., chemical dependency treatment), the Medical Services and Human Services Divisions shall establish the rate jointly. A decision will be made within 30 days of the receipt of complete information. Information regarding the establishment of a rate may be requested through the Medical Services Division.

Note: Under provisions of the juvenile code, the Department does not pay for evaluations that are ordered by the juvenile courts to be completed at the Youth Development Center at Geneva and Kearney.

41-003.02 Providers: If resources outside the Nebraska Department of Social Services are used to obtain a psychological or psychiatric, mental health, chemical dependency, evaluation and/or treatment, the resource(s) must be -

1. A state licensed community mental health center which has a provider agreement, as stated in 471 NAC 20-004.01A;
2. A master or doctoral level clinical psychologist;
3. A psychiatrist;
4. A mental health facility of the Nebraska Department of Public Institutions;
5. A licensed or formally approved hospital which provides psychiatric services (See service limitations 471 NAC 20-006.01);
6. An individual with a masters in social work or clinical or counseling psychology; or
7. A certified drug and alcohol counselor for chemical dependency evaluations only.

41-003.03 Evaluations: The worker shall follow 471 NAC 41-003.01 and 41-003.02 in obtaining evaluations of the child. Evaluations must be conducted in the least restrictive or intrusive manner.

41-003.03A Inpatient Evaluations 15 Days or Less: The worker shall obtain approval of the District Administrator or his/her designee before a child receives -

1. An inpatient psychiatric evaluation;
2. An inpatient chemical dependency evaluation (Note: an inpatient stay of up to two days for detoxification as covered by Medicaid is allowed);
3. An inpatient evaluation for eating disorders; or
4. An inpatient evaluation for behavior problems.

Before approving these evaluations, the District Administrator (or his/her designee) shall review documentation of the child's specific need for evaluation in an inpatient setting, incuding any information on attempts to secure the evaluation on an outpatient basis. Inpatient evaluations are limited to 15 calendar days.

41-003.03B Inpatient Evaluations Longer Than 15 Days: An inpatient evaluation beyond 15 days in length may be provided to a child only with approval of the appropriate District Administrator (or his/her designee) and the Mental Health Review Team. If the District Administrator approves the request to extend the evaluation, s/he shall submit documentation which justifies the medical necessity of continued inpatient evaluation to the MHRT. This documentation must be submitted as soon as possible and no later than the 14th day of the original 15-day evaluation period. The MHRT will be convened and shall respond within 24 hours or by the end of the 15th day. Documentation must include -

1. Name of district and local office, names and phone numbers of worker and supervisor;
2. Name and Social Security number of the child;
3. Name and phone number of the referring psychiatrist or physician;
4. Name of the facility;
5. Date and purpose of admission;
6. Presenting problem;
7. Reason for selecting inpatient (rather than outpatient) setting;
8. Discharge plan, including date of planned discharged; and
9. Copies of evaluations, progress reports, recommendations, etc.

41-003.04 Outpatient Mental Health Services: The Department covers outpatient mental health services to provide services in the least restrictive setting and to prevent unnecessary inpatient residential treatment. NMAP limits payment for outpatient mental health services to payment for medically necessary services for a primary acute psychiatric diagnosis (see 471 NAC 20-004). Child welfare funds may be used to pay for outpatient services to Department wards and their families if NMAP does not cover those particular services or denies payment for the services based on lack of medical necessity. Providers shall submit documentation as required in 471 NAC 20-004.04 and 20-004.05 for all outpatient services.

If the assessment of the child's and family's needs indicates the need for ongoing counseling services, the worker shall develop a counseling plan with the participation of the family. The purpose of the plan is to clarify expectations for the family, worker, and service provider and to provide the supervisor with information necessary for approval of the plan and, when appropriate, funding. It must be shared with the family.

The counseling plan must be attached to the case plan and must include the following:

1. The reasons counseling services are recommended (including problems or issues to be worked on in counseling);
2. The goals identified;
3. The type of counseling services;
4. The provider;
5. The estimated length of counseling; and
6. If child welfare funds are requested:
    a. Alternative payment resources explored; and
    b. Estimated cost of counseling.

After approval of the counseling plan by the worker and family, the worker shall send one copy of the plan/authorization to the provider and one to the Medical Services Division, Central Office and keep a copy in the case file.

The worker shall request that the provider submit a progress report at least every three months or as specified by contract. Form MC-83 may be used for this report. The worker shall review the need for continued counseling services with his/her supervisor after three months of ongoing treatment, determine progress made and need for continued services or modification in the case plan, and document the need in the case file. If services are continued, the worker and supervisor shall review and document the need for continued services at least every three months thereafter, again utilizing form MC-83. With participation of the family, the worker shall update the treatment plan at least every three months.

Supervisory review and approval are required for continuous counseling beyond an initial six-month period and every three months thereafter.

The worker shall forward a copy of all approvals (worker's or supervisor's as appropriate) to the Central Office, Medical Services Division. Approvals must be received by the Medical Services Division in order for payments to be processsed.

Also see 474 NAC 4-003.02C.

41-003.05 Inpatient Psychiatric Services: The Department covers inpatient psychiatric services to provide treatment for a Department ward who is unable to benefit from less restrictive treatment. Child welfare funds may be used to pay for inpatient treatment for Department wards if NMAP does not cover or denies a particular service for lack of medical necessity and if the services were approved by MHRT or special approval. The worker shall apply 471 NAC 41-003.01 and 41-003.02 to obtain these services. For Department wards in Institutions for Mental Disease, see 471 NAC 20-007 ff.

Inpatient treatment may be provided to a ward only with advance approval of the appropriate District Administrator (or his/her designee) and the Mental Health Review Team. After the District Administrator approves a request, s/he shall submit a written request for inpatient treatment, including the following documentation, to the MHRT:

1. Name of district and local office, names and phone numbers of worker and supervisor;
2. Name and Social Security number of the ward;
3. Name and phone number of the referring psychiatrist or physician;
4. Name of the facility;
5. Date and purpose of admission;
6. Presenting problem;
7. Reason for selecting inpatient (rather than outpatient) setting;
8. Discharge plan, including date of planned discharge; and
9. Copies of evaluations, progress reports, recommendations, etc.

The MHRT shall meet and provide a response within 24 hours, or by the end of the 15th day when the District Administrator has previously approved inpatient evaluation.

The MHRT has the authority to -

1. Approve inpatient treatment for the period of time that is medically necessary;
2. Approve additional days of inpatient treatment (to approve additional days, the team must receive a request from the District Administrator and conduct a review of evaluations, recommendations, progress reports, etc.);
3. Conduct follow-up reviews of a case while the ward is receiving inpatient treatment; and
4. Conduct on-site interviews as part of the assessment and decision-making process.

Decisions made by the team are final. If inpatient treatment is not approved for a Department ward who is in the facility, the ward must be moved within 24 hours. No exceptions to this requirement will be allowed.

41-003.05A Out-of-State Inpatient Psychiatric Treatment: The worker shall request approval for out-of-state inpatient psychiatric treatment according to the process in 474 NAC 4-009.16 ff.

41-003.06 Chemical Dependency Treatment

41-003.06A Outpatient Chemical Dependency Counseling: The Department covers outpatient chemical dependency counseling to provide treatment in the least restrictive setting which permits the child to continue to receive public education and reside in the community. Whenever possible, the family must be included in the treatment alternatives. Child welfare funds may be used for payment of outpatient chemical dependency counseling as contracted by the Department.

If a placement worker determines that a Department ward may have a chemical dependency problem, the worker shall arrange an evaluation by a certified drug-alcohol counselor. Treatment for a family member may be made from Family Support funds when the goal is reunification (see 474 NAC 4-009.32B8c(1)). If treatment is indicated, the first alternative must be outpatient counseling with a qualified professional.

If the assessment by a certified drug-alcohol professional identifies the need for treatment, the worker shall present a plan for treatment to the service supervisor for approval. The plan for treatment must include -

1. Reports from all prior assessments and treatments;
2. The resource that will provide the services;
3. The estimated cost of treatment;
4. The estimated length of treatment; and
5. A listing of special requirements from the provider (i.e., progress reports, diagnosis, prognosis, possible court appearances, and collateral consultations).

If the supervisor approves the plan for treatment, s/he shall submit the plan to the District Administrator for a decision. The worker forwards one copy of the authorization to the provider, one copy to the Medical Services Division, and files a copy in the service file.

Payment of services in the last category must be at or below Medicaid rates. If there is no Medicaid or Medicaid-comparable rate (e.g., chemical dependency treatment), the rate shall be established jointly by the Medical Services and Human Services Divisions. A decision will be made within 30 days of the receipt of complete information. Information regarding the establishment of a rate may be requested through the State Ward Medical Unit.

The length of treatment is determined by the youth's progress and a joint decision made by the caseworker with input from the counselor and approval of the supervisor. The caseworker shall monitor the treatment case plan to ensure that the treatment is being followed and continues to be appropriate.

41-003.06B Inpatient Chemical Dependency Treatment: The Department covers inpatient chemical dependency treatment to provide intensive chemical dependency treatment that cannot be provided on an outpatient basis. Before inpatient chemical dependency treatment is authorized, the placement worker shall explore all appropriate outpatient resources and document in the case record. Inpatient chemical dependency treatment must be approved by the MHRT as described in 471 NAC 41-003.05.

41-003.06C Out-of-State Treatment: The worker shall request approval for out-of-state chemical dependency treatment according to the process in 474 NAC 4-009.16 ff.

41-004 Early and Periodic Screening, Diagnosis, and Treatment (EPSDT): The Early and Periodic Screening, Diagnosis, and Treatment Program was established by Title XIX of the Social Security Act. It is funded by a combination of state and federal money.

Section 43-1311, Reissue Revised Statutes of Nebraska, 1943 requires that a child have a medical examination and any necessary further diagnosis and evaluation within two weeks of removal from his/her home.

Section 68-1020, R.S. Supp., 1984 authorizes payment from state funds for EPSDT services for Department wards who are not Medicaid-eligible.

41-004.01 Purpose and Scope: EPSDT is a service available to all individuals age 20 and younger eligible for medical assistance. The purpose of EPSDT is to provide -

1. Early detection of illness or defects through a screening examination;
2. Follow-up of the condition detected during a screening; and
3. Continuity of care. It is intended to encourage and ensure that treatment is available and received by those eligible and in need of treatment.

Child welfare funding may be used to pay for EPSDT for Department wards if NMAP does not cover or denies the claim for a particular service or if the child is not Medicaid-eligible.

41-004.02 Benefits of Preventive Health Care: Preventive health care provides the following benefits for the child:

1. Early detection and treatment of health problems to prevent permanent impairment and to increase the chance of successful treatment;
2. Protection from certain preventable diseases by immunization for children at an early age;
3. Maintenance of good health and assurance of normal development through periodic check-ups; and
4. Savings of future medical costs.

41-004.03 Worker Responsibilities (Also see 474 NAC 9-009.32A.)

41-004.03A Informing the Child and Parents: A child must have a medical evaluation and any necessary further diagnosis and evaluation within two weeks of removal from his/her home. The worker who has responsibility for the initial placement or the ongoing case manager shall explain the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program to the child or the unit receiving the cash assistance (e.g., foster parent, facility administration) within ten days of placement. The explanation must include a review of the EPSDT pamphlet. The worker shall ensure that there is an opportunity to ask questions about EPSDT.

The worker responsible for placement or the ongoing case manager shall ensure that the State Ward Medical Unit is contacted by the foster parent or contacts the State Ward Medical Unit to provide the name and address of the screening physician. The State Ward Medical Unit shall send Forms MC-5 and EPSDT-3FC to the provider. The provider shall return the completed forms to the State Ward Medical Unit. The State Ward Medical Unit shall send a copy to the worker for the case record. The worker shall follow-up to ensure that the child's medical needs are properly treated.

In addition, for Department wards, the IM worker shall send to the child and/or family or facility notification when the child is due for medical and dental exams according to the periodicity schedule or annually after the initial informing.

The worker shall adapt these informing procedures to meet the needs of persons with handicapping conditions, e.g., blindness, deafness, etc. Translated materials or an interpreter are appropriate for informing individuals who cannot understand the English language.

For those individuals accepting EPSDT and requesting services, the case manager shall provide assistance in arranging transportation, locating a doctor or a dentist, or scheduling appointments.

Also see 474 NAC 4-009.32B2.

41-004.03B Assisting With Appointments and Transportation: The worker shall offer assistance or referral in scheduling appointments and providing transportation for the screening exam and treatment services and provide these if requested and necessary. To ensure timely delivery of services, the worker shall have available, upon request, the names and locations of Medicaid providers (physicians, clinics, and dentists) and Title V Medically Handicapped Children's Program providers.

The worker responsible for placement or the ongoing case manager shall ensure that the State Ward Medical Unit is contacted by the foster parent or contacts the State Ward Medical Unit to provide the provider(s)' name. The State Ward Medical Unit shall send Form MC-5 and/or Form MC-13, as appropriate, to the appropriate provider.

The screening exams are to be performed within 120 days of the initial and periodic request. The case manager or designated worker shall establish a method of tracking whether the exams were performed, such as contacting the foster parent or facility, contacting the State Ward Medical Unit, or checking computerized information (e.g., Medicaid claim history on Job 045, or EPSDT printouts). If the screening is overdue, the worker shall make at least one contact in an effort to provide timely services. One followup contact is considered a good faith effort to provide timely delivery of services.

As follow-up, the case manager or designated worker shall inform the child or family/facility of the need for further diagnosis or treatment services and assure that transportation and appointment scheduling is provided if requested and necessary, to enable the child to receive timely diagnosis and treatment as stated on the child health record or on Form MC-5 (EPSDT) or MC-13 (dental). This can be accomplished by Form EPSDT-4FC or a similar contact. The case manager or designated worker shall establish a method of tracking to assure the timely provision of services. The case manager or designated worker shall make at least one contact in an effort to provide timely services. One follow-up contact is considered a good faith effort to assure initiation of treatment.

For children who are not wards of the Department, see 471 NAC 18-005 ff and 468 NAC 5-000 ff.

41-004.03C Documenting Contact and Assistance: Written documentation in the ward's IM file of the child is necessary to show -

1. That the child and foster parent or facility administration have been informed. Check the agency record at the time of the initial or subsequent contact that the child and family or facility have been informed of the EPSDT program in writing and by verbal explanation. This is accomplished by the completion of Form CWI-10 and by entry on Form PDS-110 (see 474 NAC 4-009.32A1). The informing date is the initial custody date;

2. That the supportive services of appointment scheduling and transportation assistance have been offered to the child and foster parent and are provided if requested. This is accomplished by completing Form CWI-10 and by an entry on Form PDS-110 (see 474 NAC 4-009.32A1).
3. The State Ward Medical Unit will send Form MC-5 for Department wards to the screening physician. Upon receipt of Form MC-5 from the screening physician, the State Ward Medical Unit sends a copy to the IM foster care worker to record and forward to the worker.

After the Department ward has received a screening, the provider shall send Form MC-5 directly to the State Ward Medical Unit, for claims processing and payment. The State Ward Medical Unit shall send a copy to the appropriate IM foster care worker in the local or district office. The IM foster care worker enters data directly to show that the EPSDT service has been completed. The IM foster care worker shall copy Form MC-5 and send the copy to the appropriate placement worker to file in the service file.
For children who are not wards of the Department, see 471 NAC 18-005 ff.

The State Ward Medical Unit copy of Form MC-5 is the record of the completed medical screening, and the State Ward Medical Unit copy of Form MC-13 is the record of completed dental screening for children age three and older. The case manager shall document the need for the initiation of treatment in the child's health record and send a reminder of the need for treatment, if indicated, by using a reminder letter, EPSDT-4FC, or similar contact.

41-004.04 Coordination With Other Requirements for Physical Examinations: The worker and the State Ward Medical Unit shall make efforts to coordinate screening with programs such as required physicals in the public schools, Head Start, placement in a group home, and other programs which require examinations. Physicians shall use Form MC-5 for screening to avoid duplication of claims.

Under state law, a child must receive a medical examination within two weeks of removal from his/her home. Form MC-5 is used by physicians to avoid duplication of claims for this examination.

The EPSDT exam may be used to meet the required examination after a child's removal from his/her home.

41-004.05 Referral for Services Not Covered by Medical Assistance: The worker shall provide referral assistance for treatment not covered by NMAP but found to be needed as a result of conditions disclosed during the screening exam. This may include referral to the Title V Medically Handicapped Children's Program or services provided for a sliding fee or at no cost. This referral assistance must include giving the child and/or family the names, addresses, and the telephone numbers of providers who have expressed a willingness to provide services not covered by NMAP at little or no expense to the client. Workers may contact the EPSDT coordinator in the Medical Services Division for referral resources.

41-004.06 Payment Procedure: For payment procedure, see 471 NAC 18-005.06.

41-005 Dental Treatment: All dental procedures paid for with child welfare funds are governed by the guidelines of NMAP, 471 NAC 6-000 ff. Child welfare funding may be used only if the claim is denied by NMAP or the services are not covered by NMAP. NMAP requires authorization of all dental treatment that exceeds a total cost of $145 prior to the provision of the treatment. The $145 prior authorization amount does not include fees for exams, radiograms, prophylaxis, and topical application of fluoride (see 471 NAC 6-005 and 6-006).

To request approval for a proposed dental program, the dentist shall submit the completed Form MC-13 with all necessary mounted radiograms to the Medical Services Division for the dental consultant's review and approval as required in 471 NAC 6-005.01.

If need for emergency treatment arises and the child or youth must be seen before authorization can be obtained from the dental program specialist, the caseworker is authorized to secure emergency treatment. The worker shall inform the dentist that only the emergency is to be treated. The caseworker shall contact the Medical Services Division dental program specialist immediately for authorization for payment of the emergency.

If NMAP does not cover or denies a treatment plan (e.g., orthodontic treatment, cosmetic procedures) and the worker's assessment of the youth's needs reflects a need for a particular treatment, the worker or the dentist shall send a request to the Central Office Medical Services Division to the attention of the state ward medical program specialist. The request must contain -

1. A complete explanation of what needs to be done (treatment plan, length and cost of treatment);
2. Reasons for the procedure - cosmetic, psychological, physical, etc.;
3. Supporting information from an orthodontist, dentist, psychiatrist, or M.D.; and
4. Follow-up treatment plan, cost and length of treatment, and the estimated date of completion.

A decision to approve or disapprove this care is made by the Medical Director in consultation with Human Services staff. A decision will be made within 30 days of the receipt of complete information. A copy of the decision is sent to the child's worker and to the State Ward Medical Unit.

If the initial request is denied, the worker may send additional information to the Human Services and Medical Services Divisions for review and reconsideration.

41-006 Visual Care Services: All visual care services paid for with child welfare funds are governed by the guidelines of NMAP, 471 NAC 24-000 ff. Child welfare funds may be used to pay for visual care services only if the claim is denied by NMAP because of lack of medical necessity, the service is not covered by NMAP, or the provider is a non-Medicaid provider. To request approval to use child welfare funds to purchase other special provisions that are medically necessary when NMAP has denied the special provisions, the worker or the physician shall send a request to the Central Office Medical Services Division to the attention of the state ward medical program specialist. The request must include a physician's statement that contains the following:

1. History of the condition/illness;
2. Physical findings and other signs and symptoms, including pertinent laboratory data;
3. Recommend service/procedure; and
4. Expected outcome.

A decision to approve or disapprove the request is made by the Medical Director in consultation with Human Services staff. A decision will be made within 30 days of the receipt of complete information. A copy of the decision is sent to the child's worker and to the State Ward Medical Unit.

If the initial request is denied, the worker may send additional information to the Human Services and Medical Services Divisions for review and reconsideration.

There is no provision available for a child to supplement or pay a portion of a Medicaid-covered visual care service. If a youth desires contact lenses, more expensive frames than Medicaid will allow, tinted lenses, prescription sunglasses, or any other special provisions not covered by Medicaid, these may be paid out of the child's own funds or by the child's parents if they are willing to do so.

41-007 Durable Medical Equipment and Medical Supplies: All child welfare fund purchases or rental of any durable medical equipment and medical supplies must be in accordance with regulations of NMAP, 471 NAC 7-000 ff. Child welfare funds may be used for the purchase or rental of durable medical equipment and/or medical supplies if the service is denied because of lack of medical necessity or not covered by NMAP. To request approval to use child welfare funds for the purchase or rental of durable medical equipment and/or medical supplies, the worker shall send a request to the Central Office Medical Services Division state ward program specialist. The request must include a physician's statement that contains the following:

1. History of the condition/illness;
2. Physical findings and other signs and symptoms, including pertinent laboratory data;
3. Recommend service/procedure; and
4. Expected outcome.

A decision to approve or disapprove the request is made by the Medical Director in consultation with Human Services staff. A decision will be made within 30 days of the receipt of complete information. A copy of the decision is sent to the child's worker and to the State Ward Medical Unit.

If the initial request is denied, the worker may send additional information to the Human Services and Medical Services Divisions for review and reconsideration.

The approval must contain -

1. A prescription from a licensed practitioner which describes the condition necessitating the medical need for the equipment and/or services;
2. The rental and purchase price of the item;
3. Name and address of the provider; and
4. Length of time the item is needed.