



# DEPARTMENT OF ECONOMIC SECURITY

Your Partner For A Stronger Arizona

## Division of Developmental Disabilities

December 2009

# e – Therapist Bulletin

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### Quarterly Report

The Quarterly Report has been updated and the report now has spell check capability. The revised form will always have the date that it has been revised. Under the Home Program Progress/Oversight section, therapists must write out the specific activities they are recommending for the individual/family/caregiver to do each day so individuals with developmental disabilities can meet their outcomes. It is important that those activities are written so that the family/caregiver can follow through and the therapist can document how the family /caregiver is implementing the home program.. As always, if you have questions or concerns with the reports, please email or call Miriam Podrazik. Her email address is [MPodrazik@azdes.gov](mailto:MPodrazik@azdes.gov) and her telephone number is 602-542-6962.

### Equal Opportunity Employer/Program

Under Titles VI and VII of the Civil Rights Act of 1964 and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975, the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, and disability. The Department must make a reasonable accommodation to allow a person with a disability to take part in a program service or activity. For example, this means if necessary, the Department must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that the Department will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program of activity because of your disability, please let us know of your disability needs in advance if at all possible.

To request this document in alternative format or for further information about this policy, contact the Division of Developmental Disabilities ADA Coordinator at (602) 542-6825; TTY/TTD Services: 7-1-1.

### EPSDT (Early and Periodic Screening, Diagnosis and Treatment)

If a provider claims they are not paid timely, they have the ability to file a claim dispute with the Health Plan. The Health Plans must follow federal guidelines. They must pay or deny a claim within 30 days. If they deny in within 30 days, the provider files a claim dispute which is then reviewed by the Health Plan. If the provider still disagrees with the decision they can request a hearing with an Administrative Law Judge who makes a recommendation to AHCCCS and AHCCCS makes the final determination.

Please see page 2 for a breakdown of EPSDT and how it fits in with the Division of Developmental Disabilities.



# Therapy Payor source

The chart below is a means to help understand the many different ways that individuals with developmental disabilities receive therapy services. These guidelines have been written to better explain procedures for the Coordination of Therapy Services under the Early Periodic Screening Diagnostic and Treatment (EPSDT) Program.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a comprehensive child health program of prevention, treatment, correction, and amelioration of health problems for Medicaid members under the age of 21. A DD individual falls under the targeted category when he/she qualifies for AHCCCS financially but not medically.

## Payor Referral Source for Therapy

Age Range	Final Payor
<b>0-3 (AzEIP) DDD only (non-AHCCCS)</b> - If family has TPL and agrees to usage, provider bills TPL first. If there is no TPL, the Division is the primary payor.	DDD, if TPL denies
<b>0-3 AHCCCS eligible (targeted)**</b> - If family has TPL, provider obtains a prior authorization from the health plan before billing the TPL.	AHCCCS Health Plan*
<b>0-3 ALTCS</b> - If family has TPL, provider bills TPL first.	DDD, if TPL denies
<b>3 and above-DD only (non-AHCCCS)</b> with no TPL	DDD-only when funding is available
<b>3 and above-DD only (non-AHCCCS)</b> TPL	TPL only
<b>3-21 AHCCCS eligible (targeted)</b>	AHCCCS Health Plan*
<b>21 and above AHCCCS eligible (rehabilitative therapies only)</b>	AHCCCS Health Plan*
<b>3 and above-ALTCS</b> - If family has TPL, provider bills TPL first. If there is no TPL, the Division is the primary payor.	DDD, if TPL denies

\* **Health Plans:** APIPA (Arizona Physicians Independent Physician Association), CMDP (Comprehensive Medical & Dental Program), Health Choice AZ, Mercy Care Plan, Phoenix Health Plan, Pima Health Plan, UPH/UFC (University Physicians/ University Family Care), AIHP (American Indian Health Program)

\*\*For 0-3 population

The team completes the IFSP and the Service Coordinator (SC) sends the IFSP and other documentation (e.g., an evaluation report) to the Maternal Child Health Coordinator (MCH) at the specific health plan. The MCH Coordinator works with the PCP to have the PCP determine whether the therapy services identified on the IFSP are medically necessary. If yes, the therapy authorization request is then sent to the health plan. If approved, the family is referred to the provider in the health plan for the authorized therapy sessions. The MCH Coordinator and SC work together throughout this process.

If denied the SC fills out information on the denial and sends up to the Central Office Policy and Program Development Director or the ALTCS Program Administrator. The family should be asked to appeal the denial however the Division can authorize and provide the denied IFSP service in the interim.

Acute Care Plans (APIPA, MCP, Care 1<sup>st</sup>, Capstone) pay for rehabilitative therapy (therapy after surgery, etc.) for individuals who are ALTCS eligible. DDD is responsible for habilitative service payments.

**Regardless of which payor source the individual falls under, if the family has a Third Party Liability (TPL), it must be billed first. Before billing the TPL, therapy providers must first obtain a prior authorization from the consumer's health plan.**

**More about this subject and prior authorizations with the health plans will be discussed in the January 2010 issue of the e-Therapist Bulletin.**

## From Business Ops:



The MCID listing is no longer on the DD website. There was confusion with it and the file isn't necessary. To look up a consumer's MCID, please go to the final authorization screen.

As a reminder, at the beginning of each calendar year, therapy providers are required to obtain and verify current insurance information for the individuals they serve. As in past years, effective January 1, 2010, therapy providers are required to bill private medical insurance for all therapy services provided to Division of Developmental Disabilities individuals, since 2009 waivers expire on December 31, 2009.

As a requirement in your contract's Special Terms and Conditions:

### 1. Definitions of Terms

Third Party Liability means the resources available from a person or entity that is or may be, by agreement, circumstances, or otherwise, liable to pay all or part of the medical expenses incurred by a Division consumer (A.A.C. R6-6-101; A.A.C. Title 9, Chapter 22, Article 10).

Third Party Payor means any individual, entity or program that is or may be liable to pay all or part of the medical cost of injury, disease or disability of a Division consumer (A.A.C. R6-101).

Once the insurance company is billed and an Explanation of Benefits (EOB) is received from the insurance company, a waiver may be requested. Listed below are items to be considered when requesting a waiver:

- If the consumer has private insurance, the Division cannot be billed until the private insurance company has been billed and an Explanation of Benefits has been sent to you.
- Please use the appropriate Waiver Request Form when requesting your waiver – the waiver form is on the DDD website. If you have modified the form, ***please keep it within the format it was originated in.***
- Waiver requests should be faxed to 602-542-8193. The waiver request must include the consumer name, ASSISTS number, Service Code and insurance company name. Any and all supporting documentation, to include the Explanation of Benefits must be included with the request.
- Waivers will be granted for each specific service (OCE-Occupational Therapy Evaluation, OCT-Occupational Therapy; PHE-Physical Therapy Evaluation, PHT-Physical Therapy; SPE-Speech Therapy Evaluation, SPT-Speech Therapy).
- EOBs should state the provider name, the type of service, and the first date for which the waiver is requested.
- Providers may not share or use another provider's Explanation of Benefits.
- If the EOB states "prior to the coverage effective date" or "termination of coverage", please verify the insurance information with the insurance company, family or support coordinator.
- When an individual has two insurance plans (mother and father both have a policy the consumer is listed on) you must bill the primary first, then the secondary insurance. To determine whose policy is primary, whichever parents' birthday falls first in the calendar year, their policy is the primary. Once you have both EOB's, send them both with your Waiver Request Form.
- If the EOB is faxed, please make sure the whole document is readable. Some documents read edge to edge so you may want to reduce the document before faxing.
- Please do not duplicate your waiver request. If you have not received your completed waiver request within a few days, there could be a problem that may take some time to resolve. Please give us a week to try to resolve any issues before checking on the status of the waiver.

If you have questions about waivers, please feel free to contact Carol Garcia at 602-364-1640, Peggy Lopez at 602-542-6095 or Kim Maldonado at 520-742-7679 x 130. For Division billing questions, please call your Central Office bill payer or Judy Niebuhr at 602-542-6798.



## Monthly reminder about evaluation reports...

Quarterly progress reports are due to Support Coordinators no later than fifteen (15) days after the end of each quarter that the service is provided. There are no exceptions to this contractual rule.

On the first Friday of the month you will receive a Statewide list of ALTCS-eligible individuals who are in need of therapy services. Individuals will be identified by age, district, and zip code. The intent of sharing this information is to help both you and the Division coordinate the provision of therapy services. Therapists should contact the appropriate District Therapy Coordinator in initiate the therapy service referral process.

Your contact person for each district is listed below.

District I: Kathy Hornburg  
Phone: **602-246-0546**  
Fax: 602-246-0880  
[KHornburg@azdes.gov](mailto:KHornburg@azdes.gov)

District II: Altagracia Gasque  
Phone: **520-519-1711 x 1133**  
Fax: 520-748-8765  
[AGasque@azdes.gov](mailto:AGasque@azdes.gov)

District III: Tobie Trejo  
Phone: **928-526-0334**  
Fax: 928-773-8496  
[TTrejo@azdes.gov](mailto:TTrejo@azdes.gov)

District IV: Esther Panuco  
Phone: **928-669-9293 x 231**  
Fax: 928-669-5539  
[EPanuco@azdes.gov](mailto:EPanuco@azdes.gov)

District V: Peggy K. Lopez  
Phone: **520-723-5351 x 1024**  
Fax: 520-723-7618  
[PeggyLopez@azdes.gov](mailto:PeggyLopez@azdes.gov)

District VI: Linda Southwell  
Phone: **928-428-0474 x 1140**  
**520-860-0044 (cell)**  
Fax 928-348-7725  
[LSouthwell@azdes.gov](mailto:LSouthwell@azdes.gov)

