AX CA ESSENTIAL RECORDS

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CHAPTER 78 - MEDICAL SERVICES

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78.04 GENERAL INFORMATION

The information in this section should be familiar to all service workers, regardless of function. The service worker is not expected to know specifics of all Medical Care services, or the exact procedures for obtaining them; however, the worker should have a broad general knowledge of the medical program in order to be able to inform clients of services which are or are not available. Staff should also know how to supplement knowledge, or where to go for help when the need arises. For more detailed information regarding the medical program, refer to WAC 388 Chapters 81 through 92.

1. Program eligibility

   a. Medical Assistance (MA) is a Federally matched program which provides full scope medical care within limitation of available funds to:

      (1) Recipients of AFDC or beneficiaries of SSI.

      (2) Essential persons of converted SSI beneficiaries.

      (3) Children receiving foster care.

      (4) Individuals under age 21 who qualify for the H-program. (See WAC 388-82-005(2))

      (5) Recipients of General Assistance who can be categorically related.

      (6) Individuals who meet eligibility standards for AFDC or SSI except that their income and/or resources exceed budgetary standards for a federal aid grant. This would be the FAMCO recipient.

      (7) Persons in the Adult categories who were open for FAMCO on December 31, 1973 and who have had a continuous medical need since that time.

      (8) Pay retroactively for unpaid medical bills three months prior to date of application for all categories except GAU and M.O.

   b. Medical care services (MS) are fully stated funded and provide services to persons who do not meet eligibility requirements for MA but who are:

      (1) Eligible to receive continuing GAU grant, or dependents, other than spouses included in federal aid grants.

      (2) Recipient of non-continuing general assistance who cannot be related to Title XVI, or in need of medical care only <u>and</u>

(3) Medically eligible because of an acute and emergent condition.

2. Scope of care (See WAC 388-86)

a. Medical Assistance:

(1) Services provided;

(a) Ambulance service and other means of transportation for medical reasons.

(b) Early and periodic screening services to eligible individuals under age 21. See also G. 82.46, 62.140.

(c) Family planning services. See also G 58.

(d) Home health agency services.

(e) Inpatient and outpatient hospital care.

(f) Other laboratory and X-ray services.

(g) Skilled Nursing Facility and Intermediate Care.

(h) Physicians services in the office or away from the office as needed for necessary and essential medical care.

(2) Services provided within limitations of available funds;

(a) Anesthetization services

(b) Blood when not available from other sources.

(c) Chiropractic services

(d) Dental services

(e) Drugs and pharmaceutical supplies

(f) Eyeglasses and examinations

(g) Hearing aids and examinations

(h) Medical social services

(i) Oxygen

(j) Physicial therapy services

(k) Physical medicine and rehabilitation (details on this service are in WAC 388-86-112)

(l) Special duty nursing services

(m) Speech services

(n) Surgical appliances, prosthetic devices and certain other aids to mobility

(o) Treatment, transplants, dialysis, equipment and supplies for acute and chronic non-functionary kidneys

(p) Treatment for detoxification of alcoholics in certified hospital facilities and detoxication centers, limited to 3 days.

(3) Medical care out of state;

(a) Recipients eligible for federal categories who are temporarily out of the state are provided comparable services to that available for recipients in the state.

(b) In border situations when necessary medical care is unavailable locally, but is available in a bordering state or Canada, such care may be provided outside the state, provided that comparable care is not available in a less distant area within the state.

(c) A recipient who moves to another state with the intent to establish residence is not eligible for medical care after eligibility has been terminated in this state.

(d). Dental care out of state is limited to acute and emergent conditions.

b. State financed medical care services provided

(1) GAU not related to Federal aid category;

(a) Full scope medical care

(b) Exceptions

i. care not provided out of state other than in border situations.

ii. not eligible for retroactivity

(2) GAN and MO not related to Title XVI;

(a) $100 deductible per family over a 12 month period from date of denied application for medical care, within seven days prior to initial application.

(b) Condition must be acute and emergent

i. acute having a short and relatively severe course, not chronic.

ii. Emergent occurring unexpectedly and demanding immediate action.

iii. Exceptions

1) condition of less urgency where medical experience indicates a failure to treat will usually result in the rapid development of an emergent situation.

2) family planning and obstetrical care

3) other care requested by the attending physician and approved by the local medical consultant as medically necessary

iv. Once care is initiated, it is continued to a logical completion.

v. In addition, an acute and emergent condition will be assumed to exist when an applicant for medical care indicates he has an undefined medical condition. Provided financial eligibility has been established, at least one office call will be allowed for diagnosis. Treatment will be contingent upon the criteria for acute and emergent being met.

vi. Acute inpatient psychiatric care is included.

(c) Services not provided by the Medical Care Program.

i. Organ transplants, other than kidney.

ii. Narcotic addiction detoxication.

iii. Care in private psychiatric hospitals that are not certified under Title XVIII (Medicare).

iv. Care in state mental institutions for recipients under age 65.

v. Treatment of tuberculosis after a diagnosis has been established.

vi. Well baby care, except as provided under EPSDT program. See G 82.46.

vii. Cosmetic or experimental procedures.

viii. Orthodontia

(d) Exclusions and limitations

i. No payment is made to the physician for mileage.

ii. No payment is made to the physician for prescription refills.

iii. No payment will be made for podiatric items or services:

a) Which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

b) Which constitute personal confort items.

c) Where such expenses are for cosmetic surgery.

d) Where such expenses are for:

1) The treatment of flat foot conditions and the prescription of supportive devices therefor,

2) The treatment of sublixations (incomplete or partial dislocations) of the foot, or

3) Routine foot care including the cutting or removal of corns, calluses, the trimming of nails, and other routine hygienic care.

e) These limitations apply to services provided by a podiatrist in his office, in a patient's home, in a hospital or nursing home.

iv. No payment is generally made for medical supplies used in conjunction with an office visit; however, payment may be used for items such as slings and swaths, clavicle and shoulder splints, cervical collars and ace bandages, subject to the limitations of the physician's acquisition cost.

(e) How clients obtain Medical care

In order to obtain medical care each eligible recipient will receive monthly a medical coupon booklet containing six coupons. These coupons are used for billing purposes by those providing medical services or supplies. Except where restrictions are listed on the coupons, the coupons do not by themselves limit the frequency or kinds of care clients may receive. These determinations are made by current regulations of which providers of medical services or supplies are aware.

i. There are two kinds of medical coupon booklets issued. The DSHS 6-28 (white) is sent to clients by the state office on a monthly basis following original certification for care. The DSHS 13-30 (yellow) is issued by the ESSO when the certification for medical care is submitted to the state office after the deadline for the regular warrent roll or when a client has lost his booklet or has exhausted his medical coupon supply. For additional information, please refer to the Forms Section DSHS 6-28 and DSHS 16-33, Instructions to Holders of Medical Coupon Booklets.

ii. A client contacting the ESSO requesting medical care should be referred to his attending physician and advised to take his medical ID booklet with him. The service worker will inform him that:

a) It is his responsibility to inform each provider of medical care of his eligibility for public assistance medical care so that the vendor may bill this division.

b) Failure to provide a vendor with this information within a timely period may make the client responsibile for payment for this medical care.

iii. The client should be advised of services that the medical program does not cover. Physicians who believe that their clients require an excluded service should submit the request in writing on the state's billing form (SF 9903) for the Medical Consultant to review.

iv. See 78.12 1. for the effect of additional payments or contributions by the A/R on the cost of care.

(f) General Condition of Payment

i. The Department is responsible for payment of service rendered to a recipient only when the services have been properly authorized and the recipient certified as eligi -

ii. The fees and rates established by agreement between the Department and providers of service constitute the full charge for approved medical care and services provided to recipients by the providers.

iii. When a provider of services furnishes service to a known eligible recipient and does not bill the Department for services for which the Department is responsible for payment, the recipient is under no obligation to pay the provider.

iv. A provider of services to a person determined eligible subsequent to the time service was rendered may be paid under the following conditions only:

a) The person must have been certified as both financially and medically eligible at the time the service was rendered,

b) Payment has not been made,

c) The request for payment is approved as a case exception (See WAC 388-81-030).

3. Prepaid Group Practice Plans Available

a. Group Health Cooperative of Puget Sound - The Department has an agreement with the Group Health Cooperative of Puget Sound to provide comprehensive medical, surgical and hospital coverage on a prepaid basis to a limited group of recipients of AFDC grants and SSI beneficiaries in the Rainier, Capitol Hill, Kent, Federal Way, Burien and Olympia areas. Each of these offices has an established quota. Current members of GHCPS in each of the above listed offices and in the King North, Bellevue and Snohomish areas becoming eligible for an AFDC grant may elect to continue their coverage with GHCPS. Only in the Kent area is prepaid coverage available to recipients of continuing assistance in the OEO program.

(1) Each family selecting GHCPS service is furnished with a GHCPC plastic identification card. Except in emergency, a family selecting the GHCPS must secure service from a GHCPS facility. If emergent hospitalization is necessary in another facility, responsibility for notification of GHCPS rests with the enrolled family if payment is to be considered by the GHCPS.

(2) Cost of emergent care for enrolled members not approved by GHCPS and nonemergent care secured from GHCPS facility is the responsibility of the family. Services not available

at GHCPS and not covered by the contract such as dental care, nursing home care, etc., will be available to the recipient and paid by the department if approved.

(3) The family also received the department's medical ID booklet bearing the notation "NO HOSP, MD OR RX CARE EXCEPT AT GRP HEALTH."

b. Community Health Board of Seattle - This is an entity established by the Seattle Model City Program to administer a program to provide medical care to needy families in the Seattle area not on assistance. Some of the enrolled families later become continuing money grant recipients.

The department has a contract with the CHB which provides for their medical care. Those families so enrolled are restricted to receiving their care through the CHB and their medical ID booklet will carry a restrictive overprint similar to the Group Health enrollees except it will say "NO HOSP, MD OR RX CARE EXCEPT THRU COMM HLTH BD."

c. The Inland Health Association (IHA) is a nonprofit corporation providing health care in Deer Park and surrounding area within a radius of approximately fifty miles. The department has a contract with this corporation to provide medical care to a limited number of recipients through the facilities of the Tri-County Hospital Association (TCHA). Those enrolled are restriced to receiving their care in the TCHA facilities except, in case of emergency, out-of-area care requires notification of IHA within 24 hours. The medical coupons of all enrollees will carry a restrictive overprint "NO HOSP, MD OR RX CARE EXCEPT THRU INLAND HLTH."

d. Kaiser Foundation Plan is available to Clark County recipients receiving AFDC who have chosen to receive care through Kaiser Plan facilities and who have ben certified eligible by the DSHS ESSO.

GHCPS, IHA and Kaiser Foundation is also available to foster children who are in homes of foster parents who are members of GHCPS or IHA. These children would continue to be medically eligible for GHCPS or IHA as long as they are financially eligible and remain in the same foster home.

Enrollees in the Kaiser Plan can be identified by the following overprint in the lower section of the Medical Care Identification Booklet (Medical Coupon); "NO HOSP, MD OR RX CARE EXCEPT THRU KAISER PLAN". Any recipient with this overprint on the medical coupon is enrolled with the Kaiser Plan and will be ineligible for hospital care, physician's services or drugs through any other facility unless referred and approved by the Kaiser Plan. Payment to any providers of such referred or emergency care is the contract responsibility of the Kaiser Foundation.

Some services provided under Medicaid are not included in the Kaiser Plan coverage and the overprinted Medical Coupon is valid for such services elsewhere in accordance with the rules, procedures and restrictions currently in effect. These services include: Dental, chiropractic, psychiatric, podiatric, rental or purchase of durable medical equipment, alcoholic detoxification, corrective appliances and artificial aides, except glasses (which are supplied by Kaiser).

78.06 SERVICES REQUIRING SPECIAL APPROVAL

1. Nursing care consultant.

   a. Patient care supplies for use at home or in a skilled nursing facility. Examples include catheters and related disposable equipment, disposable colostomy bags and other materials used in care of colostomes and ileostomecs, surgical dressings.

   b. Home health services for recipients who are restricted to acute and emergent care, and any extending beyond the first calendar month.

   c. Applicant or recipient need for medical care in skilled nursing or intermediate care facility or other setting, except hospital.

2. Medical Consultant

   a. Approval required but may be obtained after the fact:

      (1) All services provided to recipients of GAU or MO who cannot be related to a federal aid program.

      (2) All hospital admissions.

      (3) Medical care obtained out of state and in certain border situations.

      (4) Consultant or specialist referrals when they exceed two consultants or specialists.

      (5) Drugs not listed in the Department formulary or any single prescription exceeding $15 in cost.

   b. Prior approval is required for:

      (1) All surgical procedures that are not acute and emrgent.

      (2) X-Ray therapy.

      (3) Prosthetic devices and appliances except braces; and surgical prostheses costing less than $150 if provision will expedite recipient release from hospital.

      (4) Allergy testing.

(5) Special duty nursing services

(6) Initial provision of oxygen and respiratory therapy service for recipients in skilled nursing facilities and those under 65 in their own homes.

If any of the above medical services are denied by the Medical Consultant, payment for the services is the responsibility of the client.

3. Office of Personal Health Services

a. Certain services which require prior approval by the local medical consultant also require prior approval by the Chief, Office of Personal Health Services.

b. The following services require such approval except where full time medical consultants are employed.

(1) Surgical procedures that are not acute and emergent.

(2) The following requests for prosthetic devices and major appliances.

(a) Requests for purchase of all items exceeding $50 in value, except for external braces for head, trunk and extremeities, nonreusable appliances costing less than $150 if provision of the appliance will expedite the recipient's discharge from the hospital.

(b) All rental (including deductibles and coinsurance under Medicare Part (B), regardless of cost.)

(c) All repairs for appliances.

c. Special duty nursing services.

4. Approval for inpatient Physical Medicine and Rehabilitation for the severly disabled is obtained through the Office of Medical Assistance. See WAC 388-86-112 and 78.04 2 a (2) (k).

a. A coordinating committee consisting of representatives from the Vocational Rehabilitation, Community Services,and Health Services Divisions, review all referrals with supporting clinical information, and assigns priorities for approval, and monitors follow up as necessary.

b. Hospitals and referring physicians should be advised to contact the Committee through: The Office of Medical Assistance (MS 10-1), Special Programs, Olympia, Washington 98504 (Attention: Mary A. Rice, R.N., Supervisor), telephone 753-0888.

State form 13-207 (9-74), Identification of Severely Disbled Persons, may be used for initial identification purposes.

c. ESSO personnel, when involved in a referral, are encouraged to send all available medical and social information to the Committee, but need not engage in case development activity, as the Committee can assume this responsibility.

d. The Committee also will explore, in behalf of the patient, eligibility for various programs, including Medical Assistance, Vocational Rehabilitation, Crippled Childrens Services, Medicare, private and group insurance programs, so that optimum utilization of appropriate services will occur.

78.08 PROCEDURES FOR FURNISHING SPECIFIC MEDICAL CARE

Requests for specific medical care services outlined in this section should be referred to Support Services (i.e., Medical Clerk, Medical Unit) to initiate the approriate forms required to complete the service.

1. Appliances, Prosthetic Devices and Aids to Mobility

a. Aids to mobility, major prosthetic appliances such as braces, corsets, artificial limbs, and similar items of medical equipment are provided to eligible recipients within the limitations of available funds when one or more of the following is met:

(1) A period of hospitalization may be reduced.

(2) It is part of a plan to rehabilitate a potentially employable person.

(3) It will enable the person to return to, or to continue to live in his own home.

(4) A nursing home patient requires full time use of an appliance and will benefit materially from its use.

(5) The furnishing of the appliance will result in financial savings to the division.

b. When a recipient expresses a need for any of the above items, he should be referred to his attending physician. If the physician considers the item a necessity for his patient, he submits his request in writing to the ESSO.

(1) No approval is required for the purchase of external braces involving the neck, trunk and extremities.

(2) Other non-reuseable items costing less than $150 do not require approval if provision of the appliance will expedite a recipient's release from a hospital.

(3) Prior approval by the Office of Personal Health Services is required for:

(a) Purchase of reuseable medical appliances and aids to mobility costing more than $50.

(b) Purchase of non-reuseable surgical appliances or prosthetic devices costing more than $100, except as described in subsection (2),

(c) Rental of durable medical equipment regardless of cost,

(d) All repairs to state or privately owned equipment.

c. Crutches (including children's sizes), canes, and oxygen regulators should be available in the ESSO. Other reuseable medical equipment may be available within the ESSO. The medical clerk will have a listing of this equipment.

d. A recipient age 65 or over who has Medicare--Part B benefits, must utilize this resource for the purchase or rental of any items approved by Medicare. Payment of Medicare coinsurance and deductibles by the Department for purchase of all items costing more than $50 (except as described in Subsection (b)) and for all rentals must have prior approval of the Office of Personal Health Services.

e. It the item costs more than $50.00 and cannot be provided from ESSO inventory, the service worker must write a brief social background (on routing slip Memo form) for a patient living in his own home or congregate care facility showing recipient's living arrangement, why the item is required, what it will do for the client, and what the alternatives would be if it were not provided. If the recipient is in a nursing facility, the nursing care consultant provides information regarding the length of time the patient will need the appliance, his ability to utilize it, and the benefit he may be expected to receive from it. This is referred to the medical support service worker.

f. If an appliance is needed immediately on an emergency basis, or provision of the appliance will enable the recipient to leave a hospital or nursing home, the situation should be discussed with the support services worker handling the program.

g. Necessary repairs to privately owned or state owned appliances may be provided.

h. Reusable durable medical equipment purchased by the department is loaned to eligible recipients and must be returned if the recipient is no longer eligible for assistance or no longer needs the appliance. Appliance loan agreement form DSHS 13-14F must be signed by the recipient for such equipment.

The service worker will explain these limitations to the client and may obtain his signature on this form, DSHS 13-14F. He should determine that the client is able to use the medical appliance and help the client to utilize it to the best advantage.

i. The medical clerk can provide information to the worker regarding medical resources (such as therapist's services or home health agencies-including visiting nurses) and procedures for obtaining these services. Additional sources of services available within the community should be kept on record in the ESSO.

2. BLOOD

The department provides for the purchase of needed whole blood or plasma only when it is not available to the patient from other sources. ESSO should make every effort to have blood donations replaced rather than paid for. Families or friends of recipients who have received blood should be encouraged to donate a unit of blood to replace each unit which was provided. Donors should tell the blood bank the name of the person who received blood. Donations may also be made in the name of the department.

ESSO should also explore the possibility that the recipient may be a member of an organization such as a lodge, union, church, etc., which maintians a blood bank account or whose members are prepared to replace blood or plasma used by members.

For persons eligible for Medicare benefits, payment will be made only for the first three units of blood or plasma in any spell of illness since Medicare pays for blood, after the first 3 pints, during any spell of illness. The Department will pay the deductible and coinsurance in such cases.

The department will not pay for blood or plasma when its source is by donation, but it will pay necessary handling and processing charges.

For hospitalized patients, this service is billed and paid as a part of the hospital billing. When provided by a hospital as an out-patient service, it may be added to the total billing for the out-patient service.

Blood bank service charges will be paid when applicable.

3. DENTAL SERVICES

a. Persons eligible for full scope medical care are also eligible for basic dental services subject to the conditions and limitations set forth in the contract between the department and the Washington Dental Service. Questions relating to dental care and dentists are to be directed to WDS.

b. Prior authorization is required for basic dental services and dental surgery for recipients of medical assistance and GAU, and requests should be submitted directly by the dentist to the Washington Dental Service.

c. Prior authorization is not required for emergency dental care if all needed services are completed in one office call.

d. Dentures and other services not considered basic may be provided only with prior approval of the dental consultant. Dentures purchased by the department and subsequently lost will only be replaced in extenuating circumstances and with prior approval by the Chief of the Office of Personal Health Services.

e. Dental service for recipients of non-continuing general assistance not related to a federal aid program, or MO, is limited to relief of pain and surgical repair of the maxilla and/or mandible. No out-of-state care is provided except in border situations.

4. E.P.S.D.T.

See procedures in G 82.46.

5. EYEGLASSES AND EXAMINATIONS

a. Prior approval of the local medical consultant or ESSO designee is required for refractions and glasses.

b. The following guidelines are used in considering authorization for refractions and glasses: Refractions are authorized to substantiate the degree of refractive error as a prerequisite to approving glasses. Refraction and glasses may or may not be made if it is evidenced there is no refractive error (20/20 vision) or if the refractive error is so minimal as to not warrant the use of glasses.

c. In general, only complete pairs of glasses are approved. Lenses only will be authorized to replace broken lenses or when the patient has reusable frames. This justification should appear on the DSHS 6-29. Authorization for lenses only should be denied if there is not reasonable justification or if there is indication the vendor may be intending to bill the patient privately for the frames.

d. Trifocals will be authorized only when adequate justification is presented. They are generally supplied to persons involved in close reading related to work activity.

Tinted glasses are not provided, nor are wire frames.

Any deviation must be requested as an exception to policy.

6. HEARING AIDS

a. Who is eligible for a Hearing Aid

The department shall provide within available funds a hearing aid or a one-time repair of a privately owned aid to a person who has evidence of a minimum 50 dB (decibel) hearing loss in the better ear and is:

(1) A recipient of a continuing grant; SSI beneficiary

(2) A recipient of FAMCO, except for individuals under 21 years of age.

(3) All individuals under 21 years of age will be referred to the Crippled Children's Services, Conservation of Hearing Program through a local health department. Under CCS the individual will receive:

(a) An otological evaluation to determine if surgical or medical treatment can correct or improve the hearing impairment or if there are contra-indications for hearing aid usage.

(b) A hearing aid consultation from an approved facility where this service is available. This may include an audiological facility in the public schools.

(c) Upon the recommendation of the audiologist in an approved facility who performs the hearing aid consultation, an aid may be placed with the individual at the time of the hearing aid consultation or the individual may be referred to an approved local hearing aid dealer for a specific aid or unusual fitting, regardless of the decibel loss specified in WAC 388-86-040.

(d) A limited amount of hearing therapy provided for the purpose of training the individual in the use of hearing aids is necessary for the first time users of aids. School age children will be referred when appropriate to the public schools for this training, but pre-school age children and those who are unable to receive this training through the schools may be authorized by CCS to receive this training through other appropriate facilities. (For speech therapy see Manual E, 68.60 and WAC 388-86-090)

(e) For procedures on the EPSDT program in this manual, refer to 82.46 and 62.70.

(4) A recipient must be physically and mentally competent to operate the equipment before a positive determination to purchase or repair a hearing aid is made.

b. <u>Initial Referral to ESSO Designee</u>

(1) When a hearing aid or repair of a privately owned hearing aid has been requested by an <u>applicant</u> for a continuing grant or for

FAMCO, financial eligibility shall be determined by the ESSO before determination of medical eligibility is established. If found financially eligible for a continuing grant or financially and medically eligible for FAMCO, medical eligibility for a hearing aid will be based on a referral by the ESSO for auditory screening by a participating provider to determine if the hearing loss meets the established decibel loss. MO recipients are not eligible; however, a case exception may be requested if the denial of an aid or repair of an aid would result in the applicant becoming eligible for a continuing grant or result in the loss of employment.

(2) Service workers will refer the name of each eligible recipient requesting a hearing aid or repair of a privately owned aid to the ESSO designee (support services worker) assigned to this program for the scheduling of an appointment with an approved provider selected by the recipient.

(3) Nursing home patient/recipients, who otherwise meet the eligibility requirements for a hearing aid, may be referred for hearing aid evaluation by the joint recommendation of the nursing care consultant and adult service worker. Similarly, a recipient, age 65 or over, in a state mental institution or tuberculosis sanitarium may be referred for hearing aid evaluation by the instituion through the Mental Health Service Representative and/or nursing care consultant, and adult service worker for joint consideration.

(4) A recipient who evidences medical problems and/or a degree of incompetency which would prevent reasonably successful hearing aid use should not be referred for a hearing aid. In addition, the report made by the provider of hearing aids may also result in a decision that the recipient is medically ineligible to receive a hearing aid because of physical and/or personality problems rather than the minimum decibel loss.

c. Responsibility of Recipient

Once the recipient has been provided with a one-time repair of a privately owned hearing aid or been provided with a hearing aid by the department, the repaired or new equipment becomes his personal property, and he will be responsible for:

(1) All repairs after the expiration of the one year warranty for new aids or 90 day warranty on repaired aids.

(2) The purchase of his own batteries and hearing aid attachments.

(3) Any hearing aid replacement.

The recipient should be informed of (1), (2) and (3) above and further notified that, during the warranty period, problems relating to the hearing aid are to be taken directly to the provider of service for adjustment.

7. PATIENT TRANSPORTATION

a. The department shall provide to eligible individuals transportation for necessary medical or remedial care purposes within the limitations specified in WAC 388-86-085.

b. Ambulance transportation shall be provided when the medical necessity is such that the use of any other method of transportation is inadvisable. No approval is required.

c. The transportation of an eligible individual by means other than ambulance requires approval by the ESSO medical consultant or the ESSO designee.

(1) The department will not generally pay for the use of a privately owned vehicle to transport a recipient needing nonemergent medical care to a doctor's office or other source of nonemergent medical or remedial care in his community. If, however, public or donated transportation is not available, or if the recipient is physically unable to use such transportation, the department may provide transportation.

(2) If family or donated transportation is not available to individuals in the EPSDT program, the department may provide transportation.

(3) When the department requires a recipient to undergo special physical examination or treatment, including consultant referral relative to examination or treatment, the department shall pay for his round trip transportation within or outside the local community when donated transportation is not available. Public transportation such as taxi or bus may be provided; transportation furnished by a friend, relative or by the individual is payable at seven cents a mile.

8. PHYSICAL THERAPY AND RELATED SERVICES

a. Physical therapy, other than that provided in a hospital as part of inpatient treatment, may be authorized within the availabiltiy of funds only when such therapy:

(1) Will avoid the need for hospitalization, or

(2) Will reduce the length of stay of a recipient in a nursing home, or

(3) Will assist the recipient in becoming employable, or

(4) Is medically indicated in unusual circumstances and is requested by the attending physician and concurred with by the medical consultant.

b. Physical therapy must be performed by a registered physical therapist and must have prior approval by the ESSO medical consultant.

c. Speech therapy, as an adjunct to necessary treatment of a medical or remedial condition for which the department has assumed initial responsibility, may be authorized subject to the availability of funds and:

(1) the treatment must have prior approval by the local medical consultant,

(2) the fee for service must be agreed to in advance of therapy,

(3) the therapy must be performed by a speech pathologist or audiologist who has been granted the certificate of clinical competence by the American Speech and Hearing Association, or who has completed the equivalent educational and work experience necessary for such certificate,

(4) The department reserves the right to limit the number of treatments based on professional judgment.

(5) Speech evaluation and services will be provided as outlined below. Unless otherwise staed in these procedures, all children with maxillofacial defects should be referred to the Crippled Children's Services for an evaluation and determination of service needs.

(6) Speech and language services available to children through the public schools under RCW 28A.13 will be considered as a resource before Title XIX funds are utilized. (Note: The services under this RCW are mandatory for children age 6 and older and optional for younger children.)

(7) Extent of Services

Speech and language services will be considered for recipients with problems of aphasia, hearing loss and post-laryngetomy surgery. Other problems not in these three categories will be considered individually.

d. Aphasic Patients

(1) Speech therapy will not be approved when:

(a) The handicapping condition occured more than one year prior to the request for therapy.

(b) The patient is not neurologically stable.

(c) The diagnosis is global aphasia.

(d) The patient is eligible for available public school speech therapy services.

(2) Speech therapy may be approved by the medical consultant when the speech pathologist has justified such therapy by evidencing that:

(a) The patient is neurologically stable; that is, the physician has given medical clearance indicating that patient is neurologically ready for speech assessment.

(b) A diagnostic evaluation has been administered which indicates a positive prognosis (must be a standardized test).

(c) A treatment plan has been outlined on DSHS 15-79(X) 7/73, Request for Speech Services.

(3) Initial treatment therapy will be limited to the following parameters until reports justify an extension of treatment.

(a) Once a week will be authorized by justification of circumstances - 26 sessions.

(b) Twice weekly for three months - 26 sessions

(c) Thrice weekly for two months - 26 sessions

(d) Four times weekly for 6 1/2 weeks - 26 sessions

(4) Extension of treatment for aphasic patients

(a) Must be justified by progress and prognosis on an objective basis.

(b) Pre- and post-therapy test scores.

(c) Any additional sessions will be approved only as specified in c. above.

(5) Therapy may be extended, when approved, up to a maximum of six months, including initial treatment.

(6) Request for extended therapy must be made on DSHS 15-79(X) and include:

(a) Treatment plan specifying areas to be remedied and therapy approach on the established form.

(b) A therapy schedule (meeting requirements of section (4) (a) above).

e. Speech therapy and auditory training related to hearing loss.

(1) Therapy may be approved for subjects who have a medical diagnosis of:

(a) Sudden, bilateral onset of hearing loss;

(b) Rapid, progressive bilateral loss.

(2) Therapy will not be approved for subjects who:

(a) Do not meet the criteria in (1) (a) and (b) above.

(b) Qualify for public school speech therapy services.

(3) Approved therapy will be 30 minutes per session up to a maximum of 16 sessions.

(4) Therapy will not be extended beyond the above limits.

f. Post-laryngetomy patients

Requests for speech services will be submitted for consideration on an individual basis.

g. All other requests for speech therapy services must meet the requirements that the therapy is an adjunct to necessary treatment of a medically remedial condition and will be accomplished by a signed recommendation of a physician. The requester will submit information as outlined on DSHS 15-79(X), Request for Speech Services.

78.10 MEDICAL ASSISTANCE RELATED TO DISABILITY

1. FAMCO related to Title XVI

a. Persons eligible

(1) Those determined to meet Title XVI disability criteria,

(2) who have a medical need, and

(3) who meet financial eligibility factors.

b. Title XVI Disability criteria

(1) Disabled person is one who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months or, in the case of a child under the age of 18, if he suffers from any medically determinable physical or mental impairment of comparable severity. A physical or mental impairment is an impairment that results from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic technique, except that an applicant for disability who is medically determined to be a drug addict or alcoholic shall be ineligible for any month unless such individual is undergoing any treatment that may be appropriate for his condition as a drug addict or alcoholic at an institution or facility approved for that purpose (so long as such treatment is available) and demonstrates compliance with the terms, conditions and requirements of such treatment.

c. Presumptive eligibility (X-program) may be established when there is a medical need and the individual appears to meet the Title XVI criteria for disability, subject to final determination by the Office of Personal Health Services, Disability Insurance Benefits Section.

d. Service worker's responsibility

(1) The initial presumption of disability will be based on the client's State of Employment and Health on form DSHS 14-50. This is filled out by the client at time of application. If the applicant is in a skilled nursing facility the form DSHS 14-50F is not required.

(2) The original form DSHS 14-50F is sent to financial services and a copy is routed to the Social Services Section.

(3) The service worker has the responsibility for securing social information regarding the individual's disability which will assist the DIB section in making their determination.

(4) The service worker will review the form DSHS 14-50F and secure additional information for the required two copies of form DSHS 13-15(X), Disability Social Information

(5) Information may be secured for the client, other agencies, client's past history, members of his family or other persons, as appropriate.

(6) Upon completion of DSHS 13-15(X), submit both copies, together with DSHS 14-50F to Support Services, who may add additional documents to complete the packet.

(7) The completed packet will be returned to the service worker for collation and final review prior to submission by Support Service to Office of Personal Health Services, Disability Insurance Benefits.

(8) After a decision is reached by DIB, Support Services will notify both the service worker and the financial service technician of the determination, and supply one copy of the DSHS 14-37(X) Transmittal Summary for each record.

2. Grandfather "P" program recipients

a. Grandfathered "P" program recipients are those who were certified as eligible prior to January 1, 1974 using criteria in effect at that time and who have received continuous medical coverage since that date. They are not automatically eligible for disability related to Title XVI, and determination of eligibility under Title XVI is required as outlined in 78.10, 1, d above.

b. Grandfathered "P" recipients who do not meet Title XVI criteria may be recertified for medical assistance according to the criteria in WAC 388-93.

c. If a grandfather P recipient does not continue to meet these requirements he is terminated, and any subsequent determination of eligibility is based on Title XVI criteria.

d. Changes in disability are evaluated by the Office of Personal Health Services to determine whether the disability continues to exist. Any changes noted by the service worker should be reported to the Financial section for appropriate action.

78.12 ALTERNATIVE RESOURCES FOR MEDICAL CARE

1. Effect on Eligibility for the Division's Medical Care Service

   All other resources for medical care available to the A/R at the time of application must be utilized to the full extent possible for medical care prior to participation by the Department.

   Additional payments or contributions by an A/R or other person meant to increase the level of care beyond that normally provided are considered as non-exempt resources and will be applied against the cost of care normally provided under the program.

2. The following other sources of medical care are available for many individuals. Use of these resources should be considered wherever appropriate.

   a. Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)

      Dependent spouses, children and certain other blood relatives of serviceman on extended active duty, of retirees, and of those who died on active duty, who may be eligible for public asssistance, are authorized medical care, both in-patient and out-patient services at military and public health hospitals. There is no cost for out-patient care to the individual.

      Information should be obtained from the military and public health facilities providing medical care which are located in the following areas of the state.

      U.S. Naval Hospital, Bremerton
      U.S. Air Force Hospital, Fairchild (Spokane)
      Madigan Ceneral Hospital, Tacoma
      U.S. Naval Hospital, Whidby Island (Oak Harbor)
      U.S. Public Health Service Hospital, Seattle

      Hospitalization and out-patient services from civilian sources are also authorized for dependents of active-duty service members, of retirees and dependents of deceased active-duty members; except that hospitalization may not be authorized for <u>active-duty service dependents</u> in the area where a military hospital is located and beds are available. These dependents are required to use such military facilities.

      Payment for civilian hospital care for dependents of active-duty service members is at a fixed amount for a spell of illness. Dependents of deceased service members and retirees and their dependents will pay a percentage of the hospital's charges and fees of professional persons for medical care furnished on an in-patient basis. The government will pay the remaining percentage on the charges. Out-patient care obtained from participating vendors is based on a deductible per fiscal year per family.

The military personal affairs officer or personnel officer at each military installation wil assist in obtaining the necessary identification cards and determination of eligibility for medical care. Congress may change this program from time to time and all potentially eligible persons should check with the nearest military installation. The dependent children of a divorced serviceman usually retain their eligibility for medical care described above, but the former spouse becomes ineligible for care with the divorce.

When service personnel are separated from service, the medical care for their dependents terminates. The date of termination is the date of separation. Termination of eligibility for children of active-duty members of the armed forces is the date they become twenty-one years of age or marry, or enter the service before their twenty-first birthday. An exception to this rule is if the child is handicapped because of a mental or physical condition or is attending school full time after his twenty-first birthday and remains in dependency status. Long-term definitive care of a handicapped dependent or active-duty personnel is authorized only in public or private hospitals or other institutions. The serviceman participates financially in this program depending on the rank he holds.

This program encompasses the severly handicapped, mental retardation and mental illness. No duration of care is imposed as long as the serviceman remains on active duty.

b. Crippled Children's Services

(1) The serviceworker, when it is clear that a child will need help because of a physical handicap, should refer the child's family to the local health department. The Crippled Children's Service of the Health Services Division are a resource that should not be overlooked.

(2) Children who have an organic disease, defect or condition which would hinder normal growth and development should be referred to CCS for a determination of service(s) available to them. The CCS program is administered at state level through each local health district/or department and more information may be obtained by calling them locally.

(3) CCS provides preventive, diagnostic and treatment services for children up to the age of 21. Conditions that are covered include:

(a) Chronic defects of the musculoskeletal system due to infection, injury, metabolic disorder, growth or nutrition, neoplasm or congenital malformation;

(b) Chronic defects requiring plastic reconstruction to correct a functional loss including severely disfiguring congenital or acquired defects;

(c) Cleft lip and palate and other maxillofacial defects requiring surgical repair, orthodontic reconstruction, prosthodontia and speech or hearing therapy;

(d) Otolaryngeal conditions which may lead to permanent impairment or hearing;

(e) Acquired or congenital heart disease amenable to surgical correction;

(f) Cerebral palsy;

(g) Congenital malformations of the digestive and genitouinary systems amenable to surgical correction;

(h) Selected medical disorders which may result in mental retardation if treatment is not provided;

(i) Congenital or acquired chronic disorders of the central nervous system for which an acceptable corrective treatment procedure has been developed;

(j) Selected disorders of the blood: e.g., sickle cell anemia, hemophilia, chronic hemolytic or aplastic anemia;

(k) Cystic Fibrosis: financial support is limited to costs related to initial diagnostic efforts and necessary therapy therapeutic hospitalization and associated charges which are consequences of the congenital disorder.

(4) Conditions not covered by CCS include:

(a) Mental retardation;

(b) Acute illness or injury - e.g., pneumonia, fractures, burns, rheumtic fever, encephalitis, meningitis, etc.;

(c) Malignant neoplasms with poor prognosis;

(d) Allergic conditions and diseases of the skin;

(e) Disorders of the blood and blood forming organs, except as noted in (i) above.

(f) Psychotic, psychoneurotic and personality disorders;

(g) Pregnancy and the complications thereof;

(h) Minor musculoskeletal defects which are ultimately insignificant in regard to function, i.e., tibial torsion, femoral torsion, knock knees, flat feet, pigeon toes, pronated ankles or feet;

(i) Minor non-handicapping congenital defects as, undescended testis, inguinal or umbilical hernia, hydrocele;

(j) Conditions associated with premature birth;

(k) Dental conditions unrelated to an eligible condition;

(m) Disorders of vision.

(5) In addition, CCS is not available, even though it is an eligible condition, if the only service is custodial, the condition cannot be alleviated by treatment, or prognosis for life is poor.

(6) Financial eligibility is determined by the S.O. CCS staff and all services must be pre-authorized. It's important that the local medical community be aware of these services, especially because of the follow-up. CCS is reimbursed from Title XIX for services provided to eligible children.

c. Indian Health Service

(1) The Department of Social and Health Services is considered the first resource for Indians in need of medical care assistance. There is a Community Health Representative (CHR) stationed in almost all Indian reservation communities. The ESSO has the name of this person on file.

(2) Indian Health Services may be available to an Indian under the following conditions:

(a) Does not meet Department's requirements for financial or medical assistance.

(b) Applicant qualifies only for acute and emergent care under Medical Only (MO) program or medical care in connection with a non-continuing grant.

(c) Medical services not provided or restricted in the Department's Medical Care Program.

(3) Instances may occur in which a family unit will have some members' medical needs taken care of under the DSHS medical care program, while other members come under the IHS program. For example, in an Indian family in which the father is fully employed at low wages and the mother present and functioning in the home, the children could be eligible for medical assistance (MA) under the "H" category.

(4) Neither parent, however, would be eligible for medical assistance (MA) since they cannot come under the "H" program unless they are under twenty-one years of age (or mother is pregnant) and the family cannot be related to AFDC. The mother or father, if requiring other than acute and emergent care, should be referred to the IHS medical care program through the CHR.

(5) Even in instances in which an Indian is eligible for full scope of care, specific services may be provided by the IHS program which are not available under the DSHS medical care program due to limitation of funds or restrictions in the program. Examples of such restrictions are presently in the areas of non-emergent, appliances, immunizations, and eyeglasses. IHS also has a more comprehensive dental program than that offered by DSHS. Any Indian child between the ages of two through eighteen living on a reservation, public domain land, or trust land, and who is receiving public assistance and needs dental care should be referred to this program. The IHS has dentists under contract in Auburn, Bellingham, Centralia, Elma, Everson, Ferndale, Forks, Kingston, Lacey, Marysville, Mount Vernon, Olympia, Poulsbo and Shelton. An IHS dentist is stationed on the west side of the Olympic Peninsula. This dental unit travels periodically from Neah Bay to Forks to Taholah, remaining at each of these locations for up to six months. No special application is needed to obtain care at these locations; the dentist makes appointments and takes care of the dental needs of those Indians who present themselves, although priority is given to children.

d. University of Washington School of Dentistry

The school accepts certain cases, including some involving children's orthodontia, which are of value from a teaching standpoint. The patient must be psychologically suited to treatment in a demonstration situation. Inquiries from the ESSO regarding this program should be directed to the school.

e. Veterans' Administration

(1) Recipient's of public assistance who are also veterans of military service and are in need of medical care should be referred to the Veterans' Administration for determination

of their medical eligibility. The above appies to both service and non-service-connected medical conditions. Priority for medical care in VA hospitals is given to:

Veterans who have service-connected medical conditions or whose conditions were aggravated by military service, and all other veterans who are in medical need and cannot afford to pay for medical care.

(2) The veteran/recipient may apply for care at any VA hospital or VA regional office having medical facilities. Application may be made in person or by mail.

Veteran's Administration establishes priorities for care and the veteran may be ineligible for various reasons.

(3) Veteran's Administration hospitals in the State of Washington are located in:

American Lake (Tacoma)	Vancouver
Seattle	Walla Walla
Spokane	

(4) VA Health Benefits Services for Dependents and Survivors

Medical care for dependents and survivors, when approved by the VA, will be paid for in the same manner and under the same conditions as care provided under CHAMPUS. Persons determined eligible by the VA will be known as CHAMPUSVA (Civilian Health and Medical Program for the Veterans Administration). Persons who meet the dependent and survivor CHAMPUSVA requirements may apply in person or by writing to the nearest VA hospital or outpatient clinic. They will furnish the necessary application form and related instructions and determine eligibility.

f. The following persons are eligible and should be referred to CHAMPUSVA:

(1) The spouse or child of a veteran who has a total disability, permanent in nature, resulting from a service-connected disability.

(2) The surviving spouse or child of a veteran who has died as the result of a service-connected disability.

The eligibility of children is not affected by divorce or by remarriage of the surviving spouse (except that a stepchild relationship would cease when the stepchild leaves the veteran's household). A child adopted by the widow within two years of the veteran's death has eligibility for medical benefits.

g. Child refers to an unmarried child, including:

(1) Legitimate child, a legally adopted child, a stepchild who is a member of the veteran's household or was a household member at the time of the veteran's death, or an illegitimate child.

(2) Under 18 years of age, regardless of whether or not dependent on veteran for support.

(3) Eighteen years of age or older but incapable of self-support because of a mental or physical incapacity that existed before the age of 18.

(4) Under age 23, enrolled in a course of instruction at an approved educational institution.

(5) If a child is married before reaching age 18, eligibility stops. If the marriage is terminated, the child may again be entitled to care as a dependent.

h. CHAMPUSVA excludes the following:

(1) Domiciliary or custodial care.

(2) Well baby care; physical exams, and immunizations which are not for diagnostic or treatment purpose.

(3) Refractions/glasses

(4) Hearing aids, orthopedic shoes and prosthetic appliances (other than artificial limbs and eyes.)

(5) Routine dental and orthodontia care.

Persons determined eligible for CHAMPUSVA are required to pay deductibles and coinsurance on the same basis as the CHAMPUS health care program for active duty dependents.

i. Workman's Compensation, Department of Labor and Industries

Persons injured during their regular employment are to be directed by the Department to the Labor and Industries District Office in their area if an injury report has not been filed. Under Workman's Compensation, injured workmen may receive both a monthly compensation and medical care for as long as the injury has incapacitated them. Determination of extent of injury rests with the attending physician and Labor and Industries.

j. Other Resources

Applicants or recipients may have private health and accident or other insurance coverage that they are expected to utilize when the Department determines their eligibility. Some insurance policies provide cash benefits directly to the insuree. These benefits are expected to be applied toward the cost of medical care. Persons applying for medical care who have excess income and/or resources, and who are determined to be financially eligible by ESSO, will participate in the cost of their medical care to the extent of the excess.

78.120 PATIENT RETURNING TO STATE INSTITUTIONS

1. Former state hospital patient

When a former state hospital patient becomes unmanageable in a nursing home, the ESSO should contact the Mental Health Professional regarding commitment.

When a patient is returned to the state hospital, the nursing home prepares 13-31(X) to report the patient's condition and behavior. This report, along with the patient's personal effects and medicines, should accompany the patient to the hospital.

The ESSO shall send the hospital a brief statement of the pertinent facts concerning the patient's readmission.

2. Patient from school for retarded unsuccessfully placed

If a patient on leave from a school for the retarded does not make a satisfactory adjustment in the nursing home of initial placement, the case service worker, jointly with the case service worker of the Bureau of Developmental disabilities and the Nursing Care Consultant, shall consider trial placement in another home.

If the patient cannot be managed in a nursing home, the nursing care consultant, if available, or the service worker should advise the case service worker of the Bureau of Developmental Disabilities and request that the school provide transportation to the institution.

The ESSO will forward a brief report of the pertinent facts relating to the patient's return to the case service worker of the Bureau of Developmental Disabilities with a copy for the superintendent of the school.