Bureau for Children with Medical Handicaps (BCMH)

Ohio Department of Health
The mission of the Bureau for Children with Medical Handicaps is to assure, through the development and support of high quality coordinated systems, that children with special health care needs and their families obtain comprehensive care and services which are family-centered, community-based and culturally competent.
What is BCMH?
Bureau for Children with Medical Handicaps

- Health care program located within the Ohio Department of Health
- Provide services for children who qualify for one or more of the following program Components:
  - Hospital Based Team Service Coordination
  - Diagnostic Program
  - Treatment Program
How is BCMH funded

• **Title V Federal Maternal and Child Health Block Grant**
  ➢ All States Receive Title V funding for children with special health care needs. Services authorized/program names differ among all states. For state specific information please refer to internet link below:
    
    [https://perfdata.hrsa.gov/mchb/mchreports/link/statelink_result.asp](https://perfdata.hrsa.gov/mchb/mchreports/link/statelink_result.asp)
  
• State general revenue funds
• County tax assessments
• Hospital audit funds
• Donation funds
How BCMH Helps Families

- Safety net program for children who have an eligible chronic medical condition. Provide linkage to a network of specialized healthcare providers.
- Families obtain payment for needed medical services
- Assist families in obtaining a Medical Home For Children with Special Health Care Needs
- Link with local Public Health Nurses
Public Health Nurse Services

- Authorized for every child on the BCMH Program
- Identification of CSHCN and referral to appropriate providers/agencies
- Service coordination
- Home visits
- Child/family/community assessments
- Advocacy for children and families
- Coordination with other agencies and systems that serve CSHCN, e.g. schools, MRDD, EI, JFS
Hospital Based Team Service Coordination Program (HBTSC)

- Provides access to a hospital based team service coordinator who assists families to identify and obtain needed services for their child.
- The hospital based team service coordinator works in collaboration with the local public health nurses. The local PHN works to identify community resources/services; while the HBTSC works to assist families in obtaining hospital based services.
Hospital Based Team Service Coordination (HBTSC)

**Eligibility for HBTSC:**
- Under age 21
- Resident of Ohio
- Under the Care of a recognized BCMH credentialed specialty team
- Completed Medical Application submitted by HBTSC
- No financial Eligibility Required
- May still apply for DX and TX programs to obtain payment for needed medical services.
Diagnostic Program

• To diagnose or rule out a chronic medical condition

• To establish a plan of treatment for a qualifying chronic medical condition

• Authorization period – 6 Months
Diagnostic Program
Eligibility

- Under age 21
- Permanent resident of Ohio
- Under the care of a BCMH credentialed physician
- Have a possible chronic medical condition
- **No** financial eligibility requirement
What services are covered under the Diagnostic Program?

- Basic Outpatient/Basic Physician Services (automatically authorized)
  - Consults/office visits to BCMH- credential physicians
  - Lab tests, x-rays, special tests
  - Public health nurse services provided by Local health departments
  - Physical, Occupational and Speech Therapy evaluations

- Major Services (must be requested)
  - Up to 5 days inpatient hospitalization
  - Biopsies/anesthesia
  - Care Management Services
  - Psych/Neuropsych evaluations
DX BCMH Program – Ineligible Conditions/Services

- Acute conditions/care
- Common refractive errors
- Emotional/behavioral/mental health problems
  - Diagnose/Rule out Autism but at this time do not cover treatment services
- Experimental care
- Learning disabilities
- Physical exams
- Routine well-child care
Treatment Program

- To provide access to specialized medical services based on recognized standards of clinical care for medically and financially eligible,
- Medical application submitted on behalf of the child from a BCMH credentialed physician
- Authorization period: 1 year
- Annual renewal - meet medical and financial program criteria
Treatment Program
Eligibility

• Under age 21 (separate program for adults with cystic fibrosis and hemophilia)
• Permanent resident of Ohio
• Under the care of a BCMH credentialed physician
• Have an eligible chronic medical condition
• Family meets financial eligible criteria
Examples of eligible chronic medical conditions for the Treatment program

- AIDS
- Birth defects
- Cancer
- Cerebral palsy
- Chronic pulmonary disease
- Cleft lip/palate
- Congenital heart defects
- Cystic fibrosis
- Diabetes
- Epilepsy
- Hearing loss
- Hemophilia
- Juvenile arthritis
- Scoliosis
- Severe vision disorders
- Sickle cell disease
- Spina Bifida
Ineligible medical Conditions/Services

- Acute conditions/care
- Common refractive errors
- Emotional/behavioral/mental health problems
- Experimental care
- Learning disabilities
- Orthodontia (For qualifying craniofacial anomalies)
- Physical exams
- Routine well-child care
Treatment program authorized services

• Service packages are authorized for treatment of the qualifying diagnosis and include:
  – Basic medical services
  – Appropriate major medical services;
  – Dental services, excluding orthodontic*
Examples of Major medical Services - Treatment Program

- Dental (cleanings, fillings, x-rays (twice a year))
- Durable Medical Equipment
- Inpatient hospitalization
- Medical supplies
- Orthotics/prosthetics
- Prescription medications
- Special formula
- Surgery/anesthesia
- Therapies
General guidelines for Application Process

Medical

• Qualifying medical Condition
• BCMH credentialed managing physician
• Physician must submit the Medical application form (MAF) on behalf of the child
• MAF or Release of information and Consent signed by parent/legal guardian/client

Financial

• If income eligible must apply to Medicaid/Healthy Start through local Ohio Department of Job and Family Services (ODJFS) before applying to BCMH
• Complete and submit Combined Program Application (CPA) and supply accompanying financial documentation
Medical Application Form (MAF) for BCMH Programs

- For the service coordination program, the team service coordinator must complete and sign the MAF.

- For the diagnostic and treatment programs, the BCMH managing physician must complete and sign the Medical Application Form (MAF).

- The parent or legal guardian (or client, if age 18 or older) must sign the MAF or the BCMH Release of Information Form before any action can be taken on the case.

- Completed MAF must be received by BCMH within 60 days of the date of service in which coverage needs to begin.
**Medical Application**

**Ohio Department of Health**

Bureau for Children With Medical Handicaps, 246 North High Street, P.O. Box 1603, Columbus, Ohio 43216-1603

- Diagnose:  
- Treatment:  
- Case Renewal:  
- Service Coordination:  
- PHN Referral:  
- Adult Hemophilia:  

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Child/Client's name last, first, mill</td>
</tr>
<tr>
<td>2.</td>
<td>Case number (Child/Client)</td>
</tr>
<tr>
<td>3.</td>
<td>Address</td>
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<tr>
<td>4.</td>
<td>County</td>
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<tr>
<td>5.</td>
<td>City</td>
</tr>
<tr>
<td>6.</td>
<td>Social Security number (Child/Client)</td>
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</tbody>
</table>
| 7.   | Sex:  
- Male  
- Female |
| 8.   | Ethnic group |
| 9.   | Ohio resident:  
- Yes  
- No |
| 10.  | Parent's/Legal guardian's name last, first |
| 11.  | Address |
| 12.  | Social Security number |
| 13.  | Home phone |
| 14.  | Work phone |
| 15.  | Parent's/Legal guardian's name last, first |

**Insurance Information**

- Health insurance coverage:  
- Policy number:  
- Health insurance company name:  
- Name of insured:  
- Begin date:  
- End date:  
- Carrier number:  

- Dental insurance coverage:  
- Policy number:  
- Dental insurance company name:  
- Name of insured:  
- Begin date:  
- End date:  
- Carrier number:  

- Vision care insurance coverage:  
- Policy number:  
- Vision care insurance company name:  
- Name of insured:  
- Begin date:  
- End date:  
- Carrier number:  

**Data required in order to process**

*HEA 2016 12/08*
**Children/Client’s name**

**Case number**

**34. If child/client has any other handicapping condition(s), please describe**


**35. Name of primary care physician**

**36. Name of primary care dentist**

**37. Major Services**

<table>
<thead>
<tr>
<th>Category of service</th>
<th>Name and address of provider</th>
<th>Provider number</th>
<th>Unit of service</th>
<th>Source of payments</th>
</tr>
</thead>
</table>

**38. Recommendations (Include all Plan of Treatment, Medical Report and/or Discharge Summary)**

**39. Managing physician/service coordinator’s signature**

**Date**

**40. Initial date of exam**

**41. Name of person completing form**

**Telephone**

**42. Most recent date of exam**

**Public Health Nurse Referral**

**43. Name**

**44. Health department**

**45. Telephone**

**46. Reason**

**Date of scheduled exam**

I hereby authorize the managing physician or service coordinator listed above to submit this application to the Ohio Department of Health, Bureau for Children with Medical Handicaps (hereinafter referred to as “BCMH”), for services for the child/client therein referred to as “client” named on the front of this application. I authorize BCMH to release confidential information concerning the client and medical condition and treatment, any and all financial information and third-party coverage to county and local health departments located in the city or county where the client lives or receives treatment and to health care and service providers, facilities and third-party payers and their agents and employees in the purposes of providing or facilitating the delivery of or arranging for services to the client. This authorization includes the release of any and all information concerning the client’s medical conditions and treatment, including if applicable, the client’s HIV testing or diagnosis of AIDS or AIDS-related conditions.

I certify and attest that all the information given by me on this form and other BCMH application forms is true and accurate. I hereby give my permission to have all financial information verified. I authorize the release to BCMH of any and all information pertaining to my contract of insurance as to claims filed on behalf of client and amounts paid and to whom those claims or amounts were paid.

This release authorization is effective from the date of my signature and will remain in effect until such time as I expressly revoke it in writing. I understand that the above-referenced information will not be released to any other entity without an additional written release authorization from me or other person having legal authority to provide such release or as required by law.

I have read this authorization to release information and fully understand its contents.

**47. Parent/subsidiary/client’s signature**

**Date**

**Print name**

**Relationship to client/child**

**48. Approved**

- [ ] 1. Yes
- [ ] 2. No

**49. Program**

**Code**

**50. Effective date**

**51. Expiration date**

**52. Dental reason**

**Code**

**53. Dental reason**

**Code**

**54. Nurse case manager**

**Date**

**DATA REQUIRED IN ORDER TO PROCESS**
Role of Managing Physician

- Managing Physician
  - Identify children with possible chronic medical condition
  - Refer to appropriate BCMH credentialed providers
  - Completes the Medical Application Form
  - Provides Comprehensive, coordinated care with family, providers, Local Public Health Nurses
  - Accepts referrals from local Public Health Nurses
Nurse Practitioner Role with BCMH

• Be a BCMH credentialed APN
• Able to initiate BCMH MAF with MP signature and medical report from APN accepted with MD agreeing.
• Renewals and Interim requests can be signed/completed by BCMH credentialed APN.
Nutritional services

- Nutritional Therapy Consults
  - Community Dietitians
  - Hospital Based nutritionist

- Nutritional Support for children with qualifying diagnoses such as:
  - Metabolic disorders, Cystic Fibrosis, Gastrostomy, severe food hypersensitivity, disorders/anomalies of digestive tract
  - Nutrition Support Request Form along with required supporting documentation required

- Thickener
  - Physician/Nurse Practitioner submit Interim Request Form
Financial Application Process

- Financial application packet is sent to the family upon receipt of the Medical application form from the physician requesting Treatment services for a child.
- BCMH Financial Guidelines are based at 185% Federal Poverty Level. Packet contains the Combined Programs Application (CPA), information about the Medicaid Healthy Start Program, and instructions on how to complete the financial application process.
Financial Application Process for Ohio Resident/Non-citizen

- Proof of Ohio residency
- Apply for Healthy Start if within income guidelines
- Submit Healthy Start denial/acceptance notification to BCMH
- Submit financial information to BCMH
- Family must meet financial requirements for treatment services
Client Eligible – What’s Next?

- Letter of approval (LOA)
- Request for additional services using Interim Request Form (IRF)
- Prior Authorization (PA)
- Renewals
- Concerns
Letter of Approval

- Services have been approved, a Letter of Approval (LOA) is sent to the parent, managing physician, hospital (if known), and the local health department.
- The Letter of Approval contains:
  - Demographic information for parent/child and name of managing physician
  - Insurance/Medicaid coverage
  - Name of local health department
  - Type of program, e.g. diagnostic, treatment
  - Child’s diagnosis/diagnoses
  - Services authorized, approved providers, units of service authorized
  - Identification of first payer
Additional Services Identified: Interim Request Form (IRF) Process

- Submit IRF form along with supporting medical documentation for the needed service.
- Examples: Adding a Diagnosis; adding Surgeries/Special Procedures; inpatient hospitalization, Emergency Department visits; Thickener
- BCMH requesting Physician must sign the IR
- Submits IR to BCMH via fax or mail.
Interim Request for BCMH Services

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<tr>
<th>Date</th>
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<tbody>
<tr>
<td>Child's name</td>
</tr>
<tr>
<td>Birthdate</td>
</tr>
<tr>
<td>Parents' names</td>
</tr>
<tr>
<td>Managing physician</td>
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<tr>
<td>Person completing form</td>
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Directions: Please type one form for each child for whom you are requesting services and submit to the above address. Be specific as to type of service/equipment, date services need to begin, units of services needed and name and address of BCMH provider.

<table>
<thead>
<tr>
<th>Services requested</th>
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<tbody>
<tr>
<td>Type of service</td>
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Statement of medical necessity for requested service is required.

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Signature of managing physician | Date
IR and Prior Authorization (PA), what is the difference?

**IR**
- BCMH Form
- Needed to add specialized major medical services to approved BCMH LOA’s.

**PA**
- Form is the Ohio Department of Job and Family Services Prior Authorization JFS 03142
- Completed by the BCMH credentialed Durable Medical Equipment (DME) provider/Pharmacy or other ordering organization.
- BCMH Special Authorization Nurse Reviews PA and determines Medical eligibility
Renewal Process

- Clients enrolled on BCMH TX program with continued medical and financial eligibility
- 60 Days prior to expiration of LOA a renewal form will be sent to the Managing Physician-This form must be signed by the managing physician, date of last exam noted and supporting medical documentation need to submitted to BCMH.
- Family will receive a financial application packet if they are not currently on Medicaid/Healthy Start
Claim Submissions

- Must be a BCMH approved provider
- Billing Form-CMS 1500/hospital claim form UB-04
- Use AMA CPT codes
- Claims submitted with-in a year of Date of Service (DOS)
- Follow the claims submission procedure for the primary insurance
- Providers can bill BCMH for services not covered by the family’s insurance or denied by submitting to BCMH the rejected claim along with the EOB
- If the insurer paid more than BCMH allowable fee the provider will receive a remittance advice showing $0.00, payment by insurance is then to be expected to be payment in full.
Claim Submission

- BCMH is ALWAYS payer of last resort
- Providers should bill BCMH after they have submitted the claim to the families insurance/Medicaid. The invoice sent to BCMH should reflect what insurance has already paid.
- The Ohio Revised Code prohibits providers from charging BCMH approved families for co-payments or deductibles for services authorized by BCMH
- Parents can not bill BCMH, nor can BCMH reimburse parents
- NO Balance Billing
BCMH Claims Processing

- Physician Care Management, Diabetic and Nutrition Service codes are on web site for provider office reference
- Vision Provider billing codes handout
- Claims unit is now using NPI numbers for provider numbers.
- 60 days is time line for checking status of a claim
- BCMH Claims Processing Unit Phone number (614)466-2720
Care Management

- The Bureau understands that children with Chronic Medical Conditions and their families require more specialized care from providers and more time related to this care.
- BCMH physicians/nurse practitioners who provide prolonged care services are able to be compensated for their time spent working with BCMH approved clients.
- Eligible on all TX Letters of Approval and can be requested on DX LOA’s via the MAF.
- A description of BCMH Physician Care Management and payable service codes list can be located on our website.
Why apply to BCMH if Healthy Start/Medicaid eligible?

- BCMH will pay for items that are not under the Healthy Start /Medicaid package of services:
  - Public Health Nurses Services
  - Formula thickener
  - Positioning car seat
  - Additional pair of glasses
  - Just Cause Dis-enrollment from Medicaid HMO
How can I find BCMH approved providers/More BCMH Information?

- Please visit our website at www.odh.ohio.gov
- Click on “B” in the alphabet at the top of the page. Click on BCMH.
Obtaining information from BCMH

Address: Bureau for Children with Medical Handicaps
          P.O. Box 1603
          Columbus, OH 43216-1603

Telephone: (614)466-1700

Fax: (614)728-3616

E-Mail: BCMH@odh.ohio.gov

Information Needed when Contacting BCMH:
  • Your Name/Phone number/email address
  • Client’s Name/Date of Birth/BCMH case number
  • Brief description of question and the best time to return your call.