

# EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT (EPSDT)



## MEDICAID FOR CHILDREN

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1/26/2010

# WHY HEALTH CHECK/ EPSDT ARE IMPORTANT

- Promotes preventative health care by providing for early and regular medical and dental screenings.
- Provides medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening.

# HEALTH CHECK/EPSDT OVERVIEW

➤ **Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)** defined by federal law and includes:

- Periodic Screening Services
- Vision Services
- Dental Services
- Hearing Services
- Other Necessary Health Care



# EPSDT OVERVIEW

CON'T.

- Rehabilitative services for developmental disabilities
- Mental health and substance abuse services
- Medical and adaptive equipment
- Transportation
- In-home nursing, personal care, and specialized therapies
- Out-of-home residential, facility and hospital services
- Other medically necessary care



# EPSDT OVERVIEW

CON'T.

- The full array of EPSDT services must be coverable within the scope of those listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act]. EPSDT requires Medicaid to cover these services if they are medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]. *Please refer to handout for listing of services.*

**NOTE:** Under EPSDT, North Carolina Medicaid must make available a variety of individual and group providers qualified and willing to provide EPSDT services.



# EPSDT CRITERIA

- Must be listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act].
- Must be medically necessary "to correct or **ameliorate** a defect, physical or mental illness, or a condition [health problem] identified by screening".



# EPSDT CRITERIA

CON'T.

**“Ameliorate”** means to:

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

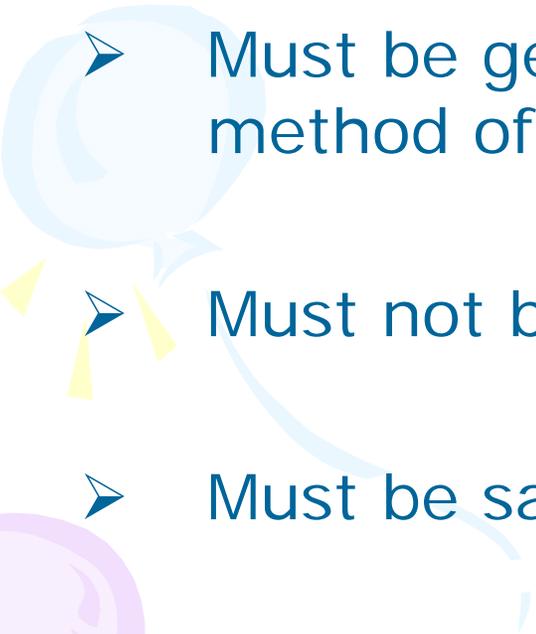


# EPSDT CRITERIA

## CON'T.



Must be determined to be medical in nature.



Must be generally recognized as an accepted method of medical practice or treatment.



Must not be experimental, investigational.



Must be safe.



Must be effective.

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# EPSDT FEATURES

- No Waiting List for EPSDT Services
- No Monetary Cap on the Total Cost of EPSDT services
- No Upper Limit on the Number of Hours under EPSDT
- No Limit on the Number of EPSDT Visits to a Physician, Therapist, Dentist or Other Licensed Clinician



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# EPSDT FEATURES

CON'T.



- No Set List that Specifies When or What EPSDT Services or Equipment May Be Covered



- No Co-payment or Other Cost to the Recipient



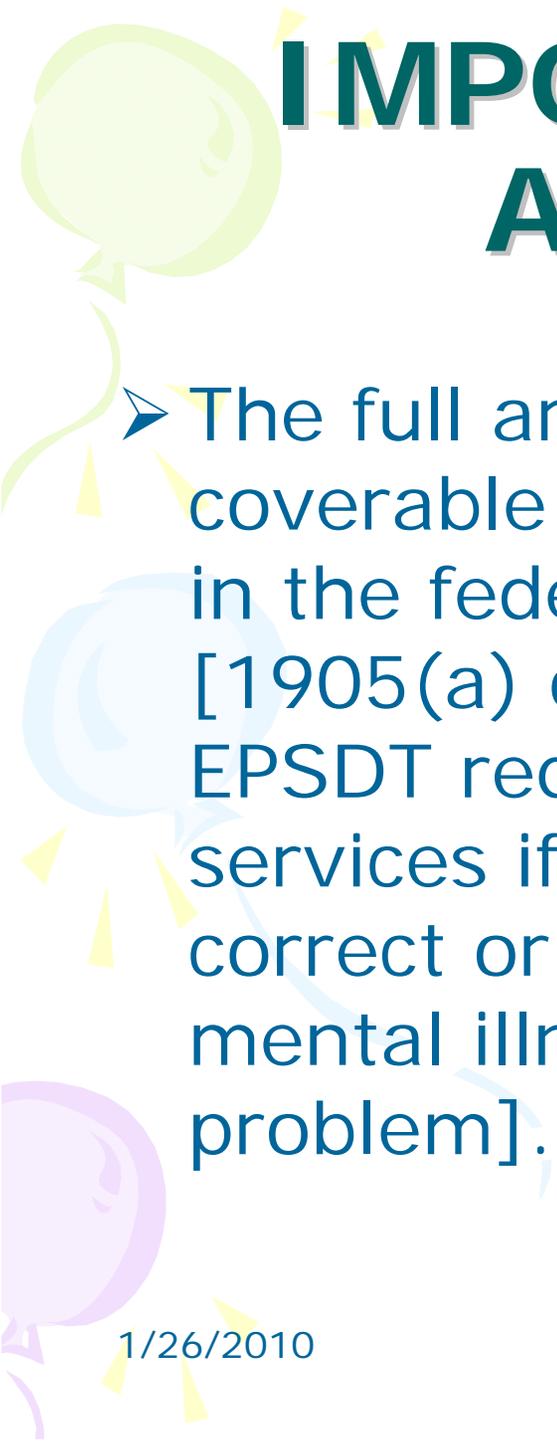
- Coverage for Services that Are Never Covered for Recipients **21 Years of Age and Older**



- Coverage for Services Not Listed in the N.C. State Medicaid Plan

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# IMPORTANT POINTS ABOUT EPSDT

- The full array of EPSDT services must be coverable within the scope of those listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act]. EPSDT requires Medicaid to cover these services if they are medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition [health problem].



# IMPORTANT POINTS ABOUT EPSDT

CON'T.

- EPSDT services do not have to be services that are covered under the North Carolina State Medicaid Plan or under any of the Division of Medical Assistance's (DMA) clinical coverage policies or service definitions or billing codes.



# IMPORTANT POINTS ABOUT EPSDT

CON'T.

- EPSDT covers short-term and long-term services as long as the requested services will correct or ameliorate the child's condition. For example, a service must be covered under EPSDT if it is necessary for immediate relief (e.g., pain medication). Treatment need not ameliorate the child's condition taken as a whole, but need only be medically necessary to ameliorate one of the child's diagnoses or medical conditions.



# EPSDT OPERATIONAL PRINCIPLES

- The specific coverage criteria (e.g., particular diagnoses, signs, or symptoms) in the DMA clinical coverage policies or service definitions do **NOT** have to be met for recipients under 21 years if the service is medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problem].

# EPSDT OPERATIONAL PRINCIPLES

CON'T.

- The specific numerical limits (number of hours, number of visits, or other limitations on scope, amount or frequency) in DMA clinical coverage policies, service definitions, or billing codes do **NOT** apply to recipients under 21 years of age if more hours or visits of the requested service are medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problem]. This includes the hourly limits on Medicaid Personal Care Services (PCS) and Community Support Services (CSS).

# EPSDT OPERATIONAL PRINCIPLES

CON'T.

- Other restrictions in the clinical coverage policies, such as the location of the service (e.g., PCS only in the home), prohibitions on multiple services on the same day or at the same time (e.g., day treatment and residential treatment) must also be waived under EPSDT as long as the services are medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problem].



# EPSDT OPERATIONAL PRINCIPLES

CON'T.

- Out of state services are **NOT** covered if medically necessary similarly efficacious services are available in North Carolina. Out of state services delivered without prior approval will be denied unless there is retroactive Medicaid eligibility.



# EPSDT OPERATIONAL PRINCIPLES

CON'T.

- EPSDT also covers personal care services, wheelchairs, and other medical services or equipment which are needed to compensate for a health problem or maintain the child's health in the best condition possible.

# EPSDT OPERATIONAL PRINCIPLES

CON'T.

- Durable medical equipment (DME), assistive technology, orthotics, prosthetics, or other service requested do **NOT** have to be included on DMA's approved lists or be covered under a CAP waiver program in order to be covered under EPSDT subject to meeting the criteria specified in this policy.



# EPSDT OPERATIONAL PRINCIPLES

CON'T.

- The prohibition in CAP/C on skilled nursing for purposes of monitoring does not apply to EPSDT services if skilled monitoring is medically necessary. (Example: PDN)
- Case management is an EPSDT service and must be provided to a child with a Medicaid card if medically necessary to correct or ameliorate regardless of eligibility for a CAP waiver.



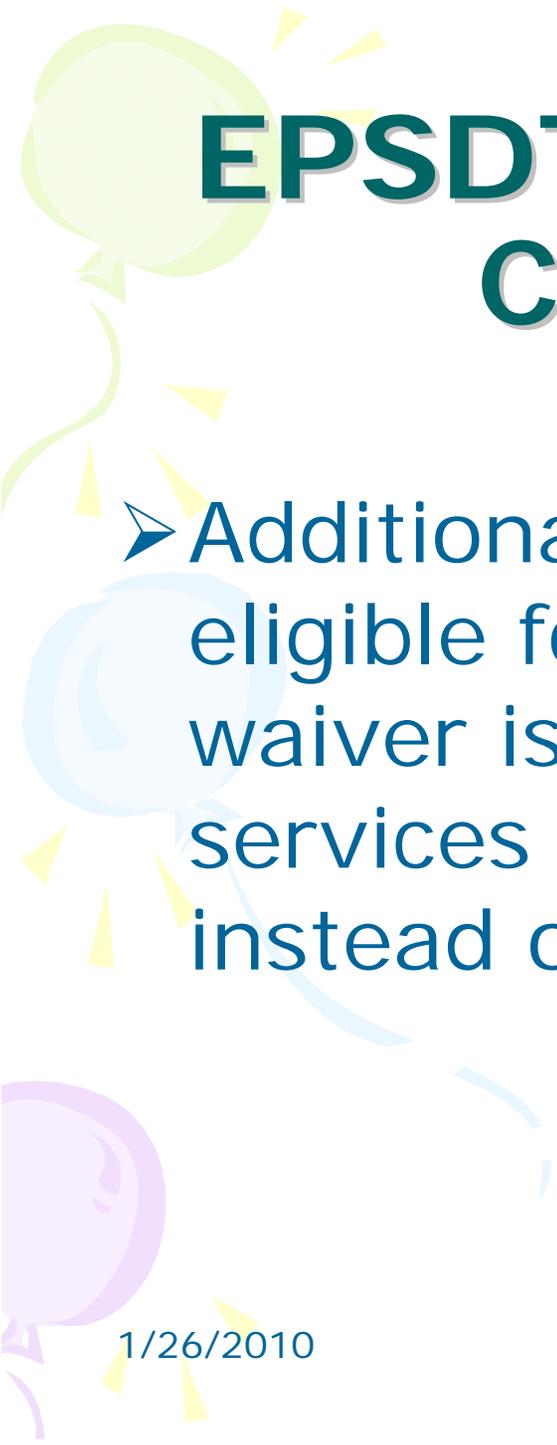
# EPSDT OPERATIONAL PRINCIPLES

CON'T.

- Medicaid will cover treatment that the recipient under 21 years of age needs under this EPSDT policy. DMA will enroll providers, set reimbursement rates, set provider qualifications, and assure the means for claims processing when the service is not already established in the North Carolina State Medicaid Plan.

# EPSDT COVERAGE AND CAP WAIVERS

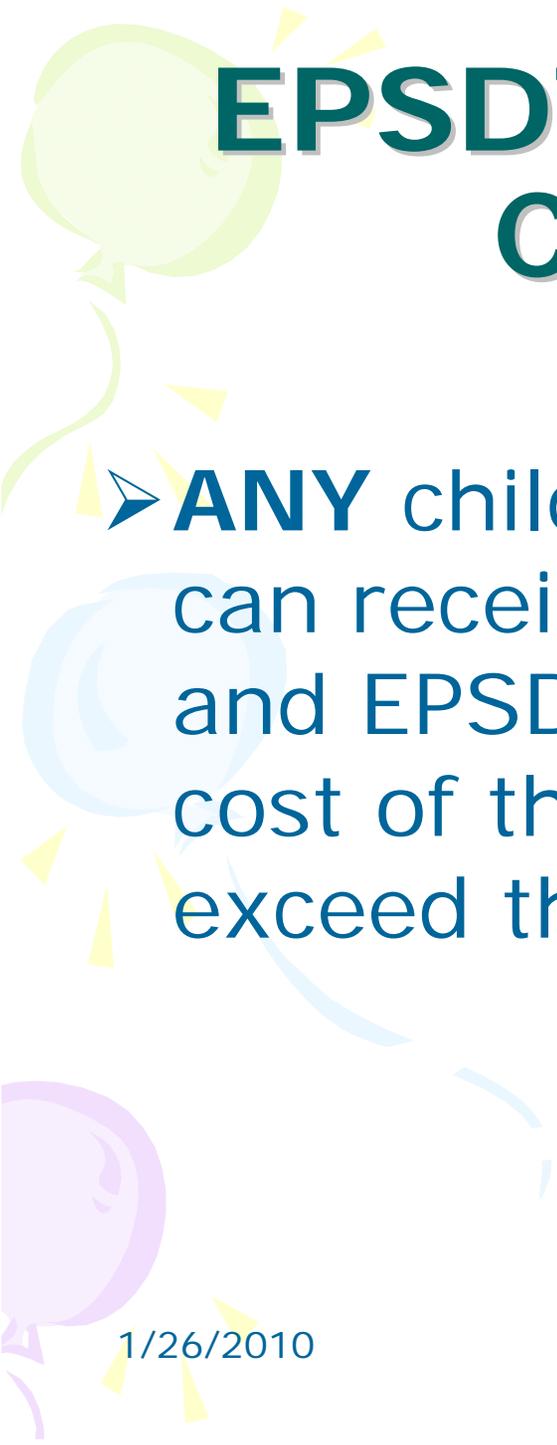
- Waiver services are available only to participants in the CAP waiver programs and are not a part of the EPSDT benefit unless the waiver service is **ALSO** an EPSDT service (e.g. durable medical equipment).



# EPSDT COVERAGE AND CAP WAIVERS

CON'T.

- Additionally, a child financially eligible for Medicaid outside of the waiver is entitled to elect EPSDT services without any monetary cap instead of waiver services.



# EPSDT COVERAGE AND CAP WAIVERS

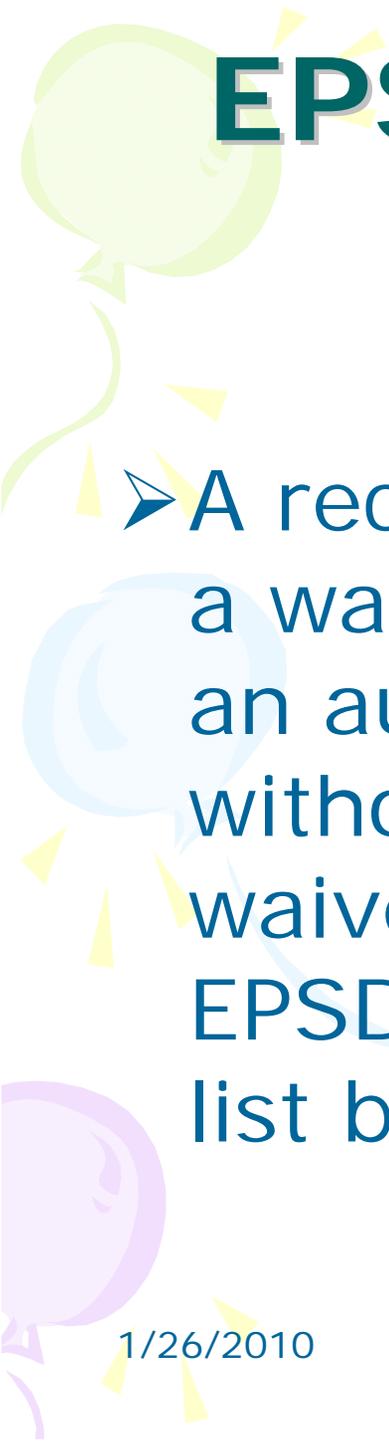
CON'T.

- **ANY** child enrolled in a CAP program can receive **BOTH** waiver services and EPSDT services. However, the cost of the recipient's care must not exceed the waiver cost limit.

# EPSDT COVERAGE AND CAP WAIVERS

CON'T.

- If enrolled in the Community Alternatives Program for Persons with Mental Retardation and Developmental Disabilities (CAP-MRDD), prior approval to exceed \$100,000 per year must be obtained.



# EPSDT COVERAGE AND CAP WAIVERS

CON'T.

- A recipient under 21 years of age on a waiting list for CAP services, who is an authorized Medicaid recipient without regard to approval under a waiver, is eligible for necessary EPSDT services without any waiting list being imposed.

# EPSDT COVERAGE AND CAP WAIVERS

CON'T.

- EPSDT services must be provided to recipients under 21 years of age in a CAP program under the same standards as other children receiving Medicaid services. For example, some CAP recipients under 21 years of age may need daily in-school assistance supervised by a licensed clinician through community intervention services (CIS) or personal care services (PCS). **It is important to note that Medicaid services coverable under EPSDT may be provided in the school setting, including to CAP-MRDD recipients.**



# EPSDT COVERAGE AND CAP WAIVERS

CON'T.

- **Only** a CAP/DA case manager can deny, reduce, or terminate a CAP/DA waiver service.
- All EPSDT requests must be forwarded to the DMA CAP/DA consultants for review and response.

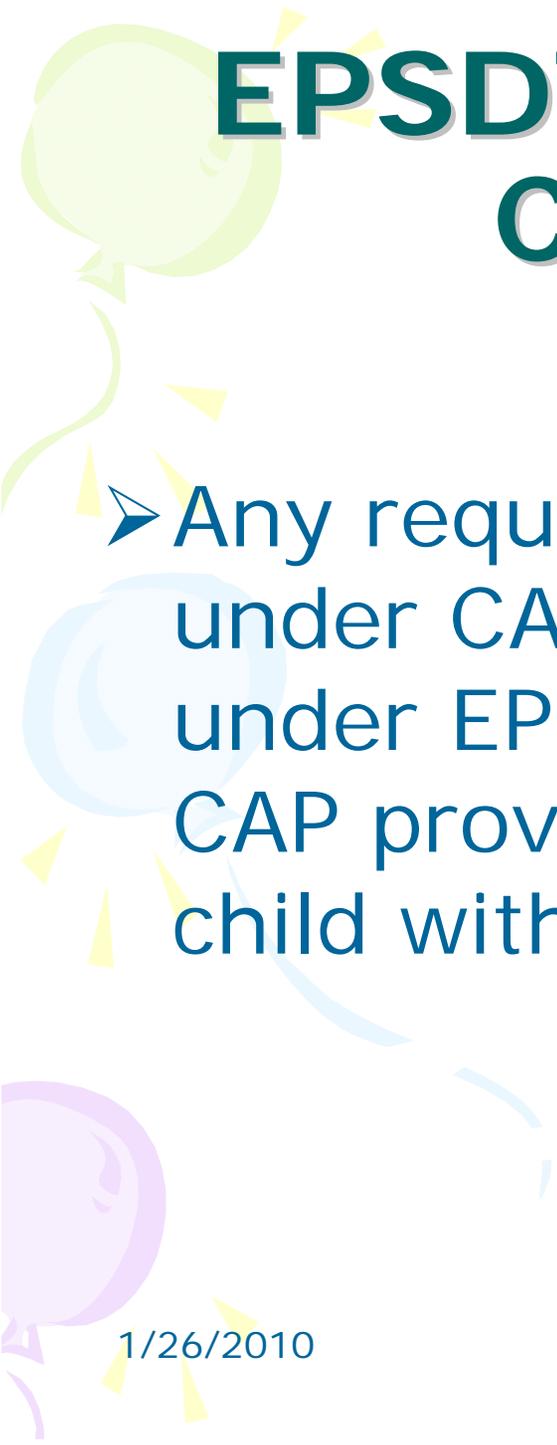
# EPSDT COVERAGE AND CAP WAIVERS

CON'T.

- **A CAP/C or CAP-MRDD case manager may not deny, either formally or informally, a waiver or EPSDT service request supported by a licensed clinician.**

**CAP/C:** Requests must be forwarded to DMA CAP/C Nurse Consultants.

**CAP-MRDD:** Requests must be forwarded to ValueOptions for recipients under 21 years of age who receive services under the CAP-MR/DD waiver, as well as for children not in a waiver who have a case manager.



# EPSDT COVERAGE AND CAP WAIVERS

CON'T.

- Any request for services **OR** appeal under CAP must also be considered under EPSDT as well as under the CAP provisions if the appeal is for a child with Medicaid.

# EPSDT COVERAGE AND MH/DD/SA SERVICES

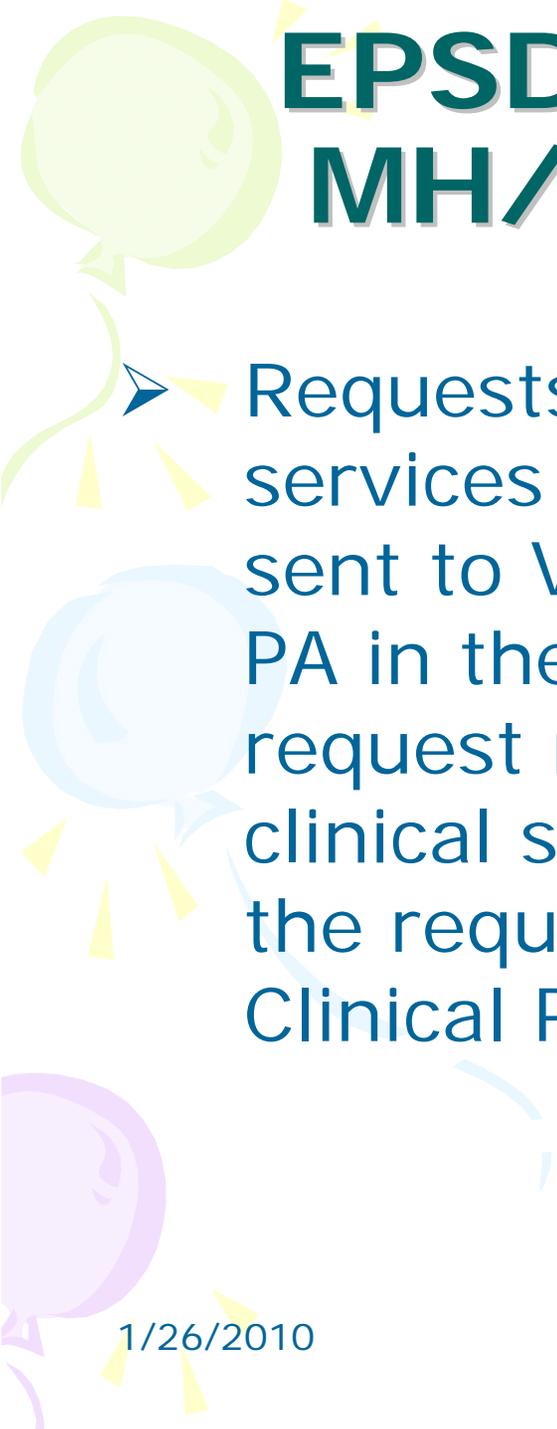
- Staff employed by local management entities (LMEs) **CANNOT** deny requests for services, formally or informally. Requests must be forwarded to ValueOptions or the other appropriate DMA vendor if supported by a licensed clinician.



# EPSDT COVERAGE AND MH/DD/SA SERVICES

CON'T.

- LMEs may NOT use the Screening, Triage, and Referral (STR) process or the DD eligibility process as a means of denying access to Medicaid services. Even if the LME STR screener does not believe the child needs enhanced services, the family must be referred to an appropriate Medicaid provider to perform a clinical evaluation of the child for any medically necessary service.



# EPSDT COVERAGE AND MH/DD/SA SERVICES

CON'T.

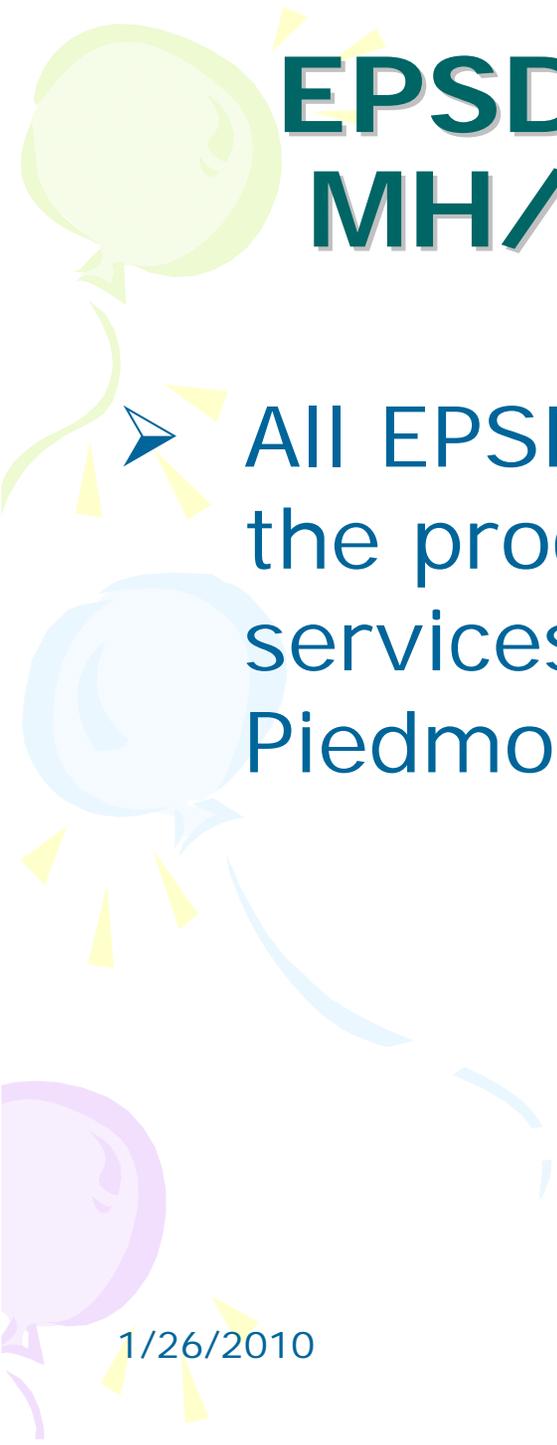
- Requests for prior approval of MH/DD/SA services for recipients under 21 must be sent to ValueOptions or LME if handling PA in their catchment area. If the request needs to be reviewed by DMA clinical staff, ValueOptions will forward the request to the Assistant Director for Clinical Policy and Programs.



# EPSDT COVERAGE AND MH/DD/SA SERVICES

CON'T.

- If a recipient under 21 years of age has a developmental disability diagnosis, this does not necessarily mean that the requested service is habilitative and may not be covered under EPSDT. The EPSDT criteria of whether the service is medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problem] apply. Examples include dual diagnoses and behavioral disorders. All individual facts must be considered.



# EPSDT COVERAGE AND MH/DD/SA SERVICES

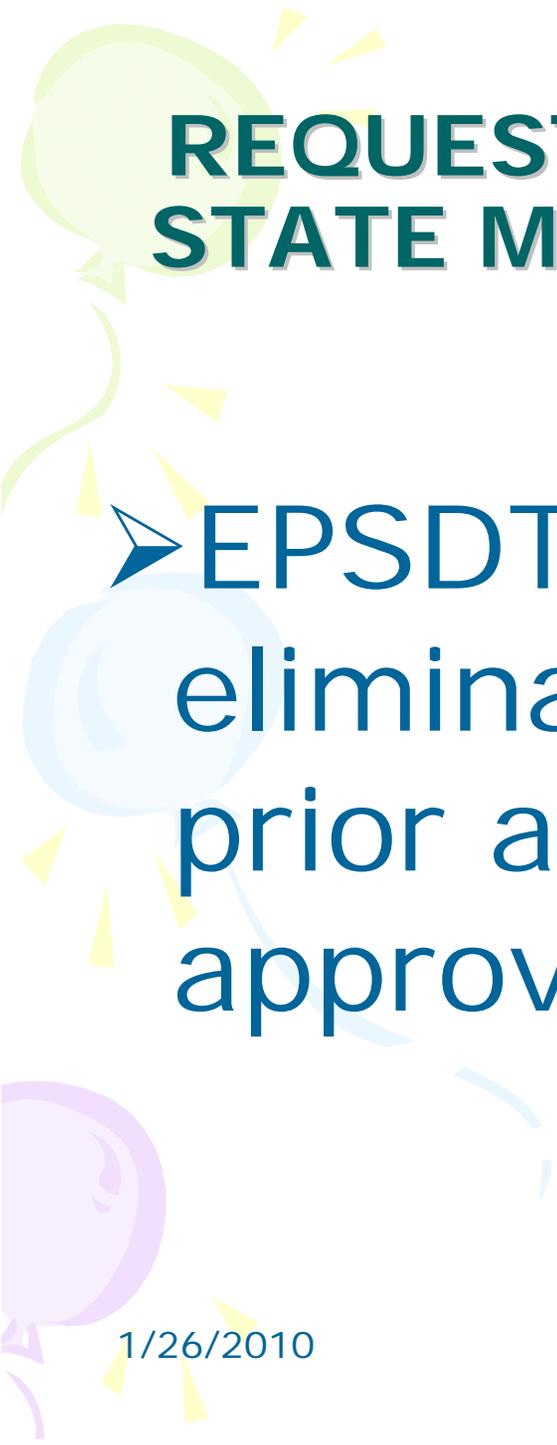
CON'T.

- All EPSDT requirements (except for the procedure for obtaining services) fully apply to the Piedmont waiver.



# REQUESTING PA FOR A COVERED STATE MEDICAID PLAN SERVICE

- Covered state Medicaid plan services are defined as requests for services, products, or procedures covered by the North Carolina State Medicaid Plan.



# REQUESTING PA FOR A COVERED STATE MEDICAID PLAN SERVICES CON'T.

- EPSDT does **NOT** eliminate the need for prior approval if prior approval is required.

# REQUESTING PA FOR A COVERED STATE MEDICAID PLAN SERVICES

## CON'T.

- Requests for EPSDT services do **NOT** have to be labeled as such. Any proper request for services for a recipient under 21 years of age is a request for EPSDT services. When state staff or vendors review a covered state Medicaid plan services request for PA or continuing authorization (UR) for an individual under 21 years of age, the reviewer will apply the EPSDT criteria. For recipients under 21 years of age enrolled in a CAP waiver, a request for services must be considered under EPSDT as well as under the waiver.

# REQUESTING PA FOR A COVERED STATE MEDICAID PLAN SERVICES

## CON'T.

- Providers or family members may write directly to the Assistant Director for Clinical Policy and Programs, Division of Medical Assistance requesting a review for a specific service. DMA vendors and contractors must consider any request for state Medicaid plan services for a recipient under 21 years of age under EPSDT criteria when the request is made by the recipient's physician, therapist, or other licensed practitioner in accordance with the Division's published policies.



# REQUESTING PA FOR A COVERED STATE MEDICAID PLAN SERVICES CON'T.

- When requesting prior approval for a covered service, providers should refer to the Basic Medicaid Billing Guide, section 6. Requests should be submitted to the appropriate vendor as specified in that section.

# REQUESTING PA FOR A COVERED STATE MEDICAID PLAN SERVICES

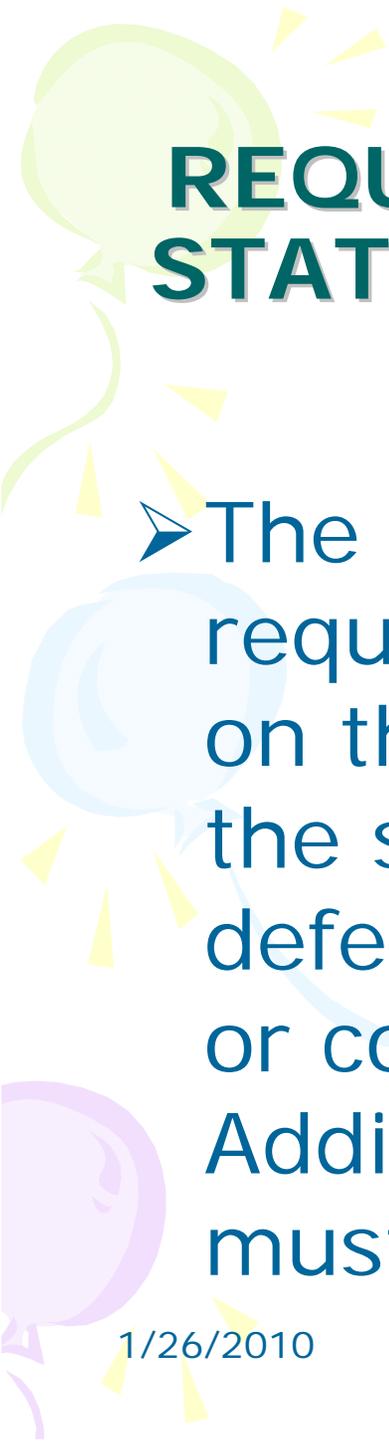
## CON'T.

- EPSDT requests for prior approval for services must be fully documented to show medical necessity. This requires current information from the recipient's physician, other licensed clinicians, the requesting qualified provider, and family members or legal representative. If this information is not provided, Medicaid or its vendor will have to obtain the needed information, and this will delay the prior approval decision.

# REQUESTING PA FOR A COVERED STATE MEDICAID PLAN SERVICES

## CON'T.

- If the recipient does not meet the clinical coverage criteria or needs to exceed clinical coverage policy limits, submit documentation with the prior approval request or other required program documentation that shows how the service at the requested frequency and amount meets all EPSDT criteria, incl. medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problem].



# REQUESTING PA FOR A COVERED STATE MEDICAID PLAN SERVICES CON'T.

- The decision to approve or deny the request under EPSDT must be based on the recipient's medical need for the service to correct or ameliorate a defect, physical [or] mental illness, or condition [health problem]. Additionally, all other EPSDT criteria must be met.

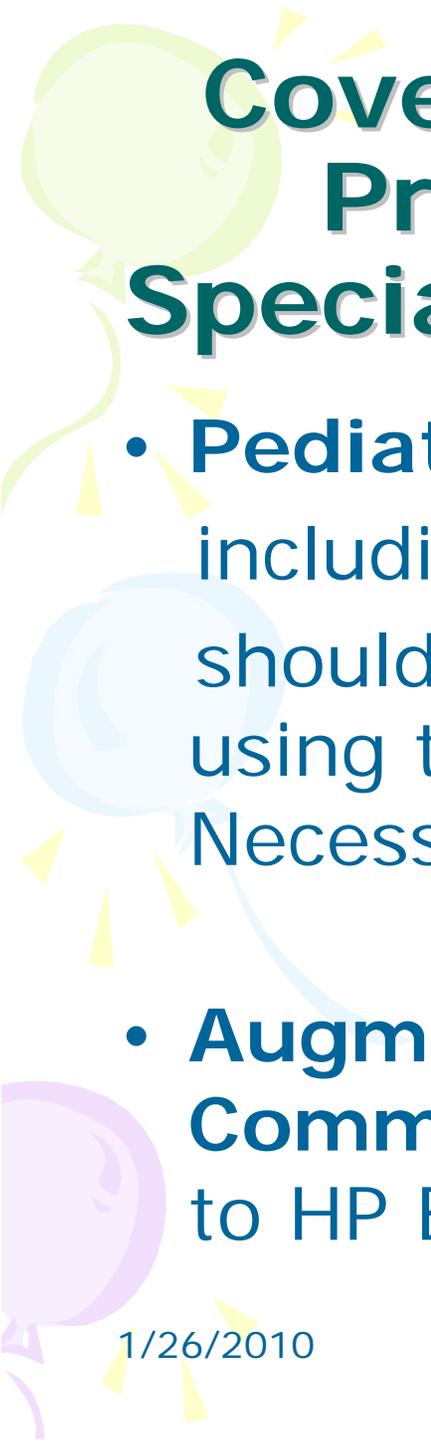
# REQUESTING PA FOR A COVERED STATE MEDICAID PLAN SERVICES

CON'T.

- North Carolina Medicaid retains the authority to determine how an identified type of equipment, therapy, or service will be met, subject to compliance with federal law, including consideration of the opinion of the treating physician and sufficient access to alternative services. Services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner, the determination process does not delay the delivery of the needed service, and the determination does not limit the recipient's right to a free choice of providers.

# REQUESTING PA FOR A COVERED STATE MEDICAID PLAN SERVICES CON'T.

- It is not sufficient to cover a standard, lower cost service instead of a requested specialized service if the lower cost service is not equally effective in that individual case.



# Covered Services Previously Processed by Children's Special Health Services (CSHS)

- **Pediatric mobility systems**, including non-listed components, should be sent to HP Enterprise Services using the Certificate of Medical Necessity/Prior Approval (CMN/PA form).
- **Augmentative and Alternate Communication Devices** should be sent to HP Enterprise Services.



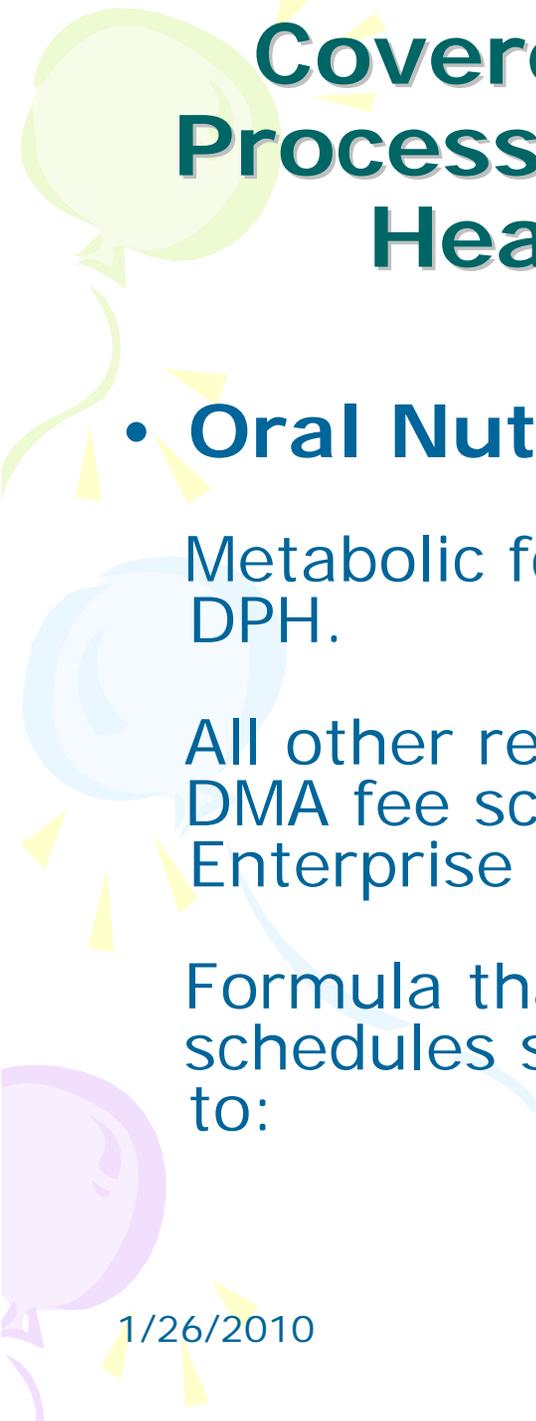
# Covered Services Previously Processed by Children's Special Health Services (CSHS)

CON'T.

- **Cochlear Implant and Accessories**

Fax all requests for external parts replacement and repair, in letter format, to the appropriate cochlear or auditory brainstem implant manufacturer. The manufacturer will process requests, obtain prior approval for external speech processors, and file claims. Guidelines for the letter requesting external parts replacement or repair can be obtained from the cochlear or auditory brainstem manufacturer.

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# Covered Services Previously Processed by Children's Special Health Services (CSHS)

CON'T.

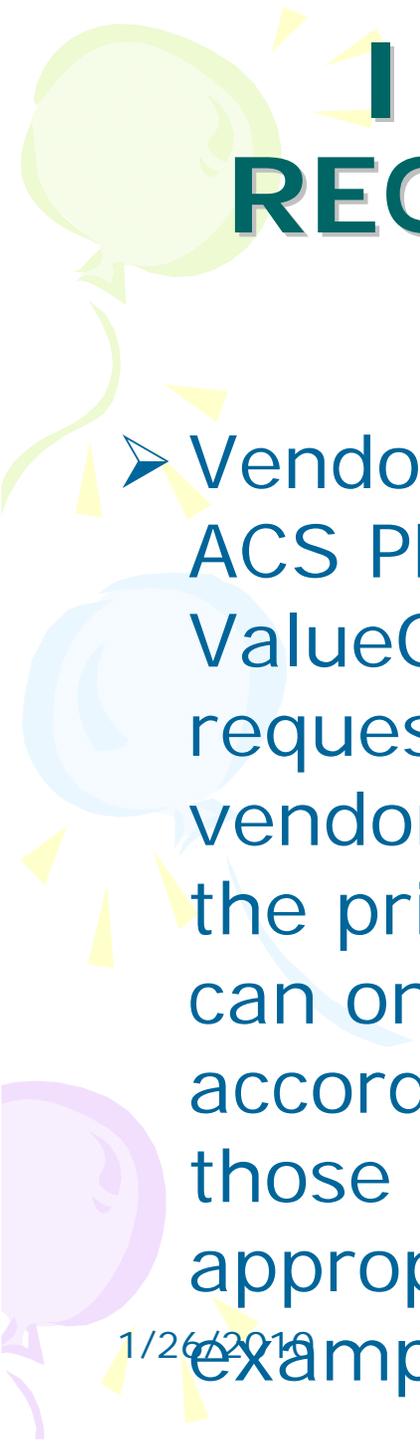
- **Oral Nutrition**

Metabolic formula requests should be sent to DPH.

All other requests for formula that appear on the DMA fee schedules should be sent to HP Enterprise Services.

Formula that does not appear on the DMA fee schedules should be sent as an EPSDT request to:

Assistant Director  
Clinical Policy and Programs



# INAPPROPRIATE PA REQUESTS RECEIVED BY VENDORS

- Vendors (CCME, HP Enterprise Services, ACS Pharmacy, CCME, MedSolutions, ValueOptions) may receive service requests from providers for which the vendor is not responsible for conducting the prior approval reviews. As vendors can only authorize specific services in accordance with DMA-vendor contracts, those requests should be forwarded to the appropriate vendor for review. For

1/26/2016  
example:



# INAPPROPRIATE PA REQUESTS RECEIVED BY VENDORS CON'T.

- If ValueOptions receives a request for breast surgery, the request should be forwarded to the prior approval section at HP Enterprise Services.
- Should HP Enterprise Services receive a request for physical therapy, the request should be forwarded to CCME.



# INAPPROPRIATE PA REQUESTS RECEIVED BY VENDORS CON'T.

- Should a vendor receive a request for Medicaid Personal Care Services (PCS) for a recipient **under 21 years of age**, the request should be forwarded to DMA, PCS Nurse Consultant.

# REQUESTING PA FOR A NON-COVERED STATE MEDICAID PLAN SERVICES

- Requests for non-covered state Medicaid plan services are requests for services, products, or procedures that are not included at all in the North Carolina State Medicaid Plan **but coverable** under federal Medicaid law, 1905(a) of the Social Security Act for recipients under 21 years of age.

# REQUESTING PA FOR A NON-COVERED STATE MEDICAID PLAN SERVICES

CON'T.

- Requests for non-covered state Medicaid plan services and requests for a review when there is no established review process for a requested service should be submitted to:

Assistant Director for Clinical Policy and Programs

Division of Medical Assistance

2501 Mail Service Center

Raleigh, NC 27699-2501

FAX: 919-715-7679



# Requesting PA For Non-Covered State Medicaid Plan Services CON'T.

- Requests for Medicaid prior approval of DME, orthotics and prosthetics, and home health supplies that do not appear on DMA's lists of covered equipment should be submitted to the Assistant Director, DMA.



# SERVICES FORMERLY PROCESSED BY CHILDREN'S SPECIAL HEALTH SERVICES



- Oral Nutrition

Formula that does not appear on the DMA fee schedules should be sent as an EPSDT request to:

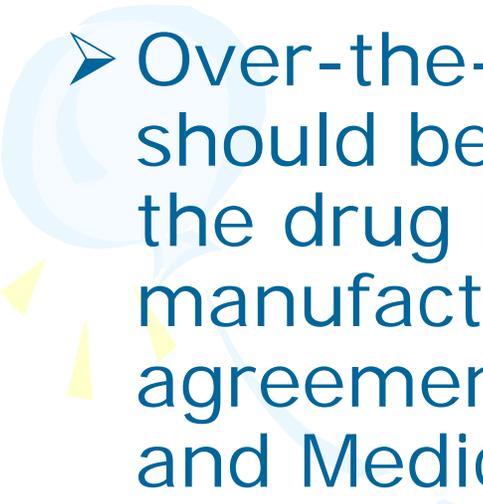


Assistant Director  
Clinical Policy and Programs



# SERVICES FORMERLY PROCESSED BY CHILDREN'S SPECIAL HEALTH SERVICES

CON'T.

- 
- Over-the-counter (OTC) medications should be sent to the Assistant Director if the drug has an NDC number and the manufacturer has a valid rebate agreement with the Centers for Medicare and Medicaid Services (CMS) **but** the drug does not appear on DMA's approved coverage listing of OTC medications.



# **SERVICES FORMERLY PROCESSED BY CHILDREN'S SPECIAL HEALTH SERVICES CON'T.**

Effective with date of request September 1, 2008, Children's Special Health Services no longer authorizes payment for ramps, tie downs, car seats, and vests.

These items are not included in the durable medical equipment covered by Medicaid, nor are they covered under Early Periodic Screening, Diagnostic, and Treatment services, which cover medical equipment and supplies suitable for use in the home for Medicaid recipients under the age of 21. However, if the recipient is covered under a Medicaid waiver, these items may be considered.

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# DOCUMENTATION REQUIREMENTS

Documentation for either covered or non-covered state Medicaid plan services should show how the service will correct or ameliorate a defect, physical or mental illness, or a condition [health problem].

This includes:

- documentation showing that policy criteria are met;
- documentation to support that all EPSDT criteria are met;
- evidence-based literature to support the request, if available.

Should additional information be required, the provider will be contacted.



# DOCUMENTATION REQUIREMENTS

CON'T.

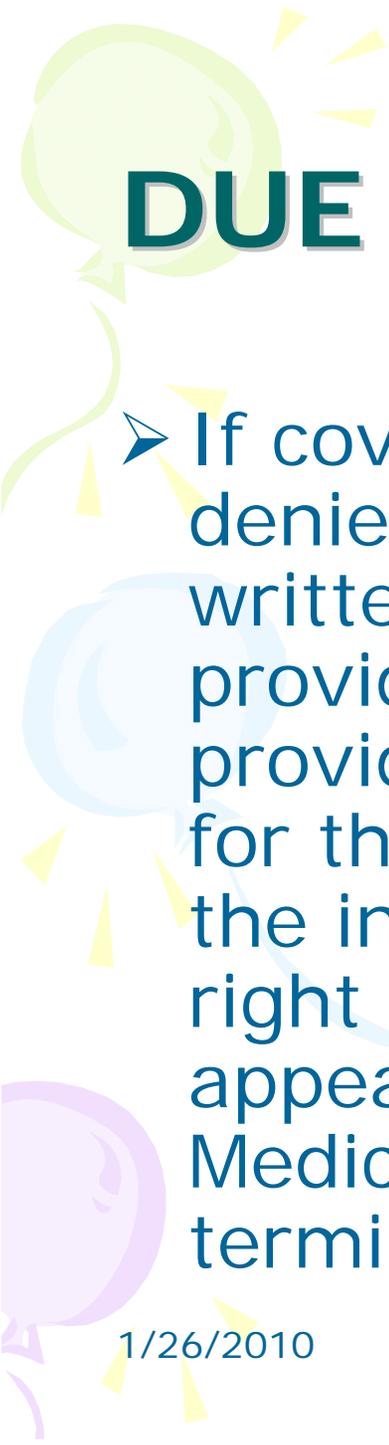
- Requests for non-covered state Medicaid plan services may be submitted on the Non-Covered State Medicaid Plan Services Request form for Children under 21 Years of Age.
- This form is located on the DMA website:

**<http://www.ncdhhs.gov/dma/provider/forms.htm>**



# DUE PROCESS PROCEDURES

- Requests for prior approval of covered and non-covered state Medicaid plan services are to be decided with reasonable promptness, usually within 15 business days. **No request for services for a recipient under 21 years of age will be denied, formally or informally, until it is evaluated under EPSDT.**



# DUE PROCESS PROCEDURES

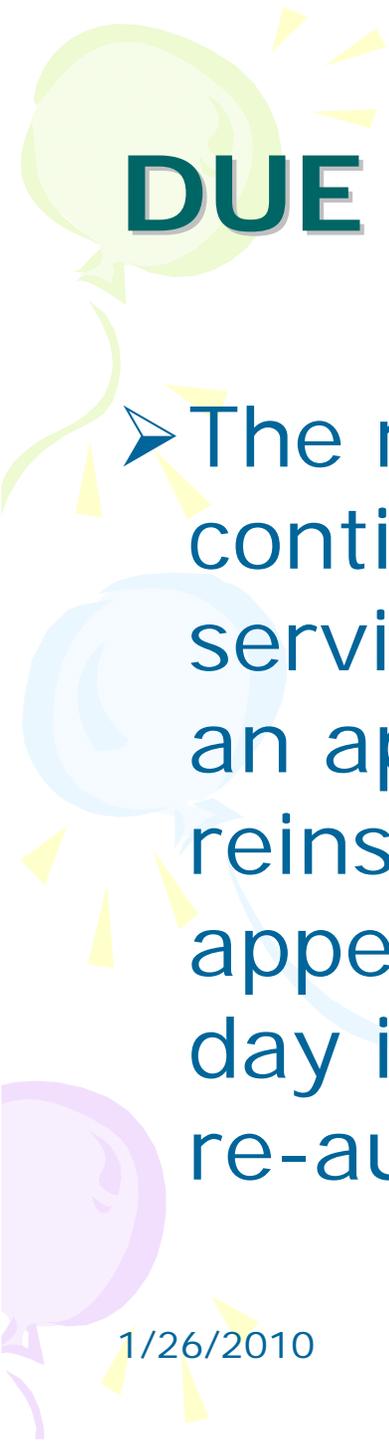
CON'T.

- If covered or non-covered services are denied, reduced, or terminated, proper written notice with appeal rights must be provided to the recipient and copied to the provider. The notice must include reasons for the intended action, law that supports the intended action, and notice of the right to appeal. Such a denial can be appealed in the same manner as any Medicaid service denial, reduction, or termination.

# DUE PROCESS PROCEDURES

CON'T.

- Effective date of the notice:
  - **Initial Request**—date notice mailed
  - **Concurrent Request**—**10 days** from date notice mailed
  
- The recipient has **30 days** from the date the notice was mailed to file an appeal with the Office of Administrative Hearings.
  
- Providers, in consultation with DMA and/or its vendors, should reduce or terminate services based on type of request and whether or not an appeal was filed.



# DUE PROCESS PROCEDURES

CON'T.

- The recipient has the right to continued Medicaid payment for services currently provided pending an appeal. This includes the right to reinstatement of services pending appeal if there was less than a 30 day interruption before submitting a re-authorization request.

# DUE PROCESS PROCEDURES

CON'T.

- Unless there is a change in the request or the recipient's clinical status, providers should not submit service requests for the service under appeal.
- Maintenance of service is in effect for the pendency of the appeal.

# DUE PROCESS PROCEDURES

CON'T.

- When a recipient appeals a reduction or termination of current services, continue the appealed service at the previous level or the level requested by the provider, whichever is lower. If DMA is notified by the Office of Administrative Hearings that an appeal has been requested, the provider will be instructed to reinstate (or do not terminate/reduce) the service. Continue the service until notified about the outcome of the appeal.

# DUE PROCESS PROCEDURES

CON'T.

- Providers must continue to follow all service provision requirements (including all applicable state and federal rules and regulations).
- Providers can **submit a request for a new amount of the same service** or a new request for different services during the appeal.



# DUE PROCESS PROCEDURES

## CON'T.

The following are **NOT** acceptable reasons for denial of coverage under EPSDT:

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- "This is the responsibility of the school system."
  - "Close supervision, redirection, safety monitoring, assistance with mobility and other ADL's, improving socialization and community involvement, and controlling behavior are not service goals covered under EPSDT."
  - "The services would not correct or improve the child's diagnosis."



# DUE PROCESS PROCEDURES CON'T.

## Unacceptable denial reasons for EPSDT coverage:

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- "EPSDT criteria do not include monitoring a child's actions for an event which may occur."
  - "EPSDT services are not long term or ongoing."
  - "Teaching coping skills cannot be covered under EPSDT."

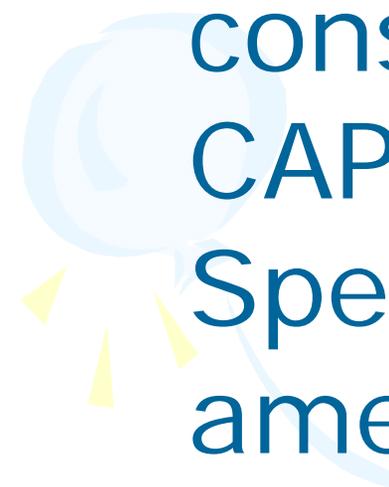


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# DUE PROCESS PROCEDURES

CON'T.

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- CAP appeals will be considered under both the CAP criteria **AND** EPSDT. Specifically, the definition of amelioration is in effect and must be applied to pending appeals.
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# OUTREACH

- A special mailing, addressing EPSDT and how to request EPSDT services, will be distributed to recipients and their legal representatives.
- This policy instruction shall be posted at both DMA and DMH websites.



# EPSDT WEBSITES

➤ **Basic Medicaid Billing Guide**

<http://www.ncdhhs.gov/dma/basicmed/>

➤ **Health Check Billing Guide**

<http://www.ncdhhs.gov/dma/healthcheck/index.htm>

➤ **EPSDT Provider Page**

<http://www.dhhs.state.nc.us/dma/provider/epsdthealthcheck.htm>

# EPSDT Provider Website



DMA SERVICES

FOR COUNTY STAFF

For Providers

STATISTICS AND REPORTS

DMA HOME

Medicaid Providers

- A-Z Provider Topics
- Calendars
- Claims
- Community Care (CCNC/CA)
- Contacts for Providers
- Enrollment
- EPSDT and Health Check**
- Fee Schedules/Cost Reports
- Forms
- Fraud and Abuse
- HIPAA
- Library (bulletins, policies)
- National Provider Identifier
- Programs and Services
- Seminars

ABOUT DMA

DHHS > DMA > Medicaid Providers > EPSDT and Health Check

## EPSDT and Health Check

### EPSDT

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is the federal law that says Medicaid must provide all medically necessary health care services to Medicaid-eligible children. The services are required even if the services are not normally covered by children's Medicaid. [More EPSDT Information](#)

[EPSDT and Health Check Information for Consumers](#)

### Health Check

The Health Check program facilitates regular preventive medical care and the diagnosis and treatment of any health problem found during a screening. [More Health Check Information](#)

### EPSDT and Health Check Quick Links

- [EPSDT Policy Instructions \(updated November 24, 2008\)](#)
- [Health Check Billing Guide, April 2009](#)
- [Health Check Coordinator Directory](#)
- [Non-Covered State Medicaid Plan Services Request Form for Recipients under 21 Years of Age \(updated January 2009\)](#)