

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



## MEDICAID FOR CHILDREN

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# 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/EPSTD Overview

- **Early and Periodic Screening, Diagnostic, and Treatment (EPSTD)** defined by federal law and includes:
  - Periodic Screening Services
  - Vision Services
  - Dental Services
  - Hearing Services
  - Other Necessary Health Care

# EPSDT Overview CON'T.

- Recipients under 21 must be afforded access to the full array of EPSDT services within the scope of the category of services listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act]. Please refer to handout for a listing of these 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.

# 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

# 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 Over 21 Years of Age
- Coverage for Services Not Listed in the N.C. State Medicaid Plan

# 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.
- 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. 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.
- 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.

- 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 Coverage And CAP Waivers

- CAP Waiver services are available only to participants in the CAP waiver programs and are not a part of the EPSDT benefit.
- 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.
- 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 is eligible for necessary EPSDT services without any waiting list being imposed.
- 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 and **may be provided in the school setting, including to CAP-MRDD recipients.**

# 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. **Only DMA and its contractors can determine if a Medicaid recipient meets criteria for a covered Medicaid 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 the LME if the LME is handling PA in their catchment area.

# 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.

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

# Requesting PA For A Covered State Medicaid Plan Service

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 Service

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 Service

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 Service 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 Service 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 EDS using the Certificate of Medical Necessity/Prior Approval (CMN/PA form).

Augmentative and Alternate Communication Devices should be sent to EDS.

# **Covered Services Previously Processed by Children's Special Health Services (CSHS) CON'T.**

**Cochlear/Auditory Brainstem  
Implants 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.

# Inappropriate PA Requests Received By Vendors

- Vendors (EDS, ACS Pharmacy, CCME, and 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.

# Requesting PA For 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 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**

Non-covered services previously reviewed by Children's Special Health Services (CSHS) were transferred to DMA July and August 2008.

Only the requests for those services listed below should continue to be sent to the Assistant Director, Clinical Policy and Programs, DMA.

- Oral Nutrition (excludes metabolic formula) that does not appear on the DMA fee schedules should be sent to the Assistant Director, Clinical Policy and Programs.

# SERVICES FORMERLY PROCESSED BY CHILDREN'S SPECIAL HEALTH SERVICES

CON'T.

- Over-the-Counter (OTC) Medications  
The OTC 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.

# Documentation Requirements

- Documentation for either covered or non-covered state Medicaid plan services (medical, dental, or MH/DD/SA) should show how the service will correct or ameliorate a defect, physical or mental illness, or a condition [health problem].
- This includes a discussion about how the service, product, or procedure will correct or ameliorate (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) as well as the effectiveness and safety of the service, product, or procedure. 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, citation 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.

- The recipient has **30 days** from the date the notice was mailed to file an appeal with the Office of Administrative Hearings.
- If the recipient does not file an appeal, the determination to deny, reduce or terminate the service becomes effective on the **30<sup>th</sup> day**.
- Providers, in consultation with DMA and/or its vendors, should reduce or terminate services.

# Due Process Procedures CON'T.

- The recipient has the right to continued Medicaid payment for services currently provided pending an informal and/or formal 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.

- 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 obtaining reauthorizations for continuing services and all applicable state and federal rules and regulations).
- Providers can submit new requests for different services during the appeal.

# Due Process Procedures CON'T.

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

- "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.

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

- "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."

# EPSDT Websites

- **Basic Medicaid Billing Guide**

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

- **Health Check Billing Guide**

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

- **EPSDT Provider Page**

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



NC Department of Health and Human Services

# NC Division of Medical Assistance

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  
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Quick Links  
Clinical Coverage Policies

DHHS > DMA > Medicaid Providers > EPSDT and Health Check > EPSDT

## 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.

Together, [Health Check](#) and EPSDT provide for the complete care of children and youth in Medicaid.

### EPSDT Quick Links

- [EPSDT Policy Instructions \(updated November 24, 2008\)](#)
- [Non-Covered State Medicaid Plan Services Request Form for Recipients under 21 Years of Age \(updated January 2009\)](#)
- [Basic Provider EPSDT Training](#)
- [Comprehensive Provider EPSDT Training](#)

### What Treatment Services are Covered?

Services must be ordered by the child's physician or another licensed clinician. Prior approval from the Division of Medical Assistance may be required to verify medical necessity for some services.

The services must meet all of the conditions stated below:

1. The service must be medically necessary to correct or ameliorate a defect, physical or mental illness or a condition that is identified through a screening examination