Early and Periodic Screening, Diagnostic & Treatment Benefit (EPSDT)
OHP Comprehensive Child and Youth Benefit

CCO Guidance Document

HEALTH SYSTEMS DIVISION

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Early & Periodic Screening, Diagnosis and Treatment (EPSDT)

This guide is to assist coordinated care organizations (CCOs) in their implementation of expanded coverage of EPSDT services (the Oregon Health Plan's comprehensive child and youth benefit) effective January 1, 2023.

What is EPSDT?

EPSDT is a benefit that provides comprehensive and preventive health care services for children and youth under age 21 who are enrolled in Medicaid and the Children's Health Insurance Plan (CHIP). States are required to provide comprehensive services and furnish all Medicaid coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions, based on certain federal guidelines. **In Oregon, EPSDT constitutes the child and youth benefit within the Oregon Health Plan.**

- **Early:** Assessing and identifying problems early
- **Periodic:** Checking children's health at periodic, age-appropriate intervals
- **Screening:** Providing physical, mental, developmental, dental, hearing, vision and other screening tests to detect potential problems
- **Diagnostic**: Performing diagnostic tests to follow up when a risk is identified and
- **Treatment:** Control, correct or ameliorate (make more tolerable) health problems found.

The Centers for Medicare and Medicaid Services (CMS) requires that states follow a periodicity schedule for children's services. Oregon uses the Bright Futures periodicity schedule.

EPSDT is governed by the following regulations:

- Oregon Administrative Rule 410-130-0245 – Early and Periodic Screening, Diagnostic and Treatment Program
- Code of Federal Regulations 42 CFR § 441 Subpart B – Early and Periodic Screening, Diagnostic and Treatment (EPSDT) of Individuals Under Age 21

OHA's EPSDT webpage can be found here.

Background

The Oregon Health Plan has historically covered most EPSDT services. However, Oregon's 2017-2022 1115(a) Medicaid waiver and prior waivers allowed the state to "restrict coverage of treatment services identified during an EPSDT screening for individuals above age 1 to the extent that such services are not consistent with a prioritized list of conditions and treatments." Through public comment and community dialogue during the 1115(a) Medicaid waiver renewal process in 2021-2022, OHA received clear feedback from the community including advocates, children's service organizations and other interested parties that the 2017-2022 waiver regarding EPSDT was preventing children from receiving medically necessary services.

After careful consideration of community input and a comprehensive internal review, OHA decided not to seek renewal of the waiver regarding EPSDT. **At the direction of the Centers for Medicare & Medicaid Services (CMS), Oregon must meet all EPSDT benefit requirements for children and adolescents beginning January 1, 2023.**

Covering EPSDT services for children from birth until their 21st birthday will increase access to the full breadth of preventive, developmental, dental, mental health, and specialty services so that Oregon's children and youth are supported holistically in their education, growth, development, and health.

Expanding the scope of EPSDT services for OHP members under age 21 requires significant systems changes at the Oregon Health Authority and in each Coordinated Care Organization. OHA recognizes that the transition will require ongoing work to identify and address areas for improvement.

Child and Youth Benefit Coverage Expansion

EPSDT is a comprehensive child and youth health care benefit for OHP members ages birth to 21 (EPSDT coverage ends when a person turns 21).[1] **This includes physical, dental, behavioral health, and pharmacy services.**

Beginning January 1, 2023, OHP must cover any medically necessary and medically appropriate services for enrolled children and youth until their 21st birthday, regardless of:

- The location of the diagnosis on the Prioritized List of Health Services.
- Whether it pairs or is a non-pairing service.
- Whether it is a historically non-covered ancillary service.
- Whether it is covered under the State Plan.

[1] Although EPSDT is a federal *Medicaid* benefit, OHA applies the same EPSDT requirements to members ages birth to 21 who have *non-Medicaid* funded OHP-equivalent benefits. This includes individuals enrolled in the Healthier Oregon Program or HOP. The EPSDT requirements are identical in CCOs' Medicaid and non-Medicaid contracts.

Services and items which do not have a Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code are not required to be covered under EPSDT at this time.

The Prioritized List remains a guidance tool for identifying services that may require documentation of medical necessity and medical appropriateness (and dental appropriateness, if applicable) for members under age 21. The Prioritized List cannot, however, be used as the basis for denying services under EPSDT or referenced in Notices of Adverse Benefit Determination (NOABD)as a denial reason.

The Health Evidence Review Commission (HERC) has recently reviewed previously non-covered services with the unique needs of children and youth in mind and continues to make updates to the Prioritized List to minimize the need for individual reviews prior to approval of services. Please see Appendix A for a summary of these updates to the Prioritized List.

Coverage requirements for CCOs:

Beginning January 1, 2023, CCOs and OHA must cover all medically necessary and medically appropriate[2] services for members under age 21, regardless of pre-set limits or guidelines.

- All services for members under age 21 must be:
  - Approved; or
  - Reviewed individually for medical necessity and medical appropriateness (or dental appropriateness, for a dental service) **prior** to denial[3]

The Oregon Department of Justice advises, and federal guidance supports, that review of previously not covered services prior to denial is required by the federal EPSDT benefit. Other states' systems and processes for approving or denying EPSDT services rely upon individual review of medical necessity and medical appropriateness to comply with the federal EPSDT benefit.

These requirements are effective January 1, 2023. Full implementation is expected by the end of Q1 2023. Compliance will be monitored through the quarterly Exhibit I Notice of Adverse Benefit Determination (NOABD) sample evaluation beginning with the Q2 2023 submissions.

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[2] Medically Necessary, Medically Appropriate, and Dentally Appropriate are defined in Oregon Administrative Rule 410-120-0000.

[3] Claims with clerical errors such as incorrect entries of diagnostic codes and other incorrectly entered factual information may be denied without first conducting an individual review for medical necessity and medical appropriateness.

CCOs and OHA cannot:	CCOs and OHA can:
Deny a service or claim solely because it is below the funding line, non-pairing, or a historically "non-covered" ancillary service. This includes automatic denial by claims processing systems of services that have historically not been covered.	Deny a claim for administrative errors such as incorrect entries of diagnostic codes and other incorrectly entered factual information **without** first conducting an individual review for medical necessity and medical appropriateness.
Deny a claim solely due to a lack of chart notes or other documentation of medical necessity and medical appropriateness (see footnote regarding requesting the documentation if it is not received with the claim).[4]	Deny a service or claim if it is not medically necessary and medically appropriate (or dentally appropriate, for a dental service) for the child/youth, based on individual review of clinical documentation.
Require prior authorization for all historically non-covered services (for example, those below the line on the Prioritized List) solely as a way to operationalize EPSDT coverage expansion (see more information below).	Choose to automatically approve previously not covered services without a review for medical necessity and medical appropriateness.
Require prior authorization for any EPSDT screening services.	Use the Prioritized List as a guidance tool but not a denial tool.

Prior authorization (pre-service review) cannot be required for any EPSDT screening services. Additionally, under EPSDT, prior authorization cannot be used as an administrative tool solely to manage operational processes. For example, it is not consistent with federal EPSDT requirements to require prior authorization for all historically non-covered services for children and youth under 21 solely as a means to operationalize EPSDT coverage expansion.

It is, however, acceptable to use prior authorization as a utilization management tool under EPSDT (for example, to manage services that are high cost, high risk, or new procedures). This also allows OHA and CCOs to establish limits on the number of treatment services a child may receive (for example, 10 physical therapy visits) and require prior authorization for coverage of medically necessary and medically appropriate services above those limits. Utilization management techniques used for mental health and substance use disorders should comply with the Mental Health Parity and Addiction Equity Act.

At this time, OHA is not adding prior authorization requirements to any additional historically non-covered services for EPSDT for the fee-for-service program. For more information about EPSDT processes in the fee-for-service program, see the EPSDT Provider Guide. CCO contract

[4] In the Fee-for-Service program, OHA is encouraging providers to submit clinical documentation with claims for historically non-covered services that do not require prior authorization. If clinical documentation is not received with the claim, OHA will reach out to request the documentation be submitted within 14 days. If documentation is not submitted within 14 days, OHA may then deny the claim. Providers are then asked to re-submit the claim with the appropriate documentation attached. CCOs are encouraged to align with this practice. Please see OHA's EPSDT provider guide for more details. As a reminder, OHA and CCOs can also choose to approve services without a review for medical necessity and medical appropriateness.

requirements around prior authorization processes and timelines are not changing. In 2023, OHA will be updating the Oregon Administrative Rules for EPSDT to align with CMS approved authority; the new rule will include EPSDT-specific prior authorization requirements (reflected in this guidance document) that will take precedence over the general prior authorization process in OAR 410-141-3835.

Dos and don'ts regarding prior authorization (pre-service review):

Dos:

- Prior authorization must be conducted on a case-by-case basis, evaluating each child's needs individually.

Don'ts:

- Prior authorization cannot be required for all historically non-covered services (for example, those below the line on the Prioritized List) solely as a way to operationalize EPSDT coverage expansion.
- Prior authorization procedures cannot delay delivery of needed treatment services and must be consistent with the preventive intent of EPSDT and CCO contract requirements around prior authorization processes and timelines.
- Prior authorization cannot be required for any EPSDT screening services.

There are no required changes to CCOs' medical review processes, within the following parameters:

- CCOs cannot use a definition of medical necessity for children and youth that is more restrictive than the OHA's definition.
    - Medically Necessary, Medically Appropriate, and Dentally Appropriate are defined in Oregon Administrative Rule 410-120-0000.
- The staff member conducting the review needs the proper level of license/certification necessary for the type of decision they are making. If it is a technical denial because the claim is missing a data element there is likely no clinical training needed to decide that. On the other extreme if the decision is highly clinical it may need to be a licensed specialist. Please see Exhibit B, Part 2, Section 3, Paragraph a of the CCO contract for further information.
- Providers should also refer to Statement of Intent 4 on the Prioritized List when making determinations of medical necessity and medical appropriateness for children and youth under 21.
- Providers may not refuse to render or refer care based on Prioritized List placement only or the fact that the service was historically not covered. Determinations must be made based on the child's individual needs.
- OHA has produced a policy change memo for OHP providers and an EPSDT Provider Guide with additional information (this guide focuses primarily on fee-for-service providers but may be a useful resource for CCOs and CCO providers)

- OHA is scheduling provider education sessions for early 2023; registration and recordings will be posted at Oregon.gov/EPSDT

Pharmaceutical reviews for coverage will be aligned with the requirements for individual review of medical necessity and medical appropriateness as required under EPSDT. The following language is being added to the Prior Authorization Request for Medications and Oral Nutritional Supplements (OHP 3978), effective January 1, 2023: "List all applicable diagnosis codes or contributing factors causing or exacerbating a funded condition, including any relevant comorbid conditions or impacts on growth, learning or development." The addition of this language is intended to help facilitate individual reviews as required by EPSDT.

Currently there are no changes regarding School-Based Health Services provided by public school districts for services required by the Individuals with Disabilities Education Act (IDEA). Please see Oregon Administrative Rule 410-141-3565 (8)(D)(h) for more information.

Please note: While CCOs' claims processing systems are being updated to facilitate updated review and approval processes for EPSDT, the following guidelines apply:

- Utilization controls can still be used. However, any established limits on services must be considered tentative pending an individual review for medical necessity and medical appropriateness (or dental appropriateness, as applicable). All medically necessary and medically appropriate services must be covered, regardless of pre-set limits.
- Final denial decisions must be based on case-by-case review of medical necessity and medical appropriateness (or dental appropriateness, as applicable), and the reason for a final denial cannot be solely that the service is below the line, non-pairing, or a non-covered ancillary service.

Communication Requirements for CCOs

Federal guidelines require a combination of face-to-face, written, and oral communication methods designed to inform all EPSDT beneficiaries (or their families/guardians) about EPSDT services. In order to meet this requirement, CCOs will need to:

- Provide information in clear and nontechnical language;
- Make sure information is available to those whose primary language is not English;
- Provide information in alternate formats, including but not limited to braille or sign language; and
- Develop website content for members regarding EPSDT.

Note: OHA EPSDT staff are available to review CCOs' EPSDT web content and other materials upon request. Please refer to the Member materials process to determine if your content needs to be submitted to OHA for approval.

Federal guidelines and CCO contracts require that all EPSDT-eligible members are informed of

EPSDT services and how to access them (this includes pregnant members and foster and adoptive parents).

- New members must be informed within 60 days of enrolling.
  - CCOs meet this requirement by sending member handbooks within 14 days of enrollment.
  - The 2023 CCO Model Member Handbook has been updated to include EPSDT information and is located on the CCO Contract Forms webpage.
  - A fact sheet for OHP members is available on the OHA EPSDT webpage.
- Members must be informed immediately following birth for newborn infants.
- Members who have not used EPSDT services must be re-informed annually.

Communication of EPSDT benefits must include:

- The benefits of preventive healthcare;
- What EPSDT services are available;
- Age of eligibility for services;
- Availability of transportation & scheduling assistance;
- Availability of translation services; and
- That members are able to request a case-by-case review of a denied service/claim.

A fact sheet for OHP members is available in multiple languages at Oregon.gov/EPSDT.

Additional Federal EPSDT Requirements

In addition to required communication about EPSDT services, CCOs are required to:

- Ensure that care is provided in a coordinated way with an emphasis on prevention
- Ensure transportation assistance is received by EPSDT-eligible members who request it
- Ensure scheduling assistance is received by EPSDT-eligible members who request it
- Ensure screening requirements for EPSDT are met by reporting in accordance with and complying with the selected periodicity schedule. In Oregon, this is the American Academy of Pediatrics and Bright Futures Guidelines and periodicity schedule.

Additionally:

- It is required that medically necessary visits outside of Oregon's periodicity schedule be covered. There is an obligation under EPSDT to connect children with necessary treatment. This includes treatment for illness, injury, changes in condition, and other issues not identified in a periodic screening visit.
- CCOs and their Participating Providers should all be culturally competent. This aligns with Oregon requirements that CCOs are required to ensure the provision of culturally and linguistically responsive services and providers in Oregon need to ensure they comply with HB 2011 (2019), which directs specified health care professional boards

to require people authorized to practice the profession regulated by the board to complete cultural competency continuing education.

- CCOs cannot use a definition of medical necessity for children that is more restrictive than the OHA's definition.
  - Medically Necessary and Medically Appropriate are defined in Oregon Administrative Rule 410-120-0000.
- Services under the EPSDT benefit must be provided with reasonable promptness. CCOs meet this requirement by complying with the CCO access to care standards in OAR 410-141-3515.

No Longer Required:
After consultation with CMS, OHA learned that it is not required for a Primary Care Provider (PCP) assignment and member obligations to be assigned and agreed to in writing by the EPSDT member and/or member's family as noted in 42 CFR § 441 Subpart B. Requirements for PCP assignment will remain as currently outlined in CCO contract (Exhibit B, Part 4, Section 2, Paragraph l) and OAR 410-141-3860.

Grievance & Appeal System Requirements

Under Federal EPSDT guidelines, CCOs must follow existing Grievance and Appeal System requirements per 42 CFR 438.400 - 438.424, OARs 410-141-3875 - 410-141-3915, and Exhibit I of the CCO Contract. Per existing Grievance and Appeal System requirements, only OHA approved Member notice templates, inclusive of the required language outlined in the QA Notice Template Evaluation Criteria, may be used when communicating with members about service denials, grievances, and appeals.

Questions, Comments & Concerns

More information can be found at OHA's EPSDT webpage.

For questions or comments regarding this guidance document or EPSDT coverage for OHP members under age 21, please contact EPSDT.Info@odhsoha.oregon.gov.

Please note: OHA will update this guidance as new information, program improvements and/or quality improvement needs are identified.

Resources

- EPSDT fact sheet for OHP members (available in additional languages at Oregon.gov/EPSDT)
- EPSDT Policy Change Memo for Providers
- EPSDT Provider Guide

- Oregon Administrative Rule 410-130-0245 – Early and Periodic Screening, Diagnostic and Treatment Program
- Code of Federal Regulations 42 CFR § 441 Subpart B – Early and Periodic Screening, Diagnostic and Treatment (EPSDT) of Individuals Under Age 21
- Medicaid.gov
  - EPSDT – A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents
- Health Resources & Service Administration - Maternal & Child Health Bureau
- Medicaid and CHIP Payment and Access Commission
- Bright Futures – American Academy of Pediatrics

Appendix A

The following summary encompasses select items reviewed by HERC related to EPSDT and Lines 473-662 of the Prioritized List. Changes listed below are incorporated into the 01/01/2023 Prioritized List unless a later effective date is indicated.

Appendix A

The following summary encompasses select items reviewed by the Health Evidence Review Commission (HERC) related to EPSDT and Lines 473-662 of the Prioritized List. Changes listed below are incorporated into the 01/01/2023 Prioritized List unless a later effective date is indicated.

CODE KEY
Reviewed but no changes planned
Already approved changes

Agenda Item	Meeting Date	Effective Date	Summary of change (or recommended change, decision not to change)	ICD-10 code movement	CPT/HCPCS code movement
Congenital ear anomalies without hearing impairment	10/6/2022	1/1/2023	Added coverage of microtia with a new guideline.	Q17.2 added to Line 406	21086 added to Line 406
Genitourinary with minimal or no treatment required (genital and urinary organs)	10/6/2022	1/1/2023	Minor changes made.	N91.4 and N91.5 added to Diagnostic Workup File (DWF); N93.9 added to Line 423	
Deformities of foot	10/6/2022		Housekeeping changes only.	Q66.90 added to Line 543	
Conduct disorder/impulse disorders (A type of behavior disorder)	8/11/2022	10/1/2022	BHAP recommended adding to funded region	Added to line 420: F63.81, F91.0, F91.1, F91.2, F91.8	
Behavioral health coding	8/11/2022	10/1/2022	Review of social emotional learning codes.		G0396, G0397, G2011 added to DWF; 90846-90853 added to Line 65
Sleep disorders other than sleep apnea (including insomnia)	8/11/2022	**1/1/2024**	Added insomnia above the funding line for cognitive behavioral therapy for insomnia (CBTi). Consider role of medication.		90785, 90832-90838, 90853 added to Line 202
Benign neoplasm of the digestive system (Surgery for an abnormal growth found in the stomach or intestines)	5/19/2022	10/1/2022	Added benign carcinoid tumors to funded region	D3A.010-D3A.019, D3A.092, D3A.094-D3A.096 added to Line 157; D3A.093 added to 214	
Esophageal ulcer and other code clean-up items	3/10/2022	10/1/2022	Added to funded region	D78.02 added to 285; K22.10 added to 56; N96 added to DWF	C9761 added to 49,180,352
Generalized muscle weakness	3/10/2022	10/1/2022	Added to funded region	M2.81 added to 71,292,345,377	
Handicapping malocclusion	11/18/2021	1/1/2023	Added coverage of HCM with a revised guideline; implementation issues underway	Added to Line 256: K00.1-K00.9, M26.211-221, M26.23-29, M26.31-37, M26.4, M26.70, Z46.4; D7298-D7300 to Lines 42,356,300	
Dorsal rhizotomy	3/10/2022	10/1/2022	Added to funded region		63185 and 63190 added to line 185
Corneal abcess	3/10/2022	10/1/2022	Added to funded region	H16.311-319 added to 244	
Lichen planus	3/12/2020	10/1/2022	Change name of line to reflect mild/moderate; severe forms on funded line as defined by Guideline Note 21	n/a	
Mastoiditis	3/12/2020	10/1/2022	Added to funded region	H70.10-13 added to 170; H70.90-93 added to 170	
Nightmare disorder	11/18/2021	1/1/2022	Added to funded region	F51.5 added to line 173	
Oral candidiasis (thrush)	8/12/2021	10/1/2021	Added to funded region for feeding problems in newborns line	B37.0 added to line 18	
Phimosis (acquired penile complications, circumcision etc)	10/7/2021	1/1/2022	Clarified coverage criteria for acquired vs congenital anomalies of the penis. Added to funded region for acquired anomalies.	N48.83 and N48.89 added to line 424;	54162 added to line 424
Polydactyly	3/12/2020	10/1/2022	Clarified earlier decision to confirm in funded region	Q69.9 added to line 359	

Agenda Item	Meeting Date	Effective Date	Summary of change (or recommended change, decision not to change)	ICD-10 code movement	CPT/HCPCS code movement
Rhinoplasty/septoplasty/ deviated septum	8/12/2021	10/1/2022	Created new criteria for septoplasty, clarified conditions for coverage in new guidelines (118 and 216). Some new coverage and new limitations for services that would be cosmetic.	n/a	
Selective mutism	11/18/2021	1/1/2022	Moved to funded anxiety line	F94.0 added to line 414	
Sjogren syndrome	3/10/2022	10/1/2022	Added to funded region	M35.00 added to 330	
Tendon and ligament injuries	3/10/2022	10/1/2022	Added to funded region for full tears	S46.001A-S46.009D added to 417; S46.091A-S46.999D to 376; S56.001A-S56.899D to 376; S66.001A-S66.599D to 376; S76.091A-S76.399D; S86.001A-S86.399D; S96.001A-S96.299D to 376	
Viral endocarditis, myocarditis, pericarditis, cardiomyopathy	3/10/2022	10/1/2022	Added to funded region	B33.20-B33.24 added to 81	
Vitiligo	10/7/2021	1/1/2022	Added vitiligo as a funded condition. Affects children's social function	L80 added to Line 426	
Acquired torsion of penis	3/10/2022	10/1/2022	Added to funded region	N48.82 added to 424	
Child growth and development	11/18/2021	1/1/2022	Added path to coverage for treatments supporting growth, development and participation in school for children	No code changes; created SOI 4	
Vitiligo of eyelid	3/10/2022	10/1/2022	Added to funded region	H02.731-H02.739 added to 426	
Congenital anomalies of knee (Knee problems since birth)	10/6/2022	n/a	No change made.		
Temporomandibular Joint Syndrome (TMJ) (Pain and dysfunction in the jaw joint and muscles controlling jaw movement)	8/11/2022		Review evidence; no change recommended at this time		
Physical therapy for minor musculoskeletal conditions (Injuries and disorders that affect the human body's movement or muscles, tendons, ligaments, nerves, discs, blood vessels, etc.)			Limited benefit; would be very difficult to implement		
Allergic rhinitis (Nasal allergies/Hay fever)			No change; little impact on health except when comorbidity or growth/development/school exceptions apply		
Angiodema (Swelling (edema) of the lower layer of skin and tissue just under the skin)	11/18/2021	1/1/2022	Removed unfunded duplicate line (no substantive change, was already covered)		
Benign bone neoplasm			No change made; serious benign neoplasms are on line 401; Guideline 137 clarifies which are covered.		
Congenital anomalies of female genital tract excluding vagina			No change: Diagnoses on this line have no treatment. Other anomalies that require repair are on funded line(s)		
Dermatophytoses (ringworm, etc.)			No change; primary care and preferred medications should be sufficient for these conditions		
Diaper rash			No change: Primary care and preferred medications (nystatin) should be sufficient		

Agenda Item	Meeting Date	Effective Date	Summary of change (or recommended change, decision not to change)	ICD-10 code movement	CPT/HCPCS code movement
Dysmenorrhea			No change; primary care and preferred medications (NSAIDS, birth control) should be sufficient for these conditions		
Hodeolum/chalazeon			No change; primary care and preferred meds should be sufficient for these conditions. Rare exceptions can be considered through existing processes		
Mild eczema			No change; primary care and preferred medications should be sufficient for these conditions		
Mild psoriasis			No change; primary care and preferred medications should be sufficient for these conditions		
Minor burns			No change: Primary care and preferred medications should be sufficient		
Pica (Persistent eating of non-food items (for example clay, wool, lead, wood) at an age when it is considered to be developmentally inappropriate)	3/10/2022	10/1/2022	No change: Removed ambiguity of coverage for pica in children (should have already been in funded region), renamed line to clarify that the unfunded line is "Pica in adults"		
Symptomatic urticaria			No change; primary care and preferred medications should be sufficient for these conditions		
Angiosarcoma of liver; intrahepatic bile duct carcinoma			Liver angiosarcoma has a very poor prognosis with any treatment (6 months even with surgery). Per NIH, the only treatment of bile duct carcinoma is palliative care		
Central retinal artery occlusion			Reviewed; no effective treatment is available		
Conversion disorders F44.4-7, include non-epilectic seizures			Cognitive behavioral therapy would be available with another underlying disorder such as depression. No other treatment for actual disorder indicated		
Cysts of Bartholin's gland and vulva			N75.1 (Abscess of Bartholin's gland) is included on line 205. Cysts typically have no symptoms and do not need treatment		
Enophthalmos			Treatment is directed at underlying diseases, which appear in funded region		
Infectious mononucleosis			Primary care should be sufficient; there is no treatment for this condition		
Miscellaneous rare congenital anomalies			Individual consideration will be required		
Nasal polyps			and saline. Surgery indicated if causing chronic sinusitis due to blockage of sinus ostia (would be covered on chronic sinusitis line)		
Personality disorders			No effective treatment		
Secondary and ill-defined neoplasms			Treatment should be targeted to primary cancer, which would be covered.		
Thrombosed and complicated hemorrhoids			Generally treated with fiber and observation. Could be addressed based on individual review		
Tension headaches			Primary care and NSAIDs are effective treatments.		