Services to OHP Children and Youth: Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

Oregon Health Authority

HEALTH SYSTEMS DIVISION

Coverage, authorization and billing for EPSDT services

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Oregon HEALTH PLAN

Contents

Introduction

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for Medicaid and CHIP-enrolled children under age 21. In Oregon, EPSDT constitutes the Oregon Health Plan benefit for children and youth under age 21. An EPSDT fact sheet for OHP members is available on OHA's EPSDT web page.

States are required to provide comprehensive medically appropriate and medically necessary services needed to correct and ameliorate health conditions, based on certain federal guidelines, to all Medicaid-enrolled children and youth under age 21. This coverage includes physical, dental, behavioral health and pharmacy services. Compliance with these federal guidelines is required for both fee-for-service (FFS, also known as "open card") OHP members and coordinated care organizations (CCOs) for CCO-enrolled OHP members.

- **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.

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.

This guide describes the change to EPSDT policy and coverage with which both CCOs and OHA must comply. Further, this guide describes **the specific billing and prior authorization processes that apply to members with fee-for-service (open card) OHP.**

About this guide

Effective January 1, 2023, OHA and the CCOs cover the full scope of EPSDT services. This guide provides information about services that were previously not covered, that are now eligible for coverage for OHP members under age 21.

This guide is for health care clinicians and providers to:

1. Understand the change to EPSDT policy as required by federal regulations for both OHA and CCOs, and
2. Learn how to seek approval and reimbursement for medically necessary and medically appropriate EPSDT services provided to OHP FFS (open card) members, including how to:
   - Request prior authorization from OHA for services that require them

- Bill OHA for EPSDT services
- Submit documentation for post-service review
- Document care that is medically necessary and appropriate

OHA recognizes that many providers serve both CCO members and FFS (open card) members, and that this adds complexity to implementation. Providers serving CCO members should consult the specific CCO for its procedures for billing and reimbursement.

OHA and CCOs must:

- Comply with the EPSDT policy change and coverage requirements, effective January 1, 2023 (described in Background, below)
- Ensure that services to OHP members under age 21 are **not** denied without an individual review for medical necessity and medical appropriateness, except in cases where a technical review identifies an error such as information entered incorrectly.
- Abide by a definition of medical necessity and medical appropriateness that is not more restrictive than that listed in Oregon Administrative Rule 410-120-0000
- Follow the Bright Futures periodicity schedule.
- Follow guidance for the application of prior authorization to EPSDT services (currently under development).

CCOs and OHA may differ in:

- Prior authorization procedures
- Billing procedures

Regardless of procedural differences, coverage for EPSDT services must be consistent across CCOs and OHA: All medically necessary and medically appropriate services must be covered for OHP-enrolled children and youth until their 21st birthdays.

Provider types

This guidance is for anyone who renders, refers, or seeks approval for EPSDT services for OHP members under age 21, including but not limited to:

- Pediatricians, family physicians and internal medicine physicians
- Physician assistants, nurse practitioners and other advanced practice practitioners
- Behavioral health providers
- Dentists and other oral care providers
- Therapists (physical therapy, occupational therapy, speech-language pathology)
- Naturopathic doctors
- Chiropractors
- Specialists and other clinicians and teams who serve children and youth
- Office staff who prepare and submit bills and documentation

For providers serving fee-for-service (open card) members:

To facilitate prompt processing of claims and prior authorization requests, please ensure you provide OHA with updated contact information for the contact(s) who can provide

documentation of medical necessity and medical appropriateness.

- You can update your contact information by contacting Provider Enrollment at 1-800-336-6016, Option #6 or provider.enrollment@odhsoha.oregon.gov.

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.**

OHA hopes this guide helps providers understand and implement this change to help OHP-covered children, youth and families access the broad range of healthcare services available to them under this benefit.

Expanding the scope of EPSDT services for OHP members under age 21 requires significant systems changes at OHA and in each CCO. OHA aims to implement these changes with minimal disruption and recognizes that the transition will require ongoing work to identify and address areas for improvement. To improve communication and collaboration between OHA and providers throughout the process, we encourage providers to ensure they have updated their contact information as described above.

Additional resources

More information can be found at OHA's EPSDT web page and these resources:

- EPSDT fact sheet for OHP members
- Medicaid.gov
- EPSDT – A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents
- Health Resources & Service Administration - Maternal & Child Health Bureau
- Bright Futures periodicity schedule

Questions, comments and concerns

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.

If you have concerns with patient access to services, please reach out to one of the following contacts:

- OHP Client Services Unit 1-800-273-0557
  - Email: OHP.ComplaintResolution@odhsoha.oregon.gov
- OHA Ombuds Program OHA.OmbudsOffice@odhsoha.oregon.gov
  - Phone: 1-877-642-0450 (message line only)

Covered services and coverage criteria

Under EPSDT, OHP covers any medically necessary and medically appropriate service for enrolled children and youth until their 21st birthday.

EPSDT services are covered for OHP Plus members ages birth to 21. Members transition to adult coverage when they turn 21.

CMS requires states to follow a periodicity schedule for children's services. Oregon uses the Bright Futures periodicity schedule.

The Prioritized List and EPSDT

Services under the funding line of the Prioritized List of Health Services are generally not covered for adults but **beginning January 1, 2023, they must be covered for OHP members under 21 when medically necessary and medically appropriate.** Examples of services that may now be covered, include but are not limited to:

- Treatment of acne in some cases that affect child growth, development, and participation in school.
- Treatment of some tendon and ligament injuries.
- Treatment for conduct disorder and oppositional defiant disorder for children 18 or under.
- Orthodontic treatment for handicapping malocclusion. Prior authorization criteria that address this condition specifically will be available no later than January 1, 2023.
- Ancillary services that were previously not covered, such as durable medical equipment when determined to be medically necessary and medically appropriate.

The Health Evidence Review Commission (HERC) continues to review clinical evidence and make updates to the Prioritized List to minimize the need for individual reviews prior to approval of services. 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. It cannot, however, be used to deny services under EPSDT.

- Medically Necessary, Medically Appropriate and Dentally Appropriate are defined in Oregon Administrative Rule 410-120-0000 (146) and (147).
- 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 age 21.

Please refer to the steps outlined in this document to submit documentation justifying/explaining how the service is medically necessary and appropriate (or dentally appropriate, in the case of a dental service). It is important that providers:

- Do not refuse to render or refer for care based on Prioritized List placement, and
- Know that medically necessary and medically appropriate services must be covered, regardless of pre-set limits or guidelines.

To learn more, see the Prior Authorization and Billing sections of this guide. For CCO-enrolled members, consult the specific CCO for its procedures for billing, authorization, and reimbursement.

Fee-for-service pharmaceutical reviews will follow EPSDT requirements for individual review of medical necessity and appropriateness for services that were previously not covered. More information about pharmacy prior authorization requests can be found in the Prior Authorization section.

Related rules and laws

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

Prior authorization

OHA's processes for reviewing prior authorization requests for fee-for-service (Open Card) members are not changing. OHA is working to develop guidance for which EPSDT services should require prior authorization.

EPSDT screening services may not be subject to prior authorization requirements.

For CCO-enrolled members, consult the specific CCO for its procedures for medical review and authorization.

Process overview

OHA uses the Medical Management Review (MMR) process to determine fee-for-service reimbursement of services requiring prior authorization. The MMR process includes clinically trained staff with subject matter expertise who review requests for medical necessity and appropriateness.

Upon review of all submitted documentation, OHA will approve or deny the request. For approvals, OHA will approve for the level of care or type of service that meets the patient's medical need. For sample provider notices, please see the Prior Authorization Handbook.

How to submit prior authorization requests

You can submit requests in two ways.

- **The most efficient and effective submission pathway is the MMIS Provider Portal at https://www.or-medicaid.gov.** If you need assistance using the Provider Portal, please contact the Prior Authorization hotline: (800) 336-6016, option 3.

  or

- Fax the ODHS/OHA Prior Authorization Request Form (MSC 3971) under a **completed EDMS Coversheet (**MSC 3970) to OHA. The coversheet lists two fax numbers. Select the appropriate number depending on urgency of the request.

For all requests, submit clinical documentation to OHA as listed below.

Document	Required information/criteria
EDMS Coversheet (MSC 3970)	■ Submit the PA request with the EDMS Coversheet
Completed PA request (MSC 3971 or the Provider	■ The requesting provider's NPI ■ PA assignment code

Document	Required information/criteria
Web Portal PA request)	■ Member's Oregon Medicaid ID number ■ Primary diagnosis code ■ Secondary diagnosis code(s), as appropriate ■ CPT code(s) requested ■ Number of units requested ■ The performing provider's NPI ■ Date of request ■ Expected service start and end dates
Supporting medical documentation	■ For example, diagnostic testing reports, chart notes, and other objective data. ■ Demonstrate "least costly alternative" to meet medical necessity and appropriateness by including documentation of alternatives considered or trialed and why the alternatives are not appropriate.
Signed letter of medical necessity from the treating practitioner	■ Required when making a request for approval by exception of current rules and guideline notes. ■ Summarizes why the service is medically necessary and medically appropriate for this individual and why the service or item is the 'least costly alternative.' ■ For treatment of comorbid conditions, explains how the service meets the criteria described in OAR 410-141-3820(10)(a). ■ Demonstrates the requested codes have been completely evaluated and there are no other paired codes that apply to the patient's situation, as required by OAR 410-141-3820(11).

Required documentation

After review of your request, OHA may ask for additional documentation to determine if the service is medically necessary and medically appropriate (or dentally appropriate, as applicable), as defined in Oregon Administrative Rule 410-120-0000(145)(146).

If your request has missing or inadequate documentation:

You need to provide OHA complete documentation within 30 days of OHA's response. If documentation is not received within 30 days, OHA will automatically deny the request due to missing information. The opportunity to re-submit remains available.

If your request is complete, accurate and timely:

If the documentation demonstrates services are medically necessary and medically appropriate and the service meets coverage criteria, OHA will notify you of approval as soon as possible.

Service denials

For both OHA and CCOs, denials for services to OHP members under age 21 must be because the service is not medically necessary and medically appropriate (or dentally appropriate if a dental service) for that child or youth. Some requests may be denied for missing required documentation as specified above.

For any prior authorization request or claim for OHP members under age 21, OHA and CCOs must:

- Make prior authorization decisions based on case-by-case review of medical necessity and medical appropriateness (or dental appropriateness, in the case of a dental service).
- Provide OHP members written Notice of Action (for FFS) or Notice of Adverse Benefit Determination (for CCOs) when denying a service.
  - The notice must comply with federal requirements as well as those outlined in OAR 410-141-3885 (2) and OAR 410-141-3885 (3). Notices must contain:
    - A statement of the intended action,
    - The specific reasons and legal support for the action,
    - An explanation of the individual's appeal and/or hearing rights, and
    - The member's rights to representation.

Fee for service pharmacy prior authorizations

Providers should submit information supporting medical necessity and medical appropriateness with fee-for-service pharmacy prior authorization (PA) requests for members under 21 years of age. This may include documentation that the member meets the following:

- Drug specific criteria outlined in the Oregon Medicaid Pharmaceutical Services Prior Authorization Criteria. For more information, see the Pharmaceutical Services web page.
- FDA-approved or compendia-supported indication;
- Trial and failure, contraindication, or intolerance to at least 2 preferred products (when available in the PDL class); and
- Documentation that the condition/symptoms are of sufficient severity that it impacts the patient's health. For example, quality of life, function, growth, development, ability to participate in school, perform activities of daily living.

Providers are encouraged to reach out to the **Oregon Pharmacy Call Center at 888-346-0178** with questions.

For prescriptions covered by the member's CCO, contact the CCO for their prior authorization procedures.

Billing OHA

This section describes how to submit and resolve claims billed to OHA. For claims billed to CCOs, please refer to the CCO's claim submission and resolution processes.

Eligibility and enrollment

Please verify OHP eligibility and enrollment prior to rendering service or billing. Prior authorization is not a guarantee of OHP eligibility or payment. Go to the OHP Eligibility Verification page to learn more.

Billing and coding

Refer to Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code descriptions and standards for more information.

Submitting claims that received a Prior Authorization

If you have received prior authorization from OHA for treatments for fee-for-service (open card) members under age 21, please submit the claim along with the Prior Authorization Number. You can submit this claim in two ways:

- Send the claim via secure email to OHA with the documentation included. The email address is OHA.FFSOHPClaims@odhsoha.oregon.gov. If you do not have the ability to send a secure email, please request one from OHA.FFSOHPClaims@odhsoha.oregon.gov.
- Mail the claim to OHA with the documentation attached. The address is OHA Claims Unit, 500 Summer St NE E44, Salem, OR 97301

Submitting documentation with claims (post-service review)

OHA is working to update the Medicaid Management Information System (MMIS) no later than March 2023 to address claims for historically not covered services for fee-for-service (open card) OHP members under age 21. Claims for historically non-covered services that do not require a prior authorization will suspend, not deny, for OHA to review for medical necessity and appropriateness.

If you are submitting a claim for post-service review, we encourage you to submit clinical documentation supporting the medical necessity and medical appropriateness of the services provided with the claim. You can do this in two ways:

- Please send the claim via secure email to OHA with the documentation included. The email address is OHA.FFSOHPClaims@odhsoha.oregon.gov. If you do not have the ability to send a

secure email, please request one from OHA.FFSOHPClaims@odhsoha.oregon.gov.

- Mail the claim to OHA with the documentation attached. The address is OHA Claims Unit, 500 Summer St NE E44, Salem, OR 97301

CCOs are also expected to ensure their systems do not automatically deny claims for previously not covered services provided to OHP members under age 21. Please refer to the member's CCO for specific claim submission and resolution processes.

Resolving suspended claims

Once OHA systems are updated (anticipated no later than March 2023), the following guidelines apply:

- To see if OHA suspended a claim, you can search for submitted claims with a "Suspended" status on the MMIS Provider Portal at https://www.or-medicaid.gov.
- To get Provider Portal access or help identifying suspended claims, please contact Provider Services at 1-800-336-6016 or Team.Provider-Access@odhsoha.oregon.gov.

OHA will also attempt to reach out to the billing and/or rendering provider when a claim suspends. **Please ensure updated contact information for the contact(s) who can provide the relevant documentation.**

- You can update your contact information by contacting Provider Enrollment at 1-800-336-6016, Option #6 or provider.enrollment@odhsoha.oregon.gov.
- Provide the email address(es) of the contact(s) who will be able to access and submit the documentation within 14 days of the date of request through secure email to OHA.

OHA will request documentation from the referring provider that supports medical necessity and appropriateness via secure email.

- See sample documentation of medical necessity/appropriateness in the Documentation section of this guide.
- Send requested documentation, including the ICN of the suspended claim, via secure email to OHA.FFSOHPClaims@odhsoha.oregon.gov. If you do not have the ability to send a secure email, please request one from OHA.FFSOHPClaims@odhsoha.oregon.gov.
- If you do not submit requested documentation within the requested timeframe, OHA may deny the claim. In this case, please resubmit the claim with the requested documentation for OHA review.

Billing members for non-covered services

Because they receive Medicaid benefits, OHP members have special rights under federal and state law. It is against the law for you to require them to pay for any services covered by Medicaid, except when **all** of the following occurs:

- OHA denies your PA request or claim because it does not meet criteria.
- You submitted accurate, timely and complete documentation for the prior authorization request/claim or post-service review.
- The member or their representative signed a Medicaid-specific Agreement to Pay Form (OHP

3165 or OHP 3166) that shows they understand the services are not covered, and agree to pay for them.

- You bill only for services provided after the date the client signed the OHP 3165 or OHP 3166 form.

You may not bill the member for more than OHP's usual reimbursement rate for the services. You may not collect a deposit or advance payment from an OHP member. Billing a member in any other circumstance constitutes fraud and may be prosecuted (OAR 410-120-1280(1)(b)). In addition, you may not bill the member:

- For any services OHP would not reimburse if the PA request had been approved.
- If OHA denies your PA request due to lack of complete, accurate, and timely documentation. OAR 410 120 1280(1)(b) requires that the member "may not be billed for services or treatments that have been denied due to provider error (*e.g.,* required documentation not submitted, prior authorization not obtained, etc.").

If you have billing questions or concerns

Please review this guide, notices received from OHA, and the OHP Billing Tips page. If you still have questions or concerns, call the Provider Services Unit at 1-800-336-6016.

Documentation

General requirements

Documentation should be original documentation by the provider delivering care. It should:

- Explain why the service is medically necessary and medically appropriate (or dentally appropriate) for the child's health and development.
- Demonstrate that the requested code(s) have been thoroughly evaluated and there are no other paired codes that apply to the patient's situation, as required by OAR 410-141-3820(11).

Documentation for medical necessity and appropriateness should include the following elements:

- Individual's diagnosis or condition.
- Treatment, service or item being requested.
- Summarize why the service or item is medically necessary and medically appropriate for this individual.
- Summarize why the service or item is the "least costly alternative" to meet medical necessity and appropriateness by including documentation of alternatives considered or trialed and why the alternatives are not appropriate.
- For treatment of comorbid conditions, explains how the service meets the criteria described in OAR 410-141-3820(10)(a).
- Demonstrates the requested codes have been completely evaluated and there are no other paired codes that apply to the patient's situation, as required by OAR 410-141-3820(11).

Sample documentation

Examples of medical necessity documentation can be found at these links:

- https://www.aacpdm.org/UserFiles/file/BRK13.pdf (sample on slides 48-51)
- https://www.arcind.org/wp-content/uploads/2015/01/EPSDT-ABA-Appeal-Letter.pdf
- https://ccf.georgetown.edu/wp-content/uploads/2018/09/EPSDT-Medical-Necessity-Webinar-9-20-18-1-1.pdf (sample, slide 40)

Below is a sample of a medical necessity letter for a child's adaptive car seat. It demonstrates the appropriateness of each requested service for the child's medical and developmental needs that will minimize the need for additional follow up.

Requesting Provider
123 Main Street
Anytown, OR 97000

June 13, 2022

To whom it may concern,

We conducted an adaptive needs transportation evaluation for Mary Member on June 13, 2022. Mary is an 11-year-old child with hypotonic cerebral palsy (G80.8) and global developmental delay (F88). Currently, Mary rides in a Current Brand combination car seat in her family's vehicle. The Current Brand is rated to 65 pounds and 52 inches tall. At 58 pounds and 48 inches, Mary is nearing the seat's maximum height and weight restrictions.

At her current height and weight, Mary has nearly outgrown every conventional car seat in the U.S. market. There are no conventional seats that meet her current needs and allow for growth.

We tried several adaptive car seats (brands/models A, B and C) with Mary and determined that the XYZ adaptive car safety seat produced by Acme Manufacturing Company best meets Mary's needs, and will do so for many years. The XYZ car seat:

- Can be customized to best support Mary's positioning needs now and as she grows.
- Is the most cost-effective solution. The base price with the necessary accessories is $1325.00. The base price for a comparable seat with the same accessories is $2001.50.
- Has an upper height limit of 62 inches, upper weight limit of 115 pounds, and 7-year life span.

To best meet Mary's needs and safety, we request the following:

1. The XYZ Standard pediatric positioning support device: 1000XYZ-S (HCPCS E1399)
2. 3-inch seat depth extension (to accommodate growth and best support Mary's legs, hips and back): 100XYZ-SE3 (HCPCS E1399)
3. Quick-change incontinence cover: The XYZ cover is very hard to correctly put on the seat. The quick-change cover will allow for easy cleaning without uninstalling the car seat. 100XYZ-QCC (HCPCS E1399)
4. Spanish instructions

We request that Acme Manufacturing ship the car seat, accessories and instructions to our location at 123 Main Street, Anytown OR. This way we can help the family assemble the car seat and provide hands-on education on installation and harnessing.

Thank you for your time and consideration to fund this invaluable piece of safety equipment for Mary and her family.

Attachments:

- Price detail list, Acme Manufacturing Company
- Pricing comparison, Comparable Manufacturing Company