Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

Coverage, authorization and billing for EPSDT services

January 2025

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Introduction

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

EPSDT guidelines require Oregon to cover all medically necessary and medically appropriate (and dentally appropriate) services needed to correct and ameliorate health conditions for all OHP members under age 21. This coverage includes physical, dental, vision, behavioral health and pharmacy services.

As of Jan. 1, 2023, Oregon Health Authority (OHA) must comply with EPSDT for fee-for-service (FFS, also known as "open card") OHP members and coordinated care organizations (CCOs) must comply 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.

Effective Jan. 1, 2025, OHP members ages 19 and 20 may qualify for Young Adults with Special Health Care Needs (YSHCN) benefits. If they qualify, they are entitled to EPSDT coverage, which will last until their 26th birthday. For more information about the YSHCN program, please see the YSHCN guidance for OHP providers.

Covering EPSDT services increases child and young adult access to the full range of preventive, developmental, dental, behavioral health and specialty services. This holistically supports their growth, development, health and education. Oregon's expansion of EPSDT coverage requires both systems and culture change for OHA, CCOs and providers. All providers should:

- Communicate with patients and families about their rights and access to medically necessary and medically appropriate (and dentally appropriate) services,
- Refer and seek authorization for needed services for patients, and
- Avoid assumptions about coverage because of past experience.

About this guide

This guide:

- Describes EPSDT policy and coverage as required by federal regulation for both OHA and CCOs.
- Describes the specific billing and prior authorization processes that apply to members with FFS (open card) OHP.
- Clarifies that OHA and CCOs must cover all services determined to be medically necessary and medically appropriate (or dentally appropriate, for a dental service) for an OHP member under age 21 or an OHP member with YSHCN benefits.

OHA knows that many providers serve both CCO members and FFS (open card) members. Providers serving CCO members should consult the member's CCO for its procedures for prior authorization, billing and reimbursement.

Provider types

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

- Physicians including pediatricians, family physicians and internal medicine physicians
- Physician assistants, nurse practitioners and other advanced practice clinicians
- Naturopathic doctors
- Behavioral health clinicians
- Dentists and other oral care providers

- Therapists (physical therapy, occupational therapy, speech-language pathology)
- 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 help OHA promptly process claims and prior authorization requests, please ensure OHA has current contact information for those who can provide documentation of medical necessity and medical appropriateness. To do this, you can:

- Contact Provider Enrollment at 1-800-336-6016, Option #6 or provider.enrollment@odhsoha.oregon.gov.
- Include accurate, direct contact information within each claim and/or prior authorization request.

Requirements for OHA and CCOs

OHA and CCOs must:

- Comply with EPSDT coverage requirements for those who qualify, including OHP members with YSHCN benefits.
- Deny services for EPSDT-eligible OHP members only when:
  - An individual review indicates the service is not medically necessary or medically/dentally appropriate for the member, or
  - The claim or prior authorization request cannot be approved for technical reasons such as data entry errors or member ineligibility.
- Abide by a definition of medical necessity and medical appropriateness that is not more restrictive than the definitions of EPSDT Medical Necessity and EPSDT Medical Appropriateness listed in OAR 410-151-0001.
- Not set hard limits or caps on the amount of services or number of visits for members eligible for EPSDT. These are determined based on the needs of the individual member and may be subject to prior authorization.

- Follow the Bright Futures periodicity schedule and the OHP Dental Periodicity Schedule. Preventive care guidance for 21 through 25-year-olds under EPSDT (OHP members with Young Adults with Special Health Care Needs benefits) is forthcoming and will be added to this document when available.
- Comply with the Mental Health Parity and Addiction Equity Act in the application of utilization management for behavioral health services.

For denials of any EPSDT prior authorization request or claim, OHA and CCOs must:

- Make prior authorization and post-service review decisions based on case-by-case review of EPSDT Medical Necessity and EPSDT Medical Appropriateness (or dental appropriateness, in the case of a dental service).
- Provide OHP members a written Notice of Denial (for fee-for-service members) or Notice of Adverse Benefit Determination (for CCO-enrolled members). The notice must comply with federal requirements as well as those outlined in OAR 410-141-3885 and OAR 410-120-1865. 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.

CCOs and OHA may differ in:

- Prior authorization procedures
- Billing procedures

Background

OHP 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 and medically or dentally appropriate 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 will meet all EPSDT benefit requirements for children and adolescents on and after January 1, 2023.

Expanding the scope of EPSDT coverage for OHP members under age 21 requires significant systems and culture changes at OHA, in each CCO and among providers. OHA has aimed 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 throughout the process, we encourage providers to ensure they have updated their contact information with OHA and to reach out to the EPSDT team at EPSDT.Info@odhsoha.oregon.gov with any questions.

New for 2025: Oregon's 1115 Medicaid Waiver also grants the state authority to implement the Young Adults with Special Health Care Needs (YSHCN) program for qualifying OHP members ages 19 through 25. Effective January 1, 2025, OHP members with YSHCN benefits also receive ESPDT coverage up to the age of 26, as long as their re-assessment confirms continued eligibility (OHA will re-assess YSHCN eligibility every two years). See the YSHCN guidance for OHP providers for more information.

OHA intends for this guide to help providers understand and implement these changes to help OHP-covered children, youth, young adults and families access the broad range of health care services available to them under this benefit.

Additional resources

More information can be found at OHA's EPSDT web page (includes recorded webinars for providers) and these resources:

- EPSDT fact sheet for OHP members
- EPSDT FAQ
- EPSDT guidance for CCOs

- EPSDT Oregon Administrative Rules
- 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
- OHP Dental Periodicity Schedule

Questions, comments and concerns

For questions or comments regarding this guidance document or EPSDT coverage for OHP members under age 21 or OHP members with YSHCN benefits, 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:

- For FFS/open card inquiries, contact OHP Client Services at 1-800-273-0557 or Ask.OHP@oha.oregon.gov.
- For CCO members, find the CCO's contact information at OHP.Oregon.gov/CCO-Contacts.
- If members still need help after contacting OHA or the CCO, contact the OHA Ombuds Program at OHA.OmbudsOffice@odhsoha.oregon.gov or 1-877-642-0450 (message line only).

Covered services under EPSDT

OHP covers any medically necessary and medically appropriate health care service for members under age 21 and members with YSHCN benefits.

This includes any screenings, checkups, tests, treatments, pharmacy services and follow-up care for the child or youth's:

- Physical health (including vision and hearing),
- Oral/dental health, and
- Behavioral health.

To be covered, in addition to being EPSDT Medically Necessary and EPSDT Medically Appropriate (or EPSDT Dentally Appropriate; all defined in OAR 410-151-0001) for the individual member, services must:

- Have an appropriate diagnosis (ICD-10) and procedure code (CPT, CDT or HCPCS).
- Be coverable under OHP. For example, purely cosmetic procedures are excluded from OHP coverage.

Medicaid must be a good steward of state and federal resources. CCOs and OHA may choose to cover the least costly effective option that will meet the member's needs.

The Prioritized List and EPSDT

OHP must cover services for members under age 21 and members with YSHCN benefits if they are EPSDT Medically Necessary and EPSDT Medically Appropriate (or EPSDT Dentally Appropriate), **regardless of placement on the Prioritized List.**

This means OHA, CCOs and providers:

- Cannot deny or refuse to render or refer for a service just because it is "below the line" or "does not pair."
- May continue to use relevant coverage guidance or guideline notes to inform their determination of medical necessity and medical/dental appropriateness for the individual member.
- Cannot use the Prioritized List, coverage guidance or guideline notes to determine coverage broadly or for an entire age group or population under EPSDT.
- Should also refer to Statement of Intent 4 on the Prioritized List when making determinations of medical necessity and medical appropriateness.

OHP still does not generally cover services below the funding line on the Prioritized List for adults aged 21 and over, with the exception of OHP members with YSHCN

benefits. The Health Evidence Review Commission (HERC) continues to review clinical evidence and make updates to the Prioritized List. These updates will minimize the need for individual reviews prior to approval of services.

CMS requires states to follow a periodicity schedule for children's services. Oregon uses the Bright Futures periodicity schedule and the OHP Dental Periodicity Schedule. However, EPSDT-eligible members may get care outside this schedule for any changes in health.

Examples of services that OHP may cover for EPSDT-eligible members

These 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 of eating disorders.
- Allergy testing and shots related to nasal allergies affecting growth, development, and participation in school.
- Orthodontic treatment for handicapping malocclusion, according to OHA's coverage criteria.
- Ancillary services that were previously not covered, such as durable medical equipment when determined to be medically necessary and medically appropriate.

Determining coverage

EPSDT Medically Necessary, EPSDT Medically Appropriate and EPSDT Dentally Appropriate are defined in OAR 410-151-0001. To meet the criteria in this OAR, clinical documentation must clearly demonstrate how the service is EPSDT Medically Necessary and Appropriate (or EPSDT Dentally Appropriate, in the case of a dental service) for the circumstances of the individual child or youth.

It is important that providers:

- Do not refuse to render or refer for care based on Prioritized List placement.

- Know that services below the funding line require individual review for EPSDT Medical Necessity and Medical Appropriateness, even if OHP historically did not cover the services.

See the Prior Authorization and Billing sections of this guide to learn how to:

- Request prior authorization from OHA for services that require them.
- Request a pre-service review to determine coverage before providing a service, even if prior authorization is not required.
- Submit documentation for post-service review.
- Document medical necessity and medical appropriateness (or dental appropriateness) of a service.

For CCO-enrolled members, consult the specific CCO for its procedures for billing, authorization, and reimbursement.

Fee-for-service pharmaceutical reviews follow EPSDT requirements for individual review of medical necessity and appropriateness. For more information, see the Prior Authorization section of this guide.

Related rules and laws

The following rules and regulations govern EPSDT:

- OAR Chapter 410, Division 151
- Code of Federal Regulations 42 CFR § 441 Subpart B – Early and Periodic Screening, Diagnostic and Treatment (EPSDT) of Individuals Under Age 21
- EPSDT Medically Necessary, EPSDT Medically Appropriate and EPSDT Dentally Appropriate are defined in Oregon Administrative Rule 410-151-0001.

Prior authorization

Under EPSDT, OHA and CCOs may continue to use prior authorization as a utilization management tool as outlined in the EPSDT CCO Guidance Document. However, EPSDT screening services may not be subject to prior authorization requirements.

The following section describes prior authorization processes for FFS (open card) members. For CCO members, consult the specific CCO for its procedures for medical review and authorization.

Physical, behavioral and dental health care

Providers can use this process to:

- Seek approval for services that require prior authorization.
- Seek a pre-service review, even if the service does not require prior authorization.

OHA clinical staff with subject matter expertise review requests for EPSDT Medical Necessity and Appropriateness. Upon review of all submitted documentation, OHA will approve or deny the request. For sample provider notices, please see the Prior Authorization Handbook.

For prior authorizations related to Children's Psychiatric Residential Treatment Facilities (PRTF), email Comagine Health at UROregon@comagine.org. The PRTF processes are under review. OHA will update this guide accordingly and accepts questions about PRTF processes at Medicaid.Programs@odhsoha.oregon.gov.

How to submit prior authorization requests

You can submit requests in two ways.

- The MMIS Provider Portal at **https://www.or-medicaid.gov**. This is the preferred, and most efficient and effective submission pathway. If you need help using the Provider Portal, please call 1-800-336-6016, Option #5. or
- Fax the ODHS/OHA Prior Authorization Request Form (MSC 3971) under a completed EDMS Coversheet (MSC 3970, and included in the online MSC 3971 form) to OHA. The coversheet lists two fax numbers. Select the appropriate number depending on the urgency of the request. Please note the coversheet must be on page one for successful processing.

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 Portal PA request)	• The requesting provider's NPI • PA assignment code • Member's Oregon Medicaid ID number • Primary diagnosis code • Secondary diagnosis code(s), as appropriate • CPT or HCPCS 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 alternatives are not appropriate.
Signed letter of medical necessity from the treating practitioner	• Required when requesting medically necessary and medically appropriate services that fall outside of current rules and guideline notes (requesting "approval by exception"). Include: • Why the service is medically necessary and medically appropriate for this individual. • Why the service or item is the least costly effective option that meets the member's needs.

Document	Required information/criteria
	• For treatment of comorbid conditions, how the service meets the criteria described in OAR 410-141-3820(10)(a). • Why the requested codes are clinically appropriate and there are no other paired codes that apply to the patient's situation, as required by OAR 410-141-3820(11).

After review of your request, OHA may ask for additional documentation to determine if the service is EPSDT Medically necessary and EPSDT Medically Appropriate (or EPSDT Dentally Appropriate, as applicable).

If your request has missing or inadequate documentation:

You need to provide OHA complete documentation within 30 days of OHA's response. If OHA does not receive documentation within 30 days, OHA will deny the request due to missing information. The opportunity to resubmit remains available.

If your request is complete, accurate and timely:

If the documentation demonstrates services are EPSDT Medically Necessary and EPSDT Medically/Dentally Appropriate and the service meets coverage criteria, OHA will notify you of approval as soon as possible.

Please ensure updated contact information for those who can provide the relevant documentation. To do this:

- Contacting Provider Enrollment at 1-800-336-6016, Option #6 or provider.enrollment@odhsoha.oregon.gov.
- Include accurate, direct contact information within each prior authorization request and/or claim.

Pharmacy services

Submit information supporting EPSDT Medical Necessity and EPSDT Medical Appropriateness. This may include documentation that the member meets the following criteria:

- 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 two preferred products (when available in the Preferred Drug List class).
- 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 take part in school, perform activities of daily living.

Providers can call the Oregon Pharmacy Call Center at 888-202-2126 with questions about FFS prescription coverage.

For physical health prescriptions for CCO members, contact the CCO for its prior authorization procedures.

Billing OHA

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

For claims for School-Based Health Services (SBHS), please refer to the SBHS Provider Resources page.

Eligibility and enrollment

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

For information on how to determine whether a member has YSHCN benefits, please see the YSHCN guidance for OHP providers.

Billing and coding

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

Submitting claims

Providers should submit claims according to the OHP Professional Billing Instructions (for professional claims) and the OHP Institutional Billing Instructions (for institutional claims).

The Medicaid Management Information System (MMIS) now suspends FFS claims for manual review if they are for services:

- Provided to OHP members under age 21 or OHP members with YSHCN benefits,
- Do not require a prior authorization, and
- Are below the line, non-pairing, or otherwise not historically covered.

OHA will review these claims for EPSDT Medical Necessity and Appropriateness. OHA may contact you for documentation supporting the medical necessity and medical/dental appropriateness of the service.

Resolving suspended claims

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,** please contact Provider Services at 1-800-336-6016, Option #5 or team.provider-access@odhsoha.oregon.gov
- **For help identifying suspended claims,** please contact Provider Services at 1-800-336-6016, Option #5 or DMAP.providerservices@odhsoha.oregon.gov.
- If you do not submit sufficient documentation with your claim, OHA will also attempt to reach out to the billing and/or rendering provider when a claim suspends. OHA will request documentation from the referring provider via secure email.

- See sample documentation of medical necessity/appropriateness in the Documentation section of this guide.
- Fax requested documentation under a **completed EDMS Coversheet** (MSC 3970), including the Internal Control Number (ICN) of the suspended claim.
    - Check the box on the coversheet that says “Claim Documentation”
    - Send to the fax number listed beside the “Claim Documentation” box.
- If you do not submit requested documentation within 14 days, OHA may deny the claim. In this case, please resubmit the claim with the requested documentation for OHA review.

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. To do this:

- Contact Provider Enrollment at 1-800-336-6016, Option #6 or provider.enrollment@odhsoha.oregon.gov.
- Include accurate, direct contact information within each claim and/or prior authorization request.

If you have billing questions or concerns

Please review this guide, notices received from OHA, and the OHP Billing Tips page. For outstanding questions or concerns, call Provider Services 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 EPSDT Medically Necessary and EPSDT Medically Appropriate (or EPSDT Dentally Appropriate) for the individual 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 EPSDT Medical Necessity and Appropriateness should include the following elements:

- Individual's diagnosis or condition.
- Treatment, service or item being requested.
- Why the service or item is medically necessary and medically appropriate for this individual.
- Why the service or item is the least costly effective option that meets medical necessity and appropriateness by including documentation of alternatives considered or trialed and why the alternatives are not appropriate.
- For treatment of comorbid conditions, 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).
- For School-Based Health Services (SBHS), schools can use a provider's Written Recommendation which is the equivalent to a Letter of Medical Necessity. For more information, please visit the SBHS Provider Resources page.

Please note: The FFS/Open Card Medical Management Committee (MMC) and Behavioral Health Management Committee (BHMC) view the intent of the EPSDT benefit as ensuring that children and youth get the health care they need to be healthy and participate in school or work. In general, the MMC's and BHMC's review and approval for services will be for the duration of the treatment plan. This means that services started prior to the member's 21st birthday but that need to continue past the 21st birthday (or 26th birthday, for OHP members with YSHCN benefits) will most likely/most often be approved until the completion of the service. Appropriate documentation will be required to support this coverage.

CCOs have the authority to determine how they will consider coverage of ongoing services beyond age 20 (or age 25, for OHP members with YSHCN benefits).

Sample documentation

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

- 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 and medical appropriateness 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.

<Provider address>
<Date>

We conducted an adaptive needs transportation evaluation for Mary Member on June 13, 2022. Mary is 11 years old. She has 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 needs and allow for growth.

We tried several adaptive car seats (brands/models A, B and C) with Mary. We found 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 as she grows.
- Is the most cost-effective. The base price with necessary accessories is $1325.00. A comparable seat with the same accessories is $2001.50.
- Has a height limit of 62 inches, weight limit of 115 pounds, and lasts 7 years.

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

1. 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 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 equipment for Mary and her family.

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact the EPSDT Program at EPSDT.Info@odhsoha.oregon.gov.

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