EPSDT Provider Education

Early and Periodic Screening,
Diagnosis & Treatment (EPSDT)

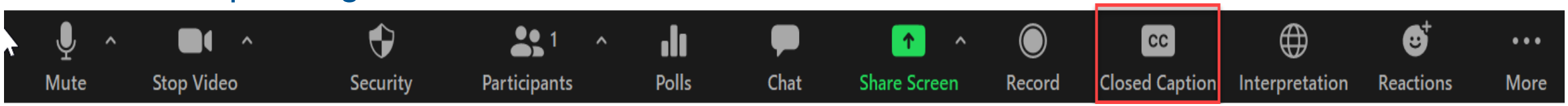
Deep dive regarding documentation, prior authorization and billing for EPSDT services

February 7, 2023

Oregon Health Authority

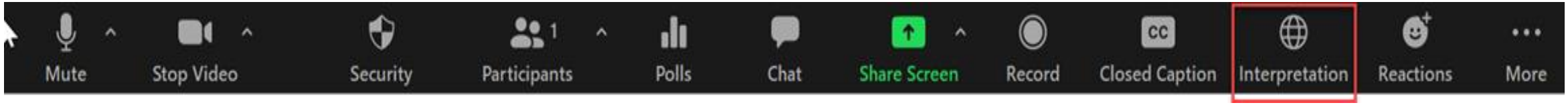
Webinar Logistics

- This session will be recorded
- Private chat or email Tom Cogswell (thomas.cogswell@dhsoha.state.or.us) with any Zoom issues
- Closed captioning is available:



- American Sign Language (ASL) interpretation is available. Pin the ASL Interpreter's video by clicking on the "More" button next to their name

- Todos los participantes que hablan español deberán seleccionar el botón Interpretación y luego el canal en español para que aparezca el sonido.



Oregon Health Authority

Today’s presenters and EPSDT team

Margaret Cary, MD, MPH, OHP Fee For Service Clinical Director
Brenden Magee, Provider Clinical Support Unit Manager
Mary Durrant, Manager, Claims and Encounter Data Services Unit
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EPSDT Team:
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Welcome and review of policy change

Margaret Cary, MD, MPH, OHP Fee For Service Clinical Director

Objectives for the session

Providers will:

- Be reminded of the EPSDT policy change, effective January 1, 2023
- Understand what is required for both CCOs and OHA for Open Card (FFS)
- Understand the definitions of Medical Necessity and Medical Appropriateness and how to document them
- Understand how to seek Prior Authorization for Open Card (FFS) patients
- Understand how to bill for post-service review for Open Card (FFS) patients
- Be provided with a checklist to enable timely communications with OHA
- Know where to access detailed guidance and submit questions

What has changed with EPSDT in Oregon?

First…what is EPSDT?

- The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid.
- States must follow a periodicity schedule for children's services. Oregon follows the Bright Futures periodicity schedule.
- 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.** It is not a separate program requiring enrollment and is for both CCO-enrolled and Fee-for-Service members.

Until 2023, one element of EPSDT was waived

- Most EPSDT services have been provided in Oregon for many years.
- Oregon's 2017-2022 1115 Medicaid waiver and prior waivers allowed the state to restrict coverage for **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.
- This means Oregon did not cover **treatment** services that were "below the line" on the Prioritized List of Health Services for kids between the ages of 1 and 21.

What changed on January 1, 2023?

- No EPSDT requirements are now waived in Oregon.
- Under EPSDT, OHP covers **all 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 “non-covered” ancillary service
    - Whether it is covered under the Oregon’s Medicaid State Plan

CCO and Open Card implementation

OHA (for Open Card) and CCOs must both:

- Comply with the EPSDT policy change and coverage requirements, effective January 1, 2023
- Ensure that services to OHP members under age 21 are **not** denied without an individual review for medical necessity and medical appropriateness.
- 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

CCOs and OHA (Open Card) may differ in:

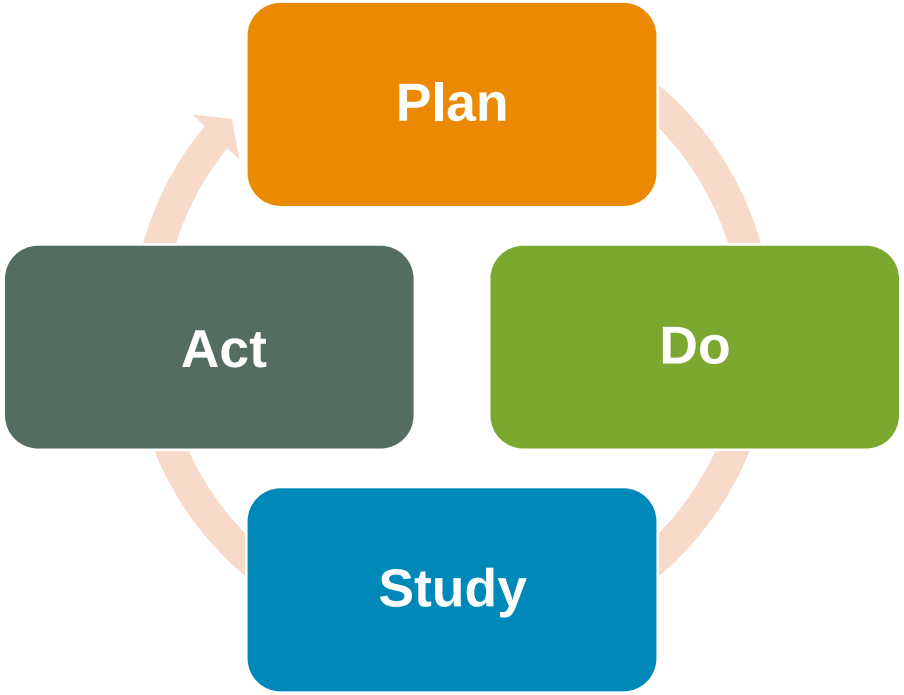
- Prior authorization procedures.
- Billing procedures

Dos and don’ts under EPSDT

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.
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.	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.
Deny a claim solely due to a lack of chart notes or other documentation of medical necessity and medical appropriateness	Choose to automatically approve previously not covered services without a review for medical necessity.
Require prior authorization for any EPSDT **screening** services.	Use the Prioritized List as a guidance tool and not a denial tool.

Pathway to implementation

- **These requirements became effective January 1, 2023.**
- Monitoring for CCO compliance will begin Q2 2023.



Medical Necessity and Medical Appropriateness

Medically Necessary and Medically Appropriate

- Medically Necessary, Medically Appropriate and Dentally Appropriate are defined in Oregon Administrative Rule 410-120-0000.
- States are required to provide comprehensive medically appropriate and medically necessary services needed to correct and **ameliorate** health condition
- This includes services which, based on the child's **individual circumstances**, adversely affect the child's ability to grow, develop, or participate in school (Statement of Intent 4 on the Prioritized List).
- Documentation needed to demonstrate medical necessity and appropriateness for Open Card are outlined in OHA's EPSDT Provider Guide.

Medical Necessity

Medical Necessity means health services and items that are required by a client or member to address one or more of the following:

- The prevention, diagnosis, or treatment of a client or member's disease, condition, or disorder that results in health impairments or a disability;
- The ability for a client or member to achieve age-appropriate growth and development
- The ability for a client or member to attain, maintain, or regain independence in self-care, ability to perform activities of daily living or improve health status; or
- The opportunity for a client or member receiving Long Term Services & Supports (LTSS) as defined in these rules to have access to the benefits of non-institutionalized community living, to achieve person centered care goals, and to live and work in the setting of their choice;
- A medically necessary service must also be medically appropriate. All covered services must be medically necessary, but not all medically necessary services are covered services.

…and Medical (and Dental) Appropriateness

Medical (and Dental) Appropriateness means health services, items, or supplies that are:

- Recommended by a licensed health provider practicing within the scope of their license;
- Safe, effective, and appropriate for the patient based on standards of good health practice and generally recognized by the relevant scientific or professional community based on the best available evidence
- Not solely for the convenience or preference of an OHP client, member, or a provider of the service item or medical supply;
- The most cost effective of the alternative levels or types of health services, items, or medical supplies that are covered services that can be safely and effectively provided to a Division client or member in the Division or Managed Care Entity's judgment;
- All covered services must be medically appropriate for the member or client, but not all medically appropriate services are covered services.

EPSDT & Pharmacy

- **Pharmaceutical reviews** for coverage will be aligned with the requirements for individual review of medical necessity and medical appropriateness as required.
- There is no required change to prior authorization **processes** under EPSDT at this time.

- To encourage the submission of timely and complete documentation, 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.

Pharmacy Prior Authorization

- Update all PA criteria to support individualized review for members younger than 21 years of age who have a historically unfunded diagnosis, to evaluate on a case-by-case basis whether the requested medication is medically appropriate and necessary
- Standard definitions for medically appropriate and necessary use will include:
    - FDA-approved or compendia-supported indication;
    - Trial and failure, contraindication, or intolerance to at least two preferred products (when available in the class); and
    - Documentation that the disease is of sufficient severity that it impacts the patient's health

The Prioritized List and EPSDT

The Prioritized List under EPSDT

- Under EPSDT, CCOs and OHA must cover **all medically necessary and appropriate (or dentally appropriate, in the case of a dental service) services for children and youth under age 21.**
- The Health Evidence Review Commission (HERC) reviews clinical evidence and update the Prioritized List. The List remains a **guidance tool** for identifying services that may require documentation to establish medical necessity and medical appropriateness (or dentally appropriateness) for members under 21.
- Location of a service on the Prioritized List may **not** be the sole reason for denial of a service.
- Note for providers who also serve adults: These changes do not apply to adults (ages 21+). Services under the funding line on the Prioritized List are generally not covered for adults.

What *has* been moved on the Prioritized List?

The Health Evidence Review Commission has recently completed review of historically non-covered services with the unique needs of children and youth in mind to minimize the need for individual reviews prior to approval of services.

Examples of services moved above the line related to EPSDT:

- Treatment for conduct disorder and oppositional defiant disorder for children 18 or under.
- Treatment of tendon and ligament injuries (full tears)
- Orthodontic treatment for handicapping malocclusion. Review criteria that addresses this condition specifically may be found here.

For more information: Prioritized List of Health Services

Prior Authorizations and post service reviews

Prior Authorization under EPSDT

- Prior authorization must be conducted on a case-by-case basis, evaluating each child's needs individually.
- There is no required change to prior authorization **processes** under EPSDT at this time.
- Prior authorization procedures may not delay delivery of needed treatment services and must be consistent with the preventive intent of EPSDT.
- Prior authorization may not be required for any EPSDT **screening** services.
- It is 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).
- 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.
- The staff member conducting the review needs the proper level of license/certification necessary for the type of decision they are making.

EPSDT and Durable Medical Equipment

- Durable Medical Equipment (DME) may be affected by the EPSDT policy change. Many services reviewed under the policy change in the Fee For Service (Open Card) program have been for DME.
- Statement of Intent 4 is a meaningful factor in reviewing DME.
- OHA and CCOs still need to consider “least costly alternative” and whether alternatives have been tried.
- When requesting DME under EPSDT it is essential to provide specific details pertaining to the unique medical necessity of each individual and how the equipment requested meets that need.

Examples of treatment services that have been approved through individual Medical Management Review

- Treatment (i.e., acne) or procedures (i.e., tonsil removal) in some cases that affect child growth, development and participation in school
- Ancillary services that were previously not covered, such as durable medical equipment when determined to be medically necessary and medically appropriate.
- Additional therapy sessions beyond a defined threshold (e.g. 10 visits)

Who may submit PA documentation?

- A referring provider should have the proper level of licensing/certification or scope of practice necessary to assess the medical necessity and medical appropriateness of that service.
- A referring provider must have a National Provider Identifier (Federally Qualified Health Center/Rural Health Centers and Indian Health Care Providers have a provider/clinic NPI).

Documentation needed for Prior Authorization review for EPSDT

- EDMS Coversheet (MSC 3970)
- Completed PA request (MSC 3971 or the Provider Web Portal PA request)
  - Must have a primary diagnosis code, and a secondary diagnosis as appropriate.
- Supporting clinical documentation
- Signed letter of Medical Necessity and Medical Appropriateness from the treating practitioner, specific to individual needs.

What's necessary to document Medical Necessity and Medical Appropriateness for Open Card?

- 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).

- Explain why the service is medically necessary and medically appropriate (or dentally appropriate) for the **INDIVIDUAL child's** health, development and participation in school.
  - Include the individual's diagnosis or condition. Secondary diagnosis may be included
  - 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).

Prior Authorization submission process

- **Preferred method:**
  - **MMIS Provider Portal at https://www.or-medicaid.gov**

- If necessary:
  - Fax the ODHS/OHA Prior Authorization Request Form (MSC 3971) under a completed EDMS Coversheet (MSC 3970) to OHA using the contact numbers provided on the MSC 3970.

- **If you need assistance using the Provider Portal: (800) 336-6016, option 5.**
- **If you need assistance verifying the need for PA or to check PA status, please contact the Prior Authorization hotline (M-F 8am-5pm): (800) 336-6016, option 3.**

Who is the Medical Management Review Committee?

- There are nine Nurse Reviewers on the Medicaid Provider Clinical Support Unit.
- The four doctors on MMC are:
    - **Ariel Smits**, MD MPH, MPhil, Public Service Physician, Medical Director of the Health Evidence Review Committee (HERC): Board certified in family medicine.
    - **Dawn Mautner**, MD, MS, OHA Medicaid Medical Director: Board certified in Family Medicine.
    - **Jeff McWilliams**, MD, Medical Director, Kepro: Board certified in Medical Oncology, Hematology, Internal Medicine.
    - **Margaret Cary**, MD, MPH, OHP Fee for Service Clinical Director: Board certified in General (Adult) and Child & Adolescent Psychiatry.

What's a post service review for FFS (Open Card claims)?

- If a claim suspends for a service that would historically have denied as not paired or below the line of the Prioritized List, this is called a **Post Service Review**. In order to seek a post service approval, the provider may:

    A. Submit documentation (the same as required for a PA) with the claim or soon after; **OR**

    B. If claim is submitted without documentation, OHA will attempt to contact the provider to seek this documentation within 14 days. This is why having provider contact information updated with Provider Enrollment is critical.

- If 14 days passes without response from the provider, OHA may deny the claim. The provider has the ability to resubmit the claim and necessary documentation if that happens.
- Documentation may be submitted directly using an EDMS coversheet or can be emailed including the EDMS coversheet to OHA.FFSOHPClaims@dhsoha.state.or.us

Member rights and what if a requested service is denied?

Service denials

- Any denial of coverage must be in writing. **Providers should not refuse to render or refer for care.**
- OHP members must be provided a written Notice of Action (for FFS) or Notice of Adverse Benefit Determination (for CCOs) when denying a service.
    - Notices must contain:
        - A statement of the intended action and effective date
        - 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.

What recourse do providers and members have?

- If a provider or member/guardian disagrees with a denial decision, they can appeal the decision.
    - Any denial notice should include instructions on how to appeal or request a hearing.
    - All OHP members have the right to a fair hearing for denials.
- If a provider submits additional clinical documentation, that will be reviewed as part of the appeal or hearing process.

Ensuring patient access to services

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)

How can I stay informed as a clinician or provider organization?

Checklist: What should Providers do to prepare?

All providers should:

- ✓ NOT assume historically non-covered services continue to be non-covered. They MUST be considered for each individual child/youth.
- ✓ Monitor claims/prior authorizations in Q1, 2023 and be prepared to re-submit if need be.
- ✓ Review EPSDT Provider Guide and Member Fact Sheet
- ✓ Sign up for Provider Matters and the Transformation Center Resources email (sign up here: https://www.surveymonkey.com/r/OHATransformationCenterTA) to receive information about upcoming EPSDT webinars for providers
- ✓ Bookmark this page: **Oregon.gov/EPSDT**
- ✓ **Contact our team with questions: EPSDT.Info@odhsoha.oregon.gov**

What should Providers do to prepare?

Fee-for-Service providers should:

- ✓ Update contact info with Provider Enrollment at OHA to facilitate communication about post-service reviews
  - ✓ Provider Enrollment at 1-800-336-6016, Option #6 or provider.enrollment@odhsoha.oregon.gov
- ✓ Ensure the ability to send secure email (resources in OHA's EPSDT Provider Guide)

CCO providers should:

- ✓ Consult the specific CCO for its procedures for billing, authorization, and reimbursement

Where to find more information

OHA has developed the following materials to share information about this change:

- EPSDT Policy Change Memo for OHP providers
- EPSDT Guidance for OHP Providers
- EPSDT Guidance Document for CCOs
- EPSDT Fact Sheet for OHP members (available in 13 languages)

Oregon.gov/EPSDT

All guidance documents and EPSDT communication materials will be available and updated on this page.

Additional provider resources:

- OHP Tools for Providers webpage: https://www.oregon.gov/oha/HSD/OHP/Pages/Provider-Splash.aspx
- Checking eligibility for OHP Members: https://www.oregon.gov/oha/HSD/OHP/Pages/Eligibility-Verification.aspx
- How to submit for prior authorization (PA Guide): https://www.oregon.gov/oha/HSD/OHP/pages/pa.aspx
- How to bill OHP for services Submitting claims: https://www.oregon.gov/oha/HSD/OHP/Pages/Billing.aspx
- How to use the OHP MMIS Provider Web Portal: https://www.oregon.gov/oha/HSD/OHP/Pages/webportal.aspx
- Weblink for the MMIS Provider Web Portal: https://www.or-medicaid.gov

- Contact Provider Services
    - Phone: 800-336-6016
        - For claims option 5, then option 1.
        - For MMIS Password unlock and reset option 5, then option 2.
    - Email for questions on already submitted claims: DMAP.Providerservices@odhsoha.oregon.gov
    - Email to submit claims for special handling: OHA.FFSOHPCLAIMS@odhsoha.oregon.gov

Recordings available!

- **Session one: Overview of the EPSDT policy change and implementation**
- **Session Two: Ensuring EPSDT access: Documenting medical necessity, prior authorization and related processes for fee-for-service (FFS, or “Open Card”) patients**

Visit Oregon.gov/EPSDT for more information

EPSDT Regulations and Resources

- 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
- EPSDT - A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents
- Medicaid.gov
- Health Resources & Service Administration – Maternal & Child Health Bureau
- Medicaid and CHIP Payment and Access Commission

Questions?

EPSDT.Info@odhsoha.oregon.gov

Dialogue with collaborators and partners, including families and members, helps us center equity. Thank you for your ongoing participation, and for providing us with the partnership and insights that help us better serve Oregon's communities.

Thank you