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

## CCO Guidance Document

Oregon Health Authority

HEALTH SYSTEMS DIVISION

# Contents

## Early & Periodic Screening, Diagnostic 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 (OHP).**

- **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 Chapter 410 Division 151 – 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

Prior to the current 2022-2027 Medicaid 1115 Waiver, OHP covered most EPSDT services. Prior waivers allowed Oregon 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 process that resulted in the current waiver, OHA received clear feedback from the community, including advocates, children's service organizations and other interested parties, that Oregon's approach to EPSDT services in prior waivers prevented 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 CMS, Oregon must meet all EPSDT benefit requirements for children and adolescents effective January 1, 2023.**

Covering EPSDT services for children from birth until their 21st birthday increases access to the full range of preventive, developmental, dental, behavioral health, and specialty services so Oregon's children and youth are supported holistically in their growth, development, health and education. Oregon's expansion of EPSDT coverage requires both systems and culture change for OHA, each CCO, and among providers. OHA has aimed to implement these changes with minimal disruption and recognizes that the transition requires 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.**

**Effective January 1, 2023, OHP must cover any medically necessary and medically appropriate (or dentally appropriate) services for enrolled children and youth until their 21st birthday**, regardless of:

- The placement of the service 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.

Services and items which do not have a Current Procedural Terminology (CPT), Current Dental

[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. The EPSDT requirements are identical in CCOs' Medicaid and non-Medicaid contracts.

Terminology (CDT) or Healthcare Common Procedure Coding System (HCPCS) code are not required to be covered under EPSDT at this time.

The Prioritized List remains a tool for identifying services that may require documentation of medical necessity and medical appropriateness (and dental appropriateness, if applicable) for members under age 21. Additionally, the Health Evidence Review Commission (HERC) publishes coverage guidance and guideline notes which may be used to inform a determination of medical necessity and medical appropriateness for the individual member. The funding line on the Prioritized List cannot, however, be used as the basis for denying services under EPSDT or referenced in Notices of Adverse Benefit Determination (NOABDs) as a denial reason.

In 2022, the HERC 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.

If you believe there is a need for HERC to change its decision about a service (to facilitate broad coverage of a service beyond what is available with EPSDT), you can email HERC.Info@oha.oregon.gov to request a review.

## Coverage requirements for CCOs:

**Effective January 1, 2023, CCOs and OHA must cover all medically necessary and medically appropriate or dentally 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 non-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.

[2] EPSDT Medically Necessary, EPSDT Medically Appropriate, and EPSDT Dentally Appropriate are defined in Oregon Administrative Rule 410-151-0001.

[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.

**These requirements were effective January 1, 2023.** Compliance is being monitored through the quarterly Exhibit I NOABD sample evaluation beginning with the Q2 2023 submissions.

Additional EPSDT program monitoring plans will be developed starting in 2024, through an iterative process with all CCOs as well as the Fee-for-Service (Open Card) program.

| 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 historically were not 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 (e.g., 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 non-covered services without a review for medical necessity and medical appropriateness. |
| **Require prior authorization for any EPSDT screening services.** | Use relevant guideline notes from the Prioritized List as guidance to inform determinations of medical necessity and medical appropriateness. |

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 (e.g., 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 (e.g., 10 physical therapy visits) and require prior authorization for coverage of

[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.

medically necessary and medically appropriate services above those limits. Utilization management techniques used for mental health and substance use disorders must comply with the Mental Health Parity and Addiction Equity Act.

OHA has not added 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 (Open Card) program, see the EPSDT Provider Guide. CCO contract requirements around prior authorization processes and timelines are not changing. Requirements for utilization management under EPSDT are set forth in OAR 410-151-0003.

**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 (e.g., those below the line on the Prioritized List) solely as a way to operationalize the EPSDT coverage expansion that was effective January 1, 2023.
- 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.
    - EPSDT Medically Necessary, EPSDT Medically Appropriate, and EPSDT Dentally Appropriate are defined in Oregon Administrative Rule 410-151-0001.
- The staff member conducting the review needs the proper level of license/certification necessary for the type of decision they are making. If the decision is highly clinical it may need to be a licensed specialist. Please see Exh. B, Part 2, Sec. 3, Para. a of the 2024 CCO contract for further information.

CCOs should ensure their provider networks are informed of the following guidance and resources:

- Providers shall not refuse to render or refer for care based on Prioritized List placement and should not make assumptions about coverage based on past experience. Determinations must be made based on the child's individual needs.
- OHA has hosted several webinars for providers regarding EPSDT. All recordings and materials are available at Oregon.gov/EPSDT

- 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). The provider guide was updated in November 2023.

Pharmaceutical reviews for coverage follow requirements for individual review of medical necessity and medical appropriateness as required under EPSDT. The following language was 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.

## 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 plain language, 6th grade reading level, and using a minimum 12-point font or large print (18-point);
- Make sure information is available in non-English languages prevalent in the service area;
- Upon request, provide information in alternate formats and using auxiliary aids and services, 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 by contacting EPSDT.Info@odhsoha.oregon.gov. 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 in OHP.
    - CCOs meet this requirement by sending member handbooks within 14 days of enrollment in a CCO.
    - The CCO Model Member Handbook includes 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.
    - CCOs meet this requirement by sending member handbooks within 14 days of a newborn being enrolled in the CCO.
- 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. Distribution of this fact sheet or similar, or of a CCO member handbook that contains the above information, will satisfy the communication requirements. However, other or additional outreach may be most appropriate depending on the needs of the member/family. For example, phone, text message or in-person communication may be more effective depending on circumstances.

## 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; and
- 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.
    - EPSDT Medically Necessary, EPSDT Medically Appropriate and EPSDT Dentally Appropriate are defined in Oregon Administrative Rule 410-151-0001.
- 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.

## 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 Member Notice Template Evaluation Criteria posted on the CCO Contract Forms webpage, 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 FAQ (available in Spanish at Oregon.gov/EPSDT)
- EPSDT fact sheet for OHP members (available in additional languages at Oregon.gov/EPSDT)
- EPSDT Policy Change Memo for Providers
- EPSDT Provider Guide (updated 11/29/23)
- Oregon Administrative Rule Chapter 410 Division 151– 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
- Bright Futures – American Academy of Pediatrics

## Appendix A

The following summary encompasses select items reviewed by the 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. | | |