Benefits for OHP Children and Youth (Ages 0 to 21): Early and Periodic Screening, Diagnostic 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 21 years of age. 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.

Oregon is required to provide comprehensive medically necessary and medically appropriate (and dentally appropriate) services needed to correct and ameliorate health conditions, based on certain federal guidelines, to all OHP-enrolled children and youth under age 21. This coverage includes physical, dental, vision, 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.

Effective January 1, 2023, OHA and CCOs cover the full scope of EPSDT services.

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 (described in more detail below) 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 the change to EPSDT policy and coverage with which OHA and CCOs must comply.
- 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.

This guide is for health care clinicians and providers to:

1. Understand 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 services provided to OHP FFS (open card) members.

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 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 under age 21, 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 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.
- You can also 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, effective January 1, 2023 (described in

Background, below).

- Ensure services to OHP members under age 21 are **not denied** without an individual review for medical necessity and medical appropriateness (or dental appropriateness), except in cases of technical errors such as information entered incorrectly or member ineligibility.
- 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 (please note that, effective January 1, 2024, definitions of medically necessary, medically appropriate, and dentally appropriate specific to the EPSDT population will be found in OAR 410-151-0001).
- Not set hard limits or caps on the amount of services or number of visits for members under age 21. Determinations must be made based on the needs of the individual member and may be subject to prior authorization.
- Follow the Bright Futures periodicity schedule.
- Comply with the Mental Health Parity and Addiction Equity Act in the application of utilization management for behavioral health services.

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

- Make prior authorization and post-service review 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 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.

OHA intends for this guide to help providers understand and implement this change to help OHP-covered children, youth 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
- 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 (FFS/Open Card inquiries) OHP.ComplaintResolution@odhsoha.oregon.gov
- For CCO members, find the CCO's contact information here: https://www.oregon.gov/oha/HSD/OHP/Pages/Coordinated-Care-Organizations.aspx
- OHA Ombuds Program 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.

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 medically necessary and medically appropriate (or dentally appropriate) for the individual member, services must:

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

Medicaid is required to 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.

CMS requires states to follow a periodicity schedule for children's services. Oregon uses the Bright Futures periodicity schedule. However, children and youth under age 21 may get care outside this schedule for any changes in health.

The Prioritized List and EPSDT

Beginning January 1, 2023, OHP must cover services for members under age 21 if they are medically necessary and medically appropriate (or dentally appropriate), **regardless of the funding line 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 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 for children and youth under age 21.

OHP still does not generally cover services below the funding line on the Prioritized List for adults age 21 and over. 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.

Examples of services that OHP may now cover for members under 21

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 for conduct disorder and oppositional defiant disorder for children 18 or under.
- 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

Medically Necessary, Medically Appropriate and Dentally Appropriate are defined in Oregon Administrative Rule 410-120-0000 (146) and (147) (please note that, effective 1/1/2024, definitions of medically necessity, medically appropriateness and dentally appropriateness specific to the EPSDT population will be found in OAR 410-151-0001).

Please refer to the steps outlined in this document guide to submit clinical documentation justifying/explaining how the service is medically necessary and appropriate (or 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 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 all services for members under age 21. For more information, see the Prior Authorization section of this guide.

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 (please note that effective 1/1/2024, the EPSDT rules will be in OAR 410-151-0000 through 410-151-0008)
- 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. Please note that effective January 1, 2024, definitions specific to the EPSDT population will be in OAR 410-151-0001).

Prior authorization

Under EPSDT, OHA and CCOs may continue to use Prior Authorization as a utilization management tool, within the requirements 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:

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

OHA clinical staff with subject matter expertise review requests for 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 and will change in the future. This guide will be updated accordingly. Additional questions can be routed to 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 assistance using the Provider Portal, please contact the Prior Authorization hotline: (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 cover sheet 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 Web 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. ■ 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 medically necessary and medically appropriate (or 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 documentation is not received within 30 days, OHA will 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.

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.
- You can also include accurate, direct contact information within each prior authorization request and/or claim.

Pharmacy services

Submit information supporting medical necessity and 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 participate 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 prescriptions covered by the member's CCO, 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.

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.

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

Prior-authorized services

If you received prior authorization from OHA, please submit the claim along with the Prior Authorization Number. You can submit this claim in two ways:

- **Send the claim and supporting documentation via secure email to OHA with the documentation included (highly preferred).** 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

Post-service review

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,
- Do not require a prior authorization, and
- Are below the line, non-pairing, or otherwise not historically covered.

OHA will review these claims for medical necessity and appropriateness. OHA may contact you for documentation supporting the medical necessity and medical appropriateness of the service.

When you submit these claims, please submit clinical documentation supporting the medical necessity and medical appropriateness of the services billed. 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. **This is the preferred and most efficient submission pathway.** 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

If the patient is a member of a CCO, please refer to the member's CCO for specific claim submission and resolution processes.

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.

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.
- You can also include accurate, direct contact information within each claim and/or prior authorization request.

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. For outstanding 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 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 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).

Please note: The FFS/Open Card Medical Management Committee (MMC) views the intent of the EPSDT benefit as ensuring that children and youth get the healthcare they need to be healthy and thrive. In general, the MMC's review and approval for services will be for the treatment plan and will most likely include approval for services that are started prior to the member's 21st birthday but need to continue past the 21st birthday. 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 21.

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 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.

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