Frequently Asked Questions – EPSDT

Early and Periodic Screening, Diagnostic & Treatment Program

This document provides answers to common questions regarding Oregon's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, with a focus on guidance for coordinated care organizations (CCOs) and Oregon Health Plan (OHP) providers.

Guidance documents with requirements for CCOs and OHP providers (along with provider education resources and member materials) can be found at www.Oregon.gov/EPSDT. This FAQ is not meant to be substitute for reviewing the full guidance documents.

Contents

Overview

1. What services are included in the EPSDT benefit?

EPSDT is a comprehensive child and youth health care benefit for OHP members ages birth to 21. Medically necessary and medically appropriate physical, dental, behavioral health, and pharmacy benefits are covered through EPSDT. This includes screenings, checkups, tests and follow-up care, including for vision, hearing and oral/dental health.

2. Who qualifies for EPSDT benefits?

Oregon Health Plan members under the age of 21 qualify for EPSDT benefits. This includes children and youth under age 21 who enrolled in OHP through the Healthier Oregon program.

3. Do children and youth need to enroll separately in EPSDT?

No, it is not a separate benefit. OHP members under age 21 will automatically receive EPSDT coverage.

4. Is the EPSDT benefit available for Fee-for-Service (FFS)/Open Card OHP members?

Yes. EPSDT covers all members under 21 on the Oregon Health Plan. This includes FFS/Open Card members and members enrolled in coordinated care organizations (CCOs).

5. Why are we hearing so much about EPSDT now? Has something changed?

Starting January 1, 2023, additional services are covered under EPSDT. OHP now covers all medically necessary and medically appropriate services for members under age 21, regardless of placement on the Prioritized List of Health Services.

6. How have other states made this transition to full EPSDT?

All other states and U.S. Territories, plus the District of Columbia, have implemented full EPSDT for many years. Oregon was the only state with a Prioritized List and a waiver related to EPSDT coverage, so our implementation of full EPSDT coverage began January 1, 2023.

7. Does EPSDT apply to healthcare coverage that isn't the Oregon Health Plan?

No. EPSDT requirements only apply to the Oregon Health Plan.

8. Is the process for appeals and hearings changing under EPSDT?

The process is not changing, but bears repeating:

Any denial of coverage must be in writing. Providers should not refuse to render or refer for care. Under federal law and state rules, OHP members must be provided a written Notice of Denial or Notice of Adverse Benefit Determination when coverage of a service is denied.

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.

If the notice is from a CCO, the member can appeal the decision with the CCO. After the appeal they can also ask OHA for a hearing. If the notice is from OHA, the member can ask OHA for a hearing. A provider can work with the member to request an appeal or hearing on the member's behalf.

More information about OHP appeals and hearings can be found here.

9. How can I stay informed about EPSDT in Oregon?

There are several ways to stay informed about EPSDT including:

- Bookmark www.Oregon.gov/EPSDT and visit regularly for updates
- Review the posted change log for any changes to CCO guidance, provider guidance, or this FAQ
- Sign up for Provider Matters (for OHP Providers) or the CCO Weekly Update (for CCOs)
- Email EPSDT staff with any questions at EPSDT.Info@odhsoha.oregon.gov

Coverage

10. How does EPSDT work with the Prioritized List of Health Services?

Beginning January 1, 2023, services for OHP members under age 21 must be covered if they are medically necessary and medically appropriate, regardless of placement on the Prioritized List. CCOs and OHA cannot deny a service just because it is "below the line," though they may consider any relevant guideline notes to inform their determination of medical necessity and medical appropriateness for the individual member. Please note that services below the line on the Prioritized List are still generally not covered for adults aged 21 and over.

11. Besides things below the line on the Prioritized List, what else can now be covered?

Any service or support that was historically not covered must be covered when medically necessary and medically appropriate (or dentally appropriate) for the individual member under age 21, with few exceptions (see question 12). Here are some service categories that historically may have had restrictions for coverage, which now must be considered based on the needs of the individual:

- Certain pharmaceuticals and therapeutics
- Durable medical equipment

- Other ancillary services
- Services not in Oregon's Medicaid state plan or included in the OHP Plus benefit package, but coverable under federal Medicaid law.

12. What things are not covered by EPSDT?

While we cannot make broad across-the-board determinations, examples of what are generally not covered by EPSDT include:

- Treatment that is not medically necessary AND medically appropriate for the individual.
- Things that do not have an appropriate diagnosis and procedure code (CPT or HCPCS).
- Anything that is not Medicaid coverable, meaning federal Medicaid won't allow payment for it. However, there are some services and populations that receive the OHP Plus benefit package that are not federally funded but are paid for by the state.

13. Does the recent change in EPSDT mean that everything will now be covered for OHP members under 21?

No. In addition to being medically necessary and medically appropriate, the following are true:

- Services must have an appropriate diagnosis and procedure code (CPT or HCPCS) to be covered.
- Services must be coverable as part of the OHP Plus benefit package. For example, purely cosmetic procedures are not covered under federal rules.
- Medicaid is required to be a good steward of resources. CCOs and OHA may choose to cover the least costly effective option that will meet the member's needs.

14. What is something not in our state plan that would be covered under EPSDT?

Oregon has a Medicaid "State Plan" that defines the Oregon Health Plan services (including services that Oregon chooses not to cover though they may be federally allowed). An example that would be covered when medically necessary and medically appropriate is non-sedating antihistamines for allergic rhinitis.

15. Are there limits on the amount of services or visits that will be covered?

Under EPSDT, there cannot be any hard limits on the amount of services or number of visits that are covered. All medically necessary and medically appropriate services and visits must be covered for members under age 21. OHA and CCOs are allowed to set limits after which prior authorization is required and may also require the least costly effective option that meets the member's needs.

16. Which screenings are required to be covered under EPSDT?

Covered screening visits are offered at age-appropriate intervals (these are also known as well child visits or adolescent well visits). Oregon follows the American Academy of Pediatrics and Bright Futures guidelines and periodicity schedule. Well child visits must include the following:

- Full physical exam
- Full health and developmental history (including assessment of both physical and mental health development)
- Developmental screening

- Preventive laboratory tests (including lead toxicity testing and genetic testing)
- Appropriate immunizations
- Assessment of nutritional status
- Anticipatory guidance and health counseling for parents and children
- Referrals for medically necessary health and behavioral health treatment

EPSDT also covers screenings for vision, hearing and oral/dental health.

EPSDT also covers unscheduled screenings, assessments, check-ups and exams that can happen at any time. This can be due to an illness, injury or a change in condition.

17. In the past, certain medical equipment/therapy/medications that I requested for my patients were always denied. How do I know it will be covered now?

Under EPSDT, services that are determined to be medically necessary and medically appropriate (or dentally appropriate) for the individual child or youth under age 21 should be approved. Requests for services must be considered based on the individual needs of the member and any denials for coverage must be made in writing. Providers may consult this guide to learn more about FFS/Open Card prior authorization and billing procedures, including documentation of medical necessity and medical appropriateness. CCO providers should consult with the CCO about its specific procedures for submitting documentation of medical necessity and medical appropriateness. Providers should ensure that they are rendering or referring to medically necessary and medically appropriate care and not limiting their care or referrals based on past experience of denials.

18. Who determines whether something is medically necessary and medically appropriate?

“Medically necessary” and “medically appropriate” are determinations made via clinical judgment of a member’s circumstances, based on the needs of the individual child or youth. Providers may need to submit documentation to OHA (for FFS/Open Card members) or the CCO to demonstrate medical necessity and medical appropriateness. OHA and the CCOs use established review processes (conducted by appropriate clinical staff) to make decisions regarding medical necessity and medical appropriateness.

19. How are medically necessary, medically appropriate and dentally appropriate defined?

Effective January 1, 2024, definitions of medically necessary, medically appropriate and dentally appropriate that apply specifically to the EPSDT population are found in Oregon Administrative Rule 410-151-0001:

“EPSDT Medically Necessary”

(a) Means health services, items and medical supplies that are required to address one or more of the following for an EPSDT Beneficiary:

(A) The prevention, diagnosis, treatment or amelioration of an EPSDT Beneficiary’s disease, condition, or disorder that results in health impairments or a disability;

(B) The ability for an EPSDT Beneficiary to achieve age-appropriate growth and development. Services that may be EPSDT Medically Necessary to achieve age-appropriate growth and development include but may not be limited to services that are reasonably calculated to improve the EPSDT Beneficiary’s ability to participate in work or school, or the prevention, diagnosis, detection,

treatment, cure, correction, reduction, or alleviation of the effects of a physical, mental, behavioral, nutritional, dental, genetic, developmental or congenital condition, injury, or disability, regardless of whether they are included on the Prioritized List of Health Services (defined in OAR 410-120-0000) or are below the funding line on the Prioritized List of Health Services;

(C) The ability for an EPSDT Beneficiary to attain, maintain, or regain independence in self-care, ability to perform activities of daily living or improve health status; or

(D) The opportunity for an EPSDT Beneficiary receiving Long Term Services & Supports (LTSS) to have access to the benefits of non-institutionalized community living, to achieve person-centered care goals, to participate in their own care planning, and to live and work in the setting of their choice.

(b) An EPSDT Medically Necessary service must also be EPSDT Medically Appropriate. All covered services must be EPSDT Medically Necessary for the EPSDT Beneficiary.

“EPSDT Medically Appropriate”

(a) Means health services, items, or medical supplies that are:

(A) Recommended by a licensed health practitioner practicing within the scope of their license; and

(B) Safe, effective, and appropriate for the EPSDT Beneficiary and generally recognized by the relevant scientific or professional community based on the best available evidence, which includes medical literature and expert consensus opinion and takes into account EPSDT Beneficiary values; and

(C) Impactful in improving access to care, ability to actively participate in care, work, school, or social activities and not solely for the convenience or preference of an EPSDT Beneficiary, caregiver, or a provider of the service, item, or medical supply; and

(D) The most cost-effective level or type of health services, items, or medical supplies that are covered services that can be safely and effectively provided to an EPSDT Beneficiary.

(b) All covered services must be EPSDT Medically Appropriate for the EPSDT Beneficiary, but not all EPSDT Medically Appropriate services are covered services.

“EPSDT Dentally Appropriate”

(a) Means dental services, items, or dental supplies that are:

(A) Recommended by a licensed health practitioner practicing within the scope of their license; and

(B) Safe, effective and appropriate for an EPSDT Beneficiary based on standards of good dental practice and generally recognized by the relevant scientific or professional community based on the best available evidence, which includes medical literature and expert consensus opinion and takes into account EPSDT Beneficiary values; and

(C) Impactful in improving access to care, ability to actively participate in care, work, school, or social activities; and not solely for the convenience or preference of an EPSDT Beneficiary, caregiver, or a provider of the service, item or dental supply; and

(D) The most cost-effective level or type of health services, items, or supplies that are covered services that can be safely and effectively provided to an EPSDT Beneficiary.

(b) All covered services must be EPSDT Dentally Appropriate for the EPSDT Beneficiary but not all EPSDT Dentally Appropriate services are covered services.

Under EPSDT, states are required to provide comprehensive medically necessary and medically appropriate services needed to correct and ameliorate health conditions. This includes services which, based on the child's individual circumstances, affect the child's ability to grow, develop, or participate in school.

20. What is an example of something that is medically necessary but not medically appropriate? What about something that is medically appropriate but not medically necessary?

Examples of medically necessary, but not medically appropriate may include:

- A drug that is needed to treat an individual's condition but is not safe for that individual because it would have an adverse interaction with another drug they are taking.
- Only an expensive prescription is prescribed when a generic could be used.

Examples of medically appropriate, but not medically necessary may include:

- A child with a broken front tooth who could have a cap but is not in pain or experiencing impaired functioning in any way.
- Acne medication for a youth whose acne is not impeding their wellbeing, functioning or participation in school or other activities.

21. How does Statement of Intent 4 work now that EPSDT fully covers any service that is medically necessary and medically appropriate for members under 21?

Statement of Intent 4 is a guideline note on the Prioritized List that can be used by clinical reviewers when considering the effectiveness and appropriateness of a service for children. Providers may continue to refer to Statement of Intent 4 when making determinations of medical necessity and medical appropriateness for children and youth under 21.

22. What has changed around coverage of Durable Medical Equipment (DME)?

DME are ancillary services, and historically some items were not covered. Under EPSDT, like other services, DME must be covered for an OHP member under age 21 if determined to be medically necessary and medically appropriate through an individual review. As with other EPSDT services, DME items must be coverable under federal Medicaid law to be covered by EPSDT.

The majority of services reviewed to date in the FFS/Open Card program under the EPSDT policy change have been for DME. Statement of Intent 4 on the Prioritized List is a meaningful factor in reviewing DME. OHA and CCOs may still consider the least costly effective option for the member and whether alternatives have been tried.

Please note that a revision to the Oregon Administrative Rules regarding DME is forthcoming.

23. Does EPSDT cover things related to a member's social needs?

In general, EPSDT covers services that can be paid under federal Medicaid law and are medically necessary and medically appropriate for the individual child or youth. As such, services need to have an appropriate diagnosis and billing code (CPT or HCPCS) in order to be covered by EPSDT. If a CCO-enrolled member has health needs that are not billable under Medicaid, please check with the CCO regarding other pathways for meeting these needs.

A new Health Related Social Needs benefit for OHP members was approved by the federal government as part of Oregon's 2022-2027 1115 OHP Demonstration Waiver. However, the Health Related Social Needs coverage will be a new benefit for a group of individuals who meet additional eligibility criteria.

24. Does EPSDT cover Z codes?

Z codes are a subset of ICD-10 (diagnosis) codes that are used to identify "factors influencing health status and contact with health services." They indicate a reason for an encounter and are not considered procedure codes. Services billed with Z codes may be covered by EPSDT as long as they are medically necessary, medically appropriate and covered by Medicaid. Not all Z codes are covered under federal Medicaid law.

25. Does EPSDT cover services provided in schools, related to Individualized Education Programs (IEPs)?

If services listed in an IEP are solely for school or education purposes, then it is the responsibility of the school to provide/pay for those. If the IEP services are for education purposes but would also serve the individual outside of the school setting (for example, in the home or for everyday living) then they would qualify for OHP coverage under EPSDT. As with other EPSDT services, school-based services must be coverable under federal Medicaid law to be covered by EPSDT.

26. I saw that orthodontia is now covered by OHP in some cases. What is covered? What is the process for getting it covered?

Orthodontic treatment for handicapping malocclusion is covered effective January 1, 2023, when individual circumstances meet specific review criteria similar to what is used in other state Medicaid programs (the criteria can be found here). Handicapping malocclusion and/or handicapping dentofacial deformity are conditions that affect speech, chewing and other functions.

27. Can a CCO deny a service if the provider is not "in-network" or do they need to approve because it's EPSDT?

Under EPSDT there have been no changes to CCO requirements regarding coverage of "in-network" and "out-of-network" providers. A CCO is not required to cover services provided by providers out-of-network if there is an in-network provider who can provide the service. However, if a medically necessary and medically appropriate service is not available through an in-network provider, the CCO must cover a service when provided by an out-of-network provider and assist with the referral to an out-of-network provider. CCOs are allowed to require prior authorization for out-of-network services.

28. If physical health isn't covered under the member's benefit package with the CCO, we (the CCO) will deny coverage of a physical health service. What is the appropriate language to include in the denial letter?

Per OAR 410-141-3885, the Notice of Adverse Benefit Determination (NOABD) must include a clear and thorough explanation of the specific reasons for the adverse benefit determination. As such, the CCO should ensure that the denial reason language is clear that the services may be covered by

OHP fee-for-service, even if they are not covered under the CCO benefit package. An example of acceptable language would be:

Your [CCO] coverage only includes [oral health, behavioral health]. Your [CCO] coverage does not include [physical, behavioral health care]. You may have [physical, behavioral health care] covered via OHP fee-for-service. Please contact OHP Client Services at 800-273-0557 for help.

29. Can CCOs use Health Related Services funds to pay for EPSDT services?

No. All EPSDT services are covered by the Oregon Health Plan and should be billed accordingly. Because Health Related Services (HRS) cannot be used for covered services, HRS cannot be used to pay for EPSDT services.

30. What happens with coverage of treatment for a condition that isn't covered for adults, but has been covered for a member under 21; does the coverage continue past their 21st birthday?

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.

One example that has been recently reviewed and approved is treatment for an individual with handicapping malocclusion who started orthodontia treatment at age 20, but the treatment would not be complete until after the 21st birthday. That said, these requests will be reviewed on a case-by-case basis and may require additional authorization after age 21. Coordinated Care Organizations have the authority to determine how they will consider coverage of ongoing services beyond age 21.

Prior Authorization & Billing

31. Do EPSDT services require prior authorization?

CCOs and OHA may require prior authorization for some services (see question 32). They cannot require prior authorizations for EPSDT screening services.

32. Can CCOs or OHA decide to require prior authorization for EPSDT services?

CCOs and OHA cannot require prior authorization for all historically non-covered EPSDT services (for example, those below the line on the Prioritized List) solely as a way to operationalize the January 1, 2023 EPSDT coverage expansion. It is, however, acceptable to use prior authorization to manage some services, like those that are high cost, high risk, or new procedures.

33. Can CCOs continue to require prior authorization for non-emergent out-of-network care (with exceptions)?

Yes. Under EPSDT there are no changes regarding how CCOs can use prior authorization for out-of-network services.

34. Who needs to request prior authorization?

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 the 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).

35. What is the difference between the prior authorization process for FFS/Open Card and the prior authorization process with a CCO?

The prior authorization process for FFS/Open Card is described in the EPSDT provider guide and is managed through the Oregon Health Authority's Provider Clinical Support Unit.

For a CCO-enrolled member, the provider should consult the CCO for its specific procedures.

For prior authorizations related to Children's Psychiatric Residential Treatment Facilities (PRTF), providers may reach out to OHA's contractor Comagine Health for assistance at UROregon@comagine.org. The PRTF processes are under review and will change in the future. This FAQ and associated guides will be updated at that time. Additional questions can be routed to Medicaid.Programs@odhsoha.oregon.gov.

36. What about claims that don't require a prior authorization? When do we submit clinical documentation for those?

As a reminder, EPSDT requirements for individual review for medical necessity and medical appropriateness prior to denial apply regardless of whether it is a claim or a prior authorization request.

For a CCO-enrolled member, the provider should contact the CCO for its specific procedures.

For FFS/Open Card members, providers have the option to submit a pre-service review request to determine coverage before providing a service, even if prior authorization is not required. To submit a pre-service review request:

- Preferred method: MMIS Provider Portal at https://www.or-medicaid.gov
- If necessary: Fax the ODHS/OHA Prior Authorization Request Form (MSC 3971) to OHA using the contact numbers provided on the MSC 3971. Please note that the completed EDMS cover sheet (included in MSC 3971) must be on page one for successful processing.

For FFS/Open Card post-service review, the provider can either send a claim, letter of medical necessity and supportive documentation to the OHA Claims Unit (OHA.FFSOHPClaims@odhsoha.oregon.gov) requesting a review or submit a claim and wait for OHA to reach out requesting supporting clinical information. The Medicaid Management Information System (OHA's claims processing system) has been updated to suspend claims for items that historically were not covered for members under 21. When a claim suspends, OHA staff will reach out to the provider to request any documentation needed prior to finalizing the claim. The provider will have 14 days to respond to the request for documentation, or the claim may be denied.

37. How will I (a provider) know if more documentation is needed?

If you are working with a CCO, please contact the CCO for its specific procedures.

For FFS/Open Card EPSDT claims with a date of service 1/1/23 or after, OHA will reach out to providers when claims suspend for being below the line or non-pairing. OHA will work with clinic staff to get the necessary documentation and review for medical necessity and medical appropriateness. Providers can expedite this claims processing by submitting documentation with the claim.

Please note that if a FFS/Open Card claim has been denied, attaching additional documentation will not trigger an additional review; you will need to submit a new claim form with the additional documentation. If you are requesting a review or submitting documentation based on OHA outreach, please send the claim, letter of medical necessity/appropriateness and supportive documentation to OHA.FFSOHPClaims@odhsoha.oregon.gov.

To facilitate timely communication with OHA, please remember to update your contact information with Provider Enrollment at 1-800-336-6016, Option #6 or provider.enrollment@odhsoha.oregon.gov. It can be difficult to identify the right clinical team member(s) to get the documentation needed, so we urge you to ensure the correct information is on file with OHA and your CCO(s).

For any additional questions, please visit www.Oregon.gov/EPSDT or reach out to EPSDT.Info@odhsoha.oregon.gov

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