

Early and Periodic Screening, Diagnostic and Treatment Services: *The Medicaid Benefit for Children*

Section II: The “EPSDT” Medical Necessity Review

Revised: July, 2017

Today's Agenda

General Introduction to Today's Presentation

Mini Review of Due Process and EPSDT:

- North Carolina's System of Mediations, Appeals and Monitoring of the Beneficiary's Right of Due Process

Why is "Early and Periodic Screening, Diagnosis and Treatment" so Important in Medicaid?

- Defining Key Terms
- State Roles & Responsibilities
- Understanding Federal Mandates for Children's Coverage: How Medicaid for Kids is Unique

Pediatric Medical Necessity, Federal Standards and the EPSDT Review

- Medicaid's Standards of Review for Children
- Recommended Proposed Approach

Important Details in Implementing the Social Security Act 'EPSDT' Guarantees

- Critical Details about EPSDT and Service Delivery
- When Waivers and Medicaid Services Meet

Questions and Answers

***“EPSDT” Reviews and Pediatric
Medical Necessity***

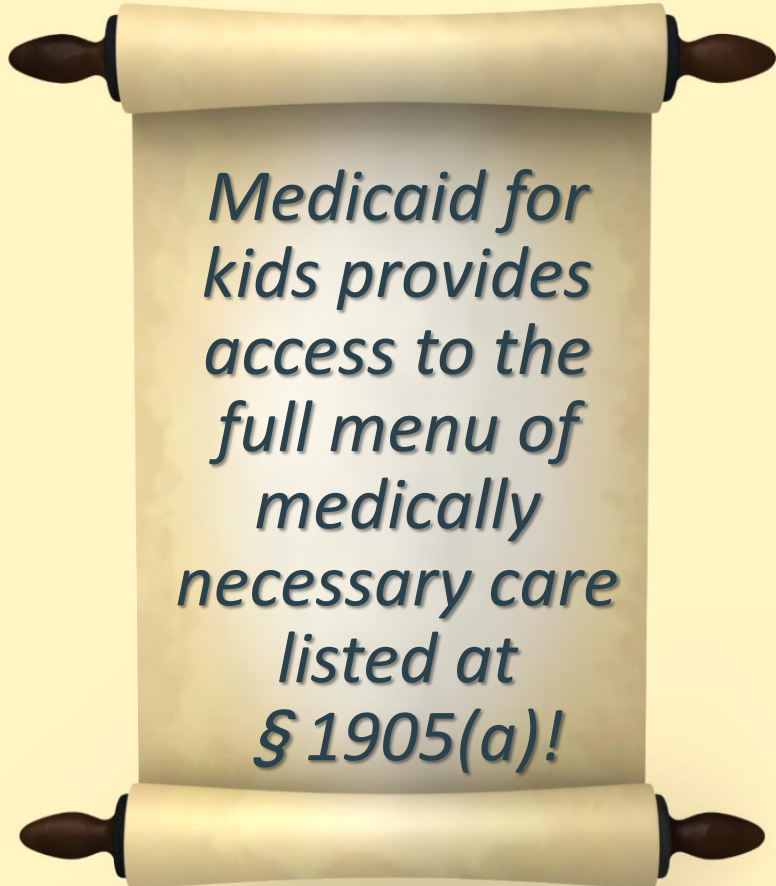
**Medicaid’s Healthcare Benefit
for Children
and
Application of EPSDT Medical
Necessity Criteria**



Section 2 Learning Objectives:

- **Pathways** to an EPSDT Review;
- **Definitions** of Durable Medical Equipment and Pharmacy Products
- **Federal Medical Necessity Criteria and the Uniform EPSDT Review;**
- **The “Correct or Ameliorate” Standard;**
- The Process of Professional Review for Medical Necessity **under EPSDT Federal Criteria;**
- **General Guidance** for Composing Your Communication of an Adverse Benefit Determination.

Remember!



Medicaid for kids provides access to the full menu of medically necessary care listed at § 1905(a)!

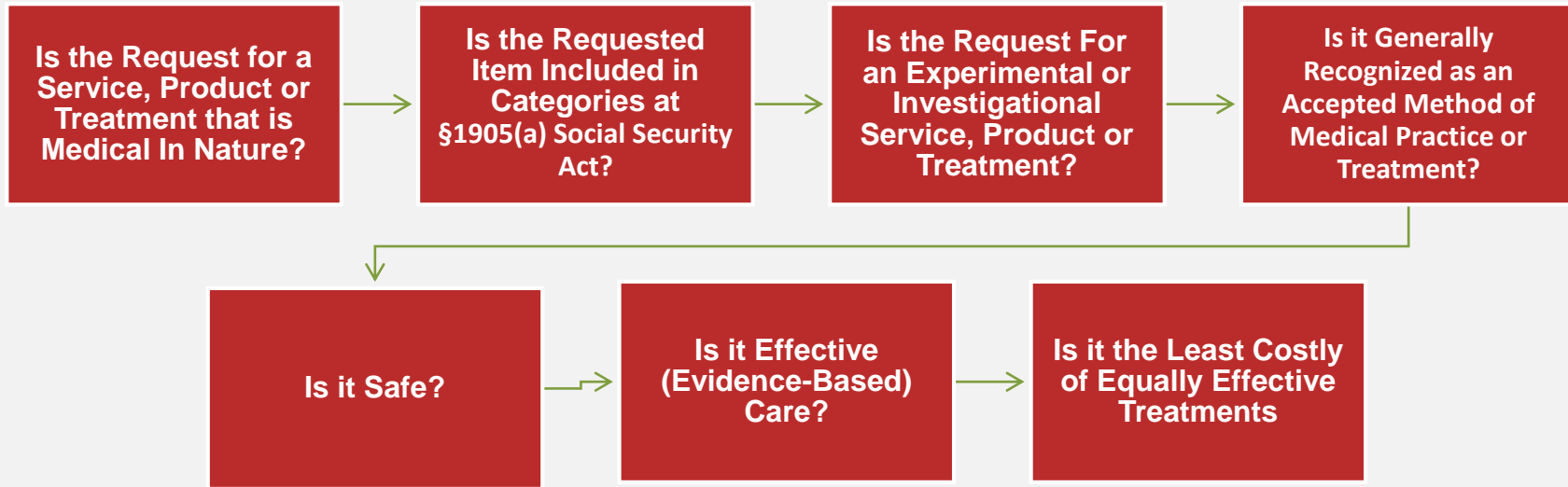
The Uniform Professional Medical Necessity Review
per Federal EPSDT Criteria is:



*The Heartbeat
of Medicaid's Child Benefit*

EPSDT Review Criteria Found at §1905(r)

The Pathway of a Medical Necessity Review per EPSDT Federal Criteria:



Remember:

- The term ***‘Medically Necessary’*** pertains to a ***‘Medical Service’*** and to its purpose to ***“Correct or Ameliorate”*** a ‘diagnosed ***medical*** condition’. These decisions are made by appropriately licensed medical professionals, and they pertain to services coverable at § 1905(a) of the Social Security Act.

Pathways to an EPSDT Medical Necessity Review

The EPSDT benefit 'runs in the background' 24/7

Any properly submitted request for a Medicaid service for a beneficiary under 21 years old will receive a medical necessity review per EPSDT federal criteria before an adverse benefit determination is issued.



- A parent/caregiver may make a request for service using a 'non-covered service request form'.
- A non-covered service request is usually made through an ordering practitioner/provider, as the provider must substantiate medical necessity.
- **Remember!** Requested services must be 'Medical in Nature' and must be included in the broad categories of services listed at § 1905(a) of the Social Security Act.

Pathways to an EPSDT Medical Necessity Review

Remember!

A required component of a properly requested service is the requestor's rationale for medical necessity by EPSDT standards. Documentation that the service is standard of medical care, safe and evidence-based treatment for the child and his/her unique medical conditions must accompany the request.

It is the responsibility of the ordering practitioner to provide documentation for medical necessity per EPSDT Criteria.

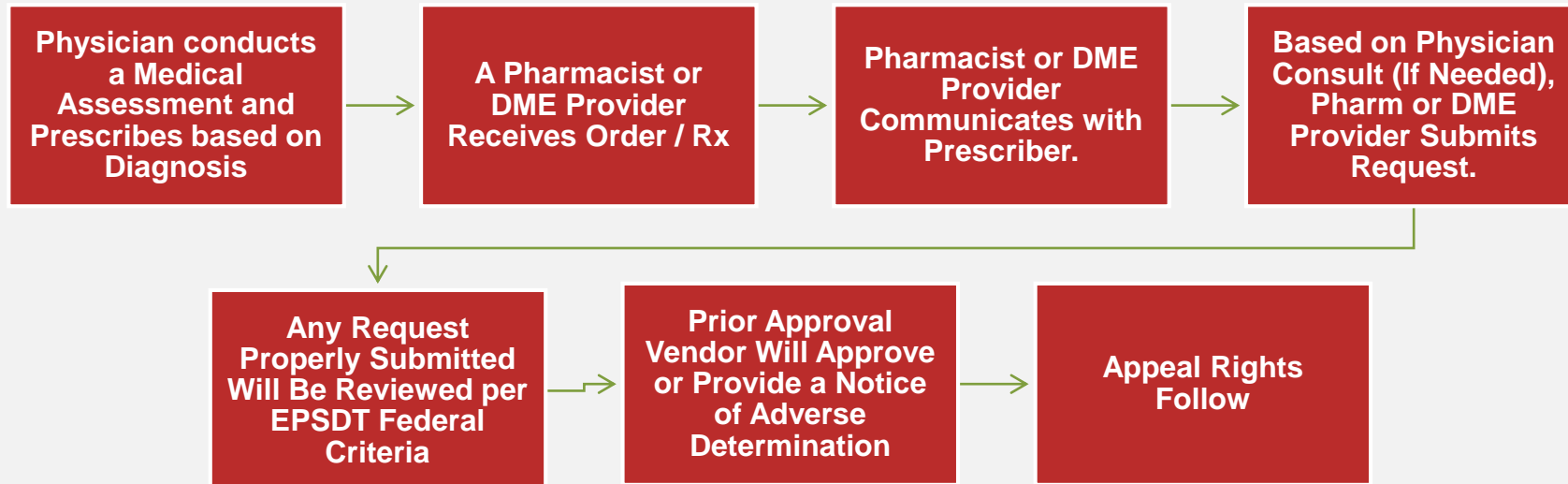
An EPSDT Medical Necessity Review is required whenever:

A properly requested service, product or treatment:

- Is not included in Medicaid's State Plan/Covered by State Clinical Policies;
- Is requested at frequencies, amounts quantity or in durations that exceed a state policy limit;
- Would be denied should State Policy limits, exclusions or definitions be applied.

Flow for Order of a 1905 (a) Coverable Service

The Life of a Physician's Order for Drugs, Services or Products:



Best Practice Considerations:

- * A Physician should be ordering a service after a complete medical evaluation. A prescribed service should be demonstrated effective to 'correct or ameliorate' a health condition.

Important EPSDT Benefit Details

Common Misunderstandings in Coverage Criteria: *Durable Medical Equipment*

Durable Medical Equipment, or DME is customarily:

- Used to serve a **medical** purpose;
- Generally, **is not useful to an individual in the absence of a disability, illness or injury;**
- Can withstand **repeated use, and;**
- Is usually **removable**.



Important EPSDT Benefit Details

Common Misunderstandings in Coverage Criteria: *Pharmacy Products*

“Pharmacy” is customarily physician prescribed, and is :

...a drug for which the federal government receives a rebate.

Medicaid does cover some “Over The Counter” drugs, vitamins and supplements, but only when the products are prescribed / ordered by an appropriately licensed practitioner to treat (correct or ameliorate) a diagnosed medical condition.



Review Per: DEPARTMENT OF HEALTH AND HUMAN SERVICES Centers for Medicare & Medicaid Services 42 CFR Part 447 [CMS–2345–FC] RIN 0938–AQ41 Medicaid Program; *Covered Outpatient Drugs – Covered OTC items.*

<https://www.gpo.gov/fdsys/pkg/FR-2016-02-01/pdf/2016-01274.pdf>

Documentation is Essential:

Requests for prior authorization must be fully documented to show medical necessity

Full documentation may include:

- **Current clinical assessment** from the beneficiary's physician;
- Specific specialist reports;
- Documentation on the nature of the requested service as 'standard of care' for the clinical condition diagnosed;
- Citation of evidence base supporting effectiveness of the requested service for the individual's medical condition(s).



Medicaid or its vendor may need to request missing information, delaying decisions, or even causing the request to 'void' as incomplete if certain required items are missing.

Details about The Consideration of Pediatric Medical Necessity



Rendering a Decision on a Requested Product, Service or Treatment for Kids:

- *Rehabilitative Focus*
- *Defining “Ameliorate”*
- *Deciding on Effective Treatment*
- *Content of Adverse Letters*

The EPSDT Benefit and 'Services that Restore'

**Medicaid Reimburses for
Rehabilitative Services Coverable
at Social Security Act § 1905(a)**

The EPSDT Benefit and 'Services that Restore'

The Medicaid Act {CFR 440.130(d)} defines **'rehabilitative'** (restorative) services as:

"Any medical or remedial service recommended by a physician or other clinical practitioner working within their scope of practice under state law, for the maximum *reduction* of physical or mental disability and *restoration* of an individual to the best possible functional level."



- *The service does not have to 'cure' or completely restore an individual to a previous level of function.*
- *Services coverable by the EPSDT benefit must be 'medical in nature' but need not be included in either coverable policies, service definitions or billing codes posted by DMA or its agents.*

Habilitative Services and Emerging Best Practice

A Word of Caution:

Interpretation of:

- *service definitions* in State Plans;
- the inclusion of services defined as '*medical*' in nature', and;
- the borderlines between '*habilitative*' (waiver) services covered under 42 U.S.C. §1396n(c)(5)(A) of the Social Security Act and '*rehabilitative*' (medical) services coverable under 42 U.S.C. § § 1396a(a)(10)(A), 1396a(a)(43), § 1905 (a)(r) of the Act; may need *careful review* based on medical diagnoses, evolving best practice treatments and changing federal guidance.



Autism /ASD and Coverage of Treatments under § SSA 1905(a):

The Role of Medicaid's EPSDT's
Benefit extends to "*Habilitative Care*"
in the treatment of Autism Spectrum
Disorders

DSM-5 and Autism Spectrum Disorders

What is an 'Autism Spectrum Disorder'?

A serious neurodevelopmental disorder characterized by restricted repetitive behaviors, interests and activities, impairing a child's ability to interact with others and causing significant problems in interpersonal functioning.

Key Definition

Autism spectrum disorder (ASD) is now defined by the American Psychiatric Association's **Diagnosis and Statistical Manual of Mental Disorders (DSM-5)** as a single disorder that includes disorders that were previously considered separate — autism, Asperger's syndrome, childhood disintegrative disorder and pervasive developmental disorder not otherwise specified.

Treatment Needs of the Child with ASD

- Children with ASD were in a challenging position for receiving evidence – based, effective modalities of treatment.
- Treatment approaches aimed at building new skills and behaviors /reducing maladaptive behaviors are considered '*habilitative*' by definition of the Medicaid Act, so not reimbursable under 42 C.F.R. 1396 1905.
- Habilitative services were available to 'waiver' enrollees, at risk of institutionalization, and;
- Not all ASD diagnosed children qualified under waiver criteria.
- Waitlists do not exist in Medicaid/EPSDT, but waitlists for waiver slots do exist.

What Did CMS Say?

- Evidence-based treatments, including communication approaches and behavioral treatments are now eligible for Federal Financial Participation (FFP) under three State Plan authorities:
 - Other Licensed Practitioners (OLP)
 - Preventive Services
 - Therapies



Note:

CMS did not specifically endorse ABA therapy (Applied Behavioral Analysis) in their statement.

Medical Necessity Review and the EPSDT Benefit

The “Correct or Ameliorate” Standard of Medical Necessity

Ameliorate

“To make more tolerable”

- improve or maintain the recipient’s health in the best condition possible,
- compensate for a health problem,
- prevent it from worsening, or
- prevent the development of additional health problems

The federal government’s intent was to both *relieve children’s suffering* and to *prevent the development and progression of debilitating and difficult/expensive to treat health conditions*.



Medical Necessity Review and the EPSDT Benefit: The AAP Standard of Medical Necessity for Children's Treatment



AAP Definition of Pediatric Medical Necessity:

“...health care interventions that are **evidence based, evidence informed, or based on consensus advisory opinion** and that are recommended by recognized health care professionals, such as the AAP, to promote optimal growth and development in a child and to prevent, detect, diagnose, treat, ameliorate, or palliate the effects of physical, genetic, congenital, developmental, behavioral, or mental conditions, injuries, or disabilities.”

<http://pediatrics.aappublications.org/content/pediatrics/132/2/398.full.pdf>

The EPSDT Medical Necessity Review

Decisions on medical necessity of a treatment, product or service requested for Medicaid enrolled children are based on:

Traditional evidence (patient-centered or scientific evidence for children) grading with a hierarchy or algorithm of standards should be applied.

In the absence of available traditional evidence or algorithms, ***professional standards of care*** for children must be considered.

Consensus expert pediatric opinion may serve as references for defining essential pediatric care when other, more rigorous standards are not available.



Source:

<http://pediatrics.aappublications.org/content/pediatrics/132/2/398.full.pdf>

The EPSDT Review Process

A professional or panel, appropriately licensed and credentialed with respect to the service requested must:



- *Review* the individual needs of the child as submitted in the request with reference to each element of the EPSDT criteria and all applicable law, policy and standards of best practice;
- *Research* best practice, peer reviewed journals and find support in data for **effectiveness of requested service in the individual case** as presented in the request, allowing case-based exceptions to those guidelines and policies as required by EPSDT standard;
- If unable to approve, the reviewer must compose an **individualized and clear decision** in a letter of Adverse Determination, and mail timely to beneficiary and requestor.

A Due Process Review:

When a requested service **does not meet** EPSDT medical necessity criteria, the Adverse Benefit Determination letter must ***indicate clearly the reasons for the decision***:

- When a professionally conducted EPSDT review determines that a requested service cannot be reasonably expected to 'correct or ameliorate' a health condition, a letter of *Adverse Determination* must be sent forward to the beneficiary and the requestor.
- *The reasoning for the decision should be clear*, and should link the clinical presentation of the beneficiary (as submitted by the requestor) to the evidence base related to the specific service requested.



Adverse Benefit Determination



When, in general, a requested service is:

- Medical in nature, and is within the categories of service described in § 1905 (a) of The Medicaid Act;
- An evidence-based / best practice intervention;

...but is not recommended for this beneficiary, a fact-based response, related to the individual's clinical presentation should answer the following question clearly :

“Which specific elements of the beneficiary's clinical presentation and treatment history indicate that the service would not now be effective?”



Adverse Benefit Determination

When a letter of Adverse Benefit Determination must be issued:

- Proper written notice with appeal rights must be provided to the recipient and copied to the provider.
- When a service currently authorized is being reduced or terminated, the notice must be mailed at least 10 days before the effective date of the action.



The notice must include:

- Clearly written reasons for the intended action,
- Citation of law that supports the intended action, and
- Notice of the right to appeal, with clear instructions on how to request a hearing.

§1905 (a)(r) Medicaid Coverable Services

- Prescription Drugs
- Dentures
- Eyeglasses
- PT, OT, And Services For Speech, Hearing, And Language Disorders
- Prosthetics
- ICF-MR Services
- Medical Care, Including Transportation To Care
- Diagnostic, Screening, Preventative, And Rehab Services
- Inpatient Psych Hospitalization
- TB / Respiratory Related Services
- Personal Care Services
- Hospital Services: In and Outpatient
- Rural Health Clinic Services
- FQHC Services
- Lab and X-ray Services
- Family Planning Services/Supplies
- Physician Services
- Dental Services, including Med/Surg
- Home Health
- Private Duty Nursing
- Clinic Services
- Hospice Services
- Case Management Services
- Primary Care Case Management