



North Carolina Medicaid

Division of Medical Assistance

The Medicaid Benefit for Children and its Federal Guarantees

Early and Periodic Screening, Diagnostic And Treatment Services: The Medical Necessity Review



The Foundation of the EPSDT Benefit

Statutory, CFR and CMS Publication References for The Benefit

- 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43),
- 1396d(a)(4)(B), 1396d(r)
- 42 C.F.R. §§ 441.50-441.62
- CMS, State Medicaid Manual, part 5
- CMS, ***EPSDT-A Guide for States***: Coverage in the Medicaid Benefit for Children and Adolescents Youth
- (June 2014), http://www.medicaid.gov/medicaid-chipprogram-information/bytopics/benefits/downloads/epsdt_coverage_guide.pdf

Early and Periodic Screening, Diagnosis and Treatment

Medicaid's benefit for its eligible children is identified by the familiar title addressing it in the Social Security Act

EPSDT is **not**:

- A special funding program.
- A stand-alone coverage with a special application process.
- A freestanding funding source for a limited class of services.

EPSDT **is**:

- A comprehensive healthcare plan focused on **prevention** and **early treatment**.
- A flexible plan with a menu of benefits available to be tailored to children's individual and developmental needs, not to private insurer benchmarks.

Early and Periodic Screening, Diagnosis and Treatment

‘EPSDT’ refers to Medicaid's benefit for its eligible children is identified by the familiar title addressing it in the Social Security Act.

So

If EPSDT means ‘the Medicaid Benefit’ for eligible kids, why the fuss over the words ‘EPSDT service’?

Just what IS an ‘EPSDT service’?

Early and Periodic Screening, Diagnosis and Treatment

Any service requiring an approval by EPSDT criteria is an 'EPSDT Service'

- A service **not on the state benefit plan** but included in the federal menu of services, available to children when prior approved per EPSDT criteria;
- A service provided at levels, amounts, frequencies or durations **exceeding state policy limits**, available when prior approved per EPSDT criteria;
- A service approved per EPSDT criteria by overriding strict eligibility or clinical criteria written in state policy.

Medical Necessity Reviews and The EPSDT Benefit

The Uniform Professional Medical
Necessity Review
per Federal EPSDT Criteria is
The Heartbeat
of the Benefit



The EPSDT Benefit and *'Services that Restore'*

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

The EPSDT Benefit Covers Rehabilitative Services

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

- “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.

Formal EPSDT Medical Necessity Criteria

*To qualify for Coverage Outside of Policy Limits
or As a Non-Covered Service, the Requested
Service Must Be:*

- Coverable under §1905 (a)(r), Social Security Act
- Medical in Nature,
- Not Experimental or Investigational,
- Generally Recognized as an Accepted Method of Medical Practice or Treatment,
- Safe,
- *Effective,*
- Least Costly Treatment of Equally Effective Choices.

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*.

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.

Medical Necessity Reviews and The EPSDT Benefit

When a Professional Medical Necessity Review
per Federal EPSDT Criteria results in an
Adverse Benefit Determination...



Adverse Benefit Determinations

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 Determinations

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, the statement should answer a key question with fact-based responses related to the individual:

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

Adverse Benefit Determinations

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 that care
- Diagnostic, screening, preventative, and rehabilitative services
- Inpatient psychiatric hospitalization
- TB / Respiratory related services
- Personal Care Services
- Hospital services, inpatient and outpatient
- Rural health clinic services
- FQHC services
- Lab and X-ray services
- Family planning services and supplies
- Physician services
- Dental services, including medical and surgical
- Home Health
- Private Duty Nursing
- Clinic Services
- Hospice Services
- Case Management /Primary Care CM