What is an "EPSDT" Service?

The Benefit covers any treatment or procedure listed within Social Security Act §1905(a) decided by an EPSDT standard of review to be medically necessary to **"correct or ameliorate**" defects and physical and mental illnesses and conditions." For children with multiple or complex medical conditions, a service requested may be approved under EPSDT's benefit even if it does not impact the child's condition overall, so long as it is effective in treating one of the child's diagnosed health conditions. The benefit includes both preventive and treatment components.

An EPSDT service:

EPSDT services may include **any** medical service listed in the categories of services found at *§1905(a) of Social Security Act.* These services are coverable when an individualized review per **federal EPSDT criteria** establishes that they are 'medically necessary.' This means that the services requested can reasonably be expected to 'correct or ameliorate' a child beneficiaries' health condition, regardless of their coverage status by a state Medicaid Plan

Remember, no service for a child may be denied, reduced, or terminated before is it reviewed per EPSDT criteria.

Early and Periodic Screens (Wellness Visits)

Preventive health visits are provided at intervals recommended by the American Academy of Pediatrics (AAP "**Bright Futures**" Publication). Early Periodic Screens include the following **federally required** components:

- Comprehensive health history and physical exam.
- Surveillance/screening for developmental and behavioral health problems.
- All recommended ACIP immunizations.
- Vision, hearing, and dental health screenings.
- Routine and medically necessary lab testing.
- Health education and anticipatory guidance to family.
- Referral for any suspected or diagnosed health conditions.

Comprehensive Treatment Services

When determined to be medically necessary by an EPSDT review, children may receive any medical service found within broad categories listed within §1905(a) of the *Social Security Act, including:*

- Services not on the state's Medicaid Plan;
- Services exceeding levels, amounts, frequencies, or durations exceeding state policy limits;
- Services that contain strict eligibility or clinical limits in state clinical policy coverage criteria unmet by the beneficiary.