Fact Sheet
Early and Periodic Screening, Diagnosis and Treatment

What is the NC Medicaid EPSDT Benefit for Children?

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is the federal law (44 CFR Subpart B) that states that Medicaid must provide all medically necessary health care services to Medicaid-eligible children under the age of 21.

Even if a service is not covered under the NC Medicaid State Plan, it can be covered for beneficiaries under 21 years of age if the service is listed in 1905(a) of the Social Security Act and if all EPSDT criteria are met.

EPSDT: PREVENTATIVE SERVICES

EPSDT covers preventative services for beneficiaries under the age of 21, which includes Health Check or wellness visits and comprehensive screenings.

- All preventative services provided under EPSDT should include the EP modifier on the claim, when submitted to the health plan or NC Medicaid Direct.
- These services do not require prior authorization.
- These services include wellness or Health Check visits and comprehensive screenings

The required components of a Health Check visit are:

- Comprehensive health and developmental history that assesses for both physical and mental health, as well as for substance use disorders
- Comprehensive, unclothed physical examination
- Appropriate immunizations in accordance with the schedule for pediatric vaccines established by the Advisory Committee on Immunization Practices
- Laboratory testing (including blood lead screening appropriate for age and risk factors)
- Health education and anticipatory guidance for both the child and caregiver

EPSDT: DIAGNOSIS AND TREATMENT

EPSDT also covers Diagnosis and Treatment services (DT). This includes treatment for conditions found during a comprehensive screening.

- If a service is not covered under the Medicaid State Plan, a request can be made for coverage under EPSDT for any Medicaid beneficiary under 21 years of age.
- EPSDT medical necessity reviews are conducted on a case-by-case basis by the managed care health plan that receives the request or by NCTracks for Medicaid Direct.
- Any request for non-covered services, or service requests that fall outside of the policy guidelines and limitations, do require prior authorization submitted to either the appropriate managed care health plan, or to NCTracks if the beneficiary is covered under Medicaid Direct.
- Requests for Diagnostic and Treatment services do NOT require an EP modifier but should have a prior authorization which authorizes the requested service.
- Must be medical in nature
- Must be coverable under §1905(a) of the Social Security Act
- Must not be experimental or investigational
- Must be generally recognized as an accepted method of medical practice or treatment
- Must be safe
- Must be effective

EPSDT: REQUESTS FOR COVERED SERVICES

- Requests for covered services for an individual under the age of 21 are made to the appropriate health plan through their standard process or through NCTracks for beneficiaries in Medicaid Direct.
- If it is within the clinical policy coverage guidelines, the request is reviewed the same as any other request.
- If the request is for a covered service, but outside of the clinical coverage guidelines, it will be reviewed under EPSDT criteria. If the request meets the federal EPSDT criteria, it may then be approved. If it is not approved in full after being reviewed under EPSDT criteria, then a notice of Adverse Benefit Determination is sent to the beneficiary.
- The beneficiary has the right to appeal any Adverse Benefit Determination. Please review the Health plans policies and procedures for information on how to submit an appeal for that designated health plan. This information can also be found in the Adverse Benefit Determination letter, which is sent by Medicaid Direct or the health plan, notifying the beneficiary of the denial. For Medicaid Direct beneficiaries, an appeal can be requested by mail, phone, fax or in-person. You have 60 days from the date the Adverse Benefit Determination was issued to file an appeal.
- EPSDT reviews are conducted on a case-by-case basis for all requests received for beneficiaries under the age of 21, ensuring they meet federal EPSDT criteria and that the requested service is medically necessary to “correct or ameliorate” a defect, physical or mental illness or a condition that is identified through a screening examination.

EPSDT: LIMITS WITHIN CLINICAL POLICY

- The specific numerical limits (number of hours, number of visits, or other limitations on scope, amount or frequency) in DHB or the designated health plans clinical coverage policies, service definitions, or billing codes do NOT apply to recipients under 21 years of age if more hours or visits of the requested service are medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problem].
- Other restrictions in the clinical coverage policies, such as the location of the service, prohibitions on multiple services on the same day or at the same time (e.g., day treatment and residential treatment) must also be waived under EPSDT as long as the services are medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problem].

EPSDT: PRIOR APPROVALS

- Requests for prior approval of services must be fully documented to show medical necessity.
- Requests should include current information from the beneficiary's physician, other licensed clinicians, the requesting qualified provider, and/or family members or legal representative.
- If this information is not provided, the health plan or NCTracks for Medicaid Direct will have to obtain the needed information, and this will delay the prior approval decision.
- The form to submit a non-covered service request for Medicaid Fee-for-Service beneficiaries under 21 years of age is located here: Non-Covered State Plan Services Request Form 21 under (NC Medicaid-3402) 12019.pdf
- The managed care health plans may have separate forms and processes for submitting requests for non-covered services, and you can find those in their provider manuals.

EPSDT: CLAIM REIMBURSEMENT

Upon identification of an EPSDT claim per federal guidelines and requirements, all EPSDT claims are paid by Medicaid Direct and the health plans as the primary payer. The health plans shall chase any recovery from the liable third-party payer unless it has been determined as not cost-effective to pursue recovery. EPSDT claims are exempt from the standard coordination of benefits regulations in which Medicaid is the payer of last resort.

Depending on how the provider bills, the health plan may need to pay and chase claims that would have been cost-avoided. For example, if a provider submits a bundled claim, and the bundled claim includes any cost-avoided services, suppose the cost-avoided services cannot be identified and adjudicated separately. In this case, the health plan must pay and chase the entire bundled claim to ensure compliance with federal requirements.

EPSDT TRAININGS

Currently, NC Medicaid is providing trainings to all NC Medicaid Managed Care health plans, and reviewing their EPSDT processes and procedures to ensure they align with federal guidelines. NC Medicaid has completed several trainings for providers on the EPSDT benefit for Medicaid beneficiaries under 21 years of age. We will continue these trainings to educate providers and beneficiaries about the services available to them and the guidelines around EPSDT. Please review NC Medicaid's website for updates on any upcoming trainings.

Fact Sheets will be updated periodically with current information. For more information, please visit Early and Periodic Screening, Diagnostic and Treatment Form | NC Medicaid (ncdhhs.gov)