

EPSDT POLICY INSTRUCTIONS UPDATE

Background

Federal Medicaid law at 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act] requires state Medicaid programs to provide Early and Periodic Screening, Diagnostics, and Treatment (EPSDT) for recipients under 21 years of age. Within the scope of EPSDT benefits under the federal Medicaid law, states are required to cover any service that is medically necessary “to correct or ameliorate a defect, physical or mental illness, or a condition identified by screening,” whether or not the service is covered under the North Carolina State Medicaid Plan. The services covered under EPSDT are limited to those within the scope of the category of services listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act]. The listing of EPSDT/Medicaid services is appended to this instruction.

EPSDT services include any medical or remedial care that is medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problem]. This means that EPSDT covers most of the treatments a recipient under 21 years of age needs to stay as healthy as possible, and North Carolina Medicaid must provide for arranging for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment the need for which is disclosed by such child health screening services. “**Ameliorate**” means to 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. Even if the service will not cure the recipient’s condition, it must be covered if the service is medically necessary to improve or maintain the recipient’s overall health.

EPSDT makes short-term and long-term services available to recipients under 21 years of age without many of the restrictions Medicaid imposes for services under a waiver **OR** for adults (recipients 21 years of age and over). For example, a service must be covered under EPSDT if it is necessary for immediate relief (e.g., pain medication). It is also important to note that treatment need not ameliorate the recipient’s condition taken as a whole, but need only be medically necessary to ameliorate one of the recipient’s conditions. The services must be prescribed by the recipient’s physician, therapist, or other licensed practitioner and often must be approved in advance by Medicaid. See the *Basic Medicaid Billing Guide, Section 6* (on the Web at <http://www.ncdhhs.gov/dma/basicmed/>), for further information about EPSDT and prior approval requirements.

EPSDT Features

Under EPSDT, there is:

1. No Waiting List for EPSDT Services

EPSDT does not mean or assure that physicians and other licensed practitioners or hospitals/clinics chosen by the recipient and/or his/her legal representative will not have waiting lists to schedule appointments or medical procedures. However, Medicaid cannot impose any waiting list and must provide coverage for corrective treatment for recipients under 21 years of age.

2. No Monetary Cap on the Total Cost of EPSDT Services*

A child under 21 years of age financially eligible for Medicaid is entitled to receive EPSDT services without any monetary cap provided the service meets all EPSDT criteria specified in this policy instruction. If enrolled in a Community Alternatives Program (CAP), the recipient under 21 years of age may receive **BOTH** waiver and EPSDT services. However, it is important to remember that the conditions set forth in the waiver concerning the recipient’s budget and continued participation in the waiver apply. That is, the cost of the recipient’s care must not exceed the waiver cost limits specified in the CAP waivers for Children (CAP/C) or Disabled

Adults (CAP/DA). Should a recipient enrolled in the CAP waiver for Persons with Mental Retardation and Developmental Disabilities (CAP/MR-DD) need to exceed the waiver cost limit, prior approval must be obtained from ValueOptions.

***EPSDT services are defined as Medicaid services within the scope of the category of services listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act]. See attached listing.**

3. No Upper Limit on the Number of Hours or Units under EPSDT

For clinical coverage policy limits to be exceeded, the provider's documentation must address why it is medically necessary to exceed the limits in order to correct or ameliorate a defect, physical or mental illness, or condition [health problem].

4. No Limit on the Number of EPSDT Visits to a Physician, Therapist, Dentist, or Other Licensed Clinician

To exceed such limits, the provider's documentation must address why it is medically necessary to exceed the limits in order to correct or ameliorate a defect, physical or mental illness, or condition [health problem].

5. No Set List that Specifies When or What EPSDT Services or Equipment May Be Covered

Only those services within the scope of those listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act] can be covered under EPSDT. See attached listing. However, specific limitations in service definitions, clinical policies, or DMA billing codes **MAY NOT APPLY** to requests for services for children under 21 years of age.

6. No Co-payment or Other Cost to the Recipient

7. Coverage for Services That Are Never Covered for Recipients 21 Years of Age and Older

Only those services within the scope of those listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act] can be covered under EPSDT. See attached listing. Provider documentation must address why the service is medically necessary to correct or ameliorate a defect, physical and mental illness, or condition [health problem].

8. Coverage for Services Not Listed in the N.C. State Medicaid Plan

Only those services within the scope of those listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act] can be covered under EPSDT. See attached listing.

EPSDT Criteria

It is important to note that the service can only be covered under EPSDT if all criteria specified below are met.

1. EPSDT services must be coverable services within the scope of those listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act]. For example, "rehabilitative services" are a covered EPSDT service, even if the particular rehabilitative service requested is not listed in DMA clinical policies or service definitions.
2. The service must be medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] diagnosed by the recipient's physician, therapist, or other licensed practitioner. By requiring coverage of services needed to correct or ameliorate a defect, physical or mental illness, or a condition [health problem], EPSDT requires payment of services that are medically necessary to sustain or support rather than cure or eliminate health problems to the extent that the service is needed to correct or ameliorate a defect, physical or mental illness, or condition [health problem].
3. The requested service must be determined to be medical in nature.

4. The service must be safe.
5. The service must be effective.
6. The service must be generally recognized as an accepted method of medical practice or treatment.
7. The service must not be experimental/investigational.

Additionally, services can only be covered if they are provided by a North Carolina Medicaid enrolled provider for the specific service type. This may include an out-of-state provider who is willing to enroll if an in-state provider is not available.

IMPORTANT POINTS ABOUT EPSDT COVERAGE

General

1. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. EPSDT services must be coverable within the scope of those listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act]. EPSDT requires Medicaid to cover these services if they are medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]. “**Ameliorate**” means to 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.
3. Recipients under 21 must be afforded access to the full panoply of EPSDT services, including case management. Case management must be provided to a Medicaid eligible child if medically necessary to correct or ameliorate the child’s condition regardless of eligibility for CAP waiver services.
4. EPSDT services need not be services that are covered under the North Carolina State Medicaid Plan or under any of the Division of Medical Assistance’s (DMA) clinical coverage policies or service definitions or billing codes.
5. Under EPSDT, North Carolina Medicaid must make available a variety of individual and group providers qualified and willing to provide EPSDT services.
6. EPSDT operational principles include those specified below.
 - a. When state staff or vendors review a covered state Medicaid plan services request for prior approval or continuing authorization (UR) for an individual under 21 years of age, the reviewer will apply the EPSDT criteria to the review. This means that:
 - (1) Requests for EPSDT services do **NOT** have to be labeled as such. Any proper request for services for a recipient under 21 years of age is a request for EPSDT services. For recipients under 21 years of age enrolled in a CAP waiver, a request for services must be considered under EPSDT as well as under the waiver.
 - (2) The decision to approve or deny the request will be based on the recipient’s medical need for the service to correct or ameliorate a defect, physical [or] mental illness, or condition [health condition].
 - b. The specific coverage criteria (e.g., particular diagnoses, signs, or symptoms) in the DMA clinical coverage policies or service definitions do **NOT** have to be met for recipients under 21 years if the service is medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problems].
 - c. The specific numerical limits (number of hours, number of visits, or other limitations on scope, amount or frequency) in DMA 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]. This includes the hourly limits and location limits on Medicaid Personal Care Services (PCS) and Community Support Services (CSS).

- d. Other restrictions in the clinical coverage policies, such as the location of the service (e.g., PCS only in the home), 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].

Out-of-state services are NOT covered if similarly efficacious services that are medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problems] are available anywhere in the state of North Carolina. Services delivered without prior approval will be denied. There is no retroactive prior approval for services that require prior approval, unless there is retroactive Medicaid eligibility. See DMA's *Basic Medicaid Billing Guide, Section 6* (on the Web at <http://www.ncdhhs.gov/dma/basicmed/>), for further information regarding the provision of out-of-state services.

- e. Providers or family members may write directly to the Assistant Director for Clinical Policy and Programs, Division of Medical Assistance, requesting a review for a specific service. However, DMA vendors and contractors must consider any request for state Medicaid plan services for a recipient under 21 years of age under EPSDT criteria when the request is made by the recipient's physician, therapist, or other licensed practitioner in accordance with the Division's published policies. If necessary, such requests will be forwarded to DMA or the appropriate vendor.
- f. Requests for prior approval for services must be fully documented to show medical necessity. This requires current information from the recipient's physician, other licensed clinicians, the requesting qualified provider, and/or family members or legal representative. If this information is not provided, Medicaid or its vendor will have to obtain the needed information, and this will delay the prior approval decision. See procedure below for requesting EPSDT services regarding further detail about information to be submitted.
- g. North Carolina Medicaid retains the authority to determine how an identified type of equipment, therapy, or service will be met, subject to compliance with federal law, including consideration of the opinion of the treating physician and sufficient access to alternative services. Services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner, the determination process does not delay the delivery of the needed service, and the determination does not limit the recipient's right to free choice of North Carolina Medicaid enrolled providers who provide the approved service. It is not sufficient to cover a standard, lower cost service instead of a requested specialized service if the lower cost service is not equally effective in that individual case.
- h. Restrictions in CAP waivers such as no skilled nursing for the purpose of monitoring do not apply to EPSDT services if skilled monitoring is medically necessary. Nursing services will be provided in accordance with 21 NCAC 36.0221 (adopted by reference).
- i. Durable medical equipment (DME), assistive technology, orthotics, and prosthetics do NOT have to be included on DMA's approved lists or be covered under a CAP waiver program in order to be covered under EPSDT subject to meeting the criteria specified in this policy.
- j. Medicaid will cover treatment that the recipient under 21 years of age needs under this EPSDT policy. DMA will enroll providers, set reimbursement rates, set provider qualifications, and assure the means for claims processing when the service is not already established in the North Carolina State Medicaid Plan.

- k. Requests for prior approval of services are to be decided with reasonable promptness, usually within 15 business days. No request for services for a recipient under 21 years of age will be denied, formally or informally, until it is evaluated under EPSDT.
- l. If services are denied, reduced, or terminated, proper written notice with appeal rights must be provided to the recipient and copied to the provider. The notice must include reasons for the intended action, citation that supports the intended action, and notice of the right to appeal. Such a denial can be appealed in the same manner as any Medicaid service denial, reduction, or termination.
- m. The recipient has the right to continued Medicaid payment for services currently provided pending an informal and/or formal appeal. This includes the right to reinstatement of services pending appeal if there was less than a 30 day interruption before submitting a re-authorization request.

EPSDT Coverage and CAP Waivers

1. Waiver services are available only to participants in the CAP waiver program and are not a part of the EPSDT benefit unless the waiver service is ALSO an EPSDT service (e.g. durable medical equipment).
2. Any request for services for a CAP recipient under age 21 must be evaluated under BOTH the waiver and EPSDT.
3. Additionally, a child financially eligible for Medicaid outside of the waiver is entitled to elect EPSDT services without any monetary cap instead of waiver services.
4. ANY child enrolled in a CAP program can receive BOTH waiver services and EPSDT services. However, if enrolled in CAP/C or CAP/DA, the cost of the recipient's care must not exceed the waiver cost limit. Should the recipient be enrolled in the Community Alternatives Program for Persons with Mental Retardation and Developmental Disabilities (CAP/MR-DD), prior approval must be obtained to exceed the waiver cost limit.
5. A recipient under 21 years of age on a waiting list for CAP services, who is an authorized Medicaid recipient without regard to approval under a waiver, is eligible for necessary EPSDT services without any waiting list being imposed by Medicaid. For further information, see "No Waiting List for EPSDT" on page 2 of this instruction.
6. EPSDT services must be provided to recipients under 21 years of age in a CAP program under the same standards as other children receiving Medicaid services. For example, some CAP recipients under 21 years of age may need daily in-school assistance supervised by a licensed clinician through community intervention services (CIS) or personal care services (PCS). It is important to note that Medicaid services coverable under EPSDT may be provided in the school setting, including to CAP/MR-DD recipients. Services provided in the school and covered by Medicaid must be included in the recipient's budget.
7. Case managers in the Community Alternatives Program for Disabled Adults (CAP/DA) can deny a request for CAP/DA waiver services. If a CAP/DA case manager denies, reduces, or terminates a CAP/DA waiver service, it is handled in accordance with DMA's recipient notices procedure.
No other case manager can deny a service request supported by a licensed clinician, either formally or informally.
8. When a recipient under 21 years of age is receiving CAP services, case managers must request covered state Medicaid plan services as indicated below. Covered state Medicaid plan services are defined as requests for services, products, or procedures covered by the North Carolina State Medicaid Plan.
 - a. **CAP/C:** Requests for medical, dental, and behavioral health services covered under the North Carolina State Medicaid Plan that require prior approval must be forwarded to the appropriate

vendor and a plan of care revision submitted to the CAP/C consultant at DMA in accordance with the CAP/C policy. A plan of care revision for waiver services must be submitted to the CAP/C consultant as well.

- b. **CAP/DA:** Requests for medical, dental, and behavioral health services covered under the North Carolina State Medicaid Plan that require prior approval must be forwarded to the appropriate vendor and a plan of care revision submitted to the CAP/DA case manager in accordance with the CAP/DA policy. A plan of care revision for waiver services must be submitted to the CAP/DA case manager as well. **All EPSDT requests must be forwarded to the CAP/DA consultant at DMA.**
 - c. **CAP/MR-DD:** All EPSDT and covered state Medicaid plan requests for behavioral health services must be forwarded to ValueOptions. This includes requests for children not in a waiver who have a case manager. Requests for medical and dental services covered under the North Carolina State Medicaid Plan must be forwarded to the appropriate vendor (medical or dental) for review and approval. Do **NOT** submit such requests to ValueOptions. Plan of care revisions must be submitted in accordance with the CAP/MR-DD policy.
EXCEPTION: Behavioral health services requested for individuals residing in the Piedmont Cardinal Health Plan (PCHP) catchment area. See item d below.
 - d. All EPSDT and covered state Medicaid plan requests for *behavioral health services* for Medicaid recipients in the Piedmont Cardinal Health Plan (PCHP) catchment area must be forwarded to PCHP. The PCHP catchment area includes Cabarrus, Davidson, Rowan, Stanly, and Union counties. Requests for *medical and dental services* covered under the North Carolina State Medicaid Plan must be forwarded to the appropriate vendor (medical or dental) for review and approval. Do *not* submit such requests to PCHP. Plan of care revisions must be submitted in accordance with the Piedmont Innovations waiver policy.
9. An appeal under CAP must also be considered under EPSDT criteria as well as under CAP provisions if the appeal is for a Medicaid recipient under 21 years of age.

EPSDT Coverage and Mental Health/Developmental Disability/Substance Abuse (MH/DD/SA) Services

1. Staff employed by local management entities (LMEs) CANNOT deny requests for services, formally or informally. Requests must be forwarded to ValueOptions or the other appropriate DMA vendor if supported by a licensed clinician.
2. LMEs may NOT use the Screening, Triage, and Referral (STR) process or DD eligibility process as a means of denying access to Medicaid services. Even if the LME STR screener does not believe the child needs enhanced services, the family must be referred to an appropriate Medicaid provider to perform a clinical evaluation of the child for any medically necessary service.
3. Requests for prior approval of MH/DD/SA services for recipients under 21 must be sent to ValueOptions or LME if providing utilization review for their catchment area. If the request needs to be reviewed by DMA clinical staff, ValueOptions will forward the request to the Assistant Director for Clinical Policy and Programs.
4. If a recipient under 21 years of age has a developmental disability diagnosis, this does not necessarily mean that the requested service is habilitative and may not be covered under EPSDT. The EPSDT criteria of whether the service is medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problem] apply. Examples include dual diagnoses and behavioral disorders. All individual facts must be considered.
5. All EPSDT requirements (except for the procedure for obtaining services) fully apply to the Piedmont waiver.

PROCEDURE FOR REQUESTING EPSDT SERVICES

Covered State Medicaid Plan Services

Should the service, product, or procedure require prior approval, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior approval. **If prior approval is required** and if the recipient does not meet the clinical coverage criteria or needs to exceed clinical coverage policy limits, submit documentation with the prior approval request that shows how the service at the requested frequency and amount is medically necessary and meets all EPSDT criteria, including to correct or ameliorate a defect, physical or mental illness, or condition [health problem], to the appropriate vendor or DMA staff. When requesting prior approval for a covered service, refer to the *Basic Medicaid Billing Guide*, section 6. If the request for service needs to be reviewed by DMA clinical staff, the vendor will forward the request to the Assistant Director for Clinical Policy and Programs. Should further information be required, the provider will be contacted. See the Provider Documentation section of these instructions for information regarding documentation requirements.

In the event **prior approval is not required** for a service and the recipient needs to exceed the clinical coverage policy limitations, prior approval from a vendor or DMA staff is required. See the Provider Documentation section of these instructions for information regarding documentation requirements.

Services Formerly Covered by Children's Special Health Services (CSHS)

Previously, requests for pediatric mobility systems, cochlear implants and accessories, ramps, tie-downs, car seats, vests, DME, orthotics and prosthetics, home health supplies, not listed on DME fee schedules for recipients under 21 years of age, oral nutrition, augmentative and alternative communication devices, and over-the counter medications were approved and processed by CSHS. These services have been transferred from CSHS to Medicaid as specified below.

- **Pediatric Mobility Systems**, including non-listed components—Send to HP Enterprise Services using the Certificate of Medical Necessity/Prior Approval (CMN/PA form). Refer to Clinical Coverage Policy 5A, *Durable Medical Equipment*, for details (on DMA's website at <http://www.ncdhhs.gov/dma/mp/>).
- **Cochlear/Auditory Brainstem Implants and Accessories**—Fax all requests for external parts replacement and repair, in letter format, to the appropriate cochlear or auditory brainstem implant manufacturer. The manufacturer will process requests, obtain prior approval for external speech processors, and file claims. Guidelines for the letter requesting external parts replacement or repair can be obtained from the cochlear or auditory brainstem manufacturer.
- **Oral Nutrition Formula on DMA Fee Schedules**—Send requests except those for metabolic formula to HP Enterprise Services. Refer to Clinical Coverage Policy 5A, *Durable Medical Equipment*, for details (on DMA's website at <http://www.ncdhhs.gov/dma/mp/>). Metabolic formula requests should be sent to the Division of Public Health.
- **Augmentative and Alternative Communication Devices on DMA Fee Schedules**—Send requests to HP Enterprise Services.
- **Ramps, Tie Downs, Car Seats, and Vests**—Effective with date of request September 1, 2008, CSHS no longer authorizes payment for ramps, tie-downs, car seats, and vests. These items are not included in the DME covered by Medicaid, nor are they covered under EPSDT services, which cover medical equipment and supplies suitable for use in the home for Medicaid recipients under the age of 21. However, if the recipient is covered under a Medicaid waiver, these items may be considered **if covered under the waiver**.

Non-Covered State Medicaid Plan Services

Requests for non-covered state Medicaid plan services are requests for services, products, or procedures that are not included at all in the North Carolina State Medicaid Plan **but are coverable** under federal Medicaid law, 1905(r) of the Social Security Act, for recipients under 21 years of age. See attached listing. **Medical and dental** service requests for non-covered state Medicaid plan services, and requests for a review when there is no established review process for a requested service, should be submitted to the Division of Medical Assistance, Assistant Director for Clinical Policy and Programs, at the address or facsimile (fax) number specified on the Non-Covered State Medicaid Plan Services Request Form for Recipients under 21 Years of Age. Requests for non-covered state Medicaid plan **mental health services** should be submitted to ValueOptions. The Non-Covered State Medicaid Plan Services Request Form for Recipients under 21 Years of Age is available on the DMA Web site <http://www.ncdhhs.gov/dma/provider/forms.htm>. To decrease delays in reviewing non-covered state Medicaid plan requests, providers are asked to complete this form. A review of a request for a non-covered state Medicaid plan service includes a determination that **ALL** EPSDT criteria specified in these instructions are met.

Requests for the services listed below should be sent to the Assistant Director, Clinical Policy and Programs, DMA and should be submitted on the Non-Covered State Medicaid Plan Services Request Form for Recipients under 21 Years of Age as specified at the end of this section and unless otherwise specified.

- **Any other service not listed on the DMA fee schedules for recipients under 21 years of age that appears at 1905(a) of the Social Security Act**
- **Over-the-Counter (OTC) Medications**—If the OTC has a National Drug Code (NDC) number and the manufacturer has a valid rebate agreement with the Centers for Medicare and Medicaid Services (CMS), but the drug does not appear on DMA's approved coverage listing of OTC medications.

Send requests for the services immediately above, any other non-covered state Medicaid plan services that are coverable under 1905(a) of the Social Security Act, or requests for a review when there is no established review process for a requested service on the Non-Covered State Medicaid Plan Services Request Form for Recipients under 21 Years of Age and mail or fax to

Assistant Director for Clinical Policy and Programs
Division of Medical Assistance
2501 Mail Service Center
Raleigh NC 27699-2501
FAX: 919-715-7679

Provider Documentation

Documentation for either covered or non-covered state Medicaid plan services should show how the service will correct or ameliorate a defect, physical or mental illness, or a condition [health problem]. This includes

1. documentation showing that medical necessity and policy criteria are met;
2. documentation to support that all EPSDT criteria are met; and
3. evidence-based literature to support the request, if available.

Should additional information be required, the provider will be contacted.

Instructions to Vendors Who Receive Prior Approval Requests Inappropriately from Providers

Vendors (HP Enterprise Services, ACS Pharmacy, CCME, and ValueOptions, etc.) may receive service requests from providers for which the vendor is not responsible for conducting the prior approval reviews. As vendors can only authorize specific services in accordance with DMA-vendor contracts, those requests should be forwarded to the appropriate vendor for review. For example:

1. If ValueOptions receives a request for breast surgery, the request should be forwarded to the prior approval section at HP Enterprises Services.
2. Should HP Enterprise Services receive a request for physical therapy, the request should be forwarded to CCME.
3. Should a vendor receive a request for Medicaid Personal Care Services (PCS) for a recipient **under 21 years of age**, the request should be forwarded to DMA, PCS Nurse Consultant, if the PCS clinical policy requires prior approval for the service requested in that case.

It should be noted that there may be a delay in making a decision when a provider sends a prior approval request to a vendor for which the vendor is not responsible for conducting the prior approval review. Once the request is received by the appropriate vendor, a decision will be reached promptly, usually within 15 business days of receipt of the request by the appropriate vendor.

Outreach

A special mailing publicizing Medicaid's EPSDT Policy instructions will be distributed to recipients and their legal representatives in the near future. The document will address general information about EPSDT, the Division's EPSDT Policy Instructions, and procedures for requesting services under EPSDT.

This policy instruction shall remain posted at both DMA and DMH websites. DMA and DMH will regularly inform their staff, related DHHS Divisions, vendors, agents, Medicaid providers, families, and other agencies working with children on Medicaid (e.g. schools, Headstart, WIC, Smart Start, etc.) about this EPSDT policy and its procedures for EPSDT services. A summary of this policy and procedure, and a reference to the website address where it is posted, will be included in the Medicaid Consumer Guide for Families, in annual inserts with Medicaid cards, and in Medicaid provider bulletin articles at least annually. All affected staff, vendors, and providers will receive training on EPSDT policy and procedures.

DHHS Division Directors will transmit these instructions to staff and vendors/ contractors.

For Further Information about EPSDT

- Important additional information about EPSDT and prior approval is found in the *Basic Medicaid Billing Guide*, sections 2 and 6, and on the DMA EPSDT provider page. The web addresses are specified below.

Basic Medicaid Billing Guide

<http://www.ncdhhs.gov/dma/basicmed/>

Health Check Billing Guide

<http://www.ncdhhs.gov/dma/healthcheck/>

EPSDT Provider Page

<http://www.ncdhhs.gov/dma/epsdt/>

- DMA and its vendors will conduct trainings beginning fall 2007 for employees, agents, and providers on this instruction. Details will be published as soon as available.

ATTACHMENTS:

- Listing of Medicaid (EPSDT) Services Found in the Social Security Act at 1905(a) [42 U.S.C. § 1396d(a)]
- Non-Covered State Medicaid Plan Services Request Form

LISTING OF EPSDT SERVICES FOUND AT 42 U.S.C. § 1396d(a) [1905(a) OF THE SOCIAL SECURITY ACT]

- Inpatient hospital services (other than services in an institution for mental disease)
- Outpatient hospital services
- Rural health clinic services (including home visits for homebound individuals)
- Federally-qualified health center services
- Other laboratory and X-ray services (in an office or similar facility)
- EPSDT (*Note: EPSDT offers periodic screening services for recipients under age 21 and Medicaid covered services necessary to correct or ameliorate a diagnosed physical or mental condition*)
- Family planning services and supplies
- Physician services (in office, recipient's home, hospital, nursing facility, or elsewhere)
- Medical and surgical services furnished by a dentist
- Home health care services (nursing services; home health aides; medical supplies, equipment, and appliances suitable for use in the home; physical therapy, occupation therapy, speech pathology, audiology services provided by a home health agency or by a facility licensed by the State to provide medical rehabilitation services)
- Private duty nursing services
- Clinic services (including services outside of clinic for eligible homeless individuals)
- Dental services
- Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders
- Prescribed drugs
- Dentures
- Prosthetic devices
- Eyeglasses
- Services in an intermediate care facility for the mentally retarded
- Medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law, specified by the Secretary (also includes transportation by a provider to whom a direct vendor payment can appropriately be made)
- Other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level
- Inpatient psychiatric hospital services for individuals under age 21
- Services furnished by a midwife, which the nurse-midwife is legally authorized to perform under state law, without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider throughout the maternity cycle
- Hospice care
- Case-management services
- TB-related services
- Respiratory care services
- Services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner, which the practitioner is legally authorized to perform under state law
- Personal care services (in a home or other location) furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease
- Primary care case management services

Definitions of the above federal Medicaid services can be found in the Code of Federal Regulations 42 CFR 440.1-440.170 at http://www.access.gpo.gov/nara/cfr/waisidx_06/42cfr440_06.html.