EPSDT PROCEDURAL POLICY INSTRUCTIONS

Background

Federal Medicaid law at 42 U.S.C.§ 1396d(r) and 1396a(a)(10)(A), a(a)(43), and d(a)(4)(B) [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].

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]. **"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. 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 and all Managed Care Organizations (MCO's) must arrange and provide for (either directly or through referral to appropriate agencies, organizations or individuals) corrective treatment when the need for such treatment is identified through a child health screening service or encounter with a licensed practitioner. Any qualified provider operating within the scope of his or her practice, as defined by state law, can provide a periodic or interperiodic screening. The screening need not be conducted by a Medicaid provider in order to trigger EPSDT coverage for follow up diagnostic services and medically necessary treatment by a qualified Medicaid provider.

EPSDT makes short-term and long-term services available to recipients under 21 years of age without many of the restrictions Medicaid imposes on services for adults or under a waiver. For example, a service must be covered under EPSDT if it is necessary for immediate relief. 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 *Medicaid Health Plan Billing Guide,* **Section 3.27** (on the Web at Health Plan Billing Guidance | NC Medicaid), for further information about EPSDT and prior approval requirements.

Consistent with federal disability rights laws and the Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999), state Medicaid programs and their contractors, including managed care organizations, must ensure that services covered under EPSDT are provided in the most integrated setting appropriate for the child, which includes clinics, or in schools, and at home, and must avoid unnecessary placements in segregated treatment settings.

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 Division of Health Benefits (DHB) 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 medically necessary.
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.
8. EPSDT includes preventive screenings for beneficiaries under the age of 21, per the guidelines in the American Academy of Pediatrics: Bright Futures Periodicity Schedule, which can be found here: AAP Bright Futures Periodicity Schedule (aap.org)

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 a0nd completes enrollment if an in-state provider is not available.

For beneficiaries enrolled with a Managed Care Organization (MCO), if the provider network is unable to provide necessary services, covered under the contract, to a particular enrollee, the MCO, PIHP (Prepaid Inpatient Health Plan), or PAHP (Prepaid Ambulatory Health Plan) must adequately and timely cover these services out of network for the enrollee, for as long as the MCO, PIHP, or PAHP's provider network is unable to provide them [42 CFR 438.206(b)(4)].

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 waiver program, 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.

For child beneficiaries who are waiver enrollees, approval of the *waiver services* which cannot be covered under EPSDT as well as the delivery and cost of the recipient's waiver services must be in compliance with the requirements established by the waiver *and* with applicable Medicaid policy.

When a child who is enrolled in a waiver program is otherwise eligible for Medicaid, all conditions set forth in the waiver concerning continued participation in the waiver apply as to waiver services.

If the requested service is both a waiver service and an EPDST service, it must be covered as an EPSDT service and should not be counted toward the recipient's waiver budget.

The beneficiary participating in a North Carolina waiver program may exceed policy or program limits on any individual service qualifying as *both* a waiver service and as a coverable service under the child Medicaid EPSDT Benefit. Prior approval for the over-limit service must be requested and approved *before* the service is delivered and *before* the waiver limit is exceeded.

***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 of services covered under 1905(a) of the Social Security Act. However, specific limitations in service definitions, clinical policies, or DHB 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
Children under the age of 21 are exempt from copayment.

7. Coverage for Services That Are Never Covered for Recipients 21 Years of Age and Older
Non-covered services may be covered under the EPSDT if those services are within the scope of those listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act]. See attached listing of services covered under 1905(a) of the Social Security Act. 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
Services not listed in the N.C. Medicaid State Plan may be covered under EPSDT if those services are within the scope of those listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act] and they are determined to be medically necessary to correct or ameliorate the child's health condition. See attached listing of services covered under 1905(a) of the Social Security Act.

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. 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 and meets federal EPSDT requirements.
3. Recipients under 21 must be afforded access to the full array of EPSDT services, covered under 1905(a) of the Social Security Act.
4. EPSDT services need not be services that are covered under the North Carolina State Medicaid Plan or under any of the DHB clinical coverage policies or service definitions or billing codes.
5. Under EPSDT, North Carolina Medicaid and the Managed Care Organizations must make available a variety of qualified providers willing to provide EPSDT services.
6. EPSDT operational principles include those specified below.

When state staff or vendors review a covered state Medicaid plan service 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 when it falls outside the clinical policy limits, scope and duration. This means that:

1. Requests for EPSDT services do **NOT** have to be labeled as such. Any properly submitted request for services for a recipient under 21 years of age that fall outside of clinical policy limits, scope and duration ***is*** a request for EPSDT services.
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].

a. The specific coverage criteria (e.g., particular diagnoses, signs, or symptoms) in the DHB 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]. A child who meets EPSDT eligibility criteria is not required to have

a specific diagnosis for the provision of services, as screening may identify symptoms that require attention but do not meet diagnostic criteria. This requirement may be of particular importance to children who need behavioral health services.

b. The specific numerical limits (number of hours, number of visits, or other limitations on scope, amount or frequency) in DHB 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).
c. 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].
d. Out-of-state services are NOT required to be covered if equally effective 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.
e. DHB vendors, contractors and MCO's must review any properly submitted request for state Medicaid plan services that fall outside the clinical policy limits scope and duration, 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.
f. Requests for prior approval for services must be appropriately documented to show medical necessity. This requires current information from the recipient's physician, other licensed clinicians, or the requesting qualified provider. If this information is not provided, Medicaid, its vendor or the MCO will have to obtain the needed information, and this will delay the prior approval decision. See procedure below for requesting EPSDT services for Medicaid Direct beneficiaries and beneficiaries covered under Managed Care.
g. North Carolina Medicaid and the contracted MCO's retain 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. Durable medical equipment (DME), assistive technology, orthotics, and prosthetics do NOT have to be included on DHB'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.
i. DHB and the MCO's will enroll or contract with providers, set reimbursement rates, and assure the means for claims processing when the service is not already established in the North Carolina State Medicaid Plan.

j. Requests for prior approval of services are to be decided with reasonable promptness as outlined in the section below. No properly submitted request for services for a recipient under 21 years of age will be denied, formally or informally, until it is evaluated under EPSDT.
k. 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 the specific reasons for the intended action, citation that supports the intended action, and notice of the right to appeal.
l. The recipient has the right to continued Medicaid payment for services currently provided, including services that received a time-limited approval through prior authorization, 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 reauthorization request.

EPSDT Coverage and CAP Waivers

1. Home and community-based services (HCBS) offer through waiver 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 a Section 1905(a) service for a CAP recipient under age 21 must be evaluated first under EPSDT and then under Social Security Act under 1915(c) if the service can't be covered by EPDST.
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 waiver can receive BOTH waiver services and EPSDT services. For individuals under the age of 21 enrolled in a 1915(c) HCBS waiver, services covered through the waiver are not covered under EPDST. The cost and delivery of the waiver services must be in compliance with the coverage limitations established by the waiver application and applicable Medicaid policy.

   When a child who is enrolled in a waiver program is otherwise eligible for Medicaid, all conditions set forth in the waiver concerning continued participation in the waiver apply as to waiver services.

   If the requested service is both a waiver service and an EPDST service, it must be covered as an EPSDT service and should not be counted toward the HCBS waiver service limit.

   The beneficiary participating in a North Carolina 1915(c) HCBS waiver program may exceed policy or program limits on any individual service qualifying as *both* a waiver service and as a coverable service under the child Medicaid EPSDT Benefit. Prior approval for the over-limit service must be requested and approved *before* the service is delivered and *before* the waiver limit is exceeded.

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 waiver 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 personal care services (PCS). It is important to note that Medicaid services coverable under EPSDT may be provided in a community or school setting, when a location of the service other than in the home is determined to be medically necessary by an individualized EPSDT review. The service is coverable by Medicaid at 1396(a) [1905(a)] as Personal Care Services. 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 DHB's recipient notices procedure. **No other case manager can deny a service request supported by a licensed clinician, either formally or informally**.

7. 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 via the CAP IT system for processing in accordance with the CAP/C policy. A plan of care revision for waiver services must be submitted via the CAP IT system for processing according to the clinical coverage policy.
    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 authorized approver in accordance with the CAP/DA policy. A plan of care revision for waiver services must be submitted to the CAP/DA authorized approver in accordance with clinical coverage policy. **All EPSDT requests must be forwarded to the CAP/DA consultant at DHB.**
    c) **Innovations Waiver:** All EPSDT and covered state Medicaid plan requests for behavioral health services must be forwarded to the appropriate LME-MCO for that catchment area. This includes requests for children not in a waiver who have a case manager. Requests for dental services covered under the North Carolina State Medicaid Plan must be forwarded to the appropriate vendor (General Dynamics and Information Technology) for review and approval. Do **NOT** submit such requests to the Managed Care Organizations. Plan of care revisions must be submitted in accordance with the Innovations policy.
8. 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/Intellectual and Developmental Disability/Substance Abuse (MH/IDD/SA) Services

Consistent with section 1905(r)(5) of the Act, states must provide coverage for an array of medically necessary mental health and SUD services along the care continuum in order to meet their EPSDT obligation. The array of services includes, but is not limited to:

1) screening and assessment;
2) services to build skills for mental health and/or to address early signs or symptoms of concern with or without a diagnosis;
3) community-based services at varying levels of intensity necessary to correct or ameliorate a wide range of behavioral health acute and/or chronic conditions, including routine community-based services as well as community-based services to meet more intensive needs;
4) services address urgent and crisis needs; and
5) inpatient care only when medically necessary.

Process for submitting an EPSDT Request:

1. Requests for MH/SUD services for Medicaid Direct beneficiaries under the age of 21 must be forwarded to the appropriate LME/MCO
2. 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. All individual facts must be considered. Note that a child with co-occurring medical, developmental, and/or behavioral health conditions may need more complex case management to support the child's access to services and supports provided by a wide range of providers, state agencies, and the education system.
3. All EPSDT requirements apply to the 1915(b) waiver. https://www.ncdhhs.gov/documents/files/1915bc-factsheet/download

Managed Care Organizations (MCOs) will comply with all requirements of the EPSDT benefit when authorizing and reviewing service requests for beneficiaries under the age of 21. Any service coverable under federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act] and medically necessary per EPSDT criteria to correct or ameliorate a defect, physical or mental illness, or other health condition shall be made available to an eligible child under 21 years of age. Medical necessity decisions are made on a case-by-case basis, are always individualized and are responsive to the particular child's current needs.

MCO care coordinators and other non-UR staff may not deny requests for services, including EPSDT services, formally or informally. MCOs may not use the Screening, Triage, and Referral (STR) process or IDD eligibility process as a means of denying access to Medicaid services. It is not appropriate for an MCO screener to make a decision on a recipient's need for services. The family must be referred to an appropriate Medicaid provider to perform a clinical evaluation of the child and to request any medically necessary service.

The county that maintains current Medicaid eligibility for a beneficiary determines which Prepaid Inpatient Health Plan (PIHP)/ Tailored Plan (TP) will review requests for behavioral health services coverable under the child Medicaid (EPSDT) benefit. The Tailored Plan/ PIHP for the county **where the beneficiary lives** will be responsible for acting on requests for EPSDT Benefit behavioral health services

when a beneficiary resides outside of the county where eligibility is maintained by DSS. For more information, please see: http://www.ncdhhs.gov/dma/lme/LME-Contact-Info.html.

To locate the appropriate vendor in the beneficiary's county/catchment area and/or service type, please refer to the Utilization Review Contractor table on the prior approval Web page at: http://ncdhhs.gov/dma/provider/priorapproval.htm.

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, Managed Care Organization or NC Medicaid vendor. When requesting prior approval for a covered service, refer to the *Health Plan Billing Guidance | NC Medicaid*, section 3.27.2. For Medicaid Direct beneficiaries, if the request for service needs to be reviewed by NC Medicaid clinical staff, the vendor will forward the request to the Clinical Policy business unit. 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 MCO, or Medicaid Direct vendor may be required. See the Provider Documentation section of these instructions for information regarding documentation requirements.

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. 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 appropriate Managed Care Organization, or NC Medicaid vendor. The process and procedures for submitting non-covered service requests for beneficiaries under the age of 21 can be found in each Managed Care Organization's provider manual. 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.

If the recipient is enrolled with a Managed Care Organization, the request should be submitted to the appropriate MCO for review utilizing the processes outlined in their provider manual.

Requests for the services listed below should be sent to the appropriate Managed Care Organization or Medicaid Direct vendor. For Medicaid Direct beneficiaries the request for a non-covered service 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, unless otherwise specified. For beneficiaries covered

by a Managed Care Organization, please review their member or provider handbook for information on how to submit a non-covered service request for a recipient under 21 years of age.

- **Any other service not listed on the DHB fee schedules for recipients under 21 years of age that appears within 1905(a) of the Social Security Act**
- **Over-the-Counter (OTC) Medications**
- **Non-Rebatable Drugs-** Under section 1905(a)(4)(B) and (r) of the Act, states are required to cover all medically necessary services described in section 1905(a) of the Act for children under the age of 21 who are eligible for EPSDT, including prescribed drugs, regardless of any payment arrangement. What this means is that any prescribed drug covered under Medicaid EPSDT requirements is eligible for federal financial participation (FFP), regardless of the applicability of section 1927. In other words, even if the drug is not a covered outpatient drug in accordance with section 1927(k)(2) of the Act or the drug is a covered outpatient drug and a manufacturer does not have in effect a drug rebate agreement, the drug is covered under Medicaid and is eligible for FFP if prescribed under EPSDT requirements

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.

Prior Approval Requests: Submission to Appropriate Vendors or PIHP

NC Medicaid Direct vendors (GDIT, Acentra Health (NCLIFTSS), Carolinas Center for Medical Excellence (CCME), Beacon) 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 DHB vendor contracts, those requests should be forwarded to the appropriate vendor for review. For example for Medicaid Direct beneficiaries:

1. If Beacon receives a request for breast surgery, the request should be forwarded to the prior approval section at GDIT.
2. Should GDIT receive a request for physical therapy, the request should be forwarded to CCME.
3. A request for a Medicaid Direct recipient that is requesting Personal Care Services (PCS) for a recipient **under 21 years of age**, should be submitted to Acentra Health (NCLIFTSS). If the request is for a recipient covered under Medicaid Managed Care, the request should be submitted to the appropriate Health Plan.

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.

Prior Approval Requests: Managed Care Organizations

For more information on where to submit prior approval requests for the Tailored Plans & PIHPs, please see the document within the link: Tailored Plan Provider Playbook

For more information on where to submit prior approval requests for the Standard Plans, please see the document in the link: Managed Care Provider Playbook

To eliminate a delay in making a decision when a provider sends a prior approval request to a Managed Care Organization that is not responsible for conducting the prior approval review. Once the request has been received by the appropriate Managed Care Organization, a decision will be reached within 14 days, unless an extension of an additional 14 days is requested per 42 C.F.R. § 438.210(d).

For cases in which a provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the child's life or health or ability to attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 72 hours after receipt of the request for service, as per 42 C.F.R. § 438.210(d)(2).

Outreach

Information about EPSDT will be distributed by NC Medicaid's Managed Care Organizations to recipients and their legal representatives through their member handbook. The document will address general information about EPSDT, and procedures for requesting services under EPSDT, including information about interpretation services, transportation assistance, and how to access benefits provided by that Managed Care Organization. This information must be provided in an accessible format, in prevalent non-English languages, and be available in alternative formats upon request and at no cost to the enrollee, as per 42 C.F.R. § 438.10.

NC Medicaid's Managed Care Organizations are contractually required to perform outreach to members and or their guardians monthly when due or overdue for preventive screenings.

This policy instruction shall remain posted on the DHB website. DHB-will 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.

For Further Information about EPSDT

- Important additional information about EPSDT and prior approval is found in the *Medicaid Health Plan Billing Guide*, section 3.27, and on the DHB EPSDT provider page. The web addresses are specified below.
  Basic Medicaid Billing Guide

Health Plan Billing Guidance | NC Medicaid

Health Check Billing Guide

Provider Policies, Manuals, Guidelines and Forms - Provider Policies, Manuals, Guidelines and Forms (nc.gov)

EPSDT Provider Page

NC DHHS: Early Periodic Screening, Diagnostic and Treatment Medicaid Services for Children

ATTACHMENTS:

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

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 eCFR :: 42 CFR 440.170