Acentra HEALTH

Early and Periodic Screening, Diagnostic and Treatment Services

January 23, 2025

Today’s Discussion Topic

- EPSDT Review: CAP/C CME Virtual Training

Today’s Presenters:
Chanetta Hinnant, CAP Team Lead SW

Housekeeping

- Today’s Presentation will be 30 minutes
- Q&A – 10 minutes at the end of the presentation
  - This portion of the training is for questions
  - Questions can be entered in the Q&A chat
- (A recording of today’s presentation and the PowerPoint will be posted on NCLIFTSS Website hosted by Acentra Health.)

Early and Periodic Screening, Diagnostic and Treatment Services

Introduction to “EPSDT”

Coverage in the Medicaid Benefit for Children and Adolescents

EPSDT provides a comprehensive array of prevention, diagnostic, and treatment services for low-income infants, children and adolescents under age 21, as specified in Section 1905(r) of the Social Security Act (the Act).

Early and Periodic Screening, Diagnostic and Treatment Services

Medicaid's Mission for Members Under 21 Years Old

EPSDT's goal is to assure that individual children get the health care they need when they need it – the right care to the right child at the right time in the right setting.

Children's health problems should be addressed before they become advanced, and treatment is more difficult and costly.

Early and Periodic Screening, Diagnostic, and Treatment Services

- is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age **if** the service is **medically necessary** health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

- This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

- Medically necessary 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 beneficiary'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 beneficiary's right to a free choice of providers.

Early and Periodic Screening, Diagnostic, and Treatment Services

- EPSDT does not require the state Medicaid agency to provide any service, product or procedure:
  1. That is unsafe, ineffective, experimental or investigational.
  2. That is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

- Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary'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 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.

Early and Periodic Screening, Diagnostic, and Treatment Services

Under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program, a variety of requests can be made, including:

- **Screening services**: Comprehensive health and developmental history, physical exam, immunizations, and laboratory tests
- **Diagnostic testing and evaluations**: Follow up testing and evaluations for health problems identified during a well-child check-up or other visit
- **Dental services**: Tooth restoration, pain and infection relief, dental health maintenance, and more
- **Hearing services**: Diagnosis and treatment for hearing defects, and hearing aids
- **Speech-language pathology services**: Identification, screening, diagnostics, treatment, and counseling
- **Durable medical equipment**: Cushions, bed rails, and augmentative communication devices
- **Rehabilitative services**: Physical and occupational therapy to improve a health condition or relieve pain

Medicaid Benefit for Children

EPSDT IS

- A comprehensive healthcare plan focused on **prevention** and **early, best-practice treatment**.
- A **flexible and seamless plan** with a broad menu of medical treatments, products and services available to be tailored to children's **individual** and **developmental** needs, not to private insurer benchmarks.

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 and CAP/C Participation

Section 2.2.2

- A Medicaid beneficiary child approved to participate in CAP/C is entitled to receive Durable Medicaid Equipment, Home Health Services, Pharmacy and other State Plan services when the eligibility requirements are met consisting of an evaluation through the EPSDT review process. **A child participating in CAP/C who meets the criteria for a specific, requested Medicaid service, is not eligible to receive that specific, requested Medicaid service through CAP/C.**

CAP/C and DME (State Plan Service)

- If the services being requested are available under State Plan Medicaid, the services cannot be covered under a waiver. HCBS waivers only cover services and items that are not otherwise available under the State Plan

- HCBS waivers cannot cover items that are DME. Any item that falls under the category of DME needs to be requested through DME and not CAP. If an appropriate DME request is denied by Medicaid, it is typically denied for lack of medical necessity or for failure to respond to a request for additional information. DME could also be denied as experimental, although that is rare. CAP should not cover DME when it was denied under the State Plan as not medically necessary or as experimental, or for failure to respond to a request for additional information. Those types of denials show the DME is not in line with Medicaid requirements and the family has the option to appeal that denial or to submit a new request to DME to cure the issues.

- CAP may cover an item that is determined to be a non-DME item. For the item to be covered, there must be a justification of need that will assist in avoiding an institutional placement.

DME Items Versus Non-DME Items

DME Items

- Mobility devices: Walkers, wheelchairs, canes, crutches
- Beds: hospital beds, pressure mattresses. Medical cribs
- Hoyer Lifts
- Communication Devices: iPads
- Transfer Boards
- Breathing Devices-ventilators/oxygen concentrators
- Feeding Devices-infusion/feeding pumps
- Prosthetics and orthotics: Artificial limbs and braces
- Activity Chairs
- EpiMonitor

Non-DME Items

- Wheelchair ramps
- Grab bars
- Toilet seats
- Baby monitor
- Carriers (child)
- Wagons
- Orthopedic pillows
- Changing tables

Why DME Related Items Should Not be Submitted to CAP/C

- When the beneficiary is under the age of 21, EPSDT applies.
- By federal law, Medicaid is not allowed to have an exhaustive list of DME. If the requested item is appropriately categorized as DME, then the item is covered by Medicaid.
- An item that can be requested through DME will result in a duplication of services with CAP/C.
- An item requested through DME by way of EPSDT is evidence of equally effective, less costly alternatives available statewide. The key factor is EPSDT!
- If the requested item is or looks like DME, the request should be submitted to DME for review.

More of Why DME Related Items Should Not be Submitted to CAP/C

- In compliance with the CMS Home Health Final Rule Title 42, §440.70, items not listed in **Attachment A, Section C** or in the Durable Medical Equipment fee schedule will be considered for coverage if requested by a provider, or a beneficiary through a provider, and submitted for prior authorization (PA) review of medical necessity. For beneficiaries under age 21, please request an "EPSDT review" using NC Tracks. Refer to section **2.2 Special Provisions** for more information about EPSDT. For beneficiaries aged 21 and older, please submit the request through NC Tracks per the procedure detailed in **Attachment D**.

Applying for non-covered services under EPSDT

- Please visit: Knowledge Base - NC Medicaid Beneficiary Service Portal , the EPSDT page. There is a specific form to request non-covered services under EPSDT and there is a link to that form.

- Per Attachment A, Section C Procedure Code(s) "Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided." In this case the procedure code for a power lift is E0635. NC Medicaid DME enrolled providers can request unlisted codes (codes not on the fee schedule) as required by federal law.

- The provider needs to submit a PA request for E0635 PATIENT LIFT, ELECTRIC WITH SEAT OR SLING. The request would need the following documentation:
  - a Certificate of Medical Necessity form
  - documentation of a physician face-to-face visit
  - a PT or OT Letter of Medical Necessity
  - the manufacturer quote.
  - The Letter of Medical Necessity must include why a hydraulic or mechanical lift will not work for this individual and why the total electric lift is the only lift that will meet the beneficiary's medical needs. They need to explain in detail. *For example, if the hydraulic or mechanical lift will not work because of the size of these Hoyer lifts, then the request should include the dimensions of the room, doorways, etc. that are a problem and a detailed explanation of the "size" issue.* We recommend submitting additional photos and measurements to explain why a standard Hoyer lift will not work. Medical necessity must show why this specific lift is necessary. Documentation should be provided to support why NO lift will work; and why an electronic lift is needed rather than hydraulic lift.

Plan of Care (POC) Requests

- Once a POC request is received, it is reviewed by the POC reviewer to determine if the request is a DME related item. Arrange to work with the physician or a DME provider to initiate the request.

- If the request is considered DME, a request for information (RAI) will be sent to the CME with this verbiage:

  - **The requested service appears to be a coverable State Plan service:**
  - **Determine if the request is a DME related item. Arrange to work with the physician or a DME provider to initiate the request.**
  - **If an EPSDT denial letter is provided, the request can be submitted in a CAP/C POC for consideration of reasonable need.**
  - **If supporting EPSDT documentation is not received to support the approval of this service using one of the CAP/C home and community-based services, the request will be denied specific to EPSDT guidelines of coverable State Plan services for Medicaid beneficiaries under the age of 21.**

Key Takeaways

- **The overall intent (in addition to averting the risk of institutionalization) of the waiver is to cover items/services that are not otherwise available under "regular" Medicaid. Simply, if the beneficiary can receive the DME from Medicaid, then the waiver is not needed and should not cover the item.**
- **DME related Items not listed on the DME fee schedule may still be requested through EPSDT review.**
- **Always upload EPSDT decision letter when submitting POC request to CAP/C for review.**
- **If the item is not DME, but the needs described in the POC request are appropriate for DME. The item should be addressed by DME.**
- **Each denial presented to DME for beneficiaries under 21, a denial is not issued until it goes through the EPSDT process.**

Questions & Answers