Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Refresher & Process Updates

OHP Provider Education Session

December 4, 2023

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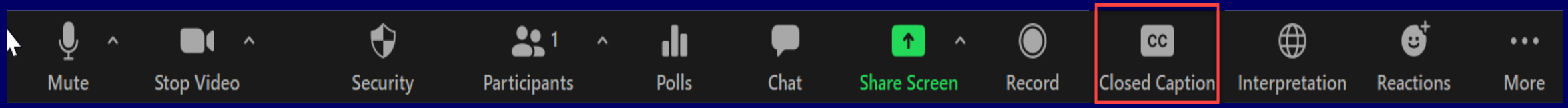
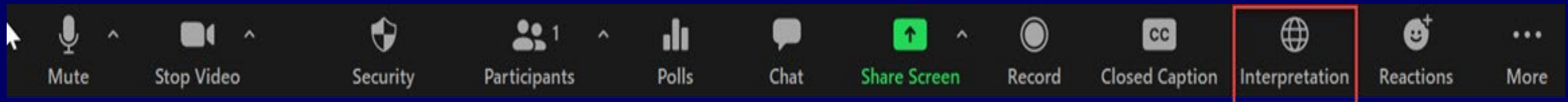
Webinar Logistics

- This session will be recorded
- Private chat or email Tom Cogswell (thomas.cogswell@oha.oregon.gov) with any Zoom issues
- Closed captioning is available:



- American Sign Language (ASL) interpretation is available. Pin the ASL Interpreter's video by clicking on the "More" button next to their name
- Todos los participantes que hablan español deberán seleccionar el botón Interpretación y luego el canal en español para que aparezca el sonido.



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Today's Presenters

- Dawn Mautner, MD, MS, Oregon Health Plan Medical Director
- Jessica Ickes, MPA, EPSDT Lead/Children's Policy Analyst
- Liz Stuart, MPH, Children's Health Policy Project Manager
- Mary Durrant, Claims & Encounter Data Services Manager
- Brenden Magee, RN, BSN, MHA, Provider Clinical Supports Unit Manager

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The Headlines

- Medically necessary and medically appropriate services for children and youth up to age 21 on OHP are now covered, upon individual review.
- Updated EPSDT Provider Guide is available now!
- MMIS has been updated!

Action items:

1. ***Do not assume OHP will not cover*** a service based on past experience.
2. **"Below the line" no longer applies to OHP members under age 21.**
3. ***Update your contact information*** with OHA and your CCO.

If you have any questions or concerns, contact:

EPSDT.Info@odhsoha.oregon.gov

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EPSDT Policy in Oregon

What is it? What has changed?

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First…what is EPSDT?

- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is a federal benefit that provides comprehensive and preventive health care services for children under age 21 who are enrolled in the Oregon Health Plan (OHP).

- States are required to provide comprehensive services and **furnish all Medicaid coverable, medically appropriate, and medically necessary services needed to correct and ameliorate health conditions** for an individual child or youth.

- **In Oregon, EPSDT constitutes the child and youth benefit within the Oregon Health Plan.** It is not necessary to enroll in a separate program to access these benefits.

Oregon.gov/EPSDT

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Expanded EPSDT coverage

- Most EPSDT services have been provided in Oregon for many years.
- Historically, for kids between ages 1 and 21, Oregon did not cover **treatment** services that were “below the line” on the Prioritized List of Health Services.
    - This was allowed under an agreement with the federal government.
    - This waiver was not renewed. Effective January 1, 2023, all medically necessary and appropriate treatments must be covered, regardless of their location on Prioritized List.

(The Prioritized List of Health Services can be used as a tool to show which services are generally covered by the Oregon Health Plan).

Who qualifies for EPSDT services?

- Oregon Health Plan (OHP) members under age 21 (members transition to adult coverage on their 21st birthday).

These policies apply to both Open Card (Fee for Service) and CCO-enrolled members

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The policy change does NOT mean *all* services are covered in *all* cases

- CCOs and OHA may require prior authorization for some services.
  - Prior authorization cannot be required for **screening** services.
- Services must have an appropriate diagnosis and billing code (CPT or HCPCS).
- Services must be eligible for Medicaid coverage.
- CCOs and OHA may require use of a preferred provider network.
- Medicaid must be a good steward of resources and may choose to cover the least costly effective option.

CCO and Open Card implementation

Both OHA and CCOs must:

- Comply with the EPSDT policy change and coverage requirements, effective January 1, 2023
- **Not deny services without individual review** for medical necessity and medical appropriateness (or dentally appropriateness) for OHP members under age 21
- Abide by a definition of medical necessity and medical appropriateness that is not more restrictive than that listed in Oregon Administrative Rule Chapter 410 Division 151 (effective 1/1/2024).
- Follow the Bright Futures periodicity schedule

CCOs and OHA may differ in:

- Prior authorization procedures
- Billing procedures

Details and examples

The nitty gritty

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Medical Necessity and Medical Appropriateness

- Effective January 1, 2024, definitions of Medically Necessary, Medically Appropriate and Dentally Appropriate that are specific to EPSDT will be found in Oregon Administrative Rules Chapter 410, Division 151.
- States are required to provide comprehensive medically appropriate and medically necessary services needed to correct and **ameliorate** health conditions for members under age 21.
- This includes services which, based on the child's individual circumstances, improve the child's ability to **grow, develop, or participate in school**.
- Providers may need to send information that demonstrates medical necessity and appropriateness to OHA or the CCO to get services covered.

Medically Necessary, but not Medically Appropriate

- A drug that is needed to treat an individual's condition, but is actually not safe because it would have an adverse interaction with another drug they are taking.
- A child with a diagnosis, who needs a drug that is only tested and approved for adults
- Only an expensive prescription is prescribed when a generic is available and appropriate

Medically Appropriate, but not Medically Necessary

- A child with a broken front tooth who could have a cap, but is not in pain or experiencing any impaired function
- Tonsillectomy in most cases
- Acne medication might be appropriate because a youth has acne, but the acne is not impeding their functioning or participation in school or other activities

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Case example: Acne medication

Prior to EPSDT policy change:

- For conditions below the funding line on the Prioritized List, acne medication would be denied, and addressed through exception process only.

Post EPSDT Policy Change:

- Each request must be individually reviewed for medical necessity and medical appropriateness before a denial is issued.
- If the condition is determined to be severe enough to impact the patient's ability to fully participate in school, their growth or development AND comes from the preferred class of drugs it may be approved.

Case example: Handicapping Malocclusion

Prior to EPSDT policy change:

- Was denied, and addressed through exception process only.

Post EPSDT Policy Change:

- Must be individually reviewed for medical necessity and medical appropriateness prior to issuance of a denial.
- Specific criteria are required and may be accessed here.

Open Card review process

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Getting services approved for Open Card Members

- Prior authorizations are required for some services.
- A **post-service review** is when a claim is submitted that is below the line or non-pairing, and did not require a PA.
- In addition, providers have the option to submit a **pre-service review** request to determine coverage before providing a service, even if a PA is not required

Changes to Medical Management Information System (MMIS) for Fee For Service (Open Card)

- Previously if a service was below the funding line an automatic denial would occur.
- Now, MMIS has been changed to no longer send auto denials for services that were below the funding line for OHP members under the age of 21.
- These claims will now suspend for a **post-service review.**
- A technical review will be done and then if needed it will be sent for a clinical review.

- The EPSDT Provider Guide has been updated to reflect these changes.

Submitting Open Card claims for post-service review

- To submit a claim for post-service review, providers should:
    A. Send the claim via secure email **with supporting documentation** to OHA.FFSOHPClaims@odhsoha.Oregon.gov **(this is the preferred submission pathway).**
    B. Submit by mail (see EPSDT Provider Guide for details).

- If you do not submit documentation with your claim, OHA will attempt to reach out to request documentation.
    - If you do not submit requested documentation within 14 days, OHA may deny the claim. You can resubmit the claim and necessary documentation if that happens.

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Identifying suspended claims

- To see if a claim has suspended, search for claims with a “Suspended” status on the MMIS Provider Portal at https://www.or-Medicaid.gov

- Contact Provider Services if you need help:
  - Getting Provider Portal Access (1-800-336-6016, Option #5 or team.provider-access@odhsoha.Oregon.gov)
  - Identifying suspended claims (1-800-336-6016, Option #5 or DMAP.ProviderServices@odhsoha.Oregon.gov)

Resolving suspended claims

- If you do not submit sufficient documentation with your claim, OHA will attempt to reach out to the billing and/or referring provider to request documentation.

- Fax requested documentation under a completed EDMS Coversheet, including the Internal Control Number of the suspended claim.
  - Check the box on the coversheet that says “Claim Documentation.”
  - Send to the fax number listed beside the “Claim Documentation” box.

- If you do not submit requested documentation within 14 days of the request, OHA may deny the claim.
  - In this case, please resubmit the claim with the requested documentation.

- For more information, please see the EPSDT Provider Guide

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Who is the Medical Management Review Committee?

- There are 11 Nurse Reviewers on the Medicaid Provider Clinical Support Unit.
- The four doctors on MMC are:
  - **Dawn Mautner**, MD, MS, OHP Medical Director: Board certified in Family Medicine.
  - **Ariel Smits**, MD, MPH, MPhil, Public Service Physician, Medical Director of the Health Evidence Review Committee (HERC): Board certified in Family Medicine
  - **Jeff McWilliams**, MD, Medical Director, Acentra: Board certified in Medical Oncology, Hematology, Internal Medicine.
  - **Margaret Cary**, MD, MPH, OHP Behavioral Health Clinical Director: Board certified in General (Adult) and Child & Adolescent Psychiatry.

Member rights: what if a requested service is denied?

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Service denials

- Any denial of coverage must be in writing. **Providers should not refuse to render or refer for medically appropriate and necessary care.**
- OHP members must be provided a written Notice of Action (for FFS) or Notice of Adverse Benefit Determination (for CCOs) when denying a service.
  - Notices must contain:
    - A statement of the intended action and effective date
    - The specific reasons and legal support for the action
    - An explanation of the individual's appeal and/or hearing rights, and
    - The member's rights to representation.

What recourse do members and providers have?

- If a member/guardian or provider disagrees with a denial decision, they can appeal the decision or request a hearing.
  - Any denial notice should include instructions on how to appeal or request a hearing.
  - All OHP members have the right to a fair hearing for denials.
- If a provider submits additional clinical documentation, that will be reviewed as part of the appeal or hearing process.

Ensuring member access to services

If you have concerns with member access to services, please reach out to one of the following contacts:

- OHP Client Services Unit 1-800-273-0557
  - Email: OHP.ComplaintResolution@odhsoha.oregon.gov
- For CCO members, call the Customer Service line for the CCO. The number is on the back of the Oregon Health Plan card, or may be found on the CCO List
- OHA Ombuds Program OHA.OmbudsOffice@odhsoha.oregon.gov
  - Phone: 1-877-642-0450 (message line only)

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Resources for providers

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Checklist: What should Providers do?

- **All providers should:**
- ✓ NOT assume historically non-covered services continue to be non-covered. They MUST be considered for each individual child/youth.
- ✓ Monitor claims/prior authorizations and submit additional documentation as needed
- ✓ Review EPSDT Provider Guide **(updated!)** , FAQ **(updated!)** and Member Fact Sheet
- ✓ Sign up for Provider Matters
- ✓ Bookmark this page: **Oregon.gov/EPSDT**
- ✓ **Contact our team with questions: EPSDT.Info@odhsoha.oregon.gov**

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What should Providers do?

Fee-for-Service providers should:

- ✓ Ensure access to the MMIS Provider Portal (https://www.or-medicaid.gov)
  - ✓ Provider Services at 1-800-336-6016, Option #5 or team.provider-access@odhsoha.oregon.gov
- ✓ Update contact info with Provider Enrollment to facilitate communication about post-service reviews
  - ✓ Provider Enrollment at 1-800-336-6016, Option #6 or provider.enrollment@odhsoha.oregon.gov
- ✓ Ensure the ability to send secure email (resources in OHA's EPSDT Provider Guide)
- ✓ Contact Provider Services for any general questions about claims that have denied: DMAP.ProviderServices@odhsoha.oregon.gov

CCO providers should:

✓ Consult the specific CCO for its procedures for billing, authorization, and reimbursement. You can find your CCO's provider services number here.

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Webinar Recordings available

- **Early and Periodic Screening, Diagnostic and Treatment Program (EPSDT) Overview**
- **Ensuring EPSDT access: Documenting medical necessity, prior authorization and related processes for fee-for-service (FFS, or "Open Card") patients**
- **EPSDT for Behavioral Health and Behavior Rehabilitation Service Providers**
- **This webinar, soon!**

Visit Oregon.gov/EPSDT for slides and recordings

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Where to find more information

OHA has developed the following materials to share information about this change:

- EPSDT Guidance for OHP Providers **(updated on 10/25/23)**
- EPSDT Fact Sheet for OHP members (available in 13 languages)
- EPSDT Frequently Asked Questions **(updated on 11/29/23)**
- EPSDT Policy Change Memo for OHP providers
- EPSDT Guidance Document for CCOs

All EPSDT guidance documents and communication materials are available at **Oregon.gov/EPSDT**

For additional tools for OHP providers, please visit https://www.oregon.gov/oha/HSD/OHP/Pages/Provider-Splash.aspx

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EPSDT Regulations and Resources

- Oregon Administrative Rule 410-130-0245 – Early and Periodic Screening, Diagnostic and Treatment Program (will move to OAR Chapter 410, Division 151 effective 1/1/24)

- Code of Federal Regulations 42 CFR § 441 Subpart B – Early and Periodic Screening, Diagnostic and Treatment (EPSDT) of Individuals Under Age 21

- EPSDT - A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents
- Medicaid.gov
- Health Resources & Service Administration – Maternal & Child Health Bureau

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Questions? Presentation requests?

EPSDT.Info@odhsoha.oregon.gov

Dialogue with members, families, and collaborators like you helps us center equity and do the right work. Thank you for your dedication to healthy families, and for your ongoing partnership and insights that help us better serve Oregon's communities.

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