Question & Answer Log

Early & Periodic Screening, Diagnosis & Treatment (EPSDT) Provider Education Webinar # 1

EPSDT Program Overview
January 24, 2023
12-1 p.m.
Recording: https://www.youtube.com/watch?v=LJVPeFvqXhs

This document provides a summary of all questions asked during this provider education session and corresponding answers from OHA staff. Some questions and answers have been edited for clarity. ***Please Note:*** *This document is not meant to be a substitute for reviewing the full guidance documents, which include all EPSDT requirements. All EPSDT materials and guidance are available at www.Oregon.gov/EPSDT*

Questions & Answers

What about claims that don't require a prior authorization? When do we submit documentation for those?

As a reminder, EPSDT requirements for individual review for medical necessity and medical appropriateness prior to denial apply regardless of whether it is a claim or a prior authorization request.

For a CCO-enrolled member, the provider should contact the CCO for its specific procedures.

For Fee-for-Service (FFS) or Open Card members, providers have the option to submit a prior authorization request to determine coverage before providing a service, even if prior authorization is not required. To submit a prior authorization request:

> Preferred method: MMIS Provider Portal at https://www.or-medicaid.gov
>
> If necessary: Fax the ODHS/OHA Prior Authorization Request Form (MSC 3971) under a completed EDMS Coversheet (MSC 3970) to OHA using the contact numbers provided on the MSC 3970.

For FFS/Open Card post-service review, the provider can either send a claim, letter of medical necessity and supportive documentation to the OHA Claims Unit (OHA.FFSOHPClaims@odhsoha.oregon.gov) requesting a review or submit a claim and wait for OHA to reach out requesting supporting clinical information. Currently, the claim may deny, but OHA will follow up to request the clinical documentation. Once the Medicaid Management Information System (OHA's claims processing system) is updated (anticipated for late March 2023),

OHA will suspend claims for items that historically were not covered for members under 21 and will reach out to the provider to request documentation prior to finalizing the claim. The provider will have 14 days to respond to the request for documentation, or the claim may be denied.

Will the Prioritized List remain in place with a line though?

The Prioritized List remains in effect for the Oregon Health Plan, but the funding line on the Prioritized List may not be used to deny services for OHP members under age 21. Services above the funding line will continue to be covered as in the past, and services below the line must be covered for an individual under age 21 when determined by OHA (for FFS/Open Card) or the CCO to be medically necessary and medically appropriate, even if they would not have been covered before January 1, 2023.

Guideline notes from the Prioritized List can be used in the context of individual case review and can serve as clinical guidance or further justification of the medical necessity and medical appropriateness determination. They should not be used to determine coverage across the board or for an entire age group or population under EPSDT.

Is this presentation going to cover behavioral health services specifically?

EPSDT requirements apply to behavioral health coverage in addition to physical health, dental/oral health, and pharmacy. The EPSDT team provided a webinar on February 15, 2023, for Behavioral Health and Behavior Rehabilitation Services providers. The recording and materials for this webinar are available at www.Oregon.gov/EPSDT.

Does the Prioritized List not apply to children at all for any service or is it just that the Prioritized List does not apply to children only for EPSDT? Can you please clarify? Thanks!

Any Medicaid coverable service provided to an Oregon Health Plan member under the age of 21 is EPSDT. As of January 1, 2023, the location of something on the Prioritized List cannot be used as a reason for denying a service to a member under 21. Services above the funding line will continue to be covered as in the past, and services below the line must be covered for an individual under age 21 when OHA (for FFS/Open Card) or the CCO determines them to be medically necessary and medically appropriate, even if they would not have been covered before January 1, 2023.

The Prioritized List is an important tool for evaluating the evidence behind treatments and other health services. The list, which includes “guideline notes,” is maintained by the Health Evidence Review Commission (HERC). Guideline notes linked to the Prioritized List may be used to support the individual evaluation of medical necessity and medical appropriateness (or dental appropriateness) for members under 21. However, guideline notes may not be applied to determine coverage for children and youth across the board.

If the EPSDT expansion is effective 1/1/2023, will the claims for members under 21 that were denied prior to this 1/1/2023 for being “below the line” or “not pairing,” that providers appeal in 2023, now be eligible for payment?

For denied claims with a date of service prior to 1/1/23, providers can use existing appeals processes to submit clinical documentation and request a review for medical necessity and medical appropriateness.

For claims denied by a CCO, providers should consult the CCO for its specific processes. For FFS/Open Card EPSDT claims with a date of service 1/1/23 or after, OHA will reach out to providers when claims deny for being below the line/non-pairing. OHA will work with clinic staff to get the necessary documentation and review for medical necessity and medical appropriateness. Once the Medicaid Management Information System (OHA's claims processing system) is updated (anticipated for late March 2023), OHA will suspend claims for items that historically were not covered for members under 21 and will reach out to the provider to request documentation prior to finalizing the claim. OHA may deny the claim if no documentation is provided after 14 days, though the provider may resubmit the claim.

To facilitate timely communication with OHA, please remember to update your contact information with Provider Enrollment at 1-800-336-6016, Option #6 or provider.enrollment@odhsoha.oregon.gov. It can be difficult to identify the right clinical team member(s) to get the documentation needed, so we urge you to ensure the correct information is on file with OHA and your CCO(s).

Can a CCO deny a service if the provider is not "in-network" or do they need to approve it because it's EPSDT?

Under EPSDT there have been no changes to CCO requirements regarding coverage of "in-network" and "out-of-network" services. A CCO is not required to cover services provided by providers out-of-network if there is an in- network provider who can provide the service. However, if a medically necessary and medically appropriate service is not available through an in-network provider, the CCO must cover it when provided by an out-of-network provider and must coordinate the referral to an out-of-network provider. Note that CCOs often require prior authorization for out-of-network services.

Can you confirm for us again that EPSDT equates to any service provided for children 1-21?

EPSDT constitutes the Oregon Health Plan benefit for OHP members under the age of 21. Any medically necessary and medically appropriate, Medicaid coverable service provided to an OHP member from **birth** to 21 is part of the EPSDT benefit.

If we have a specific procedure typically denied but frequently provided by us because of medical necessity, is there a way we can ask for it to be covered without having to get each individual patient preauthorized each time?

Yes. There are several options to address this concern.

For something frequently denied by a CCO, please reach out directly to that CCO. If you have continued concerns regarding denials by a CCO, please reach out to EPSDT.Info@odhsoha.oregon.gov.

For Fee-for-Service/Open Card, please reach out to OHA at EPSDT.Info@odhsoha.oregon.gov with more information and we will review the request.

You can also request a review by the Health Evidence Review Commission at any time by emailing HERC.Info@oha.oregon.gov. HERC regularly re-reviews evidence and updates guideline notes that help clinical staff consider medical necessity and medical appropriateness. Services above the

funding line and in alignment with HERC guideline notes are likely to be approved for individuals more easily since they may not require individual review.

For services previously denied as not covered, how do we know if we can now get it covered unless we do a preauthorization?

Under EPSDT, all services that are Medicaid coverable and billable (even if not historically covered by the state's Medicaid program), and determined to be medically necessary and medically appropriate for the individual member under age 21 should be covered. For FFS/Open Card members, prior authorization is required for some services, and may be requested to confirm coverage of services that were historically not covered. To do so, the provider would submit a prior authorization request with the required clinical documentation and a letter of medical necessity/medical appropriateness to facilitate individual review.

For services for CCO-enrolled members, please consult with the CCO regarding its specific procedures and requirements.

For any continued concerns about denials of services after review for medical necessity and medical appropriateness, please reach out to EPSDT.Info@odhsoha.oregon.gov.

Should we wait to attach documentation until it is requested?

If you are working with a CCO, please contact the CCO for its specific procedures.

For FFS/Open Card EPSDT claims with a date of service 1/1/23 or after, OHA will reach out to providers when claims deny for being below the line or non-pairing. OHA will work with clinic staff to get the necessary documentation and review for medical necessity and medical appropriateness. Providers can expedite this claims processing by submitting documentation with the claim.
Once the Medicaid Management Information System is updated (anticipated for late March 2023), OHA will suspend claims for items that historically were not covered for members under 21 and will reach out to the provider to request documentation prior to finalizing the claim.

Please note that if an FFS/Open Card claim has denied, attaching additional documentation will not trigger an additional review; you will need to submit a new claim form with the additional documentation. If you are requesting a review or submitting documentation based on OHA outreach, please send the claim, letter of medical necessity/appropriateness and supportive documentation to OHA.FFSOHPClaims@odhsoha.oregon.gov

To facilitate timely communication with OHA, please remember to update your contact information with Provider Enrollment at 1-800-336-6016, Option #6 or provider.enrollment@odhsoha.oregon.gov. It can be difficult to identify the right clinical team member(s) to get the documentation needed, so we urge you to ensure the correct information is on file with OHA and your CCO(s).

Does this new policy apply to diagnosis codes as well as the CPT/HCPCS code? Such as, a diagnosis previously not covered can now be reviewed for possible coverage/payment?

Yes, services related to a diagnosis previously not covered may now be reviewed for coverage. Coverage must be based on medical necessity and medical appropriateness for that individual

member and be a service that has a billable code and that can be covered under federal Medicaid regulations

Will EPSDT cover anything related to social health needs identified by the provider?

In general, EPSDT covers services that can be paid under federal Medicaid guidelines and are medically necessary and medically appropriate for the individual child or youth. As such, services need to have an appropriate diagnosis, CPT and/or HCPCS code in order to be covered by EPSDT. If a CCO-enrolled member has health needs that are not billable under Medicaid, please check with the CCO regarding other pathways for meeting these needs.

A new Health Related Social Needs benefit for OHP members was approved by the federal government as part of Oregon's 2022-2027 1115 Medicaid Waiver. However, the Health Related Social Needs will be a new benefit for a group of individuals who meet additional eligibility criteria. Additional information will be available in the coming months.

Can Z codes be covered under EPSDT? They always seem to be the exception.

The EPSDT benefit covers all medically necessary and medically appropriate services for individuals under 21 years old. Coverage is not determined by or predicated on any specific diagnosis.

Z codes are a subset of ICD-10 codes that are used to identify "factors influencing health status and contact with health services." They indicate a reason for an encounter and are not considered procedure codes. Services billed with Z codes may be covered by EPSDT as long as they are medically necessary and medically appropriate for the individual. Federal guidelines may prevent coverage of some services billed using Z codes.

What will outreach to providers for needed clinical documentation look like?

If you are working with a CCO, please contact the CCO for its specific procedures.

In the FFS/Open Card program, claims reviewers will reach out via email (if an email address is on file) to request documentation for medical necessity and medical appropriateness for the individual. In cases where no email address is available, outreach will be via a phone call to the number we have on file at OHA. FFS/Open Card providers should ensure their contact information is up to date with OHA to facilitate communication about clinical documentation. Please contact Provider Enrollment at 1-800-336-6016, Option #6 or provider.enrollment@odhsoha.oregon.gov

Will outreach apply to prior authorizations or only for claims? Are CCOs required to follow up with outreach also?

To understand the requirements of CCOs under EPSDT, please review the EPSDT CCO Guidance Document. If you are working with a CCO, please reach out to the CCO for its specific procedures.

In the FFS/Open Card program, outreach will be for claims or for prior authorization requests that were received but did not have complete clinical information.

With utilization management decisions in other lines of business, decision making tools and criteria are used to assess for medical necessity (especially for surgical requests). OHA often gives guideline notes in a similar fashion. If an OHP member under the age of 21 doesn't meet the guideline note for the requested surgery, can we use this as evidence that it is not medically necessary?

The Prioritized List and its Guideline Notes can be used as guidance under EPSDT. However, every determination of medical necessity and medical appropriateness must be based on the individual member's unique situation. There are cases in which the guideline note can serve as guidance but there are mitigating factors that make the service or procedure medically necessary and medically appropriate for that individual regardless of the general guidance of the guideline note. So yes, guideline notes can be used in the context of individual case review and can serve as clinical guidance or further justification of the medical necessity and medical appropriateness determination but should not be used to determine coverage across the board or for an entire age group or population under EPSDT.

Do you know if this means that treatment for dyslexia will be covered? This has previously always been denied but is essential for so many kids.

Dyslexia is on the Health Evidence Review Commission's Diagnostic Workup File, which enables coverage of evaluation and management visits and psychological assessments within certain parameters. Additionally, under EPSDT, Medicaid coverable treatments that are medically necessary and medically appropriate for the individual child or youth should be covered.

We are seeing a large increase in previously denied expensive Durable Medical Equipment (DME) items (special car seats, fancy cubby beds, etc). Would you expect the CCOs to cover a large set of new DME items?

Under EPSDT, Durable Medical Equipment and other services not historically covered by the state's Medicaid program must be covered for OHP members under age 21 if they can be shown to treat or ameliorate a disease or condition and are medically necessary and medically appropriate for the individual member. The least costly effective option may be required as described in Oregon Administrative Rule 410-120-0000(147)(d).

Would vision therapy be covered under EPSDT? It's usually denied.

The Health Evidence Review Commission found insufficient evidence of effectiveness for CPT code 97533 (vision therapy). If claims for vision therapy are submitted for OHP members under age 21 they will be reviewed for medical necessity and medical appropriateness and may be approved or denied depending on individual circumstances.

For any additional questions, please reach out to EPSDT.Info@odhsoha.oregon.gov