Outpatient Specialized Therapies Video Conference Seminar

Date: April 27, 2010
Time: 1:00 p.m. to 4:00 p.m.

Presented by:
HP Enterprise Services &
Carolinas Center for Medical Excellence

north carolina medicaid

Resources

- DMA Website www.ncdhhs.gov/dma
- Basic Medicaid Billing Guide
- Clinical Coverage Policy #10A, Outpatient Specialized Therapies
- Clinical Coverage Policy #10B, Independent Practitioners
- Clinical Coverage Policy #10C, Local Education Agencies

For Providers

HHS Home | A-Z Site Map | Divisions | About Us | Contacts | En Español Search DHHS Search DMA GO

NC Department of Health and Human Services

NC Division of **Medical Assistance**

Home

DMA Services | For County Staff | For Providers | Statistics and Reports

- DMA HOME
- Providers
  - Health Choice Providers
  - Medicaid Providers
    - A-Z Provider Topics
    - Calendars
    - Claims and Billing
    - Community Care (CCNC/CA)
    - Contacts for Providers
    - Enrollment
    - EPSDT and Health Check
    - Fee Schedules/Cost Reports
    - Forms
    - Fraud and Abuse
    - HIPAA
    - Library (bulletins, policies)
    - National Provider Identifier
    - Programs and Services
    - Seminars
- ABOUT DMA
- CONTACT DMA

DHHS > DMA > Providers

Medicaid and Health Choice Providers

Service specific information for North Carolina Medicaid providers. Please select the program or service from the menu below and click GO.

SELECT PROGRAM OR SERVICE Go

Medicaid Information for Consumers

Health Choice Information for Consumers

Announcements

Suspension of Mandatory Cost Reporting

DMA and the DHHS Controller's Office are suspending mandatory cost reporting for providers of enhanced mental health services, community based personal care services, adult care home personal care and special care services, CAP/MR-DD services, and residential treatment facility services.

- Memo to Providers, February 3, 2010 (184 KB)

What's New

- April 2010 Basic Medicaid Billing Guide
- March 2010 Medicaid Bulletin
  - Update to article titled *Medically Necessary Incontinence, Ostomy, and Urological Supplies*

February 2010 Pharmacy Newsletter (118 KB)

Fee Schedules

HHS Home | A-Z Site Map | Divisions | About Us | Contacts | En Español Search DHHS Search DMA

NC Department of Health and Human Services

NC Division of **Medical Assistance**

Home

DMA Services | For County Staff | For Providers | Statistics and Reports

DMA HOME

Providers

Health Choice Providers

Medi[illegible]oviders

A-Z [illegible]er Topics

Cal[illegible]

Cla[illegible] Billing

[illegible]are (CCNC/CA)

Cont[illegible] for Providers

Enrollment

Fee Schedules

Fraud and Abuse

HIPAA

Library (bulletins, policies)

National Provider Identifier

Programs and Services

Seminars

ABOUT DMA

DHHS > DMA > Providers

Medicaid and Health Choice Providers

Service specific information for North Carolina Medicaid providers. Please select the program or service from the menu below and click GO.

SELECT PROGRAM OR SERVICE Go

Medicaid Information for Consumers

Health Choice Information for Consumers

Announcements

Suspension of Mandatory Cost Reporting

[illegible]r's Office are suspending mandatory cost reporting for providers of enhanced [illegible]munity based personal care services, adult care home personal care and [illegible]R-DD services, and residential treatment facility services.

- Memo to Providers, February 3, 2010 (184 KB)

What's New

- April 2010 Basic Medicaid Billing Guide
- March 2010 Medicaid Bulletin
  - Update to article titled *Medically Necessary Incontinence, Ostomy, and Urological Supplies*

Who's Who in Medicaid

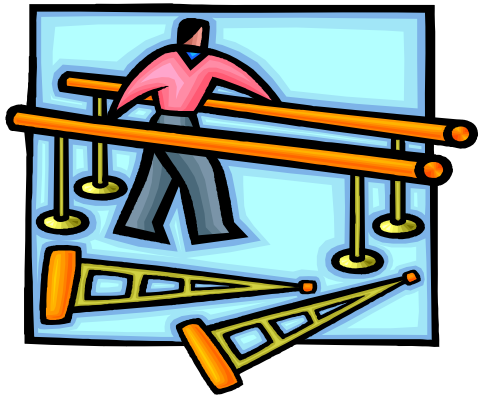
- Center for Medicare and Medicaid Services
  - CMS
- Department of Health and Human Services
  - DHHS
- Division of Medical Assistance
  - DMA

Who's Who in Medicaid cont.

- Department of Social Services
  - DSS
- HP Enterprise Services
  - HP, formerly Electronic Data Systems (EDS)
- Computer Sciences Corporation
  - CSC

Who's Who in Medicaid Prior Approval

- The Carolinas Center for Medical Excellence (CCME)
- Contracted by DMA to review prior approval authorizations
- Submit all authorizations via CCME's prior approval website



Outpatient Specialized Therapies

- Services include:
  - Evaluations
  - Re-evaluations, and/or multidisciplinary evaluations
  - Therapeutic physical, occupational, speech, respiratory (only covered under the IP program for under 21), and audiologic services

Provider Responsibility

- Verify Recipient Eligibility & Carolina Access
- Prior Approval
- Maintain Medical Records
- Billing and Payment
- Overpayments

Eligible Recipients

- Need for service must be confirmed by licensed medical professional
- Must be Medicaid-eligible when the services are provided
- Verify eligibility category
- Program may have service restrictions

Eligibility Verification Methods

- Automated Voice Response System (AVR)
  - 1-800-723-4337
- Annual Medicaid Identification Card
- Recipient Eligibility Verification Web Tool
  - Submitter ID & Password
- EDI Vendor

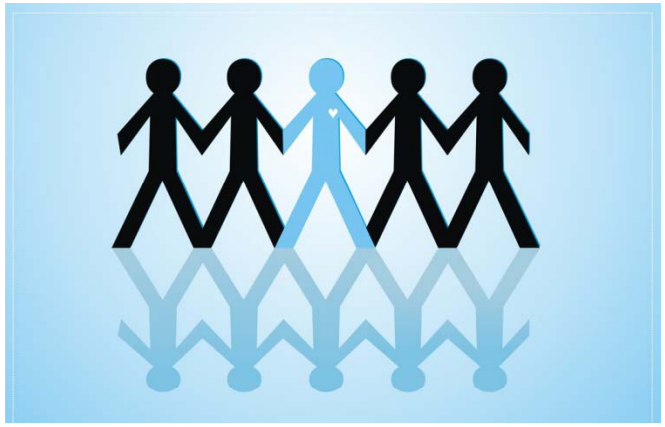
Carolina Access (CA)

- Required referral process for recipient's enrolled through CA program
- Referral must be obtained from the Primary Care Physician identified
- Medicare recipients are exempt from this policy
- Complete list of CA exemptions-section 4 Basic Medicaid billing guide

CA Override Request

- Considered only for extenuating circumstances

http://www.ncdhhs.gov/dma/ca/CAOverrideForm.pdf

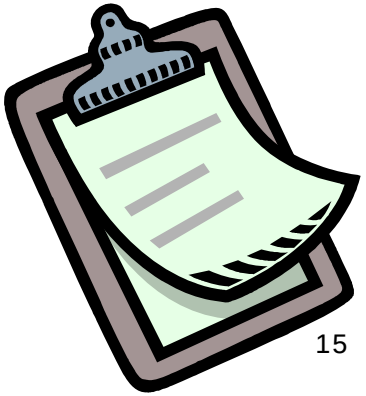


Common Denial Codes

- Associated with CA
  - EOB 270
    - Billing provider is not the recipient's Carolina Access PCP. Authorization is missing or unresolved
  - EOB 286
    - Incorrect authorization number on claim form. Verify number and refile claim

Provider Responsibility

- Verify Recipient Eligibility & Carolina Access
- Prior Approval
- Maintain Medical Records
- Billing and Payment
- Overpayments



Prior Authorization (PA)

- PA not required for dually eligible Medicaid/Medicare recipients
- Obtaining PA does not
  - Guarantee payment
  - Ensure recipient eligibility on the date of service
- Retroactive PA

Prior Authorization (PA) cont.

- Required at start of treatment services
- Providers must request PA under the same provider number that will be used for billing
- PA's do **not** transfer if the recipient changes providers

PA for Recipient's under 21

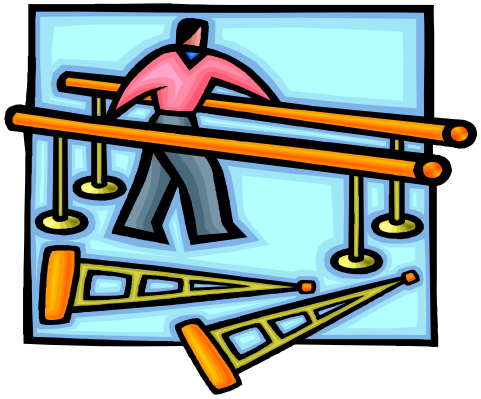
- Required at the start of **all** treatment services
- Effective immediately 12/1/2009 date of service
- For Local Education Agencies (LEAs)
  - PA process is deemed met by the IEP process
- PA required for continued treatment
  - After 52 visits per recipient, per discipline, in a 6-month period

PA for Recipient's 21 years and older

- Required at the start of **all** treatment services
- Effective immediately 1/1/2010 date of service
- Up to 30 combined visits of all therapy treatment visits per calendar year
- Evaluations and re-evaluations not subject to service limitations

Covered Outpatient Specialized Therapies

- All Outpatient Specialized Therapies must be medically necessary
  - Refer to Medical Necessity Guidelines
- Recipients under 21
  - Provided by allowable outpatient provider
- Recipients 21 and over
  - Only when provided by:
    - home health providers
    - hospital outpatient departments
    - physician office
    - area mental health centers



Provider Responsibility

- Verify Recipient Eligibility & Carolina Access
- Prior Approval
- Maintain Medical Records
- Billing and Payment
- Overpayments

Documenting Services Include

- Recipient name and Medicaid Identification Number
- Copy of the treatment plan
- Copy of the medical providers order for treatment services
- Description of services performed and dates of service
- The duration of service

Documenting Services Cont.

- The signature of the person providing each service
- A copy of each test performed or a summary listing all test results, and the written evaluation report.
- Documentation relating to the financial, medical, or other records necessary of services billed

Provider Responsibility

- Verify Recipient Eligibility & Carolina Access
- Prior Approval
- Maintain Medical Records
- Billing and Payment
- Overpayments

Claim Submissions

- Electronic submission
  - Electronic Claims Submission (ECS) Agreement to DMA for each billing provider number
- Clearinghouse, with software obtained from an approved vendor, or through
  - NC Electronic Claims Submission (NCECS Web Tool)
- Paper submission

Billing Information

- CA Overrides are reported on the NCECS web tool under
  - "Referring Physician Provider Number"
    (Carolina Access Physician Number)

- Electronic Funds Transfer (EFT)

- Checkwrite schedule
  - Cut-off date and time
  - http://www.ncdhhs.gov/dma/provider/calendar.htm

Billing Information cont.

- Submit separate claims, if applicable for:
  - Assessment/evaluation
  - Treatment services
  - For each type of service provided
  - Adhere to billing guidelines for each provider specialty

Billing Requirements/Diagnosis Code

- Primary treatment diagnosis entered first
  - Supports medical necessity
- Discipline-specific diagnosis code entered as secondary (Specific to CMS-1500 and 837p)
  - V57.0 Respiratory Therapy
  - V57.1 Physical Therapy
  - V57.21 Occupational Therapy
  - V57.3 Speech Therapy

Tips for Billing

- Any outpatient setting allowed by the provider's type and specialty
- Providers must bill their usual and customary charges
- Only home health agencies and hospitals request PA in visits
- All other providers request PA according to how the CPT code is billed

Billing Units

- Follow applicable guidelines based on your provider type and specialty
- Examples are listed:
  - 1 unit = 1 event
  - 1 unit = 60 min
  - 1 unit = 1 visit
  - 1 unit = 15 minutes

Billing for Services Rendered

- The provider of the service may be the biller of the service
- List the attending provider on claim, if a group practice is billing
- All providers must be enrolled with Medicaid

Provider Responsibility

- Verify Recipient Eligibility & Carolina Access
- Prior Approval
- Maintain Medical Records
- Billing and Payment
- Overpayments

Post-Payment Validation Reviews

- Monitoring utilization, quality, and appropriateness of all services rendered
- Statistically valid random sample from paid claims
- Written notice of findings will be sent to specialized therapy provider who is subject to the review
- Overpayments

Frequently Used Forms

DHHS Home | A-Z Site Map | Divisions | About Us | Contacts | En Español Search DHHS Search DMA GO

NC Department of Health and Human Services

NC Division of **Medical Assistance**

Home

DMA SERVICES | FOR COUNTY STAFF | For Providers | STATISTICS AND REPORTS

DMA HOME

Medicaid Providers

- A-Z Provider Topics
- Calendars
- Claims and Billing
- Community Care (CCNC/CA)
- Contacts for Providers
- Enrollment
- EPSDT and Health Check
- Fee Schedules/Cost Reports
- Forms
- Fraud and Abuse
- HIPAA
- Library (bulletins, policies)
- National Provider Identifier
- Programs and Services
- Seminars

DHHS > DMA > Medicaid Providers > Forms

Forms for Medicaid Providers

Forms on this page are in the PDF format unless noted. The free Adobe Acrobat Reader is required to view and print PDF files.

County Forms

Medicaid and Health Choice Applications for Consumers

Frequently Used Forms

- Electronic Claims Submission (ECS) Agreement for Groups
- Electronic Claims Submission (ECS) Agreement for Individuals
- Electronic Funds Transfer (EFT) Authorization Agreement
- Fee Schedule Request
- Medicaid Claim Adjustment Request
- Medicaid Resolution Inquiry
- Medicare Crossover Reference Request
- Non-Covered State Medicaid Plan Services Request Form for Recipients under 21 Years of Age
- Reporting a Change in Provider Status

Expand All Items Below | Collapse Items Below

Administrative

Medicaid Resolution Inquiry

Medicaid Overrides

- Resolution Inquiry Form
  - Used <u>only</u> when requesting
    - Time Limit Override
    - Third Party Override
    - Medicare Override
- Attached with Explanation of Benefits (EOB) and paper claim
- Mail to: HP Enterprise Services PO Box 300009 Raleigh, NC 27622

Other Insurance Information

- Private Insurance pays, submit electronic claim to Medicaid
- Non-payment indicated? Submit claim on paper with EOB
- Claim and EOB needs a Resolution Inquiry Form attached
- Check “Third Party Override” box
  - Applied to the Deductible, Non-Covered Service, Policy Terminated
  - Exceeds maximum benefits for the year

DMA-2057/Electronic Transmissions

- Update recipient's commercial insurance information
- Transmit electronically via secured internet connection
  - New & preferred method
- Ability to send claim upon receipt of the confirmation e-mail from vendor
- hms website http://ncprovider.hms.com

Contact Information

- PA inquiries and questions DMA/Nora Poisella nora.poisella@dhhs.nc.gov
- PA assistance CCME 1-800-228-3365, option 8 or email priorauth@thecarolinascenter.org
- Billing questions HP Enterprise Services 1-800-688-6696 or 919-851-8888
- Provider enrollment CSC EVC Call Center 1-866-844-1113 or email NCMedicaid@csc.com

Outpatient Specialized Therapies Questions?

Please address all questions at this time for

CCME, DMA, or HP

EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT)

MEDICAID FOR CHILDREN

Contacts: EPSDT Nurse Consultant
Division of Medical Assistance
Telephone #: 919-855-4260
FAX #: 919-715-7679

Why Health Check/ EPSDT are Important

- Promotes preventative health care by providing for early and regular medical and dental screenings.

- Provides medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening.

Health Check/EPSDT Overview

- **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)** defined by federal law and includes:
  - Periodic Screening Services
  - Vision Services
  - Dental Services
  - Hearing Services
  - Other Necessary Health Care

EPSDT Overview cont.

- Recipients under 21 must be afforded access to the full array of EPSDT 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]. Please refer to handout for a listing of these services.

- **NOTE:** Under EPSDT, North Carolina Medicaid must make available a variety of individual and group providers qualified and willing to provide EPSDT services.

EPSDT Criteria

- Must be listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act].

- Must be medically necessary "to correct or **ameliorate** a defect, physical or mental illness, or a condition [health problem] identified by screening".

EPSDT Criteria cont.

- **"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.

EPSDT Criteria cont.

- Must be determined to be medical in nature.
- Must be generally recognized as an accepted method of medical practice or treatment.
- Must not be experimental, investigational.
- Must be safe.
- Must be effective

EPSDT Features

- No Waiting List for EPSDT Services
- No Monetary Cap on the Total Cost of EPSDT Services
- No Upper Limit on the Number of Hours under EPSDT
- No Limit on the Number of EPSDT Visits to a Physician, Therapist, Dentist or Other Licensed Clinician

EPSDT Features CON'T.

- No Set List that Specifies When or What EPSDT Services or Equipment May Be Covered
- No Co-payment or Other Cost to the Recipient
- Coverage for Services that Are Never Covered for Recipients Over 21 Years of Age
- Coverage for Services Not Listed in the N.C. State Medicaid Plan

Important Points About EPSDT

- The full array of 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].

Important Points About EPSDT cont.

- EPSDT services do not have to 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.

Important Points About EPSDT cont.

- EPSDT covers short-term and long-term services as long as the requested services will correct or ameliorate the child's condition. For example, a service must be covered under EPSDT if it is necessary for immediate relief (e.g., pain medication). Treatment need not ameliorate the child's condition taken as a whole, but need only be medically necessary to ameliorate one of the child's diagnoses or medical conditions.

EPSDT Operational Principles

- 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.

- 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. This includes the hourly limits on Medicaid Personal Care Services (PCS).

EPSDT Operational Principles cont.

- 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.

- Out of state services are **NOT** covered if medically necessary similarly efficacious services are available in North Carolina. Out of state services delivered without prior approval will be denied unless there is retroactive Medicaid eligibility.

EPSDT Operational Principles

- Durable medical equipment (DME), assistive technology, orthotics, prosthetics, or other service requested 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.

EPSDT Operational Principles cont.

- The prohibition in CAP/C on skilled nursing for purposes of monitoring does not apply to EPSDT services if skilled monitoring is medically necessary. (Example: PDN)

- Case management is an EPSDT service and must be provided to a child with a Medicaid card if medically necessary to correct or ameliorate regardless of eligibility for a CAP waiver.

EPSDT Coverage And CAP Waivers

- CAP Waiver services are available only to participants in the CAP waiver programs and are not a part of the EPSDT benefit unless the waiver service is **ALSO** an EPSDT service.

- 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.

EPSDT Coverage And CAP Waivers cont.

- **ANY** child enrolled in a CAP program can receive **BOTH** waiver services and EPSDT services. However, the cost of the recipient's care must not exceed the waiver cost limit.

- If enrolled in CAP for Persons with Mental Retardation and Developmental Disabilities (CAP/MR/DD), prior approval to exceed $100,000 per year must be obtained.

EPSDT Coverage And CAP Waivers cont.

- A recipient under 21 years of age on a waiting list for CAP services is eligible for necessary EPSDT services without any waiting list being imposed.

- 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 and **may be provided in the school setting, including to CAP/MR/DD recipients.**

EPSDT Coverage And MH/DD/SA Services

- 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.

EPSDT Coverage And MH/DD/SA Services CON'T.

- LMEs may NOT use the Screening, Triage, and Referral (STR) process or the 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. **Only DMA and its contractors can determine if a Medicaid recipient meets criteria for a covered Medicaid service.**

EPSDT Coverage And MH/DD/SA Services CON'T.

- Requests for prior approval of MH/DD/SA services for recipients under 21 must be sent to ValueOptions or to an LME if handling PA in their catchment area.

EPSDT Coverage And MH/DD/SA Services cont.

- 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.

Requesting PA For A Covered State Medicaid Plan Service

- Covered state Medicaid plan services are defined as requests for services, products, or procedures covered by the North Carolina State Medicaid Plan.
- EPSDT does **NOT** eliminate the need for PA if PA is required.

Requesting PA For A Covered State Medicaid Plan Service cont.

- 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. When state staff or vendors review a covered state Medicaid plan services request for PA or continuing authorization (UR) for an individual under 21 years of age, the reviewer will apply the EPSDT criteria. 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.

Requesting PA For A Covered State Medicaid Plan Service cont.

- EPSDT 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 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 PA decision.

Requesting PA For A Covered State Medicaid Plan Service cont.

- 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 to correct or ameliorate a defect, physical or mental illness, or condition [health problem].

- Additionally, all other EPSDT criteria must be met.

Requesting PA For A Covered State Medicaid Plan Service cont.

- 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.

Services Formally Covered by CSHS

- **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 PA for external speech or sound processors, and file claims. Guidelines for the letter requesting external parts replacement or repair can be obtained from the implant manufacturer.

Services Formally Covered by CSHS cont.

- **Pediatric mobility systems**, including non-listed components, should be sent to HP Enterprise Services using the Certificate of Medical Necessity/Prior Approval (CMN/PA form).
- **Augmentative and Alternate Communication Devices** should be sent to HP Enterprise Services.

Services Formally Covered by CSHS cont.

- **Oral Nutrition**
  - Metabolic formula requests should be sent to DPH.
  - All other requests for formula that appear on the DMA fee schedules should be sent to HP Enterprise Services.
  - Formula that does not appear on the DMA fee schedules should be sent as an EPSDT request to:

    Assistant Director
    Clinical Policy and Programs

Inappropriate PA Requests Received By Vendors

- Vendors (CCME, HP Enterprise Services, ACS Pharmacy, MedSolutions, and ValueOptions) 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.

Requesting PA For 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 coverable** under federal Medicaid law, 1905(r) of the Social Security Act for recipients under 21 years of age.

Requesting PA For Non-Covered State Medicaid Plan Services cont.

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 the request to the Assistant Director, Clinical Policy and Programs, Division of Medical Assistance.

Requesting PA For Non-Covered State Medicaid Plan Services cont.

- Requests for Medicaid prior approval of DME, orthotics and prosthetics, and home health supplies that do not appear on DMA's lists of covered equipment should be submitted to the Assistant Director, DMA.

Requesting PA For Non-Covered State Medicaid Plan Services cont.

- Oral Nutrition

  Formula that does not appear on the DMA fee schedules should be sent as an EPSDT request to:

  Assistant Director
  Clinical Policy and Programs

Requesting PA For Non-Covered State Medicaid Plan Services cont.

Effective with date of request September 1, 2008, Children's Special Health Services 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, 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.

Requesting PA For Non-Covered State Medicaid Plan Services CON'T.

- 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:

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

Documentation Requirements

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:

- documentation showing that policy criteria are met;
- documentation to support that all EPSDT criteria are met;
- evidence-based literature to support the request, if available.

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

Documentation Requirements cont.

- Requests for non-covered state Medicaid plan services may be submitted on the Non-Covered State Medicaid Plan Services Request form for Children under 21 Years of Age.
- This form is located on the DMA website:
- **http://www.ncdhhs.gov/dma/provider/forms.htm**

Due Process Procedures

- Requests for prior approval of covered and non-covered state Medicaid plan 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.**

Due Process Procedures cont.

- If covered or non-covered 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, law 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.

Due Process Procedures cont.

- Effective date of the notice:
  - **Initial Request** – date notice mailed
  - **Concurrent Request – 10 days** from date notice mailed
- The recipient has **30 days** from the date the notice was mailed to file an appeal with the Office of Administrative Hearings.
- Providers, in consultation with DMA and/or its vendors, should reduce or terminate services based on type of request and whether or not an appeal was filed.

Due Process Procedures cont.

- The recipient has the right to continued Medicaid payment for services currently provided pending a 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.

Due Process Procedures cont.

- When a recipient appeals a reduction or termination of current services, continue the appealed service at the previous level or the level requested by the provider, whichever is lower. If DMA is notified by the Office of Administrative Hearings that an appeal has been requested, the provider will be instructed to reinstate (or do not terminate/reduce) the service. Continue the service until notified about the outcome of the appeal.

Due Process Procedures cont.

- Providers must continue to follow all service provision requirements (including obtaining reauthorizations for continuing services and all applicable state and federal rules and regulations).

- Providers can submit new requests **for a new amount of the same service** or new requests for different services during the appeal.

Due Process Procedures cont.

- Unless there is a change in the request or the recipient's clinical status, providers should not submit service requests for the service under appeal.

- Maintenance of service is in effect for the pendency of the appeal.

Due Process Procedures cont.

The following are **NOT** acceptable reasons for denial of coverage under EPSDT:

- "This is the responsibility of the school system."
- "Close supervision, redirection, safety monitoring, assistance with mobility and other ADL's, improving socialization and community involvement, and controlling behavior are not service goals covered under EPSDT."
- "The services would not correct or improve the child's diagnosis."

Due Process Procedures cont.

The following are **NOT** acceptable reasons for denial of coverage under EPSDT:

- "EPSDT criteria do not include monitoring a child's actions for an event which may occur."
- "EPSDT services are not long term or ongoing."
- "Teaching coping skills cannot be covered under EPSDT."

EPSDT Websites

- 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/provider/epsdthealthcheck.htm

EPSDT Provider Website

HHS Home | A-Z Site Map | Divisions | About Us | Contacts | En Español Search DHHS Search DMA GO

NC Department of Health and Human Services

NC Division of **Medical Assistance**

Home

DMA Services | For County Staff | For Providers | Statistics and Reports

DMA HOME

Medicaid Providers

- A-Z Provider Topics
- Calendars
- Claims and Billing
- Community Care (CCNC/CA)
- Contacts for Providers
- Enrollment
- **EPSDT and Health Check**
- Fee Schedules/Cost Reports
- Forms
- Fraud and Abuse
- HIPAA
- Library (bulletins, policies)
- National Provider Identifier
- Programs and Services
- Seminars

ABOUT DMA

DHHS > DMA > Medicaid Providers > EPSDT and Health Check

EPSDT and Health Check

EPSDT

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is the federal law that says Medicaid must provide all medically necessary health care services to Medicaid-eligible children. The services are required even if the services are not normally covered by children's Medicaid. More EPSDT Information

EPSDT and Health Check Information for Consumers

Health Check

The Health Check program facilitates regular preventive medical care and the diagnosis and treatment of any health problem found during a screening. More Health Check Information

EPSDT and Health Check Quick Links

- EPSDT Policy Instructions (updated 1/11/10) (63 KB)
- Health Check Billing Guide, April 2009
- Health Check Coordinator Directory
- Non-Covered State Medicaid Plan Services Request Form for Recipients under 21 Years of Age

Thanks for Joining us!

…The End