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5.1 Description

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a federally mandated program for children up to age 21 which emphasizes the importance of prevention through early screening for medical, dental and behavioral health conditions and timely treatment of conditions that are detected.

5.2 Amount, Duration and Scope

5.2.1 General Program Overview

The scope of required services for the EPSDT program is broader than for the Medicaid program in general. Federal requirements imposed by the EPSDT statutory provisions of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89) mandate that the State cover all Title XIX services included in Section 1905 (a) of the Act when medically needed, to correct or ameliorate defects and physical and mental illness and conditions discovered as a result of EPSDT screening. The OBRA '89 requirements also include an annual reporting of the State's participation in and provisions of the EPSDT program's services.

The combination of each element of the EPSDT program's name makes the program unique:

- Early – A child's health is assessed as early as possible in the child's life in order to prevent or find potential diseases and disabilities in their early stages, when they are most effectively treated.
- Periodic – Assessing a child's health at regularly scheduled intervals to assure that a condition, illness, or injury is not incipient or present.
- Screening – A comprehensive child health assessment to determine if a child has a condition, illness, or injury that should be referred for more definitive evaluation and/or treatment.
- Diagnosis – The definitive evaluation by appropriate medical practitioners to determine the nature, extent or cause of a condition, illness or injury.
- Treatment – The medical and remedial services permitted under Medicaid and determined medically necessary for problems identified during screening or diagnostic procedures.

The program's scope also includes:

- Informing EPSDT eligible recipients and their families about the benefits of preventive health care, how to obtain timely EPSDT services, and providing health education and anticipatory guidance. Informing can be done either orally (on the telephone, face-to-face or

films/tapes) or written. Informing should be done in non-technical language and use accepted methods for informing persons who are blind or deaf, or cannot read or understand the English language.

- Assistance with scheduling and transportation, upon request.
- Periodic screening, and medically necessary diagnosis and treatment of conditions detected as a result of screenings; including but not limited to timely immunizations and tuberculosis screening, treatment of defects in vision and hearing; and diagnosis and treatment of acute and chronic medical, dental and behavioral health conditions.
- Accountability of services. Medical records and documentation on the methods used in informing, screening, diagnosis and treatment services shall be maintained.
- Timeliness of services. Timely informing, periodic screening, diagnosis and treatment services.

5.2.2 *Scope of Services*

a) EPSDT Screens

The EPSDT periodic screening schedule generally follows the most current American Academy of Pediatric (AAP) Guidelines for Health Supervision. The screening is a brief assessment designed to identify individuals who need a more intensive assessment; not a single instrument used at one point in time, but a set of processes and procedures used over time. If it is determined at the time of the screening that immunization is needed and appropriate to provide at that time, then immunizations must be provided at that time.

- Medical screens to assess the individual's health status include the following types:
 - 1) Complete periodic screens at the following ages:
 - Infancy: By age 1 month, 2, 4, 6, 9, and 12 months
 - Early Childhood: At 15, 18, and 24 months, and at 3 and 4 years
 - Late Childhood: At 5, 6, 8, 10, and 12 years
 - Adolescence and Older: At 14, 16, 18 and 20 years.
 - 2) Interperiodic screens are allowed between the complete periodicity screens.

3) Partial screens are allowed when additional screens for one or more specific conditions are needed.

- Dental Screens

Every six months starting at age one year, optional from age 6 months.

b) Diagnosis and Treatment Services

- Inpatient, outpatient hospital and clinic services including X-ray and laboratory examinations
- Drugs, biological and medical supplies including medical equipment and appliances
- Physicians' (including osteopathic) services
- Nursing facility services and home health services
- Whole Blood
- Eye examinations, refractions and eye glasses
- Dental Services
- Family planning services
- Psychiatric/Psychological services
- Diagnostic, screening, preventive and rehabilitative services
- Prosthetic devices, including hearing aids
- Transportation to, from, and between medical facilities, including inter-island or out-of-state air transportation, food, and lodging as necessary
- Respiratory care services
- Hospice care services
- Personal care, private duty nursing, case management and chiropractic services are covered when determined medically necessary by the DHS and prior authorizations have been completed.

5.3 Elements of EPSDT Medical Periodicity Screens, Matrix and Guidelines

The following elements for children up to age 21 years have been developed by the EPSDT Advisory Committee and must be completed for each age-appropriate assessment:

- a) Initial and interval Health History
- b) Development/Behavior Assessment
- c) Height
- d) Weight
- e) Head Circumference
- f) Blood Pressure Readings
- g) Vision Screening
- h) Hearing/Language Screening
- i) Audiogram
- j) Physical Examination
- k) Immunization
- l) Tuberculin skin testing
- m) Lead Risk Assessment
- n) Blood Lead Level
- o) Hemoglobin/Hematocrit
- p) Other Lab screens
- q) Oral exam/recommend dental visit
- r) Fluoride
- s) Health education and counseling

For details on the elements for the EPSDT medical periodicity screens, refer to the Hawaii EPSDT Periodic Screening Guidelines on the next page. Refer to Chapter 14 “Dental Services” or Appendix 6, EPSDT complete Dental Screen Guidelines for EPSDT dental screenings.

5.3.1 *Hawaii’s Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Periodic Screening Guidelines (See next page)*

Hawaii’s Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Periodic Screening Guidelines

- 1 Perform and document in client’s health record all **non-shaded** elements for the appropriate age.
- 2 Obtain relevant development/behavior/school history; utilize age appropriate developmental screen (e.g., R-PDQ, ICMQ, CDI, DENVER II, ELM, HearKit, appraisal of young child—gross motor, fine motor communication, self-help/self-care, socio-emotional, cognitive skill development; evaluation of school age child—attention skills, learning disability, peer relationships, psychological/psychiatric problem) and behavioral questionnaire/survey (e.g., Eyberg).
- 3, 4, 5 Take measurements and plot on age and sex-appropriate growth chart.
- 6 Chart blood pressure reading and technique.
- 7 Vision Screening

| <u>Age</u> | <u>Exam</u> |
|--------------------|--|
| Birth - 1 month | Appearance of eyes; red reflex |
| 2 months | Appearance of eyes; red reflex Corneal light reflex; alignment; follow object |
| 4 months | Corneal light reflex; alignment; follow object |
| 6 months | Corneal light reflex; alignment; follow object EOM; cover test |
| 9 months – 3 years | EOM; cover test |
| 4 – 20 years | Visual acuity |
- 8 Hearing/language screening is required at every periodic exam except when audiogram is required.

| <u>Age</u> | <u>Hearing Milestones</u> |
|------------------|---|
| Birth – 3 months | Responds to loud noises |
| 4 – 5 months | Turns to sound source |
| 8 months | Imitates parent’s sounds |
| 12 months | Understands simple phrases |
| | <u>Speech Milestones</u> |
| 2 years | Spontaneous speech using 2-3 word phrases |
| 3 years | Consistently uses beginning consonants m, n, h, p, g, f, w |
| 4 years | Readily understands with good grammar |
- 9 An audiogram is required between ages 4 to 6 years with follow up as indicated.
- 10 Document physical exam findings in chart.

- 11 Use most currently available recommendations of the Department of Health/Immunization Branch Advisory Committee on Immunization Practices, American Academy of Pediatrics, American Academy of Family Physicians, Centers for Disease Control. See Appendix 1 for the website address.
- 12 Tuberculosis risk assessment at each periodic visit after age 6. High risk: child with history of known exposure to household contact/recent immigrant, individuals who are HIV-infected, incarcerated, and PPD converters. At a minimum, mantoux at age 12-15 months and at initial entry into school.
- 13 Perform and document that verbal lead risk assessment was completed utilizing the Child Lead Risk Questionnaire form. SLRA results must be documented in child's health record.
- 14 Blood Lead Level Test. Refer to most current CDC Lead Poisoning Guidelines.
- 15 Hemoglobin or Hematocrit for anemia screening at age 9 – 12 months and 12 – 14 years for females, unless otherwise indicated for males.
- 16 Other optional lab screen includes: Urinalysis/urine bacteria screen; sickle cell screen; G6PD screen CBC.
- 17 Perform oral exam at every visit. Recommend a dental visit starting at age 12 months and every 6 months thereafter.
- 18 Prescribe supplemental fluoride therapy with or without multivitamins between ages 6 months to 12 years.
- 19 Provide age appropriate anticipatory guidance for general health, mental health/depression, suicide, nutrition, development, safety, sexuality, parenting; may use American Academy of Pediatrics Guidelines for Health Supervision.

5.4 Claims Submittal

Claims for EPSDT services must be submitted on a CMS (formerly HCFA) 1500 form. Providers must bill for preventative EPSDT services using the preventative service, office or other outpatient services and preventive medicine CPT codes (99201 – 99215, 99381 – 99385, 99391 – 99395, 99431 99432 and 99435) with an 'EP' modifier in order to receive the global rate for this service. If the 'EP' modifier is not included with the CPT code, payment will be at the fee schedule rate.

Providers referring the recipient either back to themselves or to a specialist for follow-up treatment of a condition identified during the preventative visit must record an 'E' indicator in the FL 24H field of the 1500 form. The 'E' indicator is only recorded when a referral for follow-up treatment or evaluation is done. Otherwise, the field is left blank.

The system will allow global payment for preventative visits based on an age range of the recipient and the number of AAP recommended health screens for that age range. Preventative services provided in excess of the recommended number of screens will be paid at the standard fee schedule rate.

The 209 Screening Invoice form is no longer required.

5.5 Payment

A global fee reimbursement for the complete medical screen includes costs associated with any mandatory or optional office procedures such as drawing blood and immunization administration. Vaccines available through the federally funded Department of Health (DOH) Vaccines for Children (VFC) Program are not eligible for reimbursement.

A reduced global fee is allowed to provide “catch-up” immunizations for individuals who have not completed immunizations recommended for an earlier age. The fee includes a brief office visit to ascertain the absence of acute illness, review of the immunization schedule and its administration and counseling. The vaccines are available through the federally funded DOH VFC program. “Catch-up” visits should be billed using CPT codes for immunization administration/toxoids (90471-90474) with an ‘EP’ modifier. Providers may only bill one global service per day and may not bill for the service during the same visit as an EPSDT preventive visit.

See Chapter 2, “EPSDT Program Providers” for EPSDT Provider requirements.

5.6 Exclusions

Services which have not been determined medically necessary, not prior authorized or experimental in nature.

5.7 Optional Covered Services

The following optional covered services are available to recipients up to age 21 years when the client’s physician has completed and submitted a prior authorization and DHS has determined that the services are medically necessary:

- 1) Personal Care Services means the services that are provided by a certified nurse aide including assistance with feeding, bathing, grooming and other activities of daily living.
- 2) EPSDT skilled nursing (private duty nursing services) means the services provided by a licensed professional nurse within the scope of practice permitted under Hawaii statutes. The services provided require the skills and education of a licensed professional nurse, and include patient assessment and monitoring, direct nursing care, and active participation in the implementation and modification of the patient’s plan of care.

- Prior authorization requests for personal care and skilled nursing services must include the following completed and signed documentation:
 - a) Medicaid Form 1144 – Request for Medical Authorization
 - b) Current medical summary and/or recent hospital discharge summary
 - c) Current social summary, which identifies all formal services in place for the client, including the names and service hours of each service.
 - d) A Medically Fragile Case Management Scoring Tool completed, signed and dated by the primary care physician or supplier.
- Refer to Appendix 6 for more details on skilled nursing services. (See EPSDT Case Management Manual)
- 3) Chiropractic Services – Prior authorization request for this service must include medical justification documentation.
 - a) Medicaid Form 1144 – Request for Medical Authorization
 - b) Current medical summary and/or recent hospital discharge summary
- 4) EPSDT Case Management services means services which will assist an eligible individual with medical assistance in gaining access to needed medical, social, educational and other services. Activities allowable include:
 - Assessment of the eligible individual to determine service needs
 - Development of a specific care plan
 - Referral and related activities to help the individual obtain needed services, and
 - Monitoring and follow-up.

5.8 EPSDT Case Management

5.8.1 Description

- a) EPSDT Case Management is for a medically fragile individual who requires ventilator-dependence, tracheostomy-dependence, or otherwise requires intensive, continuous medical monitoring and interventions consequent to chronic serious medical conditions.
- b) EPSDT Case Management means services which will assist an individual eligible for medical assistance in gaining access to needed medical, social, educational, and other services.

5.8.2 Amount, Duration and Scope

5.8.2.1 General

EPSDT case management is covered when all of the following are met:

- The individual in need of case management is Medicaid eligible and under the age of 21.
- The individual is/will be able to safely reside in a home or foster home and does not need to be cared for in a facility for medical reasons.
- There is medical need for case management due to the medical condition of the individual and the need for coordination of multiple services/items.
- The individual cannot/will not be able to reside safely in a home without receiving specialized services/items in the home.
- The provision of such services will improve the care the family and service providers furnish to the patient and enable the patient to remain in the home safely.

5.8.2.2 Requirements

a) Records

- The EPSDT Case Manager must keep written documentation of his/her case management activities (assessment/reassessment, plan of care development, implementation, and changes, advocacy, liaison, coordination of care, quality)
- Records must be dated and signed
- All state and federal privacy and confidentiality requirements must be met

b) Visits/Contacts (by phone/fax/e-mail)

Standards for visits/contacts vary depending upon the level of EPSDT case management being provided and will be explained in the following sections.

c) Qualifications of EPSDT case management provider

- EPSDT case management provider must be provided by an entity that has licensed professional nurses and/or licensed physicians. The nurse must work with a physician. The physician may be an employer, a consultant to the nursing staff, an employee, or the patient's physician.
 - In all cases the primary case manager must be a licensed professional nurse or a licensed physician.
 - Although case management activities may be provided by the staff of the entity, the licensed professional nurse and/or physician must supervise, consult and/or advise the staff providing the activity.
 - All assessments of the patient's medical condition must be performed by the licensed professional nurse or physician.
- d) Details of the scope and responsibilities of EPSDT Case Management are outlined in the EPSDT Medically Fragile Case Management Manual see Appendix 6.

5.8.2.3 *Limitations*

EPSDT Case Management Acuity Levels and Procedure Codes.

a) Case Management for ventilator-dependent or tracheostomized children while still in the acute care hospital

- Only for initial discharge from acute care facility to a home/community based non-institutional setting:
- At least one visit to the family and home prior to discharge must be made. Included in the evaluation of the home is the power (electricity) outlets, safety for oxygen use, working telephone, need for special setting, bed/crib, whether the home is large enough to accommodate the equipment the child needs, etc. Also, an evaluation of the family and its capability to care for the child—resources such as relatives, church group, involvement with other community service groups, etc.

- Visits to the child and family while in the hospital to understand and learn the child's care plan. Evaluation of the family's ability to implement the care plan. No maximum number of visits.
- All transportation, meals and lodging for the case managers who come from neighbor islands are the responsibility of the case manager.
- Preparation for initial discharge from hospital is as follows:
 - 1) The case manager must work with the hospital discharge planner for discharge including arrangements for transportation of the patient and any hospital based professional staff who will accompany the patient.
 - 2) The case manager must ensure that the equipment/supplies are in the home and functioning prior to discharge.
- b) Case Management for ventilator-dependent or tracheostomized children after initial discharge from the hospital
 - Must be present in the home upon arrival of the patient.
 - Must make at least 3 home visits, and contact family by telephone, fax or e-mail at least 4 times, in the 2 weeks following initial discharge from the hospital; following subsequent hospitalizations which result in substantial changes in the patient's care plan or home care requirements; or whenever the child has an acute intercurrent illness requiring intervention by the child's treating physician.
 - Otherwise, case manager must visit the patient in the home at least once weekly, and contact the family by telephone, fax or e-mail at least twice per week, once the child is stable and the caregivers in the home have demonstrated their ability to provide good care.
- c) Case Management for those children who are not ventilator dependent or tracheostomized
 - This case management is of lesser intensity than the previous level.
 - It begins upon notification that a Medicaid eligible child who has been hospitalized for more than 30 days is being prepared for discharge to the home.
 - It can begin when a medically fragile child is identified in the community.

- Upon authorization of EPSDT Case Management, the following visits and contacts are expected:
 - 1) Initial assessment by a registered nurse (R.N.) within 2 days of initial discharge from the hospital.
 - 2) Initial assessment by a registered nurse (R.N.) within 1 week of acceptance of a child already in the community.
 - 3) Weekly face-to-face visits by a registered nurse (R.N.) for the first 2 weeks. Contact with the family at least 2 times a week by phone, fax or e-mail for the first 2 weeks.
 - 4) After the first 2 weeks, if the patient is stable and doing well, one R.N. face-to-face visit every 2 weeks, once a week contact with family by phone, fax or e-mail.
- d) Maintenance Case Management for those children who have been stable (either vent/trach or other) and have not required frequent assessments, care plan modifications, and whose families need only intermittent assistance to access services
- One face-to-face case manager visit a month and twice a month contact with family by phone, fax or e-mail.
- e) Additional hours provided with Case Management or Maintenance Case Management Services to address changing medical needs. Prior Authorization request must include a completed and signed “Supplemental Report for Medically Fragile Case Management Code” (included in EPSDT Medically Fragile Case Management Manual in Appendix 6).

5.8.2.4 Authorization

Prior authorization through the Med-QUEST medical consultant is required.

Request for prior authorization for EPSDT Case Management services must include the following completed and signed documentation:

- Medicaid Form 1144 – Request for Prior Authorization
- Medically Fragile Case Management Scoring Tool (included in EPSDT Medically Fragile Case Management Manual in Appendix 6)
- Supplemental Report for Medically Fragile Case Management Code, when appropriate

5.8.2.5 *Payment*

See Appendix 6, Guidelines and Special Programs, Manual for Early and Periodic Screening, Diagnosis and Treatment, Medically Fragile Case Management and Expanded EPSDT Services for billing guidelines.