

Substance Abuse Summit

October 7, 2013

Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT)

- Services **Today**
 - Program Description
 - Managed Care Requirements
 - Responses to Questions Submitted Through the Summit Survey
- Services **Tomorrow** (after January 1, 2014)
 - Changes due to the Affordable Care Act



EPSDT SERVICES

EPSDT is *federally mandated* for Medicaid-eligible children and is defined in 42 USC 1396d.

Children must be under the age of 21. Covered until the last day of the month in which they turn 21 (e.g. child's 21st birthday is June 20, 2012; services covered through June 30, 2012.)

An application or assessment *is not required* to access EPSDT services. EPSDT is not a program that may help obtain eligibility.

Services must be *medically necessary* and *appropriate* to be covered under EPSDT Special Services.

The following components are included:

Screening – routine physical (well child or well-baby check up) at appropriate intervals as recommended by the AAP with the components recommended by the AAP for the age.

Diagnosis and Treatment – services required as a result of a screening which are not covered or have exceeded benefit limits implemented by the traditional Medicaid Program.



EPSDT SUBSTANCE ABUSE SERVICES

- In provider type letters #A-92, #A-378, #A-223, dated July 8, 2013, DMS clarified that *substance abuse services* for children under the age of 21 *are covered* under the EPSDT program.
- Providers may bill for substance abuse services *with primary diagnosis* for children under the age of 21 enrolled in the Medicaid program or the Kentucky Children's Health Insurance Medicaid Expansion Program.
- **NEW** – If a provider is already enrolled in Medicaid, DMS no longer requires a separate EPSDT number to bill these services. **You may use your current number.** If you have a question about how this will operate with the MCO, please contact your MCO representative.

EPSDT SPECIAL SERVICES

- The service must be *medically necessary* and *appropriate* for that particular child.
- The service *cannot be covered elsewhere* in Medicaid (based on actual non-coverage or coverage limitations). Refer to Section 8, Title 907, KAR 11:034.
- Rates: If there is no reimbursement methodology established in Medicaid, reimbursement rates for EPSDT Special Services are *negotiated*. Refer to Section 4, Title 907, KAR 11:035.
- Medicaid is the *payor of last resort*. All other insurers must be billed prior to billing Medicaid for EPSDT Special Services.
- If Medicaid makes any payment for an EPSDT Special Service, the member *may not be billed* for any additional amount for that same service.
- KCHIP Phase III members *are not eligible* for EPSDT Special Services. These are members who have a status code on the Member Eligibility File of P7 .

MANAGED CARE REQUIREMENTS

As outlined in MCO contracts, each MCO is responsible for providing EPSDT services to all members under the age of 21.

An MCO **must**:

Provide ***all needed diagnosis and treatment*** for eligible members in accordance with the Kentucky Administrative Regulation for EPSDT services, Title 907, Chapter 11 (907 KAR 11:034). Out-of-network providers shall provide treatment if the service is not available within the Contractor's network.

Provide EPSDT Special Services for eligible members, including identifying providers who can deliver the medically necessary services described in federal Medicaid law and **develop procedures for authorization and payment for these services.**



MANAGED CARE REQUIREMENTS

continued

An MCO **must**:

Establish and maintain an effective and on-going Member Services case management function for eligible members and their families to provide education and counseling with regard to Member compliance with prescribed treatment programs and compliance with EPSDT appointments.

This function shall assist eligible members or their families in obtaining sufficient information so they can make medically informed decisions about their health care, provide support services including transportation and scheduling assistance to EPSDT services, and follow up with eligible members and their families when recommended assessments and treatment are not received.



Survey Q&A

Majority of questions centered around:

- Prior Authorizations
 - Criteria
 - Documentation
 - Medical Necessity
- Covered Services

SURVEY Q&A

PRIOR-AUTHORIZATION

Is there set criteria?

- Yes. Each MCO uses nationally recognized criteria although the criteria may differ from MCO to MCO.
- Medical necessity criteria varies from MCO to MCO and admission is often denied based on lack of two prior levels of care even though care may not exist in home community.

Is there a way to expedite? Timeliness of pre-authorization determination is a problem.

NOTE: It is recommended you contact the representative from each MCO to learn more about prior-authorization criteria or how to obtain timely authorization,



PRIOR-AUTHORIZATION

GENERALLY

All EPSDT Special Services must be **prior-authorized**, no matter the service or cost.

Prior-authorization requirements are detailed in Section 9 of Title 907, KAR 11:034.

DMS has contracted with a Peer Review Organization (PRO) for the medical necessity review/prior-authorization process for services provided through Medicaid fee-for service.

Applicable McKesson Interqual *criteria* are used by the Peer Review Organization to complete reviews of each request. (Refer to Title 907, KAR 3:130 Medical Necessity.)

Prior-authorizations are done on a case-by-case basis. What may be approved for one child, may not be approved for another.

Prior-Authorizations are generally issued for 30 days at a time.



PRIOR-AUTHORIZATION

continued

A mental health diagnosis is **NOT** required to prior-authorize substance abuse services for Medicaid eligible children under 21. A primary diagnosis of substance abuse alone may be used for Medicaid eligible children.

If the procedure code for the medically necessary substance abuse EPSDT service is already established and applied by a Medicaid program, that procedure code is used.

A valid CPT code that is not used by the Medicaid program may still be authorized.

If the service is medically necessary and within the provider's scope of practice, submit the request with procedure code for prior authorization to the peer review vendor, Carewise.



PRIOR-AUTHORIZATION

continued

The information required at the time the prior-authorization request is made includes but is not limited to:

- Child's name
- Child's Medicaid number
- Child's date of birth
- Child's county of residence
- Provider name
- EPSDT provider number
- Child's diagnosis
- Procedure being requested
- Length of time, if applicable.



PRIOR-AUTHORIZATION

continued

The following **documentation** may be required by Carewise or DMS to complete review of **medical necessity** for a prior-authorization:

- Letter of medical necessity from the doctor
- Other evaluations
- Testing results

The time frame authorized for services depends on the actual service.

The actual prior-authorization letter should be issued within 5-7 days.

Approval letters are sent to provider only.

Denial letters are sent to both provider and member with appeal rights. Only the member can appeal the decision. The provider cannot appeal.



PRIOR-AUTHORIZATION

continued

Definition of “*medically necessary*” set forth in 907 KAR 11:034, Section 9:

- (a) The service shall be to **correct or ameliorate** a defect, physical or mental illness, or condition;
- (b) The service to be provided shall be **medical or remedial in nature**;
- (c) The service shall be **individualized** and consistent with the recipient's medical needs;
- (d) The service shall **not** be requested primarily for the **convenience** of the beneficiary, family, physician or another provider of services;
- (e) The service shall **not** be **unsafe or experimental**;
- (f) If an alternative medically accepted mode of treatment exists, the service shall be the **most cost-effective** and **appropriate** service for the child;
- (g) A request for a diagnosis or treatment service in a community-based setting:
 - 1. May **not** be approved if the costs would exceed those of equivalent services at the appropriate institutional level of care; and
 - 2. Shall be **individually assessed** for appropriateness in keeping with the standards of medical necessity and the best interest of the child.
- (h) The service to be provided shall be:
 - 1. **Generally recognized** by the appropriate medical profession as an accepted modality of medical practice or treatment;
 - 2. **Within** the authorized **scope** of practice of the provider; and
 - 3. An **appropriate mode of treatment** for the medical condition of the recipient;
- (i) Scientific evidence, if available, shall be submitted consisting of:
 - 1. **Well designed and well conducted investigations** published in peer-review journals, demonstrating that the service is intended to produce measurable physiological outcomes;
 - 2. In the case of psychological or psychiatric services, **measurable psychological outcomes**, concerning the short and long-term effects of the proposed service on health outcomes;
 - 3. Opinions and evaluations published by national medical organizations, consensus panels and other technology evaluation bodies supporting provision of the benefit, shall also be considered if available;
- (j) The **predicted beneficial outcome** of the service shall outweigh potential harmful effects;
- (k) The services **improve the overall health outcomes** as much as, or more than, established alternatives.

SURVEY Q&A: COVERED SERVICES

What services are covered under EPSDT? General overview of all services that are covered by EPSDT regarding the Substance Use Disorder (SUD)...would like to review all covered services.

Services currently covered under EPSDT SS provider contracts include 90801, 90804, 90862, 99203, 99213, 99214, and 99374.

A SUD service that is not currently covered by EPSDT will be reviewed and added to the EPSDT SS provider contract billing rules when:

- The service is not covered by another Kentucky Medicaid program (Refer to Section 7 of 907 KAR 11:034)
- The service meets medical necessity requirements in Section 9 of Title 907 KAR 11:034 and Title 907 KAR 3:130.



CHANGES DUE TO THE AFFORDABLE CARE ACT

THERE IS A CHANGE A-COMING... January 1, 2014

Coverage for all Medicaid eligible
New benefit package
Expanding provider types

NOTE that ALL changes discussed here are still a *work in progress!*

DMS is currently waiting on approval from CMS regarding several changes.

Once these changes are approved, DMS will adopt the changes and amend state regulations.

Provider outreach and education will be forthcoming.



New Benefits

Substance Use Disorder Services: These benefits are subject to change, have been filed with CMS but have not been approved

- Screening, assessment, and / or evaluation
- Screening, brief intervention, and referral treatment
- Psych testing
- Medication management
- Medication assisted treatment
- Crisis intervention / Outpatient mobile crisis
- Residential crisis stabilization
- Day treatment
- Case management
- Targeted case management
- Intensive case management
- Peer support
- Brief treatment
- Parent training
- Wellness recovery support / Crisis planning
- Care coordination and health promotion (See Case Management)
- Comprehensive care management (See Case Management)
- Intensive outpatient program
- Individual, group, family, and collateral outpatient therapies
- Partial hospitalization
- Psychiatric residential treatment facilities (for children)
- Residential

Expanding Provider Types

- In addition to new benefits and expanded coverage to more Kentuckians, the Cabinet has also chosen to allow additional provider types to enroll as individual Medicaid providers.
- One new major category will be Behavioral Health Providers
 - Licensed counselors, psychologists, etc.
- Existing provider types can still provide the services covered.

Providers

Newly enrolling providers will not have a second EPSDT number.

Providers currently enrolled in Medicaid will not be required to use the second number to bill for substance abuse services. The EPSDT number will eventually be phased out for those providers with another number.

**More information on enrollment
in the new provider types is forthcoming**



EPSDT INFORMATION

For more information about EPSDT Special Services you can visit the following webpage:

- <http://chfs.ky.gov/dms/epsdt+special+services.htm>.
- Find a link to the EPSDT provider type 45 billing manual by scrolling down the menu on the right side of the page.
- At the bottom of the webpage, find information about EPSDT Special Services provider enrollment.

For information about DMS EPSDT Special Services prior-authorization, contact the DMS peer review organization, Carewise, formerly known as “SHPS”, at 800-292-2392 and select the “EPSDT Option.” Ask to speak to someone about “EPSDT special services” prior-authorization.

For information about DMS EPSDT Special Services Billing, contact the DMS billing services vendor HP at 800-807-1232.



EPSDT CONTACT INFORMATION

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If you have questions about current Medicaid provider enrollment, contact Provider Licensing and Certification at the toll free number below :

Toll free: (877) 838-5085 Monday to Friday 8 a.m. - 4:30 p.m. ET

Information about new provider types and enrollment will be forthcoming.

