



## **Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) Requirements in the Managed Medical Assistance Program**

### **❖ Overview**

EPSDT provides a comprehensive array of prevention, diagnostic, and treatment services for low-income infants, children and adolescents under the age of 21 years, as specified in Section 1905(a)(4)(B) of the Social Security Act (the Act) and defined in 42 U.S.C. § 1396d(r)(5) and 42 CFR 441.50 or its successive regulation.

The EPSDT benefit is more robust than the Medicaid benefit for adults and is designed to assure that children receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible.

Health plans are required to comply with all EPSDT requirements for their Medicaid enrollees under the age of 21 years.

### **❖ What services are covered under EPSDT?**

EPSDT entitles Medicaid enrollees under the age of 21 years, to any treatment or procedure that fits within any of the categories of Medicaid-covered services listed in Section 1905(a) of the Act if that treatment or service is necessary to “correct or ameliorate” defects and physical and mental illnesses or conditions. This requirement results in a comprehensive health benefit for children under age 21 enrolled in Medicaid.

Services include, but are not limited to:

- ◆ Behavioral Health Overlay Services
- ◆ Child Health Check-Up Services
- ◆ Chiropractic Services
- ◆ Dental Services
- ◆ Durable Medical Equipment/ Medical Supply Services
- ◆ Early Intervention Services
- ◆ Hearing Services
- ◆ Home Health Visit Services
- ◆ Hospital Services, including Psychiatric Services
- ◆ Nursing Facility Services
- ◆ Optometric Services
- ◆ Personal Care Services
- ◆ Physician Services
- ◆ Podiatry Services
- ◆ Private Duty Nursing Services
- ◆ Prescribed Drug Services

- ◆ Targeted Case Management Services

In addition to these services, Medicaid must provide any other medical or remedial care, even if the agency does not otherwise provide for these services or provides for them in a lesser amount, duration, or scope (42 CFR 441.57).

## ❖ **Frequently Asked Questions (FAQs)**

- ◆ **What are “special services” for children?**

*As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the SSA, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within Florida Medicaid policy or the associated fee schedule may be approved, if medically necessary.*

*Prior authorization is required in order to receive reimbursement for special services that meet one or more of the following conditions:*

- *The service is not listed in the service-specific Medicaid Coverage and Limitations Handbook as a covered service;*
- *The service is not included in the applicable fee schedule;*
- *The service is described in the service-specific handbook as an “excluded service”;*
- *The amount, frequency, or duration of the service exceeds the limitations specified in the service-specific handbook or the fee schedule.*

- ◆ **Are health plans required to provide services that are not covered by Florida Medicaid?**

*Yes, health plans are required to provide “special services” as described above if the service falls within a benefit category for which the plan is responsible (e.g., durable medical equipment). Each plan must establish a process for determining and authorizing coverage for any service, good, product, or device that is not covered by Florida Medicaid, consistent with EPSDT and as detailed in Attachment II, Core Contract Provisions, Section V.A.1, Required Benefits.*

- ◆ **What services are carved out of managed care?**

*The following services are carved out of managed care and available to recipients based upon the eligibility criteria for each service:*

- ◆ *Home and Community-Based Waiver services (excluding services provided under the LTC program)*
- ◆ *Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) services*
- ◆ *Medical Foster Care services*
- ◆ *Prescribed Pediatric Extended Care (PPEC) services*
- ◆ *Newborn hearing screening*
- ◆ *Early intervention services*

- ◆ *Behavior analysis (for children diagnosed with autism or autism spectrum disorders)*
- ◆ *Program for All-inclusive Care for Children (PACC)*
- ◆ **Does the health plan have to provide services that are carved out of managed care?**

*No, the health plan is not required to provide services that are carved out of managed care as described above. The health plan is responsible for providing care coordination/case management and referral for the appropriate care.*

- ◆ **How does the health plan assist health plan enrollees with services that are carved out of managed care?**

*The health plan is responsible for arranging, coordinating, and referring the enrollee to the appropriate program to meet the enrollee's needs. The health plan is required to provide basic information to assist the enrollee in understanding the type of service available and, when appropriate, arrange an appointment for the enrollee to obtain the service. For more information regarding coverage of these services, refer to the specific coverage policies found at:*

*[https://ahca.myflorida.com/medicaid/review/specific\\_policy.shtml](https://ahca.myflorida.com/medicaid/review/specific_policy.shtml)*

*In the event the health plan is having difficulty arranging an appointment for a service carved out of managed care for the enrollee, the health plan may contact Florida Medicaid's Recipient and Provider Assistance to obtain additional information, by calling 1-(877)-254-1055.*