Ohio | Department of Medicaid

Mike DeWine, Governor
Jon Husted, Lt. Governor

Maureen M. Corcoran, Director

TO: Medicaid Coordinators, Contracted Managed Care Plans
MyCare Ohio Coordinators, Contracted MyCare Ohio Plans

FROM: Megan Powell, Interim Chief
Policy and Program Development Section, Office of Managed Care

SUBJECT: Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program

DATE: June 17, 2019

The purpose of this correspondence is to reiterate certain requirements of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program, otherwise known as Ohio Medicaid's Healthchek Program. As you are aware, Medicaid managed care and MyCare Ohio plans (hereinafter referred to as "plan") must ensure that members under age 21 have access to services that are available in accordance with federal EPSDT requirements found at 42 U.S.C. 1396d(r) as amended. This includes medically necessary services covered by Ohio Medicaid, as well as any medically necessary screening, diagnostic and treatment services available to Medicaid consumers pursuant to 42 U.S.C. 1396d(a) that go beyond the applicable coverage and limitations set forth in Division 5160 of the Ohio Administrative Code (OAC).

Prior Authorizations/Coverage Determinations for EPSDT

- OAC rule 5160-1-01 stipulates two medical necessity definitions: one for individuals covered by EPSDT (any individual under age 21 with access to state plan services), and a second for individuals not covered under EPSDT. Plans must ensure that staff and/or delegated entities are educated regarding the two different medical necessity definitions.
- Prior authorizations and coverage determinations must be reviewed for medical necessity as defined in OAC rule 5160-1-01(A).
- Prior authorizations and coverage determinations requests that include a code that is not valid, include a code that is not on the Medicaid fee schedule, or exceed Ohio Medicaid coverage and/or limitations must still be reviewed for medical necessity. While it is understood that providers ultimately must submit a claim with a code that will be accepted, it is critical that access to a medically necessary service is not denied and/or delayed due to a code issue. Plans and/or delegated entities must make their prior authorization and coverage determination while working with the provider to identify an applicable code for billing purposes (e.g. plans may have to have the claim submitted with a miscellaneous code).

Information to Members/Providers to Reflect EPSDT

- Notices to members or providers (e.g. denial reasons on notices of action, state hearing forms/appeal summaries, etc.) must explicitly indicate that prior authorization and coverage determinations are based on medical necessity.

- To clearly reflect that plans and/or delegated entities are utilizing the correct definition when making prior authorization and coverage determinations, plans must cite OAC rule 5160-1-01(A), at a minimum, as the supporting regulation for their decision.
- Any plan and/or delegated entity policies, materials that reflect coverage (e.g. prior authorization lists), and/or benefit limitations must prominently include a disclaimer such as "providers can request prior authorization to exceed coverage or benefit limits for members under age 21."
- Explanation of Payment (EOP) or Explanation of Benefit (EOB) notices must clearly reflect that coverage decisions for members under age 21 are based on medical necessity for services available to Medicaid consumers pursuant to 42 U.S.C. 1396d(a).

If you have any questions regarding the above information, please contact ManagedCarePolicy@medicaid.ohio.gov.