Sentara Health Plans

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Provider Desk Reference

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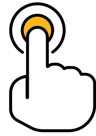

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This document was developed by Sentara Health Plans as a general guide for our provider network. For detailed information, you are encouraged to review the **Department of Medical Assistance Services (DMAS) EPSDT Supplement B**.

Overview

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is designed for general information purposes only, and providers should always refer to the Sentara Health Plans Provider Manuals and the provider agreement for the most detailed and up-to-date requirements. EPSDT is a federal law (42 CFR § 441.50 et seq). No special enrollment procedures are required. The managed care program promotes a "medical home" so that members under the age of 21 receive both sick and well care from their primary care provider (PCP) instead of episodic care from an emergency room.

EPSDT is designed to:

- identify health concerns early
- ensure that treatment is provided before problems become complex
- medically justify that services are provided to treat or correct identified problems

Screenings

EPSDT screenings, also known as well-child visits, should be performed by the Sentara Community Plan member's PCP or EPSDT screening provider in accordance with the American Academy of Pediatrics (AAP) Recommendations for Preventive Pediatric Health Care for Managed Care Organizations (MCO) and Fee-for-Service (FFS) plans. EPSDT screenings include comprehensive, periodic health assessments, or screenings, from birth through age 20, at intervals as specified in the EPSDT medical periodicity schedule established by AAP and DMAS requirements.

Screening components include:

- a comprehensive health and developmental history (including assessment of both physical and mental health development)
- a comprehensive unclothed physical exam
  - vision screening by a standardized testing method according to the DMAS periodicity schedule
  - hearing screening by a standardized testing method according to the DMAS periodicity schedule
  - developmental screening with a standard screening tool according to the AAP guidelines
- age-appropriate immunizations as needed according to the Advisory Committee on EPSDT Supplement B 5 Immunization Practices (ACIP) guidelines
- appropriate laboratory tests.
  - hemoglobin/hemacrit;
  - tuberculin test (for high--risk groups); and
  - blood lead testing including venous and/or capillary specimen (finger stick) in accordance with EPSDT periodicity schedules and guidelines using blood level determinations as part of scheduled periodic health screenings appropriate to age and risk and in accordance with the EPSDT schedule. A blood lead test result equal to or greater than five (5) ug/dL obtained by capillary specimen (finger stick) must be confirmed using a venous blood sample.

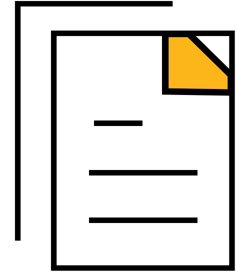
Periodicity Table

Infancy	Early Childhood	Late Childhood	Adolescence
3–5 days	12 months	5 years	11 years
1 month	15 months	6 years	12 years
2 months	18 months	7 years	13 years
4 months	2 years	8 years	14 years
6 months	30 months	9 years	15 years
9 months	3 years	10 years	16 years
	4 years		17 years
			18 years
			19 years
			20 years

Additionally, the following related activities must occur:

- Advise families of the importance of regular preventive healthcare for their children and explain EPSDT services.
- Provide or arrange for initial and periodic EPSDT preventive health screenings according to the DMAS periodicity schedule and screening requirements.
- Ensure that the initial screening is scheduled within thirty days of notification of managed care assignment and immediately upon notification of newly assigned newborns unless the services are declined.
- Notify families when the next screening is due, including those families who have previously declined screening services, and encourage them to keep all screening appointments.
- Schedule the next screening appointment and maintain periodicity and tracking system on screenings.
- Follow up on missed or incomplete screenings, including contacting families and rescheduling the screenings promptly.
- Coordinate care for children referred to other qualified providers for screening services and specialty care and obtain results of the screenings and other healthcare services.
- Maintain a comprehensive and integrated medical record of all healthcare the child receives, including complete documentation of all EPSDT screening components and immunizations given.

Comprehensive Health and Developmental/Behavioral History



During the initial screening, the screening provider must obtain a comprehensive health, developmental/behavioral, mental health, and nutritional history from the child's parents or a responsible adult familiar with the child, or directly from an adolescent, when appropriate. The history must be updated at each subsequent screening visit to allow serial evaluation.

A comprehensive initial history includes:

- family medical history (health of parents and current family members, identification of family members with chronic, communicable, or hereditary diseases)
- patient medical history (prenatal problems, neonatal problems, developmental milestones, serious illnesses, surgeries, hospitalizations, allergies, and current health problems and medications)
- nutritional history; immunization history; environmental risk (living conditions, water supply, lead, sewage, pets, smokers in home)
- family background of emotional problems, problems with drinking or drugs, or history of violence or abuse
- patient history of behavioral and/or emotional problems (educational environment and performance, family and social relationships, hobbies, sports)

In addition, for all adolescent children, the initial history must include:

- history of sexual activity, if appropriate
- menstrual history for females
- obstetrical history, if appropriate

Documentation

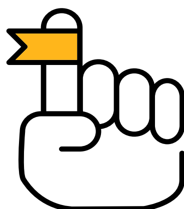
Sentara Health Plans Medical Record Documentation Standards

- A current active problem list must be maintained for each member. It should be legible and updated as appropriate. Significant illnesses and chronic medical conditions must be documented on the problem list. If there are no identified significant problems, there must be some notation in the progress notes stating that this is a well-child/adult visit.
- Allergies and adverse reactions must be prominently displayed. If the member has no known allergies or history of adverse reactions, this is appropriately noted in the record. A sticker or stamp noting allergies/NKA on the cover of the medical record is acceptable.
- Past medical history (for patients seen three or more times) must be easily identified and include family history, serious accidents, operations, and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations, immunizations, and childhood illness.
- Each page of the medical record contains the patient's name or ID number. All entries are dated.
- Working diagnoses and treatment plans are consistent with medical findings.
- All requested consults must have return reports from the requested consultant, or a phone call follow-up must be noted by the PCP in the progress note. Any further follow-up needed or altered treatment plans should be noted in progress notes. Consults filed in the chart must be initialed by the PCP to signify review. Consults submitted electronically need to show representation of PCP review.

Medical records must contain the following information specific to EPSDT screening services:

- which age-appropriate screening was provided in accordance with the AAP and Bright Futures periodicity schedule and all EPSDT-related services whether provided by the PCP or another provider
- documentation of a comprehensive screening must, at a minimum, contain a description of the components utilized
- when a developmental delay has been identified by the provider and an appropriate referral has been made.
- the date screening services were performed, the specific tests or procedures performed, the results of these tests and procedures, and the specific staff member who provided the service
- separate documentation of each required component of screening, including vision and hearing screening and immunizations (the DMAS-353, available in the provider portal, may be used for this purpose)
- documentation of medical contraindication or a written statement from a parent or guardian on a child screened for whom immunizations were due and not given and attempts the screening provider made to bring the child up to date on immunizations
- identification of any screening component not completed, the medical contraindication or other reason why it could not be completed, and attempts the screening provider made to complete the screening
- documentation of a medical contraindication or other reason for delay in vision or hearing screening if not performed on the same day as a medical screening
- documentation of declination of screening services by parents
- documentation of missed appointments and of at least two good-faith efforts to reschedule according to the periodicity schedule

- referrals made for diagnosis, treatment, or other medically necessary health services for conditions found in screenings and documentation of follow-up done to ensure services or treatment were provided within 60 days of the screening; date next screening is due; documentation of direct referral for age-appropriate dental services
- Continuity and coordination of care among all providers involved in an episode of care, including PCP and specialty physicians, hospitals, home health, skilled nursing facilities, and free-standing surgical centers, etc., must be documented when applicable.
- There should be documentation present in the records of all adult patients (emancipated minors included) that advance directives have been discussed. If the patient does have an advance directive, it should be noted in the medical record. A copy of the advance directive should be present in the record.
- Clinical information relevant to the patient under review is contained in the record or in a secure computer system, stored and accessible in a nonpublic area, and available upon identification by an approved person. All office staff must comply with HIPAA privacy practices.
- An assessment of smoking, alcohol, or substance abuse should be documented in the record for patients 12 years and older. Referrals to a behavioral health specialist should be documented as appropriate.
- Records should indicate that preventive screening services are offered in accordance with the Preventive Health Guidelines of Sentara Health Plans. This should be documented in the progress notes for adults 21 years and older.



Sentara Behavioral Health Medical Record Documentation Standards

Medical records may be audited, according to the Sentara Behavioral Health Treatment Record Documentation Guidelines that incorporate accepted standards for medical record documentation as shown below:

- history of present illness
- psychiatric history
- substance use assessment
- mental status examination
- diagnosis (all five axes)
- medical history, including allergies and adverse reactions (physicians only)
- medication management (physicians only)
- allergies and adverse reactions to medications
- treatment planning
- risk assessment
- evidence of continuity of care – documentation of collaboration with the member's PCP regarding medication and treatment rendered, or documentation of the member's refusal to consent to same

After obtaining the patient's informed consent prior to the release of information, the provider is expected to notify the PCP when the member presents for an initial behavioral health evaluation and continued treatment, including significant changes in the patient's condition, changes in medication, and termination of treatment.

Clinical information relevant to the patient under review is contained in the record or in a secure computer system, stored and accessible in a nonpublic area, and available upon identification by an approved person. All office staff must comply with HIPAA privacy.

Patient information should be in chronological or reverse chronological order and in a consistent, logical format.

Medical Necessity and Secondary Review

The state may determine the medical necessity of the service and subject the service to service authorization for purposes of utilization review. In addition to the traditional review for medical necessity, children who are denied services that do not meet the general coverage criteria must receive a secondary review to ensure that the EPSDT provision has been considered. Denial for services to children cannot be given until this secondary review has been completed. No service provided to a child under EPSDT can be denied as "noncovered," "out-of-network," and/or "experimental" unless the approved secondary review applying EPSDT criteria has been completed and determined that it is not medically necessary.

Clinical Trials

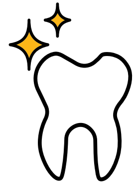
Clinical trials are considered on a case-by-case basis using EPSDT criteria when no acceptable or effective standard treatment is available for the child's medical condition.

Treatment and Referrals

The following general requirements apply to EPSDT referrals:

- The referral duration will be at the discretion of the provider and must be fully documented in the patient's medical record.
- The PCP is responsible for the informing, tracking, follow-up, and documentation requirements of EPSDT.
- Screenings not performed by the child's PCP may require a referral from the PCP.
- A referral to the appropriate professional should be made if dietary or nutritional problems are identified.
- Referral information and contact information can be found online.
- Children not enrolled in managed care are not subject to this referral requirement.

Dental Referrals



EPSDT regulations require a direct referral to a dentist beginning at age 3.

- An oral inspection must be performed by the screening provider as part of each physical examination for a child screened at any age. The oral inspection is not a substitute for a complete dental screening examination provided through direct referral to a dentist.
- The initial dental referral must be provided at the initial medical screening, regardless of the periodicity schedule, on any child age 3 or older unless it is known and documented that the child is already receiving regular dental care.
- The importance of regular dental care must be discussed with the family (and child as appropriate) on each screening visit for children 3 years and older.
- A referral must be made for needed dental services when any screening, even as early as the neonatal examination, indicates a need for dental services at an earlier age.

Developmental Delay

Enrolled members under age three diagnosed with a developmental delay must receive an appropriate referral to the Infant and Toddler Connection of Virginia and document in the member's record. Sentara Health Plans will assist in further diagnosis and treatment as well as transportation and scheduling to receive services for early intervention, at the family's request.

Specialized Services Referral

Treatment services that are approved through the EPSDT benefit but are not available through the State Plan for Medical Assistance are called EPSDT Specialized Services. When a screening indicates the need for diagnosis or treatment, the physician's progress notes must so indicate.

- The child may be referred for medically necessary specialty care or other health services if the PCP or screening provider is not able to provide the treatment.
- The screening provider, if not the child's PCP, must contact the child's PCP to request a referral and authorization for the treatment or other services.
- The PCP must follow up on all EPSDT referrals resulting from a screening to ensure that the child receives the requested treatment or other services within 60 days and document the results in the child's medical record.

Sentara Health Plans Medical Services Access

For all Sentara Health Plans members, the following applies for medical referrals:

- A PCP referral is not required for members to access health services.
- Physicians may not refer to out-of-network providers unless authorized by the health plan.
- Physicians must obtain authorization from the health plan prior to recommending the member obtain care out-of-network.
- HMO plans will not pay if the services are provided to the member by a nonparticipating provider.
- Providers must receive authorization before services are rendered for any services requiring authorization.
- PCPs or specialists may not authorize noncovered benefits or out-of-network services unless medically necessary and pre-authorized by the plan.
- Exceptions may apply for emergencies and network accessibility.

Sentara Behavioral Health Services Access

A PCP referral is not required for members to access behavioral health services.

Member Outreach Requirements

Informing is accomplished through outreach activities such as face-to-face discussions, telephone conversations, and written communications and is intended to increase EPSDT screening participation. **Outreach and informing are joint responsibilities of DMAS, the Department of Social Services (DSS), Sentara Health Plans, and providers.**

At a minimum, Sentara Health Plans member outreach initiatives include:

- welcoming new members monthly and the MHHS screening
- conducting outbound calls to members to: educate on benefits; locate a PCP, if needed; and schedule their initial visit, if desired
- ascertaining if the member is impacted by any social determinants of health, and referring appropriately to close gap(s)
- reviewing immunization, eye exam, well-child check-up, and prenatal/postpartum incentive programs
- referrals to GED programs if needed/desired
- enrollment in the college assistance program, which reimburses college application fees, when applicable

The above information is logged so that Sentara Health Plans care coordinators and case managers are aware.

Authorizations

EPSDT screenings, inter-periodic screenings, and the required components of the screenings do not require service authorizations. **All treatment services require service authorization before the service is rendered by the provider.**

Specialized Services Authorizations

Reimbursement for EPSDT Specialized Services is limited to the hours of treatment and medical or clinical supervision as specified in the treatment plan and as approved by DMAS or Sentara Health Plans. All specialized service requests require physician documentation outlining the medical necessity, frequency, and duration of the treatment. To qualify for reimbursement through the EPSDT benefit, EPSDT Specialized Services must be approved before the service is rendered by the provider.

Detailed information on the service authorization of behavioral therapy, nursing, personal care inpatient services, and audiology and hearing aid services defined is available via the **MES Provider Portal**.

Obtaining an Authorization at Sentara Health Plans

The preferred method to obtain an authorization is through the secure provider portal.

Receiving authorization is contingent upon medical necessity as supported by medical criteria and standards of care. Sentara Health Plans does not provide incentives to influence authorization decisions, promote denials of coverage of care, or encourage under-utilization of services. Sentara Health Plans follows the National Committee for Quality Assurance guidelines for timeliness of utilization management decisions.

Obtaining an Authorization at Sentara Health Plans (continued)

Elective Admissions

Requests for elective admissions must be submitted for prior authorization **fourteen days prior to scheduling an admission or procedure.** Treatment by nonparticipating providers must receive authorization from Sentara Health Plans in the same time frame as above.

The requesting provider should receive an authorization for services within fourteen days if all the necessary clinical information is provided with the initial authorization request and the service is covered under the member's benefit plan. Lack of clinical information to support authorization approval will delay processing.

Failure To Obtain Authorization

Failure to obtain authorization for services will result in the denial of payment, and the provider may be held responsible for the cost of services rendered. Authorization determines medical necessity. It does not determine the level of payment or coverage and therefore does not guarantee payment. Payment decisions are also based on eligibility for services on the procedure date and benefits provided through the member's health plan. Please see the Sentara Health Plans Provider Manual for the list of services requiring authorization, except in the case of emergency treatment.

Urgent Authorization Requests

Authorization may also be obtained by phone for medically urgent requests. Clinical Care Services personnel are available to process faxed requests and medically urgent telephone requests between 8:00 a.m. and 5:00 p.m., Monday through Friday, EST. A confidential voicemail is available between the hours of 5:00 p.m. and 8:00 a.m., Monday through Friday, and 24 hours on weekends and holidays.

Please note on the authorization form if the request is urgent and requires expedited review. To qualify: failure of an immediate review would result in loss of life or limb or result in permanent injury.

Special Billing Instructions

Virginia Medicaid requires the use of Health Care Financing Administration Common Procedure Coding System (HCPCS/CPT) codes and definitions published in the current edition of the Physician's Current Procedural Terminology (CPT) in billing EPSDT covered screenings. The CPT Manual may be obtained by calling the American Medical Association at **1-800-621-8335.** The Health Insurance Claim Form, CMS-1500 (08-05), must be used to bill for screening services and immunizations.

To learn more, you may review the **Billing and Payments section of the Sentara Health Plans Provider Manual.**

Home and Community-based Services Waivers

Some services are available outside of the state plan under Social Security Act Section 1915(c) through Home and Community-based Services Waivers. Services covered under Section 1915(c) are not covered under EPSDT unless they are also allowable services under Section 1905(a). For more information on Home and Community-based Waivers, providers may contact the DMAS provider call center at **1-800-552-8627** or refer to **dmas.virginia.gov/#/ltss**.

Helpful Resources

DMAS Provider Manuals

EPSDT Supplement B

MES Provider Portal

Commonwealth of Virginia Referral Directory by City/County

Sentara Health Plans Online Resources:

- Sentara Health Plans Provider Manual
- Doing Business With Sentara Health Plans
- Avoid Common Claims Submission Errors
- Submit an Authorization
- Provider Portal Authorization Tips
- Visit the Close Care Gaps Web Page

Sentara Health Plans Billing and Claims Resources

- EPSDT Coding Reference Sheet (Well Child Forms)
- Sentara Health Plans Claims and Billing Quick Reference Guide