Oregon Health Authority

Question & Answer Log

EPSDT Overview for Behavioral Health and Behavior Rehabilitation Service Providers
February 15, 2023
3:00-4:30 p.m.
Recording: https://www.youtube.com/watch?v=YZVYFoRKZvg

This document provides a summary of all questions asked during this provider education session and corresponding answers from OHA staff. Some questions and answers have been edited for clarity. ***Please Note:*** *This document is not meant to be a substitute for reviewing the full guidance documents, which include all EPSDT requirements. All EPSDT materials and guidance are available at www.Oregon.gov/EPSDT*

Questions & Answers

What Provider Type must an agency be registered as in order to bill for EPSDT services? Is it just provider type 33? That would be a heavy administrative burden for many organizations that don't provide clinical services as a primary function.

EPSDT applies to all provider types, not just type 33.

Are Qualified Mental Health Associates (QMHAs) and Qualified Mental Health Professionals (QMHPs) able to bill under the licenses of other enrolled behavioral health providers?

When enrolling through OHA's Provider Enrollment Unit, QMHPs and QMHAs enroll as a rendering provider and the agency they work for enrolls as the billing provider.

Is this change effective for all dates of service 1/1/23 and forward or is it by date of admission (with respect to Psychiatric Residential Treatment Services, SubAcute and Day Treatment)? If a client was admitted to one of these levels of care on 12/15/22 is EPSDT still effective 1/1/23?

For an inpatient service billed on an inpatient claim form, the date of service is the date of discharge. If the date of inpatient discharge is on or after January 1, 2023, it will fall under the new EPSDT guidance. If the member is admitted into a care plan that started before 1/1/23, each date of service will be looked at individually. The dates of service prior to 1/1/23 will process under the previous guidance, and the dates of service 1/1/23 and after will process under the new EPSDT guidance. For dates of service prior to 1/1/23, a provider can and has always been able to request a review via appeal. Additionally, for Fee-for-Service/Open Card claims with dates of service 1/1/23 and after, OHA will be reaching out to the provider to ensure a review, but that process does not happen for claims with dates of service prior to 1/1/23 (in those cases, the provider must initiate the

review/appeal). If you are working with a CCO, please consult with them directly for their specific procedures.

Does the change in EPSDT policy apply to gender affirming medical services?

Gender affirming care, like any other treatment service, will be reviewed on an individual basis for medical necessity and medical appropriateness. If gender affirming care is medically appropriate and medically necessary for an individual member, then it must be covered.

What about if one CCO approves something as medically necessary and another CCO does not?

Under EPSDT, medical necessity and medical appropriateness must be individually reviewed. If a member or provider believes a CCO has denied something inappropriately, they should make use of the appeal process at the CCO, making sure to provide the necessary clinical documentation. If the CCO overturns the denial, then the process ends there. If the CCO upholds their denial, the member/guardian has the option to request an administrative review (hearing) with OHA (a provider can work with the member/guardian to request a hearing on the member's behalf). These are established processes that have not changed under EPSDT. More information about the appeals and hearings process can be found at
https://www.oregon.gov/oha/HSD/OHP/Pages/Appeals-Hearings.aspx

If you identify any concerning trends in terms of denials, please don't hesitate to reach out to one of the following contacts:

OHA Ombuds Program
Email: OHA.OmbudsOffice@odhsoha.oregon.gov
Phone: 1-877-642-0450 (message line only)

EPSDT staff: EPSDT.Info@odhsoha.oregon.gov

Is it possible to get medical necessity review prior to services to avoid having non-covered services? We're concerned about being on the line for nonpayment if the medical review is only after the claim is submitted.

For a CCO-enrolled member, the provider should contact the CCO for its specific procedures regarding pre-service review for medical necessity and medical appropriateness.

For Fee-for-Service/Open Card members, providers have the option to request a pre-service review even if prior authorization is not required for the service. To submit a pre-service review request:

- Preferred method: MMIS Provider Portal at https://www.or-medicaid.gov
- If necessary: Fax the ODHS/OHA Prior Authorization Request Form (MSC 3971) to OHA using the contact numbers provided on the MSC 3971. Please note that the completed EDMS cover sheet (included in MSC 3971) must be on page one for successful processing.

I'm confused by the statement that OHA and CCOs can't deny based on whether something is or is not paired on the Prioritized List. Given that HERC establishes whether something pairs based on clinical evidence, why would CCOs cover services that are not supported by evidence?

Part of EPSDT is a recognition that we are combining broader health evidence with the unique needs of an individual youth or child based on their circumstances. The Prioritized List and its guideline notes can be used as guidance under EPSDT. However, every determination of medical necessity and medical appropriateness must be based on the individual member's situation. So yes, the clinical evidence captured in the Prioritized List can and should be used in the context of individual case review and can serve as justification of the medical necessity and medical appropriateness determination. However, it should not be used to determine coverage across the board or for an entire age group or population under EPSDT.

Can community-based outpatient sexual abuse specific treatment (SAST) be billed for youth that are in a Behavioral Rehabilitation Service (BRS) program? As a county agency we provide both a BRS program and community-based sexual abuse treatment program. We currently pay our provider for the sexual abuse treatment out of County General Funds for youth that are in our BRS program. Would we be able to bill through our BRS program for this outpatient treatment or does this have to be billed outside of our BRS program?

It would need to be billed separately as an outpatient service, not as a BRS provider (which is paid for as a residential daily rate). Since many services offered through SAST are behavioral health services, providers could bill on an outpatient basis for those services when rendered by a qualified provider. Documentation would need to show the treatment is medically necessary and medically appropriate.

Court ordered services for youth may also be covered by Medicaid when determined medically necessary and medically appropriate. To bill Medicaid, whether to the Fee-for-Service/Open Card program or to a CCO, the provider must be enrolled as an Oregon Medicaid provider. For services to Fee-for-Service/Open Card members, the provider must follow OHA's behavioral health billing and authorization requirements. For services to CCO members, the provider must follow the specific CCO's requirements, which may include prior authorization for non-contracted providers. Contact the specific CCO for information.

Does the suspension of historically non-covered claims impact Individuals with Disabilities Education Act (IDEA) school-based claims?

IDEA services should be covered by the school. For services in an Individualized Education Program (IEP) that are Medicaid coverable and billed to the OHA Fee-for-Service/Open Card program, the claim will be suspended for an individual review for medical necessity and medical appropriateness before being processed. Claims billed to CCOs will go through a similar process, though procedures may differ.

Will CCOs be required to support long term residential services if they are deemed medically necessary and medically appropriate?

CCOs are required to pay for services deemed medically necessary and medically appropriate, regardless of length of stay (this does not apply to services covered solely on a fee for service basis). It is reasonable as a utilization management practice to require a re-authorization request be

made after a certain period of time. Re-authorization requests need to be reviewed for medical necessity and medical appropriateness and approved or denied accordingly.

One slide says utilization management "should" conform with the Parity Act, not "must" conform. Which is more accurate?

Utilization management techniques used for mental health and substance use disorders **must** comply with the Mental Health Parity and Addiction Equity Act.

Prior OHA guidance stated "not least costly" could not be used as a denial reason. Is this allowed for Durable Medical Equipment (DME)?

OHA and CCOs cannot deny something based solely on cost. This is prohibited under federal EPSDT guidance. However, we still need to be good stewards of public funds and so cost is part of the decision-making process regarding coverage.

DME needs to be medically necessary and medically appropriate to treat or ameliorate a disease or condition for that individual member. The least costly effective option may be required as described in Oregon Administrative Rule 410-120-0000(147)(d).

Do these changes apply to psychological assessment for children? Previously I have had prior authorizations for testing for Attention-Deficit/Hyperactivity Disorder or learning disabilities (being assessed in an outpatient setting, not through a school) denied, based on it being deemed "academic" vs "medical."

This is a great example of when clinicians have the opportunity to describe why it is medically necessary and medically appropriate for the child or youth to have that psychological assessment and why it might support the diagnosis or treatment planning, or their development and participation in school. The justification that needs to be made for Medicaid coverage is why it is medically necessary and medically appropriate for that child to have that assessment, and not just how it will help a child's academic team/special education team do planning and education programming.

How are you addressing the primary payer issues related to services listed in an Individuals with Disabilities Education Act - Individualized Education Program (IDEA-IEP)?

The EPSDT policy change is a coverage expansion and does not make changes with respect to the primary payer for services in an IEP. If you encounter payment issues related to school-based services, please contact EPSDT.Info@odhsoha.oregon.gov and we will assist in routing your questions.

What is OHA doing to make Behavioral Rehabilitation Service (BRS) residential available to the community, given demand may go up with new EPSDT criteria? Can a CCO pay for BRS residential services now?

OHA is currently exploring ways to expand access to BRS. BRS is a carve out service and not covered by CCOs at this time.

How long can you suspend an authorization request?

The suspension process discussed on the webinar applies only to claims and is separate from prior authorization processes.

What about behavioral health services with an above the line diagnosis like generalized anxiety disorder but with a billing code or service not previously covered, like biofeedback/neurofeedback?

Under EPSDT, coverage is based on an individual review for medical necessity and medical appropriateness, which gives the flexibility to tailor the treatment to the specific child or youth and their specific circumstances. A clinician can make the case that a specific treatment like biofeedback is the most appropriate, the most necessary, and the most effective treatment for a child or youth based on their condition, circumstances, growth and development. Clinicians should provide thorough documentation to OHA or the CCO to make the case for coverage. Coverage should not be denied without review of this documentation.

Will EPSDT be expanding reimbursement for Z codes?

The EPSDT benefit covers all medically necessary and medically appropriate services for individuals under 21 years old. Coverage is not determined by or predicated on any specific diagnosis.

Z codes are a subset of ICD-10 codes that are used to identify “factors influencing health status and contact with health services.” They indicate a reason for an encounter and are not considered procedure codes. Services billed with Z codes may be covered by EPSDT as long as they are medically necessary and medically appropriate for the individual. Federal guidelines may prevent coverage of some services billed using Z codes.

For any additional questions, please reach out to EPSDT.Info@odhsoha.oregon.gov