Utah Department of
Health & Human Services
Integrated Healthcare

Utah Medicaid Provider Manual

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services

Division of Integrated Healthcare

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1 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit policies

1-1 General overview

The mission of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit is to ensure that individuals under the age of 21, who are enrolled in Medicaid, receive age-appropriate screening, preventive, and treatment services that are medically necessary to correct or ameliorate identified conditions. In other words, the goal is to provide the right care to the right child at the right time in the right setting. The broad scope of the EPSDT program supports a comprehensive approach to high-quality healthcare and patient outcomes.

It is important to note that the services outlined throughout this manual are of no cost to the EPSDT eligible member, with some exceptions made for EPSDT members ages 18-20. For additional information concerning co-pay requirements for EPSDT members aged 18 years or older refer to Utah Administrative Rule R414-1 and Attachment 4.18A.

Before billing an EPSDT member for any costs, all required criteria must be met.

1-1.1 Early and periodic

The EPSDT benefit helps eligible members receive quality health care as early as possible to correct or enhance health outcomes through early detection.

Early prevention further supports the overarching goal of the EPSDT program by helping ensure the identification, diagnosis, and treatment of conditions before they become more complex and costly to treat. This is accomplished through the emphasis of preventive and comprehensive care. It is important that EPSDT members receive all recommended preventive services and any medical treatment needed to promote healthy growth and development.

Assessment of children's health at age-appropriate intervals is an essential component of the EPSDT benefit. Infants, children, and adolescents should visit a healthcare provider regularly. To help encourage frequent and effective healthcare interventions, there are multiple state and federal programs that coordinate outreach on behalf of EPSDT members. These include:

1. Baby Watch Early Intervention Program
2. Birth to 5: Watch Me Thrive!

3. Case managers
4. Children with Special Health Care Needs
5. Local health departments
6. Managed healthcare outreach programs
7. School-based services
8. Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

In alignment with the standards defined by the American Academy of Pediatrics (AAP), Utah Medicaid has adopted the Recommendations for Preventive Pediatric Health Care guidelines that outline when screenings should occur.

Bright Futures, as developed by the AAP, is a tool providers should use when planning appropriate care and screenings for EPSDT members. The Bright Futures initiative helps healthcare providers and families understand the types of care that infants, children, and adolescents should receive and when they should receive it, which, in turn, leads to prevention-based, family focused, and developmentally oriented care.

In further support of this initiative, the American Academy of Pediatric Dentistry (AAPD) has published the Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance/Counseling, and Oral Treatment for Infants, Children, and Adolescents for dental related care.

It is important to note that EPSDT members may receive additional check-ups and screenings, beyond the periodicity schedules, when a condition or problem is suspected.

The families of EPSDT members are encouraged to seek early and repeated well-child health care visits for their children. These visits should start as early as possible, ideally at birth, and continue throughout childhood and adolescence. These preventive services should be pursued as early as possible, even in cases where an EPSDT member may be older than the recommended age.

1-1.2 Screening

Health screenings provide physical, mental, developmental, dental, hearing, vision, and other tests to detect potential problems or conditions in pediatric patients. EPSDT members should receive regular well-child check-ups of their physical and mental health, growth, development, and nutritional status. A well-child check-up should include:

1. A comprehensive health and developmental history,
2. Physical health assessments,
3. Behavior health assessments,
4. Age-appropriate immunizations,
5. Vision and hearing tests,
6. Dental exams,
7. Laboratory tests, including blood lead level assessments at certain ages, and
8. Health education, including anticipatory guidance.

Screenings are also often completed within public schools and other community locations. PCPs should encourage parents/responsible caregivers to share results from school and community screenings during appointments, which may include a formal referral for additional testing.

1-1.3 Diagnostic

Screenings may lead to the performing of diagnostic tests to follow up when a health risk is identified. When a well-child check-up or other visit to a health care professional shows that a child or adolescent may potentially have a health problem, follow-up diagnostic testing and evaluations must be provided. This includes testing related to the diagnosis of physical health, mental health, substance use, vision, hearing, and dental problems.

Providers are responsible for assisting EPSDT member(s) with appropriate referrals to a specialty provider when additional diagnostic services are required because of screening/assessment findings.

1-1.4 Treatment

Under the EPSDT benefit, medically necessary healthcare services are covered for treatment of physical and mental illnesses or other conditions discovered through clinical decision making and diagnostic procedures. Treatment should be based on the need to correct or ameliorate the member's physical or mental condition. EPSDT members are eligible for medically necessary treatment even when the screening occurs outside of the provider's office, e.g. at school or in other setting.

Primary care providers (PCP) of EPSDT members should oversee any coordination of care needs required by their patient. Care coordination in the PCP setting involves organizing patient care activities and sharing information with relevant participants concerned with a patient's healthcare to achieve safer and more effective outcomes.

Care coordination promotes the delivery of high-quality and high-value healthcare, while meeting the medical needs of EPSDT members. Care coordination may include the initiation of care management, medication management and reconciliation between multiple providers, sharing of diagnostic results and assessments, and the compiling of medical records into a single repository.

1-2 Exceptions for non-covered services

When an EPSDT member requires medically necessary services, those services may be covered by Medicaid, even if the requested service is not typically covered under the Medicaid benefit.

Necessary health care, diagnostic services, treatment, or other measures to correct or ameliorate defects, physical or mental illness or conditions are available based on medical necessity. Prior authorization is required before providing these services. Exceptions are considered through the prior authorization and/or utilization review process, which is accessed through either submitting a request for prior authorization or submitting a hearing request in response to an adverse benefit determination.

Refer to Chapter 2, Prior Authorization, for additional information concerning documentation and submission requirements for the exception process.

1-3 Outreach, prevention, and appointment assistance

Medicaid contracts with local health departments (LHD) to aid EPSDT members and their family/responsible care givers with scheduling appointments, follow-up care, and education.

Refer to Chapter 1-4.5, Local Health Departments and Targeted Case Management for Early Childhood, for additional information.

In addition, providers are encouraged to provide or arrange for all the appropriate EPSDT services for each child. These services should occur at each age level in a timely manner,

and proper documentation and reporting of the services must be included in the patient record.

1-4 Additional state/federal programs

This chapter includes information concerning several state and federal programs available to EPSDT members. Providers are encouraged to refer EPSDT members to these programs, where applicable.

1-4.1 Baby Watch Early Intervention Program

The Baby Watch Early Intervention Program (BWEIP) focuses on enhancing early growth and development in infants and toddlers. This program includes children birth through age 3, who have not yet entered the public school system, and who have developmental delays or disabilities. BWEIP provides individualized support through the rendering of certain Medicaid covered services and training to children and their families. For additional information concerning BWIEP refer to the Individuals with Disabilities Education Act Part C (IDEA).

As children enter into the public school system they transition from the BWEIP to the School-Based Skills Development Program. The services delivered by each are adapted to meet the needs of the EPSDT member. For more information about the services and procedures associated with this program, refer to the Baby Watch Early Intervention Program.

1-4.2 Birth to 5: Watch Me Thrive

Birth to 5: Watch Me Thrive! encourages healthy child development, universal developmental and behavioral screenings for young children, and support for the families and providers who care for them. For more information concerning this program see the following websites:

1. Office Of Early Childhood Development
2. A Compendium of Screening Measures for Young Children

1-4.3 Children with Special Health Care Needs

The Children with Special Health Care Needs (CSHCN) program works to improve the health and quality of life for children with special health care needs. This is achieved through early screening, early detection, data integration, care coordination,

education, intervention, and family training. This is accomplished through the Title V Maternal and Child Health Block Grant.

CSHCN activities focus on reduction of preventable death, disability, and illness in children due to chronic and disabling conditions by promoting family-centered coordinated care.

To learn more, see Children with Special Health Care Needs and the programs it supports.

Provider and families may also refer to Health Resources & Services Administration - Children and Youth with Special Health Care Needs (CYSHCN) and the Centers for Disease Control and Prevention – Children and Youth with Special Healthcare Needs in Emergencies for additional information.

1-4.4 Foster care

For information concerning individuals in foster care please refer to the following resources:

1. Section I: General Information, Chapter 8-2.10 Custody medical care program (Children in foster care).
2. Foster Care Medicaid
3. Independent Living and Transitioning From Foster Care
4. Young Adults Formerly in Foster Care: Challenges and Solutions
5. Custody Medical Program

1-4.5 Local Health Departments (LHD) and targeted case management for early childhood

The Division of Integrated Healthcare (DIH) contracts with Local Health Departments (LHD) to provide outreach services to families.

Services provided through the LHDs include:

1. Information for EPSDT eligible individuals, including adults who are pregnant, concerning EPSDT services available to the member, such as age-appropriate screenings, well child visits, and immunizations.
2. Setting appointments or arranging screening services

3. Arranging (through referral) for corrective treatment for medical and mental health conditions discovered through EPSDT screenings.
4. Missed appointment follow-up contact.

Children born to women enrolled in Medicaid become eligible for a Targeted Case Management Service focused on childhood development. Parents/responsible guardians may contact an LHD in their area to see if an EPSDT member should receive or would benefit from Targeted Case Management Services.

Refer to the Targeted Case Management for Early Childhood provider manual for additional information.

1-4.6 Managed healthcare outreach programs

Medicaid contracts with managed care plans, referred to as Managed Care Entities (MCEs), to coordinate care for EPSDT members. Screenings, care management, special healthcare needs and disease management, assistance in finding and scheduling care with a primary care or specialty provider, and pre/post-natal care are some of the many services coordinated by the MCEs.

Refer to the Managed Care page located on the Medicaid website for additional information on how to contact a managed care plan.

1-4.7 School-based services

The School-Based Skills Development Program allows public schools and charter schools to provide special education services to some EPSDT members starting upon entry into the school system. These services are delivered within the school setting and are tailored to each EPSDT member as stated in their Individualized Education Plan (IEP). Medicaid reimburses the school for certain covered services included in a student's IEP. For additional information please refer to the Individuals with Disabilities Education Act Part B (IDEA).

To learn more about the services and procedures associated with this program, refer to the School-Based Skills Development Manual.

1-4.8 Special supplemental nutrition program for Women, Infants, and Children (WIC)

The Supplemental Nutrition Program for Women, Infants, and Children (WIC) provides nutrition and breastfeeding services and supplemental foods to pregnant

women, mothers, infants, and children up to their 5th birthday. WIC offers families personalized one-on-one nutrition consultation, a wide array of nutrition education, individualized breastfeeding support, and referrals to other public health programs. Pregnant and postpartum women, infants, and children under 5 years of age who are current Medicaid members are eligible to participate in the WIC program.

Providers and members are encouraged to visit Utah Women, Infants, and Children (WIC) for additional information.

1-5 General coverage

Throughout this chapter the different services available for EPSDT members will be outlined, including the extent of eligibility requirements, coverage, limitations, restrictions, and authorization criteria required where applicable. Each chapter may also include information related to relevant screening services, diagnostics, and treatments for conditions related to the specific service.

Medicaid coverage includes the following types of services:

1. Audiology
2. Behavioral
    a) Autism Spectrum Disorder (ASD)
    b) Developmental delays
    c) Mental Health
    d) Substance use disorders (SUD)
    e) Tobacco cessation
3. Dental
4. Fertility preservation
5. Genetic testing
6. Home based services
    a) Home Health
    b) Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)
    c) Personal Care
    d) Private Duty Nursing (PDN)
    e) Hospice

   f) Physical Therapy (PT)/Occupational Therapy (OT)/Speech-language Pathology (SLP)
7. Inpatient services
8. Integrated healthcare
9. Interpretive services
10. Laboratory and radiology services
11. Nursing and long-term care services
12. Medications and pharmacy
13. Primary care services
    a) Family planning
    b) Preventive services
    c) PCP services
    d) Vaccines/immunizations – Vaccines for children (VFC)
    e) Well-child check-ups
14. Transportation
15. Vision

1-6 Audiology – hearing services

Audiology services are a covered benefit for EPSDT members when determined to be medically necessary.

Medicaid covers diagnostic examinations, assessments for a hearing aid(s) and, when appropriate, a hearing aid or assistive listening device. Medicaid also covers repairs of hearing aids.

Diagnostic audiology evaluations require an order from a QHP that include the procedures that may be used for a hearing aid assessment and any other diagnostic tests appropriate for the specific diagnosis.

For members enrolled in a managed care entity (MCE), providers may need to obtain a prior authorization (PA) or referral from the MCE before visiting an audiologist or other QHP for evaluation and/or treatment. FFS Medicaid members may also require a PA for certain services. To determine which service requires a PA, refer to the Coverage and Reimbursement Lookup.

State funding, other than Medicaid, may also support audiology services through Early Intervention for ages 0 to 3 years.

The following audiological services are covered for EPSDT members who are at risk for hearing impairment:

1. Preventive care
2. Screening
3. Evaluation
4. Diagnostic testing
5. Hearing aid evaluation
    a) Ear mold services, fitting, orientation, and follow-up
6. Audiologic habilitation includes but not limited to:
    a) Speech
    b) Hearing
    c) Gestural communication

1-6.1 Hearing observation and screening

The first two years of life are a critical period for language acquisition. The AAP recommends observation and screening services designed to detect hearing loss in infants before 3 months of age, with appropriate intervention no later than 6 months of age. Screening tests vary according to age and should be part of EPSDT screening services. Refer to the Bright Futures/AAP periodicity schedule for recommended screening ages and related guidance.

In addition, the Joint Committee on Infant Hearing's Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs contains recommendations to help identify children who need early and more frequent assessments.

For additional information concerning reimbursement policy for audiology services refer to the Utah State Plan, Attachment 4.19-B.

1-6.1.1 Newborn hearing screening

Every infant should be provided with a physiologic hearing screening examination at the earliest feasible time for the detection of hearing impairments. Newborns that do not pass the newborn hearing screen should be referred to an audiologist, or other QHP, for additional evaluation to determine the extent of hearing loss, as well as possible causes.

For more information on newborn hearing screening refer to Utah Administrative Code R398-2. Newborn Hearing Screening and the Utah Department of Health and

Human Services Early Hearing Detection and Intervention Program. For specific code coverage refer to the Coverage and Reimbursement Code Lookup.

1-6.1.2 Hearing screening of older children

Hearing screenings for EPSDT members should be performed according to the Bright Futures/AAP periodicity schedule.

Hearing screenings completed within public schools are not covered by Medicaid. These screening efforts should not be duplicated unless the child is at risk and the situation warrants additional screening. Screening results from the school should be documented in the member's medical records. Parents/caregivers should be encouraged to share results from school screenings during appointments, which may include a formal referral for additional testing.

1-6.2 Hearing referral standards

When a chronic hearing deficit is suspected or has been confirmed by the EPSDT member's PCP or other QHP, a referral to a specialist, such as an audiologist or otolaryngologist, should be arranged at an appropriate time.

1-6.3 Hearing aids/assistive listening devices

Hearing aids require PA. If a hearing aid assessment is recommended, an order from a QHP is required. If the subsequent hearing test shows a change in hearing thresholds or the need for a new hearing aid, a PA must be obtained before proceeding with the hearing aid refitting. The hearing aid may be provided by an audiologist, other QHP, or by a durable medical equipment (DME) provider enrolled with Medicaid.

1. Hearing aids must be guaranteed by the manufacturer for a period of at least one year.
2. The initial ear mold, fitting of the hearing aid on the EPSDT member, and necessary follow-up procedures (i.e. conformity evaluation, counseling, adjustments, testing batteries, etc.) are part of the global rate and will not be reimbursed separately.
    a) The global rate covers a period of 12 months.
3. If a follow-up examination results in a recommendation for a different model of hearing aid, the original aid must be exchanged for another aid within 60 days of the follow up examination.

4. The provider who supplies the hearing aid must accept the return of a new hearing aid within 60 days if the prescribing QHP determines that the hearing aid does not meet the medical need and requires exchange.
5. Audiology related service costs for EPSDT members who reside in an ICF/ID facility are included in the per diem rate paid to the facility. It is the responsibility of the ICF/ID facility, as defined in the Utah State Plan, Attachment 4.19-D Nursing Home Reimbursement, to provide reimbursement to the provider for these services.
    a) Exception: The hearing aid appliance is considered ancillary to the per diem rate and may be reported to Medicaid via fee for service (FFS) separately
6. Hearing aids may be replaced every three years when medically appropriate.
    a) When requesting a replacement hearing aid, a new medical examination, QHP order, and audiology evaluation is required.
    b) Exceptions to the 3-year usage limit can be made by following the process outlined in Chapter 1-2 for Non-covered services.

Hearing aid repair

Hearing aids are reimbursed as a purchase only, except in cases where a temporary hearing aid is needed during repairs. When a repair is medically indicated, Medicaid reimburses for a hearing aid rental as part of the total reimbursement for the repair.

If the repair requires the hearing aid to be returned to the original manufacturer, the provider will be reimbursed the cost indicated on the manufacturer's original invoice plus an additional $15. If the repair is completed by the provider directly, the provider may report the dispensing fee related to cost for time, acquisition cost for parts, plus an additional $15.

Dispensing fees

With PA, a dispensing fee may be reimbursed once per hearing aid for the operational lifetime of that hearing aid. This dispensing fee may only be requested outside of the services included as part of the 12-month global reimbursement period upon the provision of the initial hearing aid.

Dispensing fees include:

1. Adjusting the hearing aid to the recipient, including necessary programming on digital and digitally programmable hearing aids
2. Instructing and counseling the recipient on use and care of the hearing aid
3. Fitting and modifications of the hearing aid
4. Freight, postage, delivery of the hearing aid
5. Maintenance, cleaning, and servicing outside the first year of ownership.

Prior authorization requirements

Prior authorization requirements for hearing aids and assistive listening devices are as follows:

1. A physician or other QHP order, stating the EPSDT member has a medical indication for a hearing aid or assistive listening device.
2. The results of a comprehensive audiometric exam performed by the audiologist or other QHP to identify the type of hearing loss (i.e., conductive loss, sensorineural loss, or mixed loss)
3. Speech testing that includes:
    a) speech reception thresholds
    b) speech discrimination scores
    c) pure tone average
4. Audiogram documentation that includes details from the hearing evaluation test, including decibel loss for both right and left ears at hearing thresholds 250, 500, 1000, 2000, 4000 and 8000 Hz
    a) Monaural hearing aids may be requested if the hearing test indicates an average hearing loss in one ear of 30 dB or greater, based on a high frequency PTA specially calculated for frequencies 1000, 2000, and 4000 hertz.
    b) Binaural hearing aids may be requested for members who:
        i. Exhibit an average hearing loss of 25 dBs, based on a high frequency PTA specially calculated for frequencies 1000, 2000, and 4000 in both ears; OR
        ii. The recipient is blind, and a monaural hearing aid may be contraindicated.
5. The type of hearing aid(s) requested; monaural or binaural, and the respective medical code(s).

1-7 Developmental, social, behavioral, and mental health

Medicaid covers the detection, surveillance, screening, and assessment of infants and children for diagnosis and monitoring of developmental and behavioral health disorders. Utah Medicaid covers standardized and evidence-based developmental surveillance tools. Providers are encouraged to utilize age-appropriate diagnostic criteria for young children, such as the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-5).

PCPs can provide an array of behavioral health support including screenings and treatment for depression, anxiety, PTSD (Post-Traumatic Stress Disorder), substance use disorders, peripartum mood disorders, eating disorders, and intimate partner violence. PCPs should coordinate care with qualified mental health professionals such as therapists and psychiatrists, for members with complex mental health needs that may require a multidisciplinary team approach.

Suicidal patients are more likely to see a primary care physician than a psychiatrist in the months preceding their death. Primary care physicians are therefore in a unique position to identify at-risk individuals and possibly intervene.

PCPs should determine whether the members depression and/or suicidal ideation should be managed solely by the PCP or be referred for tertiary psychiatric care (and the urgency of the latter). All persons with clear-cut active suicidal ideation should be sent to an appropriate hospital for urgent psychiatric care.

1-7.1 Developmental checks

Developmental checks are important for the early detection and diagnosis of developmental delay in all children. Developmental surveillance should occur during every health visit to identify the risk of developmental delay, paying particular attention to children four to five years of age who are preparing to enter elementary school. Parents or responsible caregivers should be interviewed, and any concerns or issues should be further investigated as medically indicated.

The American Academy of Pediatrics (AAP) recommends developmental surveillance focused on the following six components:

1. Eliciting parent and caregiver concerns
2. Obtaining a developmental history

3. Observing the child
4. Identifying risks, strengths, and protective factors
5. Maintaining a record
6. Sharing opinions and findings

1-7.1.1 Children younger than five years old

Providers should perform developmental screenings at 9-, 18-, and 30-month visits. Medicaid utilizes guidance from the Bright Futures initiative to set a periodicity schedule for developmental screenings of EPSDT members.

1-7.2 Autism spectrum disorder screenings

Medicaid covers autism spectrum disorder (ASD) screenings at 18- and 24-months when medically indicated. Screenings must use a standardized, validated autism screening tool at the child's periodic visits. When an autism screen identifies a child as being at risk for ASD, a diagnostic evaluation should follow. See the Utah Medicaid Autism Spectrum Disorder Services provider manual for information on evaluation, treatment processes, and requirements for PAs.

1-7.3 Tobacco, alcohol, or drug use assessment

Substance use during adolescence may result in long lasting consequences including involvement in the criminal justice system, physical or behavioral issues, or poor school performance. Medicaid encourages the use of scientifically valid screening tools for adolescent children to assess substance use disorder risk. Some recommended screening and assessment tools from the National Institute on Drug Abuse (NIDA) include but are not limited to:

1. Screening to Brief Intervention (S2BI)
2. Brief Screener for Alcohol, Tobacco, and other Substance Use (TAPS)
3. Drug Abuse Screen Test (DAST-10)

1-7.4 Depression and suicide risk screening

According to the AAP, periodic screening by providers reduces the likelihood of misdiagnosis or prolonged suffering of mental health conditions in adolescence. The following screening tools are recommended by the AAP to identify youth with risk factors for depression or suicidality:

1. Patient Health Questionnaire 9: Modified for Teens
2. Columbia Depression Scale

3. Ask Suicide-Screening Questions (asQ).

In instances where screenings determine an EPSDT member is at high risk for depression or suicidal thoughts or behaviors, the provider should complete further evaluation to determine the need for referral and provide adequate behavioral health resources. Providers should educate youth and their caregivers on the National Crisis Line (988) and make referrals to appropriate mental health providers.

1-7.5 Maternal depression screening

Maternal depression can have a strong impact on parenting and child outcomes, primary care health providers can contribute to their pediatric patients' health and support by screening and assisting mothers with referrals for depression.

Maternal Depression screening should be performed at the child's 1-, 2-, 4-, and 6-month EPSDT visit.

Medicaid recommends the Edinburgh Postnatal Depression Scale (EPDS-10 or EPDS-2) but will accept other evidence-based screening tools for the monitoring and identification of depression in new mothers.

Screening by the pediatric provider, accompanied by referral and intervention protocols play an important role in linking mothers experiencing mental health issues with the appropriate interventions. Medicaid encourages providers to refer mothers with suspected mental health needs for assessment and treatment as necessary.

Refer the child's mother to the mental health plan listed on the member's Medicaid identification card. If no plan is listed on the Medicaid card, refer the mother to an enrolled Medicaid mental health provider in the mother's home area. Mental health services, at a minimum, include diagnosis and treatment for mental health conditions. Refer to the Rehabilitative Mental Health and Substance Use Disorder Services provider manual, the Physician Services provider manual, and the Coverage and Reimbursement Code Lookup for policy information related to mental health services.

1-8 Primary care services

Primary care providers (PCPs) are essential healthcare professionals who play a critical role in maintaining the health and well-being of EPSDT members. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care. A PCP can discover potential health problems

early and provide needed intervention before health problems become severe. Members who engage in early and regular screening, diagnostic and treatment services, coordinated through a PCP, will spend less time in the hospital and less money on medical costs over time due to early intervention and management of medically necessary services.

The following preventative care, screenings, history, measurements, and physical examination should be completed as part of each EPSDT visit where indicated. Refer to the Bright Futures/American Academy of Pediatrics (AAP) periodicity schedule at aap.org for additional information.

1-8.1 Preventive and screening services

Screenings (periodic comprehensive child health assessments) are regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of EPSDT members that include the following:

1. Comprehensive health and developmental history, including assessment of physical and mental health development
2. Physical examination, including a comprehensive physical exam at each EPSDT visit
3. Measurements at each EPSDT visit including:
    a) Weight/height
        i. Weight/length for each visit through 18-months
    b) Head circumference at each visit through 24-months
    c) Blood pressure beginning at 3-years of age
    d) Body mass index (BMI) beginning at age 2.
4. Developmental/behavioral health assessments/screenings including:
    a) Developmental screening at 9-, 18-, and 30-month visits
    b) Developmental surveillance
    c) Autism spectrum disorder screening at 18- and 24-months when medically indicated
    d) Behavioral/social/emotional assessments as medically indicated
    e) Tobacco, alcohol or drug use assessments beginning at age 11
    f) Depression and suicide risk screening beginning at age 12
    g) Maternal depression screening should be performed at the child's 1-, 2-, 4-, and 6-month EPSDT visit

5. Appropriate vision assessment or screenings
6. Appropriate hearing assessment or screenings
7. Administration of or referral to any laboratory tests, procedures or immunizations appropriate for age and risk factors
8. Dental assessments/screenings
    a) Oral health risk assessment, including oral observation and examination at the 6-, 9-, and 12-month EPSDT visit.
    b) Dental screening services furnished by direct referral to a dentist for children beginning at 3-years of age
9. Anticipatory guidance/health education

Each of these screening services is described more fully in the following sources:

1. Bright Futures
2. AAP Periodicity Schedule
3. Recommended Immunization Schedule for Children and Adolescents provided by the Centers for Disease Control and Prevention (CDC).

1-8.1.1 Newborn hearing screening

As authorized by Utah Administrative Rule R398-2. Newborn Hearing Screening: Early Hearing Detection and Intervention (EHDI) Program, if the hospital performing the newborn delivery is an inpatient hospital, the auditory screening is included as part of the DRG reimbursement methodology. If the hospital performing the newborn delivery is a rural hospital/critical access hospital or the delivery occurs in a non-hospital setting, the audiologists may bill Medicaid for the auditory screening.

1-8.1.2 Lead screenings

The CDC and the AAP recommend a lead risk assessment and a blood lead level test for all Medicaid eligible children between the ages of 6-months and 72-months. All children within this time frame are considered at risk for lead poisoning and should be screened.

In cooperation with the Utah Lead Coalition, Medicaid is dedicated to supporting increased member health outcomes by providing ongoing guidance for screenings related to the detection of lead toxicity. Ongoing provider and member education will bring about early identification of people who have had exposure to lead as well as

prompting advanced treatments to reduce the enduring effects of untreated lead poisoning.

While lead toxicity can affect all age groups, children remain highly vulnerable to the effects of lead toxicity with the possibility of lifelong ramifications if left untreated. Member education for the prevention of lead exposure and testing to identify those that have had exposure is of the utmost importance to prevent adverse outcomes related to lead poisoning.

As such the Utah Lead Coalition has many valuable resources related to identifying those persons who are at higher risk of exposure to lead, standards in testing for lead poisoning, what treatments are available for those who have lead poisoning, and prevention of ongoing exposure to sources of lead.

Providers are encouraged to utilize the resources and guidance available through the Utah Lead Coalition website as well as those published by the CDC "Childhood Lead Poisoning Prevention," the Unites State Environmental Protection Agency (EPA) "Lead," and the AAP "Lead Exposure and Lead Poisoning."

1-8.1.3 Anemia

Anemia is defined as a reduction in one or more of the major red blood cell (RBC) measurements obtained as a part of the complete blood count (CBC): hemoglobin concentration, hematocrit, or RBC count. A low hemoglobin concentration and/or low hematocrit are the parameters most widely used to diagnose anemia. Evaluation for anemia is one of the most common concerns in clinical practice.

The purpose of screening for anemia is to diagnose and treat correctable nutritional anemia, such as iron deficiency anemia. Providers should follow current clinical standards for diagnosis of anemia based upon the age of the child.

The risk assessment or screening for anemia should be performed as appropriate, beginning at 4-months of age, in accordance with recommendations in the Bright Futures/AAP periodicity schedule.

All children must be tested for anemia at 1-year of age.

Sickle cell disease

Sickle cell disease (Hemoglobin SS Disease) is an inherited sickle cell disorder that affects the structure of red blood cells. Sickle cell disorders affect approximately 100,000 people in the United States. 1 in 365 African American and 1 in 16,300 Hispanic American births. 1 in 13 African American babies are born with sickle cell trait.

Screening for sickle cell disease should occur as part of the newborn screenings. If an infant tests positive for sickle cell disease the American College of Medical Genetics and Genomics (ACMG) recommends that providers:

1. Inform the family of the newborn screening result.
2. Ascertain clinical status (newborns are expected to be asymptomatic).
3. Evaluate the newborn (assess for splenomegaly and send CBC).
4. Administer prophylactic penicillin.
5. Consult with sickle cell specialist immediately with in person follow up by no later than 12 weeks of age.
6. Coordinate confirmatory diagnostic testing and management as recommended by specialist.
7. Provide family with basic information about Hemoglobin S/S or Hemoglobin S/Beta Zero (β0) Thalassemia including the need for urgent evaluation if fever of ≥ 38.5°C (101°F), or signs of stroke or splenic sequestration.
8. Refer for genetic counseling.
9. Report final diagnostic outcome to newborn screening program.

Additional information, treatment guidelines and resources for sickle cell disease can be found in the following sources:

1. Department of Health and Human Services
2. Centers for Disease Control and Prevention (CDC)

1-8.1.4 Dyslipidemia

Clinical evidence suggests that atherosclerosis begins in childhood and that early atherosclerosis is associated with the presence and intensity of identified risk factors that lead to vascular disease events, such as myocardial infarction, stroke, peripheral arterial disease, and ruptured aortic aneurysm, later in life.

To assist in the effort to prevent cardiovascular disease in childhood and adolescence, dyslipidemia screening must be performed once during each of these age-range visits:

1. Between the 9-year and 11-year visits
2. Between 17-year and 21-year visits

In addition, the Bright Futures/AAP periodicity schedule indicates intervals for performing a risk assessment, beginning at 24-months of age, to determine whether further action is required.

The National Heart, Lung, and Blood Institute provides additional guidance titled Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents. This guidance is designed to assist providers in reducing the risk factors associated with cardiovascular (CV) disease in children and adolescents and provide an important, up-to-date evidence-based framework for implementation of interventions in primary care offices and specialty clinics.

1-8.1.5 Tuberculosis

Information published by the AAP indicates that the most reliable tuberculosis control program is based on aggressive, expedient contact investigations, rather than routine skin test screening. The AAP recommends that an assessment of risk of exposure to tuberculosis be included in the 1-, 6-, 12- and 24-month visit as well as in all annual visits beginning at age 3.

Only children deemed to have increased risk of exposure to persons with tuberculosis should be considered for tuberculin (Mantoux) skin testing.

The frequency of such skin testing should be according to the degree of risk of acquiring tuberculosis infection, as detailed below. Routine tuberculin skin testing of children with no risk factors and residing in low-prevalence communities is not indicated.

1. Children for whom immediate skin testing is indicated:
    a) Children with contact to persons with confirmed or suspected infectious tuberculosis, including contact to family members or associates in jail or prison in the last five years.
    b) Children with radiographic or clinical findings suggest tuberculosis.

c) Children immigrating from endemic areas, such as Asia, Africa, the Middle East, and Latin America
d) Children with travel histories to endemic countries or significant contact with indigenous persons from such countries

2. Children who should be tested annually for tuberculosis:
   a) Children infected with human immunodeficiency virus (HIV)
   b) Incarcerated adolescents
3. Children who should be tested every two to three years:
   a) Children exposed to the following individuals who are: HIV-infected, homeless, residents of nursing homes, institutionalized adolescents or adults, users of illicit drugs, incarcerated adolescents or adults, and migrant farm workers.

Children who have no risk factors but who reside in high-prevalence regions and children whose histories for risk factors are incomplete or unreliable should be considered for tuberculin skin testing at 4- to 6-years old and 11- to 16-years old. The decision to test should be based on the local epidemiology of tuberculosis in conjunction with advice from regional tuberculosis control officials.

Family investigation is indicated whenever a tuberculin skin test result of a parent converts from negative to positive (indicating recent infection). Children of healthcare workers are not at increased risk of acquiring tuberculosis infection unless the workers' tuberculin skin test results convert to positive, or the workers have diagnoses of tuberculosis disease.

The skin test interpretation guidelines for indurations of 5, 10, and 15 mm in diameter remain appropriate for decisions about contact investigations, tuberculosis control measures and preventive therapy.

Providers are encouraged to utilize the treatment guidelines and resources published by the Centers for Disease Control and Prevention.

1-8.1.6 Sexually transmitted diseases

All sexually active adolescents must be considered at high risk for most sexually transmitted infections (STIs). The Bright Futures/AAP periodicity schedule suggests performing a risk assessment for STIs annually, beginning at 11- to 21-years of age, to determine whether testing is appropriate.

1-8.2 Family and medical history

Providers must obtain and document a comprehensive family and medical history as part of the EPSDT screening process.

1-8.2.1 Measurements

The following measurements must be performed during each EPSDT exam:

1. Height or length (birth through 18 months)
2. Weight
3. Head circumference (birth through 2 years)
4. Body mass index (BMI) (beginning at 2 years)
5. Blood pressure (beginning at 3 years; or earlier for infants and children with specific risk conditions)

1.8.2.2 Height, weight, and head circumference

Providers should refer to the CDC, National Center for Health Statistics (NCHS), for information concerning height, weight, and head circumference percentile standards. If a significant deviation is discovered during assessment, the provider must conduct further evaluation and, if necessary, make appropriate referrals.

1-8.2.3 Body mass index

Providers should calculate and plot children's BMI annually, beginning at age two. The Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report is recommended to provide screening guidelines.

1-8.2.4 Blood pressure

Medicaid requires that blood pressure be measured and documented as part of each screening for children 3-years of age and older.

The American Academy of Pediatrics (AAP) publishes current percentile charts of normal blood pressure readings for various ages. Any significant deviation is a basis for further evaluation and, if necessary, a referral to a specialist.

1-8.3 Physical examinations

A complete physical exam must be provided as part of each EPSDT screening. Providers must communicate the scope and nature of the physical examination to be performed to the EPSDT member and the parent/responsible caregiver.

Suspect or positive findings from the examination must be documented and communicated with the member and/or parent/responsible caregiver. If additional diagnostics or revisions to the plan of treatment are needed, those must be documented and communicated as well. Providers are responsible for overseeing referrals and communicating necessary appointments with the member and parent/caregiver.

1-9 Vaccines and immunizations

Immunizations should be provided or arranged for each child according to the schedule recommended by the AAP. Every EPSDT visit should be an opportunity to update and complete a child's immunizations.

1-9.1 Vaccines for children program

The Vaccines for Children (VFC) program makes available, at no cost to providers, certain vaccines for administration to members 18-years old and younger.

If a vaccine is available through the VFC program, Medicaid will not reimburse the use of a non-VFC vaccine (referred to as "private stock" vaccine) for members 18-years old and younger. Immunizations will only be eligible for a dispensing fee with no reimbursement for the immunization. Providers that are not currently enrolled in the VFC program are encouraged to enroll in the VFC program to ensure members do not experience a disruption in care.

See the Centers for Disease Control (CDC) Vaccine Price List for information on what vaccines are covered under the VFC program. For general information concerning the VFC program, including provider enrollment information, see the Vaccines for Children (VFC Provider Information page.

For additional information regarding reimbursement policy for vaccines, refer to Utah Administrative Rule R414-60. Medicaid Policy for Pharmacy Program, section 7. Reimbursement.

1-10 Well-child check ups

Infants, children, and adolescents should receive regular well-child check-ups of their physical and mental health, growth, development, and nutritional status. A well-child check-up includes:

1. A comprehensive health and developmental history,
2. Physical health assessments,
3. Behavior health assessments,
4. Age-appropriate immunizations,
5. Vision and hearing tests,
6. Dental exam,
7. Laboratory tests, including blood lead level assessments at certain ages, and
8. Health education, including anticipatory guidance.

1-11 Dental

Among the many dental conditions affecting EPSDT members, dental caries (tooth decay) is the preeminent concern in the context of Medicaid services because of its substantial prevalence in the low-income population. Tooth decay continues to be the single most common chronic disease among U.S. children, even though it is highly preventable through early and sustained home care and regular professional preventive services.

EPSDT members should begin to receive oral health risk assessments by six months of age by a pediatrician or other QHP. Dental services for children, at a minimum, include preventive dental services such as preventive dental examinations, prophylaxis, topical fluoride applications, and appropriate prescriptions for fluoride supplements, fluoride treatments, and sealants. In addition, the following services are included:

1. relief of pain and infections
2. restoration of teeth
3. maintenance of oral health

The Recommended Dental Periodicity Schedule, is a summary of EPSDT dental periodicity requirements. The schedule has been adopted from the AAPD's recommendations for dental services for the target population (ages 0-21).

Orthodontic treatment is provided in cases of severe malocclusions and requires prior authorization.

Refer to the Dental, Oral Maxillofacial, and Orthodontia Services provider manual and the Coverage and Reimbursement Code Lookup tool for additional coverage information.

1-11.1 Referrals

The EPSDT member should be referred to a dental provider as follows:

1. Make the initial referral by six months of age, if determined necessary by a QHP, and yearly thereafter
2. Make the referral if the child is at least four years old and has not had a complete dental examination by a dental professional in the past 12-months
3. Make the referral at any age if the oral inspection reveals cavities, infection, or significant abnormality

1-11.2 Recommended dental services

Fluoride varnish reduces the incidence of dental caries. Fluoride varnish minimizes the risk of inadvertent fluoride consumption and is easy to use on very young children. It forms a deposit on the dental enamel that slowly releases a high concentration of fluoride ions into the dental enamel. It is effective in preventing tooth decay and remineralizes tooth damage caused by the decaying process. Fluoride varnish may be applied to a child's teeth at regular 4- to 6-month intervals starting with primary tooth eruption and continuing through age 4.

1-11.3 Well-child (EPSDT) procedure codes for fluoride varnish

Medicaid covers application of dental fluoride varnish as an optional service for children birth through 4-years as part of a well-child exam. Claims for the application of dental varnish must be submitted using the appropriate CPT code (see Chapter 6 Coding for a list of applicable CPT codes) for the corresponding visit and the appropriate CPT code to indicate the application of fluoride varnish during the visit.

For more information, training, or technical advice on the application of the varnish, contact the Oral Health Program at the Utah Department of Health and Human Services at (801) 273-2995. For more information related to claims, payments, or billing codes contact Medicaid information at (801) 538-6155.

1-12 Family planning

Family planning services means diagnostic, treatment, drugs, supplies, devices, and related counseling related to family planning methods to prevent or delay pregnancy.

Refer to the Utah Medicaid State Plan, Attachment 3.1-A & B, Attachment #4c Family Planning Services and Supplies for additional information.

1-13 Federally Qualified Healthcare Centers (FQHC) and Rural Health Clinics (RHC)

Services provided at FQHCs and RHCs are primarily outpatient health care services, including routine diagnostic and laboratory services provided by physicians, nurse practitioners, certified nurse midwives, or physician assistants.

Refer to the Rural Health Clinics and Federally Qualified Health Centers provider manual for additional information.

1-14 Fertility preservation

Fertility preservation services are covered for members undergoing gonadotoxic cancer treatments or other medically necessary treatment that are expected to render them permanently infertile (excluding voluntary sterilization) either pre or post treatment. Qualifying members must meet the following criteria:

1. The member is post-pubertal through 40 years of age.
2. Diagnosis by a qualified healthcare professional (QHP) of a condition requiring treatment which, in the QHP's professional judgment, may pose a substantial risk of sterility or lead to iatrogenic infertility (infertility caused by treatment).
3. The member's current state of health is sufficient to undergo fertility preservation procedures.
4. The member has received infertility counseling as well as psychotherapy, when medically indicated.
5. Collection and storage of embryos, eggs or sperm is consistent with established medical practices or professional guidelines published by the American Society of Reproductive Medicine (ASRM) or the American Society of Clinical Oncology (ASCO).

1-14.1 Coverage

Collection and storage of embryos, reproductive tissues, eggs, and sperm must use collection and storage processes that are consistent with established medical practices or professional guidelines published by the ASRM or the ASCO.
Coverage includes the following fertility preservation services:

1. Mature oocyte cryopreservation
2. Ovarian tissue cryopreservation
3. Ejaculated/surgically extracted sperm cryopreservation
4. Embryo cryopreservation

1-14.2 Limitations

1. Reimbursement for cryopreservation storage is covered as a single payment and includes up to a five-year storage increment.
    a) Post cryopreservation procedures for use of eggs, sperm, or embryos are not covered.
    b) Additional five-year storage increments may only be requested for member's that retain Medicaid eligibility.

1-14.3 Non-covered services

1. Cryopreservation of embryos or eggs or sperm for fertility preservation purposes other than chemotherapy or other treatments that may render an individual infertile.
2. Cryopreservation of embryos or eggs or sperm for reciprocal IVF
3. Sperm storage/banking for males requesting this service for convenience or "back-up" for a fresh specimen.

For additional code specific policy information providers may refer to the Coverage and Reimbursement Code Lookup.

1-15 Genetic testing

Genetic tests are laboratory studies of human deoxyribonucleic acid (DNA), chromosomes, genes or gene products to diagnose the presence of a genetic variation associated with a high risk of having or transmitting a specific genetic disorder.

Genetic testing must be medically necessary and ordered by a Medicaid enrolled provider, within the scope of their practice.

1. Providers must be able to counsel clients on the particular genetic test ordered and the results of that test, as it applies to the member, in consultation with a genetic specialist as needed.
2. If a provider is unable to counsel a member regarding pre- and post-genetic testing, they must refer the member to a provider capable of providing genetic counseling prior to ordering the test.

Genetic testing is medically necessary for EPSDT members when there is a reasonable expectation based on family history, risk factors, and/or symptomatology that a genetically inherited condition exists, and any of the following clinical scenarios also exist:

1. Clinical presentation fits a well-defined syndrome for which a specific or targeted gene test is available; or
2. A definitive diagnosis cannot be made based on history, physical examination, pedigree analysis, and/or standard diagnostic studies or tests; or
3. There is a clinical syndrome with a broad number of potential diagnoses, and without a specific diagnosis, the medical management will include unnecessary monitoring, testing, hospitalizations, and/or medical setbacks; or
4. There is a clinical syndrome with a broad number of potential diagnoses, and a specific diagnosis will determine prognosis and appropriate medical management.

Genetic testing may require PA. Specific coverage on CPT or HCPCS codes are found in the Coverage and Reimbursement Code Lookup.

Coverage of genetic testing by Medicaid is determined by using an evidence-based criteria tool and clinical decision making.

Documentation requirements

Documentation to support the recommendation(s) for testing must address the following:

1. Specific risk factors, the clinical scenario, and/or family history that supports the need for the requested test(s); and
2. Clinical examination and conventional diagnostic testing have not contributed to the determination of a specific diagnosis; and

3. The results of the genetic test may influence the medical management of a suspected condition.

Where criteria do not exist, submission of publicly accessible data from peer-reviewed, scientific literature and/or national databases that addresses the clinical validity, predictive value, and/or medical benefit(s) of the specific diagnostic genetic test(s) should be submitted.

1-15.1 Next Generation Sequencing (NGS)

Identifying a molecularly confirmed diagnosis promptly for an individual with a rare genetic condition can have a variety of health outcomes, including:

1. Guiding prognosis and improving clinical decision-making that can improve clinical outcome by application of specific treatments as well as withholding of contraindicated treatments for certain rare genetic conditions.
2. Surveillance for later-onset comorbidities.
3. Eliminating lower-yield testing, and additional screening(s) that may later be proven unnecessary once a diagnosis is achieved.
4. Reducing the financial and psychological impact of diagnostic uncertainty.
5. Next-generation sequencing (NGS) includes genetic testing options such as whole exome sequencing (WES) and whole genome sequencing (WGS) and can detect the most significant variant types, meaning genetic alterations with sufficient evidence to classify as pathogenic.

1-15.2 Whole Exome Sequencing (WES)

WES focuses on the genomic protein coding regions (exons). It is a cost-effective, widely used NGS method that requires fewer sequencing reagents and takes less time to perform bioinformatic analysis compared to WGS. Although the human exome represents only 1-5% of the genome, it contains approximately 85% of known disease-related variants.

WES is considered medically necessary for the evaluation of unexplained congenital or neurodevelopmental disorders in EPSDT-eligible members when all of the following criteria are met:

1. After all other appropriate diagnostic testing has been performed, and the member remains undiagnosed (e.g., targeted single-gene testing, panel testing, MRI, etc.), and
2. Results of such testing are expected to influence medical management and clinical outcomes directly.

1-15.3 Whole Genome Sequencing (WGS)

WGS, in contrast to WES, may detect larger deletions or duplications, triple repeat expansions, and pathogenic variants in deep intronic regions; regulatory regions that are outside of the coding regions; and untranslated gene regions.

WGS is considered medically necessary for the evaluation of unexplained congenital or neurodevelopmental disorders in members aged less than one year of life and currently admitted to a Neonatal Intensive Care Unit (NICU) or other intensive care setting, when all of the following prior authorization criteria are met:

1. Test is ordered by one of the following provider types, who has evaluated the member and family history, and recommends and/or orders the test:
    a) Neonatologist or intensivist in collaboration with a medical geneticist or certified genetic counselor.
    b) The member has been evaluated by a board-certified clinician with expertise in clinical genetics and counseled about the potential risks of genetic testing.
    c) Pre- and post-test counseling is performed by an American Board of Medical Genetics or American Board of Genetic Counseling certified genetic counselor.
2. Clinical indications:
    a) Absence of definitive diagnosis based on standard clinical workup.
    b) Unclear disease identity based on member's phenotype, or the member has phenotypic characteristics outside of, or in addition to, what has been established for the disease.
    c) A genetic etiology is the most likely explanation for the phenotype or clinical scenario, or the affected individual is faced with invasive procedures or testing as the next diagnostic step (e.g., muscle biopsy.)

d) No other causative circumstances (e.g., environmental exposures, injury, infection) can explain the symptoms.

8-15.4 Non-covered services

Diagnostic genetic testing, for the sole convenience of information to identify specific diagnoses for which the medical management of the member is not anticipated to be altered.

Additional types of diagnostic genetic testing that are non-covered include:

1. Experimental and/or investigational (excluding members who are participating in qualifying clinical trials for the prevention, detection, or treatment of any serious or life-threatening disease or condition as outlined in Section 210 of the "Consolidated Appropriations Act, 2021")
2. Tests for screening purposes only (excluding newborn screening as defined in Utah Administrative Code R398-2. Newborn Hearing Screening), including:
    a) preimplantation genetic diagnosis (PGD); or
    b) prenatal genetic screening; or
    c) in the absence of signs and/or symptoms
3. Tests, for the member or family members, performed solely for the purposes of genetic counseling, family planning, or health screening
4. Tests for research to find a rare or new gene not previously identified or of unclear clinical significance
5. Direct-to-consumer (DTC) genetic tests
6. Tests of a member's germline DNA to benefit family member(s), rather than the member being tested
7. Establishment of paternity
8. Genetic testing is considered not medically necessary when performed entirely for non-medical reasons (e.g., a general interest in genetic test results)

1-16 Home services

1-16.1 Home health

Medicaid covers skilled nursing and home health aides for EPSDT members. Home health services are medically necessary, part-time, intermittent health care services provided in settings defined by 42 CFR Part 440.70 when the services are medically necessary, cost-effective, and consistent with the member's medical need.

Refer to the Home Health Services provider manual for additional information.

1-16.2 Durable Medical Equipment, Prosthetics, Orthotics, And Supplies (DMEPOS)

Medicaid may approve medically necessary medical supplies and durable medical equipment for EPSDT eligible members. For information on Medical Supplies and Durable Medical Equipment service, refer to the Medical Supplies and Durable Medical Equipment Manual.

1-16.3 Personal care

The purpose of personal care is to provide supportive care to members in their place of residence, maximize independence, and prevent premature or inappropriate institutionalization. Supportive care offers a range of assistance services that enable persons with disabilities (cognitive or physical) and acute or chronic conditions to perform tasks associated with activities of daily living (ADLs) or instrumental activities of daily living (IADL).

Refer to the Personal Care Services provider manual for additional information.

1-16.4 Private Duty Nursing

Private Duty Nursing (PDN) service is a program intended for the prevention of prolonged institutionalization of an EPSDT member. Refer to the Home Health Services, Chapter 8-11 Private Duty Nursing (PDN) for additional information.

1-16.5 Hospice

EPSDT members who elect hospice services do not forfeit curative care that would otherwise be available to them through the Medicaid State Plan. Refer to Hospice Care Services, Chapter 8-9.2 Election of hospice for additional information.

1-16.6 Physical and occupational therapy

Refer to Physical Therapy and Occupational Therapy Services, Chapters 1-2 General Policy, 9-2.1 Physical therapy limitations, and 9-2.2 Occupational therapy limitations for additional information concerning expanded services for the EPSDT program.

1-17 Speech Language Pathology

Speech language pathology (SLP) services include examination, diagnosis, and treatment of speech/ communication disabilities and related factors of individuals with certain voice, speech, hearing, and language disorders. These services treat problems associated with accident, injury, illness, or birth defect. Nonorganic or

organically based SLP articulatory deviations, voice disorders, language impairments, or dysfluencies may be included in the treatment plan in some specific instances.

SLP therapy evaluations should consider audiological issues and other physical (organic) conditions restricting proper speech and language development. These issues, along with interventions must be addressed in a comprehensive treatment plan.

SLP therapy services must be ordered by a QHP and be provided by a speech-language pathologist.

SLP therapy services may require PA. Refer to the Coverage and Reimbursement Lookup for additional information.

1-17.1 SLP evaluation

EPSDT members are allowed one speech evaluation per year.

1-17.2 Covered SLP services

State funds, other than Medicaid, support speech and language therapy through Early Intervention for ages 0 to 3 years.

SLP services provided either through Early Intervention or U.S. Department of Education's Individuals with Disabilities Education Act (IDEA) are designed to assist parents/responsible caregivers to prepare a child, that qualifies for these services, for education when a speech or language disorder is present.

1. Services for children ages 2 years through 5 years are covered, if the child's speech or language deficit is at, or greater than one and one-half standard deviations below the mean as measured by an age-appropriate standardized test for articulation, phonology, fluency or language OR if using percentile score is at or below the 7th percentile. One and one-half standard deviations below the mean equals a standard score of 78.
2. Services for children eligible for preschool through age 20 are available through the educational system, but additional Medicaid services may be approved if the EPSDT member's speech or language deficit is at, or greater than two standard deviations below the mean as measured by an age-appropriate standardized test for articulation, phonology, fluency or language OR if using

percentile score is at or below the 2nd percentile. Two standard deviations below the mean equals a standard score of 70.

3. SLP services for EPSDT members under age 2 are not covered unless a specific medical diagnosis is present and medical documentation supports the medical need and efficacy of early intervention for speech therapy. Such early intervention is required to meet medical necessity criteria, as defined in the Section I: General Information provider manual, Chapter 8-1 *Medical Necessity*. If testing is possible, documentation must demonstrate that the child's speech or language deficit is at, or greater than one and one-half standard deviations below the mean as measured by an age-appropriate standardized test for articulation, phonology, fluency, or language OR if using percentile score, is at or below the 7th percentile.
4. Services for voice anomalies such as pitch, tone, or quality, are limited to velopharyngeal inadequacies due to cleft palate, submucous cleft palate, congenital short palate, palatopharyngeal paresis/paralysis, neuromuscular diseases (myasthenia gravis, multiple sclerosis, ALS, etc.).
5. Services for voice disturbances related to vocal cord pathology or vocal cord dysfunctions are limited to 5 visits. This includes vocal cord nodules, polyps, web, mucosal edema, or granulomatosis or vocal cord dysfunctions of paralysis/paresis, hyper and hypokinesis, laryngeal dystonia, or paradoxical vocal fold dysfunction.
6. Therapeutic services for training the EPSDT member in the use of a speech generating device are a covered service when medically necessary.
7. All therapeutic services are limited to a combined total of 24 sessions in a 6-month period.

1-17.3 Plan of care required

A written plan of care established by the speech-language pathologist is required. The plan of care must include:

1. Patient/member information and history
2. Current medical findings
3. Diagnosis
4. Previous treatment (if applicable)
5. Planned treatment

6. Anticipated goals
7. The type, amount, frequency and duration of the services to be rendered
8. Scores of appropriate tests that measure the disability or dysfunction must be submitted with the plan of care annually

1-17.4 SLP limitations

SLP services are limited as described below.

1. Home health speech therapy is limited to EPSDT members that are unable to leave the home for outpatient speech therapy.
2. Communication disabilities solely associated with behavioral, learning, and/or psychological disorders are non-covered, unless documented as part of a comprehensive medical treatment plan.
3. Treatment for clients who have reached maximum potential for improvement or who have achieved the stated goals, or test above the stated threshold requirements for treatment.
4. SLP treatment for speech/ communication disabilities caused by a cerebral vascular accident (CVA) or traumatic brain injury (TBI) which manifest more than six months after onset.

1-17.5 SLP non-covered services

The following services are not Medicaid benefits, except when related to accident, illness, birth defect, or injury:

1. Recipients with no documented evidence of capability or measurable improvement
2. Residents of an Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID) (included in the per diem resident rate)
3. Non-diagnostic, non-therapeutic, routine, repetitive or reinforcing procedures, such as practicing word drills or using a communication board, such as a PECS, or picture board or other procedures that may be carried out effectively by the member, family, or care givers
4. Continued training beyond the initial instruction to use a communication board, such as a PECS, or picture board
5. Self-correcting dysfunctions that are within normal limits for the recipient's age. For example: slow speech development, developmental dysfluencies, or developmental articulation errors

6. Dysfluencies such as stuttering or stammering or rhythm abnormalities
7. Articulation problems, such as “lisping” or the inability to provide certain consonants

1-17.6 Speech augmentative communication devices

Speech augmentative communication devices are covered in accordance with the Coverage and Reimbursement Code Lookup.

1-17.7 Voice prosthetics and voice amplifiers

Voice prosthetics and voice amplifiers are covered in accordance with the Coverage and Reimbursement Code Lookup. A speech-language pathologist may provide necessary training for utilization of the device.

18-1 Inpatient services

Inpatient hospital services are available to EPSDT members with surgical, medical, diagnostic, or level of care needs that require the availability of specialized diagnostic and therapeutic services, and close medical supervision of care and treatment directed toward maintenance, improvement, or protection of health or lessening of illness, disability, or pain.

Refer to the Hospital Services provider manual for additional information.

1-18.1 Inpatient intensive physical rehabilitation services

Inpatient intensive physical rehabilitation services cover acute conditions from birth through any age and are available one time per event.

EPSDT members with chronic conditions may be considered for age-appropriate developmental training. Refer to the Hospital Services provider manual, Chapter 8-6 Inpatient hospital intensive physical rehabilitation services for additional information.

1-19 Interpretive services

Effective communication between EPSDT members and providers is essential in improving health outcomes and achieving optimal health care outcomes. As Medicaid continues to experience soaring growth in individuals who don't use English as a primary language, qualified medical interpreters are increasingly critical in filling this important patient need.

Refer to Section I: General Information, Chapter 3-8 Medical interpretive services for additional information concerning interpretive services for EPSDT members.

Medicaid also offers a Guide to Medical Interpretive Services. The guide lists member eligibility requirements, contractors, languages offered, and information required from the provider.

1-20 Laboratory and radiology services

Laboratory and radiology tests provide important information about a member's health. Medically necessary laboratory and radiology services are covered for EPSDT members to assist providers with diagnosis of diseases and conditions, monitoring treatments for a disease, or to check the condition of organs and body systems. Providers are encouraged to facilitate or arrange all appropriate services for each EPSDT member at each age level in a timely manner, and properly document and report the services.

1-21 Nursing and long-term care facilities

Refer to the Long Term Care Services provider manual.

1-22 Medications and pharmacy

Under the EPSDT program, all medically necessary medical treatment, including medications is a covered service. The Centers for Medicare and Medicaid Services (CMS) guidance document "EPSDT: A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents" informs that states must provide children with the physical, mental, vision, hearing, and dental services they need to treat health problems and conditions.

As noted above, the EPSDT program covers physical and mental health and substance use disorder services, regardless of whether these services are provided under the State Plan and regardless of any restrictions that states may impose on coverage for adult services, as long as those services could be covered under the State Plan including medication management which would fall under the Medicaid pharmacy benefit. Please refer to the Pharmacy Services provider manual for further information.

Appropriate immunizations, in accordance with the schedule for pediatric vaccines established by the Advisory Committee on Immunization Practices are covered by the Vaccines for Children Program.

The EPSDT benefit does not require coverage of treatments, services, or items including pharmaceuticals that are experimental or investigational. Such services and items may, however, be covered at the state's discretion if it is determined that the treatment or item would be effective to address the EPSDT member's condition.

1-23 Outpatient physical therapy and occupational therapy

Refer to the Physical Therapy and Occupational Therapy Services provider manual for additional information concerning outpatient therapy services.

1-24 Chiropractic services

Coverage of chiropractic services is limited to spinal manipulation. Chiropractors performing manual manipulation of the spine may use manual devices. However, no additional payment is available for use of the device, nor does Medicaid recognize an extra charge for the device itself. No other diagnostic or therapeutic service furnished by a chiropractor or under the chiropractor's order is covered.

Specific coverage on CPT or HCPCS codes may be found in the Coverage and Reimbursement Code Lookup.

1-25 Transportation

Medicaid may provide reimbursement for non-emergency medical transportation (NEMT) if the member is currently eligible for EPSDT services and they do not have access to transportation to receive needed medical care.

Medical transportation is not available for services provided by non-enrolled medical practitioners or for non-covered services. Members may be asked to verify medical appointments associated with transportation services. Medicaid may not reimburse for all transportation services.

Available options for NEMT services are based on the member's medical needs and include:

1. Utah Transit Authority (UTA);

2. Paratransit;
3. Modivcare;
4. Ambulance services; and
5. Potential reimbursement for personal car mileage.

To maintain cost effectiveness while providing necessary services to EPSDT members, utilization is restricted to available services near the member's place of residence.

Note: To access medical transportation services, members must discuss transportation needs with a Department of Workforce Services (DWS) eligibility worker. DWS eligibility workers can assist the member in finding the most cost effective and efficient options available to the member.

Approval for NEMT uses the following hierarchy for NEMT utilization:

1. Personal Transportation Reimbursement
2. Members who live within UTA or Cedar Area Transportation Services (CATS) boundaries should utilize "fixed bus route" services or UTA's TRAX light rail
    a) "Fixed bus routes" refers to buses that operate on a predetermined route according to a predetermined schedule.
3. If a member cannot use UTA or CATS, but they still live within established boundaries for those services, the member can apply for UTA Paratransit transportation or CATS "Dial-A-Ride" services.
4. Members who live outside the boundaries of the UTA/CATS service areas or who are unable to use the previously mentioned services for medical reasons can utilize the contracted NEMT broker, Modivcare, for transportation services.
5. If the member exceeds established weight limits and cannot obtain the use of a manual wheelchair for Modivcare services, then NEMT ambulance services are available for member use.

For additional information, including personal transportation reimbursement, applications for services, and service limitations for the above NEMT services, please reference the Medical Transportation Manual, the Utah Medicaid NEMT website, or the DHHS Medical Policy Manual, Chapter 651 Non-Emergency Medical Transportation.

1-26 Vision services

The AAP emphasizes that eye examinations and vision assessments are critical for the detection of conditions that often result in visual impairment, signify serious systemic disease, lead to problems with school performance, and, in some cases, threaten the child's life. Undetected vision problems occur in 5%–10% of preschool children. The most serious of these problems is amblyopia, a loss of visual acuity and binocular vision that becomes irreversible after 5 years old.

Each EPSDT screening must include a visual observation with an external eye examination and a risk assessment or screening for visual acuity. See the Bright Futures/American Academy of Pediatrics (AAP) periodicity schedule for timing of required screenings.

Refer to the AAP Policy Statement Visual System Assessment in Infants, Children, and Young Adults by Pediatricians and Procedures for the Evaluation of the Visual System by Pediatricians for additional information.

Vision services include vision screenings, examinations, diagnosis, and treatment for defects in vision, including eyeglasses.

1-26.1 Screening for visual acuity

A visual acuity screen is recommended at ages 3-, 4-, and 5-years of age. Instrument-based screening may be used to assess risk at ages 12- and 24-months, in addition to the well visits at 3 through 5 years of age.

Visual acuity screening procedures and passing criteria should be followed as advised in the AAP publication, Procedures for the Evaluation of the Visual System by Pediatricians.

1-26.2 Vision referral standards

Referrals to an appropriate eye or vision specialist must be made when screening methods or parent/caregiver reports indicate that further diagnostics are warranted by a specialist. An EPSDT member may also be referred if parent/responsible guardian reports warrant a referral.

1-26.3 Corrective lenses

Corrective lenses are medically necessary to prevent permanent visual loss due to a number of eye conditions. These conditions may include, but is not limited to:

1. high or asymmetric refractive error,
2. strabismus,
3. amblyopia,
4. aphakia,
5. pseudophakia,
6. congenital ocular anomalies,
7. neurologic disorders,
8. medication side effects,
9. and for protection in cases where the member has only one well-functioning eye

A change in prescription or replacement due to normal lens wear is also considered medically necessary.

Covered lenses include single vision, bifocal, trifocal, with or without slab-off prism, in clear glass or plastic.

Separate charges for glasses fitting are not reimbursable when the provider is supplying the frame and lenses. Fitting fees are included in the reimbursement rate for the provided items.

1-26.4 Frames

Medicaid provides one standard plastic or metal frame. If the lens prescription changes, the same frame must be used when possible. Medicaid covers one pair of eyeglasses every 12-month period.

If a member requires lenticular lenses, deluxe frames will be allowed with a PA.

1-26.5 Eyeglass replacement

Eyeglasses are covered once every 12-months. When eyeglass replacement is needed prior to the end of the 12-month limit, prior authorization is required. Replacement lenses are covered and do not require PA. If the lenses alone need replacing, the provider must use existing frames.

The following prior authorization criteria must be met for eyeglass replacement requests:

1. There is a change in correction of 0.5 diopters or greater in either sphere or cylinder power in either eye.
2. A vision examination shows that a change in eyeglasses is medically necessary.
3. A change in the member's head size warrants a new pair of eyeglasses.
4. The recipient has experienced agitation or irritation from the frame material from the previous pair of eyeglasses.
5. The original pair is lost, broken, or irreparably damaged; the dispensing provider must submit a narrative explaining the reason for replacement with the prior authorization request.

1-26.6 Contact lenses

Contact lenses require PA.

1. Contact lenses may be covered under the following circumstances:
   a) Visual acuity cannot be corrected to 20/70 with glasses
   b) The refractive error is greater than +- 8D
   c) An eye disease or disorder exists that is not correctable with glasses, such as aphakia, keratoconus, nystagmus, or severe corneal distortion
2. Reimbursement of contact lenses includes fitting, measurement, member education, and follow-up care.

1-26.7 Low vision aids

Low vision aids or materials, such as magnifiers and lamps, may be covered. These items require PA.

1-26.8 Billing members for non-covered upgrades

With few exceptions, a provider may not bill a Medicaid member, as the Medicaid payment is considered payment in full. Exceptions may include a member request for a service that is not medically necessary and therefore not covered. Examples of services considered not medically necessary include, but are not limited to:

1. upgraded frames
2. tinted or transitional lenses
3. progressive lenses

A Medicaid member may choose to upgrade a covered vision service to a non-covered service, such as transitional lenses or brand-name frames. However, the member

must be willing to assume financial responsibility for the difference in the covered and non-covered services fees.

When a member requests a product or service not covered by Medicaid, the provider may bill the Medicaid member when all four conditions of Section I: General Information, Chapter 3-5 Exceptions to prohibition on billing members, are met.

The provider cannot mandate or insist the covered product or service be upgraded. The member makes the choice. Further, the provider, as a guarantee of payment by the member, may not hold the member's Medicaid member card, nor impose any other restrictions upon the member.

The amount paid by the member is the difference between the provider's usual and customary charge for the non-covered service and the provider's usual and customary charge for the covered service.

The member is not responsible for paying the difference between the Medicaid payment for the covered service and the usual and customary fee for the requested upgraded service.

If providing upgraded services, report the Medicaid covered code and charges on the first line of the claim form. On the second line, bill the non-covered code, including the modifier “GX” (HCPCS “GX” modifier description: Notice of liability issued, voluntary under payer policy) and the charges on the second line. This indicates that the member has signed an agreement of understanding of the payment responsibility for the upgrade(s). The code with the GX modifier will be non-payable. The agreement of understanding must be kept in the provider’s medical record for the member.

Example:

A member is provided with frames for prescription eyeglasses, reported by the provider using HCPCS V2020. Medicaid reimburses HCPCS V2020 at a rate of $63.82. The customary charge for frames by the provider is $80. The member chooses an upgraded eyeglass frame valued at $120. In this example, the provider would:

1. Report HCPCS V2020 with the $80 charge on the first line of the claim

2. Report HCPCS V2020 with the GX modifier and a charge of $40 on the second line of the claim
3. Medicaid would reimburse the provider $63.82 for the first line and provide no payment for the second line of the claim
4. Per the agreement signed by the member, the provider could then bill the remaining $40 to the member directly for the upgraded product.

Note that the provider may not bill the member for the $16.18 difference between the $63.82 reimbursement rate from Medicaid and the $80 customary charge from the provider, as the reimbursement from Medicaid is considered payment in full.

1-26.9 Non-covered vision services

The following services are not covered vision services for Medicaid:

1. Additional glasses, such as reading glasses, safety glasses, distance glasses, or "spare glasses"
2. Extended wear contact lenses
3. Contact lenses for moderate visual improvement and/or cosmetic purposes
4. Sunglasses, tints, or any other mechanism such as light-sensitive lenses that "darken" or photo grey lenses
5. Oversized, exclusive, or specially designed lenses
6. Special cataract lenses, unless medically necessary. Only clinical cataract lenses are covered.
7. No-line bifocal lenses and no-line trifocal lenses
8. Replacement of glasses that are broken or lost due to abuse and neglect of the member
9. Repairs due to member neglect or abuse
10. Medications dispensed in an office
11. Screening examination to determine if member has an eye problem
12. Corneal Topography
    a) With a non-covered service (e.g., radial keratotomy, Lasix eye surgery)
    b) As a screening examination
    c) Separate from evaluation & management ophthalmological services
    d) Optical Coherence Tomography (OCT) (An ultrasonic method to evaluate ocular structures which is considered investigational)

1-27 Telehealth services

Refer to the Section I: General Information provider manual, Chapter 8-4.2 Telehealth.

2 Prior authorization

Prior authorization requests for EPSDT services must be in writing and include all applicable information listed below:

1. The provider's acquisition cost for the service or item.
    a) Note: The acquisition cost, or purchase price, is the amount paid by the provider for an asset or product, either through purchasing the product directly from a manufacturer or the cost incurred by the provider to manufacture the product, Acquisition cost is not the manufacturer's suggested retail price (MSRP). Submissions that include only MSRP information for items will be returned, without processing, for the needed acquisition cost.
2. Photocopy of any durable medical equipment item(s) requested.
3. Current comprehensive evaluation of the individual's condition, completed by the appropriate therapist, that includes the diagnosis, general medical history, therapy treatment history, age, height, weight, capabilities, prognosis, specific limitations, and the purpose for any durable medical equipment that is requested.
4. Letter from the physician describing medical necessity, including the diagnosis, the medical reason for the request, the medical condition that justifies the request, and the portion of the medical history that applies to the specific request. The letter must be member specific, indicate the reasons the physician is recommending the service or equipment, whether the item or service has been provided previously, and whether the service or equipment would contribute to preventing a future medical condition or hospitalization.

All providers involved in the diagnosis, evaluation, or treatment of the member should communicate directly and work together as a team to evaluate the most appropriate services for the EPSDT member.

For additional information concerning prior authorization refer to PRISM Prior Authorization training.

2-1 Exceptions to prior authorization requirements and non-covered services

Coverage may be available for EPSDT eligible members when a service is not covered by Medicaid. Prior authorization requests for EPSDT services must be in writing and include all applicable information listed below:

1. The provider's acquisition cost or usual and customary charges for the item(s) or service.
    a) The acquisition cost, or purchase price, is the amount paid by the provider for an asset or product, either through purchasing the product directly from a manufacturer or the cost incurred by the provider to manufacture the product, Acquisition cost is not the manufacturer's suggested retail price (MSRP). Submissions that include only MSRP information for items will be returned, without processing, for the needed acquisition cost.
2. Photocopy of any durable medical equipment item(s) requested, if applicable
3. Current comprehensive evaluation of the child's condition, completed by the appropriate qualified healthcare professional, that includes all applicable medical documentation to establish the medical necessity of the requested item or service,
4. Letter from the physician describing the member specific medical necessity for the product/service, including the diagnosis, pertinent medical history, and any previous or current medical interventions utilized in treatment.

All providers involved in the diagnosis, evaluation, or treatment of the member should communicate directly and work together as a team to evaluate the most appropriate services for the member.

3 Health plans

For more information about Managed Care Entities (MCE), refer to Section I: General Information, Chapter 2, Managed care entities.

If a Medicaid member is enrolled in an MCE, the Division of Integrated Healthcare (DIH) will not pay a claim unless it is for a carved-out service. A carved-out service is a service that is covered by Medicaid but not covered by an MCE. Services that are carved out from an MCE

differ depending upon the type of MCE. Refer to Section I: General Information, Chapter 2-6 MCE carve-out services for additional information.

3-1 Mental health plans

For more information about Prepaid Mental Health Plans (PMHPs), refer to Section I: General Information, Chapter 2-8, Prepaid mental health plans, and the Rehabilitative Mental Health and Substance Use Disorder Services Provider Manual. A list of MCEs and PMHPs that Medicaid has contracted with to provide health care services is found on the Medicaid website.

For members enrolled in a PMHP, requests for services related to mental health conditions will be referred to the PMHP.

3-2 Dental plans

For more Information about dental plans, refer to Section I: General Information, Chapter 2-10, Dental plans.

MCEs are not responsible for covering the following Medicaid State Plan or waiver services. These services are "Carved-Out Services" and should be reported directly to Medicaid on a fee-for-service basis:

1. A non-pregnant adult member, except for an EPSDT enrollee,
2. A member in the custody of the Department of Health and Human Services (DHHS) and covered by Foster Care Medicaid,
3. A member that resides in a nursing home or an intermediate care facility, or
4. Enrolled in Utah's Premium Partnership for Health Insurance (UPP),
5. Facility charges for hospital and ambulatory surgical centers,
6. Dental surgical services that include general anesthesia performed at a hospital or ambulatory surgical center,
7. Emergency dental services performed in an emergency department of a hospital or an urgent care facility,
8. Services performed at Indian Health Services facilities, any tribal facility, or an Urban Indian facility,
9. Services performed at the Utah State Hospital or Utah State Developmental Center,
10. Surgical repair services performed by a dentist or oral surgeon for craniofacial anomalies, cleft lip, or palate.

3-3 Healthy Outcomes Medical Excellence (HOME) Program

For more information concerning the HOME program, refer to Section I: General Information, Chapter 2-9, HOME.

HOME is a coordinated care program that provides services normally covered by the ACOs and the PMHPs. HOME is not responsible for pharmacy services. When members enroll in HOME, they are disenrolled from their ACO and PMHP.

4 Member eligibility

It is the responsibility of the provider to verify the member's eligibility prior to every service. For additional information regarding member eligibility refer to Section I: General Information, Chapter 6, Member eligibility.

EPSDT services are available to all members enrolled in Traditional Medicaid from birth until the member's 21st birthday.

Children born to women enrolled in Medicaid are eligible for the EPSDT benefit but must be enrolled in Medicaid, themselves, to receive benefits.

Note: Historically, individuals aged 19 through 20 who were enrolled in Non-Traditional Medicaid did not qualify for EPSDT services. On December 31, 2023, the Non-Traditional Medicaid (NTM) benefit plan ended, and members formerly enrolled in the NTM plan were provided the same benefits as the Traditional benefit plan starting on January 1, 2024. Information regarding NTM services will remain in the Utah Medicaid Provider Manuals until January 1, 2025, for reporting and eligibility purposes.

5 Additional policy resources

Refer to the Section I: General Information manual for additional policy information concerning:

1. Provider participation and requirements
2. Record keeping
3. Provider sanctions
4. Member responsibilities

6 Coding

All Utah Medicaid claims require diagnosis codes and procedure codes. The appropriate diagnosis code must be entered on all claims. Procedure codes are dependent on the type

of service and claim type. Medicaid recognizes guidelines in current editions of established coding manuals or other standard literature. However, those guidelines are adopted only as far as they are consistent with application to Utah Medicaid policy. The established coding guidance materials consist of the following:

1. Healthcare Common Procedure Coding System (HCPCS)
2. Physicians' Current Procedural Terminology (CPT) Manual
3. Healthcare Common Procedure Coding System, HCPCS Level II
4. Healthcare Common Procedure Coding System, HCPCS Level III
5. International Classification of Diseases (ICD), Clinical Modification (CM), and Procedural Coding System (PCS)
6. Revenue Codes (Uniform Billing Codes-UB-04)

Refer to Section I: General Information, Chapter 11 Billing Medicaid and Chapter 12 Coding for additional reporting instructions. It is the responsibility of the provider to review Medicaid coverage policy for the procedure or service and request prior authorization (PA) or submit documentation for manual review. Refer to the Medicaid Coverage and Reimbursement Lookup for additional code specific information and fee schedule information.

7 Local Health Departments (LHD)

Bear River Health Department	***Central Utah Health Department***
655 East 1300 North Logan, UT 84341-2570	70 Westview Drive Richfield, UT 84701-1868
Office: 435 792-6541 Office Fax: 435 792-6600	Office: 435 896-5451, ext. 322 Office Fax: 435 896-4353
Davis County Health Department	***Salt Lake County Health Department***
22 S. State Street Clearfield, UT 84015-1043 Office: 801 525-5202 Office Fax: 801 525-5210	2001 South State Street, S3-700 PO Box 144575, Salt Lake City, UT 84114-4575 Office: 385 468-4150 Office Fax: 385 468-4109
San Juan Health Department	***Southeast Health Department***
196 East Center Blanding, UT 84511 Office: 435 678-2723 Office Fax: 435 678-3309	28 South 100 East Price, UT 84501-3002 Office: 435 637-3671 Office Fax: 435 637-1933
Southwest Health Department	***Summit County Health Department***
620 South 400 East #400 St. George, UT 84770 Office: 435 986-2588	650 Round Valley Dr., Suite 100 Park City, UT 84060 Office: 435 333-1504

Office Fax: 435 628-6425

Tri-County Health Department
133 South 500 East
Vernal, UT 840787-2728
Office: 435 247-
Office Fax: 435 781-0536

Wasatch County Health Department
55 South 500 West
Heber City, UT 84032-1918
Office: 435 657-3257
Office Fax: 435 654-2705

Tooele County Health Department
151 North Main Street
Tooele, UT 84074-2141
Office: 435 277-2303

Office Fax: 435 333-1580

Utah County Health Department
151 S University Ave. #1610
Provo, UT 84601
Office: 801 851-7050
Office Fax: 801 851-7055

Weber Morgan Health Department
477 23rd Street
Ogden, UT 84401-1507
Office: 801 399-7235
Office Fax: 801 399-7256

8 Definitions

Definitions of terms used in multiple Medicaid programs can be found in Section I: General Information, Chapter 1-9, Definitions and Utah Administrative Code R414-1. Utah Medicaid Program. Definitions particular to the EPSDT program are found in Utah Administrative Code R414-71. Early and Periodic Screening, Diagnostic, and Treatment Program. Section 2. Definitions.

EPSDT member is an enrolled Medicaid member, including infants, children, and adolescents, under the age of 21.

EPSDT benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid.

Responsible caregiver is defined as a person over 18 who is acting at the bequest or employment of a parent, guardian, durable power of attorney or legal next of kin of the minor child or dependent adult and who could be expected to provide adequate safety and supervision

Primary Care Provider (PCP) includes doctors, nurse practitioners, and physician assistants. They often maintain long-term relationships with members and advise and treat a range of health-related issues. They may also coordinate a member's care with specialists.

Qualified Healthcare Professional (QHP) is an individual who is qualified by education, training, and licensure who performs a professional service within their scope of practice and independently reports that professional service.

8-1 Abbreviations/initializations

AAP - American Academy of Pediatrics
AAPD - American Academy of Pediatric Dentistry
ACMG - American College of Medical Genetics and Genomics
ADL - Activities of Daily Living
ASCO - American Society of Clinical Oncology
ASD - Autism Spectrum Disorder
ASRM - American Society of Reproductive Medicine
BMI - Body Mass Index
BWEIP - Baby Watch Early Intervention Program
CDC - Centers for Disease Control and Prevention
CPT - Current Procedural Terminology
CSHCN - Children with Special Health Care Needs Program
DHHS - Department of Health and Human Services
DIH - Division of Integrated Healthcare
DMEPOS - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
DNA - deoxyribonucleic acid
EHDI - Early Hearing Detection and Intervention Program
EPSDT - Early and Periodic Screening, Diagnostic and Treatment
FFS – Fee For Service
FQHC - Federally Qualified Health Centers
HCPCS - Healthcare Common Procedural Coding System
HOME - Healthy Outcomes Medical Excellence Program
IADL - instrumental Activities of Daily Living
ICF/IF - Intermediate Care Facility for persons with Intellectual Disability
IDEA - Individuals with Disabilities Act
IEP -Individualized Education Plan
LHD - Local Health Department
MCE - Managed Care Entities
MRI - Magnetic Resonance Imaging

NCHS - National Center for Health Statistics
NEMT - Non-Emergency Medical Transportation
NGS - Next Generation Sequencing
NICU - Neonatal Intensive Care Unit
NIDA - National Institute on Drug Abuse
OT - Occupational Therapy
PA - Prior Authorization
PCP - Primary Care Providers
PCS - Personal Care Services
PDN - Private Duty Nursing
PMHP - Prepaid Mental Health Plans
PT - Physical Therapy
QHP - Qualified Healthcare Professional
RHC - Rural Health Clinics
SPL - Speech-language Pathology
SUD - Substance Use Disorder
UTA - Utah Transit Authority
VFC - Vaccines for Children Program
WES - Whole Exome Sequencing
WGS - Whole Genome Sequencing
WIC - Women, Infants and Children Program

9 Resources

For information regarding:	
Administrative Rules	• Utah Administrative Code Table of Contents • Dental, Oral and Maxillofacial Surgeons and Orthodontia. R414-49. • Medicaid Policy for Experimental, Investigational or Unproven Medical Practices. R414-1A. • Transplant Services Standards. R414-10A. • Eligibility Requirements. R414-302. • Medicaid General Provisions. R414-301. • Program Benefits and Date of Eligibility. R414-306.

	• Utah Medicaid Program. R414-1
General information including: • Billing • Fee for service and managed care • Member eligibility • Prior authorization	• Section I: General Information • Claims • Managed Care: Accountable Care Organizations • Utah Medicaid Prior Authorization webpage • Patient (Member) Eligibility Lookup Tool
Additional information including: • Anesthesia fee resources • Coverage and reimbursement resources • Procedure codes with accompanying criteria and limitations • National correct coding initiative	• Coverage and Reimbursement webpage • PRISM Coverage and Reimbursement Code Lookup • The National Correct Coding Initiative in Medicaid
State Policy and Rule updates	• Utah Medicaid Official Publications • Utah Medicaid Provider Manuals • Medicaid Information Bulletins (MIB) ○ published Special Interim MIBs • Utah State Bulletin
Provider resources	• Healthcare Providers webpage • Utah Medicaid Provider Manuals • Medicaid Information Bulletins • PRISM Portal Access • Patient (Member) Eligibility Lookup Tool • Utah Medicaid Prior Authorization • Utah Medicaid Provider Training
Other helpful information	• Bright Futures • Periodicity Schedule • Immunization Schedule for Children and Adolescents • Targeted Case Management-Early Childhood (ages 0-4) Manual • Baby Your Baby • CDC Vaccines for Children Program. • Women, Infants and Children (WIC) • Utah Lead Coalition

Federal government resources	• Social Security Act, section 1905 (a) • Code of Federal Regulations ○ Title 42. Chapter IV. Subchapter C. Part 441. Subpart B. • Medicaid.gov