Administrative Code

Title 23: Medicaid
Part 223
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

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Part 223: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

Part 223 Chapter 1: General

Rule 1.1: Program Description

A. The Division of Medicaid has established a program of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), which provide preventive and comprehensive health services for Medicaid-eligible children and youth up to age twenty-one (21). The service ends on the last day of the beneficiary's twenty first (21st) birthday month.

B. EPSDT is defined as:

1. Early is assessing health care in early life so that potential disease and disabilities can be prevented or detected in their preliminary states, when they are most effectively treated.

2. Periodic is assessing a child's health at regular, recommended intervals in the child's life to assure continued healthy development.

3. Screening is the use of tests and procedures to determine if children being examined have conditions warranting closer medical or dental attention.

4. Diagnosis is the determination of the nature or cause of conditions identified by the screening.

5. Treatment is the provision of services needed to control, correct or lessen health problems.

C. In order to administer the EPSDT program, the Division of Medicaid and potential EPSDT providers, including but not limited to, the Mississippi State Department of Health, other public and private agencies, private physicians, rural health clinics, comprehensive health clinics, and similar agencies which provide various components of EPSDT services, must sign an EPSDT specific provider agreement. Diagnostic and treatment services are primarily provided by referral to other providers.

Source: 42 U.S.C. 1396d(a)(4)(b) and (r) and Miss. Code Ann. § 43-13-121

Rule 1.2: Provider Enrollment and Participation Requirements

A. Physicians, physician assistants or nurse practitioners who wish to become EPSDT screening providers must complete the enrollment requirements, sign an EPSDT specific provider agreement and have an onsite clinic inspection before an EPSDT provider segment will be issued. EPSDT providers are designated by a special EPSDT indicator.

B. Registered nurses employed through the Mississippi Department of Education (MDE), who meet the certification requirement and the established protocols mandated by the Mississippi State Department of Health (MSDH), Mississippi Department of Education (MDE), Mississippi School Nurse Association, and Mississippi Board of Nursing, may perform EPSDT health assessments following the protocols established by the MSDH.

    1. Nurse-run clinics sponsored by medical practices/hospitals and issued provider numbers will be recognized as acceptable if they conform to the above.

    2. All established and new nurse-run clinics must adhere to the above. This process assures that registered nurses have the educational basis and clinical basis needed to perform health assessments. In addition to the certification requirement, claims submitted for these services must be submitted under the school's provider number and the billing provider must have a letter of referral affiliation on file with the Division of Medicaid.

Source: Miss. Code Ann. § 43-13-121

Rule 1.3: Early and Periodic Screening Services

A. Primary care providers or other health centers that provide primary care services must offer to conduct periodic and medically necessary interperiodic visits to screen all Medicaid-eligible children and youth up to age twenty-one (21) in accordance with the EPSDT Periodicity Schedule as recommended by the American Academy of Pediatrics, and must provide or refer such beneficiaries to assessment, diagnosis, and treatment services.

B. Dental care providers must offer to provide services to all Medicaid-eligible children and youth up to age twenty-one (21) in accordance with the Dental Schedule, and must provide or refer such beneficiaries to assessment, diagnosis, and treatment services. The Dental Schedule is a tool to help dental providers identify beneficiaries with suspected or actual dental problems that may require additional investigations, diagnosis, or treatment.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(5); Section 1905 (r) (5) of the Social Security Act (the Act), Omnibus Budget Reconciliation Act of 1989 (OBRA 89).

Rule 1.4: Periodicity Schedule

A. All children and adolescents under age twenty-one (21) who qualify for full medical assistance benefits coverage are eligible to receive EPSDT services. Eligible children must be provided written and oral information regarding the EPSDT preventative health program and a referral must be made to the provider of their choice. Medicaid beneficiaries have the right to freedom of choice of providers for Medicaid covered services. Refer to Part 200, Chapter 3, Rule 3.6.

B. The EPSDT provider must adhere to the Periodicity Schedule below to receive Medicaid reimbursement for screening services:

1) Zero to one (0-1) month,

2) Two (2) months,

3) Four (4) months,

4) Six (6) months,

5) Nine (9) months,

6) Twelve (12) months,

7) Fifteen (15) months,

8) Eighteen (18) months, and

9) Yearly beginning at the age two (2) years, up to age twenty-one (21).

C. The provider must schedule all health assessment screening appointments for the eligible beneficiary, according to the periodicity schedule. The provider must also make every effort to assist the beneficiary in keeping appointments for the health assessments.

D. The Division of Medicaid defines declination of services as the failure of the family to keep appointments after two (2) attempts within a thirty (30) day period have been made by the provider to continue their participation in the EPSDT program. A refusal of services from the family is required to remove the child from the EPSDT program.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 441.58; 43-13-117(5)

Rule 1.5: Screening Components

A. The EPSDT screen is composed of the following components which must be documented in the medical record:

1. Unclothed physical exam,

2. Comprehensive family/medical/developmental history,

3. Immunization status,

4. Lead assessment and testing,

5. Urine screening,

6. Sickle cell trait screening,

7. Anemia screening,

8. Serology,

9. TB skin test,

10. Developmental assessment,

11. Nutritional assessment/counseling,

12. Adolescent counseling,

13. Vision testing/screening,

14. Hearing testing/screening, and

15. Dental referral services.

B. Every effort should be made to assure that the required components of an EPSDT screen are accomplished in one (1) visit and that fragmentation or duplication of screening services is prevented.

C. Scheduling of initial and periodic screening of EPSDT eligible Medicaid beneficiaries is the responsibility of the EPSDT screening providers, as well as, overall care coordination.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 441, Subpart B

Rule 1.6: Documentation Requirements for EPSDT Screenings

A. The medical record must include the following critical components:

1. Consent signature,

2. Past family medical/social history and updates at each screening visit,

3. Beneficiary medical history and updates at each screening visit,

4. Mental health assessment,

5. Past immunization history and vaccine administration as indicated,

6. Age appropriate developmental assessment,

7. Age appropriate health education/anticipatory guidance,

8. Nutritional assessment to include:

    a) Plotted growth and development chart,

    b) WIC status,

    c) Anemia testing, and

    d) Other pertinent lab and/or medical tests.

9. Sickle cell test results, if indicated,

10. Hemoglobin or hematocrit,

11. Urine test for glucose and protein,

12. Lead assessment/lead testing with results according to age and risk,

13. RPR beginning at age fifteen (15), then yearly, or sooner if sexually active,

14. Tb skin test, if indicated,

15. Height, weight, and head circumference, up to age two (2), plotted on an age/sex specific growth and development chart,

16. Vision and hearing screening, subjective and objective testing results,

17. Pulse from birth to age twenty-one (21),

18. Blood pressure,

19. Documentation of unclothed physical examination,

20. Dental counseling and/or referral/status, birth through twenty-one (21) years,

21. Appropriate referral, when required, included but not limited to vision, medical and hearing,

22. Referral follow-up on conditions related to documented medical, vision or hearing abnormalities,

23. Adolescent counseling, and

24. Documentation of next screening date.

B. The Division of Medicaid and/or the fiscal agent have the authority to request any patient

records at any time to conduct random sampling review and/or document any services billed by the EPSDT provider. Refer to Maintenance of Records Part 200, Chapter 1, Rule 1.3.

Source: Miss. Code Ann. § 43-13-121; 43-13-117; 43-13-118; 43-13-129

Rule 1.7 Diagnostic and Treatment Program Services

A. EPSDT diagnostic and treatment services consists of all medically necessary services needed to correct or ameliorate physical or mental illnesses and conditions discovered by a screening, whether or not such services are covered under the State Plan; and for a Medicaid eligible child or youth under age twenty-one (21) years, if the service is determined by the Division of Medicaid or its representative to be medically necessary.

B. A medically necessary service is defined as any service that is reasonably necessary to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap or cause physical deformity or malfunction. There must also be no other equally effective, more conservative, or substantially less costly course of treatment available or suitable for the client requesting the service.

C. To receive payment for any service that is not specifically included as a covered service under any Medicaid Administrative Rule or under the federally approved State Plan, the requestor must submit a request for prior authorization.

Source: Miss. Code Ann. § 43-13-121; Section 1905 (r) (5) of the Social Security Act

Part 223 Chapter 2: Early Intervention / Targeted Case Management

Rule 2.1: Provider Participation

A. Providers

1. Qualified providers shall be state agencies, private and public providers and their subcontractors.

2. Providers must meet the following Medicaid criteria to ensure that case managers for the children with developmental disabilities are capable of providing needed services to the targeted group:

a) Demonstrated successfully a minimum of three (3) years of experience in all core elements of case management including:

1) Assessment,

2) Care/services plan development,

3) Linking/coordination of services, and

4) Reassessment/follow-up.

b) Demonstrated case management experience in coordinating and linking such community resources as required by the target population,

c) Demonstrated experience with the target population, and

d) Demonstrated the ability to provide or has a financial management system that documents services delivered and costs associated.

B. Case Managers

1. Each case manager must be a Mississippi Early Intervention Program certified service provider and have both of the following:

a) A bachelor's degree in child development, early childhood education, special education, social work, or be a registered nurse, and

b) Two (2) years' experience in service coordination for children with disabilities up to age eighteen (18) or two (2) years' experience in service provision to children under six (6) years of age.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(19)(b); 34 CFR 303

Rule 2.2: TCM Activities

A. Early Intervention/Targeted Case Management (EI/TCM) is an active ongoing process that involves activities carried out by a case manager to assist and enable a child enrolled and participating in the Mississippi Early Intervention Program to gain access to needed medical, social, educational and other services. Service Coordination to assist the child and child's family, as it relates to the child's needs, from the notice of referral through the initial development of the child's needs identified on the Individualized Family Services Plan (IFSP). Additionally, Service Coordination assists the child and child's family, as it relates to the child's needs, with ongoing service coordination, for the child, provided by the individual service coordinator selected at the time the IFSP is finalized.

B. These activities include:

1. Arranging for evaluation and assessment activities to determine the identification of services as it relates to the child's medical, social, educational and other needs,

2. Arranging for and coordinating the development of the child's IFSP,

3. Arranging for the delivery of the needed services as identified in the IFSP,

4. Assisting the child and his/her family, as it relates to the child's needs, in accessing needed services for the child and coordinating services with other programs,

5. Monitoring the child's progress by making referrals, tracking the child's appointments, performing follow-up on services rendered, and performing periodic reassessments of the child's changing service needs,

6. Make a minimum of one (1) face-to-face contact quarterly and documented successful contacts monthly,

7. Obtaining, preparing and maintaining case records, reports, documenting contacts, services needed, and the child's progress,

8. Providing case consultation, with the service providers/collaterals in determining child's status and progress,

9. Coordinating crisis assistance, intervention on behalf of the child, making arrangements for emergency referrals and coordinating other needed emergency services, and

10. Coordinating the transition of an enrolled child to ongoing services prior to the child's third (3rd) birthday.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(19)(b); 34 CFR 303

Rule 2.3: Quality Assurance and Monitoring

A. The Division will establish and maintain an assurance process that ensures a quality case management program and the delivery of necessary covered services that appropriately address the individual needs. The provider agrees to share data as part of the quality assurance program timely upon request by the Division.

B. The providers will make available to the Division the documentation/records maintained for case management services with the following information:

1. The name of eligible client,

2. Dates of case management services,

3. The nature, content, and units of the case management services received and whether goals specified in the care plan have been achieved,

4. Whether the client has declined services in the care plan, the need for and occurrences of coordination with other case managers,

5. The time line for obtaining needed services,

6. The time line for reevaluation of the plan,

7. Case Management Needs Assessment to determine the services needed and requested by the individual,

8. Service Coordination and Linkage to identify, assess, and link eligible individuals with the appropriate medical, social, and educational services to ensure that appropriate services are being provided while reducing duplication of services, and

9. Individual Service Monitoring to assure that all services are being appropriately delivered according to the Individualized Family Service Plan (IFSP) and in accordance with the established time lines.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(19)(b)

Rule 2.4: Freedom of Choice

A. Enrolled and participating recipients will have free choice of the available providers of case management services; and

B. Enrolled and participating recipients will have free choice of the available providers of other medical care under the plan.

Source: Miss. Code Ann. § 43-13-121; Section 1920(a) (23) of the Social Security Act.

Rule 2.5: Reimbursement

A. The Division of Medicaid uses rate setting as a prospective method of reimbursement on both the state and federal level. This method does not allow for retrospective settlements. The rates are determined from cost reports and appropriate audits.

B. Standard rates will be re-determined annually. The Division of Medicaid uses a fee-for-service reimbursement rate for private providers. In no case may the reimbursement rate for services provided exceed an individual facility's customary charge to the public for such services in the aggregate, except for those public facilities rendering such services free of charge or at a nominal charge.

C. Payments under the plan do not duplicate payments made to public agencies or private entities under other program authorities for the same purpose.

D. Case management providers are paid on a unit of service basis that does not exceed fifteen (15) minutes.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(19)(b); 34 CFR 303