Early Periodic Screening Diagnosis and Treatment (EPSDT) Billing Information

- The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, and developmental, and specialty services.

- States are required to provide comprehensive services and furnish all Medicaid coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions, based on certain federal guidelines. EPSDT is made up of the following screening, diagnostic, and treatment services: screening services, vision services, dental services, Hearing Services, Other Necessary Health Care Services, Diagnostic Services, and treatment services.

- For children who require a service beyond the benefit package limitations, the primary care provider (PCP) must have documented the medical necessity for the service during an EPSDT exam. Any specialist providing services must coordinate service needs with the primary care provider. All other screening, diagnosis, and treatment services that are covered under the members benefit plan are to be billed the same as any other service.

- To obtain reimbursement for services that have been identified as a result of the EPSDT exam, that are not covered in the member’s benefit package, or for service limitations that have been previously met, the specialist must provide appropriate documentation and a copy of the EPSDT referral.

- This referral must be submitted from the child’s PCP documenting medical necessity for the service requested, and appropriate documentation from specialist.

- All documentation must be faxed to the Utilization Management (UM) Vendor for documentation review and medical necessity determination. The UM Vendor will notify the referring physician and servicing vendor whether services are approved or denied and if approved, will provide the appropriate authorization number for billing purposes.

- Documentation for services that are not covered in the member’s benefit package or for service limitations that have been previously met is to be sent to the UM Vendor: ATTENTION EPSDT SERVICE MEDICAL REVIEW. If the Medicaid member is enrolled in a Managed Care Organization (MCO), the respective member’s MCO must be contacted for coordination of benefits.

- The rendering provider will be required to bill all claims to the DHHR Fiscal Agent, Attn: BMS EPSDT Program Unit. The prior authorization number issued by the UM vendor must be entered on the claim to be considered for payment.

- Any further billing assistance should be referred to the DHHR Fiscal Agent Provider Relations Department.

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