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Advocates for Basic Legal Equality, Inc.

EPSDT/HEALTHCHEK: Provider Guide To Navigating The Medicaid Managed Care System For Pediatric Patients

Prepared by Disability Rights Ohio and ABLE's Medical-Legal Partnership for Children.

In Ohio, most people who have Medicaid must join a managed care plan. Ohio's five managed care plans are Buckeye Health Plan, CareSource, Molina Healthcare, Paramount Advantage, and United Healthcare. This guide seeks to answer questions you may have about your Medicaid-eligible patients' rights and offers strategies for ensuring continuous appropriate medical coverage.

Do different Medicaid managed care plans offer different coverage to children?

Yes, but all of them must meet minimum coverage requirements under the federal Medicaid law's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) provision.

What is EPSDT?

EPSDT is a benefit available to Medicaid-eligible children under age 21. It requires that states cover any federal Medicaid service necessary to correct or ameliorate a child's physical or mental illness or condition. Ohio calls its EPSDT benefit "Healthchek."

What does EPSDT/Healthchek cover for children?

Children can receive any medically necessary health care that would be covered by federal Medicaid regardless of whether it would otherwise be covered by Ohio Medicaid. Children can also get more health care than Medicaid would cover for adults. This means that children can get the type (what kind), amount (how much), frequency (how often), and duration (for how long) of health care they need. This health care may include:

- Well-child visits and screenings
- Out-of-home residential, facility, and hospital services

Disability Rights Ohio
200 Civic Center Dr.
Suite 300
Columbus, Ohio 43215-4234

614-466-7264 or 800-282-9181
FAX 614-644-1888
disabilityrightsohio.org

Ohio Disability Rights Law and Policy Center, Inc.

- Vision, dental, and hearing screenings and services
- Rehabilitative services
- Occupational and physical therapy
- Speech pathology services
- In-home nursing, personal care, and specialized therapies
- Mental health and substance abuse services
- Medical and adaptive equipment – e.g., glasses, helmets, wheelchairs, and communication devices
- Transportation to medical appointments

Are there limits on EPSDT/Healthchek's coverage for children?

Yes. The service or treatment must be medically necessary. Managed care plans may require prior authorization and consider lower cost alternatives. In Ohio, experimental treatments are generally not covered, but the determination that a treatment is experimental must be reasonable.

What does "medically necessary" mean for children?

To be medically necessary, a procedure, item, or service must meet generally accepted standards of medical practice. If used for diagnostic purposes, it should provide unique and essential information.

In Ohio, medically necessary health care for children includes procedures, items, or services that prevent, diagnose, evaluate, correct, ameliorate, or treat an adverse health condition[1]. An adverse health condition could be any one of the following:

- An illness
- An injury
- A disease or its symptoms
- An emotional or behavioral dysfunction
- An intellectual disability
- A cognitive impairment
- A developmental disability

Medical necessity for children is broader than it is for adults. It covers procedures, items, and services that "correct" or "ameliorate" an adverse health condition. Ameliorate means to improve or maintain the child's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

How do I get a child medically necessary health care under EPSDT/ Healthchek?

You must be a Medicaid provider and recommend a procedure, item, or service as medically necessary. Making a recommendation does not guarantee coverage.

[1]Medical necessity is defined in Ohio law at Ohio Administrative Code 5160-1-01.

If prior authorization is required, you must request it through the plan's prior authorization department.

TIP: Write a detailed recommendation describing the child's condition and why the procedure, item, or service is medically necessary. Use precise language. If the procedure, item or service is necessary, say that and explain why.

If applicable, explain any lower cost alternatives that have been tried or considered, and why they failed or will fail to address the child's condition.

When do I need to request prior authorization?

The managed care plan should explain which procedures, items, and services require prior authorization. Specific forms may be required. You may need to contact the plan or any medical equipment providers to ensure you are using the appropriate and most current form.

The managed care plan may notify you if it needs more information to make a decision. Be sure to respond to any requests for additional information promptly.

TIP: Use the correct forms and timely submit them. This will help to avoid long delays and the hassle of having to resubmit forms. Also use correct coding. If you are unsure of the correct code, contact the plan's prior authorization unit for assistance.

How will I know if my prior authorization request has been approved or denied?

The managed care plan should tell you how long it has to respond to or make a decision about your prior authorization request. The managed care plan should notify you and the child of its decision and explain how to appeal if necessary. If you do not receive a timely decision, you may assume that the request has been denied.

Who can appeal the denial of a request for prior authorization?

The child's parent, authorized representative, or provider may file an appeal with a managed care plan. Any provider acting on a child's behalf must have the parent's written consent to file an appeal and must provide it to the managed care plan.

How do I appeal a denial?

The managed care plan should provide information on how to file an appeal. Generally, an appeal must first be filed with the plan before appealing through the state hearing process. You can also request an "expedited appeal" if the child's health or ability to function is at serious risk.

You may submit additional information during an appeal. Review the written decision to determine the reason for the denial and try to cure any defects that may have been

in the original request. For example, you may need to correct a code or explain why a service is medically necessary.

Some plans offer a peer to peer review. This typically involves a consultation with a plan physician and an opportunity to explain why the recommended procedure, item, or service is medically necessary.

TIP: Be prepared to appeal or advise the child's parent or authorized representative to appeal. For urgently needed care, request an expedited appeal. Refer the family to legal assistance with appeals and provide the family with documentation in support of medical necessity. Be prepared to request a peer to peer review and argue for coverage. Obtain information about the peer reviewer's credentials and area of expertise. You may need to request review by someone with a specific specialty background.

What is the timeframe to appeal?

An appeal must be filed with the managed care plan within 60 days from the date the decision was mailed. However, if the child's services are being reduced and they want those services to continue at their current level during the appeal, the appeal must be filed within 15 days and before the current "authorization period" has expired (for example, the period of time the managed care plan approved nursing services).

What happens after an appeal is filed?

The managed care plan must allow the child's authorized representative to present evidence in support of the appeal either in person or in writing. The child's representative must have access to the case file, including medical records and other documents connected with the appeal. The plan must make an "appeal resolution" decision within 15 days and mail it to the child's representative.

Can the managed care plan's appeal resolution decision be appealed?

Yes. If the child's parent or authorized representative disagrees with the managed care plan's decision, they may request a state hearing to appeal it. The Ohio Department of Job and Family Services (ODJFS) Bureau of State Hearings must receive the state hearing request within 120 days from the date of the appeal resolution decision. However, if the child needs their services to continue at their current level during the appeal, the Bureau of State Hearings must receive the state hearing request within 15 days.

The Bureau of State Hearings will then schedule a hearing before a hearing officer who will listen to evidence regarding why the recommended procedure, item, or service is necessary.

How can I provide support for a state hearing?

The child's parent or other authorized representative (for example, an attorney) may file a state hearing request and invite you to participate in the hearing either by phone or in-person. You could also provide a letter or other documentation for the child to submit into the state hearing record.

Alternatively, if you want to act as the child's authorized representative and request a state hearing, you must affirm that you will adhere to certain state and federal laws concerning conflicts of interest and confidentiality of information, and provide a signed written authorization to the ODJFS Bureau of State Hearings. There is no specific form designated for this purpose, but one option is ODM's Designation of Authorized Representative form: **https://medicaid.ohio.gov/Portals/0/Resources/Publications/Forms/ODM06723fillx.pdf.**

TIP: Provide documentation in support of medical necessity. A strong letter clearly explaining why your recommendation is medically necessary, how it will correct or ameliorate your patient's condition, and why there is no lower cost alternative can be the most important document in the appeal.

Who can I contact if I have questions or concerns about accessing EPSDT benefits?

Each managed care plan has an EPSDT/Healthchek coordinator to ensure compliance with EPSDT law. Contact the plan's member/provider services number and ask to speak with the coordinator.

Buckeye Health Plan	(866) 246-4358	**www.buckeyehealthplan.com**
CareSource	(800) 488-0134	**www.caresource.com**
Molina Healthcare	(800) 642-4168	**www.molinahealthcare.com**
Paramount Advantage	(800) 462-3589	**www.paramounthealthcare.com**
United Healthcare Community Plan	(800) 600-9007	**www.uhcprovider.com**

For concerns regarding a managed care plan's practices, contact the ODM Provider Call Center at (800) 686-1516 or **medicaid.ohio.gov/providers/enrollmentandsupport/providerassistance.aspx.**

For legal assistance, refer your patients to their local Legal Aid program and/or to Disability Rights Ohio. Call 1-866-LAW-OHIO (866-529-6446) or search the Legal Aid directory at **www.ohiolegalhelp.org/find-legal-help** to get contact information for local Legal Aid offices. Disability Rights Ohio can be reached at 800-282-9181 or at **www.disabilityrightsohio.org/intake-form**.

Prepared by Disability Rights Ohio and ABLE's Medical-Legal Partnership for Children.

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ABLE's MLPC is a partnership among Advocates for Basic Legal Equality, Inc. (ABLE), Legal Aid of Western Ohio, Inc. (LAWO), and area healthcare providers to improve the health and wellbeing of children who live in poverty by addressing social determinants of health.

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Disability Rights Ohio is a non-profit corporation with a mission to advocate for the human, civil and legal rights of people with disabilities in Ohio and is Ohio's Protection and Advocacy (P&A) system and Client Assistance Program (CAP).

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