Memorandum

S-2

Date APR 12 1991

From Director
Medicaid Bureau

Subject Clarification of Early and Periodic Screening, Diagnostic, and Treatment of OBRA 1989 Provisions (Your Memorandum Dated July 9, 1990)--INFORMATION

TO
Regional Administrator
Region III, Philadelphia
Attention: Medicaid Division

Your Reference: R3-O-DMD (24)

This is in response to your request for clarification on several issues relating to section 6403 of the Omnibus Budget Reconciliation Act (OBRA) of 1989, regarding the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program.

Your first question asks for a definition of the difference between an interperiodic screening service and visit to the doctor as a result of a complaint. While we agree, in general with your definition of an interperiodic screen, it appears to limit this type of screen to referrals from a health or educational professional. A child may receive a covered interperiodic screen by being *referred* to an EPSDT provider by a health, developmental or educational professional who comes into contact with the child outside the formal health care system, e.g., a school nurse, who detects or suspects health problem. However, the definition of an interperiodic screen also includes self and family-initiated visits to a *provider* of EPSDT services. If a problem arises outside of the regularly scheduled periodic screen, *any* screening service (including dental, vision and hearing screens) which is determined to be medically necessary is available to the participant. Using your example of an earache, a self-initiated visit to a physician would be considered medically necessary to determine if *the* child has physical illness or condition which requires further assessment, diagnosis or treatment and, as such, this can qualify as an interperiodic screen. Any necessary health care required to treat a condition detected as a result of a screen, must be provided.

Additionally, the nature of interperiodic services is discussed in the report of the House Committee on Budget. That Committee in its deliberations of interperiodic screens indicates:

> "The Committee bill also requites States to provide screening services 'at intervals other than those identified in their basic periodicity schedule, when there are indications that it is medically necessary to determine whether a child has a physical or mental illness or condition that may require further assessment, diagnosis, or treatment. These interperiodic screening examinations may occur even in children whose physical, mental or developmental illnesses or conditions have already been diagnosed, if there are indications that the illness or condition may have become more severe or hae changed sufficiently, 80 that further examination is medically necessary." (Emphasis added.)

Both sentences *describing* congressional intent about interperiodic screens discuss the need to provide further services or services for conditions already existing. Clearly, Congress anticipated that children with already existing health problems would have available diagnostic and treatment services appropriate to their needs. To view this legislation otherwise, is contrary to the preventive thrust of the *program* and the concept historically embodied in the EPSDT program to diagnose and treat health problems *early* before they worsen and become more costly.

The second question is whether the state is required to pay *for any* medically necessary diagnostic or treatment service prescribed for a child under age 21 during a regular medical visit. We also agree with your *response* to this answer. If a condition exists at the time of the screen, periodic or interperiodic, any treatment or service which is determined to be medically necessary to treat this condition, must be available to the individual. To the extent that the provider qualifies as a screening provider for the screening services furnished during a "medical visit", all medically necessary diagnostic end treatment services furnished as a result of a medical visit must be provided.

You also indicate that medically needy children are not eligible for drugs in this State. Under section 1905(r)(5) of the Social Security Act (the Act), a State if required to provide "other necessary health care, diagnostic services, treatment and other measures described in section 1905(a) to

correct or ameliorate defects and physical *and* mental illnesse and conditions discovered by the screening services, whether o not such services are coveted under the State plan." Therefore, if the condition was *present* during a screen and the treatment included providing drugs, the drugs would have to be provided to the EPSDT participant, even if not included in the State plan.

Your third question is whether the State must recognize all providers qualified to perform a service or if States may limit their enrolled providers. Section 1905(r) of the Act provides that States may not limit providers of EPSDT services to providers who are qualified to provide all diagnostic, treatment or other services. In addition, State Medicaid Manual section 5123.1(C) indicates that service providers may not be limited to either the public or private sector. States do have the flexibility to *specify* the requirements necessary to become a qualified provider, However, any limits imposed must *be* reasonable and must ensure that proper care is available for all children under age 21 in the EPSDT program. If a provider meets all qualifications and standards established by the State *for* becoming a qualified provider, there is no basis for excluding such providers from participation in the EPSDT program.

Physical therapy is listed in section 1905(a) of the Act as a service provided under Medicaid and, *therefore,* must be provided as medically necessary to treat health problems detected or suspected as a result of the screening services. We agree that a physical therapist would not be a screening provider. You indicate that the State currently limits the availability of physical therapy to enrolled clinics or home health agencies. While States may *not* arbitrarily limit who can be a qualified provider, theyare hat required to include privately practicing physical therapists who do not meet the State's established requirements. OBRA 89 does not require States to change their standards for becoming a qualified provider It may be that there *are* certain requirements or standards imposed by the State on their qualified providers which would make it difficult for privately practicing physical therapists to qualify. For example, a State may require that a physical therapist can only qualify as Medicaid provider if they operate under the direct supervision of a physician. The privately practicing physical therapist may not be able to meet

this requirement and therefore would not be qualified to be a Medicaid provider. However, if the privately practicing physical therapist requests to participate in Medicaid and meets the requirements applicable to all physical therapists, there is no reason for not including them.

The question you raised regarding physical therapists raises a larger question. That is, OBRA 89 significantly enhanced servicer to EPSDT participants by requiring States to provide all servicer listed in 1905(a) of the Act, even those not currently included in the State plan. This creates a situation where States that do *not* currently provide a particular service, such as physical therapy, now must provide this service to EPSDT participants if that service is medically necessary.

States may have to recruit, providers of those services not currently in the plan in order to assure that proper care is available to all EPSDT participants. It may recruit from the public or private sector, as it sees appropriate. The State still retains the flexibility to set its own standards in order to obtain qualified providers *of* these services, e.g., requiring physical therapists to operate under the direct supervision of a physician, as long as any limits it sets are reasonable. The State needs to provide assurances that *only* properly qualified individuals are providing services and that access to these services is sufficient to serve the target population. Therefore, the *end* result could be that providers of physical therapy or other services under EPSDT would be limited to clinics, home, health agencies or other types of providers, if they are the only providers who meet *the* State qualifications.

We recognize that this increase in services, without a corresponding increase in funding, may be economically difficult for some States. However, Congress did not appropriate any funding specifically for the EPSDT program. We believe States should continue to use their available resources to provide whatever services they determine to be medically necessary in the most efficient manner.

If you need further information, please contact Cindy Ruff of my stuff at FTS 646-1292.

Christine Nye

cc:
All Regional Administrators