

Frequently Asked Questions (FAQs)

Q: Who is responsible for submitting a request for review under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)?

A: The physician, pharmacist, or NC Medicaid Home Health or DME provider is responsible for initiating an EPSDT review. These provider types have the required forms and instructions on how to initiate a review of medical necessity. While the CAP case manager is conducting monitoring or care coordination of Community Alternatives Program (CAP) beneficiaries who are under 21 years old, if a need is identified for home health services, durable medical equipment, pharmacy or skilled services, a referral should be made to a provider selected by the CAP beneficiary. The provider is responsible for doing their due diligence to determine if the identified item can be provided or if an EPSDT review is needed. The role as a case manager is to work closely with the provider through the procurement of the item or denial of the request. One of the roles of the CAP case manager is to assist with obtaining supporting documents as requested to support the approval or recommendation of the item being requested.

Q: Does a CAP case management entity complete a request for an EPSDT review?

A: No, the CAP case management entity will not request an EPSDT review. The home and community-based services through the CAP waiver are excluded from EPSDT.

Q: What is the role of the CAP case manager in assuring the CAP beneficiary has the services they need regardless of if it is a waiver or State Plan service?

A: Individuals enrolled in the CAP waivers are eligible to use HCBS to mitigate risks and to avoid institutional placement. Monitoring the CAP beneficiary includes monthly and quarterly contact visits. During those visits, service needs are evaluated to ensure that needs continue to be met. When a new need is identified, the CAP case manager should work with the multidisciplinary team to conduct a justification of need. The collaborative discussion should assist in determining how to create a plan of care that may include State Plan or waiver services to meet the identified need. For items that are on any one of the

State Plan Fee Schedules, those services must be provided through State Plan. The referral for that service must be initiated through State Plan at which time an EPSDT review will be conducted.

Q: What is the process of an EPDST review for Medicaid beneficiaries under age 21?

A: The following is an example of the process: It is determined that a CAP beneficiary needs a walker. The CAP case manager makes a referral to a DME provider for a walker. The DME provider completes the required paperwork as designed by NC Medicaid to determine eligibility for that walker. The paperwork is submitted for processing. The paperwork is reviewed and if the request can't be approved from the supporting information, a second medical necessity review is conducted that is called an EPDST evaluation.

For CAP planning, if the EPDST evaluation concludes the item is not a medically necessity, a request can be made using one of the CAP HCBS to determine reasonable need for the requested service that will divert an institutional placement.

Q: What steps should be taken if a DME provider refuses to submit supporting documentation for an EPSDT evaluation to be conducted?

A: Review the EPDST guidance. DME vendors may refuse to submit a request for a State Plan service or not follow through with submitting additional supporting document for an EPSDT evaluation as requested. The refusal may be for various reasons (some may be valid, and others may not). The CMs need to be familiar with State Plan policy in order to address issues that may arise with vendors. When a request is made for a service, the CM should check in regularly, asking for an update and supporting documentation for the approval or denial of that service. The CM can consult with the physician to determine need and request assistance from the physician to work with the DME provider to obtain the needed item.

