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DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

6325 Security Boulevard
Baltimore, MD 2 1207

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Dear State Medicaid Director:

It has come to our attention that some States may not be fully aware of the flexibility which States may exercise in administering the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services benefit under Medicaid. While the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) mandated that all medically necessary services listed in section 1905(a) of the Social Security Act (the Act) as coverable under Medicaid be provided to EPSDT recipients, OBRA 89 did not take away a State's authority to use medical necessity or utilization controls to manage the State's Medicaid program.

First, States may place tentative limits on EPSDT services, except screening services. For example, in its Medicaid plan, a State may limit physical therapy services to 10 sessions for each Medicaid recipient. However, the State must clarify that additional sessions are available to EPSDT recipients, if they are determined by the State to be medically necessary. The State may require prior authorization for these additional services but the use of prior authorization must not delay the delivery of the needed service nor may it limit the recipient's right to free choice of providers.

Second, a State may exclude any item or service that it determines is not medically necessary, is unsafe or experimental, or is not generally recognized as an accepted method of medical practice or treatment. A State may also exclude any supplies, items or equipment that it determines are not medical in nature. For example, a State may exclude reimbursement for personal computers, including monitors and keyboards, printers and software, used to help the child in social or educational situations. While this equipment may be helpful to the child, we find it difficult to generally classify it as medical equipment. However, a State could determine that under certain circumstances this equipment may be covered under its Medicaid program where it is actually used for a medical purpose. We do not intend to provide a list of items or services which HCFA would consider nonmedical. These determinations must be reasonable, made on a State-by-State, and in the case of some items, on a case-by-case basis.

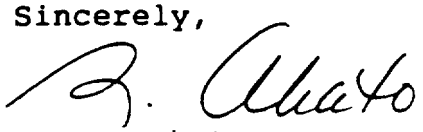
Third, a State may establish procedures to assure that services are furnished in a cost-effective manner. A State may choose to provide medically necessary services in the most economic mode, as long as the treatment made available is similarly efficacious, the determination process does not delay the delivery of the needed service and the determination does not, in essence, limit the recipient's right to a free choice of providers. Section 1902(a)(30)(A) of the Act indicates that a State plan must "provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy and quality of care . . . ."

Among the methods a State may employ "to safeguard against unnecessary utilization of care and services" is a system of prior approval of selected types of costly health care. The goal of prior authorization is to assure that the care and services proposed to be provided are actually needed, that all equally effective, less expensive alternatives have been given consideration and that the proposed service and materials conform to commonly accepted standards. For example, a State would not be required to provide an air-fluidized bed if it determines that a less costly egg-crate mattress will serve the same medical needs.

Fourth, if an agency can demonstrate sufficient access to a service described in section 1905(a) of the Act, the State is not required to furnish the service through every setting or provider type. Therefore, for example, if a State provides sufficient access to physical therapy services as part of outpatient hospital services, FQHC, clinic services, etc., the State need not provide physical therapy services through privately practicing physical therapists.

I hope this information is helpful.

Sincerely,



Rozann Abato
Acting Director
Medicaid Bureau

cc:
All Regional Administrators

All Associate Regional Administrators
Division of Medicaid