Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

Coverage, authorization and billing for EPSDT services

March 2026

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Introduction

In Oregon, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is the Oregon Health Plan (OHP) benefit for:

- Medicaid or CHIP-enrolled OHP members under age 21 and
- OHP members who qualify for Young Adults with Special Health Care Needs (YSHCN) benefits.

Federal guidelines establish the EPSDT benefit. EPSDT provides comprehensive and preventive health care services for Medicaid and CHIP-enrolled children and youth. An EPSDT fact sheet for OHP members is on OHA's EPSDT web page.

EPSDT guidelines require Oregon to cover all EPSDT Medically Necessary and EPSDT Medically Appropriate (and EPSDT Dentally Appropriate) services needed to correct, improve or ameliorate health conditions for all eligible members. This coverage includes physical, dental, vision, hearing, behavioral health and pharmacy services.

As of Jan. 1, 2023, Oregon Health Authority (OHA) must comply with EPSDT requirements for fee-for-service (FFS, also known as "open card") OHP members and coordinated care organizations (CCOs) must comply for CCO-enrolled OHP members.

- **Early:** Assessing and identifying problems early;
- **Periodic:** Checking children's health at periodic, age-appropriate intervals;
- **Screening:** Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems;
- **Diagnostic:** Performing diagnostic tests to follow up when a risk is identified; and
- **Treatment:** Control, correct or ameliorate (make more tolerable) health problems found.

Members who qualify for EPSDT should get screenings according to the required periodicity schedules:

- Bright Futures periodicity schedule and
- OHP Dental Periodicity schedule.

OHP members up to age 21 may also qualify for YSHCN benefits starting:

- Jan. 1, 2025, for ages 19 and 20, and
- Jan. 1, 2026, for age 21.

If members qualify for YSHCN, they are entitled to EPSDT coverage up to their 26th birthday. For more information about YSHCN, please see the YSHCN guidance for OHP providers. For preventive care screenings for YSHCN, OHA recommends providers follow the periodicity schedule from the U.S. Preventive Services Task Force.

Covering EPSDT services increases child and young adult access to the full range of preventive, developmental, dental, behavioral health and specialty services. This holistically supports their growth, development, health and education. Oregon's expansion of EPSDT coverage requires both systems and culture change for OHA, CCOs and providers. All providers should:

- Communicate with patients and families about their rights and access to EPSDT Medically Necessary and EPSDT Medically Appropriate (and EPSDT Dentally Appropriate) services;
- Refer and seek authorization for any needed services; and
- Not assume coverage will be denied, even for services that were denied in the past.

About this guide

This guide:

- Describes EPSDT policy and coverage as required by federal regulation for both OHA and CCOs.
- Describes the specific billing and prior authorization processes that apply to members with FFS (open card) OHP.
- Clarifies that OHA and CCOs must cover all services determined to be medically necessary and medically appropriate (or dentally appropriate, for a dental service) for an OHP member under age 21 or an OHP member with YSHCN benefits.

OHA knows that many providers serve both CCO members and FFS (open card) members. Providers serving CCO members should consult the member's CCO for its procedures for prior authorization, billing and reimbursement.

Provider types

This guidance is for anyone who renders, refers or seeks approval for EPSDT services for OHP members, including but not limited to:

- Physicians including pediatricians, family physicians and internal medicine physicians
- Physician assistants, nurse practitioners and other advanced practice clinicians
- Naturopathic doctors
- Behavioral health clinicians
- Dentists and other oral care providers
- Therapists (physical therapy, occupational therapy, speech-language pathology)
- Chiropractors
- Audiologists
- Optometrists and Ophthalmologists
- Pharmacists
- Specialists and other clinicians and teams who serve children and youth
- Office staff who prepare and submit bills and documentation

For providers serving open card(fee-for-service) members:

To help OHA promptly process prior authorization requests, please ensure OHA has current contact information for those who can provide documentation of medical necessity and medical appropriateness. To do this, you can:

- Contact Provider Enrollment at 1-800-336-6016, Option #6 or provider.enrollment@odhsoha.oregon.gov.
- Include accurate, direct contact information within each prior authorization request.

Requirements for OHA and CCOs

OHA and CCOs must:

- Comply with EPSDT coverage requirements for those who qualify, including OHP members with YSHCN benefits.
- Deny services for EPSDT-eligible OHP members only when:
  - An individual review indicates the service is not EPSDT Medically Necessary or EPSDT Medically (or EPSDT Dentally Appropriate) for the member, or
  - The claim or prior authorization request cannot be approved for technical reasons such as data entry errors or member ineligibility.
- Abide by a definition of medical necessity and medical appropriateness that is not more restrictive than the definitions of EPSDT Medical Necessity and EPSDT Medical Appropriateness (or EPSDT Dental Appropriateness) listed in OAR 410-151-0001.
- Not set hard limits or caps on the amount of services or number of visits for members eligible for EPSDT. These are determined based on the needs of the individual member and may be subject to prior authorization.
- Follow the Bright Futures periodicity schedule and the OHP Dental Periodicity Schedule. These periodicity schedules set the frequency by which certain screening services should be provided and will be covered. They are based on current standards of pediatric medical and dental practice.
- Require blood lead testing for OHP-enrolled children at age 12 months and 24 months, per Oregon Administrative Rule (OAR) 410-151-0040. Any child between ages 24 and 72 months with no record of a blood lead test must receive one. Completion of the Lead Screening Questionnaire does not meet the blood lead testing requirement for children under Medicaid.
- Comply with the Mental Health Parity and Addiction Equity Act in the application of utilization management for behavioral health services.

For denials of any EPSDT prior authorization request or claim, OHA and CCOs must:

- Make prior authorization and post-service review decisions based on case-by-case review of EPSDT Medical Necessity and EPSDT Medical Appropriateness (or EPSDT Dental Appropriateness, in the case of a dental service).
- Provide a written Notice of Action on prior authorization requests only (for open card members).
- Provide a written Notice of Adverse Benefit Determination for prior authorization requests *and* claims for reimbursement (for CCO-enrolled members).

Written notices must:

- Comply with federal requirements as well as those outlined in OAR 410-141-3885 and OAR 410-120-1865.
- Contain:
  - A statement of the intended action;
  - The specific reasons and legal support for the action;
  - An explanation of the individual's appeal and/or hearing rights; and
  - The member's rights to representation.

CCOs and OHA may differ in:

- Prior authorization procedures
- Billing procedures

Background

OHP has historically covered most EPSDT services. However, prior 1115 Medicaid waivers allowed the state to "restrict coverage of treatment services identified during an EPSDT screening for individuals above age 1 to the extent that such services are not consistent with a prioritized list of conditions and treatments" (the Prioritized List of Health Services).

OHA received clear feedback the Prioritized List prevented children from receiving some medically necessary and medically or dentally appropriate services. As of Jan. 1, 2023, Oregon meets all EPSDT benefit requirements for children and adolescents. The Prioritized List no longer limits EPSDT coverage as prior waivers allowed.

This change requires significant systems and culture changes at OHA, in each CCO, among providers and for everyone who accesses OHP for children and youth. It also requires ongoing work to identify and address areas for improvement. To improve communication and collaboration throughout the process, we encourage providers to ensure they have updated their contact information with OHA and to reach out to the EPSDT team at EPSDT.Info@odhsoha.oregon.gov with any questions.

In 2025: Oregon's 1115 Medicaid Waiver granted the state authority to implement the Young Adults with Special Health Care Needs (YSHCN) program for qualifying OHP members ages 19 and 20. Effective Jan. 1, 2025, OHP members with YSHCN benefits also receive ESPDT coverage (OHA will re-assess YSHCN eligibility every two years). Beginning in 2026, qualifying OHP members age 21 may also enroll in YSHCN. See the YSHCN guidance for OHP providers for more information.

OHA intends for this guide to help providers understand and implement these changes to help OHP-covered children, youth, young adults and families access the broad range of health care services available to them under this benefit.

Additional resources

More information can be found at OHA's EPSDT web page (includes recorded webinars for providers) and these resources:

- EPSDT fact sheet for OHP members
- EPSDT FAQ
- EPSDT guidance for CCOs
- EPSDT Oregon Administrative Rules
- Medicaid.gov
- EPSDT – A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents
- Health Resources & Service Administration - Maternal & Child Health Bureau
- Bright Futures periodicity schedule
    - Learn About Coding for Pediatric Preventive Care

- OHP Dental Periodicity Schedule
- U.S. Preventive Services Task Force.

Questions, comments and concerns

For questions or comments regarding this guidance document, EPSDT coverage for OHP members under age 21, please contact EPSDT.Info@odhsoha.oregon.gov. For EPSDT coverage for OHP members with YSHCN benefits, please contact YSHCN.info@oha.oregon.gov.

OHA will update this guidance as new information, program improvements, and/or quality improvement needs are identified.

If you have concerns with patient access to services, please reach out to one of the following contacts:

- For FFS/open card inquiries, contact OHP Client Services at 1-800-273-0557 or Ask.OHP@oha.oregon.gov.
- For CCO members, find the CCO's contact information at OHP.Oregon.gov/CCO-Contacts.
- If members still need help after contacting OHA or the CCO, contact the OHA Ombuds Program at OHA.OmbudsOffice@odhsoha.oregon.gov or 1-877-642-0450 (message line only).

Covered services under EPSDT

OHP covers any medically necessary and medically appropriate health care service for all members with EPSDT benefits.

This includes any screenings, checkups, tests, treatments, medical equipment, pharmacy services and follow-up care for:

- Physical health (including vision and hearing);
- Oral/dental health; and
- Behavioral health.

To be covered, in addition to being EPSDT Medically Necessary and EPSDT Medically Appropriate (or EPSDT Dentally Appropriate; all defined in OAR 410-151-0001) for the individual member, services must:

- Have an appropriate diagnosis (ICD-10) and procedure code (CPT, CDT or HCPCS).
- Be coverable under OHP. For example, purely cosmetic procedures are excluded from OHP coverage.

Medicaid must be a good steward of state and federal resources. For OHA (open card) or a CCO to cover any service, supply or item, providers must document that it is the most cost-effective option that will meet the member's needs.

The Prioritized List and EPSDT

OHP must cover EPSDT Medically Necessary and EPSDT Medically Appropriate (or EPSDT Dentally Appropriate) services for all members with EPSDT benefits, **regardless of placement on the Prioritized List.**

This means OHA, CCOs and providers:

- Cannot deny, or refuse to render or refer for, a service only because it is "below the line" or "does not pair."
- May continue to use relevant coverage guidance or guideline notes to inform their determination of medical necessity and medical/dental appropriateness for the individual member.
- Cannot use the Prioritized List, coverage guidance or guideline notes to determine coverage broadly or for an entire age group or population under EPSDT.
- Should also refer to Statement of Intent 4 on the Prioritized List when making determinations of medical necessity and medical appropriateness.

OHP still does not generally cover services below the funding line on the Prioritized List for adults aged 21 and over, except for OHP members with YSHCN benefits. The Health Evidence Review Commission (HERC) continues to review clinical evidence and make updates to the Prioritized List.

CMS requires states to follow a periodicity schedule for children's services. Oregon uses the Bright Futures periodicity schedule and the OHP Dental Periodicity Schedule. However, EPSDT-eligible members may get care outside this schedule for any changes in health.

Examples of services that OHP may cover for EPSDT beneficiaries

These include but are not limited to:

- Treatment of acne in some cases that affect child growth, development and participation in school.
- Treatment of some tendon and ligament injuries.
- Treatment of eating disorders.
- Allergy testing and shots related to nasal allergies affecting growth, development and participation in school.
- Orthodontic treatment for handicapping malocclusion, according to OHA's coverage criteria.
- Ancillary services that were previously not covered, such as durable medical equipment, when determined to be EPSDT Medically Necessary and EPSDT Medically Appropriate.

Determining coverage

Clinical documentation must clearly demonstrate a service is EPSDT Medically Necessary and EPSDT Medically Appropriate (or EPSDT Dentally Appropriate, in the case of a dental service) for the circumstances of the individual child or youth. EPSDT Medically Necessary, EPSDT Medically Appropriate and EPSDT Dentally Appropriate are defined in OAR 410-151-0001. It is important that providers:

- Do not refuse to render or refer for care based on Prioritized List placement.
- Know that services below the funding line require individual review for EPSDT Medical Necessity and Medical Appropriateness, even if OHP historically did not cover the services.
- Request prior authorization from OHA for services that require them.

- Know how to request a pre-service review to determine coverage before providing a service, even if prior authorization is not required.
- Submit documentation for post-service review.
- Document EPSDT Medical Necessity and EPSDT Medical Appropriateness (or EPDST Dental Appropriateness) of a service.

For CCO-enrolled members, consult the specific CCO for its procedures for billing, authorization and reimbursement.

Fee-for-service pharmaceutical reviews follow EPSDT requirements for individual review of EPSDT Medical Necessity and EPSDT Medical Appropriateness. See the Prior Authorization and Billing sections of this guide to learn more.

Related rules and laws

The following rules and regulations govern EPSDT:

- OAR Chapter 410, division 151
- Code of Federal Regulations 42 CFR § 441 Subpart B – Early and Periodic Screening, Diagnostic and Treatment (EPSDT) of Individuals Under Age 21
- EPSDT Medically Necessary, EPSDT Medically Appropriate and EPSDT Dentally Appropriate are defined in Oregon Administrative Rule 410-151-0001.

Prior authorization

Under EPSDT, OHA and CCOs may continue to use prior authorization as a utilization management tool as outlined in the EPSDT CCO Guidance Document. However, EPSDT screening services may not be subject to prior authorization requirements.

The following section describes prior authorization processes for FFS (open card) members. For CCO members, consult the specific CCO for its procedures for medical review and authorization.

Physical, behavioral and dental health care

Providers can use this process to:

- Seek approval for services that require prior authorization.

- Seek a pre-service review, even if the service does not require prior authorization.

OHA clinical staff with subject matter expertise review requests for EPSDT Medical Necessity and Appropriateness. Upon review of all submitted documentation, OHA will approve or deny the request. For sample provider notices, please see the Prior Authorization Handbook.

For prior authorizations related to Children's Psychiatric Residential Treatment Facilities (PRTF), email Comagine Health at ORURFFS@comagine.org. The PRTF processes are under review. OHA will update this guide accordingly and accepts questions about PRTF processes at Medicaid.Programs@odhsoha.oregon.gov.

How to submit prior authorization requests

You can submit requests in two ways.

- The MMIS Provider Portal at **https://www.or-medicaid.gov**. This is the preferred, most efficient and most effective submission pathway. If you need help using the Provider Portal, please call 1-800-336-6016, Option #5.

or

- Fax the ODHS/OHA Prior Authorization Request Form (MSC 3971) under a completed EDMS Coversheet (MSC 3970, and included in the online MSC 3971 form) to OHA. The coversheet lists two fax numbers. Select the appropriate number depending on the urgency of the request. Please note the coversheet must be the first page of your fax for successful processing.

For all requests, submit clinical documentation to OHA as listed below.

Document	Required information/criteria
EDMS Coversheet (MSC 3970)	• Submit the PA request with the EDMS Coversheet
Completed PA request (MSC 3971 or the Provider Portal PA request)	• The requesting provider's NPI • PA assignment code • Member's Oregon Medicaid ID number

Document	Required information/criteria
	• Primary diagnosis code • Secondary diagnosis code(s), as appropriate • CPT or HCPCS code(s) requested • Number of units requested • The performing provider's NPI • Date of request • Expected service start and end dates
Supporting medical documentation	• For example, diagnostic testing reports, chart notes, and other objective data. • Demonstrate "least costly alternative" to meet EPSDT Medical Necessity and EPSDT Appropriateness by including documentation of alternatives considered or trialed and why alternatives are not appropriate.
Signed letter of medical necessity from the treating practitioner	• Required when requesting EPDST Medically Necessary and EPSDT Medically Appropriate services that fall outside of current rules and guideline notes (requesting "approval by exception"). Include: • Why the service is EPSDT Medically Necessary and EPSDT Medically Appropriate for this individual, defined in OAR chapter 410, division 151. • Why the service or item is the least costly effective option that meets the member's needs. • For treatment of comorbid conditions, how the service meets the criteria described in OAR 410-141-3820.

Document	Required information/criteria
	• Why the requested codes are clinically appropriate and there are no other paired codes that apply to the patient's situation, as required by OAR 410-141-3820.

After review of the request, OHA may ask for additional documentation to determine if the service is EPDT Medically Necessary and EPSDT Medically Appropriate (or EPSDT Dentally Appropriate) according to OAR 410-151.

If the request has missing or inadequate documentation:

Please provide complete documentation within 30 days of OHA's response. If OHA does not receive documentation within 30 days, OHA will deny the request due to missing information. The opportunity to resubmit remains available.

If the request is complete, accurate and timely:

If the documentation demonstrates services are EPSDT Medically Necessary and EPSDT Medically Appropriate (or EPSDT Dentally Appropriate) and the service meets coverage criteria, OHA will provide notification of approval as soon as possible.

Please ensure updated contact information for those who can provide the relevant documentation. To do this:

- Contact Provider Enrollment at 1-800-336-6016, Option #6 or provider.enrollment@odhsoha.oregon.gov.
- Include accurate, email address and direct contact information within each prior authorization request.

Pharmacy services

Submit information supporting EPSDT Medical Necessity and EPSDT Medical Appropriateness (or EPSDT Dental Appropriateness). This may include documentation that the member meets the following criteria:

- Drug-specific criteria outlined in the Oregon Medicaid Pharmaceutical Services Prior Authorization Criteria. For more information, see the Pharmaceutical Services web page.
- FDA-approved or compendia-supported indication.
- Trial and failure, contraindication, or intolerance to at least two preferred products (when available in the Preferred Drug List class).
- Documentation that the condition/symptoms are of sufficient severity that it impacts the patient's health. For example, quality of life, function, growth, development, ability to take part in school, perform activities of daily living.

Providers can call the Oregon Pharmacy Call Center at 888-202-2126 with questions about FFS prescription coverage.

For physical health prescriptions for CCO members, contact the CCO for its prior authorization procedures.

Billing OHA

This section describes how to submit and resolve FFS/open card claims billed to OHA. For claims billed to CCOs, please contact the CCO or refer to the CCO's claim submission and resolution processes.

For claims for School-Based Health Services (SBHS), please refer to the SBHS Provider Resources page.

Eligibility and enrollment

Please verify OHP eligibility and enrollment prior to rendering service or billing. OHP eligibility is required for payment. Prior authorization is not a guarantee of current OHP eligibility. Go to the OHP Eligibility Verification page to learn more.

For information on how to determine whether a member has YSHCN benefits, please see the YSHCN guidance for OHP providers.

Billing and coding

Refer to Current Procedural Terminology (CPT), Current Dental Terminology (CDT) or Healthcare Common Procedure Coding System (HCPCS) code descriptions and standards for more information.

For billing and coding of EPSDT Medically Necessary and EPSDT Medically Appropriate preventive care, please see the American Academy of Pediatrics/Bright Futures guidance: Learning About Coding for Pediatric Preventive Care.

Submitting claims

Providers should submit FFS/open card claims according to the OHP Professional Billing Instructions (for professional claims) and the OHP Institutional Billing Instructions (for institutional claims).

The Medicaid Management Information System (MMIS) now suspends open card claims for manual review if they are for services:

- Provided to OHP members under age 21 or OHP members with YSHCN benefits,
- Do not require a prior authorization, and
- Are below the line, non-pairing or otherwise not historically covered.

Resolving suspended claims

The MMIS Provider Portal at https://www.or-medicaid.gov offers a way to search for suspended open card claims. You will need the “Claim Inquiry” role in the Provider Portal to search for claims.

- **To get Provider Portal access,** please contact Provider Services at 1-800-336-6016, Option #5 or team.provider-access@odhsoha.oregon.gov
- **For help identifying suspended claims or questions about the process so submit documentation with a claim,** please contact Provider Services at 1-800-336-6016, Option #5 or DMAP.providerservices@odhsoha.oregon.gov.

To resolve suspended FFS/open card claims, OHA must receive documentation that demonstrates EPSDT medical necessity and medical appropriateness of the billed service(s).

- If sufficient documentation is not submitted with the claim, OHA will not process the claim for 10 calendar days. This gives providers time to submit the required documentation.
- If documentation is not submitted within 10 days, OHA will deny the claim.
    - In this case, the option is available to resubmit the claim with the required documentation for OHA review. The claim must be resubmitted within 180 days from the date of service to be eligible for reimbursement.

For each suspended claim:

- Fax documentation under a **completed EDMS Coversheet** (MSC 3970), including the Internal Control Number (ICN) of the suspended claim.
    - Check the box on the coversheet that says “Claim Documentation”
    - Send to the fax number listed beside the “Claim Documentation” box.
- See sample documentation of medical necessity/appropriateness in the Documentation section of this guide.

If you have billing questions or concerns:

Please review this guide, notices received from OHA, and the OHP Billing Tips page. For outstanding questions or concerns, call Provider Services at 1-800-336-6016.

Documentation

General requirements

Documentation should be original documentation by the provider delivering care. It should:

- Explain why the service is EPSDT Medically Necessary and EPSDT Medically Appropriate (or EPSDT Dentally Appropriate) for the individual’s health and development.
- Demonstrate that the requested code(s) have been thoroughly evaluated and there are no other paired codes that apply to the patient's situation, as required by OAR 410-141-3820.

Documentation for EPSDT Medical Necessity and Appropriateness should include the following elements:

- Individual's diagnosis or condition.
- Treatment, service or item being requested.
- Why the service or item is medically necessary and medically appropriate for this individual.
- Why the service or item is the least costly effective option that meets medical necessity and appropriateness by including documentation of alternatives considered or trialed and why the alternatives are not appropriate.
- For treatment of comorbid conditions, how the service meets the criteria described in OAR 410-141-3820.
- Demonstrates the requested codes have been completely evaluated and there are no other paired codes that apply to the patient's situation, as required by OAR 410-141-3820.
- For School-Based Health Services (SBHS), schools can use a provider's Written Recommendation which is the equivalent to a Letter of Medical Necessity. For more information, please visit the SBHS Provider Resources page.

OHA and CCOs have the authority to determine how they will consider coverage of ongoing services beyond age 20 (or beyond age 25, for OHP members with YSHCN benefits).

Sample documentation

Below is a sample of a medical necessity and medical appropriateness letter for a child's adaptive car seat. It demonstrates the appropriateness of each requested service for the child's medical and developmental needs that will minimize the need for additional follow up.

<Provider address>
<Date>

We conducted an adaptive needs transportation evaluation for Mary Member on June 13, 2022. Mary is 11 years old. She has hypotonic cerebral palsy (G80.8) and global developmental delay (F88). Currently, Mary rides in a Current Brand combination car seat in her family's vehicle. The Current Brand is rated to 65 pounds and 52 inches tall. At 58 pounds and 48 inches, Mary is nearing the seat's maximum height and weight restrictions. At her current height and weight, Mary has nearly outgrown every conventional car seat in the U.S. market. There are no conventional seats that meet her needs and allow for growth.

We tried several adaptive car seats (brands/models A, B and C) with Mary. We found that the XYZ adaptive car safety seat produced by Acme Manufacturing Company best meets Mary's needs and will do so for many years. The XYZ car seat:

- Can be customized to best support Mary's positioning needs as she grows.
- Is the most cost-effective. The base price with necessary accessories is $1325.00. A comparable seat with the same accessories is $2001.50.
- Has a height limit of 62 inches, weight limit of 115 pounds, and lasts 7 years.

To best meet Mary's needs and safety, we request the following:

1. XYZ Standard pediatric positioning support device: 1000XYZ-S (HCPCS E1399)
2. 3-inch seat depth extension (to accommodate growth and best support Mary's legs, hips and back): 100XYZ-SE3 (HCPCS E1399)
3. Quick-change incontinence cover: The quick-change cover will allow for easy cleaning without uninstalling the car seat. 100XYZ-QCC (HCPCS E1399)
4. Spanish instructions

We request that Acme Manufacturing ship the car seat, accessories and instructions to our location at 123 Main Street, Anytown OR. This way we can help the family assemble the car seat and provide hands-on education on installation and harnessing.

Thank you for your time and consideration to fund this equipment for Mary.

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact OHP Provider Services at dmap.providerservices@odhsoha.oregon.gov or 800-336-6016. We accept all relay calls.

Medicaid Division
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OREGON HEALTH AUTHORITY