

EPSDT AND MEDICAL NECESSITY

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) provisions of federal Medicaid law have become a focus of litigation and dispute in recent years. While the law is always in flux, this outline is meant to provide some guidance on Florida's best assessment as to the current state of the law, and does not necessarily imply that Florida either agrees or disagrees with the rationales and various court decisions described below.

Summary

As this outline makes clear, the EPSDT benefit is extremely broad. States must provide all potential Medicaid services to children, even services that they do not make available to adults. States also cannot place amount, duration, and scope limitations on Medicaid services for children, and can only deny these services to children if they are not medically necessary. The state of Florida defines the term "medically necessary," and all providers must adhere to Florida's definition.

Florida's medical necessity definition limits services to those that will provide a significant benefit to a patient; excludes experimental and cosmetic procedures; limits services to those that are individualized and specific to the person and condition being treated; excludes excessive services; and excludes any service whenever a less costly, equally effective alternative service exists.

Outline

- I. **The Medicaid Program and Medicaid Services.** Medicaid is a joint venture of the federal and state governments to provide medical assistance to the needy. As part of the joint venture, each state creates a plan to provide this medical assistance and submits it to the federal government. If the federal government approves of the plan, it bears a portion of the cost of implementing and maintaining it. The federal Medicaid law provides each state with flexibility to craft and tailor a health care plan that best suits the needs of its citizens. States generally have three major ways to tailor the services available through their Medicaid programs:
 - A. **Choosing Optional Services.** Federal law, within certain parameters, gives each state authority to pick the services that it will make available through its Medicaid program. Federal law lists 28 health care services that states can pay for through Medicaid. 42 U.S.C. § 1396d(a)(1) – (28). Some of these services are mandatory, meaning

EPSDT AND MEDICAL NECESSITY

that a state has to provide them to all of its Medicaid recipients, and some are optional, meaning that a state can choose to provide them or not to provide them.

1. **Mandatory Services.** Some of the 28 listed services are mandatory, and all states must provide for them for adults on Medicaid. These include inpatient hospital services, outpatient hospital services, physician visits, lab & x-ray services, nursing home services, early and periodic screening, diagnosis, and treatment services for children, and family planning services. See 42 U.S.C. § 1396a(a)(10)(A) (requiring states to provide the services listed at § 1396d(a)(1) – (5), (17) and (21)).
2. **Optional Services.** Most of the 28 listed services are optional. States can choose to include these in their Medicaid programs, or can leave them out. Some major examples of optional services include prescription drugs, hospice, dental services, vision/optometry services, hearing services, chiropractic services, and podiatric services. Once a state decides to provide an optional service, it must provide the service throughout the state in equal amount, duration, and scope to all recipients.

- B. **Amount, Duration, and Scope Limitations.** The states can also place limits on the amount, duration, and scope of a service provided under its Medicaid program. There is only one federal caveat to this authority: the limitation cannot be so strict as to undermine the effectiveness of the service. The limitation will survive judicial review as long as it is sufficient to meet the needs of the vast majority of the state's Medicaid population.

Florida, for example, generally limits inpatient hospital services to 45 days per year. An individual may need more time in the hospital, but as a general rule on the 46th day we (and the federal government) stop paying. This is legal because the vast majority of Florida Medicaid recipients will not need more than 45 days in the hospital per year. Courts have upheld a Florida rule (no longer in use) that limited physician visits to three per month, and Florida's current Medicaid program contains a significant number of amount, duration, and scope limitations. Curtis v. Taylor, 625 F.2d 645 (5th Cir. 1980).

EPSDT AND MEDICAL NECESSITY

C. **Medical Necessity.** Each state can limit Medicaid services, if it chooses, to those that meet a state-created definition of medical necessity. Florida has a “medical necessity” requirement, and has defined this term in the Florida Administrative Code at 59G-1.010(166). Once a state has defined “medical necessity,” the courts can review the definition to ensure that it is reasonable.

II. **The EPSDT Program.** Initially, federal law did not treat children differently than adults when it came to the Medicaid service package. Many states, however, chose to provide limited service packages. As a result, when a Medicaid child was diagnosed with a disabling or life-threatening condition, the health care the child received varied from state to state. In states with expansive service packages, the Medicaid program could often meet the child’s ongoing health care needs. In states with limited packages, the child in some cases could not receive adequate health care via the available service package.

A. **The 1989 Amendment.** To eliminate this disparity, and to ensure that children had access to the most complete service package possible through the Medicaid state plan, Congress adopted 42 U.S.C. § 1396d(r)(5). Passed in 1989, § 1396d(r)(5) requires states to cover: “Such other necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) [§ 1396d(a)] to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.”

B. **Limits on the States’ Ability to Tailor their Service Packages for Children.** In essence, the 1989 amendment requires states to provide for all 28 listed Medicaid services to children, regardless of whether it provides for any or all of these services for adults. What has remained unclear, however, is whether the states have retained the ability to set amount, duration, and scope limitations on services to children, and whether the states have retained the ability to limit services based on a reasonable, state-created definition of medical necessity. Florida’s current understanding: states cannot place amount duration and scope limitations on EPSDT services, but can limit EPSDT services to those that meet a reasonable, state-created definition of medical necessity. **As a result, the ONLY reason that a state can deny a Medicaid-covered service to a child is because**

EPSDT AND MEDICAL NECESSITY

the service is not medically necessary, as that term is defined by the state.

1. **Amount, Duration, and Scope limitations.** According to the 11th Circuit Court of Appeals, states must provide all medically necessary services to children under 21, with the implication being that states can no longer use amount, duration, and scope limitations. Pittman v. HRS, 998 F.2d 887, 889 (11th Cir. 1993). This opinion remains binding law in Florida, Alabama, and Georgia, even though federal guidance from the U.S. Department of Health and Human Services actually contradicts this conclusion. CMS State Medicaid Manual §5110.

Florida has argued this point in two recent cases to no avail. In the first case, Moore v. Medows, 324 Fed. Appx. 773 (11th Cir. 2009), the 11th Circuit ignored Florida's argument on this point and reiterated the holding from Pittman that Florida must pay for all medically necessary services for children. In the second case, which was in the U.S. District Court for the Southern District of Florida, the court rejected Florida's assertion that it could define the amount, duration, and scope of "medical supplies" (a covered Medicaid service) to exclude incontinence supplies. Smith v. Benson, 703 F.Supp.2d 1262 (S.D. Fla. 2010).

2. **Medical Necessity.** Florida believes that it retains the power to create a reasonable definition of medical necessity, even after the 1989 amendments to the EPSDT benefit. Florida has a number of reasons for this belief.
 - a. First, the EPSDT language in § 1396d(r) repeatedly uses the terms "medically necessary" and "necessary," and requires all EPSDT services to meet this standard. While the statute itself does not state who or what gets to define "medical necessity," the federal government has issued guidance stating that the states get to decide what "medical necessity" and "necessity" mean. CMS State Medicaid Manual at § 5110, § 5122.

EPSDT AND MEDICAL NECESSITY

- b. Courts around the country have upheld state decisions to deny services to children because the services did not meet the state's reasonable definition of medical necessity.
- c. Moore v. Medows. While the 11th Circuit ignored Florida's argument on amount, duration, and scope limitations in this case, it acknowledged the states' ability to define and limit services based on medical necessity.
- d. Lorenzo v. AHCA. In this case, the parents sought hyperbaric oxygen treatments for their son, who had suffered significant brain damage as a result of a near-drowning incident. Hyperbaric oxygen treatments have not been proven effective for treating victims of near-drowning. The Agency denied the service based upon its definition of medical necessity, which excludes unproven or experimental services. The court upheld the denial. Lorenzo v. AHCA, 985 So.2d 703 (Fla. 4th DCA 2008).

Ultimately, to be covered as an EPSDT service, a service must meet three criteria. First, it must be "necessary." Second, it must be one of the services listed in section 1905(a), which is also known as 42 U.S.C. § 1396d(a). Third, the service must correct or ameliorate a condition discovered by a screening service.

- C. **The Service Must Be "Necessary."** As stated before, the state develops a reasonable definition of medical necessity, and practitioners must hew to this definition in prescribing and providing health care services. Courts, in turn, will occasionally review the definition for reasonableness.
- D. **The Service Must Be Listed in 1905(a), also known as § 1396d(a).** This may seem like a simple requirement, but as with everything related to Medicaid, it can get quite complicated. In particular, the Agency sees more and more attempts to use the EPSDT benefit to obtain services that are traditionally offered under waiver programs governed by another section of the Social Security Act, §1915(c). For example, the Agency sees attempts to obtain excessive amounts of covered services, in order to use the excess covered service for non-

EPSDT AND MEDICAL NECESSITY

covered purposes. One classic example of this would be to obtain 16 hours a day of personal care assistance (covered service number (24)), with the actual intent to use the assistant for ten hours a day of chore work, homemaking, generalized supervision, respite, and companionship (covered services under 1915(c)).

This issue is further complicated by listed service (13), at § 1396d(a)(13), which appears to be somewhat of a catch-all.

C. The Service Must Correct or Ameliorate a Condition Discovered by a Screening.

To the Agency's knowledge, this requirement has never been interpreted by any federal court, state court, or by the federal government through administrative guidance. Some words of warning, however: the Agency does not currently believe that this provision ties EPSDT services to a regularly scheduled screening, such as a screening performed due to a periodicity schedule.

1. While the EPSDT provisions of federal law do contemplate health screenings conducted on a periodicity schedule, the plain language of the statute also contemplates additional "screenings" performed as "medically necessary." 42 U.S.C. § 1396d(r)(1) –(5). This suggests that whenever a child presents with symptoms of an illness or injury, the investigation into and eventual treatment of the child's condition will be covered under the EPSDT benefit.
2. The language appears to be, at a minimum, akin to an "individualized" course of treatment requirement. Under federal law, the term "correct or ameliorate" is very broad, and simply means "to make more tolerable." If states had to pay for every item or service that made a condition "more tolerable," regardless of whether it was directly tied to correcting or ameliorating the child's actual condition, the EPSDT benefit would be perhaps broader than Congress intended. Florida is unsure whether a federal court would interpret this provision as meaning anything other than this.

III. Medical Necessity in Florida, Prong By Prong. The following discussion is not meant to be exhaustive, but will give some insight into how the

EPSDT AND MEDICAL NECESSITY

Agency views its definition. Florida defines medical necessity at § 59G-1.010(166) of the Florida Administrative Code. The definition states:

(166) “Medically necessary” or “medical necessity” means that the medical or allied care, goods, or services furnished or ordered must:

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

(b) “Medically necessary” or “medical necessity” for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

A. **Prong 1: “necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.”**

EPSDT AND MEDICAL NECESSITY

1. **Significance.** One key point of this first prong is to ensure that the taxpayers only pay for health care that achieves significant results or benefits, and that tax dollars are not wasted on services that achieve the insignificant.
 2. **Maintenance.** This prong does not require a service to actually improve a patient's condition. A service, such as occupational therapy, that maintains a patient in their current state and thereby prevents significant deterioration in the patient's condition will meet this prong of the definition. The key, as always, is that the service prevents *significant* deterioration.
- B. Prong 2: "individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs."**
1. **Illness or Injury.** The Agency interprets the phrase "illness or injury" broadly to include developmental disabilities and birth defects. Providers should not deny a treatment because these conditions allegedly do not amount to "illnesses" or "injuries." This prong generally excludes cosmetic treatments.
 2. **Excessive.** One key point of this first prong is to preclude a one-size-fits-all approach to services that results in some patients receiving services in excess of their needs.
- C. Prong 3: "consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational."**
1. **Proven Treatments.** This prong limits services to those that are proven to work. This type of limitation has been the source of a significant amount of litigation over the years, and courts around the country have almost universally upheld it.
 2. **Experimental Treatments.** While states can exclude these treatments, the line between a treatment that is experimental and one that is proven is not always a bright one. Florida's federal courts have developed a five part test to determine if a

EPSDT AND MEDICAL NECESSITY

proposed treatment is proven or experimental. The five areas of inquiry are:

- a. The patient mortality rate as a result of the service.
- b. How often the procedure has been performed, where it has been performed, and the success or failure of the procedure.
- c. The reputation of the medical centers and doctors who are performing the new procedure, and their record in related areas.
- d. The long term prognosis of the patients who have had the procedure performed on them and the lessons that can be derived from related procedures. And
- e. To what extent medical science in that and related areas has developed rapidly.

D. **Prong 4: “reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available.”**

1. **Less Costly, Equally Effective.** This prong generally precludes expensive items and services, when less expensive items and services exist that accomplish the same thing. An example would be a brand-name prescription drug, when a generic exists that is equally effective. Another example would be angioplasty versus open heart surgery. The goal is to achieve the same result while saving the taxpayers money.
2. **Speech Therapy Example.** Plans should keep in mind that Medicaid recipients have a federal entitlement to medically necessary services available under the plan, and plans’ contracts require them to provide for this service. Attempts to deny speech therapy via Medicaid because this therapy is allegedly available from the school system are problematic. First, schools often only provide therapy in group settings, as opposed to the one-on-one service available through Medicaid.

EPSDT AND MEDICAL NECESSITY

Schools may also provide significantly less hours of therapy than Medicaid. Thus, there are serious questions about whether the school system's services are "equally effective." Second, the taxpayers also pay for the school therapy services, often at higher rates than the Medicaid program, calling the "less costly" goal into serious question. Although this analysis is not exhaustive, the Agency generally considers this type of denial to be an inappropriate use of its medical necessity definition.

- E. **Prong 5: "furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider."** This prong comes into play when a recipient attempts to obtain excessive services, often with the intent of using a Medicaid covered service as a waiver service. One example would be a request for excessive hours of personal care assistance (a Medicaid covered service), with the intent to use the excess hours for generalized companionship, supervision, chore work, and homemaking (covered services under certain waivers).

IV. **Takeaways.**

- A. **The EPSDT Benefit is Extremely Broad.** All services available under Medicaid state plan are provided. Amount, duration and scope limitations on covered services in Agency handbooks do not apply to children under 21. The benefit is not tied as closely to the periodicity schedule as one might presume. Generally speaking, the only reason a plan can deny a covered service to a recipient under 21 is because the service does not meet Florida's definition of medical necessity.
- B. **Medical Necessity.** Plans should only use Florida's definition of medical necessity. Plans should pay for any service that is proven to work and that achieves a significant benefit for a child, regardless of whether the benefit is improvement or maintenance of the child's condition. Developmental disabilities and birth defects qualify as illnesses. The key is to ensure that the child receives services that are tailored to his or her needs, and not excessive or reliant on costly measures when less costly measures are available and equally effective.