471-000-38 Form EPSDT-5, "Plan of Care", and Completion Instructions

Use: Form EPSDT-5, "Plan of Care" is used to establish medical necessity for diagnostic and/or treatment services not specifically covered by the Nebraska Medical Assistance Program (Medicaid) but which may be covered under the HEALTH CHECK (EPSDT) program for clients age 20 and younger. Coverage criteria is listed on the back of the form.

Completion: The HEALTH CHECK screening practitioner completes the following items identified and documented during the HEALTH CHECK. In addition, if applicable, the practitioner attaches any additional relevant information (including office records) that supports medical necessity and describes the diagnostic and/or treatment services being requested. PLEASE TYPE.

Note: The proposed provider of the diagnostic and/or treatment services must be a Medicaid-enrolled provider.

The bottom portion of the form is completed by Department of Health and Human Services Finance and Support, Medicaid Division staff.

Distribution: Providers mail the completed form and attachments to: EPSDT Coordinator, P. O. Box 95026, Lincoln, NE 68509.

Note: Please submit a copy of the approved form when submitting claims related to the diagnostic and/or treatment services.

Medicaid Program

HEALTH CHECK PLAN OF CARE

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

PURPOSE: To establish medical necessity for diagnostic and/or treatment services not specifically covered by the Nebraska Medicaid Program but which may be covered under the HEALTH CHECK (EPSDT) program for persons under 21. Please see reverse for coverage criteria.

INSTRUCTIONS: Please type. Mail to: EPSDT Coordinator, P.O. Box 95026, Lincoln, NE 68509. For claim form submittal instructions see reverse side.

Patient's Name	Medicaid Number
HEALTH CHECK Screening Practitioners	Specialty
Address	Date of Examination

1. Medical problem, suspected medical problem, or concern:

2. History of condition:

3. Pertinent physical findings and other signs and symptoms, including appropriate laboratory, screening, x-ray data:

4. Recommended service/procedure:

   (Include if known):

   (a) Potential provider of service:

   (b) Where the services will be obtained:

   (c) Estimated cost;

5. Expected outcome(s) or results:

Signature of HEALTH CHECK Screening Practitioner | Specialty | Date

TO BE COMPLETED BY MEDICAID

☐ Approved (only as long as client is Medicaid eligible) ☐ Denied.

Additional comments/billing instructions: Comments and/or reasons for denial:

I certify that the listed goods or services are authorized under the rules and regulations of the Nebraska Department of Health and Human Service Finance and Support. Local Office

Signature of Authorizing Agent | Date Authorized

TREATMENT SERVICES (471 NAC 33-001.03):

HEALTH CHECK (EPSDT) follow-up services necessary to diagnose or to treat a condition identified during a HEALTH CHECK (EPSDT) health, visual, hearing, or dental screening examination are covered under the following conditions:

1. The service is required to treat the condition (i.e., to correct or ameliorate defects and physical or mental illnesses or conditions) identified during a HEALTH CHECK (EPSDT) screening examination and documented;

2. The provider of services is a Medicaid-enrolled provider;

3. The service is consistent with applicable federal and state laws that govern the provision of health care;

4. The service must be medically necessary, safe and effective, and not considered experimental/investigational;

5. Services currently covered under the Nebraska Medical Assistance Program will be governed by the guidelines of NMAP;

6. Services not covered under the Nebraska Medical Assistance Program, but defined in Section 1905(a) of the Social Security Act must meet the conditions of items 1 through 4 (above). Criteria and requirements for certain services are outlined in this Chapter. Unless otherwise outlined, ALL SERVICES NOT COVERED UNDER NMAP POLICY MUST BE PRIOR AUTHORIZED BY THE MEDICAID DIVISION, Department of Health and Human Services Finance and Support. Requests for prior authorization must be sent to: Nebraska Department of Health and Human Services Finance and Support, Medicaid Division, EPSDT Coordinator. The screening practitioner shall submit the request which must include:

   a. A copy of the screening exam form or the name of the screening practitioner and the date of the screening exam which identified the condition; and

   b. A plan of care which includes:

      (1) History of the condition;

      (2) Physical findings and other signs and symptoms, including appropriate laboratory data;

      (3) Recommended service/procedure, including (if known) the potential provider of service (e.g., equipment, supplies) or where the services will be obtained;

      (4) Estimated cost, if available; and

      (5) Expected outcome(s).

   The plan of care may be submitted on Form EPSDT-5, "Plan of Care" (see 471-000-38) or as a statement by the screening practitioner. The Medical Director or designee shall make a decision on each request in an expeditious manner. Appropriate health care professionals may be consulted during the decision-making process. A copy of the decision will be sent to the screening practitioner and the client's worker in the local HHS office. For wards of the Department, a copy of the decision is sent to the client's case manager in the local HHS office. If the initial request is denied, additional information may be sent for reconsideration.

   CLAIM FILING INSTRUCTIONS:

   - The provider of the diagnostic/treatment services must be a Medicaid-enrolled provider. If not enrolled, contact the Provider Enrollment Unit at (402) 471-9717.
   - Please submit a copy of the approved Form EPSDT-5 with all claims related to the diagnostic/treatment services.
   - Please note any billing instructions on the front of this form.