



EPSDT in Utilization Management

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Health Plans We Support



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GOALS

1. Provide basic understanding of EPSDT (Medi-Cal for Kids and Teens)
2. Define medical necessity as it applies to EPSDT
3. Clarify how EPSDT impacts Utilization Management decisions
4. Use examples EPSDT as it applies to prior authorization decisions

EPSDT (Medi-cal for Kids & Teens)

Early

Periodic

Screening

Diagnostic

Treatment

Basic Training References

DHCS Training Modules on EPSDT

<https://www.dhcs.ca.gov/services/Medi-Cal-For-Kids-and-Teens/Documents/EPSDT-Provider-Training-BD-June-2024.pdf>

DHCS Training Module References (APLs, etc.)

<https://www.dhcs.ca.gov/services/Medi-Cal-For-Kids-and-Teens/Documents/MCKT-Provider-Training-Resources-BD-June-2024.pdf>

Medi-Cal Provider Manual EPSDT

https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/032769EA-D044-4B1D-A973-C617165FE3BE/epsdt.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYyIPyP5ULO

Best Practices for Adhering to Early and Periodic Screenings, Diagnostic and Treatment (EPSDT) Requirements (2024)

<https://www.medicaid.gov/federal-policy-guidance/downloads/sho24005.pdf>

EPSDT is....

Federal law enacted in 1967 established Early and Periodic Screening, Diagnostic and Treatment (EPSDT), which guarantees all medically necessary services to children and youth under age 21 enrolled in Medi-Cal. As of 2023, California refers to EPSDT as Medi-Cal for Kids & Teens

Goal

RIGHT CARE

RIGHT TIME

RIGHT PLACE

Screening Services

1. Health and Developmental History
2. Comprehensive exam (nutrition, weight, height, BMI)
3. Behavioral Health screening (depression, tobacco, alcohol, drug use)
4. Developmental Screening (physical and mental health)
5. Age-appropriate immunizations (Bright Futures, ACIP)
6. Lab testing (including lead)
7. Oral health screening
8. Vision and hearing screening
9. Health Education and Anticipatory Guidance
10. As needed screening

Bright Futures (American Academy of Pediatrics)



Recommendations for Preventive Pediatric Health Care

Bright Futures/American Academy of Pediatrics



Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving nurturing parenting, have no manifestations of any important health problems, and are growing and developing in a satisfactory fashion. Developmental, psychosocial, and chronic disease issues for children and adolescents may require more frequent counseling and treatment visits separate from preventive care visits. Additional visits also may become necessary if circumstances suggest concerns. These recommendations represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

Refer to the specific guidance by age as listed in the *Bright Futures Guidelines* (Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. 4th ed. American Academy of Pediatrics; 2017). The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate. The Bright Futures/American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care are updated annually.

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AGE ¹	INFANCY										EARLY CHILDHOOD										MIDDLE CHILDHOOD										ADOLESCENCE									
	Prenatal ²	Newborn ³	3-5 d ⁴	By 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	30 mo	3 y	4 y	5 y	6 y	7 y	8 y	9 y	10 y	11 y	12 y	13 y	14 y	15 y	16 y	17 y	18 y	19 y	20 y	21 y								
HISTORY	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●					
Initial/Interval																																								
MEASUREMENTS																																								
Length/Height and Weight		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●					
Head Circumference		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●					
Weight for Length		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●					
Body Mass Index ⁴														●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●					
Blood Pressure ⁴		★	★	★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●					
SENSORY SCREENING																																								
Vision ⁵		★	★	★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	●	●	●	★	★	★	★	★	★	★	★	★	★	★	★	★					
Hearing		● ⁶	● ⁶	→	→	→	→	→	→	→	→	→	→	→	→	●	●	●	●	●	●	→	→	→	→	→	→	→	→	→	→	→	→	→	→					
DEVELOPMENTAL/SOCIAL/BEHAVIORAL/MENTAL HEALTH																																								
Maternal Depression Screening ⁷				●	●	●	●				●		●																											
Developmental Screening ⁸											●		●																											
Autism Spectrum Disorder Screening ⁹													●																											
Developmental Surveillance		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●					
Behavioral/Social/Emotional Screening ¹⁰		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●					
Tobacco, Alcohol, or Drug Use Assessment ¹¹																																								
Depression and Suicide Risk Screening ¹²																																								
PHYSICAL EXAMINATION ¹³		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●					
PROCEDURES ¹⁴																																								
Newborn Blood		● ¹⁵	● ¹⁵	→	→	→																																		
Newborn Bilirubin ¹⁶		●	●																																					
Critical Congenital Heart Defect ¹⁷		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●					
Immunization ¹⁸		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●					
Anemia ¹⁹							★			●	★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★					
Lead ²⁰							★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★					
Tuberculosis ²¹																																								
Dyslipidemia ²²				★			★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★					
Sexually Transmitted Infection ²³																																								
HIV ²⁴																																								
Hepatitis B Virus Infection ²⁵		●	→																																					
Hepatitis C Virus Infection ²⁶																																								
Sudden Cardiac Arrest/Death ²⁷																																								
Cervical Dysplasia ²⁸																																								
ORAL HEALTH ²⁹																																								
Fluoride Varnish ³⁰																																								
Fluoride Supplementation ³¹																																								
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●					

1. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding, per "The Prenatal Visit" (<https://doi.org/10.1542/peds.2018-1218>).
3. Newborns should have an evaluation after birth, and breastfeeding should be encouraged (and instruction and support should be offered).
4. Newborns should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital to include evaluation for feeding and jaundice. Breastfeeding newborns should receive formal breastfeeding evaluation, and their mothers should receive encouragement and instruction, as recommended in "Policy Statement: Breastfeeding and the Use of Human Milk" (<https://doi.org/10.1542/peds.2022-05798>). Newborns discharged less than 48 hours after delivery must be examined within

- 48 hours of discharge, per "Hospital Stay for Healthy Term Newborn Infants" (<https://doi.org/10.1542/peds.2015-0690>).
5. Screen, per "Clinical Practice Guideline for the Evaluation and Treatment of Children and Adolescents with Obesity" (<https://doi.org/10.1542/peds.2022-060450>).
6. Screening should occur per "Clinical Practice Guideline for Screening and Management of High-Blood Pressure in Children and Adolescents" (<https://doi.org/10.1542/peds.2017-3006>). Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.
7. A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3-year-olds. Instrument-based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at 3 through 5 years of age. See "Visual System Assessment in Infants, Children, and Young Adults by Pediatricians" (<https://doi.org/10.1542/peds.2015-3509>) and "Procedures for the Evaluation of the Visual System by Pediatricians" (<https://doi.org/10.1542/peds.2015-3507>).
8. Confirm initial screen was completed, verify results, and follow up, as appropriate. Newborns should be screened, per "Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs" (<https://doi.org/10.1542/peds.2007-2333>).

9. Verify results as soon as possible, and follow up, as appropriate.
10. Screen with audiometry including 6,000 and 8,000 Hz high frequencies once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years. See "The Sensitivity of Adolescent Hearing Screens Significantly Improves by Adding High-Frequencies" (<https://www.sciencedirect.com/science/article/pii/S1054130516000463>).
11. Screening should occur per "Incorporating Recognition and Management of Perinatal Depression into Pediatric Practice" (<https://doi.org/10.1542/peds.2018-3250>).
12. Screening should occur per "Promoting Optimal Development: Identifying Infants and Young Children With Developmental Disorders Through Developmental Surveillance and Screening" (<https://doi.org/10.1542/peds.2019-3449>).
13. Screening should occur per "Identification, Evaluation, and Management of Children With Autism Spectrum Disorder" (<https://doi.org/10.1542/peds.2019-3447>).

(continued)

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KEY: ● = to be performed * = risk assessment to be performed with appropriate action to follow, if positive ← or → = range during which a service may be provided



Utilization Management through the Lense of EPSDT

ADULTS:

BENEFIT AND MEDICAL NECESSITY

KIDS AND TEENS (Under 21)

MEDICAL NECESSITY....modified

Medical Necessity (Health Net Member Handbook, Page 60)

ADULTS (21 and over):

Medically necessary services are reasonable and necessary to protect your life, keep you from becoming seriously ill or disabled, or reduce severe pain from a diagnosed disease, illness, or injury.

KIDS & TEENS (Under 21):

Medically necessary services are necessary to correct or improve (ameliorate) defects and physical and mental illnesses or conditions

What does that mean for Kids & Teens

A service does not need to cure a condition to be covered under Medi-Cal for Kids & Teens. Services that maintain (by preventing a condition from worsening or preventing additional health problems) or improve a child's condition are covered because they “ameliorate” a condition

Medical Necessity: What it is and What it is not

Medically Necessary:

1. Service is reasonable, appropriate, and effective method to correct, maintain or ameliorate the child's medical needs
2. Service is in accordance with current medical standards or practices
3. Service's scope is sufficient to address the child's needs
4. Service is necessary to ensure for a safe environment for the child to ameliorate a given condition

Not Medically Necessary:

1. Service is experimental or investigational (considered on a case-by-case basis)
2. Service is primarily for caregiver convenience
3. Service is more expensive than an equally effective and less expensive, available service; however, cost is not a basis for determining a service should not be provided

UM Practical Implications under EPSDT (under 21)

1. No denials due to “Not a Covered Benefit”: all cases are evaluated for medical necessity on a case-by-case basis
2. Must take into account physical AND mental aspects of care
3. There can be no absolute limits on care quantities or time
4. Money (cost) can not be a limiting factor for care being provided
5. No more restrictive (Health Plan to California to Federal)
6. Not having a diagnosis is not a reason to deny a service
7. Periscope (DME) and Evolent (radiology) evaluate using EPSDT criteria
8. EPSDT criteria only applies to Medi-cal FFS and MCPs, NOT commercial plans

Example #1

A 3-year-old child with cerebral palsy is registered with CCS (California Children's Services). He has been provided with an adaptive stroller. His parents are currently divorced and are requesting that they be provided with a second adaptive stroller so that they don't have to transfer the stroller between the 2 homes.

Prior Authorization comes for the second adaptive stroller: APPROVE OR DENY

Deny: The second adaptive stroller is a convenience request. The initial adaptive stroller would be covered under CCS. The second adaptive stroller would be considered a duplicate request.

Example #2

A 12-month-old male is being evaluated by Dermatology for a hemangioma on the chest. It is still growing at this point (5 cm diameter). The Dermatologist is requesting to perform laser treatment to limit continued growth of the hemangioma, although he states that the hemangioma will involute on it's own over time.

APPROVE OR DENY:

Approve. The service is based on prevention of further growth of the hemangioma, which will limit the size and shape of the eventual skin impacted. One would also consider the psychological impact of the abnormal skin left over by the hemangioma.

Example #3

A 4-year-old male with Rett Syndrome (developmental/behavioral delays) has a request from her Pediatrician for a wheelchair. The wheelchair includes a built-in canopy attachment. The request was sent to Periscope who determined that the canopy attachment was not medically necessary. There are commercial umbrellas that could be used at lower cost.

APPROVE OR DENY?

Deny. There is an equally, less costly option. There is no determined medical condition that requires continuous shading. Cost is not the basis for the denial.

Example #4

A 19-year-old with cerebral palsy is attending physical therapy. He lives in a remote area and has not had an evaluation by a CCS paneled provider, so they have refused to cover services. In review of the physical therapy notes, it is apparent that he is not making significant improvement in his walking, but they have shown that he has maintained his range of motion in the lower extremities. He has received over 36 visits for physical therapy over the last 2 years. Continuation of physical therapy is recommended by his therapist with a new plan of care and is signed off by his primary care provider.

APPROVE OR DENY?

Approve. The member service is maintaining his function level, which would likely decrease if he were not receiving physical therapy services. Referral for Case Management would be appropriate to facilitate member care (transportation and scheduling for CCS-paneled specialty care assessment such as Neurology), CCS referral once evaluation is done, and SAR referral for PT services with CCS. Services remain the responsibility of the health plan until CCS has approved coverage.

Example #5

2-year-old presents recent diagnosis of Neurofibromatosis Type 1 (genetic testing). The member just became covered by Medi-cal through the Health Plan (MCP). The member has been referred to CCS, but they have not made a decision yet on coverage. The member was referred to a Geneticist who recommends the member get genetic testing for Hereditary Neuroendocrine Tumors (NET). The geneticist details how the test will help to determine whether expanded screening testing for tumors is needed. The prior authorization for the genetic test (CPT 81437) is listed in the Medi-Cal Provider Manual, Part 2, TAR and non-Benefit List: Codes 8000 thru 8999, page 11 as a non-benefit.

APPROVE OR DENY?

Approve. The genetic test has been identified as allowing for early intervention on potential medical complications. Although it is listed as a non-covered benefit, it would still be approved under EPSDT medical necessity criteria.

TruCare Documentation

Recent Health Plan audit reviews have focused on being able to confirm that individual authorization requests have been evaluated using EPSDT criteria. In an attempt to provide that documentation, all prior authorizations and concurrent reviews (CCRs) for members that are under 21 will include the following phrase in the “Review Summary” section:

“EPSDT criteria were considered/applied in the review of this request”

Although the medical directors are utilizing this criteria (as is required in the Health Net/CalViva Health/Community Health Plan of Imperial Valley Member Handbooks), this documentation, along with training requirements on EPSDT education, should better meet audit requirements moving forward.

Action Required: Training Attestation

To receive credit for this training, please click the link below to complete the attestation.

Important: Make sure to enter your **10-digit individually credentialed NPI** when completing the form.

[EPSDT Utilization Management Training Attestation](#)

Thank you!

