

April 13, 2026

<Provider Name>
<Provider Address 1>
<Provider Address 2>
<City> <State> zipcode5-zipcode4

Dear Provider:

RE: Clarification of Medicaid Coverage of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services

The purpose of this letter is to provide clarification of Medicaid coverage of services provided within the EPSDT benefit as indicated within the Centers for Medicare & Medicaid Services (CMS) State Health Official letter (SHO # 24-005). This information is intended to complement the Early and Periodic Screening, Diagnosis and Treatment chapter of the Michigan Department of Health and Human Services [\(MDHHS\) Medicaid Provider Manual](#) and assist providers in understanding services available to EPSDT eligible beneficiaries.

The EPSDT benefit provides necessary health care, diagnostic services, treatment, and other measures according to Sections 1905(a) and 1905(r) [42 U.S.C. 1396d] of the Social Security Act (1967) to correct or ameliorate defects and physical and mental illnesses and conditions discovered, regardless of whether such services are covered under the state plan.

Eligible Beneficiaries

EPSDT, a mandatory benefit under the federal Medicaid program, is available to beneficiaries under 21 years of age, including individuals currently and previously in foster care. Coverage of EPSDT services is particularly important for children and adolescents with disabilities, or chronic or complex health needs, because screening, diagnostic, and testing services can prevent conditions from worsening, reduce pain, and avert the development of more complex and costly illnesses and conditions.

Services

Services provided under the EPSDT benefit must be effective in meeting the child/adolescent's medical and functional needs, actually available, and not based on cost alone. In accordance with EPSDT, medical necessity is to be determined on a case-by-case basis.

L 26-21

Access

Medicaid covers services from Medicaid-enrolled out-of-state or out-of-network providers when timely access or specialized care is not available by in-state or in-network providers. Payment for out-of-state or out-of-network medical services is subject to Medicaid policies, procedures, and prior authorization (PA) requirements as outlined in the General Information for Providers Chapter of the [MDHHS Medicaid Provider Manual](#).

Well-Visits and Screening Services

EPSDT visits and screening services are covered when performed in accordance with the American Academy of Pediatrics (AAP) periodicity schedule, its components, and medical guidelines. An initial history must be obtained for each new patient at the first well-child visit and interval histories obtained at subsequent visits. If the screening is positive or problems are suspected for any physical and behavioral health conditions discovered during the well-child visit or by the screening and diagnostic procedures, further diagnosis or treatment must be completed by the primary care provider (PCP), or the child or adolescent must be referred for prompt follow-up diagnostic and treatment services by another appropriate provider.

Inter-periodic Screening Services

In accordance with EPSDT, Medicaid covers medically necessary inter-periodic screenings outside of the AAP periodicity schedule. Coverage for such screenings is required based on an indication of a medical need to diagnose an illness or condition that was not present at the regularly scheduled screening or to determine if there has been a change in a previously diagnosed illness or condition that requires additional services. EPSDT screening services, as indicated per the AAP periodicity schedule, cannot be subject to PA.

Interprofessional Consultations

Medicaid covers interprofessional consultations rendered by a physician or other qualified healthcare provider whose opinion and/or treatment advice is requested by another appropriate practitioner for the further evaluation and management of the beneficiary. Refer to the Practitioner chapter, Evaluation and Management Services section, and the Telemedicine chapter, Interprofessional Telephone/Internet/Electronic Health Record Consultations subsection of the [MDHHS Medicaid Provider Manual](#) for additional information.

Non-Emergency Medical Transportation

Non-emergency medical transportation (NEMT) expenses may be covered for beneficiaries and/or a parent/caregiver (or medically necessary attendant) for EPSDT services. Transportation coverage includes coverage for trips to and from the service (e.g., round-trip for admission, round-trip for discharge). Refer to the Non-Emergency Medical Transportation chapter of the [MDHHS Medicaid Provider Manual](#) for additional information.

There may be occasions when a beneficiary requires services beyond those ordinarily covered by Medicaid. For Medicaid to reimburse the provider in this situation, MDHHS requires that the provider obtain authorization for these services before the service is rendered. PA requests are reviewed on a case-by-case basis, with consideration of the needs of the EPSDT eligible beneficiary. Refer to the General Information for Providers Chapter, Prior Authorization section, of the [MDHHS Medicaid Provider Manual](#) for additional information.

Developmental/Behavioral/Mental Health Services

When behavioral health screenings identify symptoms that require attention but do not meet diagnostic criteria, in accordance with EPSDT requirements, beneficiaries are not required to have a specific behavioral health diagnosis to receive follow-up services. Services are to be provided in the most integrated setting appropriate for the needs of the child or adolescent (e.g. clinics, schools, home, etc.) and unnecessary placements in segregated treatment settings must be avoided. Inpatient and residential levels of care must not be the default treatment setting, either explicitly or because of a lack of capacity of services offered in integrated settings, including beneficiaries with severe needs, and should be reserved for these beneficiaries with acute needs on a short-term basis. Refer to the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter of the [MDHHS Medicaid Provider Manual](#) for additional information.

Transition of Care

For beneficiaries who have not yet transitioned to adult care and are approaching 21 years of age and will soon be transitioning out of EPSDT coverage, the PCP should develop a comprehensive care plan to facilitate the beneficiary's transition from EPSDT to adult health care coverage. The comprehensive care plan should detail the transition process, difference in service coverage, and referrals to appropriate providers and services. The PCP should also assist the beneficiary in coordinating appointments, transferring medical records, and connecting the beneficiary to new health care providers, if necessary.

An electronic copy of this document is available at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms.

Sincerely,



Meghan E. Groen, Chief Deputy Director
Health Services