

Clinical Policy: Vision: Early and Periodic Screening, Diagnosis and Treatment

Reference Number: CP.VP.27

Last Review Date: 08/2025

[Coding Implications](#)[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

This policy describes the medical necessity requirements for determining coverage of services subject to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) regulations for eligible Medicaid recipients under 21 years of age.

Policy/Criteria

- I. It is the policy of health plans affiliated with Centene Corporation® (Centene) and Envolve Vision, Inc.® (Envolve) that diagnostic services, treatment, equipment, supplies and other measures described in section 1905(a) of the SSA, codified in Title 42 of the United States Code 1396d(a) are provided to eligible Medicaid recipients under the age of 21 years if such services are **medically necessary** to correct or ameliorate a defect, a condition, or a physical or mental illness. As such, services for recipients under the age of 21 years exceeding the coverage (e.g., frequency, non-covered service) may be approved, if medically necessary. These services are considered on a case-by-case basis with individual consideration to the patient's needs when such documentation is provided.

Background

In accordance with measures described in section 1905(a) of the SSA, codified in Title 42 of the United States Code 1396d(a), eligible Medicaid recipients under the age of 21 may receive approval and coverage for all services and measures determined medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. All services requested under EPSDT that exceed Medicaid coverage or frequency limitations must be submitted with supporting clinical documentation for consideration. Requesting provider must submit all clinically relevant information pertaining to the case with the claim or authorization request. Decisions will be processed according to State mandated turnaround times.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2025, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

Reviews, Revisions, and Approvals	Date	Approval Date
New Policy	02/2022	04/2022
Annual Review	11/2022	11/2022
Annual Review	11/2023	12/2023

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Reviews, Revisions, and Approvals	Date	Approval Date
Policy clarification that supporting documentation is required for consideration of coverage under EPSDT regulations.	09/2024	10/2024
Annual Review	11/2024	12/2024
Annual Review	08/2025	10/2025

References

1. Section 1905(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a)

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <https://www.cms.gov> for additional information.

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