A Well Child Check-Up (EPSDT)

The purpose of EPSDT services is:

- To actively seek out all eligible families and educate them on the benefits of preventive health care
- To help recipients effectively use health resources and encourage them to participate in the screening program at regular intervals
- To provide for the detection of any physical and mental problems in children and youth as early as possible through comprehensive medical screenings in accordance with program standards
- To provide for appropriate and timely services to correct or ameliorate any acute or chronic conditions

This appendix offers information about the EPSDT program. It consists of the following sections:

Section	***Contents***
Understanding EPSDT	Provides an overview of EPSDT, including descriptions of screening types and services offered under EPSDT
Performing Screenings	Provides information on becoming an EPSDT screening provider, verifying recipient eligibility, critical components of screenings, and how to submit claims for EPSDT screenings
Providing and Obtaining Referrals	Describes the process for providing referrals to specialists and obtaining referrals from screening providers. This section includes instructions for Patient 1st and non-Patient 1st recipients.
Coordinating Care	Describes the administrative requirements of the EPSDT program, including consent forms and retention of medical records.
Off-site Screenings	Provides an overview of the off-site screening program, including enrollment requirements, components required, eligibility verification, referral process and reimbursement information.
Vaccines for Children	Describes the Vaccines for Children program, including enrollment instructions, which procedure codes to bill, how to bill for administration fees, and a copy of the immunization schedule.

A.1 Understanding EPSDT

The purpose of the EPSDT program is to find children with actual or potential health problems and to screen, diagnose, and treat the problems before they become permanent, lifelong disabilities. The program also offers preventive health services to Medicaid-eligible children under 21 years of age.

The EPSDT program was expanded in the Omnibus Budget Reconciliation Act of 1989 to allow additional services. The acronym EPSDT stands for:

Early	A Medicaid-eligible child should begin to receive high quality preventive health care as early as possible in life.
Periodic	Preventive health care occurring at regular intervals according to an established schedule that meets reasonable standards of medical, vision, hearing, and dental practice established by recognized professional organization.
Screening	A comprehensive, unclothed head-to-toe physical examination to identify those who may need further diagnosis, evaluation, and/or treatment of their physical and mental problems.
Diagnosis	The determination of the nature or cause of physical or mental disease, conditions, or abnormalities identified during a screening.
Treatment	Any type of health care or other measures provided to correct or ameliorate defects, physical and mental illnesses, or chronic conditions identified during a screening.

Periodicity Schedule

Periodic screenings must be performed in accordance with the schedule listed below. This schedule is based upon the recommendations of the American Academy of Pediatrics Guidelines for Health Supervision III.

- 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- 2 years
- Annually (per calendar year) through 20 years of age beginning with third birthday

NOTE:

Medicaid will reimburse for only one screening per calendar year for children over the age of three. Screening benefit availability may be verified through AVRS, DXC Provider Electronic Solutions software, or the Provider Assistance Center at DXC. Please refer to Chapter 3, Verifying Recipient Eligibility, for more information.

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If a periodic screening has not been performed on time according to the periodicity schedule (for instance, if the 2 months' periodic screening was missed), a screening may be performed at an "in between" age (for example, at 3 months) and billed as a periodic screening. In other words, the child should be brought up to date on his/her screening according to his/her age. Re-screenings should occur within 2 weeks (before or after) of the established periodicity schedule. This policy applies to recipients 0-24 months of age.

EPSDT screenings fall under six broad categories:

Type of Screening	***Description***
Initial Screening	Initial screenings indicate the first time an EPSDT screening is performed on a recipient by an EPSDT screening provider.
Periodic Screening	Periodic screenings are well child checkups performed based on a periodicity schedule. The ages to be screened are 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months, and annually beginning on or after the child's third birthday.
Interperiodic Screening	Interperiodic screenings are considered problem-focused and abnormal. These are performed when medically necessary for undiagnosed conditions outside the established periodicity schedule and can occur at any age.
Vision Screening	Vision screenings must be performed on children from birth through age two by observation (subjective) and history. Objective testing begins at age three, and should be documented in objective measurements.
Hearing Screening	Hearing screenings must be performed on children from birth through age four by observation (subjective) and history. Objective testing begins at age five, and should be recorded in decibels.
Dental Screening	Dental screenings must be performed on children from birth through age two by observation (subjective) and history. Beginning with age one, recipients must be either under the care of a dentist or referred to a dentist for dental care.
Emotional and behavioral Screening	Emotional Assessment will cover procedure code 96127 for children age 3-20. Assessment must be ordered and signed by a physician or Non- Physician Practitioner (i.e., Psychologist, Physician Assistant, and Certified Registered Nurse Practitioner).

A.2 Using PT+3 with EPSDT services

A patient education method (PT+3) has recently been developed for working with illiterate or marginally literate individuals. The PT+3 allows providers to make the most of patient contacts as opportunities to provide developmentally appropriate information for recipients and their families.

The acronym PT+3 means:

P = Personalize the problem

T = "TAKLE" the problem:

- T = set a Therapeutic Tone,
- A = Assess the knowledge level of the patient,
- K = provide Knowledge,
- L = Listen for feedback,
- E = Elaborate or reeducate as needed.

+3 = Summarize the teaching session into three essential points.

PT+3 is a standardized protocol that provides the skills and structure for health care providers to assist young or marginally literate patients in learning and remembering essential points from a health care encounter. PT+3 is designed to increase patient knowledge and compliance. Patients seem to like and understand the simplified information and providers like the process. Using PT+3 saves time for providers and enhances the medical visit for the recipient. PT+3 enables individuals to remember the most important aspects of the medical visit.

Specially designed low literacy materials are available for children (EPSDT Brochures), teens, ("How to Talk to Your Children"), and adults ("Facts about Birth Control") and are free to providers including EPSDT, Patient 1st, and Medicaid family planning providers who receive training in the use of the PT+3 method of education. For more information regarding PT+3, please fax your request to (334) 353-5203, attention "Outreach & Education." Please include your name and telephone number.

A.3 Performing Screenings

This section describes becoming an EPSDT screening provider, verifying recipient eligibility, scheduling screenings, critical components of screenings, and submitting claims for EPSDT screenings.

A.3.1 Becoming an EPSDT Screening Provider

Participation as an EPSDT screening provider is voluntary. To become an EPSDT screening provider, a provider must be an approved Alabama Medicaid provider and must have a 10-digit NPI. New providers should refer to Chapter 2, Becoming a Medicaid Provider, for instructions on receiving an application.

Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-enroll. Failure to re-enroll and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment.

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Current Medicaid providers who wish to become an EPSDT screening provider should contact the DXC Provider Enrollment Unit at the following address to obtain EPSDT screening provider enrollment forms, or you may download the information from Internet:

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DXC Provider Enrollment
P.O. Box 241685
Montgomery, Alabama 36124-1685
1 (888) 223-3630

Provider Types Eligible for Participation

Only certain Alabama Medicaid provider types may become approved EPSDT screening providers. In some cases, these providers are restricted to where they can perform screenings:

This Provider Type	***May Perform Screenings at the Following Locations:***
Physicians	Anywhere a physician is authorized to practice
Nurse practitioners	At a physician's office, Rural Health Clinic, Federally Qualified Health Care Clinic (FQHC), health department, or hospital
Registered Nurses	At a rural health clinic, Federally Qualified Health Care Clinic (FQHC), health department, or hospital **NOTE:** Two-year degree RNs who wish to perform EPSDT screenings must first complete a Medicaid-approved pediatric health assessment course (PAC) or show proof of completion of a similar program of study. BSN's are exempt from taking a PAC.
Physician Assistants	At a physician's office, rural health clinic, Federally Qualified Health Care Clinic (FQHC), health department, or hospital

Providers are not limited to those who are qualified to provide the full range of medical, vision, hearing, and dental screening services. Although a qualified provider may be enrolled to furnish one or more types of screening services, the Alabama Medicaid Agency encourages qualified providers to provide the full range of medical, vision, hearing, and dental screening services to avoid fragmentation and duplication of services.

NOTE:

Medical screenings, including the physical, must be performed by a physician, certified nurse practitioner, registered nurse, or physician's assistant, who is approved to perform well child check-ups. Other trained personnel may perform some screening components (for instance, measurements or finger sticks).

Potential EPSDT off-site providers must submit specific documents (see Section A.5) and be approved to participate as an off-site provider.

A.3.2 Verifying Recipient Eligibility

Reimbursement will be made only for eligible Medicaid recipients. Eligibility and benefit limits should be verified **prior to rendering** services to **ANY** Medicaid recipient.

NOTE:

Every effort should be made to assure that medical, vision, and hearing screenings, including immunizations, are accomplished in one visit, and that fragmentation or duplication of screening services is prevented. Section A.7, Vaccines for Children, describes the immunization schedule.

Recipient eligibility should be verified before providing services for several reasons:

- It will inform you of recipient eligibility
- You will be informed if the recipient is assigned to a managed care provider and who the managed care provider is and his/her telephone number
- You may inquire further to determine how many screenings have been performed to determine benefit availability
- It will provide you with the 13th digit of the recipient's Medicaid number for claim filing purposes

Refer to Chapter 3, Verifying Recipient Eligibility, for the various options available and for general benefit information and limitations.

A.3.3 Outreach

Outreach activities are critical to successful health screening services. The outreach process assures that eligible families are contacted, informed, and assisted in securing health-screening services.

The Alabama Medicaid Agency, in conjunction with the Department of Human Resources, informs the applicant of EPSDT services. For those recipients who do not participate in Patient 1st, a list of current EPSDT screening providers are made available for selection by the recipient. SSI (Category 4) eligible recipients are informed of EPSDT services. Until a child is assigned to a managed care provider (usually notified by mail), the Medicaid-eligible child is permitted to see any Alabama Medicaid provider for EPSDT services without a referral from a managed care provider (i.e., Patient 1st provider).

Once the child has been assigned to a managed care provider, all subsequent visits to other providers must have a prior approved written referral (Form 362) from the managed care provider. However, the following recipients are exempt from the managed care program:

- Foster children
- Dual eligible (Medicare & Medicaid)
- SOBRA-eligible adults
- Those in institutions and/or group homes
- Recipients in the Lock-in program (restricted to one physician and one pharmacy).

For more information regarding managed care systems, refer to Chapter 39, Patient 1st of this manual or call the Provider Assistance Center at (800) 688-7989.

The Alabama Medicaid Agency's goal is to provide effective outreach services for Medicaid-eligible recipients. EPSDT outreach efforts are aimed at two groups: (a) new Medicaid recipients and (b) all Medicaid-eligible recipients under 21 years of age who have not had a well child screening in the last 12 months. These recipients are notified annually. The recipient is informed about EPSDT services through an outreach letter and is encouraged to make an appointment for an EPSDT screening. Once the recipient is assigned a managed care provider, it is the managed care provider's responsibility to ensure screenings (well child checkups) are performed on time. For those recipients who do not participate in a managed care system, the EPSDT screening provider is responsible for ensuring the screenings are performed on time.

A.3.4 EPSDT Care Coordination

Effective March 1, 2004, the Alabama Medicaid Agency initiated an EPSDT care coordination service available for private and public providers. The goal for EPSDT Care Coordination Services is to provide children with opportunities to maximize their health and development by ensuring the availability and accessibility of comprehensive and continuous preventive health services throughout childhood.

The EPSDT Care Coordination services are available to any provider, at no cost, who wishes to utilize these services. The Agency, along with the Department of Public Health, has identified children at greatest risk and with the potential for effective intervention. These Medicaid eligible recipients will be targeted for outreach.

The scope of services include and are designed to support and assist your office personnel with identifying, contacting, coordinating, and providing follow up for visits with your office for children who are behind on their EPSDT screenings, immunizations, vision/hearing screenings, dental screenings, identify recipients who have high utilization of emergency room visits; follow up services for newborn hearing screenings, elevated blood lead levels, abnormal newborn screening results; follow up on referrals, missed appointments, identify children at greatest risk for targeted outreach, and coordination for teen pregnancy prevention services. In addition, Care Coordinators are available to assist with transportation services using Alabama Medicaid's Non-Emergency Transportation (NET) program. Care Coordinators may receive referrals from physicians and dentists regarding medically-at-risk clients who need assistance with keeping appointments and obtaining follow-up care. Lastly, EPSDT Care Coordinators will encourage and assist in recruiting private physicians to improve services to this population.

Participation of qualified EPSDT Care Coordination services is available to the state of Alabama's designated Title V agency, Alabama Department of Public Health. Public Health's primary role is that of care coordinator. Public Health will provide clinical EPSDT services only where those services are not available through the private sector. Public Health will identify health problems. Active physician involvement for treatment is vital. EPSDT Care Coordination services are available by contacting your local county health department. Please visit our website at www.medicaid.alabama.gov and select "General", then select "About". A list of EPSDT Care Coordinators by county and telephone numbers is available to support your office personnel.

A.3.5 Scheduling Screenings

The Alabama Medicaid Agency requires that persons requesting screening services receive the services within 120-180 days from the date the request was made. These persons should be given priority by the screening agency when scheduling appointments.

EPSDT selected providers and Primary Medical Providers (PMP) receive a periodic re-screen list each month. The provider should utilize the periodic re-screen list to notify the EPSDT-eligible recipient when the medical screening is due. An appointment should be made for the next screening on the periodicity schedule. These functions are an integral part of the full screening provider's responsibility and are essential for care coordination. Providers have a total of 120 days from due date or award date (listed on printout) to accomplish screening, necessary referral, and treatment for the recipients listed on the printout.

EPSDT-eligible Medicaid beneficiaries who request well child checkups must be provided regularly scheduled examinations and assessments at the intervals established by Medicaid policy.

Scheduling of initial and periodic screenings is the responsibility of the screening provider. Managed care providers are responsible for overall care coordination for medical, vision, hearing, and dental screenings for recipients who participate in a managed care program. The EPSDT screening provider is responsible for overall care coordination as listed above for those recipients who do not participate in a managed care system.

The EPSDT screening provider should not perform a screening if written verification exists or if notified by another provider that the child has received the most recent age appropriate screening. Also, the EPSDT screening provider should receive prior approval from the managed care provider (if applicable). An additional interperiodic screening may be performed if requested by the parent or if medically necessary.

Please refer to Section A.5, Care Coordination, for more information on screening provider responsibilities.

A.3.6 Critical Components of Screenings

This section describes critical components of periodic, Interperiodic, and vision/hearing/dental screenings. It also describes recommended health education counseling topics by age group.

Periodic Screenings

Component	***Description***
Unclothed physical exam	This is a comprehensive head-to-toe assessment that must be completed at each screening visit and include at least the following: • Temperature, and height/weight ratio • Head circumference through age two • Blood pressure and pulse at age three and above • Measure body-mass index when clinically indicated Body-mass index (BMI) – BMI should be performed at each visit if clinically indicated. BMI-for-age charts are recommended to assess weight in relation to stature for children ages 2 to 20 years. The weight-for-stature charts are available as an alternative to accommodate children ages 2-5 years who are not evaluated beyond the preschool years. However, all health care providers should consider using the BMI-for-age charts to be consistent with current recommendations. The charts are available on the American Academy of Pediatrics website at http://www.aap.org.
Comprehensive family/medical history	This information must be obtained at the initial screening visit from the parent(s), guardian, or responsible adult who is familiar with the child's history. The history must include an assessment of both physical and mental health development and the history must be updated at each subsequent visit.
Immunization status	Immunizations and applicable records must be updated according to the current immunization schedule of the Advisory committee on Immunization Practices (ACIP). Dates and providers must be recorded in the medical record indicating when and who gave the vaccines, if not given by the screening provider. The state law has been changed so that private and public healthcare providers may share immunization data. Medicaid recipients shall be deemed to have given their consent to the release by the state Medicaid Agency of information to the State Board of Health or any other health care provider, by virtue immunization data should be recorded in the medical record.

Component	*Description*
TB skin test	Children who should be considered for tuberculin skin testing at ages 4-6 and 11-16 years Children whose parents immigrated (with unknown TST status) from regions of the world with high prevalence of tuberculosis; continued potential exposure by travel to the endemic areas and/or household contact with persons from the endemic areas (with unknown TST status) should be an indication for a repeat TST Children without specific risk factors who reside in high-prevalence areas; in general, a high-risk neighborhood or community does not mean an entire city is at high risk; rates in any area of the city may vary by neighborhood or even from block to block; physicians should be aware of these patterns in determining the likelihood of exposure; public health officials or local tuberculosis experts should help physicians identify areas with appreciable tuberculosis rates Children at increased risk for progression of infection to disease: Those with other medical conditions including diabetes mellitus, chronic renal failure, malnutrition and congenital or acquired immunodeficiency's deserve special consideration. Without recent exposure, these persons are not at increased risk of acquiring tuberculosis infection. Underlying immune deficiencies associated with these conditions theoretically enhance the possibility for progression to severe disease. Initial histories of potential exposure to tuberculosis should be included for all of these patients. If these histories or local epidemiologic factors suggest a possibility of exposure, immediate and periodic TST should be considered. An initial TST should be performed before initiation of immunosuppressive therapy for any child with an underlying condition that necessitates immunosuppressive therapy. Bacille Calmette-Guérin (BCG) immunization is not a contraindication to TST. HIV indicates human immunodeficiency virus. Initial TST initiated at the time of diagnosis or circumstance, beginning at 3 months of age.* Table 2. Definitions of Positive Tuberculin Skin Test (TST) Results in Infants, Children, and Adolescents* TST should be read at 48 - 72 hours after placement **Induration >5mm** Children in close contact with known or suspected infectious cases of tuberculosis disease: Households with active or previously active cases if treatment cannot be verified as adequate before exposure, treatment was initiated after the child's contact, or reactivation of latent tuberculosis infection is suspected Children suspected to have tuberculosis disease: Chest radiograph consistent with active or previously active tuberculosis Clinical evidence of tuberculosis disease ‡ Children receiving immunosuppressive therapy ‡ or with immunosuppressive conditions, including HIV infection

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Component	*Description*
TB skin test (cont.)	**Reaction ≥15mm** Children 4 years of age or older without any risk factors *These definitions apply regardless of previous Bacille Calmette-Guérin (BCG) immunization: erythema at TST site does not indicate a positive test. HIV indicates human immunodeficiency virus. + Evidence by physical examination or laboratory assessment that would include tuberculosis in the working differential diagnosis (e.g. Meningitis). ‡ Including immunosuppressive doses of corticosteroids
Developmental surveillance and assessment	A comprehensive developmental history is required, if appropriate, to determine the existence of motor, speech, language, and physical problems or to detect the presence of any developmental lags. An age-appropriate developmental assessment is required at each screening. Information must be acquired on the child's usual functioning as reported by the child's parent, teacher, health care professional, or other knowledgeable individual. **Developmental assessments must be performed by a RN, BSN; CRNP, PA, or M.D.**
Nutritional status screening	Nutritional status must be assessed at each screening visit. Screenings are based on dietary history, physical observation, height, weight, head circumference (ages two and under), hemoglobin/hematocrit, and any other laboratory determinations carried out in the screening process. A plotted height/weight graph chart is acceptable when performed in conjunction with a hemoglobin or hematocrit if the recipient falls between the 10th and 95th percentile.
Health education including anticipatory guidance	Health education and counseling for parent(s) or guardian and the youth (if age appropriate) are required at each screening visit. Health education is designed to assist the parent in understanding what to expect in terms of development. Health education also provides information about the benefits of healthy lifestyles and practices, as well as accident and disease prevention. Providers may use the PT+3 teaching method for anticipatory guidance counseling. PT+3 should be documented in the medical record (i.e., progress notes) listing the three points emphasized.
Objective Developmental Screenings	SEE BELOW

Objective Developmental Screenings

EPSDT providers are allowed to bill for an objective developmental screening in addition to an EPSDT screening at the 9 month, 18 month, 24 month and 48 month well-child visit. EPSDT providers also have the option of providing the developmental screening anytime that surveillance (medical history of developmental risk factors, parental/caregiver concern) identifies a need. Providers are encouraged to use standardized screening tools that have a moderate to high sensitivity, specificity and validity level and are culturally sensitive. The following code, which is limited to five (5) units per date of service (five different screening tools used), may be used to bill for this screening:

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96110 - Developmental testing; limited (e.g., Developmental Screening Test II, Early Language Milestone Screen), with interpretation scoring and reporting documentation per standardized instrument (provider must document description of score).

Added: scoring, reporting documentation per standardized instrument (provider must document description of score).

In order to bill this code, providers must use a standardized screening tool. Examples of screening tools allowed for this code include, but are not limited to:

- Ages and Stages Questionnaire (ASQ)
- Denver DST/Denver II
- Battelle Developmental Screener
- Bayley Infant Neurodevelopment Screener (BINS)
- Parents Evaluation of Development (PEDS)
- Early Language Accomplishment Profile (ELAP)
- Brigance Screens II

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The developmental screening tool must be ordered by the provider or on behalf of the provider based on developmental screening written protocol/standing orders and scored (Provider must document description of score). The provider's physical or electronic signature must be in the medical record. Provider includes physician or non-physician practitioner, (i.e., Psychologist, Physician Assistant, Certified Registered Nurse Practitioner, and Certified Pediatric Nurse Practitioner). If a standardized tool has a summary form, the summary must be retained/scanned into the medical record. For any other form with no summary, retain/scan the full document.

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Brief Emotional and Behavioral Assessment

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EPSDT providers are allowed to bill for an emotional and behavioral assessment in addition to an EPSDT screening for ages 3 months to 20 years. EPSDT providers also have the option of providing the emotional and behavioral assessment anytime that surveillance (medical history of risk factors, parental/caregiver concern) identifies a need. Providers are encouraged to use standardized tools that have a moderate to high sensitivity, specificity and validity level and are culturally sensitive. The following code, which is limited to two (2) units per date of service (two different screening tools used), may be used to bill for this screening:

Added: Brief emotional/ behavioral assessment…description of score.

96127 – Brief emotional/behavioral assessment (e.g., depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument (Provider must document description of score).

Added: NICHQ, Assessment

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Examples of screening tools allowed for this code include, but not limited to:

- Ages and Stages Questionnaire/ Social Emotional (ASQ-SE)
- Modified Checklist for Autism in Toddlers (M-CHAT)
- NICHQ Vanderbilt Assessment Scales
- Behavior Assessment Scale for Children Second
- Patient Health Questionnaire (PHQ – 2 AND PHQ – 9)

Added: Patient Health Questionnaire (PHQ – 2 AND PHQ – 9)

Added: The emotional and…scan the full document.

The emotional and behavioral assessments must be ordered by the provider or on behalf of the provider based on emotional and behavioral assessment written protocol/standing orders and scored Provider must document description of score). The provider's physical or electronic signature must be in the medical record. Provider includes physician or non-physician practitioner, (i.e., Psychologist, Physician Assistant, Certified Registered Nurse Practitioner, and Certified Pediatric Nurse Practitioner). If a standardized tool has a summary form, the summary must be retained/scanned into the medical record. For any other form with no summary, retain/scan the full document.

Vision Testing/Screenings

Vision screenings are available either as a result of the EPSDT referral or as a result of a request/need by the recipient. A subjective screening for visual problems must be performed on children from birth through age two by history and observation. Gross examinations should be documented as grossly normal or abnormal. Objective testing begins at age three. Visual acuity screening must be performed through the use of the Snellen test, Allen Cards, photo refraction, or their equivalent. Objective testing must be referred out if not performed by the screening provider.

If a child is uncooperative, perform a subjective assessment. The reason(s) for not being able to perform the test must be documented in the medical record. Proceed with billing the vision screening on the same date of service as the initial or periodic screening. The child should be rescheduled for an appointment to complete the vision screening. Be sure to complete the vision screening within 30-45 days from the original screening date.

If a suspected visual problem manifests itself, regardless of whether such services coincide with the periodicity schedule, an interperiodic screening should be scheduled with the child's physician so the history and problem-focused physical exam, can be obtained and an EPSDT referral issued to the appropriate specialist or consultant.

Providers **must** use an "EP" modifier to designate all services related to EPSDT well-child check-ups, **including routine vision** and **hearing screenings**. Post payment reviews are performed to determine appropriate utilization of services.

Trained office staff may perform a vision screening if successfully trained. A staff member must meet the following criteria to be considered trained.

- Employee observes a vision screening being performed on a minimum of three patients by a skilled/trained employee
- Employee verbalizes an understanding of the steps required to perform a vision screening
- Employee performs a vision screening under supervision on a minimum of three patients successfully.

Hearing Testing/Screenings

Hearing screenings are available either as a result of an EPSDT referral or as a result of a request/need by the recipient. A subjective screening for hearing problems must be performed on children from birth through age four by history and observation. Gross examination should be documented as grossly normal or abnormal. Objective testing begins at age five. Hearing screenings must be performed through the use of a pure tone audiometer at 500 and 4,000 Hz at 25 decibels for both ears. If a child fails to respond at either frequency in either ear, a complete audiogram must be done. Objective testing must be referred out if not performed by the screening provider.

If a child is uncooperative, do a subjective assessment. The reason(s) for not being able to complete the test must be documented in the medical record. Proceed with billing the hearing screening on the same date of service as the initial or periodic screening. The child should be rescheduled for an appointment to complete the hearing screening. Be sure to complete the hearing screening within 30-45 days from the original screening date.

If a suspected hearing problem manifests itself, regardless of whether such services coincide with the periodicity schedule, an interperiodic screening should be scheduled with the child's physician so the history and problem-focused physical exam can be obtained and an EPSDT referral issued to the appropriate specialist or consultant.

Trained office staff may perform a hearing screening if successfully trained. A staff member must meet the following criteria to be considered trained.

- Employee observes a hearing screening being performed on a minimum of three patients by a skilled/trained employee
- Employee verbalizes an understanding of the steps required to perform a hearing screening
- Employee performs a hearing screening under supervision on a minimum of three patients successfully.

Providers **must** use an “EP” modifier to designate all services related to EPSDT well-child check-ups, **including routine vision** and **hearing screenings**. Post payment reviews are performed to determine appropriate utilization of services.

Dental Services

Dental care is limited to Medicaid-eligible individuals who are eligible for treatment under the EPSDT Program. Dental screenings must be performed on children from birth through age two by observation/inspection and history. Beginning with age one, recipients must be either under the care of a dentist or referred to a dentist for dental care.

A periodic oral examination is recommended once every six months for eligible Medicaid recipients under 21 years of age. Dental services include emergency, preventive, and therapeutic services as well as orthodontic treatment when medically necessary. A referral, or documentation that recipient is under the care of a dentist is required at age one and older. Follow-up is no longer mandatory. Any time a need for dental care is identified, regardless of the child’s age, the child should be referred to a dentist.

Beginning with age one, providers should educate and document that caretakers have been advised of the importance (anticipatory guidance) of good oral healthcare and the need to make a dental appointment. Additional documentation suggestions include providing the caretaker with one of the following phone numbers: dentist, Agency's Dental Program phone number to assist with locating a dentist (334) 242-5014, or the Recipient Hotline number to assist with locating a dentist (800) 362-1504.

Effective 01/01/2009, Pediatric providers (MDs, DOs, PAs, and NPs) will be able to bill in accordance with Medicaid reimbursement policies for oral assessment and application of fluoride varnish for recipients age 6 months through 35 months of age. Providers may bill assessment code D0145 (oral exam less than 3 years old, counseling with primary caregiver). D0145 can be billed once by pediatric medical provider and once by the dental provider for recipients 6 months through 35 months of age. Varnishing code D1206 (topical fluoride application) will be limited to 3 per calendar year, not to exceed a maximum of 6 fluoride varnish applications between 6 months and 35 months of age. Frequency is not allowed less than 90 days. Providers are required to bill ICD 10 diagnosis code Z01.02 or Z20.4 on or after October 01, 2015.Once a recipient has an established dental home (described in Chapter 13 section 13.2), a pediatrician cannot bill D1206.

Dental care under the Program is available either as a result of the EPSDT referral or as a result of request/need by the recipient. Conditions for each situation are as follows:

1. EPSDT Referral – If the EPSDT Screening Provider determines a recipient requires dental care or if the recipient is age one or older and is not currently under the care of a dentist, the recipient must be referred to an enrolled dentist for diagnosis and treatment. After the recipient's dental care is initiated, the consultant's portion of the Referral Form (Form 362) must be completed by the dentist and the appropriate copy must be returned to the screening provider.
2. Recipient Seeking Treatment – If a recipient who has not been screened through the EPSDT Program requires dental care, care may be provided without having a Referral Form. Dental care provided on request of the recipient is considered a partial screening. In this situation, after the required care is completed, the dentist should advise the recipient to seek an EPSDT screening provider to obtain a complete medical assessment.

NOTE:

Dental health care services are available for eligible children under age 21, as part of the EPSDT program. To obtain information about dentists, you may call the Dental Program at (334) 353-5263.

Laboratory Screenings

Laboratory screening procedures must be performed in coordination with other medical screening services at the same visit, whenever possible. If verifiable results are available from another provider that any required laboratory procedure was performed within 30 days prior to the screening visit and there is no indication of a diagnosis that would warrant that the test be redone, it is not necessary to perform the test again. However, the test results or a copy of the test results should be documented in the medical record.

NOTE:

Providers have the option of obtaining the Hgb or Hct and the lead test during the nine month or twelve month well child check-up (EPSDT screening).

The following is a list of tests and procedures of laboratory screenings:

Laboratory Test	***Description***
Newborn Screening	Newborn screening is mandated by **Statutory Authority Code of Alabama 1975, Section 22-20-3**. Every hospital or facility providing delivery services is required to screen all infants for these potentially devastating disorders. The Alabama Department of Public Health (ADPH) is responsible for administrative oversight of the Newborn Screening Program. Infants are screened for 29 primary and 45 secondary disorders which include Endocrine Disorders (Congenital Hypothyroidism and Congenital Adrenal Hyperplasia), Cystic Fibrosis (CF), Sickle Cell Disease, Hearing Loss, and Metabolic Disorders (Amino, Fatty, and Organic Acid). In April 2012, ADPH implemented voluntary screening to detect Critical Congenital Heart Disease. The Alabama Newborn Screening website has a complete list of disorders at www.adph.org/newbornscreening. Early diagnosis of these conditions may reduce morbidity, premature death, mental retardation, and other developmental disabilities. All initial screening tests are conducted by ADPH's Bureau of Clinical Laboratories (BCL). Infants 12 months of age and younger with no record of a newborn screen should be tested as soon as possible. Screening for hemoglobinopathies (sickle cell disease/trait or thalassemia) is only included on the initial newborn screen. If initial results are not satisfactory for infants from birth to 12 months of age a repeat test must be performed. Children over 12 months of age who have never been tested need only be screened when ordered by a physician. ADPH's BCL has established standards and cutoffs for newborns and infants, and therefore **cannot accept specimens on infants older than 12 months of age**. Please see the Newborn Screening Collection Guidelines at http://www.adph.org/newbornscreening/assets/ADPHBCLCollectionGuidelines.pdf Routine second testing is recommended between two and six weeks of age, with four weeks being optimal. This second screen is critical in detecting a condition that may not have been picked up on an initial screen. Confirmation of abnormal newborn screening results is always necessary. An infant with a positive screen should be referred for diagnostic testing. The Alabama Newborn Screening Program works in partnership with pediatric sub-specialists to ensure all babies identified with abnormal results receive appropriate follow-up. These specialists are located at the University of Alabama in Birmingham (UAB), University of South Alabama in Mobile, and the St. Jude Clinic in Huntsville. In addition, there are seven community-based Sickle Cell Organizations who provide counseling and follow-up for infants identified with sickle cell disease and trait. The Cystic Fibrosis Care Center at UAB provides CF care to include genetic counseling at Children's of Alabama. It should be noted physicians should not bill for laboratory tests performed by the BCL. However, procedure codes 36415 and 36416 with modifier 90 may be billed for the specimen collection when referred to an outside laboratory. All screening tests are conducted by Alabama Department of Public Health's Bureau of Clinical Laboratories.

Laboratory Test	***Description***
Public Health: Alabama Voice Response System (AVRS):	The Alabama Voice Response System (AVRS) is a Newborn Screening Information System, offered by the Alabama Department of Public Health. The AVRS provides 24-hour, seven days a week telephone reporting of screening results in 30 seconds or less directly through a toll free number, (800) 566-1556, and has the capability of providing faxed copies of results. The AVRS requires pre-registration with the screening program and positive identification of the caller through two security checks. Physicians are prompted by the system to enter their state license number (preceded by zeros, if needed, to make a seven digit number), in addition to the entry of a four-digit personal identification number or PIN. Physicians may register with the program by completing the registration form found on the Alabama Newborn Screening website at: www.adph.org/NEWBORNSCREENING/ or by calling the Newborn Screening Program at 334-206-7065. Applicants will be notified when their form has been processed. Each physician chooses his or her individual PIN and records the number on the pre-registration form. The PIN must be four numeric characters. It is the responsibility of each physician to safeguard his or her PIN. If a PIN is lost, stolen, forgotten, or if a physician suspects someone has gained access to it, immediately call the Alabama Newborn Screening Program at 334-206-7065 and a new PIN will be issued. Physicians must have available the specimen kit number found on the filter paper collection form preceded by the year of the infant's birth **or** the mother's social security number. Information is provided by recorded voice messages. The infant's name and date of birth are spelled and verified by user response before any test results are given. Along with the test result, information is provided concerning the need for repeat testing or medical follow-up. Additional information may also be obtained by contacting the Newborn Screening Program at 334-206-7065 or 1-866-928-6755.
Iron Deficiency Anemia Screening	Hematocrit or hemoglobin values must be determined at a medical screening visit between 1-9 months of age. However, providers have the option of obtaining the lead and Hct or Hgb at nine or twelve months of age. Hematocrit or hemoglobin must be determined, between 11-20 years of age, and as deemed medically necessary based on physical examination and nutritional assessment.
Urine screening	Effective 10/01/2008 the urinalysis component of an EPSDT screening is no longer a requirement. A urinalysis should only be performed if clinically indicated. Urine screening must be performed at the medical screening visit at five years of age and at each visit between 11 and 20 years of age depending on the success in obtaining a voided urine specimen. If specimen is unobtainable, SNA (Specimen Not Available) should be documented. The required screening procedure is a dipstick that shows the measurement of protein and glucose. Urine obtained from recipients between 11 and 20 years of age should be checked for leukocytes.
Chlamydia Screening	Chlamydia Screening is recommended for all sexually-active females aged <25 years annually.

NOTE:

The hgb or hct are included in the screening reimbursement and should not be billed separately.

Laboratory Test	*Description*
Lead toxicity screening	All children must have a blood lead toxicity screening at 12 and 24 months of age. Providers have the option of obtaining the lead and Hct or Hgb at 9 or 12 months of age. A lead toxicity screening is also required for any child 36 to 72 months of age who has not previously received a blood lead toxicity screening or who presents with symptoms of possible lead poisoning. All children should receive lead toxicity screenings since all children are vulnerable to blood lead poisoning. Children's blood lead levels increase most rapidly at 9-12 months of age and peak at 18-24 months of age. The screening test of choice is blood lead measurement (replaces the erythrocyte protoporphyrin (EP) test.
Other lab tests	There are several other tests to consider in addition to those listed above. Their appropriateness is determined by an individual's age, sex, health history, clinical symptoms, and exposure to disease. These may include, for example, a pinworm slide, urine culture, VDRL, GC cultures and stool specimen for parasites, ova, and blood. **Note:** The test for VDRL, gonorrhea cultures, intestinal parasites, and pinworms may be done by the Alabama Department of Public Health clinical laboratory, at NO cost to the EPSDT screening provider. The State lab slip must have "EPSDT Program" documented across the top. Other Medicaid approved laboratories may be used to run sickle cell and lead screening tests.

NOTE:

The State Laboratory will supply microvettes, mailing containers and forms for obtaining blood lead levels at no cost to providers upon request. Please contact (334) 260-3400 to obtain additional information.

Public Health Department Services

EPSDT care coordination is initiated for children with a confirmed blood lead level of > 10 μg/dL. Case management services may be requested if the physician determines the family requires additional education in the home. A physician's order is required. EPSDT care coordinators assess the family's social and environmental needs, develop case plan with goal of reducing blood lead levels, educate family regarding lead risk behaviors, schedule blood lead level retest, and refer to appropriate resources regarding lead screening guidelines. An environmental investigation is initiated for children with a confirmed venous blood lead level of ≥ 15 ug/dL. Environmentalists perform an environmental investigation on a residence to identify lead hazards and recommend interim control or abatement measure if necessary.

Blood Lead Screening and Management Guidelines

Screening Guidelines

All children should receive blood lead level (BLL) screenings at 12 and 24 months of age. Providers have the option obtaining the lead level and Hct or Hgb at 9 or 12 months of age.

A BLL screening is also required for a child who:

- Is 36 to 72 months of age and has not previously received a BLL screening.
- Has a change in risk status.
- Presents with symptoms of possible lead poisoning. (Examples: severe anemia, seizures, constipation, abdominal pain, changes in behavior.)

Lead Risk Assessment Questionnaire

Providers should assess a child's risk of blood lead poisoning beginning at 9 month of age. Children determined to be at high risk of blood lead poisoning should receive parental education, nutritional counseling, and a BLL screening as appropriate. Administering the Risk Assessment Questionnaire instead of a BLL screening does not meet Medicaid requirements. A venous specimen is preferred, although capillary samples are acceptable.

BLL (ug/dL)	**COMMENTS**
5-9	CONFIRM with venous sample within **3 months**
10-14	CONFIRM with venous sample within **3 months**
15-19	CONFIRM with venous sample within **1 months**
20-44	CONFIRM with venous sample within **5 days**
45-59	CONFIRM with venous sample within **48 hours**
60-69	CONFIRM with venous sample within **24 hours**
>70	CONFIRM with venous sample **immediately**

Venous Samples - Confirmed Diagnostic Comments

< 5	EDUCATE families about preventing lead exposure SCREEN BLL at 12 and 24 months of age, or as indicated by risk status.
5-9	OBTAIN confirmatory diagnostic (venous) test within 3 months, even if the initial sample was venous. CONTINUE follow-up testing every 3 months until 2 consecutive tests are < 5 µg/dL. EDUCATE families concerning lead absorption and sources of lead exposure (ADPH pamphlet available). Case management services EXPLAIN that there is no safe level of lead in the blood. PROVIDE nutritional counseling. COMPLETE history and physical exam. TEST for anemia and iron deficiency. PROVIDE neurodevelopmental monitoring. SCREEN all siblings under age 6. OBTAIN abdominal X-ray (if particulate lead ingestion is suspected) with bowel

	decontamination if indicated.
10-14	REFER for targeted case management via mailing ADPH-FHS 135, *Elevated Blood Lead Environmental Surveillance Form, to the address on the bottom of the form within 5 days of notification of results. PROVIDE parental education and nutritional counseling. RETEST within 3 months with venous sample.*
15-19	REFER for targeted case management and environmental investigation via mailing ADPH-FHS-135, *Environmental Surveillance Form,* to the address on the bottom of the form within 5 days of notification of results. PROVIDE parental education and nutritional counseling. RETEST within 3 months with venous sample.
20-44	REFER for targeted case management and environmental investigation via mailing ADPH-FHS-135, *Environmental Surveillance Form,* to the address on the bottom of the form within 3 days of notification of results. PROVIDE parental education and nutritional counseling. RETEST within 3 months with venous sample or more often as determined by physician.
45-59	REFER for treatment (chelation therapy*) to physician within 24 hours if asymptomatic; otherwise, refer for medical treatment immediately. REFER for targeted case management and environmental investigation via faxing ADPH-FHS-135, *Environmental Surveillance Form,* to 334-206-2983 immediately upon notification of results. PROVIDE parental education and nutritional counseling. RETEST within 1 month with venous sample or more often as determined by physician.
60-69	REFER for treatment (chelation therapy*) to physician with 24 hours if asymptomatic; otherwise, refer for medical treatment immediately. REFER for targeted case management and environmental investigation via faxing ADPH-FHS-135, *Environmental Surveillance Form,* to 334-206-2983 immediately upon notification of results. PROVIDE parental education and nutritional counseling. RETEST within 2 weeks with venous sample or more often as determined by physician.
>70	REFER for treatment (chelation therapy*) to physician within 24 hours if asymptomatic; otherwise, refer for medical treatment immediately. REFER for targeted case management and environmental investigation via faxing ADPH-FHS-135, *Environmental Surveillance Form,* to 334-206-2983 immediately upon notification of results. PROVIDE parental education and nutritional counseling. RETEST weekly with venous sample or more often as determined by physician.

***Child should only return to a lead-safe environment after chelation therapy.**

CLINICAL NOTE:

Most children with lead poisoning are asymptomatic. Symptomatic children with elevated blood lead levels should be evaluated immediately. Symptoms may include coma, seizures, bizarre behavior, ataxia, apathy, vomiting alteration of consciousness, and subtle loss of recently acquired skills. Lead encephalopathy has been reported with levels as low as 70 µg/dL.

Environmental Lead

Environmental Lead Investigations is the investigation of the home or primary residence of an EPSDT-eligible child who has an elevated blood lead level. Please refer to Chapter 101, County Health Departments, for more information.

Normal and Abnormal Diagnoses

An abnormal diagnosis should only be billed when a health problem is identified and is referred for further diagnosis and treatment services. These services may be self-referrals.

A normal diagnosis should be billed when no health problem is identified or when identified health problems are treated immediately (acute or one time problem) during the screening (same day) and no referral is made for further diagnosis and treatment services. A normal diagnosis should also be billed when the only referrals are for *routine* vision, hearing or dental services. ICD 10 diagnosis Z00.12, Z76.1 and Z76.2 for age 29 days to 17 years and Z00.0, Z00.00 and Z00.01 for age 18+ on or after October 01, 2015.

Interperiodic Screenings

EPSDT-eligible children may receive medical, vision, hearing, and dental services that are medically necessary to determine the existence of a suspected physical or mental illness or condition, regardless of whether such services coincide with the periodicity schedule for these services. Screenings that are performed more frequently or at different intervals than the established periodicity schedules are called **interperiodic screenings**. An interperiodic screening may be performed before, between, or after a periodic screening if medically necessary. Interperiodic screenings are performed for undiagnosed medically necessary conditions outside the established periodicity schedule. Interperiodic EPSDT screenings are problem-focused and abnormal.

Interperiodic screening examinations may occur even in the case of children whose physical, mental, or developmental illnesses or conditions have already been diagnosed if there are indications that the illness or condition may have become more severe or has changed sufficiently, so that further examination is medically necessary.

By performing an interperiodic screening and issuing and EPSDT referral form, physician office and other benefits will be "saved" for acute illnesses or other sickness. An interperiodic screening should be performed (where a history and problem-focused physical exam occurs) for suspected medical, vision, hearing, psychological, or dental problems in order for an EPSDT referral to be issued for further diagnosis and/or treatment. In this manner, the recipient will be referred for consultation and/or to a specialist for medically necessary and appropriate diagnostic tests and/or treatment. Vision/hearing screenings are to be performed/billed on the same date of service as an initial or periodic screening only. Vision/hearing screenings are limited to one each annually, beginning at age 3 for vision and 5 for hearing. However if a suspected vision/hearing/ dental/medical problem should manifest itself, an interperiodic screening should be performed in order for an EPSDT referral to be issued to a specialist or consultant. For more information regarding vision and hearing screenings, please refer to section A.3.5. For more information regarding dental, please refer to Chapter 13 Dentist. For dental EPSDT referral requirements, please refer to Chapter 13.

An interperiodic screening may be performed based upon a request by the parent(s) or guardian(s), or based on the provider's professional judgment relative to medical necessity. The Alabama Medicaid Agency considers **any** encounter with a health care professional who meets the qualifications for participation in the EPSDT program to be an interperiodic screen, regardless of whether the health care professional is enrolled as a provider with the Agency.

A health developmental or educational professional who comes in contact with the child outside the formal health care system may also determine whether an interperiodic screening is medically necessary. The screening provider must document the person referring the child, and a description of the suspected problem, in the record.

Documentation requirements for interperiodic screenings are:

- Consent
- Medical-surgical history update;
- Problem-focused physical examination
- Anticipatory guidance/counseling related to the diagnosis made.

Interperiodic screenings must always be filed with the patient’s other insurance first. If the primary insurance is a HMO or the provider is a FQHC, IRHC or PBRHC, the interperiodic screening code must be submitted. Once the claim has been paid/denied, Medicaid may then be billed utilizing the interperiodic screening code with an EP modifier appended. When filing for an interperiodic screening, always append an EP modifier or the visit will count against benefit limits.

If the primary insurance is not a HMO, bill the appropriate “office visit” code. Once the claim has been paid/denied from the patient’s other insurance, a claim may be filed with Medicaid utilizing the same “office visit” code with an EP modifier appended. When billing an office visit code for an interperiodic code, always append the EP modifier or the visit will count against benefit limits.

NOTE:

If any other treatments are provided the same day (injections, lab, etc.), a “1” or “4” must also be reflected in Block 24h, on each line item, or the claim will deny.

NOTE:

Effective January 1, 2007 and thereafter, interperiodic screening codes have changed. The codes for interperiodic screenings **must be billed with an EP modifier and** are as follows:

99211 EP through 99215 EP for office and/or outpatient interperiodic screenings

99233 EP for Inpatient interperiodic screenings

The new interperiodic screening codes will count against office /hospital visit limits if billed without an EP modifier.

The Evaluation and Management code level of care chosen must be supported by medical record documentation.

Each child’s primary insurance must be billed first, and then Medicaid as the payor of last resort.

SCREENING CODES

PROCEDURE CODE	DESCRIPTION	Medicaid EPSDT Provider Rate (EP)
99381 EP EPSDT NEW PATIENT	NEW PATIENT UNDER 1 YEAR OF AGE	$ 70.00
99382 EP EPSDT NEW PATIENT	NEW PATIENT 1YEAR TO 4 YEARS OF AGE	$ 70.00
99383 EP EPSDT NEW PATIENT	NEW PATIENT 5 YEARS TO 11 YEARS OF AGE	$ 70.00
99384 EP EPSDT NEW PATIENT	NEW PATIENT 12 YEARS TO 17 YEARS OF AGE	$ 70.00
99385 EP EPSDT NEW PATIENT	NEW PATIENT 18 YEARS TO 20 YEARS OF AGE	$ 70.00
99391 EP EPSDT ESTABLISHED PATIENT	ESTABLISHED PATIENT UNDER 1 YEAR	$ 70.00
99392 EP EPSDT ESTABLISHED PATIENT	ESTABLISHED PATIENT 1 YEAR TO 4 YEARS OF AGE	$ 70.00
99393 EP EPSDT ESTABLISHED PATIENT	ESTABLISHED PATIENT 5 YEARS TO 11 YEARS OF AGE	$ 70.00
99394 EP EPSDT ESTABLISHED PATIENT	ESTABLISHED PATIENT 12 YEARS TO 17 YEARS OF AGE	$ 70.00
99395 EP EPSDT ESTABLISHED PATIENT	ESTABLISHED PATIENT 18 YEARS TO 20 YEARS OF AGE	$ 70.00
99211 EP INTERPERIODIC	ESTABLISHED PATIENT PRESENTING WITH PROBLEM MINOR	$ 27.00
99212 EP INTERPERIODIC	ESTABLISHED PATIENT PRESENTING WITH PROBLEM SELF-LIMITED OR MINOR.	$ 27.00
99213 EP INTERPERIODIC	ESTABLISHED PATIENT PRESENTING WITH PROBLEM LOW TO MODERATE SEVERITY.LOW COMPLEXITY MEDICAL DECISION MAKING.	$ 27.00
99214 EP INTERPERIODIC	ESTABLISHED PATIENT PRESENTING WITH PROBLEM MODERATE TO HIGH SEVERITY. MODERATE COMPLEXITY MEDICAICAL DECESION MAKING.	$ 27.00
99215 EP INTERPERIODIC	ESTABLISHED PATIENT PRESENTING WITH PROBLEM MODERATE TO HIGH SEVERITY. HIGH COMPLEXITY DECISION MAKING.	$ 27.00

PROCEDURE CODE	DESCRIPTION	Medicaid EPSDT Provider Rate (EP)
96110 Developmental Screening	The screening is to determine whether the patient requires additional work up for a developmental disorder or at periodic intervals throughout infancy and adolescent years.	$ 10.00
96127 Brief Emotional or Behavioral Assessment	Assessment of the patient's emotions and behaviors associated with conditions such as depression or attention-deficit/ hyperactivity disorder (ADHD).	$ 3.27

NOTE:

Effective 1/1/2011, periodic screening codes 99382 EP- 99385 EP and 99392 EP- 99395 EP may not be billed in a hospital setting (inpatient or outpatient facility settings).

Intensive Developmental Diagnostic Assessment

An EPSDT Intensive Developmental Diagnostic Assessment is a multidisciplinary comprehensive screening limited to infants' age zero to under two years, and is also limited to two per recipient per lifetime. These screenings are in addition to the routine periodic screenings and must be performed by a qualified EPSDT Intensive Developmental Diagnostic Assessment Screening provider, as approved and enrolled by Medicaid.

NOTE:

Medical necessity is subject to retrospective review by the Alabama Medicaid Agency. Please refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for more information.

Interagency Coordination

The State of Alabama, in conjunction with the Interagency Coordinating Council and the Alabama Department of Rehabilitation Services will implement a system of services to the eligible population (20 USC Section 1471 et seq, Part H), with the assistance of agencies, programs, providers, and the families of eligible infants and toddlers with special needs.

The Alabama Medicaid Agency is one of nine state agencies that hold positions on the Interagency Coordinating Council. The Early Intervention Law legislates a statewide system of early intervention services for eligible infants and toddlers that is comprehensive and coordinated among all disciplines and providers involved, and encourages the development of a system of service delivery that includes parents' participation and input. Services that provide early intervention are to be coordinated across agency and provider lines.

The definition of a child eligible for early intervention includes infants and toddlers under age three inclusive, who are either (1) experiencing developmental delay equal to or greater than 25 percent as measure by appropriate diagnostic instruments and procedures in one or more of the following areas: cognitive development, physical development (including vision and hearing), communication development, social or emotional development, adaptive development; or (2) they have a diagnosed physical or mental condition which has a high probability of resulting n developmental delay are eligible for early intervention services. Early intervention services can include the following:

Audiology	Service coordination
Family training/counseling & home visits	Occupational therapy
Health	Nursing
Medical services for diagnostic/evaluation	Vision services
Nutrition	Physical therapy
Psychological services	Social work
Special instruction	Speech/language pathology
Assistive technology devices & services	Transportation

The Early Intervention Service Coordinator who receives the Child Find referral will contact the EPSDT or Patient 1st provider to obtain the EPSDT screening information and any other pertinent information. In order to coordinate services, once a well child check-up (EPSDT) has been completed and a developmental delay has been indicated, contact Child Find, (**800) 543-3098**. Please refer to the Early Intervention Child Find Referral Form at the end of this Appendix or visit Medicaid's website at: www.medicaid.alabama.gov.

NOTE:

You may refer a family to Alabama's Early Intervention System (AEIS) in addition to referring the child and family to other appropriate services. AEIS staff is located in seven districts in the state. Please call the toll free number if you are interested in information about local EI resources.

Recommended Health Education Counseling Topics

2 weeks-3 months
Nutrition - Spitting up
Hiccoughs
Sneezing, etc.
Safety
Need for affection
Immunizations
Skin and scalp care
Bathing frequency
How to use a thermometer
When to call the doctor

4-6 months
Nutrition
Safety
Teething and drooling/dental hygiene
Fear of strangers
Lead poisoning
Immunizations

7-12 months
Nutrition
Immunizations
Safety
Dental hygiene
Night crying
Separation anxiety
Need for affection
Discipline
Lead poisoning

13-18 months
Nutrition
Safety
Immunizations
Dental hygiene
Temper tantrums
Obedience
Speech development
Lead poisoning

19-24 months
Nutrition
Safety
Need for peer relationship
Sharing
Toilet training
Dental hygiene
Need for attention and patience
Lead poisoning

3-5 years
Nutrition
Safety
Dental hygiene
Assertion of independence
Type of shoes
Need for attention
Manners
Lead poisoning

6-13 years
Nutrition
Safety
Dental care
School readiness
Onset of sexual awareness
Peer relationship (male and female)
Preputertal body changes
Substance abuse
Tobacco Cessation
Contraceptive information (if sexually active)

14-21 years
Nutrition
Dental
Safety (automobile)
Understanding body anatomy
Male/female relationships
Contraceptive information
Obedience and discipline
Parent-child relationships
Alcohol, drugs, and smoking
Tobacco Cessation
Occupational guidance
Substance abuse

Providers may use the PT+3 teaching method for anticipatory guidance counseling. Providers should document PT+3 counseling was utilized and list the three points emphasized.

Providers must provide age-appropriate health education related to smoking and smoking cessation. This includes risk-reduction counseling with regard to use during routine well-child visits. In addition to routine visits, additional counseling must be provided when medically necessary for individuals under age 21.

Billing Requirements

The table below provides billing information for EPSDT screening claims:

Topic	***Explanation***
Copayment	EPSDT recipients, under 18 years of age, are not subject to co-payments.
Prior Authorization	Screenings are not subject to prior authorization.
Referral	Please refer to Section A.4, Providing and Obtaining Referrals, for more information.
Time Limit for Filing Claims	One year from the date of service
Visit Limitations	An office visit is not billable on the same day with an EPSDT screening by the same provider or provider group.
Diagnosis Codes	The *International Classification of Diseases - 10th*

Topic	*Explanation*
	Revision - Clinical Modification (ICD-10-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885, or 1-800-621-8335.
Procedure Codes and Modifiers	The following procedure codes should be used when billing comprehensive EPSDT screening services: 99381-99385 with modifier EP Initial EPSDT Screening 99391-99395 with modifier EP Periodic EPSDT Screening 99173 with modifier EP Vision Screening – Annual 92551 with modifier EP Hearing Screening – Annual Effective January 1, 2007 the interperiodic screening codes have changed. The following procedure codes (in service locations other than inpatient hospital) must be used: 99211EP-99215EP EP modifier should be used to identify services relating to Periodic and Interperiodic screening.For interperiodic screenings performed in an inpatient hospital setting, the following procedure code must be used: 99233EP EP modifier should be used to identify services relating to Periodic and Interperiodic screening. Interperiodic screening codes should have abnormal diagnosis codes. The (837) Professional, Institutional and Dental electronic claims and the paper claim have been modified to accept up to four Procedure Code Modifiers.
Intensive Developmental Diagnostic Assessment (Multidisciplinary team) An HT modifier must be appended to procedure codes 96110 and 96111 to identify Intensive Diagnostic Assessment (Multidisciplinary team)	The following procedure codes should be used when billing for an intensive development diagnostic assessment (a multidisciplinary comprehensive screening) for children under two years of age (limited to two per recipient per lifetime) 96110-HT – Developmental testing; limited (eg, Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report. (Formerly known as Intensive developmental diagnostic assessment, normal findings) 96111-HT– Developmental testing; extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments) with interpretation and report. (Formerly known as Intensive developmental diagnostic assessment, abnormal findings)
Third Party Coverage	Providers are required to file with available third party resources prior to filing Medicaid. Preventive pediatric services and prenatal care are excluded from this requirement unless the recipient has managed care coverage or Medicaid pays the provider a global fee.
Reimbursement	Governmental screening providers (including physicians) will be paid on a negotiated rate basis, which will not exceed their actual costs. Non-governmental screening providers will be paid their usual and customary charge, which is not to exceed

Deleted: ~~You must use an EP modifier in order to bypass office visit benefit limits.~~

Added: EP modified should be used to identify services relating to Periodic and Interperiodic screening.

Deleted: ~~You must use an EP modifier in order to bypass hospital visit benefit limits.~~

Added: EP modifier should be used to identify services relating to Periodic and Interperiodic screening.

Topic	*Explanation*
	the maximum allowable rate established by Medicaid.
EPSDT Indicator Reference	The EPSDT Indicator will be either a "Y" or "N", as applicable, when using electronic claims only.

Deleted: ~~initial, periodic, and interperiodic~~

Added: Initial, Periodic, and Interperiodic

NOTE:

Well child check-up visits (Initial, Periodic, and Interperiodic screenings) do not count against recipient's benefit limits of 14 physician office visits per calendar year. There is no co-pay for recipients under 18 years of age.

A.3.7 Patient 1st, Primary Care Case Management (PCCM) Referral Services

To participate in the PCCM program, physicians are required to:

- Provide an ongoing physician/patient relationship
- Provide primary care services, including prevention, health maintenance and treatment of illness and injury
- Coordinate all patient referrals to specialists and other health services
- Offer 24-hour availability of primary care or referral for other necessary medical services
- Use a preferred drug list
- Follow program procedures
- Participate in the enrollee grievance process
- Meet other minimum program criteria

Physicians who agree to serve as primary medical providers are paid fee components to provide case management services for their patients.

Please refer to the Alabama Medicaid Provider Manual, Chapter 39 for more information regarding the Patient 1st program.

NOTE:

The Patient 1st program does not extend or supersede any existing program benefit or program requirement.

A.3.8 Billing for Patient 1st Referred Services

To bill for a service that requires a Patient 1st referral, the billing provider must have a valid signed referral form in the recipient's medical record. This form should contain the PMP's number to use for billing. If a service does not require a Patient 1st referral it is not necessary to get a referral from the PMP and it is not necessary to retain a referral form in the recipient's medical record. A list of the Patient 1st services "requiring" and "not requiring" a written signed referral are listed in the Alabama Medicaid Provider Manual in Chapter 39.

When billing for referred services the PMP name/10-digit NPI, and indicator "4" must be reflected on either the CMS-1500 (blocks 17, 17a, and 24J) by the specialty physician or on the UB-04 (block 78 and the indicator "A1" in block 24) if a hospital or outpatient clinic is providing the specialty services. If all fields are not properly coded, Medicaid will reject the claim. (Refer to Chapters 5, Filing Claims, and 39, Patient 1st, of the Provider Manual for claim instructions).

If a service performed by the billing provider does **not** require a Patient 1st referral, do not enter the name of a referring physician and/or the 10-digit NPI on the CMS-1500 (blocks 17 and 17a) or on the UB-04 Claim Form (block 78).

Please refer to Chapter 5, Filing Claims, for information regarding filing claims from a Patient 1st referral.

A.4 Providing and Obtaining Referrals

One of the primary purposes of the EPSDT services is to ensure that health problems are diagnosed and treated early before they become more complex and their treatment more costly. A Medicaid eligible child who has received an EPSDT screening (well child check-up) may receive additional medically necessary health care. These services are considered above the normal benefit limitations and require a referral from an EPSDT screening provider and Patient 1st PMP, if applicable. Some of these referred services require prior authorization from the Alabama Medicaid Agency. The Alabama Medicaid Referral Form (Form 362) must be appropriately completed by the screening physician including the screening date that the problem was identified and the reason for referral.

Providers are not required to complete written referrals (Patient 1st or EPSDT) to the other providers in the same group, provided that all documentation by all physicians in that group for a specific recipient is included in one common record (electronic or paper). The medical record documentation shall clearly indicate that the PMP did a screening, identified the problem, and the referral was made to self or specialist within that group.

Providers are required to complete written referrals to other specialists in the same group if a common medical record is not used. Referrals to specialists and other physicians outside of the group are required to have a written Patient 1st and/or EPSDT referral.

A cascading referral is used in situations where more than one consultant may be needed to provide treatment for an identified condition(s). When this situation arises, the original referral form is generated by the assigned primary medical provider.

If the first consultant determines a recipient should be referred to another consultant/specialist, it is the first consultant's responsibility to provide a copy of the referral form to the second consultant. This process is continued until the condition(s) have been rectified or in remission, or referral expires, at which time a new screening and referral must be obtained. A new approval/EPSDT screening must be provided anytime the diagnosis, plan of care (care plan, plan of treatment, treatment plan, etc.), or treatment changes. The consultant must contact the PMP for a new referral/screening at that time.

Medical documentation must be present in the recipient's medical record identifying the provider making referrals between consultants. Medical documentation created as a result of a referral between consultants must be associated with the original referral from the PMP.

If a child is admitted to the hospital as a result of an EPSDT screening, the days will not count against the yearly benefit limit. Facility fees for outpatient visits will not count against the yearly benefit limit if the visit is the result of an EPSDT screening and referral. Services rendered by speech and occupational therapists are covered **only** as the result of an EPSDT screening.

Signature Requirement for Referrals: Effective May 16, 2012:

For hard copy referrals, the printed, typed, or stamped name of the primary care physician with an original signature of the physician or designee (physician or non-physician practitioner) is required. **Stamped or copied signatures will not be accepted**. For electronic referrals, provider certification is made via standardized electronic signature protocol.

A.4.1 Vision, Hearing, and Dental Referrals

If the EPSDT screening provider chooses to refer a recipient for vision, hearing, and/or dental services, the recipient must be referred to the appropriate provider for diagnosis and/or treatment. After the recipient's vision, hearing, and/or dental service is initiated, the consultant's portion of the EPSDT referral form must be completed by the consultant and the appropriate copy must be returned to the screening provider. Referral forms should be returned in 30 days, from the date of the appointment, or (if no appointment was made) from the date of the screening examination.

NOTE:

If the recipient is one year of age or older and is not under the care of a dentist, the recipient must be referred to a dentist for diagnosis and/or treatment. Follow-up on dental referrals is not required.

A referral form is completed by the screening provider when an abnormality or condition is noted during the child's screening that requires further diagnosis and/or treatment. The referring provider must document the condition(s) within the medical record (either in the medical history or physical exam portion). Medicaid has the right to recoup the screening service fees from the referring provider when a referral is made for a condition not documented in the medical record (in medical history or physical exam portion).

A.4.2 Referrals Resulting from a Diagnosis

If, as a result of a medical, vision, hearing, or dental screening, it is suspected or confirmed that the child has a physical or mental problem, the screening provider and Patient 1st PMP, if applicable, must refer the child without delay for further evaluation of the child's health status. Follow-up is required to assure that the child receives a complete diagnostic evaluation. Diagnostic services may include but are not limited to physical examination, developmental assessments, psychological and mental health evaluation, laboratory tests and any x-rays. Diagnosis may be provided at the same time or it may be provided at a second appointment. For services such as physical therapy, speech therapy, and occupational therapy that require physicians' orders, all orders must be written according to practice guidelines and state/federal law and must include the date and signature of the provider, the service(s) ordered and the recipient's name. The Pt. 1st/EPSDT referral form may be considered the physician's order as long as these guidelines are met. The physician's order/prescription date is considered "today's date" on the referral form.

The time limit for completing the referral form (Form 362) requires the form to be completed within 364 days of the date of the screening. If an abnormality or condition is noted during an EPSDT screening and an EPSDT referral form is not issued at the time (for example, sickle cell remission), an EPDST referral may be issued at a later date for the same diagnosis only (for example, sickle cell remission changes to sickle cell crisis). In this instance, the date utilized on the referral form will be the same as the date of the EPSDT screening where the abnormality/condition was noted. If another abnormality or condition occurs that was not diagnosed during an EPSDT screening, or if a condition has changed sufficiently so that further examination is medically necessary, an Interperiodic screening should be performed (or periodic screening if it is due) to identify the problem.

EPSDT referrals are valid for **one year from the date of the EPSDT screening**. Therefore the maximum time an EPSDT referral is valid is 12 months from the date of the well child check-up (EPSDT screening). The EPSDT screening date must be current to be valid. The EPSDT screening date may not be backdated or future dated. The date of the EPSDT screening should be documented under "Type of Referral" on form 362, the Alabama Medicaid Agency Referral Form. The EPSDT screening date documented on the Referral Form is the date used to determine the length of time an **EPSDT referral is valid** (regardless of a Patient 1st referral). The "Length of Referral" is used to determine the amount of time the referral is valid from the referral date and is inclusive of all types of referrals (e.g., Patient 1st referral, EPSDT referral, Targeted Case Management, etc). Please refer to Appendix E, Medicaid Forms, for additional information.

Diagnosis and treatment services may be provided by the screening provider (self-referral) or may be obtained by referral to any other practitioner or facility qualified to evaluate, diagnose, or treat the child's health problem.

NOTE:

The number of visits or months must be documented on the EPSDT referral form to be considered a valid referral.

A.4.3 Treatment

Treatment may include but is not limited to physicians' or dentists' services, optometrists' services, podiatrists' services, hospital services (inpatient and outpatient), clinic services, laboratory and X-ray services, prescribed drugs, eyeglasses, hearing aids, prostheses, physical therapy, rehabilitation services, psychological services, and other types of health care and mental health services.

If a condition requires a referral, it is the responsibility of the screening provider and Patient 1st PMP, if applicable, to:

- Document the abnormality discovered during the EPSDT screening in the record
- Determine what resources a child needs and to which provider he/she wishes to be referred (the recipient's freedom of choice of providers must be ensured)

- Make the appropriate referral in a timely manner
- Offer and provide assistance in scheduling the appointment
- Verify whether the child received the service. Referrals must be followed up within 30 days (excluding dental) from the date of the appointment with the consultant.

A.4.4 Completing the Referral Form

The Referral for Services Form 362 must be completed after a screening if further diagnosis and/or treatment are required for a child not assigned to a PMP. The referral form is completed when referring the recipient to other providers for services that were identified during the screening as medically necessary.

Refer to Appendix E, Medicaid Forms, for a sample of the Alabama Medicaid Agency Referral Form.

Screening providers must include their 10-digit National Provider Identifier (NPI), name, and address for those recipients who do not participate in managed care (i.e., Patient 1st).

PMPs must include their 10-digit National Provider Identifier (NPI), name, and address for those recipients who participate in Patient 1st.

- The **screening provider** must document the time span in which the referral is valid. The maximum time span is 12 months from the date of the screening.
- The **consulting provider** must follow the appropriate billing instructions and guidelines for completion of the CMS 1500 claim form found in Chapter 5, Section 5.2.2 of the Alabama Medicaid Provider Manual.

NOTE:

Once benefit limitations have been exceeded, Medicaid will not pay for services without the EPSDT referral. This is important for patients with chronic conditions or a problem that will require numerous visits to treat. Providers should write the referral as soon as the condition is noted so that the regular benefits are not exhausted.

The referral form should follow the recipient for all services related to the condition noted on the form. If a child is screened with a particular condition noted and referred for further diagnosis, and another condition develops that is not noted on the referral form, the child must be re-screened in order to receive expanded benefits for the second condition noted. If not re-screened, the services rendered would count against the child's routine benefit limits.

NOTE:

If the screening provider refers a child to a consultant, it is the screening provider’s responsibility to follow up. However, if the managed care provider refers the child to a consultant, it is the managed care provider’s responsibility to follow up.

A.4.5 EPSDT Referrals for Patient 1st Recipients

Scenario: A child is referred by the PMP to be screened by a county health department and appears to have a foot deformity.

Procedure: The child **must** be sent to their assigned Primary Medical Provider (PMP) to obtain the PMP referral form. The PMP may choose to

- Provide the necessary treatment
- Refer the child to an orthopedic specialist
- Instruct the screening provider to complete the referral form

The PMP must complete the Alabama Medicaid Agency Referral Form (Form 362) if referring the child to a specialist. The name and address of the screening provider should be entered to reflect, in this scenario, the county health department. The screening NPI and signature will reflect the county health department number and the signature of the health department employee who performed the screening.

The referring/PMP number reflects the NPI of the PMP. The consulting provider must use the PMP's number as the referring physician on the claim form.

In this scenario, the specialist may suggest surgery, braces, and/or therapy. All services approved by and referred by the PMP would then be covered by an EPSDT screening referral.

NOTE:

The PMP must be contacted and approve any and all referrals made by the specialist.

A.4.6 EPSDT Referrals for Non-Patient 1st Recipients

Scenario: A child is screened by a county health department and appears to have a foot deformity.

Procedure: This child is referred to a pediatrician. The pediatrician may then refer the child to an orthopedic specialist. The specialist may suggest surgery, braces, and/or therapy.

All services in this scenario are covered by the original EPSDT screening referral, which must follow the child from visit to visit. Each provider treating the condition diagnosed during the screening, and documented in the referral, must include the referring provider's number on the claim form. Please refer to Chapter 5, Filing Claims, for instructions on including the referring NPI on the claim form.

A.4.7 Billing Instructions for Referred Services

For EPSDT Referred Services

If you file hard copy claims on the **UB-04**, you must complete the following fields:

- Block 2 – Enter the screening provider's 10-digit National Provider Identifier (NPI)
- Block 24 – Enter "**A1**" to indicate EPSDT

If you file **electronically** on the UB-04 (837 Institutional) using DXC *Provider Electronic Solutions* software, please refer to the latest edition of the Provider Electronic Solutions User Manual.

If you file claims on the **CMS-1500**, you must complete:

- Block 17 – Enter the name of screening provider
- Block 17a – Enter the screening provider's 10-digit National Provider Identifier (NPI)
- Block 24H – Enter "**1**" to indicate EPSDT

If you file **electronically** on the CMS-1500 (837 Professional) using DXC *Provider Electronic Solutions* software, please refer to the latest edition of the Provider Electronic Solutions User Manual.

For Patient 1st and EPSDT Referred Services

If you file claims on the **UB-04**, you must complete:

- Block 2 – Enter the referring PMP's 10-digit National Provider Identifier (NPI)
- Block 24 – Enter "**A1**" to indicate EPSDT and managed care

If you file electronically on the UB-04 (837 Institutional) using DXC *Provider Electronic Solutions* software, please refer to the latest edition of the Provider Electronic Solutions User Manual.

If you file claims on the **CMS-1500**, you must complete:

- Block 17 – Enter the name of referring PMP
- Block 17a – Enter the referring PMP's 10-digit National Provider Identifier (NPI)
- Block 24H – Enter "**4**" to indicate EPSDT and managed care

If you file **electronically** on the CMS-1500 (837 Professional) using DXC *Provider Electronic Solutions* software, please refer to the latest edition of the Provider Electronic Solutions User Manual.

NOTE:

Each line item on the CMS-1500 Claim Form must have an indicator in Block 24 or 24H if billing for a Referred Service.

For Example: If the first line is an office visit and the indicator in Block 24 Or 24H is a "4", All additional services for that Date Of Service must also have an indicator of "4" in Block 24 Or 24H or the claim will deny.

Coordinating Care

The Alabama Medicaid Agency establishes the service standards and requirements that the providers must meet.

Providers of medical screening services are responsible for overall care coordination for those recipients that are not enrolled in a managed care system. For those recipients who are enrolled in a Managed Care system, it is the managed care provider's responsibility for overall care coordination. These ongoing activities include scheduling, coordinating, follow-up, and monitoring necessary EPSDT screening and other health services.

Care coordination enhances EPSDT Program efficiency and effectiveness by assuring that needed services are provided in a timely and efficient manner and that duplicated and unnecessary services are avoided.

A.4.8 Consent Forms

Since EPSDT screenings are voluntary services, some parents of children may decline a screening. This does not preclude the child from receiving a screening at a later date or receiving medically necessary diagnosis, treatment or other health services separate from the screening, providing such services do not exceed normal benefit limitations.

A "Consent for Services" form must be signed at each visit by the responsible adult. The consent could be a permission form to treat or a signature reflecting the date the service is rendered (e.g., a sign-in sheet). The consent for services should be filed in the patient's permanent medical record. If a sign-in logbook is used, the provider will need to keep this record for a minimum of three years plus the current year. The responsible adult must be present at the time of the screening to give pertinent history and developmental status and to receive counseling as indicated. The absence of a responsible adult as defined above would invalidate the screening. When off-site screenings are performed, the parent may complete the history form prior to the screening in compliance with Off-Site Screening Protocol. Recipients 14 years of age or older may sign for themselves.

A.4.9 Medical Records

All screening providers must maintain complete records for three years plus the current year on all children who have received services or screened. Records of all EPSDT-eligible children must be made available to Medicaid upon request. Medicaid will monitor EPSDT services provided by screening physicians or agencies on a periodic basis. If Medicaid identifies claims paid where any three findings listed as critical components of the screening process are omitted, the claim may be adjusted.

Medical records must include the following documentation. The critical components of a well child check-up (comprehensive screening) are denoted with an asterisk.

- Consent signature
- * Family history of diseases and annual updates
- * Medical history and updates at each screening
- Mental health assessment
- * History of immunizations and administration as indicated
- * Age-appropriate developmental assessment
- * Age-appropriate anticipatory guidance
- * Nutritional assessment to include recorded results of hemoglobin/hematocrit and plotted height/weight
- * Documentation of sickle cell test results
- * Recorded results of hemoglobin/hematocrit
- *urine test for protein and sugar (Effective 10/01/2008, urine screening needs to be performed only if clinically indicated)
- * Lead testing/results (according to age)
- Tb skin test
- Height, weight, temperature, pulse, and blood pressure
- * Vision and hearing assessment/testing (Considered as two critical components)
- * Documentation of the unclothed physical examination
- * Dental referral/status for recipients 1 year of age and above
- * Failure to make appropriate referral, when required (i.e., medical, vision, hearing)
- * Referral follow-up on conditions related to medical, vision, or hearing problems

A.5 Off-site Screenings

Children are our state's most important assets and yet many of them arrive at school generally in poor health. The healthier a child, the greater his or her learning potential. The Alabama Medicaid Agency is committed to helping ensure that children are healthy and ready to learn. To that end, the Alabama Medicaid Agency has developed protocols for off-site EPSDT screenings. These services must be accessible to all children, not just Medicaid-eligible children.

NOTE:

EPSDT screening providers must also contact the recipient's primary medical provider (Patient 1st) to receive prior authorizations to perform the screening.

Off-site screenings are defined as screenings that are provided off-site from a medical facility, which is limited to hospitals, physician offices, Department of Public Health (DPH) clinics, and Federal/State certified clinics. Off-site screenings occur in schools, day care centers, head start centers, and housing projects.

An off-site EPSDT screening provider must develop and adhere to confidentiality policies set out by the respective agencies and should be submitted to the agency. Information pertinent to the child's performance may be shared. Information pertinent to infectious disease shall be released only by the County Health Officer. Sharing information with others outside the local agency may take place only if parental consent has been given.

Provider is defined as and will include only a county health department clinic, hospital, FQHC, IRHC, PBRHC, or a physician's office. A provider must be located within the county or within 15 miles of the county in which the off-site screenings occur. Medical personnel performing the physical examination are limited to physicians, certified registered nurse practitioners (CRNP), certified nurse midwives (CNM), physician assistants (PA), and registered nurses (RN) employed by the facilities listed above.

Clinic is defined as a certified medical facility, under the supervision of a physician that provides a full range of medical services on a regular basis. A clinic must be equipped to handle acute care situations and provide treatment and/or management of chronic diseases. Licensed medical personnel must perform medical services.

Medical facility is defined as a Federal/State certified clinic, hospital, physician's office, or a DPH clinic where diagnosis of health problems are rendered and treatment of diseases occur. The medical facility must have a permanent location, regularly scheduled hours of operation, and a published telephone number. Medical services and supplies must also be available for treatment of abnormal conditions identified at the time of an EPSDT screening.

Physician's office is defined as a place staffed by physician(s) and other medical professionals where medical activities, such as the practice of medicine, is conducted. This office is specifically designed and set up to provide medical diagnosis and treatment of medical conditions. This office is open and operating on a published, regularly scheduled basis with a published telephone number and regularly scheduled appointments.

A.5.1 Enrollment for Off-site providers

To be considered as an EPSDT screening provider for off-site screenings, potential providers must submit the following criteria:

- A letter documenting the ability to complete all components of a screening. The physical exam portion of the screening must be completed by an approved EPSDT screening provider: physician, nurse practitioner, physician assistant, or a registered nurse. All registered nurses, except BSNs, must complete a Medicaid-approved Pediatric Assessment course or show proof of having completed a similar program of study in their professional training that prepared them to perform pediatric health assessments.
- A primary care referral list of medical providers in the county to whom you will refer to services. The referral list must include pediatricians, family and/or general practice physicians, internal medicine physicians, vision and hearing providers, and dentists. All providers must agree to be on your referral list, therefore, you must submit their written agreement with your referral list. The list must be sufficient in number to allow recipients/parents a choice in the selection of a provider.
- Documentation to demonstrate that services will be offered to all children enrolled at an off-site location, not just Medicaid-eligible children. A copy of your fee schedule must be attached to your documentation and must include fees for non-Medicaid enrollees.
- Child abuse and confidentiality policies
- A signed Matrix of Responsibilities form between the off-site location authority (school superintendent, principal, day care director, etc.) and the screening provider. Only one screening provider will be approved per location.

NOTE:

Only RNs that are employed by a FQHC, RHC, Health Department, Physicians office, and hospital may perform off-site EPSDT screenings.

- A signed agreement/letter from a local physician to serve as Medical Director. This physician may be a pediatrician, family practice physician, general practice physician, or an internal medicine physician. Proof of 6 pediatric focused credits (CME) from the previous year must be included with the signed agreement. EXCEPTION: A board-certified pediatrician should submit a copy of current certification only. **The medical director is responsible for resolving problems that the nurses encounter and rendering care for medical emergencies.**
- A monthly schedule shall be maintained designating the dates, times, and the local agency in which you will be offering the EPSDT services. The monthly schedule should be readily available and retained in either the local agency/medical facility (i.e., the facility that has been approved as an off-site EPSDT screening provider) or the recipient's medical record. Failure to maintain schedules one week in advance of Off-site EPSDT screenings may result in termination and loss of revenue.

- A document, listing members of the Peer Review Coalition of community members to serve in an advisory capacity. The committee must have the opportunity to participate in policy development and program administration of the provider's off-site program and to advise the director about health and medical service needs within the community. The committee must be comprised of parents, school personnel, public health personnel and local physicians within the local community. Members must be familiar with the medical needs of low-income population groups and with the resources available in the community.
- Information packet materials, including letters, forms, and examples of anticipatory guidance information sheets to be used. These materials must be prior approved by Medicaid.
- A copy of the waiver certificate and/or CLIA number, issued by the Division of Health Care Facility, Bureau of Health Provider Standards for the State of Alabama Department of Public Health.
- A list of all physical locations at which EPSDT screenings will be provided. A separate NPI will be assigned to each off-site location and will be distinct from any other NPI. A separate application and contract is required for each off-site location.

A.5.2 Space for Screenings

The room in which screenings are done may vary according to the availability of space. Space to perform the screening assessment must include a well-lighted private room in close proximity to hot and cold running water, a bathroom, and a nearby waiting area.

A.5.3 Parent/Guardian Consent and Follow-up

Children under 14 years of age must have written consent from their parent/guardian before participating in the screening program. Children age 14 and above may consent for themselves. The parent/guardian should be encouraged to be present during the screening.

Once the health screening is complete, the parent/guardian must be informed of the results of the screening by mail or in a one-on-one meeting. The anticipatory guidance materials must be age appropriate and the material may be given to children 14 years of age and above. Documentation must reflect that anticipatory guidance materials were mailed to parent/guardian for recipients under 14 years of age.

NOTE:

The potential provider cannot begin well child check-ups (screenings) until approval has been authorized in writing and Medicaid has enrolled the provider for off-site screenings.

A.6 Vaccines for Children

In an effort to increase the immunization levels of Alabama's children by two years of age, the Alabama Department of Public Health and the Alabama Medicaid Agency implemented the Vaccines for Children (VFC) Program on October 1, 1994,

This nationally sponsored program offers free vaccines to family and general practitioners, pediatricians, hospital nurseries, emergency rooms, and other qualified providers for children aged 18 years and under who are Medicaid enrolled and eligible, have no health insurance, or are American Indian or Alaskan Native. Free vaccines are also available to children who do not have health insurance for immunizations ("underinsured"), if they obtain those vaccines from a Federally Qualified Health Center or Rural Health Clinic.

Participation in Medicaid is not required for VFC enrollment; however, over 400,000 of Alabama's children are Medicaid enrolled.

A.6.1 Fees

Medicaid has taken the past vaccine and administration fee costs and calculated an equivalent reimbursement fee of $8.00 per dose. When multiple doses are given on the same visit, Medicaid will reimburse for each dose. When doses are given in conjunction with an EPSDT screening or physician visits, an administration fee of $8.00 per injection will also be paid for recipients 18 years of age and younger. The statewide fee-for-service will be paid for recipients 19 years of age and older. Providers are encouraged to utilize licensed available combination vaccines when indicated, rather than the individual components of the vaccine.

Providers should use the immunization(s) procedure code designated by the VFC Program when billing for the administration of an immunization. Please refer to section A.6.3 for the list of designated VFC procedure codes.

Medicaid VFC providers may give VFC vaccines to children who are Medicaid enrolled, non-Medicaid, uninsured, American Indian, or Alaskan Native. If a VFC vaccine is given to any of the above patients, with the exception of Medicaid enrolled, an administration fee not to exceed $19.79 for each vaccine administered may be charged. Underinsured patients must go to an FQHC, RHC, or county health department to receive VFC vaccines. An administration fee not to exceed $19.79 for each vaccine administered may be charged. No VFC-eligible patient should be denied immunizations because of an inability to pay the administration fee.

Physicians and health departments are not required to file recipient health insurance prior to filing Medicaid for preventive pediatric services, including administration fees for VFC. Exceptions to this rule require that all providers must file with a recipient's health plan when the plan is an HMO or other managed care plan. In addition, FQHCs and RHCs are required to file other insurance prior to filing Medicaid as are any providers receiving a lump sum payment for bundled services or a capitation payment from Medicaid.

A.6.2 Enrollment

The Department of Public Health is the lead agency in administering the VFC Program. Enrollment and vaccine order forms are available through the Immunization Division. Questions regarding enrollment should be directed to the VFC Coordinator at (800) 469-4599.

Participation in Medicaid is not required for VFC enrollment. Participation in the VFC Program is not required for Medicaid enrollment.

A.6.3 Vaccines for Children Billing Instructions

Providers must use an appropriate CPT-4 code on a CMS-1500 claim form or UB-04 claim form in order to receive reimbursement for the administration of each immunization given from VFC stock.

When immunizations are given in conjunction with an EPSDT screening visit or physician office visit, an administration fee of $8.00 per injection will be paid for recipients 18 years or younger. The statewide fee-for-service rate will be paid for recipients 19 and 20 years old.

NOTE:

A VFC provider may or may not choose to become an enrolled Medicaid provider. Enrollment as a VFC provider or a Medicaid provider is independent of each other.

The following CPT-4 codes must be used when billing Medicaid for immunizations for any recipient under age 19:

CPT-4 Procedure Code	***Immunization***
90620	Menengococcal B Vaccine - Bexsero
90621	Meningococcal B Vaccine - Trumenba
90633	Hepatitis A, 2-dose pediatric formulation (12months-18years of age) – Eff. 2/1/06
90636	Hepatitis A & B, 3-dose adult formulation (18 years of age only) – Eff. 2/1/06
90647	Hemophilus influenza type b (Pedvax)
90648	Hemophilus influenza type b (ActHib)(primary dose). Effective 08/19/09, Hibirix booster dose for ages 15 months – 4years. The ACIP recommends booster dose between 12 months and 4 years of age.
90649	Human Papilloma Virus (HPV) Vaccine, Types 6,11,16,18 (Quadrivalent), 3-dose schedule-Eff. 11/1/06 (9-18 years) Effective 10-02-09, approved for males ages 9-18.
90658	Influenza (3 years and older)
90670	Pneumococcal Conjugate, 13 valent (PREVNAR 13) (0-5 years) (no diagnosis restrictions)

Deleted: ~~90650, 90651~~

CPT-4 Procedure Code	*Immunization*
90670	Pneumococcal Conjugate, 13 valent (PREVNAR 13) eff. 06/01/13 (6-18 years) who are at high risk for invasive pneumococcal disease because of: • Anatomic or functional asplenia (sickle cell disease, other hemoglobinopathies, congenital or acquired asplenia, or splenic dysfunction) • Immunocompromising conditions (HIV infection, chronic renal failure/nephrotic syndrome, congenital immunodeficiency, diseases associated with treatment with immunosuppressive drugs/radiation therapy, including malignant neoplasms, leukemias, lymphomas, and Hodgkin disease; or solid organ transplant) • Cochlear implant • Cerebrospinal fluid (CSF) leaks.
90672	Influenza virus vaccine, quadrivalent, live, for intranasal use eff.08/01/13 (0-18 years)
90674	Influenza (4 yrs. and older) Influenza virus vaccine, quadrivalent, derived from cell cultures, subunit, preservative and antibiotic free, for intramuscular use
90680	Rotavirus Vaccine, Pentavalent, 3 dose schedule, live, for oral use (6-32 weeks of age only) eff. 2/3/06
90681	Rotarix is a new Rotavirus vaccine (RV1), and is a two-dose series, for 2 and 4 months of age- Effec. 06/25/2008
90685	Influenza Virus Vaccine, Quadrivalent, Split Virus, Preservative Free, when administered to children 6-35 months of age, for intramuscular use eff. 7/1/2013 (age 6-35 months)
90686	Influenza Virus Vaccine, quadrivalent, Split Virus, Preservative Free, when administered to individuals 3 years of age and older, for intramuscular use eff. 7/1/2013 (age 3-18 years)
90687	Vaccine for Influenza administered into muscle to children 6-35 months of age
90688	Influenza Virus Vaccine, quadrivalent, split virus, when administered to individuals 3 years of age and older
90696	Kinrix (DTaP-IPV) is indicated as a booster dose for children 4 through 6 years of age (prior to 7 years of age)-Effec. 06/26/2008
90698	Pentacel (DTaP-Hib-IPV-) is indicated as a primary series and first booster dose (doses 1-4) at 2, 4, 6 and 15-18 months of age – Effec. 06/26/2008
90700	Diphtheria, Tetanus, Acellular Pertussis (DtaP) (0yr-6yr)
90702	Diphtheria, Tetanus (DT) (0yr-7yr)
90707	Measles, Mumps, Rubella (MMR))
90710	Measles, Mumps, Rubella, and Varicella (MMRV) vaccine, Live, for subcutaneous use (1-12 years of age) – Eff. 9/6/05
90713	Poliomyelitis (IPV)
90714	Tetanus, Diphtheria (Td), preservative-free – Eff. 7-1-05 (7yr-999yr)

CPT-4 Procedure Code	*Immunization*
90715	Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis Vaccine, Adsorbed (Tdap) – Eff. 5-3-05 (7yr-999yr)
90716	Varicella (Chicken pox) vaccine *(for selected recipients)*
90723	Pediarix (DtaP-Hep B-IPV)
90732	Pneumococcal polysaccharide virus 23 valent (Pnu 23)
90733	Meningococcal Polysaccharide (MPSV4), (2-18 yr of age) – Eff. 2-10-05
90734	Meningococcal Conjugate (MCV4), (11-18 yr of age) – Eff 3-1-05
90744	Hepatitis B vaccine (Hep B)

A.6.4 ImmPRINT Immunization Provider Registry

The Alabama Department of Public Health has established a statewide immunization registry. Please visit their website at https://siis.state.al.us/ for more information.

A.6.5 Recommended Immunization Schedule

You may access the recommended immunization schedule at www.cdc.gov/nip.

The schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines. Combination vaccines may be used whenever any components of the combination are indicated and its other components are not contraindicated. Providers should consult the manufacturers' package inserts for detailed recommendations.

A.6.6 Synagis

The drug Synagis must be prior authorized through Health Information Designs (HID) at 1-800-748-0130. The new form for prior authorization is available on our website at www.medicaid.alabama.gov under Programs: Pharmacy: Prior Authorizations/Override Criteria and Forms: Instruction Booklet for Form 369 and Form 351. The appropriate administration fee may be billed in addition to Synagis.

A.7 Required Screening Protocols

The following table lists medical, vision, hearing, and dental screening protocols for infants and children by recipient age. **Refer to the following page for adolescents.**

	Infancy						Early Childhood					Middle Childhood					
Age By	**1**	**2**	**4**	**6**	**9**	**12**	**15**	**18**	**24**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
	Mo	**Mo**	**Mo**	**Mo**	**Mo**	**Mo**	**Mo**	**Mo**	**Mo**	**Yr**	**Yr**	**Yr**	**Yr**	**Yr**	**Yr**	**Yr**	**Yr**
Medical Screening [1]	X	X	X	X	X	X	X	X	X	<----------Annually---------->							
Initial/Interval History	X	X	X	X	X	X	X	X	X	<----------Annually---------->							
Measurements																	
Height and Weight	X	X	X	X	X	X	X	X	X	<----------Annually---------->							
Head Circumference	X	X	X	X	X	X	X	X	X								
Body-mass index (BMI) [8] – If clinically indicated									X	X		X	X	X	X	X	X	X
Blood Pressure/Pulse										<----------Annually---------->							
Developmental Assessment	S	S	S	S	S	S	S	S	S	<----------Annually---------->							
Physical Exam/Assessment [2]	X	X	X	X	X	X	X	X	X	<----------Annually---------->							
Procedures																	
Immunization	X	X	X	X		<-------X------>						<----X---->					
Newborn Screening 9	X+----------X+																
Anemia Screening	X----------					X											
Urine screening[3] (Effective 10/01/2008 urine screens should be performed only when clinically indicated).																	
Lead Screening [4]					X+	**X**	X+	X+	**X**	X+		X+	X+					
Nutritional Assessment	S/X	S/X	S/X	S/X	S/X	S/X	S/X	S/X	S/X	S/X		S/X	<--------Annually-->					
Health Education [5]	X	X	X	X	X	X	X	X	X	X		X	<--------Annually-->					
Vision Screening [6]	S	S	S	S	S	S	S	S	S	O		O	O	O	O	O	O	O
Hearing Screening [6]	S	S	S	S	S	S	S	S	S	S		O	O	O	O	O	O	O
Dental Screening [7]						<----------Annually---------->												
TB Skin Test [8] **(TST)**	The decision to place a TST should be made after completing a risk assessment using A.3.5 and determining the tuberculosis prevalence in the community by contacting the local health officials.																	

Key

X	Required at the visit for this age
X+	Perform blood level if unknown
S	Subjective by history and observation
O	Objective by standard testing methods
<----->	Annually
X-------X	One test must be administered during this time frame. Providers have the option of obtaining the lead and Hct or Hgb at nine or twelve months of age.
<---X--->	Range in which a service may be provided, where X indicates the preferred age
1	If a child comes under care for the first time at any point of the schedule, or if any components are not accomplished at the recommended age, the schedule should be brought up to date at the earliest possible time.
2	The physical examination/assessment must include an oral/dental inspection.
3	Urine screening (dipstick) is done if clinically indicated and must be done at 5 years and 11-21 years of age. (Effective 10/01/2008 urine screening performed only when clinically indicated).
4	All children are considered at risk and must be screened for lead poisoning. A blood lead test is required at 12 and 24 months of age. Providers have the option of obtaining the lead and Hct or Hgb at nine or twelve months of age. **X** indicated lead screening is required. X+ indicates a screening blood lead test also is required for any Medicaid-eligible child 36 to 72 months of age who has not previously been screened for lead poisoning.
5	Health education must include anticipatory guidance and interpretive conference. Youth, ages 12 to 20, must receive more intensive health education that addresses physiological, emotional, substance usage and reproductive health issues at each screening visit.
6	These screenings must be performed annually. Patient should be rescreened within 30-45 days if he/she is uncooperative.
7	A child must be referred for an annual complete dental screening beginning at age one to age 21 unless the child is under care. Anticipatory guidance should begin with age one.
8	Please refer to Section A.3.6, Critical Components of Screenings, for detailed information.
9	PMP should verify initial newborn screening results collected by the birthing facility. If unable to verify initial results collect a bloodspot specimen and mark the filter form “First Test.” The BCL will accept specimens up to 12 months of age. A second newborn screening specimen is recommended at 2-6 weeks of age (4 weeks optimal) on all full term infants with a normal first test screen. If the first test specimen was collected after two weeks of age, a second test is not recommended.

Adolescent Screening Protocols

For adolescents 11-20 years of age the following are performed annually:

- History
- Height/Weight
- Blood Pressure/Pulse
- Body-mass index (BMI) – BMI should be performed at each visit if clinically indicated. BMI-for-age charts are recommended to assess weight in relation to stature for children ages 2 to 20 years. The weight-for-stature charts are available as an alternative to accommodate children ages 2-5 years who are not evaluated beyond the preschool years. However, all health care providers should consider using the BMI-for-age charts to be consistent with current recommendations. The charts are available on the American Academy of Pediatrics website at http://www.aap.org .
- Developmental Assessment
- Physical Exam

- Urine Screening (Effective 10/01/2008 urine screening is no longer a requirement. Urine screens are done only if clinically indicated
- Nutritional Assessment
- Health Education
- Vision Screening
- Hearing Screening
- Dental Screening

An anemia screening should be performed once for adolescents 11-20 years of age.

A urine screening should be performed annually for adolescents 11-20 years of age.

Effective 10/01/2008 urine screens are no longer a requirement of adolescent EPSDT screenings. Urine screens should only be done when clinically indicated.

Immunizations are performed for adolescents 11-16 years of age according to AICP guidelines. Refer to Section A.7.4, Recommended Immunization Schedule, for the recommended ages for vaccines.

Please refer to http://www.rehab.alabama.gov/ for the Early Intervention Child Find referral form and instructions.

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