PolicyStat ID 13820819

Last Approved	6/13/2023	Area	Provider Payment Policies
Effective	7/24/2023	Lines Of Business	CHIP, Medicaid
Next Review	6/12/2024		

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

Applicable Lines of Business:

Commercial - Health Maintenance Organization (HMO), Preferred Provider Option (PPO) and Point of Service (POS)

Medicare Advantage - SecureCare HMO (includes the Dual Eligible Special Needs Plan [DSNP]) and SecureChoice PPO)

✓ West Virginia Medicaid (including Temporary Assistance for Needy Families [TANF], Expansion [WV Health Bridge] and Supplemental Security Income [SSI] populations)

Self-Funded/Administrative Services Only (ASO)

✓ West Virginia Children's Health Insurance Program (WVCHIP)

West Virginia Public Insurance Agency (WV PEIA)

Applicable Claim Type:

Dental

✓ Facility

Pharmacy

✓ Professional

Definitions:

Term	Definition
Bureau for Medical Services (BMS)	BMS is the designated single state agency responsible for the administration of the State of West Virginia's Medicaid program.
Centers for Medicare and Medicaid Services (CMS)	A federal agency that provides health coverage to more than 100 million people through Medicare, Medicaid, the Children's Health Insurance Program, and the Health Insurance Marketplace.
Children's Health Insurance Program (CHIP)	The Children's Health Insurance Program (CHIP) provides low-cost health coverage to children in families that earn too much money to qualify for Medicaid.
Current Procedural Terminology (CPT) code	A medical code set that is used to report medical, surgical, and diagnostic procedures and services to entities such as physicians, health insurance companies and accreditation organizations.
Early and Periodic Screening, Diagnostic and Treatment (EPSDT)	The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid.
Federally Qualified Health Care Centers (FQHCs)	FQHCs are outpatient clinics that qualify for specific reimbursement systems under Medicare and Medicaid.
Healthcare Common Procedure Coding System (HCPCS)	A standardized coding system that is used primarily to identify products, supplies, and services not included in CPT *codes*.
HealthCheck	The name for West Virginia's EPSDT Program.
International Classification of Diseases (ICD-10)	A system used by physicians and other healthcare providers to classify and code all diagnoses, symptoms and procedures recorded in conjunction with hospital care in the United States.
Periodicity	Periodicity refers to the established schedule for periodic medical screening, vision, hearing, and dental services.
Periodicity schedule	A schedule of screenings and assessments recommended at each well-child visit from infancy through adolescence.
Rural Health Clinics (RHCs)	RHCs are rurally located medical clinics providing healthcare services to patients in underserved areas.
Screening	A brief assessment procedure designed to identify individuals who should receive more intensive diagnosis or assessment.

Policy Purpose:

The purpose of this policy is to address general payment guidelines related to billing for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for West Virginia Medicaid members less than 21 years of age.

This policy is also applicable to members of the West Virginia Children's Health Insurance Program (WVCHIP) up to age 19 and for members aged 19 to 21 that are enrolled under the expanded CHIP pregnancy category.

Providers must be contracted and credentialed with The Health Plan (THP) and be enrolled with the Bureau for Medical Services (BMS) to perform EPSDT services.

There is no member cost sharing (such as copay, coinsurance or deductible) to obtain EPSDT services.

Policy Description:

Covered EPSDT screening services are regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth.

As part of EPSDT, screening services are provided by primary care providers at regular intervals and whenever a problem is suspected.

The following provider types are considered primary care providers:

- Advanced practice registered nurse [APRN]
- Certified nurse-midwife [CNM]
- Medical doctor [MD or DO]
- Nurse practitioner [NP]
- Physician assistant [PA]

The recommended periodicity schedule established by the American Academy of Pediatrics (AAP) and Bright Futures provides general screening guidelines for preventive pediatric health care by age group.

The periodicity schedule may be accessed at the West Virginia Department of Health and Human Resources' website which is located on-line at: https://dhhr.wv.gov/HealthCheck/WhatIs/Documents/HC%20Client%20Friendly%20Periodicity%20flyer%20%209-2016.pdf

Inter-periodic screenings are also covered at any visit outside of the AAP/Bright Futures periodicity schedule to determine the existence of a suspected illness or condition, or a change or complication to a pre-existing condition.

These screenings may be provided by any contracted provider with THP within the scope of their practice, as appropriate for the type of screening.

Prior authorization is required by THP for needs that are identified that are over the allowable or not included in the covered services.

West Virginia Medicaid and WVCHIP Reimbursement Guidelines:

HealthCheck is the name for West Virginia's EPSDT program.

EPSDT screening services target early detection of disease and illness to correct or improve a physical or mental condition and provide referral of members for necessary diagnostic and treatment services.

At a minimum, these screenings must include, but are not limited to:

- Behavioral health screening
- Comprehensive health and developmental history (which includes an assessment of both physical and mental health development)
- Comprehensive unclothed physical exam
- Dental services (furnished by direct referral to a dentist for children beginning six [6] months after the first tooth erupts or by twelve [12] months of age)
- Health education and counseling to both parents (or guardians) and children is designed to assist in understanding what to expect in terms of the child's development and provide information about the benefits of healthy lifestyles and practices as well as accident and disease prevention
- Hearing testing
- Immunizations (in accordance with the schedule for pediatric vaccines established by the Advisory Committee on Immunization Practices [ACIP])
- Laboratory tests (including blood lead screening appropriate for age and risk factors)
- Vision testing

Detailed information on the above list of screenings is available in the HealthCheck Provider Manual located on the Department of Health and Human Resources website.

Additional information is available in the HealthCheck Provider Manual.

THP provides the following services to eligible EPSDT enrollees, if the need for such services is indicated by screening:

1. Diagnosis of, and treatment for, defects in vision and hearing
2. Dental care (at as early an age as necessary) needed for relief of pain and infections, restoration of teeth, and/or maintenance of dental health
3. Appropriate immunizations
    - If it is determined at the time of screening that immunization is needed, and appropriate to provide at that time, then immunization treatment must be provided at the time of screening

Evaluation, diagnosis, and/or treatment may be provided at the time of the EPSDT screening visit, if the health care professional is qualified to provide the service(s).

When a screening indicates the need for further evaluation of an individual's health, the primary care provider shall, without delay, make a referral to a specialist(s) for evaluation, diagnosis, and/or treatment.

THP is responsible for reimbursing other necessary health care and all follow-up diagnostic and treatment services deemed medically necessary to improve or correct defects and physical and mental illnesses and conditions discovered by the screening service(s).

Medically necessary services must be contained within the categories of mandatory and optional services listed in Section 1905(a) of the Social Security Act.

The list of mandatory and optional services is available on the Social Security Administration's website.

Billing Information and Guidelines:

All EPSDT screening services must be reported with the age-appropriate evaluation and management (E & M) code.

Acceptable Medical Billing Codes:

Below is a list of commonly billed Current Procedural Terminology (CPT) and International Classification of Diseases (ICD-10) medical codes.

This list is **not** all inclusive:

CPT/HCPCS	ICD-10
96110	Z00.01
99381 - 99385	Z00.110
99391 - 99395	Z00.111
99461	Z00.121
G0438	Z00.129
G0439	Z00.2
S0302*	Z00.3
	Z02.5
	Z76.1
	Z76.2

*** List the appropriate E & M service when billing this code.**

The EP modifier must be affixed to all CPT codes billed for EPSDT services.

EPSDT claims are paid without any coordination of benefits.

Additional services during EPSDT exams:

A member may be evaluated and treated for a problem during the same visit as an EPSDT annual exam or well-child visit.

The problem must require an additional, moderate-level evaluation to qualify as a separate service on the same date.

The problem-oriented exam may be billed separately and appended with the modifier 25.

Use modifier 25 only if documenting a distinct, separately identifiable reason for the visit in the member's record.

Billing/reimbursement for Federally Qualified Health Care Centers (FQHCs)/Rural Health Clinics (RHC) billing:

EPSDT services will receive the applicable encounter rate when billed by a FQHC or RHC.

Encounters are billed on a UB-04 hospital claim form.

List CPT code T1015 (Clinic Visit/Encounter, All-Inclusive) **FIRST.**

NEXT list all pertinent CPT codes for services provided with a zero dollar ($0) or one cent (.01) charge for that DOS (some clearinghouses cannot accept a zero charge).

Affix the EP modifier to each CPT code reported.

Ill member on EPSDT screening date:

If a member is ill on the scheduled EPSDT screening date and all required components are completed and documented, the practitioner must bill the age-appropriate preventive care CPT code.

If a member is ill on the scheduled EPSDT screening date and the practitioner cannot complete all required components, the practitioner must document the treatment provided in the individual's medical record and bill the appropriate E & M CPT code for the actual service(s) provided.

More billing information may be found in The Health Plan's Provider Manual located at healthplan.org "For Providers," "Resources."

Post-payment Review:

The claim and record must include documentation that reflects the criteria of this policy, and is subject to audit by THP at any time pursuant to the terms of your provider agreement.

Date	Description
8/1/2022	Annual Review: Reviewed criteria with MHT personnel to ensure it was accurate. Updated formatting, added post-payment audit statement, and updated all references and links.
5/24/2023	Annual Review: Corrected typos. Updated links and references.

References and Research Materials:

BMS Provider Manual Chapter 519.8 Evaluation and Management Services. Bureau for Medical Services. Revised May 18, 2018. Accessed May 1, 2023. https://dhhr.wv.gov/bms/Provider/Documents/Manuals/

Chapter%20519%20Practitioner%20Services/Chapter%20519.8-Practitioner%20Services%20FINAL.pdf

West Virginia Department of Health and Human Resources. HealthCheck Provider Manual. Revised January 2015. Accessed May 1, 2023. https://dhhr.wv.gov/HealthCheck/providerinfo/Documents/All%20HealthCheck%20Provider%20Manual%20with%20updates%202-2016.pdf

West Virginia Department of Health and Human Resources. West Virginia Health Check: Periodicity Schedule. Revised July 2021. Accessed May 1, 2023. https://dhhr.wv.gov/HealthCheck/providerinfo/Documents/2021_HC_PeriodicitySschedule.pdf

Screening Services. Social Security Act 1905(a). Located at: https://www.ssa.gov/OP_Home/ssact/title19/1905.htm

Disclaimer:

This policy is intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry standard claims editing logic, benefit design and other factors are considered in developing payment policies. This policy is intended to serve as a guideline only and does not constitute medical advice, any guarantee of payment, plan pre-authorization, an explanation of benefits, or a contract. This policy does not govern whether a specific procedure is covered under any specific member plan or policy, nor is it intended to address every claim situation. The determination that any service, procedure, item, etc., is covered under a member's benefit plan shall not be construed as a determination that a provider will be reimbursed for services provided. Individual claims may be affected by other factors, including but not necessarily limited to state and federal laws and regulations, legislative mandates, provider contract terms, and THP's professional judgment. Reimbursement for any services shall be subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Unless otherwise noted within the policy, THP's policies apply to both participating and non-participating providers and facilities. THP reserves the right to review and revise these policies periodically as it deems necessary in its discretion, and it is subject to change or termination at any time by THP. THP has full and final discretionary authority for its interpretation and application. Accordingly, THP may use reasonable discretion in interpreting and applying this policy to health care services provided in any particular case.

No part of this policy may be reproduced, stored in a retrieval system or transmitted, in any shape or form or by any means, whether electronic, mechanical, photocopying or otherwise, without express written permission from THP. When printed, this version becomes uncontrolled. For the most current information, refer to the following website: healthplan.org.

All Revision Dates

6/13/2023, 9/14/2022, 8/16/2021

Attachments

BMS Provider Manual Chapter 519.8-Practitioner Services.pdf

HealthCheck Client Friendly Periodicity flyer.pdf

HealthCheck Provider Manual .pdf

Social Security Act §1905..html