Washington State Health Care Authority

Washington Apple Health (Medicaid)

EPSDT Program Billing Guide

January 1, 2023

Washington State Health Care Authority

Disclaimer

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict between this document and a Health Care Authority (HCA) rule arises, the HCA rules apply.

Billing guides are updated on a regular basis. Due to the nature of content change on the internet, we do not fix broken links in past guides. If you find a broken link, check the most recent version of the guide. If this is the most recent guide, notify us at askmedicaid@hca.wa.gov.

About this guide[1]

This publication takes effect **January 1, 2023,** and supersedes earlier guides to this program. Unless otherwise specified, the program in this guide is governed by the rules found in Chapter 182-534 WAC.

HCA is committed to providing equal access to our services. If you need an accommodation or require documents in another format, call 1-800-562-3022. People who have hearing or speech disabilities, call 711 for relay services.

> Washington Apple Health means the public health insurance programs for eligible Washington residents. Washington Apple Health is the name used in Washington State for Medicaid, the children's health insurance program (CHIP), and state-only funded health care programs. Washington Apple Health is administered by the Washington State Health Care Authority.

Refer also to the ProviderOne Billing and Resource Guide for valuable information to help you conduct business with HCA.

How can I get HCA Apple Health provider documents?

To access provider alerts, go to HCA's Provider Alerts webpage.

To access provider documents, go to HCA's provider billing guides and fee schedules webpage.

Confidentiality toolkit for providers

The Washington State Confidentiality Toolkit for Providers is a resource for providers required to comply with health care privacy laws. To learn more about the toolkit, visit the HCA website.

---

[1] This publication is a billing instruction.

Washington State Health Care Authority

Where can I download HCA forms?

To download an HCA form, see HCA's Billers and provider's webpage, and select Forms & Publications webpage. Type the HCA form number into the Search box as shown below (Example 13-835).

Copyright disclosure

What has changed?

The table below briefly outlines how this publication differs from the previous one. This table is organized by subject matter. Each item in the *Subject* column is a hyperlink that, when clicked, will take you to the specific change summarized in that row of the table.

Subject	Change	Reason for Change
Confidentiality toolkit for providers	Added new resource for health care providers required to comply with health care privacy laws	New resource
How do I verify a client's eligibility?	Created a new note box to provide updated ways to apply for Apple Health coverage	To keep information current
Who is eligible for EPSDT well-child checkups?	Updated language about who is covered	To clarify this section
Are managed care clients eligible for EPSDT well-child checkups?	Added link to HCA's MCO webpage	To assist clients and providers with accessing support
Integrated Apple Health Foster Care (AHFC)	Revised age of clients in foster care (out of home placement) from 21 to 18	To distinguish these clients from those ages 18 – 21 who are in extended foster care

Subject	Change	Reason for Change
What is an EPSDT well-child checkup?	• Added provider documentation requirements. (Relocated from "Recommended screening tools" section.) • Updated asterisk information and link regarding add-on codes • Added note box for caregiver/parent depression screening	• To improve flow and clarity • To improve clarity • To reinforce policy
What is the EPSDT periodicity schedule?	• Added a subsection and tables with updated well-child check-up schedules • Added note box about foster care • Relocated provider documentation requirements to the "What is an EPSDT well-child checkup?" section	• To reinforce policy • To highlight special circumstances • To improve readability
Elements of EPSDT well-child checkup: Measurements	Updated the height/ length measurement description of infant and small children	To provide guidance and clarification
Elements of EPSDT well-child checkup: • Autism screening • General behavioral health screening tools • Tobacco, alcohol, and drug screening	Replaced the link to screening information in each section with a link to the Bright Futures Toolkit for Commonly Used Screening Instruments	To align with the American Academy of Pediatrics best practice recommendations

Subject	Change	Reason for Change
Elements of EPSDT well-child checkup: Caregiver and parent depression screening	Depression screening required for caregivers and parents of infants up to age twelve months (instead of six months)	Policy change to address the prevalence of perinatal mental health conditions and to align with HCA's 12-month postpartum coverage
What are the time limits for scheduling requests for EPSDT well-child checkups?	• Revised the deadline to schedule the EPSDT well-child checkup for foster children • Added Note box regarding timing for initial health evaluations	To clarify that scheduling must occur within 30 days of placement, not 30 days of the request
Developmental and Behavioral Health Screening	Replaced link to the recommended screening tools with a link to the Bright Futures Toolkit for Commonly Used Screening Instruments	To align with the American Academy of Pediatrics best practice recommendations
Recommended screening tools	• Added language to introduce screenings and the Bright Futures Toolkit for Commonly Used Screening Instruments • Removed existing developmental and behavioral health screening table • Added note box with a link to the previously published developmental screening table	To align with the American Academy of Pediatrics best practice recommendations

Washington State Health Care Authority

Table of Contents

Washington State Health Care Authority

Resources Available

Topic	Resource
Where can I find information on becoming an HCA provider	See HCA's ProviderOne Billing and Resource Guide.
Questions on payments, denials, general questions regarding claims processing, or HCA-contracted managed care organization (MCO)	See HCA's ProviderOne Billing and Resource Guide.
Submitting claims for payment	See HCA's ProviderOne Billing and Resource Guide.
Questions on private insurance or third-party liability, other than HCA-contracted managed care plans	See HCA's ProviderOne Billing and Resource Guide.
Questions about prior authorization, limitation extensions, or exception to rule	See HCA's ProviderOne Billing and Resource Guide.
Referral for Mental Health	Contact the client's managed care organization
Referral for Substance Use Assessment	Washington Recovery Help Line
Where is the EPSDT Fee Schedule?	See HCA's EPSDT Fee Schedule

Topic	Resource
Obtaining prior authorization or a limitation extension	For prior authorization or limitation extension, providers may submit prior authorization requests online through direct data entry into ProviderOne. See HCA's **prior authorization webpage** for details. Providers may also fax requests to 866-668-1214 along with the following: • A completed, typed *General Information for Authorization form*, HCA 13-835. This request form must be the initial page when you submit your request. • A completed *Fax/Written Request Basic Information* form, HCA 13-756, all documentation listed on this form, and any other medical justification. See **Where can I download HCA forms?**

Washington State Health Care Authority

Program Overview

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is a federally mandated, comprehensive, and preventive health care benefit. The purpose of this program is to ensure children and adolescents age 20 and younger receive appropriate preventive, dental, mental health, developmental, and specialty services. Medically necessary treatment identified in the EPSDT well-child checkup is covered under the EPSDT benefit.

The following are descriptions of the components of the program:

Early: Assessing and monitoring a child's health and ongoing development early in life can help prevent, identify, and intervene, so potential diseases and disabilities can be addressed before they become more complex and are in their preliminary stages, when they are most effectively treated. (This means as early as possible in a child's life in the case of a family already receiving medical benefits or as soon as a child's eligibility has been established.)

Periodic: As children and adolescents grow, visits with their health care providers should occur at regular intervals to ensure continued healthy development and to monitor current or emerging needs. Section 1905 of the Social Security Act requires periodicity schedules sufficient to ensure that at least a minimum number of health examinations occur at critical points in a child's life, and that medically necessary inter-periodic screens are provided.

Screening: Providers use preventive services, including comprehensive interviews, medical examinations, and standardized tools, to identify children who require further diagnostic assessment or intervention for health and developmental issues. The five categories of screenings covered under this program are medical, vision, hearing, dental, and developmental. Screening services must be available both at established times and on an as-needed basis. When a screening indicates the need for further diagnostic assessment, refer the child and their family for diagnosis without delay.

Diagnosis: When there is an indication that a child or adolescent may have a health problem, a follow-up diagnostic assessment and additional evaluations must be provided. This includes recommendations and any necessary referrals to needed services when a diagnosis is determined.

Treatment: In response to an identified need, health care services needed to correct, ameliorate, or lessen health problems, including care coordination for chronic conditions, are administered. Services provided to the child or adolescent must be considered medically necessary (see WAC 182-500-0070).

Who can provide EPSDT well-child checkups?

- Physicians and resident physicians
- Naturopathic physicians
- Advanced Registered Nurse Practitioners (ARNPs)
- Physician Assistants (PAs)

- Registered nurses working under the guidance of a physician or ARNP may also perform EPSDT well-child checkups. (Only physicians, PAs, and ARNPs can diagnose and treat problems found in a screening.)

Is transportation to and from EPSDT well-child checkups available?

Yes. Apple Health covers non-emergency medical transportation for eligible clients to and from covered services, including well-child checkups, through contracted brokers when eligibility requirements are met. For more information, see HCA's **Transportation services (non-emergency) webpage**.

Pediatric primary care rate increase

A primary care provider rate increase is available for vaccine administration and certain pediatric care services for clients age 18 and younger.

Physician and nonphysician **practitioners** are eligible for the increase.

See the **Pediatric primary care rate increase website** for more information. To view the Enhanced pediatric fee schedule, see HCA's **Physician-Related/Professional Services Billing Guides and Fee Schedules webpage**.

Providers serving clients covered by an HCA-contracted managed care organization (MCO) should contact the individual MCO for rate information.

Washington State Health Care Authority

Client Eligibility

Most Apple Health clients are enrolled in an HCA-contracted managed care organization (MCO). This means that Apple Health pays a monthly premium to an MCO for providing preventative, primary, specialty, and other health services to Apple Health clients. Clients in managed care must see only providers who are in their MCO's provider network, unless prior authorized or to treat urgent or emergent care. See the HCA's Apple Health managed care page for further details.

It is important to always check a client's eligibility prior to providing any services because it affects who will pay for the services.

How do I verify a client's eligibility?

Check the client's Services Card or follow the two-step process below to verify that a client has Apple Health coverage for the date of service and that the client's benefit package covers the applicable service. This helps prevent delivering a service HCA will not pay for.

Verifying eligibility is a two-step process:

Step 1. **Verify the patient's eligibility for Apple Health**. For detailed instructions on verifying a patient's eligibility for Apple Health, see the *Client Eligibility, Benefit Packages, and Coverage Limits* section in HCA's ProviderOne Billing and Resource Guide.

If the patient is eligible for Apple Health, proceed to **Step 2**. If the patient is **not** eligible, see the note box below.

Step 2. **Verify service coverage under the Apple Health client's benefit package.** To determine if the requested service is a covered benefit under the Apple Health client's benefit package, see HCA's Program Benefit Packages and Scope of Services webpage.

Note: Patients who are not Apple Health clients may apply for health care coverage in one of the following ways:

- **Online**: Go to Washington Healthplanfinder - select the "Apply Now" button. For patients age 65 and older or on Medicare, go to **Washington Connections** – select the "Apply Now" button.
- **Mobile app:** Download the WAPlanfinder app – select "sign in" or "create an account".
- **Phone**: Call the Washington Healthplanfinder Customer Support Center at 1-855-923-4633 or 855-627-9604 (TTY).

- **Paper**: By completing an *Application for Health Care Coverage (HCA 18-001P)* form.
  To download an HCA form, see HCA's Free or Low Cost Health Care, **Forms & Publications** webpage. Type only the form number into the Search box (Example: **18-001P**). For patients age 65 and older or on Medicare, complete the *Washington Apple Health Application for Aged, Blind, Disabled/Long-Term Services and Supports (HCA 18-005)* form.
- **In-person**: Local resources who, at no additional cost, can help you apply for health coverage. See the **Health Benefit Exchange Navigator**.

In-person application assistance is also available. To get information about in-person application assistance available in their area, people may visit the **Washington Healthplanfinder's website** or call the Customer Support Center.

Note: Refer clients to the Health Benefit Exchange (HBE) if they are age 20 and younger and their benefit package does not cover EPSDT. This application process will evaluate these clients for a possible change in their benefit package to include EPSDT. Take Charge is an example of a benefit package that does not cover EPSDT services.

Who is eligible for EPSDT well-child checkups?

HCA pays Washington Apple Health providers to perform EPSDT well-child checkups for all children age 20 and younger who are enrolled in **Apple Health**.

What if an infant has not yet been assigned a ProviderOne Client ID?

Newborns: If a child is younger than age 60 days and has not been issued a ProviderOne Client ID, use the birthing parent's ProviderOne Client ID and put **SCI=B** in the claim notes field. Put the child's name, gender, and birth date in the client information fields.

Twins/Triplets: When using mom's ProviderOne Client ID for twins, triplets, etc., identify each infant separately using a separate claim for each. For example, the first infant would be "SCI=BA," the second infant would be "SCI=BB," and the third infant would be "SCI=BC."

Note: For parents enrolled in an HCA-contracted MCO, the MCO is responsible for providing medical coverage for the clients' newborns.

Washington State Health Care Authority

Are managed care clients eligible for EPSDT well-child checkups?

Yes. If the client is enrolled in an HCA-contracted managed care organization (MCO), ProviderOne will display managed care enrollment on the client benefit inquiry screen. All services must be requested directly through the client's Primary Care Provider (PCP). Clients can contact their MCO by calling the telephone number provided to them or use the information provided under "Contact your Apple Health plan" listed on HCA's Apple Health managed care webpage.

All medical services covered under an HCA-contracted MCO must be obtained by the client through the client's MCO provider network. The MCO is responsible for the:

- Payment of covered services.
- Payment of services referred by a participating provider to an outside provider.

> **Note:** To prevent denied claims, check the client's eligibility both before scheduling services and at the time of the service. Also make sure proper authorization or referral is obtained from the MCO. See HCA's ProviderOne Billing and Resource Guide for instructions on how to verify a client's eligibility.

For clients enrolled in an MCO, do not bill HCA for EPSDT services, as they are included in the HCA-contracted MCO's reimbursement rate.

Managed care enrollment

Apple Health (Medicaid) places clients into an HCA-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. This eliminates a person being placed temporarily in FFS while they are waiting to be enrolled in an MCO or reconnected with a prior MCO. This enrollment policy also applies to clients in FFS who have a change in the program for which they are eligible. However, some clients may still start their first month of eligibility in the FFS program because their qualification for MC enrollment is not established until the month following their Medicaid eligibility determination.

New clients are those initially applying for benefits or those with changes in their existing eligibility program that consequently make them eligible for Apple Health managed care. Renewing clients are those who have been enrolled with an MCO but have had a break in enrollment and have subsequently renewed their eligibility.

Checking eligibility

- Providers must check eligibility and know when a client is enrolled and with which MCO. For help with enrolling, clients can refer to the Washington Healthplanfinder's Get Help Enrolling page.

- MCOs have retroactive authorization and notification policies in place. The provider must know the MCO's requirements and be compliant with the MCO's policies.

Clients have a variety of options to change their plan:

- **Available to clients with a Washington Healthplanfinder account:** Go to Washington HealthPlanFinder website.
- **Available to all Apple Health clients**:
  - Visit the ProviderOne Client Portal website.
  - Call Apple Health Customer Service at 1-800-562-3022. The automated system is available 24/7.
  - Request a change online at ProviderOne Contact Us (this will generate an email to Apple Health Customer Service). Select the topic "Enroll/Change Health Plans."

  For online information, direct clients to HCA's Apple Health managed care webpage.

Clients who are not enrolled in an HCA-contracted managed care plan for physical health services

Some Medicaid clients do not meet the qualifications for managed care enrollment. These clients are eligible for services under the fee-for-service (FFS) Medicaid program. In this situation, each Integrated Managed Care (IMC) plan will have Behavioral Health Services Only (BHSO) plans available for Apple Health clients who are not in managed care. The BHSO covers only behavioral health treatment for those clients. Eligible clients who are not enrolled in an HCA-contracted managed care plan are automatically enrolled in a BHSO, except for American Indian/Alaska Native clients. If the client receives Medicaid-covered services before being automatically enrolled in a BHSO, the FFS Medicaid program will reimburse providers for the covered services. Some examples of populations that may be exempt from enrolling into a managed care plan are Medicare dual-eligible, American Indian/Alaska Native, Adoption support and Foster Care alumni.

Integrated managed care (IMC)

Clients qualified for enrollment in an integrated managed care plan receive all physical health services, mental health services, and substance use disorder treatment through their HCA-contracted MCO.

For full details on integrated managed care, see HCA's Apple Health managed care webpage and scroll down to *Changes to Apple Health managed care*.

Integrated Apple Health Foster Care (AHFC)

Children and young adults in the Foster Care, Adoption Support and Alumni programs who are enrolled in Coordinated Care of Washington's (CCW) Apple Health Foster Care program receive both medical and behavioral health services from CCW.

Clients under this program are:

- Under the age of 18 who are in foster care (out of home placement)
- Under the age of 21 who are receiving adoption support
- Age 18-21 years old in extended foster care
- Age 18 to 26 years old who aged out of foster care on or after their 18th birthday (alumni)

These clients are identified in ProviderOne as "Coordinated Care Healthy Options Foster Care."

The Apple Health Customer Services staff can answer general questions about this program. For specific questions about Adoption Support, Foster Care or Alumni clients, contact HCA's Foster Care and Adoption Support (FCAS) team at 1-800-562-3022, Ext. 15480.

Fee-for-Service Apple Health Foster Care

Children and young adults in the fee-for-service (FFS) Apple Health Foster Care, Adoption Support and Alumni programs receive behavioral health services through the regional Behavioral Health Services Organization (BHSO). For details, see HCA's **Mental Health Services Billing Guide**, under *How do providers identify the correct payer*?

American Indian/Alaska Native (AI/AN) Clients

American Indian/Alaska Native (AI/AN) clients have two options for Apple Health coverage:

- Apple Health Managed Care
- Apple Health coverage without a managed care plan (also referred to as fee-for-service [FFS])

If an AI/AN client does not choose a managed care plan, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavioral health services. See the Health Care Authority's (HCA) **American Indian/Alaska Native webpage**.

Washington State Health Care Authority

EPSDT Well-Child Checkups

What is an EPSDT well-child checkup?

EPSDT requires a periodic well-child checkup with the client's primary care provider (PCP). The recommended frequency of visits as a child grows is shown on the **Periodicity Schedule.**

Providers must document in the client's medical record that each required element of the well-child checkup was done at the visit and what the findings were.

Each well-child checkup consists of the following elements, though how the element is completed depends on the age of the child:

- Initial/interval health history and a family health history
- Measurements – age-appropriate growth including length/height and weight and blood pressure
- Sensory screening – vision and hearing*
- Developmental/behavioral health screening*
- Physical exam
- Procedures, including immunizations and laboratory tests*
- Oral health and fluoride varnish*
- Anticipatory guidance

* These elements have add-on codes that may be billed in addition to evaluation and management (E&M) codes . See descriptions about each element and the available add-on codes listed below this section. For more information about billing EPSDT E&M codes. see **What are the billing requirements specific to EPSDT?**

> **Note:** Parent and caregiver depression screening is required at well-child checkups for caregivers and parents of infants through 12 months of age. Use CPT® code 96161 with EPA #870001424 to bill fee-for-service (FFS) claims.

Washington State Health Care Authority

What is the EPSDT Periodicity Schedule?

The EPSDT well-child checkup schedule includes:

- Six checkups before age one

Infancy					
1st week	1 month	2 months	4 months	6 months	9 months

- Seven checkups between age one and age four

Early Childhood						
12 months	15 months	18 months	24 months	30 months	3 years	4 years

- One checkup every 365 days between age five through 20 years of age

See the Periodicity Schedule for more information.

> **Note:** Children in foster care may receive additional EPSDT well-child checkups. See EPSDT and Foster Care for more information.

Elements of EPSDT well-child checkup

1. **Initial/Interval health history and a family health history**

   It is the responsibility of each provider to obtain both a comprehensive client and family medical history as part of the initial well-child visit. The history should be updated at each subsequent well-child visit.

2. **Measurements**

   - **Height/length must be measured at every well-child checkup**

     Infants and small children (at least through age one) should be measured in the recumbent position, and older children standing erect. The height should be recorded and charted on a Centers for Disease Control and Prevention (CDC) growth chart or other standard growth chart in the child's medical record.

     Further study or referral is indicated for a child who has deviated from the usual percentile rank (determined by comparison with graphed previous measurements), or for a child whose single measurement exceeds two standard deviations from the norm for that age (beyond the 97th or below the 3rd percentile).

- **Weight must be measured at every well-child checkup**

  Infants should be weighed with no clothes on, small children with just underwear and older children and adolescents with ordinary house clothes (no jackets or sweaters) and no shoes. The weight should be recorded and charted on a CDC growth chart or other standard growth chart in the child's medical record. The child's weight percentile should also be entered in the child's medical record.

  Further investigation or referral is indicated for a child who has deviated from the usual percentile rank (determined by comparison with graphed previous measurements), or in a child whose single measurement exceeds two standard deviations from the norm for that age (beyond the 97th percentile or below the 3rd percentile).

- **Head circumference should be measured at every well-child checkup on infants and children up to the age of two years**

  Further investigation or referral is indicated for the same situations described in height and weight, and findings should be recorded in the child's medical record. Microcephaly and macrocephaly in newborns are abnormalities not related to nutrition and need investigation or referral for evaluation. Growth in head circumference in infants is closely related to nutritional status.

- **Blood Pressure**

  Blood pressure must be measured at every well-child checkup for all children age 3 years and older, using an appropriate-sized cuff. Findings should be recorded in the medical record. For younger children, measure blood pressure if risk factors are identified.

3. Sensory Screening

(See **Billing** section for information about additional payment for certain screening tests.)

- **Vision Testing**

For children birth to age 3 years, eye evaluations should include:

- Ocular history
- Vision assessment
- External inspection of the eyes and lids
- Ocular motility
- Pupil examination
- Red reflex examination

For children age 3 years and older, eye evaluations should include:

- Criteria listed above for children birth to age 3 years
- Age-appropriate visual acuity measurement (use of Snellen chart or similar can be billed in addition to the EPSDT E&M codes)

- Attempt at ophthalmoscopy record. If not done before hospital discharge, it should be done before 3 months of age.

- **Hearing Screening**
  Hearing screenings must be administered to every child age 4 years and older. Audiometric testing may be billed in addition to the EPSDT E&M codes using CPT® codes 92551 and 92552.

4. Developmental/Behavioral health screening

- **Developmental surveillance**

  According to the American Academy of Pediatrics, developmental surveillance is a flexible, longitudinal, continuous, and cumulative process whereby health care professionals identify children who may have developmental problems. Developmental surveillance includes information provided by the caregiver about how the child is growing and reaching developmental milestones and any concerns about their child's development. Health care professionals also maintain a developmental history, including observations of the child during the visit. Children with health issues or who miss developmental milestones must be identified as early as possible. Health care professionals must include questions related to behavior, social activity, and development in the initial and interval history.

- **Developmental screening**

  A developmental screening is the process of using a validated tool to identify risk factors, potential delays, and the need for further assessment. If a developmental screening indicates a potential delay or identified need, health care professionals must make the appropriate referrals for further evaluation or services. Complete the developmental screening according to the **Bright Futures schedule**. The completion of a structured developmental screen is required for ages 9 through 11 months, 18 months, and 30 months. Use CPT® code 96110 to report the completion of this screen.

  Note: For children ages birth – 3 years, when a developmental delay is identified, the health care professional should refer to Early Support for Infants & Toddlers (ESIT) for early intervention services.

- **Autism screening**

  A structured autism screen is required at ages 18 months and 24 months. For information on validating screening tools, see the **Bright Futures Toolkit for Commonly Used Screening Instruments**.

- **Depression screening**

  HCA covers one structured depression screening every year for children age 12 and older. If more frequent screening is needed, providers can submit a limitation extension (LE) request to HCA. See What is a Limitation Extension (LE).

- **Caregiver and parent depression screening**

  Caregiver and parent depression screening is required at well-child checkups for caregivers and parents of infants up to 12 months. Use CPT® code 96161 with EPA #870001424 for billing fee-for-service (FFS) claims.

- **General behavioral health screening tools**

  Providers are strongly encouraged to use the Bright Futures Toolkit for Commonly Used Screening Instruments for child-youth behavioral health screening during visits.

- **Tobacco, alcohol, and drug screening**

  See the Bright Futures Toolkit for Commonly Used Screening Instruments for additional information about structured screening for tobacco, alcohol, and drug use.

5. **Physical Exam**
   At each visit, an age-appropriate physical examination is required with infants totally unclothed and older children undressed and appropriately draped. All findings must be documented in the medical record.

6. **Procedures**

   - **Anemia Screening**

     Initial measurement of hemoglobin or hematocrit is recommended between ages 9 and 11 months and required by the 12-month screen if not previously done. After this, a hematocrit should only be performed if indicated by a risk assessment and/or symptoms. All premature or low-birth weight infants should have hemoglobin or hematocrit done on their first well-visit and then repeated according to the Periodicity Schedule. The results of the test should be entered in the child's medical record.

   - **Blood Lead Screening Test**

     Blood lead screening test results are a notifiable condition in Washington State. ALL blood lead screening test results (positive or negative) must be sent to the Department of Health (DOH) according to WAC 246-101. See the federal mandate for further information.

     Blood lead screening tests must be done at ages 12 and 24 months. There are two methods for blood lead screening tests: venous and capillary (results must be confirmed by an additional test). Any child between 24 and 72 months with no record of a previous blood lead screening test must receive one. A risk assessment should be performed at every visit as appropriate.

Note: Completion of a risk assessment questionnaire does not meet the Medicaid requirement for blood lead screening tests. The Medicaid requirement is met only when the blood lead screening tests (or a catch-up blood lead screening test) are conducted.

- **Tuberculin (TB) Test**

  The American Academy of Pediatrics (AAP) recommends that a child at high risk for TB exposure should be tested for tuberculosis annually. The following list includes indicators that a child is at high risk for TB exposure:

  - Has a family member or close contact with active TB disease
  - Has a family member with a positive TB skin test
  - Was born in a high-risk country (all except US, Canada, Western European countries, Australia, and New Zealand)
  - Has traveled to a high-risk country and had contact with resident population for more than one week

  Children with no risk factors who live in areas where TB is not common do not need TB tests. Children whose risk is uncertain may be tested at ages 1, 4, or 6 months and at ages 11 through 16 years. Children infected with human immunodeficiency virus (HIV) should have annual TB testing.

- **Dyslipidemia Screening**

  Dyslipidemia (cholesterol) screening is a required component once between ages 9 and 11 years and again between ages 17 and 20 years. Refer to guidelines of the National Heart, Lung and Blood Institute found on their **Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents webpage.**

- **Sexually transmitted infections**

  According to current recommendations, screening for sexually transmitted infections (STIs) is indicated for sexually active adolescents.

- **HIV**

  Screen for HIV at least once between ages 15 and 18 years. Youth at increased risk of HIV infection, including those who are sexually active, use injection drugs, or are being tested for other STIs, should be tested for HIV and be assessed annually.

- **Hepatitis C Virus Infection (HCV)**

  Screening for hepatitis C infection to occur at least once between the ages of 18 and 79 as recommended by the CDC and USPSTF.

- **Immunizations**

  Administer immunizations according to the CDC Advisory Committee on Immunization Practices (ACIP) Recommended Immunization Schedule, including "catch-up" schedules for clients who are missing any routine

vaccinations for their age. Immunizations should be brought up to date at well-child checkups and during any other visits the child makes to the health care provider.

Apple Health covers all childhood vaccines on the CDC ACIP Recommended Immunization Schedule, including those specifically required for school attendance. All routine and recommended vaccines with specific medical indications are covered.

The Washington State Department of Health (DOH) provides free vaccines for Apple Health clients 18 years of age and younger. Refer to the **Professional Administered Drug Fee Schedule** to identify the covered vaccines. When state-supplied vaccines are available, HCA pays only for the administration of the vaccine. For more information on the DOH program, including how providers can enroll, see DOH's **Childhood Vaccine Program webpage**.

If state-supplied vaccines are available from DOH that meet the immunization needs of Apple Health clients, providers will be reimbursed only for the administration of the vaccines.

For clients age 19 and 20 years who are eligible for EPSDT who have not completed all their routine childhood immunizations, providers should bring the immunizations up-to-date using vaccines purchased by the provider or refer the client to a participating pharmacy.

If an Apple Health client will be traveling outside the United States, only the routine childhood vaccines are covered. Apple Health does not cover vaccines recommended or required for the sole purpose of international travel according to WAC **182-531-0150**.

7. Oral Health

Oral health is critically important to overall health and well-being. All Apple Health clients should have a dental home or primary dental provider. Eligible clients may go to a dental provider for routine preventive care or for restorative care without a referral from the PCP. See HCA's **Dental-Related Services Billing Guide.**

Eligible clients may also go to an orthodontic provider without an EPSDT screen or referral. HCA pays for orthodontics for children with cleft lip or palates or severe handicapping malocclusions. HCA reviews all requests for orthodontic treatment or orthodontic-related services for clients who are eligible for services under the EPSDT program (WAC 182-534-0100). See HCA's **Orthodontic Services Billing Guide.**

Oral health requires ongoing supervision from health care providers. At each well-child checkup, the provider should do an oral assessment noting the number and location of teeth erupted, visible cavities and other symptoms. If the child does not have a dental home, the PCP should provide a referral. If the child is enrolled with managed care and does not have an established dental home, refer the client to the MCO.

Oral health assessment and education, includes:

- How to clean teeth as they erupt.
- How to prevent early childhood caries.
- How to recognize dental disease.
- How dental disease is contracted.
- Importance of preventive sealant.
- Application of fluoride varnish, when appropriate.
- **Fluoride varnish**
  Once teeth are present, fluoride varnish may be applied by qualified health care professional to all children. See the limits for fluoride varnish application in the Topical fluoride treatment section of HCA's **Dental-Related Services Billing Guide.** When fluoride varnish is applied during an EPSDT well-child checkup, additional payment is available by billing CPT® code 99188 with modifier DA for eligible ABCD clients.

  Clients who are enrolled in an HCA-contracted MCO, but not eligible for ABCD services, may receive fluoride varnish. Effective for dates of service January 1, 2020, through June 30, 2021, do not bill the client's MCO. Bill HCA directly for this service using CPT® code 99188 with modifier KZ.

8. **Anticipatory Guidance**
   Anticipatory guidance is the process of offering timely, appropriate, and relevant information on general and age-specific child and adolescent health and development. It provides children, adolescents, parents, and caregivers with specific advice, tailored guidance, and what to expect as children grow and mature. At each visit, pertinent information should be discussed and made available in written form to clients and their families as well as allowing for sufficient time for discussion and answering questions. Topics may include, but are not limited to:
   - Benefits of healthy lifestyles
   - Practices that promote well-being
   - Physical, emotional, and developmental changes
   - Common parenting concerns
   - General health questions

What are the time limits for scheduling requests for EPSDT well-child checkups?

Requests for EPSDT well-child checkups must be scheduled within the following time limits:

For EPSDT well-child checkup requested through:	Client:	Schedule within:
HCA's managed care organizations (MCOs), primary care case management (PCCM) organization, or primary care providers (PCPs)	Infants under age two	21 days of request
An MCO, PCCM or PCP	Children age two and older	Six weeks of request
An MCO, PCCM or PCP	Children receiving foster care (upon placement)	30 days of the original placement or as soon as possible
Community Mental Health Center, Head Start, substance use provider, or Early Childhood Education and Assistance Program (ECEAP)	People age 20 and younger	14 days of the request

Note: When a child age 17 or younger enters out-of-home placement, HCA pays for an initial health evaluation (IHE). The IHE must be scheduled within 72 hours by the foster parent or social worker.

Providers must ensure that when medically necessary services are identified during an EPSDT well-child check, appropriate treatment or referrals are made.

What if a problem is identified during an EPSDT well-child checkup?

When a health, developmental, or behavioral issue is identified during a well-child visit, the health care provider must ensure the child and family receive necessary services as long as they are medically necessary (see WAC 182-500-

0070). Health care professionals may provide services for clients only when services are within their scope of practice. Health care professionals may also refer for additional evaluation or treatment services with other Apple Health providers.

Common referrals include all the following:

- Early Supports for Infants & Toddlers (Early Intervention)
- Mental and behavioral health services
- Washington's Mental Health Referral Service for Children and Teens
- Home Visiting—Many of the home visiting programs for infants and young children in Washington are administered by the Department of Children Youth and Families.

Note:

- When a provider treats the identified condition on the same day as the well-child visit, the provider must bill the treatment or appropriate level E&M code with modifier 25 to receive additional reimbursement for the office visit. Providers must bill using the appropriate ICD diagnosis code that describers the condition found. **To ensure accurate payment, bill the treatment procedure codes and the EPSDT well-child checkup procedure codes on separate claim forms.**

- For more information regarding billing guidance for additional services, access HCA's provider billing guides and fee schedules.

When a noncovered service is recommended based on a well-child visit, HCA evaluates the request for medical necessity based on the definition in WAC 182-500-0070 and the process in WAC 182-501-0165. To request a noncovered service, send a completed Fax/Written Request Basic Information form, HCA 13-756, to the address or fax listed on the form. See Where can I download HCA forms? For authorization of services beyond the designated benefit limit allowed, a provider may request a limitation extension (LE). See What is a limitation extension (LE)?

What is the Periodicity Schedule?

The Periodicity Schedule provides information about HCA's expectations for conducting EPSDT well-child checkups and the schedule for performing the different components and screenings for each child. The footnote references and recommendations are based on the Bright Futures/American Academy of Pediatrics Recommendations for Preventative Pediatric Health Care.

Washington State Health Care Authority

EPSDT and Foster Care

What do I need to know about EPSDT for children in foster care?

Most children in foster care are covered by Coordinated Care of Washington (CCW). Contact CCW directly at 1-844-354-9876 for any questions about services to meet the health care needs for managed care clients in foster care.

For children in foster care who are fee-for-service (FFS) clients, this section explains the benefits for these children and how to bill for the services.

To be sure the medical, dental, and mental health needs of foster children are promptly addressed, HCA allows more extensive EPSDT benefits. HCA pays providers an enhanced rate for providing well-child care for foster children and the children are allowed more frequent checkups compared to other Apple Health clients.

The elements of an EPSDT well-child checkup are the same for all children. They include:

- Initial/interval health history and a family health history
- Measurements – age-appropriate growth including length/height and weight and blood pressure
- Sensory screening – vision and hearing*
- Developmental/behavioral health screening*
- Physical exam
- Procedures, including immunizations and laboratory tests*
- Oral health and fluoride varnish*
- Anticipatory guidance

*These components have add-on codes that may be billed in addition to the EPSDT evaluation and management (E&M) codes when appropriate. See information about each component and the available add-on codes in the descriptions listed below this section. See What are the billing requirements specific to EPSDT for more information about billing the EPSDT E&M codes.

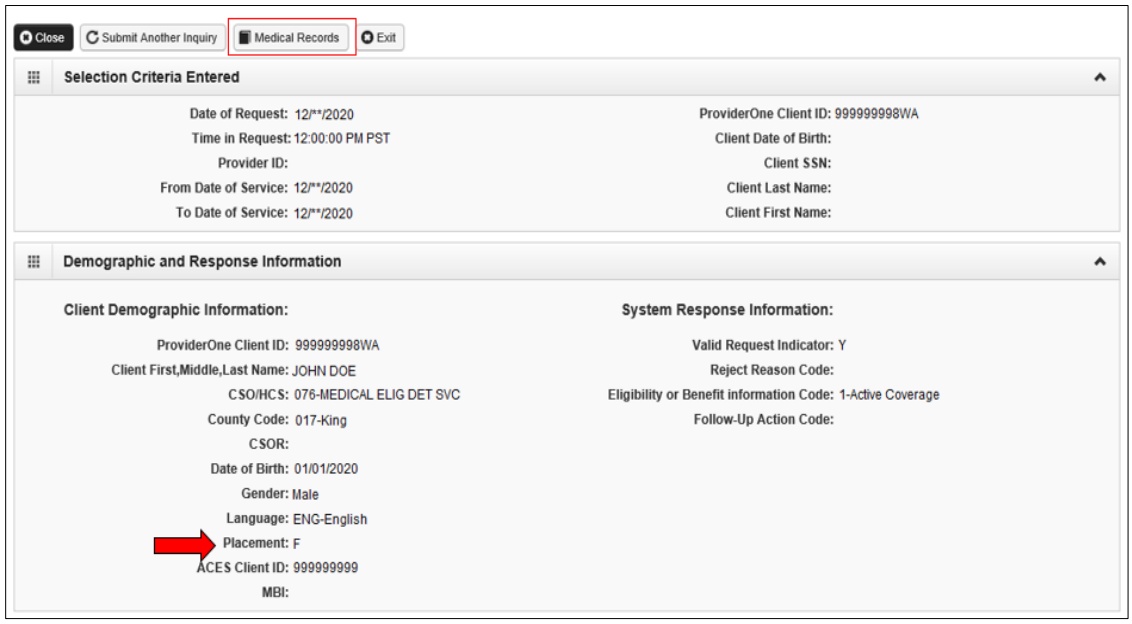
See What is an EPSDT well-child checkup for more information.

How often can a child in foster care have an EPSDT well-child checkup?

HCA allows EPSDT well-child checkups for foster care clients **without regard to the** Periodicity Schedule by billing CPT® codes 99381-99385 and 99391-99395 with a TJ modifier.

How can I identify a child in foster care placement?

The following is a screenshot from ProviderOne. The placement code (indicated by the red arrow) may allow a provider who is billing certain E&M codes to receive an enhanced rate for the service.



If the client's ProviderOne eligibility inquiry screen indicates a child is associated with one of the foster care placement codes listed in the table below, the provider must use the TJ modifier along with the appropriate procedure code(s) to be paid an enhanced rate for EPSDT well-child checkups.

Placement Code	Description
A	Adoption Support Services
F	Foster Care Placement
H	Foster Care HB2530
P	Interstate Compact in Placement of Children's Service
R	Relative Foster Care Placement
T	Tribal Foster Care Placement

How do I bill EPSDT well-child checkups to receive the enhanced rate?

Bill EPSDT well-child checkups for children in foster care by billing CPT® codes 99381-99385 and 99391-99395 with a TJ modifier. EPSDT well-child checkups for foster care children are not limited. They may be provided without regard to the Periodicity Schedule.

What is an initial health evaluation (IHE) and how is it billed?

When a child age 17 and younger enters out-of-home placement, HCA pays for an initial health evaluation (IHE) which must be scheduled within 72 hours by the foster parent or social worker. The IHE aims to identify:

- Immediate medical, mental health, or dental needs of the child.
- Additional health conditions that the foster parent and social worker need to know.
- The IHE is not intended to be as comprehensive as an EPSDT well-child checkup. If an IHE is provided:
- Bill the appropriate evaluation and management (E&M) code (new patient CPT® codes 99201 – 99205 or established patient CPT® codes 99211–99215).
- Use ICD diagnosis code Z01.89 (encounter for other specified special examinations) as the primary diagnosis.
- Use modifier TJ.

What is included in an IHE?

See the Foster Care Initial Health Screen form, HCA 13-843 (see Where can I download HCA forms) and the AAP Healthy Foster Care America Health Information Form for information on what should be included in the IHE.

Can I bill for both an EPSDT well-child checkup and an IHE?

HCA does not pay for an IHE with the same date of service as an EPSDT examination. The child will not require an IHE if an EPSDT well-child checkup is performed.

Washington State Health Care Authority

Developmental and Behavioral Health Screening

Is developmental screening part of the EPSDT well-child checkup process?

Yes. Developmental screening is done using standardized screening tools which may include caregiver interview and observation. Use CPT® code 96110, two units per billing claim, with a limit of 5 times from birth to age 3.

Refer to the **Bright Futures Toolkit for Commonly Used Screening Instruments** for examples of available standardized tools. To be reimbursed, the name of the screening tool and the score must be included in the documentation.

Is behavioral health screening part of the EPSDT well-child checkup process?

> **Note:** Eligible clients may receive a mental health or substance use assessment without an EPSDT well-child checkup or referral.

Yes. Behavioral health screenings must be done using standardized screening tools or through an interview. See **EPSDT mental health/substance use assessment referral indicators** for a list of behaviors that may indicate mental health problems.

All children age 12 and older must be screened for depression. Use CPT® code 96127 or 96160, with up to two units per billing claim line.

Caregivers of infants age 12 months and younger must be screened for depression. Use CPT® code 96161 under the infant's ProviderOne client ID. When billing CPT® code 96161 for a fee-for-service (FFS) client, use EPA # 870001424.

> **Note:** The expedited prior authorization (EPA) process is designed to eliminate the need for written/fax authorization. The intent is to establish authorization criteria and identify these criteria with specific codes, enabling the provider to use HCA's designated "EPA" number when appropriate. The billing provider must document how EPA criteria were met in the client's file and make this information available to HCA or HCA's designee upon request. See HCA's **ProviderOne Billing and Resource Guide** for information about entering EPA numbers on claims.

The **Bright Futures Toolkit for Commonly Used Screening Instruments** contains a list of recommended child-youth behavioral health screening tools that providers are strongly encouraged to use during visits. If the screening tool indicates further treatment is needed, providers should give treatment and/or make a referral to a behavioral health provider for further assessment and treatment recommendations.

Screening guidelines

Mental health and substance use screenings are intended to identify children who are at risk for, or may have, mental health or substance use problems. Screenings do not result in a diagnosis. If a screen indicates a possible problem, the child is referred for an assessment where a diagnosis and plan of care are developed.

When child abuse or neglect is suspected, a report to Child Protective Services 1-866-363-4276 must be made, even if the child is also referred for a mental health assessment.

If an eligible client is suspected or identified through the EPSDT well-child checkup as experiencing a mental health or substance use disorder, providers may refer the client to a mental health or substance use provider and assist the client/family in making appointments and obtaining necessary treatment. This referral must be made within two weeks from the date the problem is identified unless the problem is urgent. If the problem is urgent, a referral must be made immediately. The referring provider must follow-up to ensure the assessment was completed.

Document the need for the service in the client's records. The diagnosing or treating mental health or substance use provider should communicate the results of the referral back to the primary care provider.

Urgent referrals

Some behaviors, symptoms, and risk factors may signal that a child is in crisis. In these cases, the referral process must be accelerated so that the child may be assessed and treated promptly. An immediate referral must be made by telephone to the behavioral health agency whenever the child exhibits any of the following:

- Fire-setting
- Suicidal behavior or suicidal ideation
- Self-destructive behavior
- Torturing animals
- Destroying property
- Substance use, either in conjunction with other mental health concerns or if the child is age 11 and younger.
- Moderate or severe substance use with or without co-occurring mental health concerns

- Sexual acting out
- Witnessing a death or other substantial physical violence
- Experiencing sexual or physical abuse
- Out of touch with reality, delusional (psychotic decompensation)
- Imminent risk of placement in a more restrictive setting

The crisis response system should be used only if the child is a danger to himself/herself or others.

Non-urgent referral

When screening for behavioral health risk factors, use professional judgment when deciding to refer the client for further assessment of other issues, such as:

- Family issues
- Problematic peer activities
- School issues
- Somatic symptoms
- Abnormal behaviors
- Unusual feelings and thoughts
- Unusual growth and development
- Social situation problems

Children may also be referred for a behavioral health assessment at a parent's request. Make a referral if the child or parent sees the behavior or symptom as problematic, even if the issues seem minor or within normal range to you. Parents' and teachers' perceptions have shown to be the best predictors of behavioral health problems.

How are substance use screening and treatment provided?

Screening and brief intervention may be provided in the following ways:

- **Screening, Brief Intervention, and Referral to Treatment (SBIRT)**

  A comprehensive, evidence-based, public health practice designed to identify people who are at risk for or have some level of substance use disorder which can lead to illness, injury, or other long-term morbidity or mortality. SBIRT services are provided in a wide variety of medical and community healthcare settings. Any provider who has completed the SBIRT training and provides a brief intervention or a brief intervention and referral may seek reimbursement for these services using CPT® code 99408 for intervention that is less than 30 minutes. See HCA's Physician-Related Services/Health Care Professional Services Billing Guide for more details.

- **Washington Recovery Help Line**

  The Washington Recovery Help Line is the consolidated help line for substance use, problem gambling, and mental health. The help line provides anonymous and confidential crisis intervention and referral services for Washington State residents. Professionally trained volunteers and staff are available to provide emotional support 24 hours a day and offer local substance use services. To refer people experiencing substance use disorder, call the 24-hour Washington Recovery Help Line at 800-789-1511.

Recommended screening tools

Standardized screenings play a critical role in early identification and intervention for conditions impacting children and youth in the present as well as their long-term development. Health care providers and early childhood professionals use screening tools to help detect concerns early and determine appropriate referral to services and intervention. Historically, a table based off the 2016 Children's Mental Health Work Group Final Report and Recommendations to the Legislature was included in this guide to share commonly used child-youth screening tools. To align with American Academy of Pediatrics best practice recommendations, providers are encouraged to reference **Bright Futures Toolkit for Commonly Used Screening Instruments.**

Note: Providers may review the historical **Recommended Screening Tools Table** listing common child-youth screening tools, identified in the 2016 Children's Mental Health Work Group Final Report and Recommendations to the legislature.

EPSDT mental health/substance use assessment referral indicators

Category	Indicators for a Mental Health Assessment	
Family	problems separating	Parent experiencing substance use disorder
	physical abuse or neglect	parental discord
	psychological abuse	few social ties
	sexual abuse	problems with siblings
	domestic violence	death of parent/sibling
	divorce/separation	parent in criminal justice system
	chronic physical or mental illness of parent	
Peer activity	no confidence	fighting and bullying
	social isolation	

Category	Indicators for a Mental Health Assessment	
Behaviors	temper tantrums fire setting stealing tics sexually acting out lying substance use destroys property aggressive	over activity in trouble with law impulsive attachment problems in infants overly compliant to passive defiant running away truancy
Schools	school failure school refusal	absenteeism and truancy
Feelings	anxiety or nervousness feeling depressed low self-esteem	fearful suicidal
Thoughts	delusions hallucinations	incoherence self-destructive thoughts
Somatic symptoms	trouble sleeping sleepwalking night terrors	enuresis encopresis eating disorder
Social	lack of housing frequent moves financial problems	sexual abuse foster care history of detention

Category	Indicators for a Mental Health Assessment	
Growth and Developments	slow weight gain nonorganic failure to thrive mentally retarded learning disabilities	language delay attention problems speech problems

Derived from a Word Health Organization, primary care child-oriented classification system. Haeres, S.M., Leaf, P.J., Leventhal, J.M., Forsyth, B. and Speechley, K.N. (1992), Identification and management of psychosocial and developmental problems in community-based primary care pediatric practices. Pediatrics, 89(3), 480 - 485.

The indicators listed above may be elicited from caregivers and children through interviews described in professional references (e.g., American Academy of Pediatrics: Guidelines for Child Health Supervision; and the Region X Nursing Network: Prenatal and Child Health Screening and Assessment Manual). It may be appropriate to interview the child separate from the caregiver beginning at age eight years.

Screening infants and toddlers for mental health problems is an emerging science. Based on professional judgment, referral is appropriate when there are concerns that a family and social environment do not support the infant's mental wellness.

Children with behaviors not listed on the checklist should also be referred for mental health services if the parent desires. It is important to remember that if the child or parent sees the behavior or symptom as problematic, make a referral, even if the issues seem minor or within normal range to you. Parents' and teachers' perceptions have been shown to be the best predictors of mental health problems.

Immunizations

Immunizations covered by the EPSDT program are listed in the Professional Administered Drug Fee Schedule. For vaccines that are available at no cost from the Department of Health (DOH) through the Universal Vaccine Distribution program and the federal Vaccines for Children (VFC) program for children age 18 and younger, HCA pays only for the administrative cost of the vaccine and not for the vaccines themselves. These vaccines are identified in the Comments column of the Fee Schedule as free from DOH. For more information on the VFC program, see the VFC webpage.

How do I bill for vaccines for clients age 19 and 20?

- Bill HCA for the cost of the vaccine itself by reporting the procedure code for the vaccine given. DO NOT use modifier SL with any of the vaccines for clients age 19 and 20, regardless of whether or not the vaccine is available for free from DOH. HCA pays for the vaccine using the maximum allowable fee schedule.
- Bill for the administration of the vaccine using CPT® codes 90471 (first vaccine) and 90472 (additional vaccine). Providers must bill CPT® codes 90471 and 90472 on the same claim as the procedure code for the vaccine.
- See the Professional Administered Drug Fee Schedule for vaccine codes.

What vaccines are free from the Department of Health (DOH) for clients age 18 and younger?

No-cost immunizations from DOH are available for clients age 18 and younger. See the Professional Administered Drug Fee Schedule for a list of immunizations that are free from DOH. Therefore, HCA pays only for administering the vaccine.

- In a nonfacility setting:
    - Bill for the vaccine by reporting the procedure code for the vaccine given with modifier SL (e.g., CPT® 90707 SL). HCA pays for the administrative cost for those vaccines that are free from DOH and are billed with modifier SL (e.g., CPT® 90707 SL).
    - DO NOT bill CPT® codes 90460-90461 or CPT® 90471-90472 for the administration.
- To bill for the administration of vaccines in an outpatient hospital or hospital-based clinic setting, use:
    - An electronic institutional claim
    - CPT® codes 90471-90472
    - The hospital's outpatient provider NPI number

- To bill for a vaccine in an outpatient hospital or hospital-based clinic setting, use:
  - An electronic institutional claim
  - An appropriate procedure code
  - The hospital's outpatient provider NPI number
- If a vaccine is available free from DOH (see the **Professional Administered Drug Fee Schedule**), then HCA will:
  - Deny the vaccine claim line.
  - Combine vaccine payment with the payment for the administration of the vaccine.

How do I bill for stand-alone vaccine counseling?

Retroactive to dates of service on and after December 2, 2021, providers may bill for stand-alone vaccine counseling. To receive reimbursement, providers must bill using CPT® code 99401 with diagnosis code Z71.85 (encounter for immunization safety) in the primary position on the claim.

Stand-alone vaccine counseling refers to when a patient or caregiver, or both, receives counseling about a vaccine from a health care practitioner, but the patient does not actually receive the vaccine dose at the same time as the counseling (i.e., no vaccine delivery or injection occurs during the practitioner visit).

Note:

- Do not bill stand-alone vaccine counseling on the same date of service as an EPSDT appointment.
- This section applies only to routine vaccine counseling. For vaccine counseling for COVID-19 vaccines, see HCA's Apple Health COVID-19 vaccine policy (scroll down to COVID-19, then to Policies and billing guidance).

Washington State Health Care Authority

General Authorization

Authorization is HCA's approval for certain medical services, equipment, or supplies, before the services are provided to clients, as a precondition for provider reimbursement. **Prior Authorization (PA) and limitation extensions (LE) are forms of authorization.**

What is prior authorization (PA)?

Prior authorization (PA) is HCA's or its designee's approval for certain medical services, equipment, or supplies, before the services are provided to clients. When PA is applicable, it is a precondition for provider reimbursement.

What is a limitation extension (LE)?

HCA limits the amount, frequency, or duration of certain services and reimburses up to the stated limit without requiring PA. HCA requires a provider to request PA for a limitation extension (LE) to exceed the stated limits.

See Resources Available for the fax number and specific information (including forms) that must accompany the request for LE.

HCA evaluates requests for LE under the provisions of WAC 182-501-0169.

How do I obtain authorization?

Send your request to HCA's Authorization Services Office (see Resources Available). For more information on requesting authorization, see HCA's ProviderOne Billing and Resource Guide.

Billing

All claims must be submitted electronically to HCA, except under limited circumstances. For more information about this policy change, see **Paperless Billing at HCA**. For providers approved to bill paper claims, see **HCA's Paper Claim Billing Resource.**

Providers must follow HCA's billing requirements in the **ProviderOne Billing and Resource Guide.** These billing requirements include, but are not limited to, all the following:

- Time limits for submitting and resubmitting claims and adjustments
- What fee to bill HCA for eligible clients
- When providers may bill a client
- How to bill for services provided to primary care case management (PCCM) clients
- Billing for clients eligible for both Medicare and Medicaid
- Third-party liability
- Record-keeping requirements

How do I bill claims electronically?

Instructions on how to bill Direct Data Entry (DDE) claims can be found on HCA's **Billers and Providers webpage**, under **Webinars.**

For information about billing Health Insurance Portability and Accountability Act (HIPAA) Electronic Data Interchange (EDI) claims, see the ProviderOne 5010 companion guides on the **HIPAA Electronic Data Interchange (EDI) webpage.**

What are the billing requirements specific to EPSDT?

Use the appropriate diagnosis code when billing any EPSDT well-child checkup service, CPT® codes 99381-99395 (e.g., Z00.129 - Encounter for routine child health examination without abnormal findings).

Bill for services such as laboratory work, hearing tests, x-rays, or immunization administration using the appropriate procedure code(s), along with the EPSDT well-child checkup (CPT® codes 99381 - 99395) on the same claim.

When physicians and ARNPs identify physical or mental health problems, or both, during an EPSDT well-child checkup, the provider may treat the client or refer the client to another provider. Physicians and ARNPs are not limited to the procedure codes listed within this billing guide. They may also use HCA's **Physician-Related Services/Health Care Professional Services Billing Guide** as necessary. Any office, laboratory, radiology, immunization, or other procedure rendered as part of follow-up treatment must be billed on a separate professional claim from the EPSDT well-child checkup.

For information on billing for evidence-based medicine (EBM), see the **Mental Health Services Billing Guide.** When billing for services provided in a facility, refer to all appropriate HCA billing guides (such as the **Outpatient Hospital Services Program Billing Guide**) to ensure correct claim processing.