Health Care Authority

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program

Billing Instructions

Chapter 182-534-WAC

About This Publication

This publication supersedes all previous Agency *EPSDT Billing Instructions* published by the Agency.

Note: The Agency now reissues the entire billing manual when making updates, rather than just a page or section. The effective date and revision history are now at the front of the manual. This makes it easier to find the effective date and version history of the manual.

What Has Changed?

This publication has been revised by # Memo 11-26

Effective Date/Reason for Change	Section/ Page No.	Subject	Change
July 1, 2011 Clarify and update Billing Instructions	A.1	Screening	Add what a screening includes.
	C.2	Well Child Exam Form	Clarify instructions for ordering required forms for well child exams through the Department of Printing.
	C.2	Screening Exams	Clarify the age groups who can receive screening exams in the third bullet after the title "How Often Should EPSDT Screenings Occur".
	C.3	Well child exam form for foster care children	Clarify instructions for ordering required forms for well child exams through the Department of Printing.
	C.10	Synagis	Added procedure code 90378 to title.
	E.3	Vaccines for clients 19-20 years of age	Add procedure codes for vaccines under the heading Clients 19-20 years of age – All Vaccines
	E.2 and E.3	Vaccines	Add procedure codes to table 90647, 90650, 90657, 90681, 90696, 90743, 90748.

Copyright Disclosure

How Can I Get Agency Provider Documents?

To download and print Agency provider numbered memos and billing instructions, go to the Agency website at http://hrsa.dshs.wa.gov (click the ***Billing Instructions and Numbered Memorandum*** link).

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Important Contacts

Note: This section contains important contact information relevant to the EPSDT program. For more contact information, see the Agency *Resources Available* web page at: http://hrsa.dshs.wa.gov/Download/Resources_Available.html

Topic	Contact Information
Becoming a provider or submitting a change of address or ownership	See the Agency *Resources Available* web page at: http://hrsa.dshs.wa.gov/Download/Resources_Available.html
Finding out about payments, claim denials, claims processing, or Agency contracted managed care organizations	
Electronic or paper billing	
Finding Agency documents (e.g., billing instructions, # memos, fee schedules)	
Private insurance or third-party liability, other than Agency managed care	
Prior authorization, limitation extensions, or exception to rule	
Ordering the Referral for Mental Health/Substance Abuse Assessment, 01-192X	Go to: Agency If you need additional copies of this referral form, mail or fax a written request on letterhead to: DSHS Warehouse PO Box 45816 Olympia, WA 98504-5816 FAX 1-360-664-0597 Telephone 1-360-753-7057

Definitions & Abbreviations

This section defines terms and abbreviations, including acronyms, used in these billing instructions. Please refer to the Agency *ProviderOne Billing and Resource Guide* at http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for a more complete list of definitions.

Basic Health Plus (BH+) – A program jointly managed by the Health Care Authority (the Agency) for BH enrollees who are eligible for Medicaid (notably children and pregnant women). BH+ offers the expanded benefits available in the Healthy Options/Agency benefit package and allows family members in BH to remain together in the same managed health care plan rather than being on two separate plans under BH+ and HO. Pregnant BH+ enrollees are also referred to as "S" medical enrollees.

Benefit Service Package - A grouping of benefits or services applicable to a client or group of clients.

Children's Health Program - The Children's Health Program is the state-funded program for children under age 18 who are not eligible for Medicaid. (*Not to be confused with the Children's Health Insurance Program – CHIP.)*

Children's Health Insurance Program (CHIP) - A federal/state program that covers children under 19 years of age in families whose income is too high for Medicaid, but is from 200 to 250% of the Federal Poverty Level. (*Not to be confused with the Children's Health Program.)*

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) - A program providing early and periodic screening, diagnosis and treatment to persons under 21 years of age who are eligible for Medicaid or the Children's Health Program, and Children's Health Insurance Program (CHIP).

Maximum Allowable - The maximum dollar amount that the Agency will reimburse a provider for specific services, supplies, and equipment.

Medically Necessary – See WAC 182-500-0005.

Medical Nutrition Therapy - A direct interaction between the certified dietitian and the client and/or client's guardian for the purpose of evaluating and making recommendations regarding the client's nutritional status.

National Provider Identifier (NPI) – A federal system for uniquely identifying all providers of health care services, supplies, and equipment.

Usual & Customary Fee - The rate that may be billed to the Agency for a certain service or equipment. This rate may not exceed:

1) The usual and customary charge that you bill the general public for the same services; or
2) If the general public is not served, the rate normally offered to other contractors for the same services.

About the Program

What Is the Purpose of the EPSDT Program?

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is a federal preventive health care benefit. The purpose of this program is to periodically screen infants, children and adolescent clients 20 years of age and younger in order to detect physical and/or mental health problems. If a physical or mental health problem is identified, the client should be treated, or referred to an appropriate provider for treatment. EPSDT is designed to encourage continuing access to health care.

Screening includes:

- Comprehensive health and developmental history;
- Unclothed physical exam;
- Appropriate immunizations;
- Laboratory tests; and
- Health education.

Access to and services for EPSDT are governed by federal rules at 42 CFR, Part 441, Subpart B.

The Agency's standard for coverage is that the services, treatment, or other measures must be:

- Medically necessary; and
- Safe and effective.

Who Can Provide EPSDT Screenings?

- Physicians;
- Advanced Registered Nurse Practitioners (ARNPs);
- Physician Assistants (PAs);
- Nurses specially trained through the Department of Health (DOH); and
- Registered nurses working under the guidance of a physician or ARNP may also do EPSDT screenings. However, only physicians, PAs and ARNPs can diagnose and treat problems found in a screening.

Note:	DOH no longer provides training to nurses for EPSDT screenings.

Fee Schedule

You may view Agency EPSDT Fee Schedule on-line at:
http://hrsa.dshs.wa.gov/RBRVS/Index.html

Client Eligibility

Who Is Eligible for EPSDT Screenings?

The Agency pays providers for EPSDT screenings provided to clients who:

- Are 20 years of age and younger; and
- On a Benefit Service Package (BSP) that covers EPSDT.

> **Note:** Refer to the *Scope of Healthcare Services Chart* web page at: http://hrsa.dshs.wa.gov/Download/ScopeofHealthcareSvcsTable.html for an up-to-date listing of Benefit Service Packages.

Please see the Agency *ProviderOne Billing and Resource Guide* at http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for instructions on how to verify a client's eligibility.

> **Note:** Please refer clients to their local Community Services Office (CSO) if they are 20 years of age and younger and their BSP doesn't cover EPSDT. The CSO will evaluate these clients for a possible change in their BSP coverage that would enable them to receive EPSDT screenings.

Are Clients Enrolled in a Agency Managed Care Plan Eligible? [Refer to WAC 182-538-060 and 095 or WAC 182-538-063 for GAU clients]

YES! When verifying eligibility using ProviderOne, if the client is enrolled in an Agency managed care plan, managed care enrollment will be displayed on the Client Benefit Inquiry screen. All services must be requested directly through the client's Primary Care Provider (PCP). Clients can contact their managed care plan by calling the telephone number provided to them.

All medical services covered under a managed care plan must be obtained by the client through designated facilities or providers. The managed care plan is responsible for:

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

> **Note:** To prevent billing denials, please check the client's eligibility **prior** to scheduling services and at the **time of the service** and make sure proper authorization or referral is obtained from the plan. See the Agency *ProviderOne Billing and Resource Guide* at

http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for instructions on how to verify a client's eligibility.

Do not bill the Agency for EPSDT services as they are included in the managed health care plan's reimbursement rate.

Exception: The Agency covers referrals for a mental health or substance abuse assessment outside the Agency managed care plan. These referrals are paid separately on a fee-for-service basis. Providers must bill the Agency directly for these types of referrals.

Primary Care Case Management (PCCM)

For the client who has chosen to obtain care with a PCCM provider, this information will be displayed on the Client Benefit Inquiry screen in ProviderOne. These clients must obtain or be referred for services via a PCCM provider. The PCCM provider is responsible for coordination of care just like the PCP would be in a plan setting.

Note: To prevent billing denials, please check the client's eligibility **prior** to scheduling services and at the **time of the service** and make sure proper authorization or referral is obtained from the PCCM provider. Please see the Agency *ProviderOne Billing and Resource Guide* at http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for instructions on how to verify a client's eligibility.

Billing for Infants Not Yet Assigned a ProviderOne Client ID

If a child who is younger than 60 days of age and **has not been issued** an individual ProviderOne Client ID, use the mother'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. When using mom's ProviderOne client ID for twins or triplets, etc., identify each infant separately (i.e., twin A, twin B) using a *separate claim form* for each.

Note: For parents enrolled in a managed care plan, the plan is responsible for providing medical coverage for the newborn(s).

EPSDT Screening Components

What Are EPSDT Screenings?

EPSDT screenings are defined by federal rules as "regularly scheduled examinations and evaluations of the general physical and mental health, growth, development and nutritional status of infants, children and youth" that are provided as part of a health supervision program.

What Is Included in an EPSDT Screening?

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

- A comprehensive health and developmental history, updated at each screening examination;
- A comprehensive physical examination performed at each screening examination;
- Appropriate vision testing;
- Appropriate hearing testing;
- Developmental assessment;
- Nutritional assessment;
- Appropriate laboratory tests;
- Dental/oral health assessment, including:
    - ✓ How to clean teeth as they erupt.
    - ✓ How to prevent baby bottle tooth decay.
    - ✓ How to look for dental disease.
    - ✓ Information on how dental disease is contracted.
    - ✓ Preventive sealant.
    - ✓ Application of fluoride varnish, when appropriate.
- Health education and counseling; and
- Age appropriate mental health and substance abuse screening.

These components may be performed separately by licensed providers; however, the Agency encourages the provider to perform as many of the components as possible to provide a comprehensive picture of the client's health.

When performing an EPSDT screening, the provider must complete the age-appropriate "Well Child Exam Form". Use forms 13-683A through 13-686B, or another charting tool with equivalent information. These forms are available for download online at: http://hrsa.dshs.wa.gov/mpforms.shtml.

The above forms may be ordered on-line through the Department of Printing's General Store; or ordered by sending an email to fulfillment@prt.wa.gov.

Additional Screening Components

For fee-for-service clients, the following screening services may be billed in addition to the EPSDT screening codes listed on the previous page:

- Appropriate audiometric tests (CPT® codes 92552 and 92553);
- Appropriate laboratory tests, including testing for anemia; and
- Appropriate testing for blood lead poisoning in children in high risk environments (CPT code 83655). Use ICD-9-CM diagnosis code V15.86 or V82.5 (Special screening for other conditions, chemical poisoning, and other contamination) when billing.

How Often Should EPSDT Screenings Occur?

The following are Washington State's schedules for health screening visits. Payment is limited to the recommended schedules listed below:

- Five total screenings during the first year of the child's life. Below is a recommended screening schedule for children from birth to one year of age.

  ✓ 1st Screening: Birth to 6 weeks old
  ✓ 2nd Screening: 2 to 3 months old
  ✓ 3rd Screening: 4 to 5 months old
  ✓ 4th Screening: 6 to 7 months old
  ✓ 5th Screening: 9 to 11 months old

- Three screening examinations are recommended between the ages of 1 and 2.
- One screening examination is recommended per 12-month period for children ages 3 through 6.
- One screening examination is recommended per 24-month period for children ages 7 through 20, except foster care clients, who receive a screening examination every 12 months and within 30 days of foster care placement or official relative placement through the Children's Administration.

Foster Care Children EPSDT Screenings

Foster care is defined as: 24-hour per day temporary substitute care for a child placed away from the child's parents or guardians in licensed, paid, out-of-home care, and for whom the Agency or a licensed or certified child placement agency has placement and care responsibility.

The Agency pays providers an enhanced rate of $120.00 or the allowed amount, whichever is higher, per EPSDT screening exam for foster care clients who receive their medical services through the Agency's fee-for-service system. This applies to CPT codes 99381-99385 and 99391-99395 only.

If ProviderOne indicates the child is in foster care, the provider must bill with modifier TJ to receive the enhanced rate.

The Agency pays providers for an EPSDT screening exam for foster care clients without regard to the periodicity schedule when the screening exam is billed with modifier TJ.

When performing an EPSDT screening, the provider must complete the age-appropriate "Well Child Exam Form". Use forms 13-683A through 13-686B, or another charting tool with equivalent information. These forms are available for download online at: Agency.

The above forms may be ordered on-line through the Department of Printing's General Store; or ordered by sending an email to fulfillment@prt.wa.gov.

Foster Children Initial Health Evaluation (IHE)

What is the purpose of an IHE?

The purpose of this evaluation is to identify any:

- Immediate medical, urgent mental health, or dental needs the child may have; and
- Additional health conditions of which the foster parents and caseworker should be aware.

Who is eligible?

Only clients 18 years of age and younger are eligible for an IHE.

What is included in an IHE?

An IHE includes the following:

- **Careful measurement of height and weight for all children, and head circumference for children younger than age 3** – This may reveal growth delays or reflect poor nutritional or general health status.

- **Careful examination of the entire body to include the unclothing of each body surface at some point during the examination -** Because some children entering foster care have been victims of physical or sexual abuse, note and document the following:

  - ✓ Any signs of recent or old trauma;
  - ✓ Bruises;
  - ✓ Scars;
  - ✓ Deformities; or
  - ✓ Limitations in the function of body parts or organ systems.

- **Appropriate imaging studies to screen for a recent or healing fracture -** Consider if there is a history of physical abuse before placement or if signs of recent physical trauma are present.

- **Genital and anal examination (male or female).**

- **Laboratory tests for HIV and other sexually transmitted diseases –** Perform when indicated clinically or by history.

- **Documentation and prompt treatment of other infections and communicable diseases.**

- **Evaluation of the status of any known chronic illness -** To ensure that appropriate medications and treatments are available.

Note: Discuss specific care instructions directly with the foster parents and caseworker.

What fee does the Agency pay?

Payment is set at the maximum allowable fee for children's office calls.

To view the EPSDT fee schedule, go to http://hrsa.dshs.wa.gov/RBRVS/index.html#E.

> **Note:** The Agency does not pay for an IHE on the same date of service as an EPSDT examination.

How do I bill?

When you provide a foster child with the IHE within 72 hours of entering out-of-home placement, bill the Agency using the following guidelines:

- Bill the appropriate evaluation and management (E&M) code (new patient codes 99201 – 99205 or established patient codes 99211 – 99215);
- Use ICD-9-CM diagnosis code V72.85 as the primary diagnosis; and
- Use modifier TJ.

If you bill an E&M code with the diagnosis code V72.85, but without modifier TJ, the Agency will deny the claim.

> **Important Note:** The IHE is not an EPSDT examination because it is not as complex or thorough. If you feel an EPSDT examination is necessary, perform the EPSDT examination within 72 hours of out-of-home placement and bill the Agency for the exam. The child will not require the IHE if an EPSDT screening is performed.

What are the documentation requirements?

Providers must either:

- Document the IHE on the Foster Care Initial Health Evaluation form, 13-843; or
- Include documentation in the client's record that addresses all elements addressed in the "What is included in an IHE" section of this memorandum or on the Foster Care Initial Health Evaluation form.

To view and download the Foster Care Initial Health Evaluation form, go to Agency and scroll down to the appropriate form number.

What Are the Time Limits for Scheduling Requests for EPSDT Screenings?

Requests for EPSDT screenings must be scheduled within the following time limits:

If an EPSDT screening is requested through…	For clients who are…	Must be scheduled within…
The Agency's Managed Care plans, Primary Care Case Management (PCCM), or Primary Care Providers (PCPs)	Infants – within the first 2 years of life.	21 days of request.
	Children – two years and older.	Six weeks of request.
	Receiving Foster Care – Upon placement	30 days of request, or sooner for children younger than 2 years of age.
Community Mental Health Center, Head Start, substance abuse provider, or Early Childhood Education and Assistance Program (ECEAP)	Birth through 20 years of age	14 days of the request.
Providers must ensure that when medically necessary services are identified during any EPSDT screening examination, appropriate treatment or referrals are made.		

What If a Medical Problem Is Identified During a Screening Examination?

If a medical problem is identified during a screening examination, the provider may:

- Refer the client to an appropriate Agency provider or the Agency's Managed Care Plan provider, if applicable, for medical treatment; or
- Provide the service for the client (if it is within the provider's scope of practice).

Genetic Counseling and Genetic Testing

Refer to Section G of the *Physician-Related Services/Healthcare Professional Services Billing Instructions* for information on genetic counseling and testing.

If the provider chooses to treat the medical condition on the same day as the screening exam, the provider must bill the appropriate level E&M code with modifier 25 in order to receive additional reimbursement for the office visit. Providers must bill using the appropriate ICD-9-CM medical diagnosis code that describes the condition found. **The E&M code and the EPSDT screening procedure code must be billed on separate claim forms.**

Referrals

Chiropractic Services

Eligible clients may receive chiropractic services when a medical need for the services is identified through an EPSDT screening. Use the usual professional referral procedures (e.g., a prescription or letter) to refer clients for medically necessary chiropractic services.

Dental Services

Eligible clients may go to a dental provider without an EPSDT screen or referral.

Orthodontics

Eligible clients may go to an orthodontic provider without an EPSDT screen or referral. The Agency pays for orthodontics for children with cleft lip or palates or severe handicapping malocclusions ***only***. The Agency does not pay for orthodontic treatment for other conditions.

Lead Toxicity Screening

Providers are no longer required to use the Lead Toxicity Screening Risk Factor questionnaire. Health care providers should use clinical judgment when screening for lead toxicity.

Fetal Alcohol Syndrome (FAS) Screening

FAS is a permanent birth defect syndrome caused by the mother's consumption of alcohol during pregnancy. FAS is characterized by cognitive/behavioral dysfunction caused by structural and/or chemical alterations of the brain, a unique cluster of minor facial anomalies, and is often accompanied by growth deficiency.

As part of the EPSDT screening, every child six months of age and older should be screened for risk of exposure to maternal consumption of alcohol and for the facial characteristics of FAS. If there is known in-utero exposure to alcohol, or there is suspicion of facial characteristics of FAS or microcephaly, the child may be referred to a diagnostic clinic.

Washington State
Fetal Alcohol Syndrome (FAS)
Clinic Locations

King County (Univ. of WA)

Who to Contact:
Susan Astely, Ph.D
University of Washington
Fetal Alcohol Syndrome Diagnostic and
Prevention Network (FASDPN)
P.O. Box 357920
Seattle, WA 98195-7920
1-206-598-0555
1-206-543-5771 FAX

Clinic Location:
FAS DPN Clinic
Center on Human Development and Disability
University of Washington
Seattle, WA 98195
http://depts.washington.edu/fasdpn

Whitman County (Pullman)

Who to contact:
Mike Berney, Director
1-509-334-1133
Darcy Miller, PH.D (for clinic)
darcymiller@wsu.edu
1-509-334-1133
Palouse River Counseling Center
340 NE Maple Street
Pullman, WA. 99163-4120

Snohomish County (Everett)

Who to Contact:
Christie Tipton, Clinic Coordinator
1-425-258-7069

Clinic Location:
Providence Everett
Little Red Schoolhouse
900 Pacific Avenue
Everett, WA 98201

Spokane County (Spokane)

Who to Contact:
Helle Jorgensen, Clinic Coordinator
1-509- 474-3748

Clinic Location:
Providence Health Care 101 W. 8th Avenue Spokane, WA 99204
www.spokanecounty.org/health

Yakima County (Yakima)

Who to Contact:
Linda Sellsted, Clinic Coordinator
1-509-574- 3207
Fax 1-509-574-3211

Clinic Location:
Yakima Children's Village
3801 Kern Rd.
Yakima, WA 98902

Medical Nutrition Therapy

If an EPSDT screening provider suspects or establishes a medical need for medical nutrition therapy, eligible clients may be referred to a certified dietitian to receive outpatient medical nutrition therapy. Use the usual professional referral procedures (e.g., a prescription or letter) to refer clients for medically necessary medical nutrition therapy.

The Agency pays for the procedure codes listed below when referred by an EPSDT provider. **Providers must document beginning and ending times that the service was provided in the client's medical record.**

Procedure Code	Brief Description	Limitations
97802	Medical nutrition, indiv, initial	1 unit = 15 minutes; maximum of 2 hours (8 units) per year
97803	Med nutrition, indiv, subseq	1 unit = 15 minutes; maximum of 1 hour (4 units) per day
97804	Medical nutrition, group	1 unit = 15 minutes; maximum of 1 hour (4 units) per day

Fluoride Varnish (HCPCS code D1203)

Fluoride varnish is a type of topical fluoride that acts to retard, arrest, and reverse the caries process. It is applied up to three times per year to all surfaces of the teeth. The teeth then absorb the fluoride varnish, strengthening the enamel and helping prevent cavities.

Who must prescribe the fluoride varnish?

- Dentists;
- Physicians;
- Physician Assistants (PA); or
- Advanced Registered Nurse Practitioners (ARNP).

Who is eligible?

All Medicaid-eligible clients, 18 years of age and younger, may receive fluoride varnish applications. Division of Developmental Disabilities (DDD) clients age 19 and older are also eligible.

Are Managed Care Clients Eligible?

Yes. Clients enrolled in one of the Agency's managed health care plans **are eligible for fluoride varnish applications** through fee-for-service. Bill the Agency directly for fluoride varnish applications.

Synagis®

Requirements for Administration and Authorization of Synagis® (90378)

The Agency requires providers to follow the 2009 updated guidelines established by the American Academy of Pediatrics (AAP) for the administration of Synagis®.

> **Note:** *This information relates only to those clients NOT enrolled in an Agency managed care organization (MCO). For clients enrolled in an Agency MCO, please refer to the coverage guidelines in the enrollee's plan.*

Respiratory Syncytial Virus (RSV)/Synagis® Season

The Agency has established the RSV/ Synagis® season as December through April. The Agency monitors RSV incidence as reported by laboratories throughout the state and may change the dates based on the data collected.

Unless otherwise notified by the Agency, these dates are firm.

Criteria for Administration of Synagis® to Agency Clients

The Agency requires that the following guidelines and standards of care be applied to clients considered for RSV/Synagis® prophylaxis during the RSV season. The Agency established these guidelines and standards using the AAP guidelines revised and updated in 2010.

Children younger than 2 years of age at the beginning of the coverage season are covered for up to a maximum of five doses for the season, regardless of start of treatment in relation to season start and end dates, if they have one of the following conditions:

- **Children with Chronic Lung Disease (CLD):**

  - ✓ *For their* first *RSV season with CLD, clients* who have required medical therapy (supplemental oxygen, bronchodilator, diuretic, or corticosteroid therapy) for CLD within 6 months prior to the anticipated start of the RSV/ Synagis® season;

  - ✓ *For their* second *RSV season with CLD, clients* who continue to require medical therapy, ***or*** **if treatment with Synagis is ordered by a neonatologist, pediatric intensivist, pulmonologist, or infectious disease specialist.**

- **Asthma** - Children with asthma who are on daily inhaled steroid therapy, but have persistent symptoms require evaluation by an asthma specialist or pulmonologist prior to authorization for Synagis®;

- **Immunocompromised –** Children with, for example, severe combined immunodeficiency or advanced acquired immunodeficiency syndrome;

- **Hemodynamically significant cyanotic, or acyanotic congenital heart disease** and ONE of the following:

  - Receiving medication to control congestive heart failure;
  - Moderate to severe pulmonary hypertension;
  - Undergoing surgical procedures that use cardiopulmonary bypass; or
  - Infants with cyanotic heart disease.

Note: The Agency does ***not*** authorize Synagis® for the following groups of infants and children with congenital heart disease:

- Infants and children with hemodynamically insignificant heart disease (e.g., secundum atrial septal defect, small ventricular septal defect, pulmonic stenosis, uncomplicated aortic stenosis, mild coarctation of the aorta, and patent ductus arteriosus);

- Infants with lesions adequately corrected by surgery, unless they continue to require medication for congestive heart failure; and

- Infants with mild cardiomyopathy who are not receiving medical therapy for the condition.

- **Children younger than 12 months of age at the beginning of the RSV/Synagis® season with significant congenital abnormalities of the airway or a neuromuscular condition that compromises handling of respiratory tract secretions** - These clients are covered for a maximum of five doses for the season during the first year of life only;

- **Children born at 28 weeks and 6 days gestation or earlier and younger than 12 months of age at the beginning of the RSV/Synagis® season** – These clients are covered for a maximum of five doses for the season, regardless of start of treatment in relation to RSV season start and end dates;

- **Children born at 29 weeks and 0 days through 31 weeks and 6 days gestation and younger than 6 months of age at the beginning of the RSV/Synagis® season** – These clients are covered for a maximum of five doses for the season, regardless of start of treatment in relation to RSV season start and end dates;

- **Children born at 32 weeks and 0 days through 34 weeks and 6 days gestation, younger than 3 months of age at the beginning of the RSV/Synagis® season**, and having one of the following risk factors:

  ✓ Attending child care; or

  ✓ Living with siblings younger than five years of age.

  Children who qualify under these criteria should receive Synagis® only until they reach 3 months of age and may receive a maximum of **three** doses of Synagis® during the season. This means that some children may only receive one or two doses, because of their age, during the RSV/Synagis® season. Payment for any doses beyond the three allowed or administered after 3 months of age will be considered an overpayment subject to recoupment.

Other Considerations When Administering Synagis®

Administer the first dose of Synagis® 48 to 72 hours before discharge or promptly after discharge to infants who qualify for prophylaxis during the RSV/Synagis® season.

If an infant or child who is receiving Synagis® immunoprophylaxis experiences a breakthrough RSV infection, continue administering monthly prophylaxis for the maximum allowed doses as above.

Note: The Agency does not authorize Synagis® for children with cystic fibrosis.

Authorization and Billing Procedures

Please direct questions or concerns regarding billing and authorization of Synagis® to the Agency's Pharmacy Authorization Unit at 1-800-562-3022, ext.15483. Fax prior authorization requests on completed Agency prior authorization form(s) to 1-866-668-1214.

Bill the Agency Using the Following Guidelines:

- Synagis® may be dispensed and billed by a retail pharmacy for administration by a physician, or may be billed by the physician's office;
- Pharmacies bill through standard pharmacy Point-of-Sale electronic claim submission using the appropriate National Drug Code for the product dispensed;
- Physician's offices billing directly for Synagis® must bill on a CMS-1500 or comparable electronic billing format using Current Procedural Terminology (CPT) code 90378;

Criteria for Coverage or Authorization

Note: Criteria for coverage or authorization vary depending on the patient's age at the start of the RSV season.

Clients Younger than One Year of Age for the Duration of RSV/Synagis® Season

The Agency requires providers to use and accurately apply the "Criteria for Administration of Synagis® to Agency Clients." Billing for Synagis® outside of these guidelines will be considered an overpayment and will be subject to recoupment.

The Agency will continue to cover Synagis® for clients younger than one year of age without authorization, as long as utilization is appropriate. In this case, physicians and pharmacies are not required to submit paperwork or obtain pre-approval for the administration of Synagis®.

Clients Reaching One Year of Age During RSV/Synagis® Season

The Agency requires prior authorization to administer Synagis® to Agency clients who are:

- Under one year of age at the start of RSV/Synagis® season; and
- Will reach their first birthday prior to the end of the season.

Prior authorization is required to administer Synagis® to children one year of age and older. Request authorization by faxing the "Request For Synagis (Not Managed Care/Healthy Options)" form, 13-771.

Clients Between One and Two Years of Age at the Beginning of RSV/Synagis® Season

Prior authorization is required to administer Synagis® to Agency clients one year of age and older at the start of RSV/Synagis® season. Request authorization by faxing the "Request For Synagis (Not Managed Care/Healthy Options)" form, 13-771.

Clients Older than Two Years of Age at the Beginning of RSV/Synagis® Season

The Agency does not pay for administering Synagis® to clients older than two years of age.

Authorization Procedures

- **Pharmacy Billers**

  - ✓ Pharmacies must submit a request for authorization using a ProviderOne-compatible Authorization Form, 13-835A as the cover sheet.

  - ✓ To submit an authorization request complete the ProviderOne-compatible Authorization Form, 13-835A and use NDC 60574-4113-01 in box #21 regardless of the strength eventually intended for dispense. If authorized the Agency may approve the 100mg strength, or the 50mg strength, or both. . After review of the request you will receive notification of strengths, quantities, and NDCs approved.

  - ✓ The Request for Synagis (Not Managed Care/Healthy Options) Form, 13-771 must accompany ProviderOne-compatible Authorization Form, 13-835A as supporting documentation.

  - ✓ Pharmacies billing for Synagis® through standard pharmacy Point-of-Sale electronic claim submission must use the appropriate National Drug Code for the product dispensed.

- **Physician Office Billers**

  - ✓ Physician offices must submit a request for authorization using a ProviderOne-compatible Authorization Form, 13-835 as the cover sheet.

  - ✓ The Request for Synagis (Not Managed Care/Healthy Options) Form, 13-771 must follow ProviderOne-compatible Authorization Form, 13-835A as supporting documentation.

  - ✓ Physician offices billing the Agency directly for Synagis® must bill using a CMS-1500 claim form or comparable electronic billing format using Current Procedural Terminology (CPT) code 90378.

Requesting an Increase in Dose

The quantity of Synagis® authorized for administration is dependent upon the weight of the client at the time of administration. If authorization has been obtained for a quantity of Synagis® that no longer covers the client's need due to weight gain:

- Complete the appropriate ProviderOne Cover Sheet by entering the initial authorization number.
  - ✓ Pharmacy billers use the "Pharmacy PA Supporting Docs" sheet.
  - ✓ Physician office billers use "PA (Prior Authorization) Pend Forms" sheet.
- Complete the Request for Additional MG's of Synagis® Due to Client Weight Increase Form, 13-770 and submit along with the ProviderOne Cover Sheet.

The Agency will update the authorization to reflect an appropriate quantity and return a fax to the requestor confirming the increased dosage.

Evaluation of Authorization Requests

The Agency physicians will evaluate requests for authorization to determine whether the client falls within 2010 AAP guidelines for the administration of Synagis®. The Agency will fax an approval or denial to the requestor.

Please allow at least five business days for the Agency to process the authorization request.

You may verify the status of a pending authorization by calling the Medical Assistance Customer Service Center at 1-800-562-3022.

Agency forms may be downloaded at the Agency forms website at: Agency.

National Drug Code Format

National Drug Code (NDC) – The 11-digit number the manufacturer or labeler assigns to a pharmaceutical product and attaches to the product container at the time of packaging. The 11-digit NDC is composed of a 5-4-2 grouping. The first 5 digits comprise the labeler code assigned to the manufacturer by the Federal Drug Administration (FDA). The second grouping of 4 digits is assigned by the manufacturer to describe the ingredients, dose form, and strength. The last grouping of 2 digits describes the package size. [WAC 182-530-1050]

The NDC ***must*** contain 11-digits in order to be recognized as a valid NDC. It is not uncommon for the label attached to a drug's vial to be missing "leading zeros." **For example:** The label may list the NDC as 123456789, when, in fact, the correct NDC is ***0***1234***0***56789. Make sure that the NDC is listed as an 11-digit number, inserting any leading zeros missing from the 5-4-2 groupings, as necessary. ***The Agency will deny claims for drugs billed without a valid 11-digit NDC.***

Electronic 837-P Claim Form Billing Requirements

Providers must continue to identify the drug given by reporting the drug's CPT or HCPCS code in the **PROFESSIONAL SERVICE Loop 2400, SV101-1 and the corresponding 11-digit NDC in DRUG IDENTIFICATION Loop 2410, LIN02 and LIN03.** In addition, the units reported in the "units" field in PROFESSIONAL SERVICE Loop 2400, SV103 and SV104 must continue to correspond to the description of the CPT or HCPCS code.

CMS-1500 Claim Form Billing Requirements

If you bill using a **paper** CMS-1500 Claim Form for **two or fewer drugs on one claim form,** you must list the 11-digit NDC in ***field 19*** of the claim form **exactly** as follows (*not all required fields are represented in the example*):

19. 54569549100 Line 2 / 00009737602 Line 3

Line	Date of Service	Procedure Code	Charges	Units
1	07/01/06	99211	50.00	1
2	07/01/06	90378	1500.00	2
3	07/01/06	J3420	60.00	1

DO NOT attempt to list more than two NDCs in field 19 of the paper CMS-1500 Claim Form. If you bill for more than 2 drugs, you must list the additional drugs on additional claim forms. **You may not bill more than 2 drugs per claim form.**

If the 11-digit NDC is missing, incomplete, or invalid, the claim line for the drug or supply will be denied.

Mental Health/ Substance Abuse Assessments

Eligible clients may go for a mental health or substance abuse assessment without an EPSDT screening or referral.

Mental Health

Eligible clients should be screened for mental health problems as part of the EPSDT screening process. Mental Health screenings can be done using standardized screening tools or through an interview. See Page D.3 for EPSDT Mental Health/Substance Abuse Assessment Referral Indicators for a list of behaviors that may indicate mental health problems. Referral for assessment is based on professional judgment. Go to: Agency to download the Referral for Mental Health/Substance Abuse Assessment form, 01-192X. Use this form for children needing a mental health assessment.

The referral form should be sent to the appropriate assessment site and/or Regional Support Network (RSN). For a complete listing of Washington State RSNs, visit the Mental Health Division's web site at: http://www.dshs.wa.gov/dbhr/rsn.shtml.

Screening Guidelines

Mental health and substance abuse screenings are intended to identify children who are at risk for, or may have, mental health or substance abuse 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.*

Screenings for mental health or substance abuse problems in children can be done using standardized screening tools or through an interview. Referral is based on professional judgment.

When child abuse or neglect is suspected, a report to Child Protective Services ***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 screening as having a mental health or substance abuse problem, providers may refer the client to a mental health or substance abuse provider. Complete a **Referral for Mental Health/Substance Abuse Assessment** form, 01-192X, and assist the client/family in making appointments and obtaining necessary treatment(s). 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.

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

Nonurgent Referral

When screening for mental health problems, use your 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; and
- Social situation problems.

Screening infants and toddlers for mental health problems is an emerging science. Use your professional judgment to determine if referral is appropriate when there are concerns that the family and social environment do not support the infant's mental wellness.

Children should also be referred for a mental health assessment at a parent's request. 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 shown to be the best predictors of mental health problems.

Urgent Referral

Some behaviors or symptoms are significant enough to trigger an immediate referral with the mental health agency by telephone to describe the urgent nature of the referral. Behaviors/symptoms which require urgent referral include, but are not limited to:

- Fire-setting.
- Suicidal behavior or suicidal ideation.
- Self-destructive behavior.
- Torturing animals.
- Destroying property.
- Substance abuse in conjunction with other mental health concerns, or under the age of 12 years.
- Sexual acting out.
- Witnessing a death or other substantial physical violence.
- Victimization (sexual or physical abuse).
- Out of touch with reality, delusional (psychotic decompensation).
- Imminent risk of placement in a more restrictive setting.

The presence of any of these behaviors or symptoms may signal that a child is in crisis and efforts should be made to expedite the referral process so that the child may be assessed and treated promptly. The crisis response system should be used only if the child is a danger to himself/herself or others.

Substance Abuse Treatment

The categories listed in the section titled *Substance Abuse Services* may be used to help screen for substance abuse problems in an interview. To refer substance abuse cases, call the 24-hour Alcohol/Drug Helpline at 1-800-562-1240.

The following questions may be used with adolescents to screen for abuse or addiction to alcohol and/or other drugs. These questions have been scientifically validated as part of a psychometric assessment tool. **A "yes" answer to any two questions is usually sufficient to warrant a referral for assessment.**

Substance Misuse Questions:

1. Do more than half of the students you know drink alcoholic beverages or use other drugs at least once a month?
2. During your first experiences drinking alcohol or using other drugs, would a close friend have described you as sharing more of your feelings with them?
3. Have any of your early drinking or drug experiences made you feel less self-conscious in a group of people?

Substance Misuse and Abuse Question:

4. Have you ever lied to people such as your parents, teachers, or nonusing friends about your alcohol or other drug use?

Substance Abuse Questions:

5. Have you ever felt really burnt out for a day after using alcohol or other drugs?
6. Have your grades gone downhill as your use of alcohol or drugs went up?
7. Did you ever drink or get high in school?

Substance Addiction Questions:

8. Do you often skip things you need to do so you can go drink or get high?
9. Have you stolen money to buy alcohol or drugs?
10. Has any of your family (including parents, step-parents, grandparents, brothers, sisters, etc.) had or had past problems with drinking or drug use?

The presence of any of the symptoms or behaviors listed under ***Urgent Referrals*** on the preceding page may signal that the child is in crisis. You may call the **24-hour Alcohol and Drug Help Line at 1-800-562-1240**.

INFORMATION AND REFERRAL

ALCOHOL/DRUG 24-HOUR HELP LINE

- **CRISIS LINE**: 1-206-722-3700
- TOLL FREE 1-800-562-1240 (from within Washington State only)
- TEEN LINE 1-206-722-4222
- BUSINESS LINE 1-206-722-3703

Crisis Intervention…Confidential statewide telephone service providing individual guidance and assistance for people with alcohol and other drug-related problems. It provides information on a wide variety of issues and services and assists with crisis intervention techniques and referral.

WASHINGTON STATE ALCOHOL/DRUG CLEARINGHOUSE

3700 Rainier Avenue South, Suite A
Seattle, WA 98144

E-Mail: clearinghouse@adhl.org
Web site: http://adhl.org

Liz Wilhelm, Clearinghouse Manager

- 1-800-662-9111 toll free *(if calling from within Washington State)*
- 1-206-725-9696 *(if calling from out of state, or from Seattle)*
- 1-206-722-1032 FAX

Using the Clearinghouse…Anyone is welcome to use services, including prevention and community organizations, parents, treatment professionals, preschool-through college students and educators, health care practitioners and hospitals, libraries, state and government agencies, business and individuals.

! Books ! Posters ! Pamphlets ! Curricula !
! Journal and periodical articles ! Videos !

Visitors welcome.

We have a display available for community, school, and health fairs.

A Nationwide Network of Partners in Prevention.
Provides information to the public of Washington State from the national clearinghouse (NCADI) on issues relating to alcohol and other drugs. Member of the Regional Alcohol and Drug Awareness Resource (RADAR) Network of 50 states clearinghouses and specialty centers.

What kind of information is available? They provide a continually updated substance abuse resource room; information on programs, personnel and referral; networking; access to an in-depth clipping file; hundreds of complimentary copies of printed materials.

Also available are:

- ✓ *Directory of Certified Chemical Dependency Treatment Services in Washington State* (The Greenbook)
- ✓ Chapter 182-805, Washington Administrative Code (WAC) (Chemical Dependency Service Providers)
- ✓ WAC Implementation Guide (WIG) for WAC 182-805
- ✓ Forms re-ordering for DASA-Certified DUI assessment facilities: DUI/PC Assessment Report forms.
- ✓ The Courts can re-order Alcohol/Drug Diagnostic Referral Forms (9-630)
- ✓ Purchase of American Society of Addiction Medicine (ASAM) Patient Placement Criteria manuals.

EPSDT MENTAL HEALTH/SUBSTANCE ABUSE ASSESSMENT REFERRAL INDICATORS

Consider these and other symptoms/behaviors when making a referral for an assessment.

Category	Indicators for a Mental Health Assessment	
Family	problems separating	drug using or alcoholic parent
	physical abuse or neglect	parental discord
	psychological abuse	few social ties
	sexual abuse	problems with siblings
	domestic violence	death of parent/sibling
	divorce/separation	parents in criminal justice system
	chronic physical or mental illness of parent	
Peer activity	no confidence	fighting and bullying
	social isolation	
Behaviors	temper tantrums	over activity
	fire setting	in trouble with law
	stealing	impulsive
	tics	attachment problems in infants
	sexually acting out	overly compliant to passive
	lying	defiant
	substance abuse	running away
	destroys property	truancy
	aggressive	
School	school failure	absenteeism or truancy
	school refusal	
Feelings	anxiety or nervousness	fearful
	feeling depressed	suicidal
	low self-esteem	
Thoughts	delusions	incoherence
	hallucinations	self-destructive thoughts
Somatic symptoms	trouble sleeping	enuresis
	sleepwalking	encopresis
	night terrors	eating disorder
Social	lack of housing	sexual abuse
	frequent moves	foster care
	financial problems	history of detention
Growth and Development	slow weight gain	language delay
	nonorganic failure to thrive	attention problems
	mentally retarded	speech problems
	learning disabilities	

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.

REFERRAL EXPLANATION FOR TEEN AND/OR PARENT

SO YOU HAVE BEEN REFERRED FOR A MENTAL HEALTH/SUBSTANCE ABUSE ASSESSMENT… NOW WHAT HAPPENS?

You and your health care provider have talked. The next step is to refer you for an assessment to find out if you need services.

A skilled worker will meet with you and may talk about several things such as:

- **What worries you or others about you?**
- **What you and others have already done to help.**
- **Relationships at home, at school, day care, with other friends, etc.**
- **A family history.**
- **How serious your problems may or may not be.**

You and the worker will help choose the service that is right for you.

You may have questions. You may have problems in getting a Mental Health/Substance Abuse assessment. If you do, call the Agency Medical Assistance Customer Service Center at 1-800-562-3022.

Immunizations

Immunizations covered under the EPSDT program are listed in the EPSDT Fee Schedule. For those 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 program for children 18 years of age and under, the Agency pays only for the administration 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."

You must bill for the administration of the vaccine and for the cost of the vaccine itself as explained in this section.

Clients 18 years of Age and Younger – "Free from DOH"

- These vaccines are available at no cost from DOH. Therefore, the Agency pays only for administering the vaccine.
- Bill for the administration by reporting the procedure code for the vaccine given with modifier SL (e.g. 90707 SL). The Agency pays $5.96 for the administration for those vaccines that are free from DOH and are billed with modifier SL (e.g., 90707 SL).
- DO NOT bill CPT codes 90471-90472 for the administration.

See table on next page.

No Cost Immunizations from Department of Health		
Procedure Code	**Description**	**Comments**
90633	Hep a vacc, ped/adol, 2 dose	Free from DOH for children
90647	Hib vaccine prp-omp im	Free from DOH for children Effective July 1, 2011
90648	Hib vaccine, prp-t, im	Free from DOH for children
90649	H papilloma vacc 3 dose im	Free from DOH for 9- to 18-year-olds; allowed for 19- to 20-year-olds at fee; all others non-covered.
90650	Hpv vaccine 2 valent im	Free from DOH for children Effective July 1, 2011
90655	Flu vaccine no preserv 6-35m, im	Free from DOH for children
90656	Flu vaccine no preserv 3 yo & >, im	Free from DOH for children
90657	Flu vaccine 3 yrs im	Free from DOH for children Effective July 1, 2011
90658	Flu vaccine age 3 yo & over, im	Free from DOH for children
90660	Flu vaccine, nasal	Free from DOH for children
90669	Pneumococcal vacc, ped <5, IM	Free from DOH for children
90670	Pneumococcal conjugate vaccine, 13 valent, for intramuscular use	Free from DOH for age 2 mo to 71 months – routinely recommended; catch up for some high risk up to 18 as a booster.
90680	Rotovirus vacc 3 dose, oral	Covered only if free from DOH for children younger than age 1 (32 weeks).
90681	Rotavirus vacc 2 dose oral	Free from DOH for children Effective July 1, 2011
90696	Dtap-ipv vacc 4-6 yr im	Free from DOH for children Effective July 1, 2011
90698	Dtap-hib-ip vaccine, im	Covered only if free from DOH for children 0-18 years of age.
90700	Dtap vaccine, < 7 yo, im	Free from DOH for children
90702	Dt vaccine < 7 yo, im	Free from DOH for children
90707	Mmr vaccine, sc	Free from DOH for children
90710	Mmrv vaccine, sc	Free from DOH **for children only**, Non-covered for Adults.
90713	Poliovirus, ipv, sc/im	Free from DOH for children
90714	Td vaccine no prsrv >/= 7 yo, im	Free from DOH for children
90715	Tdap => 7 yo, im	Free from DOH for children
90716	Chicken pox vaccine, sc	Free from DOH for children
90723	Dtap-hep b-ipv vaccine, im	Free from DOH **for children only**, Non-covered for Adults.
90732	Pneumococcal vaccine	Free from DOH for children

(Continued) No Cost Immunizations from Department of Health		
Procedure Code	**Description**	**Comments**
90734	Meningococcal Vaccine, IM	Free from DOH for children 0-18. EPA required for 19 yrs and older
90743	Hep b vacc adol 2 dose im	Free from DOH for children Effective July 1, 2011
90744	Hepb vacc ped/adol 3 dose im	Free from DOH for children
90747	Hepb vacc, ill pat 4 dose im	Free from DOH for children
90748	Hep b/hib vaccine im	Free from DOH for children Effective July 1, 2011

Clients 18 Years of Age and Younger – "Not free from DOH"

- Bill the Agency for the cost of the vaccine itself by reporting the procedure code for the vaccine given. DO NOT use modifier SL with these vaccines. The Agency pays for the vaccine using the Agency's maximum allowable fee schedule.

- Bill the Agency for the vaccine administration using either CPT codes 90471-90472 The Agency limits payment for immunization administration to a maximum of two administration codes (e.g., one unit of 90471 and one unit of 90472).

- Providers **must** bill administration codes on the **same** claim form as the procedure code for the vaccine.

Clients 19-20 Years of Age – All Vaccines

- Bill the Agency 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 19-20 years of age, regardless of whether the vaccine is available free-of-charge from DOH or not. The Agency pays for the vaccine using the Agency's maximum allowable fee schedule.

- Bill for the administration using CPT codes 90471 (one vaccine) and 90472 (each additional vaccine). Payment is limited to one unit of 90471 and one unit of 90472 (maximum of two vaccines).

- Providers **must** bill 90471 and 90472 on the **same** claim as the procedure code for the vaccine.

Use the following procedure codes for clients 19 through 20 years of age *only*:

Code	Description	Comments
Q2035	Afluria vacc, 3 yrs & >, im	Clients 19 years of age through 20 years of age
Q2036	Flulaval vacc, 3 yrs & >, im	Clients 19 years of age through 20 years of age
Q2037	Fluvirin vacc, 3 yrs & >, im	Clients 19 years of age through 20 years of age
Q2038	Fluzone vacc, 3 yrs & >, im	Clients 19 years of age through 20 years of age
Q2039	NOS flu vacc, 3 yrs & >, im	Clients 19 years of age through 20 years of age

Billing and Claim Forms

What Are the General Billing Requirements?

Providers must follow the Agency *ProviderOne Billing and Resource Guide* at http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html. These billing requirements include, but are not limited to:

- Time limits for submitting and resubmitting claims and adjustments;
- What fee to bill the Agency 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; and
- Record keeping requirements.

Billing Requirements Specific to EPSDT

Use the appropriate diagnosis code when billing any EPSDT screening service, CPT codes 99381-99395 (e.g., V20.2).

Bill for services such as laboratory work, hearing tests, x-rays, or immunization administration, using the appropriate procedure code(s), along with the screening (CPT codes 99381 - 99395) on the same CMS-1500 Claim Form.

Reminder: When physicians and ARNPs identify physical and/or mental health problems during an EPSDT screening examination, 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 these billing instructions. They may also use the current Agency *Physician-Related Services/Healthcare Professional Services Billing Instructions* as necessary. Any office, laboratory, radiology, immunization, or other procedure rendered as part of *follow-up treatment* **must be billed** on a **SEPARATE** CMS-1500 Claim Form from the EPSDT screening.

Completing the CMS-1500 Claim Form

> **Note:** Refer to the Agency *ProviderOne Billing and Resource Guide* at http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for general instructions on completing the CMS-1500 Claim Form.

The following CMS-1500 Claim Form instructions relate to EPSDT:

Field Number	Instructions
24B	Enter one of the following Place of Service codes: 21 (Inpatient Hospital) 22 (Outpatient Hospital 11 (Office)