Washington State Health Care Authority

Medicaid Provider Guide

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

[Refer to Chapter 182-534 WAC]

November 1, 2013

Washington State Health Care Authority

A Billing Instruction

About this guide

This publication, by the Health Care Authority (agency), supersedes all previous *Early Periodic Screening Diagnosis and Treatment (EPSDT) Medicaid Provider Guides* published by the agency.

What Has Changed?

Reason for Change	Effective Date	Subject	Change
Provider Notice 13-67	**11/01/2013**	What are the requirements for administration and authorization of Synagis®?	Update the requirements for the administration and the criteria for the authorization of Synagis®.

How can I get agency provider documents?

To download and print agency provider notices and Medicaid provider guides, go to the agency's Provider Publications website.

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Alert! The page numbers in this table of contents are now "clickable"—simply hover over on a page number and click to go directly to the page. As an Adobe (.pdf) document, the guide also is easily navigated by using bookmarks on the left side of the document. (If you don't immediately see the bookmarks, right click on the document and select Navigation Pane Buttons. Click on the bookmark icon on the left of the document.)

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Resources Available

Note: This section contains important resource relevant to the EPSDT program. For more contact information, see the agency's Resources Available web page.

Topic	Contact Information
Becoming a provider or submitting a change of address or ownership.	See the agency's Resources Available web page.
Finding out about payments, claim denials, claims processing, or agency-contracted managed care organizations.	
Electronic or paper billing.	
Finding agency documents (e.g., Medicaid provider guides, provider notices and fee schedules).	
Private insurance or third-party liability, other than an agency-contracted managed care plan.	
Prior authorization, limitation extensions, or exception to rule.	
Referral for Mental Health.	Contact the local Regional Support Network (RSN).
Referral for Substance Abuse Assessment.	Washington Recovery Help Line

Definitions

This section defines terms and abbreviations, including acronyms, used in this provider guide. Refer to the agency's Medical Assistance Glossary 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.

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.

Children's Health Insurance Program (CHIP) - A federal/state program that covers children 19 years of age and younger in families whose income is too high for Medicaid, but is from 200 to 250% of the Federal Poverty Level.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) - A program providing early and periodic screening, diagnosis and treatment to persons 21 years of age and younger 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.
2) If the general public is not served, the rate normally offered to other contractors for the same services.

About EPSDT

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) 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 defect or physical or mental illness or condition is identified, the client should receive, or be referred to an appropriate provider to receive, treatment that is medically necessary to correct or ameliorate (i.e., improve) the illness or condition.

Screening includes:

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

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

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

- Medically necessary.
- Safe and effective.

Who can provide EPSDT screenings?

- Physicians
- Advanced Registered Nurse Practitioners (ARNPs)
- Physician Assistants (PAs)
- 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 the agency's EPSDT Fee Schedule.

Client Eligibility

Who is eligible for EPSDT screenings?

[Refer to WAC **182-534-0100(1)]**

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

- Are 20 years of age and younger.
- Are on a benefit package (BP) that covers EPSDT.

> **Note:** Refer to the Scope of Categories of Health Care Services Table for an up-to-date listing of BPs.

See the agency's ProviderOne Billing and Resource Guide for instructions on how to verify a client's eligibility.

> **Note:** Refer clients to their local Community Services Office (CSO) if they are 20 years of age and younger and their BSP does not 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 managed care clients eligible for EPSDT screenings?

[Refer to WAC **182-538-060 and 095]**

Yes! When verifying eligibility using ProviderOne, if the client is enrolled in an agency-contracted managed care organization (MCO), 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 MCO by calling the telephone number provided to them.

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

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

> **Note:** To prevent billing denials, 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's ProviderOne Billing and Resource Guide 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-contracted 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.

Are Primary Care Case Management (PCCM) clients covered?

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 by 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, 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. See the agency's ProviderOne Billing and Resource Guide for instructions on how to verify a client's eligibility.

What about billing for infants not yet assigned a ProviderOne Client ID?

Newborns: 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.

Twins/Triplets: 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 an agency-contracted managed care organization (MCO), the MCO is responsible for providing medical coverage for the newborn(s).

EPSDT Screenings

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.
- 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 electronic forms 13-683A through 13-686B, or another charting tool with equivalent information.

Hardcopies of the *Well Child Exam* forms may also be requested via email from the Department of Printing's Fulfillment Center at fulfillment@prt.wa.gov or to order forms online see the Department of Printing's web page.

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
- 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 the Washington State schedules for health screening visits. Payment is limited to the recommended periodicity schedules listed below:

- Five total screenings during the first year of the child's life.

Screening Visits	Age of Child
1st Screening	Birth to six weeks
2nd Screening	Two to three months
3rd Screening	Four to five months
4th Screening	Six to seven month
5th Screening	Nine to eleven months

- Three screening examinations are recommended for children one through two years of age.
- One screening examination is recommended per 12-month period for children three through six years of age.

- One screening examination is recommended per 24-month period for children 7 through 20 years of age, 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.

EPSDT screenings for foster care children

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 a licensed, paid, out-of-home care, and for whom the agency, a licensed, or a certified child placement agency has responsibility for placement and care.

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

Placement code	Description
D	Developmental Disabilities Administration (DDA) in foster care.
F	Foster Care Placement.
H	Foster Care Higher Education.
P	Interstate Compact in Placement of Children's Services.
R	Relative Foster Care Placement.
T	Tribal Foster Care Placement. **Becomes effective 1/1/2014.**

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 a TJ modifier.

When performing an EPSDT screening, the provider must complete the age-appropriate *Well Child Exam* form. Use electronic forms 13-683A through 13-686B, or another charting tool with equivalent information. Hardcopies of the "Well Child Exam" forms may also be requested via email from the Department of Printing's Fulfillment Center website.

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.
- Additional health conditions of which the foster parents and caseworker should be aware.

Who is eligible for an IHE?

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 three years of age** – 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
  - ✓ 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 for children's office calls?

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

For more information see the EPSDT fee schedule.

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

How do I bill for an IHE?

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.
- 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 when performing an IHE?

Providers must either:

- Document the IHE on the *Foster Care Initial Health* screen form, **HCA 13-843.**

-OR-

- **Include documentation in the client's record that addresses all elements addressed in "What is included in an IHE" or on the *Foster Care Initial Health Screen* form, HCA 13-843.**

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 two 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 two 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 problem is identified during a screening examination?

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

- Refer the client to an appropriate agency provider or to the client's agency-contracted managed care organization (MCO), if applicable, for medical treatment.
- Provide the service for the client (if the service is within the provider's scope of practice).

How is genetic counseling and genetic testing billed?

Refer to Reproductive Health Services in the Physician-Related Services/Healthcare Professional Services Medicaid Provider Guide 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.**

How are EPSDT referrals made?

Chiropractic services

Eligible clients may receive chiropractic services when an EPSDT screening identifies the medical need for the service. 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

Health care providers should use clinical judgment when screening for lead toxicity using nationally-recognized screening criteria.

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	Short 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.

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 (206) 598-0555 (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 (509) 334-1133 Darcy Miller, PH.D (for clinic) darcymiller@wsu.edu (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 (425) 258-7069 **Clinic Location:** Providence Everett Little Red Schoolhouse 900 Pacific Avenue Everett, WA 98201	**Yakima County (Yakima)** **Who to Contact:** Linda Sellsted, Clinic Coordinator (509) 574- 3207 Fax (509) 574-3211 **Clinic Location:** Yakima Children's Village 3801 Kern Rd. Yakima, WA 98902

Does the agency pay for fluoride varnish application?

(HCPCS code D1208)

Fluoride varnish is a type of topical fluoride that acts to retard, arrest, and reverse the caries process and is applied to all surfaces of the teeth. The teeth then absorb the fluoride varnish, strengthening the enamel and helping prevent cavities. The agency pays for the application of fluoride varnish, per provider, per client as follows:

- Three in a 12-month period through 5 years of age
- Two in a 12-month period for clients 6 through 18 years of age

Who must prescribe the fluoride varnish?

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

Who is eligible for fluoride varnish?

All Medicaid-eligible clients, 18 years of age and younger, may receive fluoride varnish applications. Clients of the Developmental Disabilities Administration (DDA) who are 19 years of age and older are also eligible to receive fluoride vanish applications.

Are managed care clients eligible for fluoride varnish?

Yes. Clients enrolled in an agency-contracted managed care organization (MCO) **are eligible for fluoride varnish applications** through fee-for-service. Bill the agency directly for fluoride varnish applications.

What are the requirements for administration and authorization of Synagis®? (CPT 90378)

The agency requires providers to follow the guidelines established by the American Academy of Pediatrics (AAP) and published in the American Academy of Pediatrics Red Book® for the administration of Synagis®.

Note: This information relates only to those clients NOT enrolled in an agency-contracted managed care organization (MCO). For clients enrolled in an agency-contracted MCO, 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 the 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 as published in the American Academy of Pediatrics Red Book®.

- **Children younger than 2 years of age** 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
  - ➢ 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
- Infants with mild cardiomyopathy who are not receiving medical therapy for the condition

- **Children younger than 12 months of age 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**– 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

  ✓ Living with siblings younger than five years of age

Children who qualify under the above criteria should receive Synagis® only until they reach three 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 three months of age will be considered an overpayment subject to recoupment.

Are there 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.

What are the authorization and billing procedures for Synagis®?

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

Bill the agency for Synagis® 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 CPT code 90378.

- To bill for the administration of Synagis® use CPT code 90471 or 90472 if:

  ✓ Dispensed through the pharmacy POS.
  ✓ Administered through the physician's office.

What is the criteria for coverage or authorization of RSV/Synagis®?

Note: Criteria for coverage or authorization vary depending on the patient's age.

- **Children younger than one year of age**

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®.

- **Children between one and two years of age**

Prior authorization is required to administer Synagis® to agency clients one year of age and older. Request authorization by faxing the Request for Synagis®, form HCA 13-771.

- **Children older than two years of age**

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

What are the authorization procedures for Synagis®?

- **Pharmacy billers**

  - ✓ Pharmacies must submit a request for authorization using the agency's General Information for Authorization, form HCA 13-835A as the cover sheet. This form must be **TYPED**.

  - ✓ Fax the form to the agency at: 866-668-1214. If authorized, the agency may approve the 100mg strength, the 50mg strength, or both. However, pharmacies must use **National Drug Code (NDC) 60574-4113-01** in box #21 on HCA form 13-835A. After the agency reviews your request, you will receive notification by fax of strengths, quantities, and NDC(s) approved.

  - ✓ The Request for Synagis, form HCA 13-771 must accompany a **typed** General Information for Authorization, form HCA 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 the agency's General Information for Authorization, form HCA 13-835 as the cover sheet. This form must be **typed**.

  - ✓ The agency's Request for Synagis®, form HCA 13-771 must be submitted as supporting documentation in addition to the General Information for Authorization, form HCA 13-835.

  - ✓ Physician offices billing the agency directly for Synagis® must bill using a CMS-1500 claim form or comparable electronic billing format using CPT code 90378.

- **Requesting an increase in Synagis® dose**

The quantity of Synagis® authorized for administration is dependent upon the weight of the client at the time of administration. If you obtained authorization 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 HCA 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 for Synagis®**

The agency physicians will evaluate requests for authorization to determine whether the client falls within 2012 AAP guidelines for the administration of Synagis®. The agency will fax an approval or denial to the requestor.

Allow at least five business days for the agency to process the authorization request.

You may verify the status of a pending authorization by using the ProviderOne *PA Inquire* feature.

What does the National Drug Code Format consist of?

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. [See 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 01234056789. 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.**

What are the billing requirements for electronic 837-P claim form?

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.

What are the billing requirements for CMS-1500 claim form?

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.

How are eligible clients screened for mental health problems?

Eligible clients should be screened for mental health problems as part of the EPSDT screening process. Mental Health screenings may be done using standardized screening tools or through an interview. See EPSDT Mental Health/Substance Abuse Assessment Referral Indicators for a list of behaviors that may indicate mental health problems.

Clients 18 years of age and younger have access to 20 mental health visits annually. See the Mental Health Services for Children, Psychiatric and Psychological Services Medicaid Provider Guide. However, if the client meets the RSN Access to Care Standards, then a referral to the Regional Support Network (RSN) should occur. Referral for assessment is based on professional judgment. For a complete listing of Washington State RSNs, see Washington State Regional Support Networks.

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.**

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 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 guidelines

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.
- 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 see 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 guidelines

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 themselves or others.

What questions are asked to screen for substance abuse treatment?

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 further 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 Referral Guidelines may signal that the child is in crisis.

To refer substance abuse cases, call the 24-hour Washington Recovery Help Line at 800-789-1511.

Washington Recovery Help Line

The Washington Recovery Help Line is the *new* consolidated help line for substance abuse, problem gambling, and mental health. The help line is an anonymous and confidential help line that provides 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 treatment for substance abuse.

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 physical abuse or neglect psychological abuse sexual abuse domestic violence divorce/separation chronic physical or mental illness of parent	drug using or alcoholic parent parental discord few social ties problems with siblings death of parent/sibling parents in criminal justice system
Peer activity	no confidence social isolation	fighting and bullying
Behaviors	temper tantrums fire setting stealing tics sexually acting out lying substance abuse destroys property aggressive	over activity in trouble with law impulsive attachment problems in infants overly compliant to passive defiant running away truancy
School	school failure school refusal	absenteeism or 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
Growth and Development	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.

EXAMPLE: 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 qualified professional 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.

If you have questions about obtaining a mental health or substance abuse assessment, call the Washington Recovery Help Line at 800-789-1511.

If you have issues accessing an agency-approved provider, contact the Medical Assistance Customer Services line at 800-562-3022.

Immunizations

Immunizations covered by the EPSDT program are listed in the Injectable 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 program for children 18 years of age and younger, 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.

Does the agency pay for administering vaccines that are free from DOH to clients 18 years of age and younger?

The agency pays only for administering vaccines that are available at no cost from DOH for children 18 years of age and younger. For clients 19 years of age and older, refer to the Injectable Drug Fee Schedule.

- In a nonfacility setting:

  ✓ 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.

- To bill for the **administration** of vaccines in an outpatient hospital or hospital-based clinic setting use:

  ✓ The UB-04 claim form or equivalent electronic transaction.
  ✓ 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:

  ✓ UB-04 claim form or an equivalent electronic transaction.
  ✓ An appropriate procedure code.

- ✓ The hospital's outpatient provider NPI number.

- If a vaccine is available free from DOH (has *CVP* in the *Auth* column of the Outpatient fee schedule), then the agency will:

  - ✓ Deny the vaccine claim line.
  - ✓ Combine vaccine payment with the payment for the administration of the vaccine.

No Cost Immunizations from Department of Health		
Procedure Code	**Description**	**Comments**
90633	Hep a vacc, ped/adol, 2 dose	Free from DOH
90647	Hib vaccine prp-omp im	Free from DOH
90648	Hib vaccine, prp-t, im	Free from DOH
90649	H papilloma vacc 3 dose im	9 through 18 years of age – Free from DOH 19 through 20 years of age – Covered by agency (21 through 26 years of age, see Physician-Related Services/Health Care Professional Services Medicaid Provider Guide).
90650	Hpv vaccine 2 valent im	9 through 18 years of age – Free from DOH 19 through 20 years of age – Covered by agency (21 through 26 years of age, see Physician-Related Services/Health Care Professional Services Medicaid Provider Guide).
90655	Flu vaccine no preserv 6-35m, im	Free from DOH
90656	Flu vaccine no preserv 3 yo & >, im	Free from DOH
90657	Flu vaccine 3 yrs im	Free from DOH
90658	Flu vaccine age 3 yo & over, im	Free from DOH
90660	Flu vaccine, nasal	Free from DOH
90670	Pneumococcal conjugate vaccine, 13 valent, for intramuscular use	Free from DOH for age 2 months to 71 months – routinely recommended; catch up for some high risk up to 18 as a booster.
90672	Flu vaccine 4 valent nasal	Free from DOH
90680	Rotovirus vacc 3 dose, oral	Free from DOH for children younger than 32 weeks.
90681	Rotavirus vacc 2 dose oral	Free from DOH
90696	Dtap-ipv vacc 4-6 yr im	Free from DOH
90698	Dtap-hib-ip vaccine, im	Free from DOH

90700	Dtap vaccine, < 7 yo, im	Free from DOH
90702	Dt vaccine < 7 yo, im	Free from DOH
90707	Mmr vaccine, sc	Free from DOH
(Continued) No Cost Immunizations from Department of Health		
Procedure Code	**Description**	**Comments**
90710	Mmrv vaccine, sc	Free from DOH
90713	Poliovirus, ipv, sc/im	Free from DOH
90714	Td vaccine no prsrv >/= 7 yo, im	Free from DOH
90715	Tdap => 7 yo, im	Free from DOH
90716	Chicken pox vaccine, sc	Free from DOH
90723	Dtap-hep b-ipv vaccine, im	Free from DOH
90732	Pneumococcal vaccine	Free from DOH
90734	Meningococcal Vaccine, IM	Free from DOH for children 0-18 years of age. EPA required for 19 years of age and older; (see the Physician-Related Services/Health Care Professional Services Medicaid Provider Guide).
90743	Hep b vacc adol 2 dose im	Free from DOH
90744	Hepb vacc ped/adol 3 dose im	Free from DOH
90747	Hepb vacc, ill pat 4 dose im	Free from DOH
90748	Hep b/hib vaccine im	Free from DOH

What about vaccines that are not free from DOH for clients 18 years of age and younger

- 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 for the administration of the vaccine using CPT codes 90471 (one vaccine) and 90472 (each additional vaccine). Payment is limited to 1 unit of 90471 and 3 units of 90472 (for a maximum administration of four vaccines).

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

What about vaccines for clients that are 19-20 years of age?

- Bill the agency for the cost of the vaccine itself by reporting the procedure code for the vaccine given. DO NOT use an SL modifier 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 of the vaccine using CPT codes 90471 (one vaccine) and 90472 (each additional vaccine). Payment is limited to 1 unit of 90471 and 3 units of 90472 (for a maximum administration of four 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 through 20 years of age
Q2036	Flulaval vacc, 3 yrs & >, im	Clients 19 through 20 years of age
Q2037	Fluvirin vacc, 3 yrs & >, im	Clients 19 through 20 years of age
Q2038	Fluzone vacc, 3 yrs & >, im	Clients 19 through 20 years of age
Q2039	NOS flu vacc, 3 yrs & >, im	Clients 19 through 20 years of age

Billing and Claim Forms

What are the general billing requirements?

Providers must follow the agency's ProviderOne Billing and Resource Guide. These billing requirements include:

- What time limits exist for submitting and resubmitting claims and adjustments.
- When providers may bill a client.
- How to bill for services provided to primary care case management (PCCM) clients.
- How to bill for clients eligible for both Medicare and Medicaid.
- How to handle third-party liability claims.
- What standards to use for record keeping.

What are the 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 in this provider guide. They may also use the agency's Physician-Related Services/Health Care Professional Services Medicaid Provider Guide 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.

How is the CMS-1500 claim form completed?

Note: Refer to the agency's ProviderOne Billing and Resource Guide for general instructions on completing the CMS-1500 claim form.