EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) PROGRAM

Provider Guide

July 1, 2014

Washington State Health Care Authority

About this guide*

This publication takes effect July 1, 2014, and supersedes earlier guides to this program.

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

What has changed?

Subject	Change	Reason for Change
What is included in an EPSDT screening?	Added note related to evidence-based medicine	PN 14-51
Assessment referral indicators	Removed	PN 14-51
Definitions	Removed	PN 14-51
EXAMPLE: Referral	Removed	PN 14-51
Psychometric assessment tool	Removed	PN 14-51

How can I get agency provider documents?

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

* This publication is a billing instruction.

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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

Topic	Contact
Where can I find information on becoming an agency provider	See the agency's Resources Available web page.
Questions on Payments, denials, general questions regarding claims processing, or agency-contracted managed care plans	
Submitting claims for payment	
Where can I find provider guides that explain program-specific billing guidelines, coverage, and limitations?	
Questions on private insurance or third party liability, other than agency-contracted managed care plans	
Questions about 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
Where is the EPSDT Fee Schedule?	See the agency's EPSDT Fee Schedule

Program Overview

Title 42 CFR, Part 441, Subpart B

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a federal preventive health care benefit. The purpose of this program is to periodically screen clients 20 years of age and younger to detect physical and mental health problems. If a problem is identified, the client should receive appropriate treatment.

Screening includes:

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

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
- Naturopathic 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: the Department of Health (DOH) no longer provides training to nurses for EPSDT screenings.

Client Eligibility

Who is eligible for EPSDT screenings?

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 that covers EPSDT.

How can I verify a patient's eligibility?

Providers must verify that a patient has Washington Apple Health coverage for the date of service, and that the client's benefit package covers the applicable service. This helps prevent delivering a service the agency will not pay for.

Verifying eligibility is a two-step process:

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

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

Step 2. **Verify service coverage under the Washington Apple Health client's benefit package.** To determine if the requested service is a covered benefit under the Washington Apple Health client's benefit package, see the agency's Health Care Coverage—Program Benefit Packages and Scope of Service Categories web page.

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

1. By visiting the Washington Healthplanfinder's website at: www.wahealthplanfinder.org.
2. By calling the Customer Support Center toll-free at: 855-WAFINDER (855-923-4633) or 855-627-9604 (TTY).
3. By mailing the application to:
   Washington Healthplanfinder
   PO Box 946
   Olympia, WA 98507

In-person application assistance is also available. To get information about in-person application assistance available in their area, people may visit www.wahealthplanfinder.org or call the Customer Support Center.

Note: Refer clients to their local Community Services Office (CSO) if they are 20 years of age and younger and their benefit package does not cover EPSDT. The CSO will evaluate these clients for a possible change in their benefit package coverage that would enable them to receive EPSDT screenings.

Are managed care clients eligible for EPSDT screenings?

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 the:

- 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.

> **Note:** 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?

Yes. 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 if an infant has not yet been 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.

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:

- 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 surveillance.
- Developmental testing with interpretation and report using a validated screening tool.
- 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.
  - ✓ 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* forms. Use electronic forms 13-683A through 13-686B, or another charting tool with equivalent information.

Note: Providers who provide evidence-based medicine (EBM), including Triple P, see the Mental Health Services provider guide.

What are the requirements for developmental and autism surveillance and screening?

See the agency's Physician-Related Services/ Health Care Professional Services Provider Guide.

What additional screening components may be billed?

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 Washington State's 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 months.
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.

How much does the agency pay for EPSDT screenings for foster care children?

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.

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.

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.

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* forms. 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.

What is the purpose of a foster child initial health evaluation (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 age three —** 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 (all clients).**

- **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, as reflected in the agency's 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.

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 for an IHE?

Providers must either:

- Document the IHE on the *Foster Care Initial Health Screen* form, HCA 13-843.
- Include documentation in the client's record that addresses all of the elements 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:	Client type	Schedule 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 the request
	Receiving Foster Care – Upon placement	30 days of the 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).
- Conduct extended developmental testing using a standardized instrument completed by the provider or other trained personnel.

What is extended developmental testing?

Extended developmental testing is used for children testing positive on screening instruments for developmental delay or autism. This testing uses standardized screening instruments provided by a physician or psychologist which are variable in length. The evaluation includes assessment of motor, language, social adaptive and cognitive function by standardized developmental instruments. Examples of extended developmental testing include the *Bayley Scales of Infant Development®, Woodcock-Johnson Test of Cognitive Abilities®, and the Peabody Picture Vocabulary Test™.*

Providers must bill the CPT code independently or in conjunction with another code, describing a separate patient encounter provided on the same day as testing (e.g., an E & M code for outpatient consultation). While the testing may require more than 60 minutes to complete, the CPT code 96111 may be reported only once each day of face-to-face patient contact. The agency allows one unit per client per year for use of code 96111; additional units may be requested through the agency's prior authorization process. Testing must be accompanied by an interpretation and formal report.

How is genetic counseling and genetic testing billed?

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.**

See *Medical genetics and genetic counseling services* in the Physician-Related Services/Healthcare Professional Services Provider Guide for information on genetic counseling and testing.

How are referrals made?

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

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

Fetal alcohol syndrome (FAS) screening

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 FAS clinic locations

King County Susan Astely, Ph.D 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** 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 Christie Tipton, Clinic Coordinator 425-258-7069 **Clinic Location:** Providence Everett Little Red Schoolhouse 900 Pacific Avenue Everett, WA 98201	**Yakima County** Linda Sellsted, Clinic Coordinator 509-574- 3207 Fax 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 in the client's medical record the beginning and ending times that the service was provided.**

Procedure Code	Short Description	Limitations
97802	Medical nutrition, indiv, initial	One unit = 15 minutes; maximum of two hours (Eight units) per year.
97803	Med nutrition, indiv, subseq	One unit = 15 minutes; maximum of one hour (Four units) per day.
97804	Medical nutrition, group	One unit = 15 minutes; maximum of one hour (Four units) per day.

Note: Due to its licensing agreement with the American Medical Association (AMA), the agency publishes only the official, short CPT® procedure code descriptions. To view the entire descriptions, see the current CPT book.

Does the agency pay for fluoride varnish application?

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 five years of age
- Two in a 12-month period for clients six through 18 years of age

Who may 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.

Note: See the agency's Physician-Related Services/Health Care Professional Services Provider Guide.

Mental Health and Substance Abuse Assessments

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

Is mental health screening part of the EPSDT screening process?

Yes. Mental health screening is 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 mental health services. See the Mental Health Services Provider Guide for details. However, if the client may meet RSN Access to Care Standards, then a referral to the Regional Support Network (RSN) should occur. Referral for assessment is based on professional judgment. See Washington State Regional Support Networks for a complete listing.

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. 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 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.

Urgent referrals

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 that require urgent referral include:

- 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.

Nonurgent referral

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

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

Use professional judgment to determine if a referral is appropriate when there are concerns that the family and social environment do not support the infant's mental wellness.

Children may 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.

How are substance abuse screening and treatment provided?

Screening and treatment may be provided in any of the following ways:

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

A comprehensive, evidence-based public health practice designed to identify people who are at risk for or have some level of substance use disorder which can lead to illness, injury, or other long-term morbidity or mortality. SBIRT services are provided in a wide variety of medical and community healthcare settings. See the agency's Physician-Related Services/Health Care Professional Services Provider Guide for more details.

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

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 (VFC) 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. For more information on the VFC program, see the VFC website.

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

How do I bill for vaccines when clients 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 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 of the vaccine using CPT® codes 90471 (one vaccine) and 90472 (each additional vaccine). Payment is limited to one unit of 90471 and three 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:

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

What vaccines are free from DOH for clients 18 years of age and younger?

The vaccines listed in the table titled *No Cost Immunizations from the Department of Health* on the following pages are available at no cost from DOH for clients 18 years of age and younger. Therefore, the agency pays only for administering the vaccine.

- 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 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

CPT Code	Short 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
90650	Hpv vaccine 2 valent im	9 through 18 years of age – Free from DOH; 19 through 20 years of age – Covered by agency
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	Covered only if free from DOH for children younger than age 1 (52 weeks)
90681	Rotavirus vacc 2 dose oral	Free from DOH
90685	Flu vaccine, quad, 6-35 months	Free from DOH for ages 6 months through 2 years

CPT Code	Short Description	Comments
90686	Flu vaccine, quad, > 3 years	Free from DOH
90696	Dtap-ipv vacc 4-6 yr im	Free from DOH
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
90702	Dt vaccine < 7 yo, im	Free from DOH
90707	Mmr vaccine, sc	Free from DOH
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 Physician-Related Services/Health Care Professional Services 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

How do I bill for 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 one unit of 90471 and three 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.

Billing and Claim Forms

How do I complete the CMS-1500 claim form?

The agency's online Webinars are available to providers with instructions on how to bill professional claims and crossover claims electronically:

- DDE Professional claim
- DDE Professional with Primary Insurance
- DDE Medicare Crossover Claim

Also, see Appendix I of the agency's ProviderOne Billing and Resource Guide for general instructions on completing the CMS-1500 claim form.

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.

Note: 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 agency's Physician-Related Services/Health Care Professional Services 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.

For information on billing for evidence-based medicine (EBM), see the Mental Health Services Provider Guide.