Washington Apple Health

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

Provider Guide

April 1, 2016

Washington State Health Care Authority

About this guide*

This publication takes effect April 1, 2016, 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
Important Changes to Apple Health Effective April 1, 2016	**Effective April 1, 2016**, important changes are taking place that **all providers** need to know. Information has been added regarding new policy for early enrollment into managed care, implementation of fully integrated managed care in SW WA Region, Apple Health Core Connections for Foster Children, Behavioral Health Organizations (formerly RSNs), and contact information for southwest Washington.	Program changes
CMS-1500 claim form	Updated information under "How do I complete the CMS-1500 claim form." Removed links to webinars. Providers should refer to the Provider Training page, Medicaid 101 for electronic billing information.	Webinars no longer available
Behavioral health organizations	Removed all references to regional support networks (RSN) and changed them to Behavioral Health Organizations (BHO). This change aligns with new rules under Chapter 182-538A, 182-538B, and 182-538C, effective April 1, 2016.	Align with changes to WAC.
Lead toxicity screening	Lead toxicity screening is required at age 12 months and 24 months for all Apple Health-enrolled children, regardless of lead-exposure risk. Additionally, all Apple Health-enrolled children between age 36 months and 72 months must receive a lead toxicity	Existing requirement of the Centers for Medicare and Medicaid Services (CMS).

* This publication is a billing instruction.

screening if they have not previously been tested. Also added information on billing for this screening.

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.

Table of Contents

Alert! This Table of Contents is automated. Click on a page number to go directly to the page.

Important Changes to Apple Health Effective April 1, 2016

These changes are important to all providers because they may affect who will pay for services.

Providers serving any Apple Health client should always check eligibility and confirm plan enrollment by asking to see the client's Services Card and/or using the ProviderOne Managed Care Benefit Information Inquiry functionality (HIPAA transaction 270). The response (HIPAA transaction 271) will provide the current managed care organization (MCO), fee-for-service, and Behavioral Health Organization (BHO) information. A Provider FAQ is available on the Washington Apple Health (Medicaid) providers webpage.

New MCO enrollment policy – earlier enrollment

Beginning April 1, 2016, Washington Apple Health (Medicaid) implemented a new managed care enrollment policy placing clients into an agency-contracted MCO **the same month** they are determined eligible for managed care as a new or renewing client. This policy eliminates a person being placed temporarily in fee-for-service while they are waiting to be enrolled in an MCO or reconnected with a prior MCO.

- **New clients** are those initially applying for benefits or those with changes in their existing eligibility program that consequently make them eligible for Apple Health Managed Care.

- **Renewing clients** are those who have been enrolled with an MCO but have had a break in enrollment and have subsequently renewed their eligibility.

Clients currently in fee-for-service or currently enrolled in an MCO are not affected by this change. Clients in fee-for-service who have a change in the program they are eligible for may be enrolled into Apple Health Managed Care depending on the program. In those cases, this enrollment policy will apply.

How does this policy affect providers?

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

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

Behavioral Health Organization (BHO)

The Department of Social and Health Services (DSHS) manages the contracts for behavioral health (mental health and substance use disorder (SUD)) services for nine of the Regional Service Areas (RSA) in the state, excluding Clark and Skamania counties in the Southwest Washington (SW WA) Region. BHOs will replace the Regional Support Networks (RSNs). Inpatient mental health services continue to be provided as described in the inpatient section of the Mental Health Provider guide. BHOs use the Access to Care Standards (ACS) for mental health conditions and American Society of Addiction Medicine (ASAM) criteria for SUD conditions to determine client's appropriateness for this level of care.

Fully Integrated Managed Care (FIMC)

Clark and Skamania Counties, also known as SW WA region, is the first region in Washington State to implement the FIMC system. This means that physical health services, all levels of mental health services, and drug and alcohol treatment are coordinated through one managed care plan. Neither the RSN nor the BHO will provide behavioral health services in these counties.

Clients must choose to enroll in either Community Health Plan of Washington (CHPW) or Molina Healthcare of Washington (MHW). If they do not choose, they are auto-enrolled into one of the two plans. Each plan is responsible for providing integrated services that include inpatient and outpatient behavioral health services, including all SUD services, inpatient mental health and all levels of outpatient mental health services, as well as providing its own provider credentialing, prior authorization requirements and billing requirements.

Beacon Health Options provides mental health crisis services to the entire population in Southwest Washington. This includes inpatient mental health services that fall under the Involuntary Treatment Act for individuals who are not eligible for or enrolled in Medicaid, and short-term substance use disorder (SUD) crisis services in the SW WA region. Within their available funding, Beacon has the discretion to provide outpatient or voluntary inpatient mental health services for individuals who are not eligible for Medicaid. Beacon Health Options is also

responsible for managing voluntary psychiatric inpatient hospital admissions for non-Medicaid clients.

In the SW WA region some clients are not enrolled in CHPW or Molina for FIMC, but will remain in Apple Health fee-for-service managed by the agency. These clients include:

- Dual eligible – Medicare/Medicaid
- American Indian/Alaska Native (AI/AN)
- Medically needy
- Clients who have met their spenddown
- Noncitizen pregnant women
- Individuals in Institutions for Mental Diseases (IMD)
- Long-term care residents who are currently in fee-for-service
- Clients who have coverage with another carrier

Since there is no BHO (RSN) in these counties, Medicaid fee-for-service clients receive complex behavioral health services through the Behavioral Health Services Only (BHSO) program managed by MHW and CHPW in SW WA region. These clients choose from CHPW or MHW for behavioral health services offered with the BHSO or will be auto-enrolled into one of the two plans. A BHSO fact sheet is available online.

Apple Health Core Connections (AHCC)

Coordinated Care of Washington (CCW) will provide all physical health care (medical) benefits, lower-intensity outpatient mental health benefits, and care coordination for all Washington State foster care enrollees. These clients include:

- Children and youth under the age of 21 who are in foster care
- Children and youth under the age of 21 who are receiving adoption support
- Young adults age 18 to 26 years old who age out of foster care on or after their 18th birthday

American Indian/Alaska Native (AI/AN) children will not be auto-enrolled, but may opt into CCW. All other eligible clients will be auto-enrolled.

AHCC complex mental health and substance use disorder services

AHCC clients who live in Skamania or Clark County receive complex behavioral health benefits through the Behavioral Health Services Only (BHSO) program in the SW WA region. These clients will choose between CHPW or MHW for behavioral health services, or they will be auto-enrolled into one of the two plans. CHPW and MHW will use the BHO Access to Care Standards

to support determining appropriate level of care, and whether the services should be provided by the BHSO program or CCW.

AHCC clients who live outside Skamania or Clark County will receive complex mental health and substance use disorder services from the BHO and managed by DSHS.

Contact Information for Southwest Washington

Beginning on April 1, 2016, there will not be an RSN/BHO in Clark and Skamania counties. Providers and clients must call the agency-contracted MCO for questions, or call Beacon Health Options for questions related to an individual who is not eligible for or enrolled in Medicaid.

If a provider does not know which MCO a client is enrolled in, this information can located by looking up the patient assignment in ProviderOne.

To contact Molina, Community Health Plan of Washington, or Beacon Health Options, please call:

MOLINA HEALTHCARE	Molina Healthcare of Washington, Inc. 1-800-869-7165

COMMUNITY HEALTH PLAN of Washington	Community Health Plan of Washington 1-866-418-1009

Beacon Health Options	Beacon Health Options 1-855-228-6502

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 organization (MCO)	
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	Behavioral Health Organization (BHO).
Referral for Substance Abuse Assessment	Washington Recovery Help Line
Where is the EPSDT Fee Schedule?	See the agency's EPSDT Fee Schedule
Obtaining prior authorization or a limitation extension	For all requests for prior authorization or limitation extension, submit: • A completed, typed *General Information for Authorization form*, HCA 13-835. This request form must be the initial page when you submit your request. • A completed *Fax/Written Request Basic Information form*, HCA 13-756, and all the documentation listed on this form and any other medical justification. Fax your request to: 866-668-1214.

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 age 20 and younger to detect physical and mental health problems. If a problem is identified, the client should receive appropriate treatment. Medically necessary treatment identified in the EPSDT screening is covered under the EPSDT benefit.

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

The agency reviews requests for noncovered health care services under WAC 182-501-0160 as an exception to rule (ETR). To request a noncovered service using the ETR process, send a completed *Fax/Written Request Basic Information* form 13-756 to the agency to the address or fax listed on the form. For authorization of services beyond the designated benefit limit allowed, a provider may request a limitation extension (LE).

Refer to the agency's ProviderOne Billing and Resource Guide for information regarding noncovered services and how to bill an agency client who is on a fee-for-service program.

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 perform 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 Washington Apple Health providers to perform EPSDT screenings of clients who are:

- Age 20 and younger.
- 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 wish to apply for Washington Apple Health can do so in one of the following ways by:

1. Visiting the Washington Healthplanfinder's website at: www.wahealthplanfinder.org.
2. Calling the Customer Support Center toll-free at: 855-WAFINDER (855-923-4633) or 855-627-9604 (TTY).
3. 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 the Health Benefit Exchange (HBE) if they are age 20 and younger and their benefit package does not cover EPSDT. This application process will evaluate these clients for a possible change in their benefit package to include EPSDT. Take Charge is an example of a benefit package that does not cover EPSDT services.

Are managed care clients eligible for EPSDT screenings?

WAC 182-538-060 and 095

Yes. If the client is enrolled in an agency-contracted managed care organization (MCO), ProviderOne will display managed care enrollment on the client benefit inquiry screen. All services must be requested directly through the client's Primary Care Provider (PCP). Clients can contact their MCO by calling the telephone number provided to them.

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

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

Note: To prevent denied claims, check the client's eligibility both **before** scheduling services and at the **time of the service.** Also make sure proper authorization or referral is obtained from the 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 agency-contracted MCO's reimbursement rate.

Note: The agency covers referrals for a mental health or substance abuse assessment outside the agency-contracted MCO. These referrals are paid separately on a fee-for-service basis. Providers must bill the agency directly for these types of referrals.

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

Newborns: If a child is younger than age 60 days and has not been issued 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, triplets, etc., identify each infant separately (e.g., twin A, twin B) using a separate claim form for each.

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

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 and education, 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.

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

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

Developmental screening: As a part of the routine well child exams conducted for clients age 9 months, 18 months, and 30 months, the agency pays for one developmental screening with each routine well child exam by a primary care provider when performed by a physician, advanced registered nurse practitioner (ARNP), or physician's assistant (PA). This screening will be paid for up until the child is age 36 months.

Autism screening: To support timely access to a formal diagnostic evaluation and referral for applied behavioral analysis (ABA) treatment or other medically necessary services, the agency pays for one additional autism screening for **all children** at age 18 months, and a second screening before age 36 months, when performed by a physician, ARNP, or PA**.**

A developmental screening for an older child may be requested using the limitation extension process. To request additional services using the limitation extension process, send a completed *Fax/Written Request Basic Information* form, 13-756, to the agency (see Resources Available). See WAC 182-501-0169 Health care coverage – Limitation extension.

See the Applied Behavior Analysis Program Guide for additional information.

Providers must use a validated screening and testing tool when billing CPT® codes 96110 and 96111.

What additional screening components may be billed?

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 (CPT® code 83655). When billing, use ICD diagnosis code Z77.011 or Z13.88 (special screening for other conditions, chemical poisoning, and other contamination).

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

- A limitation extension may be requested for medically necessary screenings that do not fall within this periodicity schedule.
- Three screening examinations are recommended for children age 1 through 2 years
- One screening examination is recommended per 12-month period for children age 3 through 6
- One screening examination is recommended per 24-month period for children age 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

- Additional screenings may be covered with a request for prior authorization. The prior authorization (PA) process applies to covered services and is subject to client eligibility and program limitations. PA does not guarantee payment. The agency reviews requests for payment for noncovered health care services according to WAC 182-501-0160 as an exception to rule (ETR).

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

The agency pays Washington Apple Health providers an enhanced rate of $120 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.

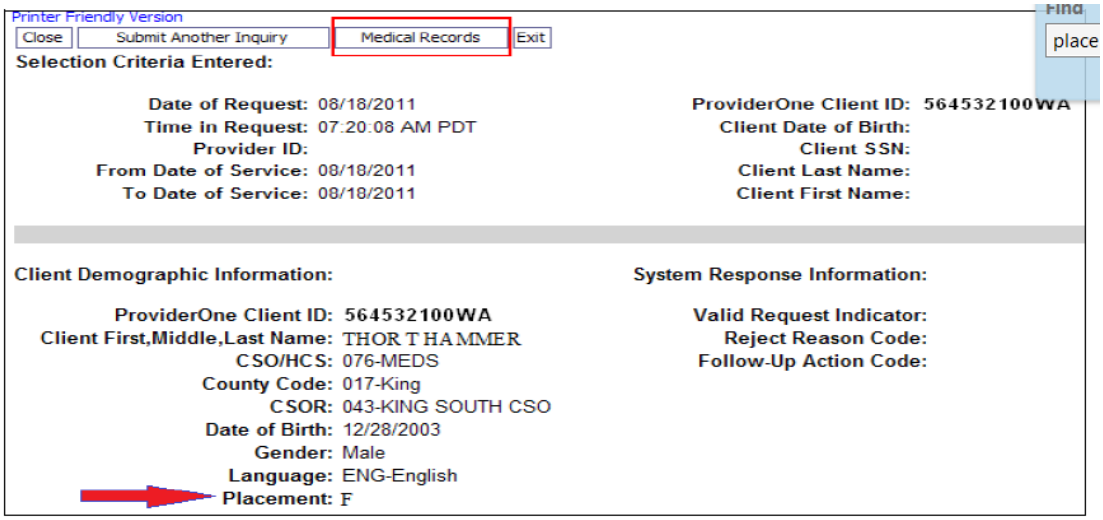
If the client's ProviderOne eligibility inquiry screen indicates a child is associated with one of the foster care placement codes listed in the table below, the provider must use the TJ modifier along with the appropriate CPT® code(s) to be paid an enhanced rate for EPSDT screening examinations.

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.

Where do I find the client's placement in the client record?

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



Note: To view the placement code table and information about how to bill for the enhancement, see How much does the agency pay for EPSDT screening for foster care children?

What is the purpose of a foster child initial health evaluation?

The purpose of an initial health evaluation (IHE) is to identify any of the following:

- 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 up to age 18 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 an IHE?

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 with 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 diagnosis code Z01.89 (encounter for other specified special examinations) as the primary diagnosis.
- Use modifier TJ.

If you bill an E&M code with the diagnosis code Z01.89 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 do one of the following:

- Document the IHE on the *Foster Care Initial Health Screen* form, HCA 13-843.
- Include documentation in the client's record that addresses all 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 – under age 2	21 days of request
	Children – age 2 and older	Six weeks of the request
	Receiving foster care – upon placement	30 days of the request, or sooner for children younger than age 2
Community Mental Health Center, Head Start, substance abuse provider, or Early Childhood Education and Assistance Program (ECEAP)	Birth through age 20	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 to receive additional reimbursement for the office visit. Providers must bill using the appropriate ICD diagnosis code that describes the condition found. **To ensure accurate payment, bill the E&M code and the EPSDT screening procedure code 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. For more details on dental services, see the Dental-Related Services Provider Guide.

> **Note:** Dental disease is the leading chronic disease of childhood; 40% of Washington kindergarteners have experienced tooth decay. Medical providers should refer a child to a dentist if the child is: 1) identified as high risk, 2) enrolled in Head Start, or 3) older than age two and has never seen a dentist.

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

Lead toxicity screening is required at age 12 months and 24 months for all Apple Health-enrolled children, regardless of lead exposure risk. Additionally, all Apple Health-enrolled children between age 36 months and 72 months must receive a lead toxicity screening if they have not previously been tested.

Fetal alcohol syndrome (FAS) screening

As part of the EPSDT screening, every child six months of age or 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.**

CPT® 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?

Yes. 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 age five
- Two in a 12-month period for clients age through eighteen

Who may prescribe the fluoride varnish?

The following providers may prescribe fluoride varnish:

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

Who is eligible for fluoride varnish?

Fluoride varnish is a covered benefit. See the Dental-Related Services Provider Guide.

Are managed care clients eligible for fluoride varnish?

Yes. Clients enrolled in an agency-contracted 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 receive 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 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 age 20 and younger have access to mental health services. See the Mental Health Services Provider Guide for details. However, if the client may meet BHO Access to Care Standards, then a referral to the Behavioral Health Organization (BHO) should be considered. Referral for assessment is based on professional judgment. See Washington State Behavioral Health Organizations 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, symptoms, and risk factors may signal that a child is in crisis. In these cases the referral process must be sped up so that the child may be assessed and treated promptly. An immediate referral must be made by telephone to the mental health agency whenever the child exhibits any of the following:

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

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

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

Children may also be referred for a mental health assessment at a parent's request. Make a referral if the child or parent sees the behavior or symptom as problematic, even if the issues seem minor or within normal range to you. Parents' and teachers' perceptions have shown to be the best predictors of 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 consolidated help line for substance abuse, problem gambling, and mental health. The help line provides anonymous and confidential crisis intervention and referral services for Washington State residents. Professionally trained volunteers and staff are available to provide emotional support 24 hours a day, and offer local treatment for substance abuse. To refer substance abuse cases, call the 24-hour Washington Recovery Help Line at 800-789-1511.

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 parent 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 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.
- Your 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 (VFC) program for children age 18 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 age 19 and 20?

- 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 age 19 and 20, regardless of whether or not the vaccine is available for free from DOH. 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 (first vaccine) and 90472 (additional vaccine). Payment is limited to one unit of 90471 and one unit of 90472.

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

- See Injectable Drug Fee Schedule for vaccine codes

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

No-cost immunizations from the Department of Health are available for clients age 18 and younger. See the Injectable Drug Fee Schedule for a list of immunizations that are free from DOH. 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 (see the Injectable Drug Fee Schedule), then the agency will:

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

How do I bill for vaccines that are not free from DOH for clients age 18 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 (additional vaccine). Payment is limited to one unit of 90471 and one unit of 90472.

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

General Authorization

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

What is prior authorization (PA)?

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

What is a limitation extension (LE)?

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

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

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

How do I obtain written authorization?

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

Billing and Claim Forms

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

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

How do I complete the CMS-1500 claim form?

Instructions on how to bill professional claims and crossover claims electronically can be found on the Medicaid Providers Training page under Medicaid 101. Also, see Appendix I of the agency's ProviderOne Billing and Resource Guide for general instructions on completing the CMS-1500 claim form (version 02/12).

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., Z00.129 - Encounter for routine child health examination without abnormal findings).

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

Note: When physicians and ARNPs identify physical or mental health problems, or both, 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 this provider guide. 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.