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Provider Early and Periodic Screening, Diagnostic, and Treatment training

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What is the Early and Periodic Screening, Diagnostic, and Treatment program?

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. Federal law (*42 CFR 441.50* et. seq.) requires a broad range of outreach, coordination, and health services under EPSDT distinct from the general state Medicaid program requirements. The goal of EPSDT is to identify and treat health problems as early as possible. EPSDT provides examination and treatment services at no cost to the member.

Who is eligible for EPSDT services?

Children under the age of 21 who are enrolled in Medicaid/FAMIS Plus.

Who is not eligible for EPSDT services?

Children enrolled in FAMIS.

Screening services under EPSDT:

- Comprehensive health and developmental history (including assessment of both physical and mental health development)
- A comprehensive unclothed physical exam
- Vision screening by a standardized testing method according to the Virginia Department of Medical Assistance Services (DMAS) periodicity schedule
- Hearing screening by a standardized testing method according to the DMAS *Periodicity Schedule*
- Developmental screening with a standard screening tool according to the American Academy of Pediatrics guidelines
- Age-appropriate immunizations as needed according to the Advisory Committee on Immunization Practices (ACIP) guidelines
- Laboratory tests (including lead blood testing at 12 and 24 months or for a new patient with unknown history up to 72 months or as appropriate for age and risk factors)
- Health education/anticipatory guidance/problem-focused guidance and counseling

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When should EPSDT Screenings occur?

Infancy	Early childhood	Late childhood	Adolescence
3 to 5 days	12 months	5 years	11 years
1 month	15 months	6 years	12 years
2 months	18 months	7 years	13 years
4 months	2 years	8 years	14 years
6 months	30 months	9 years	15 years
9 months	3 years	10 years	16 years
	4 years		17 years
			18 years
			19 years
			20 years

How are members informed of EPSDT?
Federal EPSDT regulations provide that all eligible Medicaid recipients under age 21 and their families be informed of the nature and availability of EPSDT services and how to access them.

Informing is accomplished through a number of outreach activities including face-to-face discussions, telephone conversations, and written communications. The purpose of outreach is to increase EPSDT screening participation.

Outreach and informing is the joint responsibility of DMAS, the Department of Social Services (DSS), participating MCOs, PCPs, and EPSDT screening providers.

DSS provides the following information about EPSDT services to Medicaid applicants during the initial eligibility interview including the following:
- Informs families of the benefits of regular preventive healthcare for their children
- Informs families on the range of services available and how to obtain these services
- Informs families that the services are provided at no cost the them
- Informs families on the available necessary transportation and appointment scheduling assistance

DMAS provides new Medicaid enrollees with an EPSDT brochure describing the services and how to access them. The Managed Care Help Line staff informs recipients of EPSDT services and encourages them to contact their PCP or Medicaid-enrolled EPSDT provider as soon as possible to schedule screening appointments for their children. DMAS also sends periodic mailings to all Medicaid-enrolled families to encourage their participation in EPSDT.

MCO informing and outreach responsibilities must include, at a minimum, promotion of EPSDT for new enrollees including urging them to contact their PCP to schedule an initial screening, a clear description of EPSDT services in the member handbook, and ongoing member education services encouraging participation in these services.

Who are qualified EPSDT screening providers?
Qualified providers of EPSDT screening services include:
- A physician licensed by the Board of Medicine.

- A physician assistant licensed by the Board of Medicine under the supervision as required by their license.
- A nurse practitioner licensed by the Board of Nursing under supervision by a licensed physician.
- Federally qualified health centers (FQHCs).
- Rural health clinics (RHCs).
- Local health departments.
- School-based health clinics.
- Other DMAS approved clinics.

EPSDT providers must be Medicaid-enrolled providers and must meet all applicable Medicaid provider and specific EPSDT screening requirements. There are no additional enrollment requirements for qualified providers to participate in EPSDT.

What is the PCP role in screening?
PCPs for children in MCOs must directly provide EPSDT services for all children assigned to them. Those children who are not enrolled in managed care may obtain these services from any Medicaid-enrolled physician or clinic qualified to provide and offer EPSDT services. These qualified Medicaid-enrolled fee-for-service (FFS) EPSDT providers must follow the same requirements indicated in this manual. The Managed Care Help Line maintains a list of these providers. There are no special enrollment procedures for recipients to access EPSDT services. The PCP or EPSDT screening provider (both MCO and FFS), must perform the following activities related to screening services:

- Advise families of the importance of regular preventive healthcare for their children and explain EPSDT services
- Provide or arrange for initial and periodic EPSDT preventive health screenings according to the DMAS *Periodicity Schedule* and screening requirements
- Ensure that the initial screening is scheduled within 30 days of notification of managed care assignment and immediately on notification of newly assigned newborns unless the services are declined
- Notify families when the next screening is due including those families who have previously declined screening services and encourage them to keep all screening appointments
- Schedule the next screening appointment and maintain periodicity and tracking system on screenings
- Follow-up on missed or incomplete screenings including contacting families and rescheduling the screenings promptly
- Coordinate care for children referred to other qualified providers for screening services and specialty care and obtain results of the screenings and other healthcare services
- Maintain a comprehensive and integrated medical record of all healthcare the child receives including complete documentation of all EPSDT screening components and immunizations given

MCOs may assume responsibility for some of the informing, tracking, and notifying functions of PCPs. One of the primary goals of DMAS' managed care programs is to promote a *medical home* for children so that the recipients under the age of 21 receive both sick and well care from their PCP rather than seek episodic care from and emergency room. A PCP who chooses not to directly provide screenings must enter into a formal written agreement with a local health department, FQHC, or other qualified EPSDT provider to provide screening services to children in his panel. The referral duration will be at the discretion of the provider, and must be fully documented in the patient's medical record. There is an optional referral form at the end of this training. Regardless of the screening arrangements, the PCP

must continue to be responsible for the informing, tracking, follow-up, and documentation requirements of EPSDT.

What is the *EPSDT Screening Periodicity Schedule*?
EPSDT screenings are Medicaid's well child visits and should occur according to the *American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care*. The DMAS *Periodicity Schedule* is included in this training. Providers must obtain a medical history that is inclusive of mental health risk factors and documents the family's history of mental health conditions.

EPSDT screenings, interperiodic screenings and the required components of the screenings do not require service authorization requirements. However, screenings not performed by the child's PCP require a referral from the PCP. Children not enrolled in managed care are not subject to this referral requirement.

What are the EPSDT screening components?
The below describes the required components of EPSDT screenings for members enrolled in FFS and MCOs. The EPSDT comprehensive health screening/well child visit content should be in line with the most current recommendations of the *American Academy of Pediatrics (AAP), Guidelines for Health Supervision*. Another resource for preventive health guidelines is the AAP compatible *Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents*. All components of EPSDT screenings, including specimen collection, must be provided during the same screening visit.

The following is a description of each of the required age appropriate screening components:

Comprehensive health and developmental/behavioral history
At the initial screening, the screening provider must obtain a comprehensive health, developmental/behavioral, mental health and nutritional history from the child's parents or a responsible adult familiar with the child, or directly from an adolescent, when appropriate. This history should be gathered through an interview or questionnaire. A comprehensive initial history includes a review of the:

- Family medical history (health of parents and current family members, identification of family members with chronic, communicable or hereditary diseases).
- Patient medical history (prenatal problems, neonatal problems, developmental milestones, serious illnesses, surgeries, hospitalizations, allergies and current health problems and medications).
- Nutritional history.
- Immunization history.
- Environmental risk (living conditions, water supply, lead, sewage, pets, smokers in home).
- Family background of emotional problems, problems with drinking or drugs or history of violence or abuse.
- Patient history of behavioral and/or emotional problems (educational environment performance, family and social relationships, hobbies, sports).

In addition, for all adolescent children, the initial history must include:

- History of sexual activity, if appropriate.
- Menstrual history for females.
- Obstetrical history, if appropriate.

The history must be updated at each subsequent screening visit to allow serial evaluation.

Developmental surveillance, assessment, and screening

Developmental surveillance

Developmental surveillance should be conducted at each well-child visit. Developmental surveillance is the process of recognizing children who may be at risk of developmental delays. Surveillance is longitudinal, continuous, and cumulative and is comprised of the following components: parental concerns; developmental history; observation of the child; identification of risk and protective factors; and accurately documenting the process and findings. The following are examples of conducting surveillance:

- Parental concerns: Simple questions to parents such as “Do you have any concerns about your child’s development? Behavior? Learning?” Asking about behavior can help identify issues, as parents may not be able to differentiate between development and behavior.
- Developmental history: Ask parents about changes since the last visit, and questions about age-specific developmental milestones such as walking, pointing, etc.
- Observation: The healthcare provider can often see evidence of age-specific developmental milestones, and may be able to confirm parental concerns. It is also important to monitor the parent’s response to the infant, and vice versa.
- Risk and protective factors: Infants born prematurely, at low or very low birth weight, or with prenatal exposure to alcohol, drugs, or other toxins are at risk for developmental delay. Protective factors to support infants at risk, such as participation in home visitation program, or strong connections within a loving and supportive family, should also be considered in determining the overall degree of risk.

Surveillance services are always a subjective observation by the practitioner. Reimbursement for well child visits includes surveillance activities because developmental, hearing and vision surveillance occurs during the course of each EPSDT visit. When a child has an issue that warrants further investigation by the practitioner, then the child may receive a screening to document the need for further assessment or evaluation.

Developmental screening tools

If, at any time, developmental surveillance demonstrates a risk for developmental delay, a standardized screening tool should be administered to further assess the child. As recommended by the AAP, developmental screening using a standardized screening tool should occur at 9, 18, 24 and 30 months of age or at any time when surveillance indicates a risk for developmental delay. An autism specific screening is recommended at the 18 and 24-month visit. Children should be screened for developmental concerns at least five times while they are younger than three years of age.

Developmental assessment and screening differs from surveillance because the activity of assessment and screening includes the use of a standardized developmental screening tool. The tools used may vary according to the type of screening or assessment that is provided. All of the examples listed below can be performed by a parent or other office staff and interpreted by the physician during the *face-to-face* portion of the child’s visit. These tools are designed to be used easily as part of the typical office workflow and the tools are very sensitive and specific with proven statistical validity.

Recommended developmental screening tools

Recommended developmental screening tools	
Parents' Evaluation of Developmental Status (PEDS)	Parent-report instrument used to identify general developmental delay in the general primary care population
Ages and Stages Questionnaire (ASQ)	Parent-report instrument used to identify general developmental delay in the general primary care population and/or broad high-risk population
Bayley Infant Neurodevelopmental Screen (BINS)	Practitioner-administered instrument used to identify general developmental delay in the high-risk population
Cognitive Adaptive Test/Clinical Linguistic Auditory Milestone Scale Expressive and Receptive Language Scale (CAT/CLAMS)	Practitioner-administered instrument used to identify general developmental delay in the high-risk population
Language Development Survey (LDS)	Parent-report instrument used to identify language delay in the general primary care population
Clinical Linguistic Auditory Milestone Scale Expressive and Receptive Language Scale (CLAMS)	Practitioner-administered instrument used to identify language delay in the high-risk population
Modified Checklist for Autism in Toddlers (M-CHAT)	Parent-administered instrument used to screen for autism and developmental delay in the general primary care population

Recommended tools for focused screening for suspected health conditions

Recommended tools for focused screening for suspected health conditions	
Cognitive Adaptive Test/Clinical Linguistic Auditory Milestone Scale Expressive and Receptive Language Scale (CAT/CLAMS)	Practitioner-administered instrument used to identify general developmental delay in the high-risk population
Language Development Survey (LDS)	A parent-report instrument used to identify language delay in the general primary care population

Recommended tools for focused screening for suspected health conditions	
Clinical Linguistic Auditory Milestone Scale Expressive and Receptive Language Scale (CLAMS)	Practitioner-administered instrument used to identify language delay in the high-risk population
Modified Checklist for Autism in Toddlers (M-CHAT)	Parent-administered instrument used to screen for autism and developmental delay in the general primary care population

Hearing and vision screening and surveillance
Subjective
The subjective screening for hearing and vision is part of the comprehensive history and physical examination. Children's hearing is assessed according to the AAP policy for *Hearing Assessment in Infants and Children: Recommendations Beyond Neonatal Screening*. Children's vision assessment should be provided according to the AAP policy for *Eye Examination in Infants, Children and Young Adults by Pediatricians*. Hearing and vision screenings follow the most current AAP *Periodicity Schedule* as stated in the *AAP Recommendations for Preventive Pediatric Health Care.*

The Virginia Early Hearing Detection and Intervention (EHDI) program, the AAP, and the American Speech-Language-Hearing Association provide information on objective hearing screening methods for infants and toddlers.

The EHDI program has a resource, *Protocols for Medical Management*, that defines best practices for caring for infants and young children who are in need of follow-up from universal newborn hearing screening programs and for children who are found to have hearing loss. The EHDI protocols can be accessed the Virginia EHDI Program website, **http://www.vahealth.org/hearing**. Early and consistent intervention specific to hearing loss is essential to achieving normal language development.

Information on vision assessment and surveillance may be found in The American Association for Pediatric Ophthalmology and Strabismus, the American Academy of Ophthalmology, and the AAP section on Ophthalmology.

Screening and testing using standardized methods
The provision of hearing or vision testing using a standardized instrument during the well child visit is billable on that service day as a distinct service. Hearing and vision testing using a standardized instrument is eligible for reimbursement when performed according to the DMAS periodicity schedule or when required to monitor the progression of hearing or vision loss related to the presence of identified risk factors.

Virginia law regarding hearing screening at birth
Virginia law requires that effective July 1, 2000 , all infants will be given a hearing screening before discharge from the hospital after birth. Those children who did not pass the newborn hearing screening, those who were missed, and those who are at risk for potential hearing loss should be scheduled for evaluation by a licensed audiologist.

Comprehensive unclothed physical examination

A complete unclothed physical examination must be performed at each screening visit. The examination must be conducted using observation, palpation, auscultation, and other appropriate techniques using the criteria for specific age groups described in the latest edition of the AAP *Guidelines for Health Care Supervision*. The examination must include all body parts (or areas) and systems listed below:

- Cranium and face
- Hair and scalp
- Ears
- Eyes
- Nose
- Throat
- Mouth and teeth
- Neck
- Skin and lymph nodes
- Chest and back (using a stethoscope) to check for heart and lung disorders
- Abdomen
- Genitalia
- Musculoskeletal system
- Extremities
- Nervous system

The examination must include screening for congenital abnormalities and for responses to voices and other external auditory stimuli. Evaluation of the Tanner stage and scoliosis screening must be included as part of the complete physical examination at each screening visit beginning at age ten.
In addition, the height (or length) and weight of the child must be measured. When examining a child two years of age and younger, the provider must measure the child's occipital-frontal circumference. All measurements must be plotted on age-appropriate, standardized growth grids and evaluated.

Evaluation of growth and laboratory measures is useful for assessing nutritional status. Assessing eating habits in relationship to developmental stage is also important. If dietary or nutritional problems are identified, a referral to the appropriate professional should be made. For children three and above, the physical examination must include blood pressure measurement.

As part of the physical examination, excessive injuries or bruising that may indicate inadequate supervision or possible abuse must be noted in the child's medical record. If there is suspicion or evidence that the child has been abused or neglected, State law requires medical professionals to promptly report it **800-552-7096** (*Code of Virginia Section-63-248.3*).

Immunizations and laboratory tests

Age appropriate immunizations should be provided according to the ACIP guidelines. All *catch up* schedules for missed vaccines should follow ACIP guidelines.

The child's immunization status must be reviewed from the child's medical record and interview with the parent at each screening visit. If the immunization history is based on the verbal report of the parents or other responsible adult, the information must be confirmed and properly documented, indicating the source.

Age-appropriate immunizations that are due must be administered during the screening visit. Immunizations given to a child during a screening visit may be billed separately. PCPs and other medical screening providers are required to participate in the Virginia Vaccines for Children (VFC) Program and provide necessary immunizations and information about the benefits and risks of immunizations as part of EPSDT screenings. The PCP and screening provider must ensure that every child is immunized according to the current *Childhood Immunization Schedule* approved by ACIP and AAP. A parent's refusal to allow immunizations must be documented by a statement in the child's medical record that is signed and dated by the parent. If a condition is identified during the screening that warrants deferral of necessary immunizations to a later date, the progress notes in the medical record must so indicate. The provider must follow up to reschedule the child to catch up on immunizations at the earliest possible opportunity.

Vaccines for Children Program
The Vaccines for Children (VFC) Program is a federal program established in 1984 to help raise childhood immunization rates in Virginia. VFC provides federally purchased vaccines, at no cost to healthcare providers, for administration to eligible children. Childhood immunizations and annual pneumococcal vaccinations are covered according to the most current ACIP schedule.

To be eligible for no-cost vaccines from the VFC Program, children must be under the age of 19. To be VFC eligible, they must also meet one of the following criteria:

- Medicaid/FAMIS Plus enrolled, including Medicaid MCOs
- Uninsured (no health insurance)
- Native American or Native Alaskans (no proof required)
- Underinsured (those whose insurance does not cover immunizations).

Requirement to enroll in VFC
To participate, a provider must complete the enrollment and provider profile forms provided by the Virginia Department of Health (VDH). At this point, the provider is eligible to receive free vaccines under the VFC.

On enrollment, DMAS will not reimburse the provider for the acquisition cost for vaccines covered under VFC. Medicaid will reimburse providers the administration fee for routine childhood vaccines that are available under VFC (up to the age of 19). Medicaid will reimburse the provider an administration fee per injection.

Billing codes for the administration fee
Providers must use Medicaid-specific billing codes when billing Medicaid for the administration fee for no cost vaccines under VFC. These codes identify the VFC vaccine provided and will assist the VDH with its accountability plan, which the Health Care Financing Administration (CMS) requires. The billing codes are provided in the CPT®-4 books.

Billing Medicaid as primary insurance
For immunizations, Medicaid should be billed first for the vaccine administration. This is regardless of any other coverage that the child may have, even if the other coverage would reimburse the vaccine administration costs. Medicaid will then seek reimbursement from other appropriate payers. When a child has other insurance, check *yes* in *Block 11-D* (Is there another health benefit plan?) on the *CMS-1500* (*08-05*) claim form. See the *Physician/Practitioner Manual* for further instructions.

Reimbursement for children ages 19 and 20
Since Medicaid policy provides coverage for vaccines for children up to the age of 21 , and VFC provides coverage only up to the age of 19 , there may be instances where the provider will provide immunizations to children who are ages 19 and 20. Bill Medicaid with the appropriate CPT/HCPCS code and Medicaid will reimburse the acquisition cost for these vaccines. Medicaid will not reimburse an administration fee since these vaccines were not provided under the VFC Program to this age group.

Vaccines not available under VFC
The VDH does not have contracts with the CDC for the VFC distributor to provide diphtheria tetanus and pertussis (DTP) and Hepatitis B for dialysis patients. Therefore, Medicaid will reimburse for the acquisition cost for these vaccines under CPT codes 90701 and 90747, respectively. No administration fee will be reimbursed under code since this vaccine is not available under VFC.

Single antigen vaccines
Single antigen vaccines (such as measles, mumps, and rubella) are available from the VFC contractor, but must be ordered by the provider with special justification since the combined antigen vaccine (MMR) is available. This is consistent with Medicaid policy to require medical justification for single antigen vaccines.

Pneumococcal and influenza vaccines for adults aged 19 and older
Medicaid will provide reimbursement for these vaccines only if they are reasonable and necessary for the prevention of illness. Medical justification needs to be attached to the claim. The physician's treatment plan on file in the patient's medical record must indicate that the vaccine was provided to prevent the occurrence of more serious illness in an individual *at risk*.

Situations where vaccines are not covered under VFC
There may be some situations where a child is attempting to *catch-up* on vaccines that have been missed. In some cases, the VFC program will not provide coverage for these *catch-up* vaccines, and the provider will have to purchase them from their normal vaccine distributor. If this occurs, Medicaid will continue to reimburse the provider for the acquisition cost of these vaccines as long as there is information attached to the claim indicating the reason for billing Medicaid for the acquisition cost. In addition to the attachment to the claim, use modifier 22 in *Block 24-D* of the *CMS-1500* (*08-05*) claim form.

Vaccines provided outside of the EPSDT *Periodicity Schedule*
Virginia Medicaid covers childhood immunizations under the EPSDT Program based upon a *Periodicity Schedule*. The ACIP and the AAP developed this schedule along with representatives from the American Academy of Family Physicians. See *Supplement B - EPSDT* for a copy of the immunization schedule. If the provider provides a vaccine to a child that falls outside of this immunization schedule and the vaccine does not meet the criteria for coverage under the VFC Program, Medicaid will not reimburse for immunizations unless documentation is sent along with the claim to explain the circumstances under which the vaccine was provided. In addition to the attachment to the claim, use modifier 22 in *Locator 24-D* to bill Medicaid for the acquisition cost.

Billing for childhood immunizations
The VFC Program provides routine childhood immunizations at no cost to Medicaid-eligible children up to age 19. The VDH provides these vaccines to VFC-enrolled providers. DMAS requires that PCPs serving children and EPSDT screening providers participate in the VFC program. Providers may enroll in the VFC Program by contacting VDH at **800-568-1929**. DMAS and the DMAS-contracted MCOs will not reimburse providers for the acquisition cost of vaccines that are covered under the VFC

Program. DMAS reimburses providers for the administration fee for routine childhood vaccines that are available under VFC (up to the age of 19). DMAS will reimburse the provider an $11 administration fee per injection. MCOs are responsible for provider payments of immunizations furnished to children enrolled in MCOs. Therefore, providers cannot be reimbursed by DMAS for immunizations provided to MCO enrolled children.

Reimbursement for children ages 19 and 20
Since EPSDT Federal regulations require states to provide coverage for vaccines for children up to the age of 21, and VFC provides coverage only up to the age of 19, there may be instances where the provider will provide immunizations to children who are ages 19 and 20. In these instances, the provider must use the appropriate CPT procedure code. DMAS will reimburse the acquisition cost for these vaccines. The charges in locator 24F of the *HCFA 1500* (*12-90*) claim form must reflect the actual acquisition cost per dose. Providers should refer to *Chapter V* of the *DMAS Physician Manual* for further billing guidance.

VFC Coverage of other vaccines
The VFC Program covers other vaccines not included in the ACIP immunization schedule including single antigen vaccines. If the provider chooses to provide a single antigen vaccine, such as measles, mumps, or rubella, medical justification, which documents the medical necessity of providing a single antigen vaccine when the combined-antigen vaccine is available, must be attached to the claim. Claims for measles, mumps, or rubella vaccines will automatically pend for review by DMAS staff. The VFC Program also provides coverage for the pneumococcal and influenza vaccines for high-risk patients only. When ordering these vaccines through VFC, the provider must provide medical justification. DMAS will provide reimbursement for these vaccines only if they are reasonable and necessary for the prevention of illness. Medical justification does not need to be attached to the claim, but the physician's treatment plan on file in the patient's medical record must indicate that the vaccine was provided to prevent the occurrence of more serious illness in an individual *at risk*.
Age appropriate immunizations are a federally required screening component. The provider must not submit a claim for a complete screening unless all required components that are due are administered and documented including appropriate immunizations according to age and history (unless medically contraindicated or the parents refuse at the time). Failure to comply with or properly document this screening requirement must constitute an incomplete screening and may result in denial of payments.

Laboratory procedures
EPSDT requirements for lead testing
As part of the definition of EPSDT services, the Medical Statute requires coverage for children to include both screening and blood lead tests as appropriate, based on age and risk factors. CMS requires all Medicaid-enrolled children receive a blood lead test at 12 months and 24 months of age. In addition, any child between 24 and 72 months with no record of a previous blood lead screening test must receive one. The medical record will be deemed insufficient if the child has not been previously screened. Completion of a risk assessment questionnaire does not meet the Medicaid requirement. The Medicaid requirement is met only when the two blood lead screening tests identified above (or a catch-up blood lead screening test) are conducted (**https://www.medicaid.gov/federal-policy-guidance/downloads/cib113016.pdf**).

Confirmation of blood lead levels
Blood lead level testing shall be performed on venipuncture or capillary blood; However, additional testing may be required, as described below. Filter paper methods are also acceptable and can be

performed at the provider's office. The use of handheld testing machines must be approved through the Lead-Safe Virginia Program to assure proper quality assurance and reporting of data.

Tests of venous blood performed by a laboratory certified by CMS in accordance with *42 USC § 263a*, the *Clinical Laboratory Improvement Amendment of 1988* (*CLIA*-certified), are considered confirmatory. Tests of venous blood performed by any other laboratory and tests of capillary blood shall be confirmed by a repeat blood test, preferably venous, performed by a *CLIA*-certified laboratory. Such confirmatory testing shall be performed in accordance with the following schedule (requirements of *12VAC5- 90-215*):

If result of screening test (ug/dL) is:	Perform diagnostic test on venous blood within:
5 to 9	1 to 3 months
10 to 44	1 week to 1 month
45 to 59	48 hours
60 to 69	24 hours
70 or higher	Immediately as an emergency lab test

For consultation and assistance on the treatment of children with elevated venous blood levels 70 or higher contact Emergency Lead Healthcare through their free medical hotline at **866-767-5323** (**866-SOS-LEAD**).

Lead testing procedure codes
If blood lead screening tests are conducted in the provider's offices, the code 83655 for lead blood testing is used with one of the following: 36416 or 36415, depending on whether the sample is from a capillary or venous site, as shown below.

Service description	Procedure code
Lead lab test (paid to lab or EPSDT screener)	CPT 83655
Capillary sample (finger, heel, ear stick)	CPT 36416
Venous sample (recommended)	CPT 36415

When blood lead testing is provided to a client enrolled in a Virginia MCO, please follow the MCOs specific billing instructions.
Remember to always verify Medicaid eligibility before services are rendered.

Virginia regulations for disease reporting and control
The Virginia Regulations for Disease Reporting and Control require physicians and the directors of laboratories to report any *detectable* blood lead levels in children ages 0 to 15 years to the Local Health Department within three days.

In October 2016, these regulations were updated and *lead, elevated blood levels* was renamed *lead reportable level*. *Lead reportable levels* now means any detectable blood lead level in children 15 years of age and younger and levels greater than or equal to 5 Ug/dL in a person older than 15 years of age (*12VAC5-90-10*). This requirement applies to test results confirmed by a *CLIA*-certified laboratory. Results of office-based screening tests do not need to be reported.

Many laboratories submit disease reports by means of secure electronic transmission. Reports may also be submitted by using the *Epi-1* form that can be found on the VDH website at: **http://www.vdh.virginia.gov/content/uploads/sites/13/2016/03/Epi1.pdf**.

For more information, please visit the VDH website: **http://www.vdh.virginia.gov/surveillance-and-investigation/commonwealth-of-virginiastateboard-of-health**.

Medicaid-funded environmental investigations
Environmental investigations are a service offered by Medicaid through Lead-Safe Virginia and local health departments. Environmental investigations are reimbursed to local health departments enrolled with DMAS or contracted with a Virginia Medicaid MCO. Medicaid funds are not available for the testing of environmental substances such as water, paint, or soil. Environmental investigations are conducted when certain criteria are met and may be carried out by private entities or environmental health specialists in local health departments who are licensed risk assessors. For information about what triggers an environmental lead investigation and what it includes, visit **http://www.vdh.virginia.gov/environmental-health/childhood-leadpoisoning-prevention**.

For additional questions about environmental lead testing, contact Lead-Safe Virginia toll-free at **877-668-7987**. You many also email Lead-Safe Virginia at leadsafe@vdh.virginia.gov.

Resources for more information about blood lead testing and lead exposure:

- **Lead-Safe Virginia:**
  https://www.cdc.gov/nceh/lead/programs/va.htm
- **The National Lead Information Center (NLIC): Environmental Protection Agency (EPA):**
  https://www.epa.gov/lead
- **CDC Childhood Lead Poisoning Prevention Program**
  https://www.cdc.gov/nceh/lead/
- **Coalition To End Childhood Lead Poisoning:**
  http://www.greenandhealthyhomes.org/StrategicPlanforEndingLeadPoisoning.

Additional laboratory procedures
In addition to the lead toxicity screening, the following procedures on laboratory tests are required:

Neonatal screening
The screening provider must review the results of the newborn metabolic screening for phenylketonuria, hypothyroidism, galactosemia, and other disorders performed prior to hospital discharge.

Sickle cell screening
The screening provider must review the results of the sickle cell screening performed prior to hospital discharge on the appropriate population. A sickle cell preparation must be done at the six-month-old visit if indicated in accordance with AAP guidelines.

Anemia screening
Iron deficiency anemia screening involving taking hematocrit or hemoglobin values through a finger prick or venous blood sample must be performed at screening visits in accordance with AAP guidelines.

Anemia screening is a Medicaid reimbursable service and should be administered more frequently if medically indicated. The results can be shared with the patient's written consent if the certification is needed for the Supplemental Nutritional Program for Women, Infants, and Children (WIC).

EPSDT optional screening procedures
The following is a description of optional screening procedures to be performed on children and adolescents at risk:

Tuberculin test (optional)
Tuberculin testing using the Purified Protein Derivative (PPD) skin test should be performed in accordance with AAP guidelines. The PPD test has replaced the Tyne method.

Cholesterol screening (optional)
Cholesterol and hyperlipidemia screening should be performed at each screening visit beginning at age two in accordance with AAP guidelines.

Sexually transmitted disease (STD) screening (optional)
All sexually active adolescents should be screened for sexually transmitted diseases such as chlamydia, gonococci, and syphilis at each screening visit beginning at age 11 through age 20. HIV testing should be performed if requested or if the adolescent is at high risk.

Cancer screening (optional)
A Papanicolaou (Pap) test should be performed on all sexually active females at each screening visit.

Pelvic examination (optional)
All sexually active females should have a pelvic examination. A pelvic examination and a Pap test must be offered as part of preventive health maintenance between the ages of 18 and 21.

Anticipatory guidance
Health education, also called anticipatory guidance and problem-focused guidance and counseling are provided at each well child visit according to developmental needs and with respect to patient cultural backgrounds and literacy levels.

The **Bright Futures** program has family friendly materials that provide useful anticipatory guidance information and age appropriate safety and parenting tips. For more information on Bright Futures, go to the web based training module at **http://www.vdh.virginia.gov/brightfutures**. DMAS endorses Bright Futures and Bright Futures Virginia.

Referral to dental screening
Federal EPSDT regulations require a direct referral to a dentist beginning at age three. An oral inspection must be performed by the EPSDT screening provider as part of each physical examination for a child screened at any age. Tooth eruption, caries, bottle tooth decay, developmental anomalies, malocclusion, pathological conditions, or dental injuries must be noted. The oral inspection is not a substitute for a complete dental screening examination provided through direct referral to a dentist. The PCP or other screening provider must make an initial direct referral to a dentist when the child receives their three-year screening. The initial dental referral must be provided at the initial medical screening regardless of the *Periodicity Schedule* on any child age three or older unless it is known and documented that the child is already receiving regular dental care. The importance of regular dental care must be discussed with the family (and child as appropriate) on each screening visit for children three years and

older. When any screening, even as early as the neonatal examination, indicates a need for dental services at an earlier age, referral must be made for needed dental services.

Documentation
The screening provider must retain copies of all screening claims and other Medicaid claims for at least five years from the date of service or as provided by applicable state laws, whichever period is longer.

If an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved. The PCP must maintain complete medical records on all children screened in their panel for at least five years from the date of service or as provided by applicable state law, whichever period is longer. Appropriate procedures and systems to ensure confidentiality must be in place. Medical records must contain the following information specific to EPSDT screening services:

- Reason for visit (for example, screening, follow-up, sick visit.) (Note the complaint and relevant history)
- The date screening services were performed, the specific tests or procedures performed, the results of these tests and procedures, and the specific staff member who provided the service
- Each required component of screening including vision and hearing screening and immunizations – documented separately
  - The *DMAS-353* may be used for this purpose.
- Documentation of medical contraindication or a written statement from a parent or a guardian on a child screened for whom immunizations were due and not given and attempts the screening provider made to bring the child up-to-date on immunizations
- Identification of any screening component not completed the medical contraindication or other reason why it could not be completed, and attempts the screening provider made to complete the screening
- Documentation of a medical contraindication or other reason for delay in vision or hearing screening if not performed on the same day as a medical screening
- Documentation of declination of screening services by parents
- Documentation of missed appointments and of at least two good faith efforts to reschedule according to the *Periodicity Schedule*
- Referrals made for diagnosis, treatment, or other medically necessary health services for conditions found in screenings and documentation of follow-up done to assure services or treatment were provided within 60 days of the screening
- Date next screening is due
- Documentation of direct referral for age-appropriate dental services

Special billing instructions
Virginia Medicaid requires the use of HCPCS/CPT codes and definitions published in the current edition of the *Physician's CPT* in billing EPSDT covered screenings. The *CPT Manual* may be obtained by calling the America Medical Association at **900-621-8335**. The *Health Insurance Claim Form, CMS-1500* (*08-05*) must be used to bill for screening services and immunizations. The invoice is completed and submitted according to the instructions provided in the *Medicaid Physician Manual*. Locators 24D and 24H are specific to EPSDT screening claims. The appropriate procedure modifier is required in locator 24D for each CPT code for screenings. The appropriate indicator *1* is required in locator 24H.

Referral providers authorized by the child's PCP to provide treatment or other services to that child must enter the Medicaid provider identification number of the PCP in locator 17a of the *CMS-1500* (*08-05*) in

order to be reimbursed. Subsequent referrals resulting from the PCP's initial referral will also require the PCP's authorization and the PCP's Medicaid provider number in this block.

For children enrolled in MCOs, the MCO is responsible for payment of EPSDT screening services.

EPSDT screening claims and billing information for Medicaid FFS providers and MCOs
Billing for developmental screenings
Assessment and screening is a reimbursable service when a standardized screening tool is used. Providers may bill for a developmental screening or assessment, using the CPT code 96110, (E&M) visit when modifier 25 is used along with the appropriate E&M code (CPT codes 99201-215 and 99381-395) for that visit.

Providers may use the following modifiers, when appropriate as defined by the most recent CPT. Must contain documentation to support the use of the modifier by clearly identifying the significant, identifiable service, and tool used that allowed the use of the modifier.

- Modifier 22 Unusual Procedural Service: When the service provided is greater than that usually required for the procedure code. Use of this modifier will cause the claim to pend for manual review and requires an attachment to explain the use of the modifier. Physicians should not apply this modifier unless there are unusual situations that warrant manual review.
- Modifier 24 Unrelated E&M Service by the same physician during the post-operative period.
- Modifier 25 Significant, separately identifiable E&M service on the same day by the same physician on the same day of the procedure or other services.
- Modifier 59 Distinct Procedural Service

This section describes how to claim an EPSDT periodic screening or well-child visit and when to bill for an inter-periodic or problem focused visit in lieu of a well-child visit.

Screening/well child billing guidance

- Complete Well Child/EPSDT Screening (CPT 99381-99395): Bill the appropriate evaluation and management (E&M) code for Preventive Medicine Services (screening) when all services included in the procedure code as described in the *CPT Manual* are completed and documented. Use the ICD diagnosis codes for a *healthy visit*.
- Incomplete EPSDT Screening (CPT 99381-99395): If screening is incomplete because the child is uncooperative, bill the E&M code for an appropriate office visit and reschedule the child for the next appropriate EPSDT screening/well child visit. Use the ICD diagnosis code that defines the child's health status for this *problem-focused* visit.
- Problem Focused or Inter- -99215): These are problem-focused screenings that are used to investigate specific health complaints and to refer children for any type of medical or mental health treatment. Use the ICD diagnosis code that defines the child's health status for this visit. The screening provider may not bill for a separate office visit for treatment of the child's illness or condition on the date a complete screening is billed.

Billing for hearing, vision, and developmental screenings during the EPSDT well child or problem focused visit
Objective hearing screening (CPT code 92551), vision screening (CPT code 99173), and developmental assessment (CPT code 96110) procedures performed using a standardized screening method on the same date of service as a Preventive Medicine E&M will be reimbursed separately when modifier 25 is used along with the appropriate E&M code for that visit.

Use the following modifiers, when appropriate as defined by the most recent Current Procedural Terminology (*CPT)*. The recipient's medical record **must** contain documentation to support the use of the modifier by clearly identifying the significant, identifiable service that allowed the use of the modifier.

- Modifier 22 Unusual Procedural Service: When the service provided is greater than that usually required for the procedure code. Use of this modifier will cause the claim to pend for manual review and requires an attachment to explain the use of the modifier. Physicians should not apply this modifier unless there are unusual situations that warrant manual review.
- Modifier 24 Unrelated E&M Service by the same physician during the post-operative period.
- Modifier 25 Significant, separately identifiable E&M Service on the same day by the same Physician on the same day of the procedure or other services.
- Modifier 59 Distinct Procedural Service

Billing for special or interperiodic EPSDT screenings (Medicaid FFS providers)

- Missed screenings: If a child misses a regular periodic screening, that child may be screened at the earliest possible time to bring the child into compliance with the AAP-recommended *Periodicity Schedule*. Providers should follow billing instructions for an EPSDT/well child screening.
- Interperiodic screenings: Screenings may be provided in addition to the regular *Periodicity Schedule* screenings for medical evaluation of a specific problem. Interperiodic screenings may be billed as a sick visit. However, it cannot be used to provide a school, Head Start or sports physical when a well-child visit was provided earlier that year. If a screening is needed to examine a specific issue or complete a developmental or comprehensive history related to a specific medical issue, then an interperiodic screening can be provided using the appropriate preventive medicine codes. Any caregiver, medical provider or a qualified health, developmental, or educational professional who comes in contact with the child outside of the formal healthcare system may request that an evaluative interperiodic screening be performed. These screenings require a brief narrative justifying the additional interperiodic screen in the medical record. Providers should submit interperiodic preventive and objective screening claims with a 22 modifier to the procedure code, attach the justification statement to the claim and write locator 10D of the *CMS-1500* claim form for participation in athletics often create opportunities to screen children who are not current for well child/EPSDT screenings. If the child is not current with the well child/EPSDT schedule, complete the age appropriate well child/EPSDT screen. If the child is current with the well child/EPSDT schedule, a request for a HeadStart/School Entry or sports physical does not justify the need for an interperiodic medical screening. Providers may document the well child/EPSDT screening based on the School Entrance physical forms. However, the physical exam is not a covered service when the child is current with his or her well child visit schedule.

Billing for laboratory tests

The screening provider may bill separately for laboratory tests that are performed as part of the screening and documented in the child's medical record. DMAS will only reimburse the provider actually performing the service (in other words, physician, independent laboratory, or other facility). The screening provider may bill for incurred handling and shipping charges on the *HCFA-1500* (*12-90*) when the specimens are sent to an outside laboratory.

Lead testing claims process

A list of lead testing procedure codes is included in the *EPSDT Screening Procedure Codes* will be included in this training. When lead testing is provided during a well-child visit or other healthcare

encounter, EPSDT screener must use the lead testing procedure codes with a 25 modifier in block 24D of the *CMS-1500*. Independent laboratories or EPSDT screeners that have an approved laboratory will bill the 83655 code when the lead test is performed.

If blood lead screening tests are conducted in the provider's offices, the code 83655 for lead blood testing is used with one of the following: 36416 or 36415, depending on whether the sample is from a capillary or venous site.
A comprehensive list of Medicaid-enrolled lab providers may be found by contacting the DMAS Provider HELPLINE, or by accessing the DMAS web portal at

- **http://www.dmas.virginia.gov/Content_atchs/mch/DMAS%20Lead%20Testing%20Labs.docx**
- **http://www.dmas.virginia.gov/Content_pgs/mch-home.aspx.**

When blood lead testing is provided to a client enrolled in a Virginia Medicaid MCO, the provider should follow the MCOs specific billing instructions. Providers should always verify Medicaid eligibility before services are rendered. DMAS offers a web-based internet option (ARS) to access information regarding Medicaid or FAMIS eligibility. The web portal to enroll for access to this system is **https://www.virginiamedicaid.dmas.virginia.gov/wps/portal**. The MediCall voice response system will provide the same information and can be accessed by calling **800-884-9730** or **800-772-9996**. Both options are available at no cost to the provider.

VFC or immunization billing questions
For questions relating specifically to the VFC program vaccines, contact the VDH Hotline at **800-568-1929**. The VDH Hotline is available Monday through Friday from 7 a.m. to 5 p.m. For billing questions, contact the Medicaid Provider Help Line at **800-552-8627**.

Office visits billed in conjunction with immunizations
DMAS will reimburse physicians an appropriate minimal office visit in addition to the VFC administration fee (or acquisition cost for adolescents ages 19 and 20 only) when an immunization is the only service performed.

EPSDT referrals for specialized services
When an EPSDT screening indicates the need for diagnosis or treatment for a suspected condition or abnormality, the physicians' progress notes must also indicate. The child may be referred for medically necessary specialty care or other health services if the PCP or screening provider is not able to provide the treatment or other services.

The PCP must follow up on all EPSDT referrals resulting from a screening to ensure that the child receives the requested treatment or other services within 60 days and document the results in the child's medical record.

The *Omnibus Budget Reconciliation Act of 1989* requires states to reimburse for medically necessary services not otherwise covered under the state plan for Medicaid-eligible children up to the age of 21 when such services are needed to correct or ameliorate defects, and physical and mental illness, and conditions discovered by the screening services, as long as the services are allowable under the *Social Security Act 1905(a)* and are preauthorized by DMAS.

Some services are available outside of the state plan under *Social Security Act Section 1915(c)* through *Home and Community-Based Services Waivers*. Services covered under *Section 1915(c)* are not covered

under EPSDT unless they are also allowable services under *Section 1905(*a*)*. For more information on *Home and Community-Based Waivers*, providers may contact the DMAS Provider Call Center at **800-552-8627**.

Service authorization for specialized services
Any treatment service which is not otherwise covered under the state's plan for medical assistance can be covered for a child through EPSDT as long as the service is allowable under the *Social Security Act Section 1905(a)* and the service is determined by DMAS or its contractor as medically necessary. Treatment services that are approved through the EPSDT program but are not available through the state plan for medical assistance are called EPSDT specialized services.

Reimbursement for EPSDT specialized services is limited to the hours of treatment and medical or clinical supervision as specified in the treatment plan and as approved by DMAS. All specialized service requests require physician documentation outlining the medical necessity, frequency, and duration of the treatment. To qualify for reimbursement through the EPSDT program, most EPSDT specialized services must be approved before the service is rendered by the provider.

Detailed information on the service authorization of behavioral therapy, nursing, personal care, inpatient services, and audiology and hearing aid services defines as *specialized services* under EPSDT is available on the DMAS web portal at **https://www.virginiamedicaid.dmas.virginia.gove/wps/portal**.

DMAS or its contractor service authorizes other services through the EPSDT program such as residential treatment for persons with developmental and behavioral challenges, hospital-based services to treat neurological conditions, bariatric related treatment, treatment for eating disorders, and treatment for other chronic health conditions. The services available through EPSDT are not limited to those listed.

Chiropractic services
Effective April 1, 2012, chiropractic services are available for Medicaid members under the age of 21 and through the DMAS EPSDT program. This service cannot be authorized for Medicaid members age 21 and older. Chiropractors (provider type 026) are the only providers to submit these requests. DMAS or its contractor will apply McKesson InterQual® to certain services and DMAS criteria where McKesson InterQual products do not exist. If unable to approve a request, then DMAS or its contractor will apply EPSDT criteria. The chiropractic CPT codes requiring service authorization are listed below.

Chiropractic CPT codes to submit for service authorization:
- 98940 Chiropractic manipulative treatment (CMT); spinal, one to two regions
- 98941 Chiropractic manipulative treatment (CMT); spinal, three to four regions
- 98942 Chiropractic manipulative treatment (CMT); spinal, five regions
- 98943 Chiropractic manipulative treatment (CMT); extraspinal, one or more region

Review of items denied under DME for coverage through EPSDT
In addition to the traditional review of requests for DME, children enrolled in either FAMIS Plus and FAMIS who are initially denied services under the DME program will receive a secondary review for these items using the EPSDT. Some of these services will be approved by the DMAS service authorization contractor under the already established criteria for that specific item/service and will not require a separate review under EPSDT. Some service requests may be denied using specific item/service criteria and need to be reviewed under EPSDT — some may be referred to DMAS by its contractor on a case-by-case basis. Specific information regarding the methods of submission for

children enrolled in FFS may be found at the contractor's website, **http://DMASKePRO.com**. The contractor may also be reached by phone at **888-VAPAUTH** or **888-827-2884**, or via fax at **877-OKBYFAX** or **877-652-9329**. Providers should contact the MCO for DME requests for children enrolled in managed care.

For additional information on the service authorization of DME, please see *Appendix D* of the *DMAS Durable Medical Equipment & Supplies* provider manual. A copy of this manual is available on the DMAS website.

Service authorization status

DMAS offers a web-based internet option (ARS) to access information regarding Medicaid or FAMIS eligibility, claims status, check status, service limits, service authorization, and pharmacy prescriber identification. The DMAS web portal to enroll for access to this system is **https://www.virginiamedicaid.dmas.virginia.gov/wps/portal**. The MediCall voice response system will provide the same information and can be accessed by calling **800-884-9730** or **800-772-9996**. Both options are available at no cost to the provider.

Assistive technology

To correct or ameliorate physical or mental conditions identified during EPSDT screening services, the child may be referred by the EPSDT screener or PCP for assistive technology services. Assistive technology is defined as specialized medical equipment, supplies, devices, controls, and appliances not available under the Virginia state plan for medical assistance. Assistive technology items directly enable individuals to increase their abilities to perform ADLs or to perceive, control, or communicate with the environment in which they live. Assistive technology items are expected to be portable.

To meet the definition of assistive technology, requested items must meet all of the following requirements. Assistive technology must:

- Be able to withstand repeated use.
- Be primarily and customarily used to serve a medical purpose and be medically necessary and reasonable for the treatment of the individual's disability or to improve a physical or mental condition.
- Generally not be useful to a person in the absence of a disability, physical or mental condition.
- Be appropriate for use in both the home and community.

Equipment or supplies already covered by the Virginia state plan for medical assistance may not be requested for reimbursement under EPSDT. A list of covered items is located in the *Durable Medical Equipment & Supplies* provider manual which is available on the DMAS website at **https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual**.

Providers may use the *Medicaid DME and Supplies Listing* located in *Appendix B* of this manual to ascertain whether an item is covered through the Virginia state plan for medical assistance before requesting the item through EPSDT. Equipment and supplies must be provided by a DME provider or assistive technology provider.

Criteria

Only assistive technology items that are determined to be medically necessary may be covered for reimbursement by DMAS. The following criteria must be satisfied through the submission of adequate and verifiable documentation satisfactory to DMAS. Assistive technology must be:

- Ordered by a physician to correct or ameliorate physical or mental conditions identified during EPSDT screening services.
- A reasonable and medically necessary part of a treatment plan.
- Consistent with the individual diagnosis and medical condition, particularly the functional limitations and symptoms exhibited by the individual.
- Not furnished solely for the convenience of the family, attending physician, or other practitioner or supplier.
- Consistent with generally accepted professional medical standards (i.e., not experimental or investigational).
- Provided at a safe, effective, and cost-effective level that is suitable for use by the individual.

Assistive technology must involve direct support to the individual and be for the express purpose of diagnosing, treating or preventing (or minimizing the adverse effects of) illness, injury or other impairments to an individual's physical or mental health. Therefore, services that do not involve direct support to the individual or environmental services dealing exclusively with an individual's surroundings rather than the individual are not covered. Further, even if the requested service does involve some direct support for the individual, it cannot be covered unless the device is related to diagnosis given as the reason for the service request.

Home/environmental modifications do not meet the definition of assistive technology and are not covered under EPSDT services. Environmental modifications are defined as physical adaptations to an individual's home, primary place of residence, vehicle, or workplace. Examples of environmental modifications include but are not limited to devices that are permanently affixed to the walls of the home such as grab bars, ramps, barrier free lifts, and widening of doorways.

Individuals and caregivers are responsible for determining if the individual is receiving the appropriate assistive technology in the school system and suggesting that the individualized education plan (IEP) include assistive technology. In cases where assistive technology is requested for use during school hours and not included in the IEP, the provider must obtain documentation from the school indicating why the assistive technology is not included in the IEP. Items covered under the *Individuals with Disabilities Education Act (IDEA)* cannot be covered under EPSDT. For information regarding Medicaid-covered school services, please see the *School Health Services Manual* located on the DMAS website.

Service authorization requirements
All assistive technology items must be authorized by DMAS or its contractor. Service authorization for children enrolled in managed care must be obtained through the MCO. Each assistive technology item must be recommended and determined appropriate to meet the individual's needs by a qualified professional such as an occupational therapist, physical therapist, speech language pathologist or behavioral consultant.

Medical documentation must provide a clear understanding of the individual's needs. Documentation for each requested assistive technology item must identify:

- The medical need for the requested assistive technology.
- The diagnosis related to the reason for the assistive technology request.
- The individual's functional limitation and its relationship to the requested assistive technology item.
- How the assistive technology item will treat the individual's medical condition.
- The quantity needed and the medical reason the requested amount is needed.

- The frequency of use.
- The estimated length of use of the item; Any conjunctive treatment related to the use of the item.
- How the needs were previously met identifying changes that have occurred which necessitate the assistive technology request.
- Other alternatives tried or explored and a description of the success or failure of these alternatives.
- How the assistive technology item is required in the individual's home or community environment.
- The individuals or caregiver's ability, willingness, and motivation to use the assistive technology item.

Provider documentation requirements
Documentation requirements include:
- Supporting documentation, which includes the need for the service, the process to obtain this service (contacts with potential vendors or contractors, or both, of service, costs, etc.); and the time frame during which the service is to be provided. This includes separate notations of evaluation, design, labor, and materials.
- Written documentation which proves that the item was requested and was not approved by the Virginia state plan for medical assistance as DME.
- Documentation of the date services are rendered and the amount of service needed.
- Any other relevant information regarding the device or modification.
- Documentation of the satisfaction of the individual and/or the individual's family with the service.
- Instructions regarding any warranty, repairs, complaints, or servicing that may be needed.
- The individual or caregiver's ability to use the assistive technology item effectively.

Specific information regarding the methods of submission for individuals enrolled in FFS are found at the contractor's website, **http://DMAS.KePRO.com**. The contractor may also be reached by phone at **888-VAPAUTH** or **888-827-2884**, or via fax at **877-OKBYFAX** or **877-652-9329**.

There are no automatic renewals of service authorizations. Providers must submit a service authorization request if a member requires continued services or the current authorization will end without renewal. All authorizations should be submitted prior to the first date services are rendered or prior to the last day of the current authorization in order for submissions to be timely and to avoid any gaps in service.

Medical formula covered as DME
The EPSDT program allows DMAS to provide medically necessary formula and medical foods to EPSDT eligible children under the age of 21 based on medical necessity. The current *Durable Medical Equipment & Supplies* provider manual defines EPSDT formula approval criteria in *Chapter 4* of that manual. Routine infant formula is not covered. DMAS will reimburse for medically necessary formula and medical foods when used under physician direction to augment dietary limitations or provide primary nutrition to individuals via enteral or oral feeding methods.

Medical formula and nutritional supplements must be physician recommended to correct or ameliorate a health condition that requires specialized formula and medical foods to supplement diet due to metabolic limitations or provide primary nutrition to individuals via enteral or oral feeding methods. Enrollees under the age of 5 may receive medical formula and nutritional supplements through either a local WIC office or a DMAS-enrolled DME provider. If the individual is enrolled in the WIC program, they also receive nutrition education services and checkups as well as referrals to other services that can help the

family. Individuals enrolled in Medicaid may already financially qualify for WIC. When a local WIC office provides the formula for children under the age of 5 then the WIC program forms are used to document medical necessity.

Please refer to the *Durable Medical Equipment & Supplies* provider manual for additional information.

Other related programs
Special Supplemental Nutrition Program for WIC
WIC is a supplemental food and nutrition education program that provides vouchers for the purchase of specific nutritious foods and provides nutrition counseling to pregnant, postpartum, or breastfeeding women and children under age 5 with nutritional and financial needs. PCPs and EPSDT screening providers must refer Medicaid-eligible individuals in these categories to the local health department for additional information and eligibility determination.

Head Start
Head Start is a federally funded pre-school program, which serves low-income children and their families.

There are four major components in Head Start as follows:

- Education — Head Start's education program is designed to meet the individual needs of each child. It also aims to meet the needs of the community served and its ethnic and cultural characteristics
- Health — Head Start emphasizes the importance of early identification of health problems. Since many children of low-income families have never seen a doctor or dentist, Head Start provides every child with a comprehensive health care program, including medical, dental, mental health, and nutritional services. The comprehensive EPSDT screening will meet the requirements of the Head Start Program health assessment
- Parent Involvement — Parents are the most important influence on a child's development. Parents are encouraged to participate in the Head Start program as volunteers or paid staff as aides to teachers and other staff members. Many parents serve as members of policy councils and committees and have a voice in administrative and managerial decisions;
- Social Services — The social services component of Head Start represents an organized method of assisting families to assess their needs, and then providing those services that will build on the individual strengths of families to meet those needs. Some of the activities that the social services staff use to assist families to meet their needs are: community outreach; referrals; family needs assessments; providing information about available community resources and how to obtain and use them; recruitment and enrollment of the children; and emergency assistance and/or crisis intervention.

Early Intervention Program
Early intervention services are identified in the *Part C* amendment to the individuals with early intervention services are identified in the *Part C* amendment to the *Individuals with Disabilities Education Act (IDEA)*. *Part C* provides for a discretionary grant program for states to plan, develop and implement a statewide, comprehensive, coordinated, interagency system of early intervention services to infants and toddlers with disabilities and their families.

Infant and Toddler Connection of Virginia/DMAS Early Intervention Program
The Infant and Toddler Connection of Virginia assists families of infants and toddlers with developmental delays and/or disabilities to help their children learn and develop through everyday

activities and routines so that they can participate fully in family and community activities. Since there are no income limits for this program, all children who meet the early intervention eligibility criteria and who are under the age of 3 are eligible to receive early intervention services. In order to take advantage of the services and supports available, families need to know about the system and how to access these resources. More information can be found about the Infant & Toddler Connection of Virginia at **http://www.infantva.org**.

Who is eligible for the Infant and Toddler Connection of Virginia?

- **Infants and toddlers with 25% or greater delay in one or more developmental area(s):** Cognitive, adaptive, receptive or expressive language, social/emotional, fine motor, gross motor, vision, hearing development
- **Infants and toddlers with atypical development- as demonstrated by atypical/questionable:** Sensory — motor responses, social-emotional development, or behaviors or impairment in social interaction and communication skills along with restricted and repetitive behaviors
- **Infants and toddlers with a diagnosed physical or mental condition that has a high probability of resulting in developmental delay:**
  For example, cerebral palsy, Down syndrome or other chromosomal abnormalities, central nervous system disorders, effects of toxic exposure, failure to thrive, etc.

Instructions about how to refer children to the Infant and & Toddler Connection may be found online at: **http://www.infantva.org/documents/pr-ReferralGuide.pdf**.

The referral form for the Infant & Toddler Connection can be found online at:
http://www.infantva.org/documents/forms/3094eEI.pdf.
For more information, contact:

Infant & Toddler Connection of Virginia
DBHDS, 9th Floor 1220 Bank Street
P.O. Box 1797
Richmond, VA 23218-1797
804-786-3710; **804-371-7959** Fax
www.infantva.org

Smart Beginnings

Virginia's plan for Smart Beginnings brings together the public agencies, private agencies and organizations that support Virginia's children and families to ensure that these efforts are both effective and well-coordinated. The purpose of Virginia's plan for Smart Beginnings is to build and sustain a system in Virginia to support parents and families as they prepare their children to arrive at kindergarten healthy and ready to succeed. More information regarding this program can be found at **www.smartbeginnings.org**.

Provider screening requirements

All providers must now undergo a federally mandated comprehensive screening before their application for participation or contract is approved by the MCOs, Behavioral Health Services Administrator (BHSA), a DMAS contracted Duals/Medicare-Medicaid Plan (MMP) or DMAS. Screening is also performed on a monthly basis for any provider who participates with Virginia Medicaid. A full screening is also conducted at time of revalidation, in which every provider will be required to revalidate at least every five years. The required screening measures are in response to directives in the standards established by *Section 6401(a)* of the *Affordable Care Act* (*ACA*) in which CMS requires all state Medicaid agencies to implement the provider enrollment and screening provisions of the *ACA* (*42 CFR 455 Subpart E*). These regulations were published in the *Federal Register*, *Vol. 76*, February 2, 2011,

and were effective March 25, 2011. The required screening measures vary based on a federally mandated categorical risk level. Providers categorical risk levels are defined as *limited*, *moderate* or *high*.

Limited risk screening requirements
The following screening requirements will apply to limited risk providers:

- Verification that a provider or supplier meets any applicable federal regulations, or state requirements for the provider or supplier type prior to making an enrollment determination
- Verification that a provider or supplier meets applicable licensure requirements
- Federal and state database checks on a pre- and post-enrollment basis to ensure that providers and suppliers continue to meet the enrollment criteria for their provider/supplier type and that they are not excluded from providing services in federally funded programs.

Moderate risk screening requirements
The following screening requirement will apply to moderate risk providers:

- Unannounced pre- and/or post-enrollment site visits in addition to those screening requirements applicable to the limited risk provider category listed above.

The screening requirements listed in this section are to be performed at the time of initial enrollment and at the time of revalidation, which is at least every five years.

High risk screening requirements
In addition to those screening requirements applicable to the limited and moderate risk provider categories listed above, providers in the high-risk category may be required to undergo criminal background check(s) and submission of fingerprints. These requirements apply to owners, authorized or delegated officials or managing employees of any provider or supplier assigned to the *high* level of screening. At this time, DMAS is awaiting guidance from CMS on the requirements of criminal background checks and fingerprints. All other screening requirements excluding criminal background checks and fingerprints are required at this time.

Application fees
All newly enrolling (including new locations), re-enrolling, and reactivating institutional providers who are enrolling with DMAS or the BHSA and meet the provider types are required to pay an application fee set forth in *Section 1866(j)(2)(C)* of the *Social Security Act* and *42 CFR 455.460*. If a provider class type is required to pay an application fee, it will be outlined in the Virginia Medicaid web portal provider enrollment paper applications, online enrollment tool, and revalidation process. Providers should refer to the specific MCOs and MMPs for any additional requirements. CMS determines what the application fee is each year. This fee is not required to be paid to Virginia Medicaid if the provider has already paid the fee to another state Medicaid program or Medicare or has been granted a hardship approval by Medicare.

Providers may submit a hardship exception request to CMS. CMS has 60 days in which to approve or disapprove a hardship exception request. If CMS does not approve the hardship request, then providers have 30 days from the date of the CMS notification to pay the application fee or the application for enrollment will be denied. An appeal of a hardship exception determination must be made to CMS as described in *42 CFR 424.514*.

Out-of-state provider enrollment requests
Providers that are located outside of the Virginia border and require a site visit as part of the *ACA* are required to have their screening to include the passing of a site visit previously completed by CMS or their state's Medicaid program prior to enrollment in Virginia Medicaid. If your application is received prior to the completion of the site visit as required in the screening provisions of the *ACA* (*42 CFR 455 Subpart E*) by the entities previously mentioned above, then the application will be rejected.

Revalidation requirements
All providers will be required to revalidate at least every three years. The revalidation of all existing providers will take place on an incremental basis and will be completed via the contracted MCO, MMP, the BHSA or DMAS. Providers will receive written instructions from the MCOs, MMPs, the BHSA or DMAS regarding the revalidation process, revalidation date and the provider screening requirements in the revalidation notice. If a provider is currently enrolled as a Medicare provider, the MCOs, MMPs, BHSA and DMAS may rely on the enrollment and screening facilitated by CMS to satisfy the provider screening requirements.

Ordering, referring and prescribing (ORP) providers
Code of Federal Regulations 455:410(b) states that state Medicaid agencies must require all ordering or referring physicians or other professionals providing services under the state plan or under a waiver of the plan to be enrolled as participating providers.

The *ACA* requires ordering, referring, and prescribing providers to enroll only to meet new *ACA* program integrity requirements designed to ensure all orders, prescriptions or referrals for items or services for Medicaid beneficiaries originate from appropriately licensed practitioners who have not been excluded from Medicare or Medicaid. The only exception to this requirement is if a physician is ordering or referring services for a Medicaid beneficiary in a risk-based managed care plan, the provider enrollment requirements are not applicable to that ordering or referring physician.

If a provider does not participate with Virginia Medicaid currently but may order, refer or prescribe to Medicaid members, the provider must now be enrolled to ensure claims will be paid to the servicing provider who is billing for the service. As a servicing provider, it is essential to include the NPI of any ORP on all claims to ensure the timely adjudication of claims.

Participation requirements
All providers enrolled in the Virginia Medicaid program must adhere to the conditions of participation outlined in their *Participation Agreements*/contracts, provider contracts, manuals, and related state and federal regulations. Providers approved for participation in the MCOs, MMPs and BHSA provider network must perform the following activities as well as any others specified by DMAS:

- Immediately notify DMAS, the MCOs, MMPs and the BHSA in writing whenever there is a change in the information that the provider previously submitted. For a change of address, notify DMAS, the MCOs, MMPs and the BHSA prior to the change and include the effective date of the change; Once a healthcare entity has been enrolled as a provider, it shall maintain, and update periodically as DMAS, the MCOs, MMPs and the BHSA require, a current *Provider Enrollment Agreement* for each Medicaid service that the provider offers.
- Use the MCOs, MMPs, BHSA and DMAS designated methods for submission of charges;
- Assure freedom of choice to individuals in seeking medical care from any institution, pharmacy, or practitioner qualified to perform the service(s) required and participating in Medicaid at the time the service is performed.

- Comply with *Title VI* of the *Civil Rights Act of 1964*, as amended (*42 U.S.C. §§ 2000d* through *2000d-4a*), which requires that no person be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance on the grounds of race, color, or national origin.
- Provide services, goods, and supplies to individuals in full compliance with the requirements of the *Rehabilitation Act of 1973*, as amended (*29 U.S.C. § 794*), which states that no otherwise qualified individual with a disability shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. The act requires reasonable accommodations for certain persons with disabilities.
- Provide services and supplies to individuals of the same quality and in the same mode of delivery as provided to the general public.
- Charge the MCOs, MMPs, BHSA and DMAS for the provision of services and supplies to individuals in amounts not to exceed the provider's usual and customary charges to the general public.
- Not require, as a precondition for admission, any period of private pay or a deposit from the individual or any other party.
- Accept as payment in full the amount reimbursed by DMAS. *42 CFR § 447.15* provides that a "..State plan must provide that the Medicaid agency must limit participation in the Medicaid Program to providers who accept, as payment in full, the amount paid by the agency". The provider should not attempt to collect from the individual or the individual's responsible relative(s) any amount that exceeds the usual Medicaid allowance for the service rendered. For example: if a third-party payer reimburses $5 of an $8 charge , and Medicaid's allowance is $5 , the provider may not attempt to collect the $3 difference from Medicaid, the individual, a spouse, or a responsible relative. The provider may not charge the MCOs, MMPs, BHSA, DMAS or an individual for broken or missed appointments.
- Accept assignment of Medicare benefits for dual eligible Medicaid-enrolled individuals.
- Accept Medicaid payment from the first day of eligibility if the provider was aware that an application for Medicaid eligibility was pending at the time of admission.
- Reimburse the individual or any other party for any monies contributed toward the individual's care from the date of eligibility. The only exception is when an individual is spending down excess resources to meet eligibility requirements.
- Maintain and retain business and professional records that document fully and accurately the nature, scope, and details of the healthcare provided. In general, such records must be retained for a period of at least five years from the date of service or as provided by applicable state laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved.
- Furnish to authorized state and federal personnel, in the form and manner requested, access to records and facilities.
- Disclose, as requested by DMAS, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of healthcare services to Medicaid members.
- Hold information regarding Medicaid-enrolled individuals confidential. A provider shall disclose information in his/her possession only when the information is used in conjunction with a claim for health benefits or the data is necessary for the functioning of the state agency. DMAS should not disclose medical information to the public.
- Obtain separate provider identification numbers for each physical or servicing location wanting to offer services to Virginia Medicaid recipients.

Provider responsibilities to identify excluded individuals and entities

In order to comply with federal regulations and Virginia Medicaid policy, providers are required to ensure that Medicaid is not paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities. Medicaid payments cannot be made for items or services furnished, ordered, or prescribed by an excluded physician or other authorized person when the person or entity furnishing the services either knew or should have known about the exclusion. This provision applies even when the Medicaid payment itself is made to another provider, practitioner, or supplier that is not excluded, yet affiliated with an excluded provider. A provider who employs or contracts with an excluded person or entity for the provision of items or services reimbursable by Medicaid may be subject to overpayment liability as well as civil monetary penalties.

All providers are required to take the following three steps to ensure federal and state program integrity:

- Screen all new and existing employees and contractors to determine whether any of them have been excluded.
- Search the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG) *List of Excluded Individuals and Entities* (*LEIE*) website monthly by name for employees, contractors and/or entities to validate their eligibility for federal programs.
- Immediately report to the contracted MCOs, MMPs and the BHSA any exclusion information discovered. Such information should also be sent in writing and should include the person or business name, provider identification number (if applicable), and what, if any, action has been taken to date. The information should be sent to:

DMAS
Attn: Program Integrity/Exclusions
600 E. Broad St, Suite 1300
Richmond, VA 23219
or
Emailed to providerexclusions@dmas.virginia.gov

If you have any questions about this communication, call Anthem HealthKeepers Plus, Medallion Provider Services at **800-901-0020** or Anthem CCC Plus Provider Services at **855-323-4687**.