

Reimbursement Policy

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

Policy Number: **G-06049**

Policy Section: **Prevention**

Last Approval Date: **7/21/2025**

Effective Date: **7/21/2025**

Visit our provider website for the most current version of the reimbursement policies. If you are using a printed version of this policy, please verify the information by going to <https://anthem.com/va/provider>.

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member's benefit plan. The determination that a service, procedure, or item is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must also meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence.

Ensure that you use proper billing and submission guidelines, including industry-standard, compliant codes on all claim submissions. Services should be billed with Current Procedural Terminology (CPT®) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, we may:

- Reject or deny the claim.

- Recover and/or recoup claim payment.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

Policy

The health plan allows reimbursement of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program services unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise. Reimbursement is based on the applicable fee schedule or contracted/negotiated rate.

The following EPSDT component services are included in the reimbursement of the preventive medicine Evaluation and Management (E/M) visit (unless they are appended with modifier 25 to indicate a significant, separately identifiable E/M service by the same physician on the same date of service):

- Comprehensive health history
- Comprehensive unclothed physical examination
- Health education
- Nutritional assessment
- Dental screening

The following component services are separately reimbursable from the preventive medicine E/M visit:

- Developmental screening using a standardized screening tool
- Hearing screening with or without the use of an audiometer or other electronic device
- Immunization and administration
- Urinalysis
- Vision screening
- Laboratory tests:
 - Newborn metabolic screening test
 - Tuberculosis test
 - Hematocrit and hemoglobin tests
 - Lead toxicity screening
 - Cholesterol test
 - Pap smear, for sexually active members
 - Sexually transmitted disease (STD) screening, for sexually active members

Providers should follow periodicity guidelines established by the American Academy of Pediatrics and the Centers for Disease Control.

If a provider performs EPSDT services in conjunction with a sick visit, all services are subject to our Preventive Medicine and Sick Visits on Same Day policy.

Claims Requirements

- Provider claims for EPSDT services should include all of the following items:
- EPSDT Special Program Indicator
- EPSDT Referral Indicator Codes, if applicable
- Appropriate diagnosis code(s)
- Appropriate HCPCS code identifying the completed EPSDT service (list in addition to code for appropriate E/M service)
- Appropriate E/M codes for new or established members
- Appropriate procedure code for the component services
- Applicable modifier(s) including the following:
 - **Modifier 25** - required for separate reimbursement of objective hearing screening, lead testing, vision screening, and developmental assessment procedures performed using a standardized screening method on the same date of service as a preventive medicine E/M visit.

Related Coding

Standard correct coding applies.

Policy History

- **07/21/2025** - Review approved and effective: updated claim requirement for modifier 25 by adding 'leading test'
- **06/09/2023** - Review approved and effective: updated policy template; changed modifier 59 to modifier 25 the definition remains the same
- **12/16/2020** - Review approved
- **12/21/2018** - Review approved and effective: updated policy language to allow separate reimbursement for hearing and vision screenings
- **06/06/2016** - Review approved
- **11/01/2013** - Initial approval and effective

References and Research Materials

This policy has been developed through consideration of the following:

- American Academy of Pediatrics
- Centers for Disease Control
- CMS
- State contract
- State Medicaid

Definitions

General Reimbursement Policy Definitions

Related Policies and Materials

- Modifier Usage
- Modifiers 25 and 57: Evaluation and Management with Global Procedures
- Preventive Medicine and Sick Visits on the Same Day
- Vaccines for Children (VFC) Program

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