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

Medicaid well-child visits (Child Health Check-Up Visits)

This communication applies to the Medicaid programs for Simply Healthcare Plans, Inc. (Simply) and Clear Health Alliance (CHA).

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Medicaid Managed Care

EPSDT basics

What is Early and Periodic Screening, Diagnosis and Treatment (EPSDT)?
It is a set of comprehensive and preventive health examinations provided on a periodic basis for children/adolescents. In Florida, this program is also known as Child Health Check-Up (CHCUP):

- Early: Assessing and identifying problems early
- Periodic: Checking children's health at periodic, age-appropriate intervals
- Screening: Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems
- Diagnostic: Performing diagnostic tests to follow up when a risk is identified
- Treatment: Control, correct or reduce health problems found

Who is eligible?
Children/adolescents under age 21 who are enrolled in Medicaid

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EPSDT services

EPSDT is made up of the following screening, diagnostic, and treatment services.

Screening services:

- Comprehensive health and developmental history:
  - Developmental and behavioral screening — Periodic developmental and behavioral screening during early childhood is essential to identify possible delays in growth and development, when steps to address deficits can be most effective.
- Comprehensive unclothed physical exam.
- Appropriate immunizations (according to the Advisory Committee on Immunization Practices).
- Laboratory tests (including lead toxicity screening):
  - While substantial environmental improvements have been made to reduce exposure to lead, there are still over four million children estimated to reside in housing where they are exposed to lead.
- Health education (anticipatory guidance including child development, healthy lifestyles, and accident and disease prevention).

EPSDT services (cont.)

Vision services:

- At a minimum, diagnosis and treatment for defects in vision, including eyeglasses. Vision services must be provided according to a distinct periodicity schedule developed by the state and at other intervals as medically necessary.

Dental services:

- At a minimum, dental services include relief of pain and infections, restoration of teeth, and maintenance of dental health. Dental services may not be limited to emergency services. Each state is required to develop a dental periodicity schedule in consultation with recognized dental organizations involved in child health.

Hearing services:

- At a minimum, hearing services include diagnosis and treatment for defects in hearing, including hearing aids.

EPSDT services (cont.)

Other necessary healthcare services:

- States are required to provide any additional healthcare services that are coverable under the federal Medicaid program and found to be medically necessary to treat, correct, or reduce illnesses and conditions discovered, regardless of whether the service is covered in a state's Medicaid plan. It is the responsibility of states to determine medical necessity on a case-by-case basis.

Diagnostic services:

- When a screening examination indicates the need for further evaluation of an individual's health, diagnostic services must be provided. Necessary referrals should be made without delay and there should be follow-up to ensure the enrollee receives a complete diagnostic evaluation.

Treatment:

- Necessary healthcare services must be made available for treatment of all physical and mental illness.

Medicaid well-child visits (CHCUP Visits)

Well-child visits (CHCUP Visits) include preventive and comprehensive services for eligible children birth through 20 years of age and children in the Medicaid program.

Available services:	Eligible children and young adults should have a health check-up:
• Regular physical exams • Growth measurements • Immunizations (shots) • Vision and hearing screenings • Dental screenings • Other important tests and services • Referral for diagnosis and treatment, if necessary	• At birth. • Three to five days for newborns discharged in less than 48 hours after delivery. • By 1 month of age. • At 2 months of age, 4 months of age, 6 months of age, 9 months of age, 12 months of age, 15 months of age, 18 months of age, 24 months of age, and 30 months of age. • Once every year from ages 3 to 20. Well-child visits can be completed at other times if the child needs it.

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EPSDT and HEDIS Child and Adolescent Well-Care Visits (W30, WCV)

Well-child visits are a good proxy for an EPSDT screening because EPSDT screenings are generally conducted as part of a well-child visit.

These measures are part of the Healthcare Effectiveness Data and Information Set (HEDIS®) developed and maintained by the National Committee for Quality Assurance (NCQA).

Well-Child Visits in the First 30 Months of Life (W30) — Members who had the following number of well-child visits with a PCP during the last 15 months:

- Well-child visits in the first 15 months (six visits)
- Well-child visits for age 15 to 30 months (two visits)

Child and Adolescent Well-Care Visits (WCV) — Members who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year (ages 3 to 21)

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EPSDT reporting period and goals

EPSDT performance measures and goals:

- **90-day screening ratio** — At least 80% of all expected initial or periodic screenings services for members enrolled in the plan for at least 90 continuous days should be completed according to the state's periodicity scheduled.
- **Participation ratio** — At least 80% of eligible members (90 days of continuous enrollment) should receive at least one initial or periodic screening service during the year.
- **8-month screening ratio** — At least 80% of all expected initial or periodic screenings services for members enrolled in the plan for at least eight continuous months should be completed according to the state's periodicity scheduled.

Federal fiscal year starts October 1 and ends September 30 of the following calendar year:

- Services must be provided from October 1 to September 30 of the measurement year.
- Only claims received on or before December 31 will count if they are correctly coded.

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EPSDT coding requirements

Option one — initial or periodic screening

Evaluation or reevaluation and management of an individual, including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures

New patient	Established patient
99381 — infant (age younger than 1 year)	99391 — infant (age younger than 1 year)
99382 — early childhood (age 1 through 4 years)	99392 — early childhood (age 1 through 4 years)
99383 — late childhood (age 5 through 11 years)	99393 — late childhood (age 5 through 11 years)
99384 — adolescent (age 12 through 17 years)	99394 — adolescent (age 12 through 17 years)
99385 — modifier EP (18 to 20 years)	99395 — modifier EP (18 to 20 years)

Referral codes

V — Patient refused referral

U — Patient not referred

2 — Abnormal, treatment initiated

T — Abnormal, patient referred

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EPSDT coding requirements (cont.)

Option two — Evaluation and Management (E&M) codes with diagnosis codes

Office visits with E&M codes may be used but to be counted for a well-child visit, one of the following CPT® codes must be paired with one of the following Z (diagnosis) codes:

New patient — office or other outpatient visit for the evaluation and management of a new patient, which requires three key components:

- **99202** (typically 20 minutes face-to-face)
- **99203** (typically 30 minutes face-to-face)
- **99204** (typically 45 minutes face-to-face)
- **99205** (typically 60 minutes face-to-face)

Established patient — office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of three key components:

- **99213** (typically 15 minutes face-to-face)
- **99214** (typically 25 minutes face-to-face)
- **99215** (typically 40 minutes face-to-face)

- **Z76.1:** Health supervision of infant or child (health supervision and care of foundling)
- **Z76.2:** Encounter for health supervision and care of healthy infant and child
- **Z00.121:** Encounter for routine child health exam with abnormal findings
- **Z00.129:** Encounter for routine child health exam without abnormal findings; newborn health supervision
- **Z00.110:** Health examination for newborn under 8 days old
- **Z00.111:** Health examination for newborn 8 to 28 days old
- **Z00.00, Z00.01:** Routine general medical examination at a health care facility
- **Z02.0, Z02.2, Z02.4, Z02.5, Z02.6, Z02.82, Z02.89:** Other general medical examination for administrative purposes
- **Z02.81, Z02.83:** Examination for medicolegal reason
- **Z02.1, Z02.3, Z02.89:** Health examination of defined subpopulations
- **Z00.8:** Health examination in population surveys
- **Z00.6:** Examination of participant in clinical trial
- **Z00.5, Z00.70, Z00.71, Z00.8** Other specified general medical examinations
- **Z00.8** Unspecified general medical examination

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Sick visits and well-child visits

- **Can be billed on the same day**
- **Documentation must support that both services were provided:**
  - For example, if a child is present for a problem-oriented visit and is behind/due for their well-child exam, it is appropriate to perform and report a well-child exam, codes 99381 to 99395, in addition to the acute visit, codes 99201 to 99215, if all E&M requirements are met.
- **Payment guidelines related to preventive visits:**
  - The plan will pay for both a new/established patient E&M and a new/established patient preventive visit for the same member on the same date of service if the diagnosis codes billed support payment of both codes.
  - Providers must bill the correct diagnosis codes and bill the new/established patient E&M with modifier 25 to ensure accurate payment.
  - Modifier 25 is defined as a significant, separately identifiable E&M service by the same physician or other qualified healthcare professional on the same day of the procedure or other service.

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EPSDT interventions

- EPSDT distribution of educational information — Relevant plan and EPSDT information is distributed upon enrollment to new and established members, including a new member ID card, Healthy Behaviors brochure, monthly letters and invitations emphasizing the importance of well-child visits, key elements of a well-child visit, and the periodicity schedule in order to encourage participation.
- Corporate sends out reminders for EPSDT as follows:
  - **Birthday reminders** — These are sent to members annually as reminders of services needed.
  - **90-day reminders** — These are sent after the birthday reminders to again remind members to get in for services.
  - **Provider letters** — These are sent to the provider the member is assigned to with a list of members who are overdue for services.
  - **Co-branding program** — Corporate initiative in which reminders include the plan and PCP logos and/or information. Consent from provider is required.

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EPSDT interventions (cont.)

Quarterly EPSDT training is provided to all staff including care coordination, member services, and provider services representatives in order to improve knowledge and increase understanding of EPSDT measures and interventions.

CHA outreach for EPSDT — All members are called upon enrollment by the **Member Outreach team** or their assigned care coordinator:

- Care coordinators educate members/guardians on the importance of well-child visits and invite them to participate in the **Well-Child Healthy Behaviors Program**.
- Members are offered assistance in scheduling well-child visits, coordination of transportation services, and home medical visits as needed.
- **Corporate outreach website** is used for tracking outreach activities.

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EPSDT interventions (cont.)

Targeted outreach based on area of service, membership volume, and rates.

Act now — Care coordinators block time on their schedule on a weekly basis to follow up exclusively with EPSDT current eligible noncompliant members.

Care management home visits — Care coordinators conduct home visits to members unable to be reached by phone or mail. Members are provided with assistance with coordination of services, including scheduling well-child visits, enrollment in the Well-Child Healthy Behaviors Program, transportation services, and home medical visits as needed.

EPSDT interventions (cont.)

Medical home visits — Care coordinators assist members coordinating medical home visits when needed. In collaboration with the medical home visits vendor, the plan has established a warm transfer phone line to improve timely access and coordination of well-child visits.

Panel age verification — Collaborative effort between Quality Management, Care Coordination, and Community Relations to regularly share with providers a list of members assigned to their practice, verify any age-related limitations, and emphasize the importance of scheduling services following guidelines and periodicity schedule.

EPSDT interventions (cont.)

Data analysis and system optimization — Quality Management generates a year-to-date *CMS416* report weekly for all measures. The plan has established weekly collaborative meetings with representatives from each department to discuss any concerns regarding meeting established thresholds, barriers, and root causes as well as strategies to stimulate improvement.

HIV negative membership — Care Coordination identifies HIV negative members, and a designated care coordinator assists scheduling well-child health visits and coordination of transportation services as needed. Every member is educated that they are in a specialty plan for HIV+ people and provided choice counseling information in case they wish to change plans.

Resources

Periodicity schedule 2021 — *Recommendations for Preventive Pediatric Health Care*
Bright Futures/American Academy of Pediatrics

PERIODICITY
ıEDULE 2021.indd.

Coding for Pediatric Preventive Care 2021
Bright Futures/American Academy of Pediatrics

CODING
Γ 2021 - INTERIOR

Well-Child Visits Coding Requirements

SFLPEC-1793-19
l-Child Coding Rec

Provider Bulletin: *Healthy Rewards™ Healthy Behaviors Program Information*

Healthy Rewards
ıthy Behaviors Pro

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Healthy Rewards/Healthy Behaviors

Maternal child		
Code	**Description**	**Gift card**
MCS 1 Maternity Visit	Member attends first prenatal visit within first trimester, or within 42 days of joining the plan	**$20**
	Member attends at least 6 prenatal visits during the pregnancy	**$20**
MCS 2 Postpartum Visit	Member attends a postpartum follow up visit between 7 and 84 days after delivery	**$20**
MCS 3	**Birth–15 months** Take child to doctor for at least 6 newborn visits	**$20**
	15 months–23 months Take child to their doctor for 1st well child visit	**$20**
	15 months–23 months Take child to their doctor for 2nd well child visit	**$20**

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Healthy Rewards/Healthy Behaviors

Well-child visit		
Code	**Description**	**Gift card**
WCV2-1	See doctor for one well-child visit	**$20**
WCV2-2	See doctor for all shots recommended for child's age	**$50**
WCV2-3	Get flu shot	**$20**
WCV2-4	Take child for the full HPV vaccination series	**$50**

Members must enroll in programs and complete milestones to become eligible for gift cards.

Please refer members to enroll through one of the following options:

- Visit their member website, log in, and access the **Benefits Reward Hub**:
  - Simply members: **https://www.simplyhealthcareplans.com/florida-medicaid/home.html**
  - CHA members: **https://www.clearhealthalliance.com/florida/home.html**

- Call to enroll at **888-990-8681** (**TTY711**) Monday through Friday from 9 a.m. to 8 p.m. ET

Provider Bulletin: ***Healthy Rewards™ Healthy Behaviors Program Information***

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Key takeaways

- Federal fiscal year starts October 1 and ends September 30 of the following calendar year.
- Services must be provided from October 1 to September 30 of the measurement year.
- Only claims received on or before December 31 will count if they are correctly coded.
- Sick visits and well-child visits can be billed the same day:
  - Documentation must support both services.
  - Providers must bill the correct diagnosis codes and bill the new/established patient E&M with modifier 25 to ensure accurate payment.

Performance goals

- 80% of eligible members should complete expected initial or periodic screenings.
- 80% of eligible members should receive at least one initial or periodic screening.
- 80% of members continuously enrolled for more than eight months should complete expected initial or periodic screenings services.

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Questions

Thank you

https://provider.simplyhealthcareplans.com | https://provider.clearhealthalliance.com

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